GETTING IT, TOGETHER: HOW THE NURSE/PATIENT RELATIONSHIP INFLUENCES TREATMENT COMPLIANCE FOR PATIENTS WITH SCHIZOPHRENIA

by

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ABSTRACT

Schizophrenia is a life-altering illness that affects 1% of the population worldwide. Engaging the patient with schizophrenia in treatment, both psychosocial and biological, is problematic despite the use of a myriad of treatment interventions that demonstrate mixed results. Consensus by researchers is a need for a strong positive individual relationship between providers and patients. The caseloads of nurses in community mental health centers include patients with schizophrenia. Nurses have accepted the position of healthcare promotion and illness prevention for this group of patients. Nurses have a need to understand which interventions to use in order to promote treatment compliance for patients with schizophrenia in different manifestations of the illness.

The present research study, using grounded theory, provides a model of the nursing process identifying those aspects of the nurse/patient relationship that influence treatment compliance. Identified are the processes nurses in community mental health centers use to make decisions regarding (a) which interventions to use with different manifestations of schizophrenia and (b) how nurses make decisions regarding follow-up visits. Five expert nurses and 15 patients participated in the study. Patients from three levels of compliance were interviewed by each of the nurses. Data collection included participant observation of the nurse/patient interaction, field notes, memos, demographic questionnaires, interviews with the
nurses postobservation, and a secondary literature review. The data were analyzed systematically, as they were collected by constant comparative analysis, where newly acquired data and previously collected data were continuously compared with one another.

The grounded theory research investigation identified a substantive theory; this theory was supported by the data. The basic social process of *getting it, together*, the core category of *knowing*, and the supporting categories of *socializing, normalizing, and celebrating* were introduced and discussed with the supporting field data.
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CHAPTER 1

INTRODUCTION

Problem Statement

There is no magic answer that will eliminate the tragedy of mental illness. . . . I found that any gains I made were consolidated in community treatment, where mentally ill individuals are treated as people with strengths and weaknesses instead of mental patients who can never improve. (Leete, 1987, pp. 490-491)

Schizophrenia is a mental illness that affects 1% of the population worldwide (Provencher, Fournier, & Dupuis, 1997). The National Institute of Mental Health (2001) reported that approximately 2.2 million or 1.1% of adults 18 years and older in the United States annually have a diagnosis of schizophrenia. The treatment of schizophrenia has been a major area for research worldwide. For the past 30 years, one of the foremost concerns in schizophrenia research is patient treatment compliance. Researchers have found low compliance rates, both medical and psychosocial therapies, with prescribed treatment. Patient compliance with treatment continues to be a major challenge for patients, clinicians, researchers, and administrators. Noncompliance with prescribed therapy for patients with schizophrenia has the potential for a number of significant problems with implications of poor outcomes for the health and benefit of patients. When patients are not compliant with treatment, clinicians and researchers are diminished in their ability to assess the benefit of treatment, whereas administrators have significant
issues with decision making regarding the effective use of resources (Evangelista, 1999). Much has been postulated regarding the provider/patient relationship as to the benefit of increasing treatment compliance for patients with schizophrenia, but no clear research data are available to understand the impact of the nurse/patient relationship in improving compliance behaviors.

Schizophrenia is often a persistent and pervasive illness with life-altering symptoms that affect a broad range of cognitive and conceptual systems. The clinical presentation of schizophrenia delineates the debilitating nature of this disorder, including positive, negative, and neurocognitive symptoms. Positive symptoms are exhibited as delusional ideation, thought disorder, disorganization, and auditory and visual hallucinations. Negative symptoms are frequently most problematic and consist of social withdrawal, poverty of thought, apathy, and diminished self-care. The neurocognitive dysfunction is identified by decreased executive function, perceptual difficulties, and selective inattention (Weight & Bigler, 1998).

The annual cost of schizophrenia in the United States has been estimated at $95 billion (Wyatt, Henter, Leary, & Taylor, 1995). The direct costs, those related to treatment such as inpatient or outpatient care, have been estimated at $49 billion. The indirect costs, those costs related to lost wages or work due to increased symptoms or suicide, have been estimated at $46 billion (Wyatt et al., 1995). Treatment failure or noncompliance can result in an increase of devastating symptoms for patients. An increase in symptoms can produce a disruption in
patients’ social and personal lives as well as economic burdens for them and for the community.

Engaging patients with schizophrenia in treatment is problematic despite the use of a myriad of medications and treatment interventions that may provide varying effects. Most recently, providers have increasingly used a new classification of medications: atypical antipsychotics. This classification of medications has shown greater efficacy treating the negative and cognitive symptoms of schizophrenia as well as a more favorable side-effect profile than typical antipsychotic medications (Aquila, Weiden, & Emanuel, 1999). However, no relationship to improve treatment compliance has been found with the use of atypical antipsychotic medications (Mauskopf, David, Grainger, & Gibson, 1999). Patients with schizophrenia taking atypical antipsychotic medications are no more likely to be compliant with these medications than those who are prescribed typical antipsychotics.

Treatment compliance has been defined as the degree to which a patient’s behavior is consistent with medical and health counsel or the patient’s acceptance of recommended health behaviors (Davidhizar, 1982; Evangelista, 1999; McPhillips & Sensky, 1998). McPhillips and Sensky (1998) further reiterated that it is impossible to abandon the term treatment compliance for patients with schizophrenia. Compliance is an encompassing term for an approach to a serious, chronic, and frequently disabling illness that generally lacks a significant degree of insight or acceptance by the patient. The approach to patient treatment compliance
is complex and has many medical and psychosocial variables. Patients are viewed by healthcare providers as active participants in their own healthcare. Agreement with regard to healthcare interventions between the healthcare provider and the recipient of care is an important component in the development of a healthcare plan or healthcare regimen. A trusting relationship between the nurse and the patient based on cooperation and support is believed to be the foundation of compliance (Evangelista, 1999).

A concept similar to compliance is adherence. Some dispute has surfaced about whether or not patients following medical advice should be called compliant or adherent (Corrigan, Liberman, & Engel, 1990; Davidhizar, 1982; Evangelista, 1999; Kampman & Lehtinen, 1999; Lund & Frank, 1991). Historically, most researchers have used the term compliance. Since the early literature refers to compliance, researchers relate that it is better to continue with the same terminology. However, other researchers believe that the term compliance is too forceful and that adherence should be used. The concept of compliance, as described by McPhillips and Sensky (1998), views the patient with schizophrenia as part of a complex social process. The importance of the nurse/patient negotiation and agreement in developing a plan of care is emphasized. Patients are not viewed as passive recipients of care by the nurse. The concept of compliance endorses that nurse/patient relationships can mobilize patients to operate as partners in treatment and share with their nurses the responsibility to comply with prescribed treatment (Kampman & Lehtinen, 1999).
Compliance among patients treated for schizophrenia in community mental health centers remains poor. Estimates are that from 15% to 48% of patients with schizophrenia will become noncompliant within the first year of treatment (Corrigan et al., 1990; Kissling, 1997). Repeatedly, studies have found that patients referred from an inpatient psychiatric hospitalization to outpatient follow-up care would not attend the initial outpatient visit. The failure rate for new patients can be as high as 46% (Sharma, Elkins, van Sickle, & Roberts, 1995).

Compliance rates for patients taking medications have fared no better. From 25% to 94% of patients in outpatient clinics do not take their medications as prescribed (Corrigan et al., 1990; Davidhizar, 1982). Medication compliance is difficult to measure since there are many ways patients may not follow clinicians' recommendations. Problems that occur in an outpatient setting include taking nonprescription drugs, making mistakes in dosage, making self-changes in dosage, omitting a particular medication, or stopping medication (Kane, 1985; McPhillips & Sensky, 1998).

The compliance of patients with schizophrenia in the community mental health center not only relates to taking medications but also relates to the overall treatment plan. Compliance includes scheduled treatment programs, medication clinics, group therapy, partial day care, and psychosocial rehabilitation programs that the patient may or may not attend. Nonparticipation by the patient with any part of the treatment plan is considered noncompliance.
No single treatment intervention for schizophrenia has been effective in improving the multiple symptoms and disabilities associated with schizophrenia. Researchers have found that the relationship developed by clinicians working with patients with schizophrenia has the greatest value in influencing treatment compliance (Fenton, 2000). Researchers agree that there is a need for a strong positive individual relationship with patients. Most notably, Streicker, Amdur, and Dincin (1986) concluded that, of all the factors analyzed and benefits gained from educational interventions used to enhance treatment compliance, all could be eclipsed by poor provider/patient relations. Sharma and colleagues (1995) reported that the influence of the therapeutic relationship on treatment compliance deserves further study. Individual interactions with patients rather than group programs seem to provide an increased benefit of understanding patients' needs over time and thereby of influencing treatment compliance. A variety of patients' beliefs over time about medications and treatments are individual. Treatment interventions to enhance compliance would need to meet patients' individual requirements (Davidhizar, 1987).

Nurses have worked in community mental health centers since their inception (in the 1960s). Patients treated by mental health nurses include those with severe and persistent mental illness, specifically schizophrenia. Patients with schizophrenia are most often the primary treatment responsibilities of mental health nurses in conjunction with other members of the healthcare team. Mental health nurses continue to accept the position of providers of healthcare promotion and
illness prevention for this group of patients. Mitchell (1997) reiterated that nurses are committed to providing individualized care that respects patients' choices. Yet, nurses may need to help people understand information, given patients' own personal meanings and expectations. Nurses make decisions as a result of interacting individually with each patient. Therefore, mental health nurses must understand issues of compliance from the patients' perspectives. Nurses must also comprehend and practice current treatment interventions that foster treatment compliance.

Treatment noncompliance is an issue in all areas of psychiatric illness. However, specific inquiry is lacking. How does the nurse/patient relationship affect this issue? Nursing decision making with patients with schizophrenia cannot be adequately understood without systematically studying the process of the nurses' practices. The study of the nurse/patient relationship in the context of the outpatient clinic visit needs to be evaluated and effectively interpreted. The analysis needs to include a description of (a) how nurses decide to provide care in an effective manner in order to enhance treatment compliance and (b) what problems nurses encounter to provide care and their efforts to solve these problems.

**Purpose of the Study**

The purpose of this study was to understand the processes used by nurses in an outpatient community mental health clinic to develop a nurse/patient relationship that promotes treatment compliance for patients with schizophrenia. This study followed a grounded theory approach in which the conceptual framework emerged
from the data by using constant comparative analysis. Substantive theory was
developed for an empirical area of inquiry using constant comparative analysis in
which data were continuously compared with one another (Glaser & Strauss,
1967). Theory of this type is generated by evaluating research that is directly
linked to a practice setting. Examples of substantive theories, using grounded
theory central to nursing research, include research specific to patient care
interventions (Streubert & Carpenter, 1999). Researchers, using grounded theory,
are responsible to accurately describe the basic social processes, phases, and
properties involved within the practice context, thus providing a guide to action
(Strauss & Corbin, 1998).

The major long-term goal of this research study was to bridge the gap
between the current knowledge base of the nurse/patient relationship and the
intervention development for mental health nurses working with patients with
schizophrenia to improve compliance. This grounded theory study moved towards
the discovery of a middle-range theory that was developed around a core category
as it emerged from the data. Middle-range theories have a narrow clinical scope,
focusing on limited concepts and aspects that are grounded in a practice context
(Streubert & Carpenter, 1999). A middle-range theory focuses on understanding a
phenomenon from the complex realm of everyday life in order to understand the
phenomenon of interest. Conclusions from the current study will be used in future
studies to specify how, through the nurse/patient relationship, interventions to
enhance treatment compliance can be used in multiple psychiatric settings.
According to McPhillips and Sensky (1998), existing research methodology to study compliance is fraught with difficulty. First, it is difficult to measure compliance reliably and directly. Second, those who do not comply with treatment are the least likely to volunteer for research projects. Understanding how, through the nurse/patient relationship, individual interventions by nurses can impact compliance may be key to integrating interventions into routine clinical care.

**Study Questions**

The research questions for this study focused attention on understanding the processes of the nurse/patient relationship from the perspectives of nurses working in the community mental health center. The research questions focused on how nurses in the outpatient clinic of the community mental health center impact treatment compliance for patients with schizophrenia. The following question and subquestions guided this research:

1. How does the nurse/patient relationship influence treatment compliance for patients with schizophrenia?
   a. How do nurses make decisions regarding treatment interventions for different manifestations of schizophrenia?
   b. How do nurses make decisions regarding return-for-care (follow-up) visits with patients?

The research questions were open and broad and identified the phenomenon to be studied. The research questions were framed in a manner that was flexible, leading to an in-depth exploration of the process of the nurse/patient relationship
(Strauss & Corbin, 1998).

**Conceptual Framework**

Psychiatric nurses have an extensive history of research pertaining to the nurse/patient relationship. Griffin (1997) related the importance of nurses understanding the world of patients by applying the knowledge gained in each interaction in an emancipatory way in the practice setting. Nurses care about assisting patients. Communications with patients can direct nurses to ask for information from patients regarding their perceptions of care and their concerns. Nurses draw upon the perceptions of their patients for reflexive interpretations of interventions in order to develop useful knowledge and new strategies to manage their practice. Nurses are constantly involved in a social process with their patients and in collaboration with the healthcare team. With each interaction, knowledge is further refined for use in similar situations with other patients or the healthcare team. The process is dynamic and intersubjective (Griffin, 1997; Mitchell, 1997).

**Nursing Theory**

Social interaction between nurses and patients has been a topic of nursing research for more than 40 years. The therapeutic relationship, developed by the nurse/patient interaction, was first identified and introduced by Peplau (1952). This relationship was derived from the interpersonal theory of psychiatry developmental model (Sullivan, 1953). Peplau (1968) described, “[The] aim of nursing care of psychiatric patients is to assist the patient to struggle toward full development of
his [or her] potential for productive living in the community” (p. 14). Peplau further reiterated that nursing is an interpersonal process that focuses on the patient to make “health possible for individuals in communities” (p. 16). Peplau wrote that nurses have an instrumental role in their patients’ processes of changing health-related behaviors through the formation of therapeutic relationships in which common goals are developed. Self-understanding and therapeutic use of self by nurses are emphasized (Forchuk, 1991). By using these experiential learning techniques, nursing care is seen as a maturing and enlightening influence for both the nurse and the patient (Lund & Frank, 1991; Marriner-Tomey, 1994).

Several other nursing theorists have focused on the social process between the nurse/patient. Orlando (1990) identified the nursing process as determining and meeting patients’ immediate needs for help. Nurses are encouraged to explore their own reactions and observations with patients. The reciprocal nature of the relationship between the nurse/patient has been stressed (McCann & Baker, 2001). Travelbee (1971) also described nursing as an interpersonal process that occurs between nurses and an individual or groups of individuals. Nurses assist patients to prevent or cope with illness and suffering and to find meaning in these experiences (Marriner-Tomey, 1994). Riehl (1980) drew from interpersonal nursing theory and social interactionism in order to understand nurse/patient relationships. The focus of the nurse/patient relationship is understanding patient verbal/nonverbal communication. Nurses view the actions of patients as they are perceived. Interaction transpires between nurses and patients who interpret each other’s
actions rather than just responding to them. Nurses continually assess and intervene with patients in a dynamic social process (Marriner-Tomey, 1994).

**Symbolic Interactionism**

Lowenberg (1993) suggested that grounded theory is Glaser and Strauss's (1967) version of the broader sociological school of symbolic interactionism. Grounded theory is a method of inquiry that explores social processes and social interactions. This research methodology explores the richness and variety of being human (Glaser & Strauss, 1967; Streubert & Carpenter, 1999). The philosophical underpinnings of grounded theory are based on the assumptions that individuals learn about and define their world through interactions with others. The grounded theory approach explores social processes that are directly tied to symbolic interactionism.

The goal of grounded theory is to explain how social interactions determine people's behaviors and their purposes in order to understand the phenomenon being studied. Symbolic interactionism postulates that individuals behave and interact with others as they interpret or provide meaning to the specific symbols in their lives. Symbols imply meaning, including verbal expressions, nonverbal behaviors, and dress styles (Blumer, 1969; Glaser & Strauss, 1967). The attribution of meaning is a continual process as well as a product of social interaction within people's communities. Individuals interpret their lives through these meanings and values (Glaser & Strauss, 1967; Streubert & Carpenter, 1999). Basic tenants of symbolic interactionism are based on the view that individuals can be understood in
the context of their environments (Benzies & Allen, 2001).

George H. Mead (1863-1931) is credited with refining the work of many social theorists into an approach to understand human behavior (Benzies & Allen, 2001; Blumer, 1969). Mead taught the concepts of symbolic interactionism for 40 years at the University of Chicago, but he did not publish. Blumer (1969), a student of Mead, published his work and emphasized the interpretive process in the formation of meaning in the richness of the social experience (Benzies & Allen, 2001).

The basic philosophical concepts of symbolic interactionism include the following (Blumer, 1969):

1. Individuals act toward objects on the basis of the meaning that the objects have for them.

2. Meanings held toward these objects or people are developed from interactions that these individuals have experienced.

3. Meanings can be changed and modified only by the constant interpretive process.

4. Socialization is generated by the norms of the community’s values and beliefs.

The social processes of the empirical world are embedded in grounded theory inquiry. The research questions of interest are best understood through individual interpretation of reality in a social context. Symbolic interactionism emphasizes the nature of society along with the recognition that reciprocal social
interaction has influence on the behavior of individuals within society. The acknowledgment that reciprocal social interaction influences behavior has the potential to increase the understanding of human health behaviors and their meanings in a healthcare context. Symbolic interactionism provides a fundamental perspective that can be integrated with other theoretical frameworks and complements other theoretical perspectives currently used in nursing (Benzies & Allen, 2001).

Nursing research is frequently concerned with health behaviors in everyday life. Nursing is particularly concerned with socially shared meanings between patients and caregivers (Lowenberg, 1993). Grounded theory offers a method of investigation applicable to understanding the nurse/patient relationship, as it directly affects treatment compliance for patients with schizophrenia, by recognizing the complexity in the process. Grounded theory is particularly salient to study nursing practice. In other words, each nurse brings his or her own experiences and perceptions to the interaction. Multiple realities need to be considered in order to understand the phenomenon of interest.

Assumptions

1. The patients' insights into their illnesses or attitudes about schizophrenia do not equate with compliance behavior (Cuffel, Alford, Fischer, & Owen, 1996).

2. Noncompliance with psychiatric treatment is global behavior that equally affects people of both genders, all ages, and all social classes (McPhillips
3. Patients as consumers of healthcare continually evaluate their illnesses and treatments and make decisions regarding whether or not to use them (Evangelista, 1999).

4. The beliefs and attitudes of nurses can influence patients’ compliance within the context of the nurse/patient relationship.

5. Nurses in community mental health clinics are in unique positions to evaluate the continuum of treatment compliance (from total refusal to total acceptance) and to provide interventions to enhance/maintain patient compliance.

6. Nurses draw from personal knowledge of mental illness that directly influences their interactions with patients (Raingrubber, 1999).

Significance for Nursing

Nursing research over the past 2 decades has extensively evaluated the experience of living with schizophrenia from the viewpoints of patients and family members. For the past several years, nursing research has shown a characteristic pattern of qualitative inquiries that study patients’ experiences, family/caretaker characteristics or experiences, and identification of symptoms (Fox & Kane, 1998). Of the number of research studies that have been published regarding the nurse/patient relationship, Lego (1999) related that most were published prior to 1973. Frequently, it was difficult to distinguish between the studies of the nurse/patient relationship and milieu therapy, since the two were evaluated together. Although the nurse/patient relationship in psychiatric nursing continues to
be an important research area in providing a foundation upon which further psychiatric nursing theory can be built, no evaluation of the nurse/patient relationship and its impact on treatment compliance has been identified. Lego reported that the number of unanswered questions with regard to what does or should take place in the nurse/patient relationship is overwhelming. Little research has targeted provider/patient relationships, treatment interventions, and the impact on patient treatment compliance (McPhillips & Sensky, 1998). In their review of schizophrenia research, Fox and Kane (1998) related that there continues to be a need to bridge the current knowledge base with interventions that provide a clear direction for improving treatment compliance. Research could be specifically developed for interventions that increase daily coping skills, improve general health status, and heighten the quality of life for patients experiencing symptoms of schizophrenia.
CHAPTER 2

REVIEW OF LITERATURE

Relevant Literature

The present study used a grounded theory design, as described by Glaser and Strauss (1967) and Strauss and Corbin (1998). In this qualitative approach, the researcher does not begin the project with a particular theory to guide the research; rather, the theory emerges from the data. An extensive literature review is not encouraged. Instead, in grounded theory research, the literature is reviewed to explain, support, and extend the theory generated in the study (Burns & Grove, 1997). The intent is to prevent the researcher from forcing conceptual findings into preconceived notions or preexisting conceptual frameworks and to help eliminate biases or judgments. However, before beginning a research study, the researcher must turn to the literature to formulate questions (Strauss & Corbin, 1998). A prestudy of the literature can help develop and formulate the research questions and interview guide.

The literature was specifically reviewed to evaluate the body of research in the area of treatment compliance for individuals with schizophrenia. The literature search was limited to studies available in peer-reviewed published journals through electronic database searches. Databases were explored using the following key search words: (a) treatment, (b) compliance, (c) adherence, (d) symptom
awareness, (e) schizophrenia, (f) attitude, (g) insight, and (h) nurse/patient relationship. Several electronic databases were accessed by the Internet from 1979 to 2001, including PsychINFO, PubMed Medline query, CINAHL, and the Cochrane Library. Meta-analysis articles and articles that described actual treatment interventions with adult patients were reviewed. Family studies were not included unless they were a part of an intervention that dealt directly with patients experiencing schizophrenia. Family members or significant others are often not a part of the adult lives of patients with schizophrenia, leaving this treatment option unavailable to a portion of the patient population. The literature review is organized into descriptive/qualitative studies and quantitative studies.

Descriptive/Qualitative Studies

Thirteen descriptive/qualitative research reports were reviewed and evaluated. Lin, Spiga, and Fortsch (1979) suggested that the original purpose of compliance research for patients with schizophrenia was to investigate the role of insight in compliance to taking prescribed medications. Three other studies described the purposes of their investigations as similar to those of Lin and colleagues but with the inclusion of a variety of demographic correlates (Agarwal, Sharma, Kumar, & Lowe, 1998; Amador et al., 1993; Cuffel et al., 1996). Several authors examined the question of the patients’ attitudes toward taking medications; insight towards psychiatric illnesses; and the relationship between attitude, insight, and a variety of other correlates (Adams & Howe, 1993; Buchanan, 1992; Davidhizar, 1987; Nageotte, Sullivan, Duan, & Camp, 1997;
Ruscher, de Wit, & Mazmanian, 1997; Van Dongen, 1997). Two of the studies used a qualitative approach in order to understand the individual patients’ subjective responses to treatment (Baier & Murray, 1999; Day, Bentall, & Warner, 1996). The questions under study were the following: To what extent do people with schizophrenia experience insight about the illness impact on life? How is insight developed? How does the person find meaning? Does this illness take courage (Baier & Murray, 1999)?

The results from the analysis of these studies were mixed. The relationship between attitude and insight remains unclear (Adams & Howe, 1993; Baier & Murray, 1999; Davidhizar, 1987; Davidhizar, Austin, & McBride, 1986; Day et al., 1996; Nageotte et al., 1997; Ruscher et al., 1997). Most patients had insight for some questions but lacked insight for others. Only between 36% and 45% of the patients describing insight or benefit from treatments or medications actually complied with treatment on a regular basis, leaving between 55% and 64% of the patients as noncompliant (Lin et al., 1979). Insight and attitude did not appear to be large determinants in compliance with treatment. Patients were willing to take medications despite their beliefs that they did not have schizophrenia.

Quantitative Studies

The body of descriptive research led to a multitude of quasi-experimental studies. Lin and colleagues (1979) encouraged increased efforts to educate patients to raise their insights in leading to improved treatment compliance. As with descriptive/qualitative studies, the results of these research interventions provided
little benefit in directing nurses in their efforts to rally patient treatment compliance.

Two major categories of treatment intervention, educational and psychosocial, were measured to evaluate their effects on treatment compliance. Educational interventions included psychotropic medication, schizophrenia education, compliance treatment, and cognitive/behavioral medication training. The following psychosocial approaches were evaluated: (a) family treatment in conjunction with skills training and clinic visits, (b) clubhouse/work rehabilitation, (c) hospital visit by the community therapist to the patient or community group, (d) visit by the patient from the hospital, and (e) psychotherapy (see Appendix A).

Educational Interventions

The medication/schizophrenia educational interventions include structured classes or groups lasting from 30 minutes to 1 hour and ranging from 2 to 20 sessions (Atkinson, Coia, Gilmer, & Harper, 1996; Guimon, 1995; MacPherson, Jerrom, & Hughes, 1996; Streicker et al., 1986). The main goals of these interventions are to increase the patients' awareness of symptoms, to expand their understanding of medications, and to develop a knowledge base regarding possible side effects. Of the four studies, only one found that medication compliance improved (Guimon, 1995) and, in fact, was sustained for 12 months. No further follow-up was provided.

Two studies used a motivational/educational intervention to increase medication compliance (Hayward, Chan, Kemp, Youle, & David, 1995; Kemp &
David, 1996). The medication self-management intervention concentrated on medication adherence and challenged patient views, if they differed, with full compliance. No benefit in compliance was found 1 to 2 months postintervention.

An educational intervention (medication management module), designed by the Rehabilitation Service, Brentwood Veterans Administration Medical Center, UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation, was evaluated by seven research teams (Eckman, Liberman, Phipps, & Blair, 1990; Favrod, 1993; Hornung, Kieserg, Feldmann, & Buchkremer, 1996; Hornung, Klingberg, Feldmann, Schonauer, & Monking, 1998; Kuipers, Bell, Davidhizar, Cosgray, & Fawley, 1994; Schwartz, Cohen, & Grubaugh, 1997; Smith et al., 1997). This intervention was widely distributed in conjunction with McNeil Pharmaceuticals. The manual provides skill training in four areas. Study results were mixed. Eckman and colleagues (1990) and Favrod (1993) found significant postintervention effects of increased medication compliance. Schwartz and colleagues (1997) reported increased skill development; yet, the subjects had poor overall treatment compliance rates, with females having lower skill development and higher treatment compliance at follow-up. No sustained benefit of the medication management module intervention has been found (Hornung et al., 1996; Hornung et al., 1998, Kuipers et al., 1994). The education format minimally improved medication management in the short term (less than 6 months).
Psychosocial Interventions

Four of the studies evaluated a combined effect of a family psychosocial/educational intervention and individual treatment (Hogarty et al., 1991; Kelly & Scott, 1990; Linszen, Lenior, DeHaan, Dingemans, & Gersons, 1998; Phan, 1995). Results were mixed. Both Hogarty and colleagues (1991) and Phan (1995) reported intensive long-term interventions and found significant effects that diminished rapidly over time. The researchers suggested problems with ending treatment and failure of patients to generalize. Patients were unable to maintain gains after the treating research clinician ended the relationship (Hogarty et al., 1991). Linszen and colleagues (1998) found no treatment effect, whereas Kelly and Scott (1990) found good compliance during the study but poorer compliance than control at follow-up.

Results of long-term individual treatment intervention (Frank & Gunderson, 1990) and psychosocial rehabilitation (Delaney, 1998) showed that good therapeutic alliance was associated with increased medication and therapy compliance. Frank and Gunderson (1990) encouraged studies that would identify factors contributing to the development of a positive therapeutic alliance with schizophrenic patients. Brief individual interventions showed no benefit in treatment compliance (Sharma et al., 1995).

Throughout the research reports, the interventions provided mixed results regarding the ability to enhance insight, attitudes, or treatment compliance. Researchers have consistently reported that treatment compliance is complex. For
example, awareness of the illness and the relationship to compliance behavior in schizophrenia changed over time (Cuffel et al., 1996). This finding underscores how difficult it is to identify any one variable or intervention that can improve treatment compliance. Intervention programs that focused on increasing insight showed a modest improvement in patient compliance, which quickly deteriorated after the intervention was completed (Atkinson et al., 1996; Guimon, 1995; MacPherson et al., 1996). Cognitive/behavioral programs and most psychosocial interventions focusing on training and skill enhancement reported similar concerns. Interventions, contrary to their expectations, succeeded only minimally in improving medication self-management in both the short-term and the midterm (Hornung et al., 1996; Hornung et al., 1998; Kelly & Scott, 1990; Kemp & David, 1996; Kuipers et al., 1994; Linszen et al., 1998; Sharma et al., 1995).

**Nurse/Patient Relationship**

No single treatment for schizophrenia has been effective in improving the multiple symptoms and disabilities associated with schizophrenia (Fenton, 2000). Researchers have found that the relationship developed by clinicians working with patients with schizophrenia was of the greatest value, concluding that there is a need for a strong positive individual relationship with patients. Sharma and colleagues (1995) also agreed that the influence of the therapeutic relationship deserves further study. Individual interactions with patients rather than group programs seem to provide an increased benefit for understanding patients' needs over time. Patients' beliefs about medication and treatment are individual and
change overtime. Treatment interventions need to meet these individual needs (Davidhizar, 1987).

The current guidelines developed by the American Psychological Association (2001) propose that therapeutic relationships should be comprehensive and multimodal in order to respond to an individual’s identified needs. Currently, no empirical trials of one-to-one, disorder-specific, targeted, individual psychotherapeutic approaches can help guide clinical practice (Fenton, 2000).
CHAPTER 3

DESIGN AND METHODS

A grounded theory design was used for this study. The purpose of this research was to develop a midrange theory that describes and explains the process of the nurse/patient relationship as it pertains to treatment compliance for patients with schizophrenia. The research outcome of this design was the discovery of a grounded theory that describes what is occurring within the social process of the nurse/patient interaction in the community mental health setting.

Issues related to grounded theory are discussed in this chapter. The selections of grounded theory for this area of interest are also presented: (a) site selection and population, (b) sample selection process, (c) data collection process, (d) data analysis, and (e) elements of rigor/trustworthiness.

Grounded Theory

The purpose of a qualitative research design is to allow the researcher to systematically explore the participants' views by applying the philosophy that multiple realities exist and to create meaning for individuals. For this study, a qualitative approach allowed for an in-depth study of nurse/patient relationships, suggesting that the nurse/patient relationship is related to the patients' compliance with treatment. The following research question was asked: How does the
nurse/patient relationship influence treatment compliance for patients with schizophrenia? The research question concerns an experience, the phenomenon in question (a process), and the method of choice for addressing the question (grounded theory) (Morse, 1994). Previous researchers have found that the relationship developed by the patient with the provider can influence compliance with treatment, but how or why this relationship works to enhance compliance is not clear. Quantitative research identifies that certain variables are linked to others, whereas qualitative research determines how they are linked (Sandelowski, 1997). The current study analyzed nurse/patient relationships and provided an understanding of how the social processes contribute to treatment compliance.

A grounded theory design is appropriate to use to explore social processes, and it can also be used to explore areas in which little is known or areas that have been researched to gain new understandings (Strauss & Corbin, 1998). Grounded theory studies can alter the preconceived notions of practice. Patients frequently ignore treatment interventions because they do not fit their lifestyles. Why or how interventions are beneficial can be linked through grounded theory, enhancing designs for treatment regimens that fit patients’ lifestyles and increase compliance (Glaser, 1999).

Grounded theory refers to a specific methodology developed by Glaser and Strauss (1967) in which data are systematically collected to produce a multivariate conceptual theory (Glaser, 1999). Grounded theory explores basic social processes that are directly linked to symbolic interactionism (Glaser & Strauss, 1967). In
grounded theory, reality is socially and culturally based, with the aim being the understanding of human nature and the generation of theory about social and psychological phenomenon. Symbolic interactionism is an empirical approach that directly examines the social world (Blumer, 1969). Symbolic interactionism underlies grounded theory, with research focusing on the meanings of events to people in natural settings. Grounded theory, using the tenants or assumptions of symbolic interactionism, provides a means of studying behavior and interaction to form a new perspective on understanding behavior (Sheldon, 1998).

Grounded theory starts with a research question that is situationally based and process oriented. Within the situation, the task of the researcher is both inductive and deductive. The inductive process consists of theory emerging from the data, whereas the deductive process concerns the purposeful sampling to evaluate the emerging theory. The researcher is to comprehend what is happening in the situation and to understand how each of the individuals manages his or her role while adding participants purposely to expand the emerging theory (Dick, 2001). The research question is refined through the emerging theory discovered in the data. This approach combines an analytic procedure of constant comparative analysis; a constant process of systematically gathering data; data analysis; and concept formation by observing, analyzing, and coding data (Glaser & Strauss, 1967). Purposeful theoretical sampling is used based on emerging concepts and hypotheses from constant comparative analysis to explore the range or conditions that vary among the concepts (Strauss & Corbin, 1998).
The researcher’s role in grounded theory is a pivotal part of the investigation. The researcher is the instrument and must maintain balance to critically analyze situations, recognize and avoid bias, obtain valid and reliable data, and think abstractly (Streubert & Carpenter, 1999). No individual method can capture the details of social processes. A variety of interpretive methods are used in grounded theory (Denzin & Lincoln, 1994).

Grounded theory is an important research methodology for the study of nursing phenomena. Nurse researchers recognize the significance of using grounded theory to provide information about the social life of patients and of exploring the richness and diversity of human interaction. Grounded theory contributes to the discovery and conceptualization of complex interactional processes within the social context in which they occur (Streubert & Carpenter, 1999). The researcher can discover, through the use of grounded theory, what is relevant and what works. Grounded theory makes a meaningful and lasting contribution and emerges as an entirely different way of understanding observations. This unique understanding permits the development of new and meaningful interventions (Glaser, 1999). No studies were found in the literature that reveal how the nurse/patient relationship and interventions used by the nurse within the context of this relationship promote treatment compliance, making the present study exploratory.

During my doctoral program, I conducted several pilot projects, specifically evaluating the dyad of the nurse/patient relationship. A small pilot project,
interviewing six patients with a diagnosis of schizophrenia, was accomplished using phenomenology. The central theme emerging from the interviews was "being known" by the nurse. Being known seemed to be an important ingredient in the examination of the nurse/patient relationship from the viewpoint of the patient. In a second project, using a grounded theory design, I interviewed four nurses and observed one nurse/patient interaction. The interviews provided an additional opportunity to analyze concepts with the theme of knowing and the possible importance it plays in the nurse/patient relationship. The current research study evaluated one part of the dyad and looked specifically at nurses' perspectives.

Site Selection and Population

A large community mental health center in the western United States, which contains urban, suburban, rural, and frontier populations, was the site used to obtain participants for this study. The comprehensive community mental health center has 56 adult programs in which patients with schizophrenia may participate. These programs include outpatient clinics, employment, case management, clubhouse, day treatment, in-home training services, residential treatment, inpatient contact, and adult forensic programs. The nursing staff are involved in all adult services.

The participants were sought from adult outpatient clinics. In general, registered nurses in outpatient clinics are identified as providing primary mental healthcare for a large caseload of individuals with schizophrenia. The primary care responsibilities for mental health nurses are broad and encompass a wide range of
modalities. Nurses meet with patients individually, utilizing interviewing skills, behavioral observations, and physical/mental health screening. Nurses work with patients to develop a plan of intervention unique to each patient's needs. Nurses utilize behavioral and supportive techniques, health teaching, advocacy, somatic treatment modalities, milieu, and case management to promote, restore, and prevent illness while encouraging recovery. Nurses at the community mental health center have a specific role to assist patients with medication compliance. Nurses promote medication compliance by assisting patients with obtaining their medications from the pharmacy or prescription assistance program; nurses supervise patients filling weekly medication boxes; nurses discuss concerns about side effects; nurses provide specific education with regard to medications prescribed; and nurses encourage patients to make and keep follow-up appointments with advanced practice registered nurses or psychiatrists for the assessment of new or maintenance of psychiatric medications.

Nurses at the community mental health center make individual appointments with patients for follow-up care. Patients also go to the outpatient clinic for other modalities such as attending groups, visiting with a casemanager, or meeting with their prescribers for medication evaluation. Patients have access to a number of services and personnel at the mental health center. Therefore, if they are at the clinic for other reasons, they make connections with their nurses independent of an appointment.
More than 6,000 individuals, who are designated as seriously and persistently mentally ill, are treated in these outpatient clinics annually. Demographic information from 1998 describes the parameters of the current mental health population served by the community mental health center as follows: (a) approximately 50% males and 50% females; (b) 77% adults 18 years old or older; and (c) 89.7% Anglo American, 2.5% African American, 1.9% Asian, 1.5% Native American, and 3% other. Approximately 1,200 adults receive care daily (see Appendix B).

Sample Selection Process

The nurse/patient interaction during regular clinic interviews was the focus of the present research. Therefore, two groups of participants were recruited for this study: (a) nurses in outpatient clinics and (b) patients in nurses’ caseloads. Nurse participants were approached first. Caseloads of the nurse participants were screened for patient participants by identifying a list of potential patient participants. These potential patient participants were recruited according to the inclusion criteria. Seventeen nurse/patient outpatient clinic sessions were observed. Of those sessions observed, 15 were audiotaped. Two of the interviews were not audiotaped due to audiotaping error.

Sampling Process: Nurses

Nursing supervisors served as the point of contact to gain entry into the outpatient clinics. After making contact with nursing supervisors, nurses in the
outpatient clinics were approached during team meetings to be briefed on the study’s purpose, methodology, and risks and benefits to staff and patients that might occur from involvement in this study. Questions were explored concerning the use of data, confidentiality, and procedures. Nurses were requested to participate. Nurse participants who volunteered were asked to complete a Demographic Questionnaire based on the number of years of employment experience with the mentally ill population and the number of patients with schizophrenia on their caseloads for initial inclusion in the study. In order to begin to understand the intricacies of the nurse/patient interaction, data collection began with volunteers who had the highest ranking in the number of years of experience working with the mentally ill population (Coyne, 1997). Initially, a purposive sample was selected by reviewing the demographic information from each nurse participant volunteer. Those with the most years of experience working with the mentally ill population were observed and interviewed first. As identified by Benner (1984), nurses with the most expertise should be able to connect their understandings of the situation to the most appropriate action.

Sample: Nurses

Nine nurses agreed to participate in the study. Five nurses were selected for direct participant observation with their patients, 3 from adult outpatient units, 1 from the Clozaril Clinic, and 1 from an outpatient supportive housing program. Sampling was guided by the purpose of the study: to discover how nurses in the outpatient community mental health clinic promote treatment compliance for
patients with schizophrenia.

The study began with nurses from two outpatient units. Purposive sampling was used to select the initial participants. The first two nurses were selected based on the selection criteria, the number of years of employment experience with the mentally ill population, and the number of patients with schizophrenia on their caseloads. All nurses selected were licensed as a registered nurse. As the study progressed and issues were identified, the theoretical sampling of additional nurses/participants occurred. In addition to nursing roles in traditional outpatient approaches, nursing roles in other outpatient programs were used as data sources. The population with schizophrenia is heterogeneous. Patients do not always respond to treatment in the typical outpatient setting. Patients with treatment-resistant issues are frequently given a trial of Clozaril, particularly when at least two atypical medications have failed to improve symptoms. The Clozaril Clinic is staffed by two nurses. These two nurses work closely with all of the patients at this clinic. While both nurses were present, the nurse with the most experience was targeted for observation and interview. Further sampling diversity was gained by including patients with substance abuse. The definition of treatment compliance identified those patients taking nonprescription drugs as being at high risk for noncompliance. These patients are frequently treatment refractory and experience episodes of increased symptoms with a resulting relapse of substance abuse. A nurse from the alcohol and drug mental health outpatient unit was recruited. Finally, diversity in the severity of symptoms was identified and included for
patients with schizophrenia who had demonstrated a need for additional support to manage their activities of daily living. A nurse from an outpatient supportive housing program was also recruited.

Demographic characteristics of the nurse participants are summarized in Table 1. The mean age of the nurse sample was 49 years, with a range from 38 to 54 years; the mean years of practice as a psychiatric/mental health nurse was 19 years, with a range from 11 to 27 years; and the mean years of practice at the community mental health center was 16 years, with a range from 10 to 27 years. All nurse participants were considered expert nurses by the number of years of experience in psychiatric/mental health nursing. The mean number of patients in the nurses' caseloads was 75, with a range from 47 to 99; and the mean number of patients with schizophrenia was 44, with a range from 21 to 73.

A review of demographic information shows that a varied sample was obtained. One male nurse was included in the sample. One nurse had only patients with schizophrenia in her caseload. One nurse had an associate's degree, whereas the other 4 had baccalaureate degrees. Of those sampled, each nurse identified most of his or her patients with schizophrenia as being high to moderately compliant with treatment. Of the nurse participants' caseloads, 15% were considered in the low category of compliance. Nurses in the Clozaril Clinic and in the supportive housing program, who had the higher percentage of patients with schizophrenia on their caseloads, identified only from 4% to 5% of their caseloads in the low compliance category.
Table 1

Demographic Characteristics of Nurses

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Degree</th>
<th>Years as nurse</th>
<th>Years at CMHC</th>
<th>Total patients</th>
<th>Total with schizophrenia</th>
<th>High compliance rating</th>
<th>Medium compliance rating</th>
<th>Low compliance rating</th>
</tr>
</thead>
<tbody>
<tr>
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<td>AD</td>
<td>25</td>
<td>17</td>
<td>99</td>
<td>41</td>
<td>22</td>
<td>12</td>
<td>7</td>
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<tr>
<td>2</td>
<td>54</td>
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<td>BS</td>
<td>30</td>
<td>15</td>
<td>96</td>
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<td>11</td>
<td>18</td>
<td>8</td>
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<tr>
<td>3</td>
<td>54</td>
<td>Female</td>
<td>BS</td>
<td>29</td>
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<td>17</td>
<td>11</td>
<td>58</td>
<td>51</td>
<td>35</td>
<td>13</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. AD = associate degree, BS = baccalaureate degree, and CMHC = community mental health center.
Sampling Process: Patients

Patient volunteers were approached after identifying the nurse participants. A list of potential patient participants was gathered from the nurse participants’ caseloads. Initially, patients were identified by screening for inclusion criteria.

Inclusion criteria. Patients included in the study had to meet the following criteria: (a) 19 years old or older; (b) *Diagnostic and Statistical Manual-IV* (DSM-IV) diagnosis of schizophrenia, schizoaffective disorder, or psychosis not otherwise specified; (c) English speaking; and (d) currently not under an order of commitment. Patient identification numbers were used through the mental health management information system to identify the percentage of kept/broken appointments at the outpatient unit. Nurses aided in the selection of potential patient participants by eliciting the nurses’ perceptions of the level of treatment compliance for each of these patients. Nurses have the most current information on each patient’s level of compliance with treatment. Each nurse, using the study definition of treatment compliance, identified the level of treatment compliance for each patient with schizophrenia. Patients were categorized into groups according to their compliance with treatment. Level 1 patients showed high compliance with treatment at least 100% to 75% of the time, Level 2 medium compliance at 74% to 50% of the time, and Level 3 low compliance at 49% or below at the time. The nurse participant recruited patients who met the eligibility criteria for the study, with at least 1 patient in each compliance level. The nurse introduced the study to prospective patient participants. Those patients expressing an interest to be
involved in the study were referred to me to sign an informed consent form. I arranged for a time to meet with each patient prior to the interview to explain the project, answer questions, and have him or her sign the informed consent form. Data collection, confidentiality, and risks and benefits of the study were shared with each potential patient participant during this meeting.

Sample: Patients

Fifteen patients with a diagnosis of schizophrenia participated in the study; 3 patients were recruited from each nurse participant. Nine males and 6 females were recruited; all were Anglo American (Caucasian).\textsuperscript{1} Demographic characteristics of the patient participants are summarized in Table 2. The mean age of the patient sample was 44 years, with a range from 22 to 59 years; the mean number of years treated at the community mental health center was 14, with a range from 1 to 24; and the mean number of years treated by the same nurse was 4 and the mode was 1 year, with a range from 1 to 9 years. The number of treatment programs for each patient varied, with 4 the mean and a range from 2 to 8. The number and type of medications prescribed for each patient also varied. The mean number of psychotropic medications prescribed was 4, with a range from 0 to 7. Only 1 patient was prescribed no medication during the study period. Patients were prescribed multiple psychotropic medications. Fourteen patients were prescribed antipsychotic medications; 13 of these patients were prescribed atypical

\textsuperscript{1}Caucasian was the term used on the demographic form, since this is the word used by the mental health center for collecting and distributing data on ethnicity.
Table 2

**Demographic Characteristics of Patients**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Years in treatment</th>
<th>Years with nurse</th>
<th>Number of psychosocial treatment programs</th>
<th>Number of psychiatric medications</th>
<th>Compliance rating</th>
</tr>
</thead>
<tbody>
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<td>3</td>
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<td>8</td>
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<td>Male</td>
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<td>22</td>
<td>1</td>
<td>7</td>
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<td>L</td>
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</tbody>
</table>

*Note.* H = high compliance rating, M = medium compliance rating, and L = low compliance rating.
antipsychotic medications; and several patients were prescribed more than one medication. Three patients were prescribed typical antipsychotic medications, two of which were in the form of long-acting decanoate injectables. Ten patients were prescribed antidepressant medications, and 5 patients were prescribed mood stabilizer medications. Thirteen other medications were prescribed for varying symptoms or side effects.

The psychosocial treatment programs for the patient sample included (a) individual behavioral interventions \((n = 15)\), (b) medication management \((n = 14)\), (c) residential support \((n = 8)\), (d) day treatment \((n = 8)\), (e) case management \((n = 7)\), and (f) representative payee for help with social security benefits \((n = 7)\). Patient participants were divided into three compliance groups for further evaluation. Each compliance group (high, medium, and low) contained 5 patient participants. A one-way test of homogeneity of variance was calculated using SPSS, Version 10, for the continuous variables (years in mental health, number of medications, number of treatment programs, and number of years with the same nurse). No differences were identified with the use of nonparametric post hoc tests, least significant difference test, and Bonferroni test for any of the continuous variables and the different compliance groups.

Data Collection Process

Participant observation of the nurse/patient interaction and follow-up interviews with nurse participants were the primary data sources. Observations, words, and phrases served as direct sources of data. All participant/observation
sessions and interviews were audiotaped and transcribed. Participant observation sessions and interviews lasted between 15 and 50 minutes each, which is the normally allotted time for individual treatment appointments.

I observed the nurse/patient interaction using an observation guide. I also greeted participants and interacted briefly when the patient engaged with me, but I did not attempt to influence the outcome of the interaction between the nurse/patient. Three patient participants from each compliance category were observed for each nurse participant. Following the participant observation sequence for all three patients, the nurse was interviewed using an Interview Guide.

Participants were added until saturation of the data occurred.

**Informed Consent**

Informed consent was obtained prior to data collection for each nurse and patient participant (see Appendix C). Each participant was requested to read and sign a consent form prior to participation in the study; a copy was provided to the participants upon request. Questions concerning the participant observation sessions, interviews, steps to sustain confidentiality, and risks and benefits to participate were answered. During all researcher/participant interactions, individuals engaging in the study were reminded of their personal choices in reference to answering questions. Institutional review approvals were obtained from the Institutional Review Board at the University of Utah Health Science Center and the Utah State Department of Human Services Protection of Human Rights Committee prior to beginning this study.
Data Collection Tools

Several data collection instruments were used: (a) Demographic Questionnaire, (b) Participant Observation Guide, and (c) Interview Guide. In addition, field notes and memos were kept.

Demographic Questionnaire. Each nurse participant answered a Demographic Questionnaire. Questions included age; gender; ethnic background; educational level; number of years practicing in a position as a psychiatric/mental health nurse; number of years practicing at the mental health center; number of individuals on primary caseload; and number of patients with a DSM-IV diagnosis of schizophrenia, schizoaffective disorder, or psychosis not otherwise specified (see Appendix D).

Patient demographic information was collected from each patient’s e-chart after consent to participate had been obtained (see Appendix E). The chart was reviewed for age, gender, ethnic background, diagnosis, years of treatment, years treated by the same nurse at the mental health center, number of current treatment programs prescribed, number and classification of medications prescribed, and percentage of compliance with current recommended treatment in the past year.

Participant Observation Guide. Participant observation is commonly used as a data collection tool in qualitative research. The observation of nursing practice enables the researcher to determine how the social processes actually work from a nurse’s perspective (Flick, 1998). I observed the interaction between the nurses and their patients from the nurse participants’ perspectives by listening, intensely
noticing, and recording relevant information. My role was dual in purpose. I was able to watch the interaction of the nurse/patient and to recognize actions that those in the room may not notice, looking beyond the immediate hub of activity (Ely, 1991). My presence influenced what was observed (owing to being physically present and a part of the process), but I tried to be constantly aware of my effect on the process (Flick, 1998). I was an observer, which is appropriate to the arena and is both physically and emotionally feasible (Ely, 1991). My identified role for this study was as a limited observer, with no other role than that of a researcher. I greeted the patient participants prior to the nurse/patient interview, requested the patient participant to read and sign the informed consent, and talked with the patient to develop rapport.

During the observation session, I sat outside of the field of direct vision from the patient participants and drew no specific attention during the nurse/patient interaction. A Participant Observation Guide was used to focus on specific aspects of the interviews (see Appendix F). The Participant Observation Guide was broad in focus, providing a holistic view of the situation and subject and allowing the variables to emerge.

According to Dereshiwsky (1999), the major categories of observation included the following:

1. The setting

2. The human social environment: (a) characteristics of the subject; (b) patterns, frequency, and direction of interaction; and
(c) decision-making behaviors (Who initiates them? Who ultimately makes the decision? What is the type/manner of communication regarding the decision?)

3. Activities and behaviors: (a) Who initiates the activity? (b) What were the participants' verbal and nonverbal reactions? (c) What happens at each step of the activity? (d) Who is involved? (e) How is the completion of this particular activity related to other observed behaviors?

4. Informal interactions and unplanned activities

5. Language of the participants

6. Nonverbal communication

7. What does not happen or other surprise findings?

**Interviewing and Interview Guide.** Interviewing is one of the most frequently used data-collection strategies. Open-ended interviews allowed nurse participants to share their experiences openly and fully. Semistructured interviewing provides the greatest opportunity for participants to relay information in a consistent format (Streubert & Carpenter, 1999). Interviewing and asking questions helped to understand the meaning of events that would otherwise have been vague. Interviews with nurse participants provided a closer examination of the nurse/patient interaction. These interviews were audiotaped and analyzed to assist in the discovery of patterns and their variations (Strauss & Corbin, 1998).
Interviews with each nurse participant occurred after all nurse/patient observations were completed, thus reducing the possibility of introducing researcher bias. A semistructured Interview Guide was used to allow nurse participants to explain their experiences (see Appendix G). The use of an Interview Guide provided consistency and congruency throughout the interviews. Questions were based on the research focus. The Interview Guide questions, using probes for specific detail, were enhanced as the interview progressed. A semistructured Interview Guide also allowed the interaction to remain focused, yet allowed the participants' perspectives and narratives to emerge (Fontana & Frey, 1994). The major categories of the Interview Guide include (a) information regarding the nurse's concerns for the patient during the interview, (b) decisions the nurse makes regarding specific treatment interventions, (c) signs and symptoms that the patient exhibits, (d) how the nurse decides when to schedule appointments with the patient, (e) the nurse's response to patient crisis, (f) issues of treatment compliance, and (g) differences in treatment interventions.

Field notes. Field notes were recorded immediately following the participants' observation sessions and interviews. Field notes documented observation sessions and reactions to the experience of the Participant Observation Guide. The notes chronicled what was seen and heard, and the notes also described the environment and interaction. The notes were descriptive, with thick rich detail not interpreted or summarized. The field notes became part of the data analysis, offering important insights and opportunities to increase depth and to add meaning.
to what was being said (Streubert & Carpenter, 1999).

**Memos.** I engaged in constant comparative analysis, and I wrote a running record by memoing insights, hunches, hypotheses, and discussions about the data (Strauss, 1987). Memos contain the products of analysis or direction for further analysis, and they are meant to be analytical and conceptual rather than descriptive. Several types of memos were kept such as (a) orienting memos, focusing on the overall scope of the research; (b) preliminary memos, focusing attention on an idea; (c) advanced memos, raising questions about categories; and (d) elaborate theoretical memos, opening understanding to the phenomenon. As ideas emerged and hypotheses were formulated, memos served as a decision trail to the direction of further interviews (Strauss & Corbin, 1998).

**Data Analysis**

The data were analyzed systematically, as collected, by constant comparative analysis (Glaser & Strauss, 1967). Newly acquired data and previously collected data were continuously compared with one another. Data collection, coding, and analysis occurred simultaneously and circularly. After receiving consent from the participants, the nurse/patient interactions were audiotaped and transcribed. Transcribed copies were kept intact and read initially to understand the social process as it occurred, providing immersion into the data before they were broken out (Seidel & Kelle, 1995). Analytic strategies were used, as outlined by Strauss and Corbin (1998), forming concepts, defining categories, developing these categories in terms of properties and dimensions (axial coding), and then relating a
central category or core variable through statements of relationships. The discovery of a core variable serves as the foundation of theory generation (Streubert & Carpenter, 1999). The central category or core variable, using quotes and narratives from the data, highlights the basic social process developed.

**Concept Formation**

Transcripts were analyzed line by line, using Ethnograph computer software, and coded to capture the context of the response. Code words in the Ethnograph data file produce a map of the data, helping in the discovery of categories (Seidel, 1998). Concept formation is the process of grouping similarly coded items according to defined properties and then giving them a name that represents the common link. Large amounts of data are reduced to more manageable pieces of data (Strauss & Corbin, 1998). Through careful examination of the data and in conjunction with the interplay between the analyst and the data, new concepts and novel relationships will lead to the development of categories (Strauss & Corbin, 1998).

**Concept Development**

Secondary literature review, memos, field notes derived from the Participant Observation Guide, and demographic information were used in the analysis. The Demographic Questionnaire was used for two purposes: (a) Responses were summarized, and (b) when reviewed with individual interviews, responses were used to provide additional insight into the nurses'
experiences with patients with schizophrenia. Multiple forms of data collection were analyzed to determine the properties and dimensions of categories as well as to determine the relationships between categories (Streubert & Carpenter, 1999).

The research question was refined, specifically to understand how knowing the patient impacted compliance and patient integration into the community.

After categories were developed, their properties were specified and examined for differences. The categories were compared, clustered, and reduced through axial coding, which is the process of relating categories to subcategories. Axial coding linked categories at the level of properties and dimensions in order to understand the basic social processes of "getting it, together," laying the foundation and beginning structure for theory building (Strauss & Corbin, 1998).

**Core Variable**

As the main categories became apparent, the collection of data became more selective. Theoretical sampling, sampling based on emerging findings, and the discovery of concepts were used to look at variations or differences. When further data analysis, literature review, and theoretical sampling revealed no further aspects of the developing theory, data saturation occurred. Saturation is a matter of deciding when collecting additional information is counterproductive and the capacity to generate new ideas is exhausted (Strauss & Corbin, 1998). The core variable of knowing evolved from the emerging categories. The core variable is the abstract term by which all other categories can be explained (Glaser & Strauss, 1967).
Elements of Rigor/Trustworthiness

Rigor within this qualitative study was maintained through the use of adherence to detail and accuracy in collecting, coding, analyzing, and presenting the data. Guba and Lincoln (1994) outlined a means for demonstrating rigor or trustworthiness of qualitative research. The techniques outlined include credibility, transferability, dependability, and confirmability. Theoretical sensitivity, reflexiveness, and relationality also add confidence to the developing theory.

Credibility

Credibility relates to the confidence of the truth of the findings (Guba & Lincoln, 1994). Credibility was enhanced in this study by (a) prolonged engagement, (b) triangulation of the data, (c) peer debriefing, and (d) member checks.

Prolonged engagement. I spent extended periods with each nurse participant to ensure that the study accurately reflected the participants’ experiences. I built trust with the patient participants using skills developed working with this population, helping them to feel at ease in disclosure of personal information.

Triangulation of the data. Triangulation of the data occurred through multiple methods of data collection. Methods of data collection included interviews with nurse participants, field notes, participant observations and observation guides, transcripts of nurse/patient interactions, demographic questionnaires for both nurse and patient participants, memos, and a secondary literature review.
Peer debriefing. Peer debriefing was used with the dissertation committee members. These expert clinicians/consultants were used to provide consensus on the initial coding scheme and to check coding as the process continued.

Member checks. Member checks were used to validate categories, interpret data, and identify the core variable with nurse participants. I met with nurse participants after the categories, core variable, and basic social process had been identified and then requested their input regarding analysis of the data.

Transferability

Transferability purports that the findings are meaningful or useful in other situations and verifies that the results are not context bound (Guba & Lincoln, 1994). Thick and rich description of the data and a search of similar findings in the secondary literature review make it possible for the research findings to be transferable to other areas of study.

Dependability

Dependability is met through securing credibility of the findings. Without credibility, there can be no dependability (Streubert & Carpenter, 1999). An audit trail shows the stability or traceability of variance over time (Guba & Lincoln, 1994). The audit trail for this study included (a) raw data (field notes, transcripts, and audiotapes); (b) product analysis and data synthesis (Ethnograph computer printouts); (c) process notes (detailed memos); and (d) instrument information (including questionnaires, Participant Observation Guide, Interview Guide, and
Confirmability

Confirmability reflects all other areas of credibility, transferability, and dependability of the findings, and it also provides for the interpretive objectivity of the data (the extent that the data and results are grounded in events rather than in personal construction) (Guba & Lincoln, 1994). Identified members of the dissertation committee, including expert consultants, evaluated coding schemes, concepts, category structures, and emergence of the core variable. They also provided feedback throughout the study to determine (a) findings grounded in the data established by an audit trail, (b) clarification of category structure, and (c) logical inferences.

Theoretical Sensitivity, Reflexiveness, and Relationality

Theoretical sensitivity portrays an awareness of the personal qualities and subtleties of meaning embedded in the data and an acknowledgment of my knowledge, understanding, and skill to generate categories and properties and to relate them to the core variable (Glaser, 1999). Reflexiveness refers to the dual source of insight from being both researcher and participant observer. Relationality ties these two concepts together by recognizing the connectedness between the researcher and the participants, and it also accounts for the reciprocity that occurs in the research setting (Hall & Callery, 2001). Memos reflecting my influence and cocreation of meaning were maintained to enhance the rigor of the study and to
allow for an understanding of the ongoing social process. Preconceived notions were identified prior to beginning the study. Assumptions were memoed and set aside for further reference.

Human Subjects: Ethical Considerations

The proposal was submitted to the Institutional Review Board at the University of Utah Health Science Center and the Utah State Department of Human Services Protection of Human Rights Review Committee. Informed consent was obtained prior to data collection. Each participant read and signed a consent form prior to the participant observation session or interview. Risk/benefit questions were elicited and answered. Confidentiality and anonymity were discussed and maintained by assigning codes to each participant. Code numbers were placed on transcripts, tapes, field notes, memos, and the Participant Observation Guide. Audiotapes were transcribed, reviewed, and locked in a secure file box.
CHAPTER 4

THE GROUNDED THEORY

Getting It, Together

The report for grounded theory research presents the substantive theory that is supported by the data from the investigation (Streubert & Carpenter, 1999). The report provides information on the data sources, how the data were acquired, and how the concepts were synthesized. In this chapter, the grounded theory generated during this research investigation is described. The basic social process of getting it, together, the core category of knowing, and the categories of socializing, normalizing, and celebrating are introduced and discussed with the supporting field data. The categories are not necessarily mutually exclusive. The categories are interrelated, with movement flowing between categories during the nurse/patient interaction. The process of moving between the categories through the key interpersonal modulators is included as part of the comprehensive analysis.

Process Overview

The model of the nursing process, Getting It, Together (see the Figure), used by nurses to promote treatment compliance for patients with schizophrenia in the community mental health center, is derived from the core category knowing. Knowing, the core category, relates to the nurse as having a history of interacting
Building rapport*

Socializing
- Exchanging interests
- Reviewing goals
- Relating concerns

Exploring skill development*

Normalizing
- Managing medication
- Planning activities of daily living
- Teaching healthy lifestyles

Approving community integration*

Instilling hope*

Celebrating
- Acknowledging accomplishments
- Reinforcing changes
- Praising goal attainment

Encouraging recovery*

Getting It, Together.

*Interpersonal modulators exert a combining influence that allows movement from category to category.
with the patient and, as such, having a working knowledge and understanding of
the patient in several different contexts. Knowing the patient in this manner
includes (a) understanding the diagnostic indicators, (b) presenting the specific
case, and (c) knowing individual characteristics/nuances of the patient. In
nurse/patient interactions, nurses initially engage in socialization with their
patients, exchanging interests and reviewing activities, to determine their patients’
concerns.

As issues are identified through socializing, nurses move through the core
category of knowing to the category of normalizing. Normalizing is an active
process of introducing activities of everyday life into patients’ repertoires.
Normalizing processes include (a) managing medication regimens, (b) planning for
activities of daily living, and (c) teaching healthy lifestyles. Nurses move from
knowing, socializing, and normalizing to celebrating with patients by
acknowledging accomplishments, reinforcing changes, and praising goal
attainment. Nurses progress between categories using interpersonal modulators that
exert a combining influence that allows movement from category to category. The
interpersonal modulators include (a) building rapport, (b) exploring skill
development, (c) approving community integration, (d) instilling hope, and
(e) encouraging recovery.

The nurses related that knowing the patients and having a history with them
are keys to the nursing process, getting it, together. Knowing the patient precedes
any intervention or normalization that occurs during the nurse/patient interaction.
One nurse stated,

I’ve got a history with them. If they’re not able to express themselves and express their emotions, . . . with a history, I can sort of bring that out because I would have known how close they were to something, . . . ya know, what matters to them, what is important, a history with these people gives me an idea of what is really important to them, how they are going to react to certain situations and where I need to be on guard, where I need to be more involved, where I need to . . . put my arm on their shoulder and say it’s gonna be okay, we’re going to get through this.

Over and over again, the nurses talked about the nurse/patient relationship as being embedded in the history they shared together. The significance of the history was described in the interactions that occurred in which nurses and patients picked up on subjects they had discussed previously or incidences that had been discussed in past interviews together. Previous interactions between nurses and 14 of the 15 patients had occurred multiple times during the previous 12 months. Reviewing old data or information for the next interview was not necessary. As an observer, I could not grasp the same underlying meaning to the interactions by only one observation.

The nurses reported that evolution of the relationship was important. Having a history with the patient implies understanding. The nurses described not having a lot of time in the outpatient setting to build relationships and frequently feared, as they were getting to know the patient, that they might miss significant symptoms.

I don’t have a lot of time with the client. It’s often so hurried. . . . They’re here and they’re gone, and ya know, it seems very short, and frankly, I don’t have time to see them longer, so, I think that makes it hard.
The nurses described using all the resources available in order to get to know the patient as soon as possible. They described reading through the chart, talking with family members, and discussing with the treatment team particular issues that had transpired prior to being seen by the nurse.

One of the patient participants was a new patient in the nurse’s caseload. The nurse and patient had only one prior interview. The nurse related that she had spent time reviewing the patient’s past psychiatric records from a recent hospitalization and records from the community mental health center.

Multiple interactions, as identified from the chart, were in the history of the nurse/patient relationship as well as in an implied cohesiveness that linked different interviews together. Knowing the patient is a direct result of having a history with that patient, which is a “continuity-of-care” issue. This history is necessary property to move a patient in a particular direction because of the essential background that is shared. A mutual path is traveled and shared as a patient begins to “get it.” For patients, making changes in their beliefs and actions through normalizing behaviors leads to hope, further community integration, and recovery, whereas for nurses, visualizing the results of treatment compliance over a period of time working with patients brings mutual joy and celebration. One nurse stated,

It is seeing a client get it. You know, after they have done it for so long, [they] get that and it’s really nice. It’s really nice seeing that . . . when a client gets it, that ya know they’ve walked through the darkness, they’ve gone through the hospitalization stay, then the medication regimen over and over again. They’ve been able to grasp. They understand the symptoms of their illness. They understand the side effects of the medication, and now they’re comfortable with themselves and with their illness, and they walk
out the door and walk into the community, and that’s the celebration.

The nurses described having a commitment to work with these patients. They remarked that at times the patients have symptoms and behaviors that could be frustrating and lead to difficulties in the nurse/patient relationship. Nurses consciously decide to focus on the positive. One nurse related,

The success we have with compliance and recovery and with working with people truly is caring for them as people, not seeing them as an illness, and recognize the uniqueness of them and giving them a sense of empowerment and sense of control in their own lives. . . . Letting them know they are in charge of their recovery . . . that we are going to be behind them and support them and what’s working, . . . [accomplishing getting it, together].

Knowing

Decisions regarding specific treatment interventions and decisions regarding follow-up appointments are based on knowing and understanding patient needs.

“Treatment interventions are based on what the client needs. . . . What’s going to not destroy the relationship, plus what I’m going to do that the patient understands that I’m doing in their [his or her] best interest.”

The concept of knowing is defined as understanding past problems and how they are related to current issues. Knowing is being acquainted by experience and having a unique awareness or inside information linked through the relationship. Knowing is linked at three different levels: (a) observing diagnostic indicators, (b) assessing the case, and (c) understanding the person.
Observing diagnostic indicators. All of the nurses in the study had considerable history working with patients at the mental health center. They described needing to have a working knowledge of mental illnesses, the pathology, different disorders, how medications impact the disorders, and how substance abuse or other outside factors may exacerbate mental disorders. One nurse related, "All of that is book knowledge. It is learnable." They were able to express the need to understand mental illness as the first criterion for knowing their patients. The nurses have a working knowledge of symptoms of schizophrenia, medications, side effects, and other factors that would influence the exacerbation of symptoms. The nurses knew that this knowledge was important, but it was an understanding at the surface level, a beginning place to know what to notice about the patient, a springboard for evaluation. One nurse related, "We are not dealing with books. We are dealing with people. They have rights. They have feelings. They have emotions." In order to know the patient at another level, it was prerequisite that the relationship develops.

Assessing the case. Treatment interventions were based on knowing from assessing the case. Assessing is a comprehensive activity based on evaluating each patient over multiple interactions and looking for changes over time. The nurses considered patients' affect, posturing, and the way each person walked into the office. They observed their patients for change. They discussed knowing how the patients presented with psychotic symptoms and if that presentation was different. For example, were they sleeping or eating regularly? One nurse related,
You're using all your senses when you sit down with someone and talk with them. You kinda watch how they come in, how they present, how their posture is, and what their grooming and hygiene look like. And it all kind of comes to put in focus how they are getting along in their world.

Nurses use this information to ask questions or to determine how each patient is functioning at the time of the interaction.

The nurses discussed not making hasty decisions, thinking through what they were observing, and asking specific questions to clarify concerns. The nurses looked for changes in interaction, changes in attendance for appointments or groups, and changes in how patients respond to staff and other patients. The nurses reviewed patients’ living conditions, the type of support system they have, if they had family or friends who were regularly involved in their lives, if they were employed or volunteering, and what their mental and physical needs were. One nurse related,

We assess if their grooming goes downhill suddenly, or all the sudden they’re way better or a weight loss that’s happened too rapidly or a weight gain that’s happened too rapidly. . . . All the blood pressures on people every few months, weight, everything.

Nurses can find subtle changes that occur before symptoms are out of control or difficult to manage by assessing both the symptoms of mental and physical illness and how they are interacting.

**Understanding the person.** Nurses reach a point in their relationships in which they have worked with patients for sufficient time to move the relationships to “personal knowing.” They have had a history with each of these patients, have seen episodes of decompensation, and can identify the beginning of a psychotic
episode by noticing increased symptoms.

You start to know who they are and what they are, and what they, ya know, how they are, and so it’s actually a nice thing to be able to have these histories. . . . There’s a lot of openness once they trust and know you know them and know you . . . know how you are going to work with them. Not only do we know them, they know us, and so with that, there’s a lot of openness and willingness to usually just join in treatment.

Nurses can then discuss with patients the goals that the patients have for themselves (e.g., what their plans are for the future and finding those things that matter most to them). “I think you learn how they feel about themselves. It’s things that they learn, their coping skills, their lifestyle.” The nurses began to know the day-to-day happenings in the lives of patients in their care. They comprehended what patients were doing during the day, on the weekend, in the evening, and with family or friends. “Sometimes, working with people, you know more about them than you know about your family almost.” Nurses become important to patients’ lives by influencing patients through the nurse/patient relationship. Sharing intimate information in an open manner creates a therapeutic bond that influences treatment compliance. One nurse related,

Well, they know we expect it of them, that we get on them if they don’t come in, but they obviously know that they need their medications and that they do well on them, and if they don’t take them, they don’t do well. And I think they realize that they are important to us and that we care about them.

Socializing

Knowing is impossible without socializing. The nurse/patient interaction is focusing verbally on what is happening in the patient’s life. The nurse and patient
are identifying and reinforcing the development of interpersonal skills during the interaction. Socializing is defined as seeking the company of others, adapting to the needs of self and others, and sharing experiences. Nurses and patients enjoyed talking with one another. Exchanging interests, reviewing patient goals, and relating concerns of both the patient and the nurse were the topics of this category.

**Exchanging interests.** Patients spent time chatting with nurses about their activities. Nurses generally started the conversation with “How’s it been going?” Patients talked about having coffee with friends, going to groups, spending time shopping, volunteering jobs, working, going to movies, and exercising. Patients shared with nurses their activities and accomplishments, opening their social worlds. The following narrative is an example:

P (patient): We [patient and roommate] do something different on Mondays.
N (nurse): What do you usually do?
P: We go out to eat somewhere and then we go see a movie.
N: What movie did you see Monday? Did you go to a movie Monday?
P: Yeah. It’s called the “Do Guy.”
N: Who’s in that?
P: I don’t know. It’s like a high school movie.
N: Uh huh.
P: This guy, um, this guy is like a dork in school. He goes through prison and this Black guy shows him how to be tough. So, he goes to this other school, and he’s like kicking other people’s butts. He’s like a whole new guy. He’s a tough guy now.
N: Does he turn out to be good?
P: Yeah.
N: Okay, sounds good. I saw a movie last night. It took forever. “I Am Sam.” Have you heard of that one?
P: I have.
N: Oh, my heck. It was good but felt like a 4-hour movie.
P: Yeah, I’ve seen that one. It was pretty good.
The nurse and the patient were carrying out social interaction, with the nurse often modeling behaviors for the patient and encouraging with social cues.

Patients will often stop by the mental health center to talk or simply to visit with the nurse.

They could be coming here for any other reason or whatever, and they just drop in, and they could be here for 10 minutes. And they just talk about all these different kinds of things. They just feel like they are accepted. They feel real comfortable I think. I think sometimes they just need to touch base. And it’s not just one. . . . We have a lot of patients that come here and come in and see us.

While I was waiting in the lobby to observe the nurse/patient interaction, it was not uncommon for a patient to drop by and say hello, just to chat with his or her nurse for a minute.

**Reviewing goals.** Nurses spent time during the interaction reviewing patients’ goals. They applied what they knew about patient goal attainment from previous interactions and asked specific questions about their progress. During one of the nurse/patient interactions, the patient talked about how she was managing stress at work, a goal she had been working on for many months.

P: I’ve been dealing with everything pretty well I think.
N: Have you? Good. How’s things going with coworkers?
P: I just take them with a grain of salt, deal with them when I’m there and leave ‘em there when I go home.
N: Very good.
P: However, I think I found out ways not to get too stressed because they’re not going to get any faster than what they are, and if anything, they slow down.
N: So, what are you doing differently?
P: Well, I talk to myself a lot. It gets me through the day. I still have to wait a lot, but I don’t know, I feel like I have more patience. . . . I just made up my mind that I wasn’t going to let it bother me. They’re going to be the way they are, and I might as
well not go home upset and stewing about it and wreck the whole rest of my day. I mean, if it’s wrecked for a couple of hours, that’s fine. I mean, life goes on.

N: You’ve taken a major step. You’re right, life goes on, and it’s not all about [employer].

P: I just changed my whole attitude when I go there, and I’m not so frustrated when I leave, and I don’t feel like having road rage when I get in my car and leave there.

Patients talked about common experiences and movement toward community integration.

Relating concerns. During the exchange of information, nurses were assessing the patients’ behaviors. Based on affect, posturing, hygiene, physical symptoms, or side effects, the nurses provided feedback on their observations.

Nurses shared information in the context of the relationship and the understanding they had of the person. During one of the nurse/patient interactions, the nurse observed a patient who was experiencing an increase in tremors in her lower arms and hands. The nurse assessed the patient further using an abnormal involuntary movement scale. The nurse immediately called the patient’s medical care provider for a consultation. The nurse was able to set up an urgent care appointment for that same morning before the patient left the clinic.

Other nurses noticed concerns and related them to patients during their interactions. One patient was having difficulty with personal hygiene, wearing clothing to the clinic that he had slept in the night before. Apparently, he was also having a side effect (drooling while sleeping) from his medication. The nurse mentioned her observations to the patient and her concerns for his personal hygiene (appearing in socially appropriate attire). The nurse related her concerns in a
nonjudgmental manner, having personal knowledge regarding how to interact with the patient in a way that the patient would not be offended. The patient was comfortable sharing his concerns of frequent urination and at times experiencing urinary incontinence while sleeping. The nurse and patient problem solved to have the patient seen by his primary care provider that afternoon. The nurse arranged for a case manager to take the patient to his appointment.

 Patients mentioned their concerns and frustrations with reaching goals, experiencing major obstacles, or having emotional crises that had occurred since their last appointments. Nurses listened to a multitude of differing problems such as continuing auditory hallucinations, witnessing a death of a friend in the apartment complex, being arrested due to increased confusion while driving, moving to a new apartment, having questions about past issues of being incarcerated while ill, experiencing urinary incontinence, having nightmares about the death of a roommate, experiencing conflicts in a long-term relationship, shoplifting charges, difficulty getting a balanced meal, having problems with stomach bloating, having difficulty with structuring time, and having difficulty remembering to take medication on time.

The variety of concerns is evident. Many of the patients had experienced a recent loss of a friend or family member. Nurses were those with whom patients talked about their losses. They asked patients about their feelings and were there to provide emotional support and empathy. Nurses listened to patients' concerns, clarified the issues, and then moved back through knowing to normalizing to
problem solving with the patients how to incorporate new behaviors and coping skills.

Normalizing

Nurses and patients identified concerns and areas in the patients’ lives that keep them from full recovery. The category of normalizing is more action oriented, the intervention part of the interaction. Nurses assist patients to incorporate tasks into their activities of daily living. They also explored with patients behaviors that are not necessarily a part of their lifestyles but may improve their ability to successfully function in the community. Nurses encouraged behaviors that lead to recovery, particularly focusing on new skill development.

Nurses focused specifically on medication compliance and health behaviors such as hygiene, nutrition, sleep, hypertension, physical symptoms, and appetite. Nurses also identified areas of concern with transportation, housing, money management, groceries, case management, and follow-up appointments with providers. Nurses engage patients in planning, teaching, and implementing skill development. Normalizing is the integration of new skills as part of the patients’ tasks of everyday living.

Medication compliance. Nurses spent time during the nurse/patient interaction talking directly about psychotropic medications. Nurses assisted patients with filling weekly medication boxes, filling out medication assistance forms, calling in refills to pharmacies, and scheduling appointments for follow-up with providers. Nurses described these behaviors as normalizing for patients, helping
them incorporate these behaviors to become a habit—a task that transpires on a weekly basis. One nurse related,

I think for some of them this behavior becomes normalized because they . . . have been doing it for so long. . . . They’ve been filling med [medication] boxes, or they’ve been coming to me for answers or to fill out forms or to ask me what to do with something they get in the mail. I think for a lot of them that is normal.

Nurses speak directly with patients about compliance with medications. They identify concerns regarding patients taking medications as prescribed.

Treatment compliance with medications is essential for patients to maintain stability and live in the community. Nurses discussed the difficulties that arise when helping patients take medications as prescribed. One nurse related,

She has a tendency to want to change her meds [medications] every other week. She has a tendency to adjust her levels of medications and doses to anything she wants. What [patient] doesn’t share is how many doctors she sees and how these medications, the opiates, the tranquilizers, interact with the psychotropics that she is taking. My concern is that she is never comfortable.

During the nurse/patient interaction with this patient, the nurse was clear about the problem.

N: What are you doing with the doses? Are you changing them, mixing them up, anything?
P: No.
N: To kind of fit where your mood is?
P: No. I was just doing what I was told.

Later in this interview, the patient related, “I do better with my meds [medications] when I take them at a certain time. Sometimes I mess up and take them later.” Then the patient shared that she had been taking Lortabs (prescribed by the dentist).
N: What did they give you?
P: Lortabs.
N: Well, sometimes that makes you feel worse than anything.
P: I know.

The nurse processed information with the patient, assisting her in making decisions in her best interest. Nurses can help provide choices and talk with patients about alternatives. "They have a right to choose. I will try to help them have a better life."

Planning activities of daily living. A major task of the nurse/patient interaction was problem solving the concerns patients shared regarding their activities of daily living. For many patients, problem solving took the form of helping them to structure their time and to decrease social isolation. Nurses vocalized considerable interest about patient isolation. One nurse explained her concern, "He really has no life outside of that apartment. He eats there, watches TV, smokes, and drinks his beer." Another nurse also worried about similar problems of social isolation.

I think the most important thing that I try to work with [patient] is not to isolate. He tends to lock himself up in his apartment and gets bored, gets depressed, and then he starts to drink. And he has a hard time making friends, and I don’t think he’s made any really good friends where he lives yet. So, he has a hard time with this.

Nurses search with patients for alternatives in the community that help to meet their needs for decreased isolation. Referrals are made to mental health programs such as day treatment, work rehabilitation, school, and volunteer opportunities. One nurse related,
If patients are sleeping all day long or just in the house watching television or their only activity is they walk the dog, . . . well, that's not enough. So, I try to get them to do day treatment or something like that, a couple of days a week, just to get out and be around people and more than just walking the dog.

Another nurse related,

I encourage her to do things with people in the evenings so it isn’t so hard for her, and I try to get her to hook up with friends, to do things with her mother, do things with her son, ya know, because she really struggles. . . . The main thing is that they feel useful and busy. . . . I don’t like them sitting at home all day getting depressed.

Patients need a sense of purpose, a sense of connection with others. Another patient was encouraged to participate in volunteer work. “There she experiences contact with people, and it gives her something to do during the day. She’s doing somewhat better now.”

Other concerns by the nurses regarding activities of daily living were hygiene needs, groceries, housing, laundry, money management, and transportation. One nurse related,

We help them with case management and try to get people moved into places that are reasonable and affordable. . . . We do a lot with housing, yeah, that are actually [a] better fit for them. Sometimes they will be at one place, and it just isn’t working, but they can function at another facility or at another place. And we try to help them with that.

Teaching healthy lifestyles. The nurses discussed and helped patients implement plans for healthy lifestyles. They talked with patients about diet, exercise, sleep habits, managing health-related problems of diabetes and hypertension, personal hygiene, smoking cessation, and weight loss. Nurses related
that patients do not always recognize healthy lifestyle behaviors.

We still have people in 100-degree weather who will wear a coat in here and people who are not taking care of themselves in the winter, not wearing adequate clothing. So, yes, we do talk to all the clients about their intake, their digestive problems, their clothing, hygiene, all of that.

At times, patients eat only one food for weeks at a time or wear only one set of clothes for weeks at a time. Following is an example of nurses asking specific questions on the subject of healthy behaviors:

N: Are you getting enough water to drink?
P: Yeah, I am.
N: Good.
P: I’m on that Citracel, too.
N: Have you noticed a difference since you started with that?
P: I don’t use it very often. I’ve been eating more fruits and vegetables.
N: And walking?
P: Walking is the best.
N: Yeah, walking does it best. I’m really impressed that you have been getting up so early and going walking every morning.
P: People say I look like I’m coming down.
N: Well, you’re losing weight. Your diabetes is much more under control. So, the changes you made and the things you are doing are helping you be healthier. So, you’re doing a great job.

Nurses talked with patients about substance abuse. Nurses articulated that substance abuse is a problem for patients. One nurse, working with patients with a diagnosis of substance abuse and schizophrenia, related,

I think it gets back again to the substance. . . . The substances become a coping mechanism for anything that happens whether that be positive or negative. Their response is, “I want to get high, I feel good, I wanna feel better” or “I’m feeling really bad, this is a black hole, and I don’t see anyway out. I just don’t want to feel like this right now.”
In teaching healthy lifestyles, nurses will talk with patients about these extremes. One nurse stated,

Yeah, you felt good for half an hour, but now you don’t have the money that you were going to use to pay the rent. You don’t have money for food. Your meds [medications] aren’t working well, and you’re having more side effects.

Nurses will discuss the consequences. Was the effect of the drug worth the consequences? Nurses will allow patients to experience the consequences of their behaviors. Nurses provide alternative solutions and coping strategies. Nurses do not project their values on the patient. “They have a right to choose. I will try to help them have a better life by helping them fight their substance use.”

Celebrating

Celebrating is also connected to every category. Nurses celebrate successes with patients on every level by praising, speaking to them with approval or admiration for accomplishments, strides, and gains. Celebrating can be expressed both verbally and nonverbally. Direct, overt words used include “good,” “good for you,” “okay,” “great,” “I’m glad,” “really good,” “sounds good,” “all right,” “very good,” “you have taken a major step,” “you’re getting there,” “I’m impressed,” “congratulations,” “pat yourself on the back,” “fantastic,” “very cool,” “I’m glad to hear that,” “you do a really good job,” “looks good,” and “you’ve made a lot of improvement.” Nurses also used nonverbal communication with smiles, a light touch of the hand on a shoulder, patting their own back, and clapping their hands. Celebrating occurred in three areas: (a) acknowledging
accomplishments, (b) reinforcing changes, and (c) praising goal attainment.

Acknowledging accomplishments. Nurses greeted each patient. The nurses made eye contact, smiled, welcomed each patient, and then gestured for the patient to sit down. Nurses recognized that each patient made an effort to come to the appointment and they were pleased to see them. The small day-to-day successes were noticed and appreciated. All patients had at least one but generally several accomplishments that moved them closer to their goals. The nurses consistently demonstrated their pleasure with the patients’ disclosures and helped them to acknowledge that movement had taken place toward their goals. The nurses helped the patients feel validated for the work they were accomplishing. The following narrative provides an example:

N: What do you have planned for this week?
P: I don’t know. I went to group yesterday.
N: What did they talk about?
P: We went around the room and talked to the people about their illness.
N: Um hum.
P: And how they recover a bit, things like that.
N: Ya know, you seem to like that group.
P: Yeah, I like that group.
N: How come?
P: Well C. and M., they do a good job at getting instructions out and the sheets of paper with telling about different mental illnesses and stuff.
N: Okay.
P: And how to cope with it.
N: Do you learn from that group?
P: Yeah, I think so.
N: Good.
P: I learn to be more positive.
N: Okay, so, there’s something you have been able to use in your life. Great, well, I’m glad to hear that it’s a good group and you are attending and learning to be positive.
Reinforcing changes. As patients are able to add new behaviors and to make lifestyle changes, nurses voiced these changes. Nurses related that constant reinforcement is important. Reinforcement strengthens the tendency of patients to act in a desired manner from the positive social rewards. One of the registered nurses related,

So, just the constant message, the consistent relationship. . . . We’re pretty motivated to keep him here and keep him working on the same goals. . . . It’s daily feedback on the substance abuse on the medication compliance. Even now, when he first came, he probably took 60% of his medications. We’ve got it up to about 80% at this point.

Having a support system, someone they can turn to whom they believe and trust, who cares for them, who can help them transfer information into changes, is extremely meaningful. Having consistency, reassurance, and reinforcement for those changes helps reduce relapse behaviors. Nurses were approving in language and behavior. They exhibited trust that patients would follow through with planning that had taken place during the nurse/patient interaction.

Nurses also reinforced healthy lifestyle changes. One nurse stated,

We have one who came in who is walking more and stuff like that. Every time they weigh themselves, and we keep it recorded so they know exactly to the pound. They get real excited. I think it’s cuz we’re talking about trying to eat better, exercise, drink more water in the summer time. We talk to them about it. Just what everybody should do and then they get kind of excited about that. . . . They share all that stuff, and we get excited about them making healthy changes.

The nurses celebrated with the patients as they were able to incorporate changes.
Praising goal attainment. Nurses related their perceptions of their role in working with patients with schizophrenia. One nurse shared,

It’s about them, not about me. . . . I am responsible to try and help them be the best that they can be and succeed at the things that they want to succeed at. Those are the things that I really try to keep in mind most.

The nurses described the joy of sharing personal successes with the patients. One nurse related,

It’s like working with a friend, and they tell ya they’ve made something. They made that sale, they got the promotion. . . . You shake their hand, you smile, and pat them on the back and say damn good job, and you reinforce it. Then you look at what it was that made it possible.

It is celebrating together, sharing the pain and the joy. Nurses celebrated patients reaching their goals. During participant observation, several patients reached their goals. One patient began a volunteer position, another moved into her own apartment, a patient followed through with legal action to obtain her inheritance, and another lost weight through exercise and diet. All patients met with accolades from the nurses.

One of the nurses reported that she and her staff have a yearly awards dinner with all patients in the program to celebrate their accomplishments that year.

We have an awards banquet once a year. This year, everyone’s family is invited. . . . They [the patients] get a certificate of achievement. Pictures are taken, and we as a staff spend a lot of time looking at how they have grown over the year and what they’ve done through the year. Everyone has accomplished something. We make a really big deal of it. . . . Everyone applauds, and they stand up and walk to the front. It’s kinda cool.
The nurses identified the successes, providing approval, respect, and admiration for achieving goals.

**Moving Between Categories**

The categories were not mutually exclusive. They shared similar features with each other. The categories were separated to clearly describe the properties and dimensions. Movement flowed easily between, within, and among the categories. Interpersonal modulators building rapport, exploring skill development, instilling hope, approving community integration, and encouraging recovery represented the combining influence between the categories and allowed for the flow of movement (see the Figure). The interpersonal modulators were not separate from either category but were symbolic of the connectedness between the categories. The interpersonal modulators were descriptive of what was transpiring in the relationship between the nurse and the patient in progressing towards getting it, together or treatment compliance.

**Building rapport.** Observing the nurse/patient interactions provided clear evidence of building rapport activities that occurred throughout the interaction. The different settings of the interviews were spaces of the nurses’ choosing such as an office or common area, meeting with patients individually and managing the tasks of helping with medication boxes or injections. No physical barriers were between the nurse and patient as they talked. Each of the nurses’ offices was open, decorated to personal taste with sofas, chairs, and tables. Space was sufficient to allow for personal distance. The nurses tried to provide an atmosphere for patients
to feel at ease.

From my observations and field notes, I found that nurses worked side by side with patients on medication boxes. A comfort level was exhibited by both the nurses and the patients. The nurses spoke clearly in language that the patients could easily comprehend, resulting in a sense of working together. Time was given to patients to disclose or share their concerns as the nurses listened. A sense of humor was exhibited at appropriate times. Discussing patients’ issues proceeded in a nonconfrontational manner.

Patients were offered an invitation of support. Nurses asked patients to call or stop by the office if they were having concerns or if they wanted to touch bases. In order to build rapport with patients who had not been in for treatment for a period of time, nurses would seek out patients in the community. One of the observed nurse/patient interactions occurred in the community on an outreach visit to a patient who had not been seen by the nurse for several months. The nurse visited the patient in a downtown hotel that had been converted into a rooming house. The nurse had expressed some concern about the patient. Part of the narrative follows:

N: We’ve just headed into winter and bad weather, and I hadn’t seen you all summer.
P: I know, man, I know.
N: I know how you are in the winter time.
P: Ya know, and I’ve known and it’s not now, and I’m just totally whooped. . . . I’m more excessive.
N: When you get the urge, drop in. Stick your head in and say hello.
P: And then, um, and that’s, and it’s highly appreciated. . . . It’s great though, I love it. You’ve been great.
The patient was appreciative of the nurse checking in with him. The patient was having considerable difficulty with increased psychotic symptoms. In spite of his psychiatric difficulties, the nurse was able to reach out, make a connection with the patient, and invite the patient to return to treatment. The nurse made comments to the patient to drop by at his convenience. Building rapport facilitates the movement between knowing and socializing. The nurses related that they need to concentrate on relationship building with patients throughout the time they are working together. As the relationship develops, change occurs in patient compliance.

**Exploring skill development.** Patients initiated topics of discussion as the interaction began. Nurses then clarified topics and connected them to specific patient needs. Nurses asked patients about their desired outcome (point of view) and what would meet their needs. Nurses asked specific and direct questions from knowing the patient. Exploring skill development and specific needs led into the normalizing category. Nurses and patients were able to focus on the benefits of adding new skills into their normal activities of daily living. The following narrative is an example of one of the interactions:

N: How lonely are you at your apartment?
P: I think very lonely because I just stick to myself. . . . I'm wanting to get into the habit of going to see my friend JJ.
N: Okay.
P: Over to her apartment, we've been planning on that forever and keep missing each other.
N: Uh hum.
P: And then I hurt my back and I lost my friend.
N: And you lost your friend B?
P: My very best friend B.
N: Yeah, those are important losses.
P: Yeah, so, I hate to go out and find another friend.
N: It is better than staying lonely and staying home and feeling sad.
P: Yeah.
N: Ya know, I think Dr. G. has got you on a combination of meds [medications] that’s working for your particular symptoms, ya know. It has made you feel better and you are doing this volunteer work at the library, which is getting you out of the house. But, you do need some friends.
P: Yeah.
N: You need someone to go shopping with. You need someone to go to coffee with.
P: Yeah.
N: Someone who you can sit with and talk about your grandkids with.
P: Yeah, that was B.

The nurse then talked with the patient about the loss of her best friend, processed the information, and made plans with the patient to reconnect with another friend. The interpersonal exploration of skill development is a bridge between knowing and normalizing.

**Instilling hope.** Nurses related that working with this population was their passion. I observed the emotion and intensity the nurses displayed during the participant observation interactions and while I was interviewing the nurses regarding the role they play in their patients’ lives and the reciprocation in their own lives. The nurses delineated the commitment necessary to work with patients with schizophrenia. One nurse stated,

I think of the longevity with clients, you can have the history, but the links of that history, the longevity that you spend with these clients and how it evolves over the years. . . . We do get that close and I think it is important.
The nurses vocalized that the patients have “a terrible illness” and, at times, problems with substance use, which “makes things worse.” The nurses were empathetic with patients and their needs, hopes, and desires. One registered nurse reported, “I’m certainly not going to be punitive with them because they have gotten that from the rest of the folks around them.” Nurses related that patients are estranged from their families, have few friends, and are frequently used and exploited by others. The nurses maintained an optimistic stance, which is different from others in the patients’ lives. One nurse shared,

I try to maintain a warm professional relationship with them. I try to point out problems I see coming up and where I think those problems are originating from or what they can do to change what is going on in their lives so they can be better.

Nurses, through knowing their patients, provide a reflection of the past and direction to the future. Nurses identify improvements, acknowledge contributions, approve hard work, and direct patients toward activities and behaviors that are specifically rewarding to the patients. Nurses are interested in patients making decisions in their best interests. Instilling hope is a modulator between knowing and celebrating (see the Figure). Nurses understand patients, do not “give up” easily, and are consistent when the situations are most difficult. One nurse said, “Because they [patients] still tend to turn it around [and] pull it together.”

**Approving community integration/encouraging recovery.** The interpersonal processes of approving community integration and encouraging recovery are analogous. Nurses provide feedback that progress made towards community integration is satisfactory and give support and confidence to stimulate recovery.
During the participant observation interactions, I noticed that the nurses would converse with patients about how the patients planned to reach their objectives in the week(s) to follow. I observed moments when nurses connected with patients on an emotional level. Nurses demonstrated a capacity to reflect and orchestrate with patients plans that had an impact on the needs that patients expressed.

During one specific interview, a patient was disappointed because he was unable to attend an activity at a new day-treatment program he had just begun. He was becoming discouraged, as he had enjoyed participating in this activity at a different day-treatment program. He was unable to participate in this activity, as the activity had a limit to the number of people who could attend. The activity quota was full prior to his entering the new program. The nurse reminded the patient to keep trying, acknowledging past community integration, while directing the patient by encouraging further recovery toward activities that were rewarding to him, as is demonstrated in the following narrative:

N: So, when is the next camping trip?
P: Next week. I couldn’t go. There’s three of us that couldn’t go.
N: Why was that?
P: I have to wait for the next one.
N: For the next one?
P: Yep.
N: You always enjoyed those so much.
P: I just started there, so supposedly that’s why I can’t go, because others have been coming.
N: I see. Well, shoot for the next one.

The nurse continued to endeavor to move the patient toward decisions in his best interest. They discussed other activities that he could be involved in throughout the week, deciding on several groups at the day-treatment program as
well as connecting with a program at the veterans administration.

Nurses related that treatment compliance is “what will really make or break their [patients’] success and what will make or break their [patients’] recovery.” For patients who are not motivated to be compliant with treatment, “It opens up the world for them.” The nurses, through encouraging recovery and community integration, can
give them something to look forward to, something to hope for, something that they can believe in and just give a little taste of success, if they can just get that little bit of success under their belt and say ahh, okay, I can do this.

Nurses viewed the success they shared with patients participating actively in treatment and with recovery as partially due to their consistency in working with patients and the partnership that is developed,

truly caring for them as people, not seeing them as an illness, recognizing the uniqueness of them, and giving them a sense of empowering and a sense of control over their own lives. It’s letting them know they are in charge of their recovery.

The nurses’ messages are that patients are in charge of creating their lives and they are there to support what is working.

Compliance Levels and the Model

Each of the 5 nurses identified one patient with schizophrenia on their caseload who would fit into one of each of the three compliance levels. The high compliance level included patients who were actively involved in the prescribed treatment from 100% to 75% of the time over the past 12 months; the medium compliance level included patients who participated and followed the prescribed
treatment from 74% to 50% of the time over the past 12 months; and the low compliance level included patients who followed the prescribed treatment 49% or less of the time over the preceding 12 months.

The nurses followed the Getting It, Together model with patients in all compliance levels. The nurses used this model in deciding treatment interventions, making return-for-care appointments, and helping patients understand the advantages of following treatment as mutually agreed upon. The nurses made decisions individually with patients, following the model to evaluate the needs of each patient (see the Figure).

Nurses related feeling excited about the progress of patients in the high-compliance level. Concerns expressed for these patients were with continued progress working toward their goals of recovery. Patients in the high-compliance level were identified as being able to identify and being more open about their symptoms. One nurse explained,

"Now, he will admit if he is hearing voices, um, he's managing to cope with them. I don't think his voices will ever completely go away, but I think, ya know, we're still working on our relationship, and I think he is trusting me more."

Building rapport and trust continues to deepen through each compliance level. Nurses agreed that understanding symptoms and the comfort of the relationship increase the patients' willingness to talk about real concerns and to work on issues that are important in the patients' lives. One nurse suggested, "Well, I think [patient] feels comfortable with me, and I think she feels comfortable because of the relationship.” The nurse also described that these
patients were doing well because they were following through with prescribed
treatment:

He’s taking the medications he is supposed to. I mean, he’s really
compliant with them and the blood draws. You don’t ever have to
call him up and remind him to come in or [be] concerned that he’s
not taking them the way he should. So, he’s fairly stable at this time
and continues to work and be active in the community.

Nurses depict patients at this level as being more focused on “getting their life
together.” They also shared that patients are “doing as good as [they] can”; they
are doing “remarkably well.”

Nurses working with patients in the high-compliance level utilized the entire
model of Getting It, Together. As problems occurred, nurses moved from knowing
to socializing back to knowing to normalizing to problem solving with patients and
moving towards resolution (see the Figure). Nurses interacted more with patients in
the high-compliance level, celebrating the patients’ accomplishments and further
solidifying the progress that was taking place.

Patients in the medium- and low-compliance levels were having significantly
more problems in their lives, which was evident during participant observation.
Nurses and patients in the medium- and low-compliance levels discussed
difficulties with substance use or abuse, poor social support, housing issues,
increased psychotic symptoms, recent hospitalization, difficulty accomplishing
activities of daily living, inadequate social and independent living skills, money
management troubles, untreated medical symptoms, criminal charges, isolation and
estrangement from family and friends, poor judgment and impulse control, and
cognitive deficits. The nurses used the model to effectively engage patients in treatment at any level in which the patients would be willing to participate. One nurse related her concerns as follows:

I’ve worked with him for so long that now my biggest concern is keeping him out of the hospital and in housing. [Patient] was homeless for about 6 months, had to spend time in the shelter because he stayed in the mental health housing several times and was kicked out because of his drinking. So, my biggest concern is to push his alcohol and drug use treatment at the VA [veterans administration] and hopefully keep him in housing. Ya know, he’s not ever going to quit completely, ya know, but hopefully keep it to a minimum.

As the model, Getting It, Together, depicts, nurses utilized interpersonal skills to help patients maximize their treatment despite the difficulties that happened in their patients’ lives. The goal was to work with patients where they were, to engage them in the process, and, over time, to find the thing that would help the client to want to be compliant. Getting to know that person as a person and trying to find out what would motivate compliance with them instead of using, ya know, commitments or power or threats, but really trying to find out why would they want to be compliant and finding that the patient can have the goals that he or she wants and not get stuck in the hospital.

Summary

Five nurses and 15 patients from a large western state community mental health center were observed during a nurse/patient interaction. The 5 nurses were interviewed. A grounded theory approach explaining the process used by nurses to enhance treatment compliance for patients with schizophrenia was developed. The process, getting it, together (see the Figure), used by nurses during the
nurse/patient interaction, was effective at each compliance level in enhancing and promoting treatment compliance for patients with schizophrenia living in the community. The model, Getting It, Together, was derived from observing the nurse/patient interaction and interviewing the nurse participants. The data were analyzed through constant comparative analysis. The core category of knowing, along with the complementary categories of socializing, normalizing, and celebrating, explains the role of nurses in the process of helping patients with schizophrenia joining in treatment.

While observing nurse/patient interactions, it was clear that knowing the patient provided the nurses with a clear understanding as the patients related concerns. Asking specific questions based on knowing the patient while socializing with the patient moved the process to the categories of normalizing, celebrating, or both (see the Figure). The following narrative from one of the nurse/patient interactions demonstrates the model:

N: How have you been doing with your caffeine consumption?
P: Pretty good.
N: [Laughter] Pretty good—so, tell me what pretty good means this week.
P: I haven’t bought any sodas.
N: So, you aren’t buying any more cokes?
P: No.
N: Okay.
P: But someone gave me some.
N: Okay, so, how many do you think you’ve had this week so far?
P: I’d say 12 all together.
N: People are giving you 12? Without expecting you to pay them back?
P: Uh hum.
N: Okay. You’ve had 12. Is that 12-ounce cans or 29-ounce bottles you’re talking about?
P: 12-ounce cans.
N: Okay, you had 12, 12-ounce cans.
P: I have.
N: That means 4 a day. Right?
P: No, I had 12 yesterday.
N: So, you had 12 yesterday. What do you know about caffeine?
P: It makes me go too fast. It ruins my teeth and gums. It causes me to have heart problems. I already have heart problems.
N: It can also cause problems with your stomach. What can it do to how you feel?
P: Depressed, down.
N: How about anxious?
P: Anxious.
N: How about sometimes paranoid?
P: No, not paranoid.
N: Okay, I have another question for you.
P: Okay.
N: Do you really want to stop drinking caffeine?
P: I’ve had a hard time convincing myself.
N: Do you think that’s what keeps you from saying no when they offer it to you?
P: Uh huh, because I want it.
N: I know. And you know, . . . it’s not about me, but caffeine affects you, not me.
P: I’m not going to have another.
N: I’m feeling kind of stuck. Are you?
P: About what?
N: The caffeine thing.
P: I promise I’ll be doing better today.
N: Ya know, once again, it’s not really for me that you need to be doing it.
P: I know, it is for me. I’m convinced.
N: Good. Good, okay, you feel that way, that it’s for your own health. Just keep trying, okay? You’ve actually made a lot of improvement and progress. You really have. Okay, so, give yourself credit for the progress.
P: Okay.

By knowing and understanding patients, nurses are able to talk about concerns during socialization and then approach nursing interventions in an open
and honest manner in normalization. Nurses can then acknowledge patients and celebrate their accomplishments.
CHAPTER 5

DISCUSSION

This chapter provides linkages between the Getting It, Together model and other theoretical perspectives. Implications for nursing practice, education, and research are also presented.

Related Literature

The role and primary function of mental health nurses are difficult to define (Hamblet, 2000; Jackson & Stevenson, 2000; Krauss, 2000; O’Brien, 2000). Mental health nurses are facing pressure to examine the nature of their practice and to articulate their primary function. The role of mental health nurses is not only difficult to establish by the nursing profession but ambiguity also exists of their role by other mental health professionals and by the population in general (Jackson & Stevenson, 2000; Spink & Go, 1998). A public survey for the Mental Health Foundation 1990, called “Mental Health Survey of Public Attitudes,” revealed that the general public was unable to articulate or recognize the central role of nurses in the community care of patients with schizophrenia. Of the 1,804 adults surveyed, only 14% considered nurses as the caregiver who could most successfully help patients with schizophrenia transition to a normal life in the community (Spink & Go, 1998).
Nurses have been identified by other mental health professionals as having high visibility tasks such as giving injections and managing medications (Hamblet, 2000). The role that mental health nurses have identified as being most essential is related to building interpersonal relationships with patients, but it is also less visible. Jackson and Stevenson (2000) found that community mental health nursing has moved away from task-oriented labor to a more interactive approach working with patients in ordinary settings. Nurses are frequently involved with clinical management tasks where patients live, work, and play, necessitating a shift in the nurse/patient relationship. One goal becomes the establishment of a genuine and respectful negotiated partnership with patients that continues over a lengthy period of time (Krauss, 2000). Both nurses and patients develop relationships that are longitudinal. Nurses and patients develop histories together that affect how they respond in the relationship. Nurses form a graduated sense of understanding and knowing their patients through this shared history (Raingrubber, 1999).

Recognizing and understanding patterns of behaviors exhibited by patients come from relationships based on history and knowing the patient (Liaschenko, 1997; Raingrubber, 1999; Tanner, Benner, Chesla, & Gordan, 1993). Jackson and Stevenson (2000) ascribed the role of mental health nurses as being able to understand from interactions with patients what they need or expect at any time. The core category from this study, knowing me, knowing you, involved a predictive dimension in which nurses can understand how patients want to be responded to, given the understanding of each patient’s world. Raingrubber (1999)
described this concept even further. Understanding a patient comes in part from previous experiences with other patients who manifested similar symptoms and in combination with understanding the current patient’s present needs. Mental health nurses are able to anticipate and recognize patient needs from present symptoms. Knowing the patient by anticipating and recognizing needs is a significant role for mental health nurses. Jackson and Stevenson (2000) related that members of the professional team depend on mental health nurses knowing the most about their patients. Nurses spend more time with patients than others on the healthcare team, making this nursing time unique.

Knowing the patient is a part of nursing that has been identified by researchers as essential to nursing practice (Liaschenko, 1997; Tanner et al., 1993). Knowing can be described as a state of having knowledge, an awareness, or an understanding that is gained from practice, experience, or study (Carper, 1978; Kramer & Chinn, n.d.). In a social context, nurses have discussed a variety of ways in which they have knowledge of patients.

Knowing the patient has been linked to skilled or expert nurses in providing patients with required services for the situation. The more skilled nurses become in perceiving and empathizing with others, the more knowledge they will gain to use in other situations. Skilled nurses gain alternative modes of perceiving with a greater number of experiences (Liaschenko, 1997; Tanner et al., 1993).

Knowledge of a case or diagnostic categories is one level of knowing. Nurses have a working knowledge of biomedical issues, protocols for diagnostic
categories, possible complications, patient outcomes, and clinical interventions. In beginning a relationship, nurses explore patients’ histories, demographics, and supports as well as how and what they know from their experiences as related to a particular patient. This knowledge enhances skilled nursing care and the use of clinical judgment as well as increasing culturally appropriate responses (Liaschenko, 1997; Tanner et al., 1993).

Liaschenko (1997) delineated another dimension of knowing the patient. Knowing the patient as a person was a dimension of the nurse/patient relationship in which the nurse demonstrated a deep commitment to patient agency or knowing the patient as a person who acted with desires and intentions. Nurses understand patients’ motivations and how they engage with the world. Nurses attempt to integrate treatment into patients’ patterns of daily living by providing them with a sense of confidence about living their lives (Liaschenko, 1997).

Knowing is a central theme for the nurse/patient relationship. Knowing the patient well enough to share an alliance is the basis from which nurses and patients move toward recovery (McCann & Baker, 2001; O’Brien, 2000; Whittemore, 2000). From the current study, it was found that knowing the patient was key in facilitating transitions, guiding when and how to disclose information, and assisting patients to move toward their goals and beyond their limitations. Knowing the symptoms of mental illness and treatment provided nurses with the ability to assess patients’ mental status over the course of their interactions. Knowing patients’ everyday world allowed nurses to assess their particular early warning signs of
relapse. Knowing patients also directly influenced nurses’ decisions of how to prioritize information and to take action from this information (Liaschenko, 1997; McCann & Baker, 2001; O’Brien, 2000).

From the current study, results demonstrated that knowing each patient as a person related to spending time with the patient, giving the patient an opportunity to talk, and helping the patient understand the meaning of his or her experiences. The nurse/patient relationship provided a safe environment for the patient to talk. Nurses described visits with patients as taking on a social context. The nurse and the patient shared experiences. It was important during the nurse/patient interaction for nurses to talk about themselves, being open and using self-disclosure to help patients be at ease (Jackson & Stevenson, 2000; McCann & Baker, 2001; O’Brien, 2000).

Conversations with patients provided avenues for nurses to assess their patients’ mental states. Nurses assessed for specific symptoms of their patients’ illnesses during their interactions that allowed for the opportunity to intervene if the patients’ presentations alerted the nurses to possible problems (McCann & Baker, 2001; McDonald & Badger, 2002; O’Brien, 2000).

From the patients’ perspectives, socialization with their nurses allowed them to verbally express their current needs and concerns. Patients could also receive feedback from nurses in the form of reality testing of their concerns. This interaction occurred in an environment where patients viewed nurses as friends or advocates and where patients shared personal experiences and information in a two-
way relationship based on reciprocity and respect (Jackson & Stevenson, 2000).

Community mental health nurses acknowledged the importance of the social aspect of the nurse/patient interaction. This interaction became a social time for patients (Jackson & Stevenson, 2000; McDonald & Badger, 2002; Muir-Cochrane, 1998; White, Bebbington, Pearson, Johnson, & Ellis, 2000).

According to Muir-Cochrane (1998), a consistent and understanding approach was seen as essential to enhance treatment compliance with increased outcomes of the patient returning for further clinic appointments. Muir-Cochrane noted that establishing rapport, making a connection, and mutually relating with the patient were essential functions of the nurse/patient relationship. Mutually relating with the patient involved conversing about social issues. This socialization facilitated openness and honesty when relating. Openness and honesty helped patients relate their concerns about their illnesses or with areas in their lives in general. As seen in the current study, the social and intimate nature of the interaction acted as a catalyst for nurses to play an educative role in relation to the patients' concerns. The patients' ability to recognize early warning signs, the effects of medication on maintaining wellness, and the identification of side effects were enhanced through this interaction (McCann & Baker, 2000; Muir-Cochrane, 1998).

Knowing the patient was a priority of the nurse prior to providing treatment intervention. Knowing was also an important aspect prior to educating patients about their illness and to providing treatment options. Nurses used educational
interventions to inform patients about "normal" and "safe" ways to confront personal issues (O'Brien, 2000). During the current study, I found that knowing the patient also contributed substantially to exploring problems with patients. Nurses would reframe situations to provide a normalizing frame of reference to the issue or concern. Nurses acknowledged patients' feelings, which normalized and clarified patients' feelings, helping to explore future options (McCann & Baker, 2001; O'Brien, 2000).

Within the nurse/patient relationship, knowing was an important element in helping patients set realistic and achievable goals. Nurses worked with patients to plan for the future. Nurses helped patients to choose their own goals, making it more likely that patients would actually achieve their goals (McCann, 2002).

The normalizing process included ways of reestablishing social networks and friendships that had been lost due to significant symptoms of patients' illnesses. The normalizing process was also part of the nurses' role to encourage and facilitate the development of a continuum of community relationships (Forchuk, Jewell, Schofield, Sircelj, & Valledar, 1998). Nurses discussed the value of renewing relationships and planned with patients how to reconnect with their social worlds. This type of social support provided a normalizing function and reestablished social networks (McCann, 2002; White et al., 2000).

The partnership between a nurse and a patient fostered the patient's recovery through setting and achieving goals, increasing knowledge, improving social skills, and strengthening support systems. Patient involvement in community
activities was effective in normalizing daily life experiences and in decreasing perceived barriers of stigma (Adams & Partee, 1998; McCann, 2002; O'Brien, 2000).

Setting and achieving goals were important aspects of instilling hope for patients with schizophrenia living in the community. It was not unusual for patients to have lived in large institutions or to have gone for help in emergency departments, which may not have allowed patients to actively participate in setting their own goals, thus stripping them of hope (Kirkpatrick et al., 1995; McCann, 2002). Patients could experience a cycle of disempowerment that leads to symptoms of institutionalization, including apathy, resignation, anger, submissiveness, depression, anxiety, and withdrawal (Kirkpatrick et al., 1995).

Harrison and colleagues (2001) encouraged optimism as an important aspect of recovery for patients with schizophrenia. Over a period of 15 years, they observed a pattern of positive outcomes for patients with schizophrenia. They also related that expectations of recovery and hope for the future of patients by providers should not be overlooked. Data supported the case for providing encouragement for community integration and employment for patients with schizophrenia. DeSisto, Harding, McCormick, Ashikaga, and Brooks (1995) related that the most important value of treatment programs for patients with schizophrenia comes from the “pervasive attitude of hope and optimism about human potential, through the vision that, if given the opportunity, persons with mental illness could become self-sufficient” (p. 340).
Strategies planned with patients during the nurse/patient interaction, which were based on knowing the person, made a difference in patients experiencing a sense of hope. As was described during this study, the process of knowing the patient enabled the nurse and patient to discuss his or her hopes and dreams. Nurses encouraged patients, enabling them to experience a sense of hope. Through the nurse/patient interaction, nurses attempted to weave these hopes and dreams into interventions and move toward recovery (McCann, 2002).

Motivation for personal growth cannot be imposed by nurses on patients; rather, motivation needs to be nurtured. Nurses assist patients with planned successes to move forward in their daily lives. As successes occur, patients experience an increase in self-esteem and hope. A sense of purpose within the context of the supportive relationship contributes to this transition (Kirkpatrick et al., 1995; McCann, 2002).

The treatment message from nurses (i.e., they are available to walk with patients on their journey towards recovery) gives a message of hope to patients. Treatment includes learning from setbacks and celebrating the steps toward recovery (Harding & Zahniser, 1994).

The process involved working cooperatively with patients, assisting them to set realistic goals, and planning strategies together to reach those goals. The goal of the nurse/patient relationship was to enhance wellness through the development of interpersonal, problem-solving, and community-living competencies (Forchuk et al., 1998). Only through fostering the nurse/patient relationship, knowing the
patient as a person, and valuing the patient as a person can hope be instilled (Kirkpatrick et al., 1995; Liaschenko, 1997; McCann, 2002; McDonald & Badger, 2002; White et al., 2000).

Implications for Nursing Practice

Treatment compliance is a complex, formidable concept with many intervening variables (Dunbar-Jacob et al., 2000). Findings from this study offer new and refreshing perspectives by looking at the nurses’ role in treatment compliance for patients with schizophrenia. The application of the nursing process, getting it, together, as it related to nursing responsibilities, formulation of outcomes, and ethical care, was presented for discussion.

One action that mental health nurses must embrace is to take a critical look at current nursing responsibilities in caring for patients in community mental health centers. In this period of health maintenance organizations, managed care, cost containment, and biotechnology, the nurse/patient relationship is not well understood or appreciated. The public and other mental health professionals need to be informed of the role and value of mental health nurses (Hamblet, 2000; Krauss, 2000).

The past decade has been described as the “decade of the brain.” Unprecedented emphasis has been placed on advances in the biosciences to manage symptoms of schizophrenia. Yet, currently, numerous people throughout the United States cannot benefit from the technology due to ineffective or nonexistent relationships with their healthcare providers (Krauss, 2000). Current advances in
technology are useless if not incorporated into action through a caring relationship (Dunbar-Jacob et al., 2000; Krauss, 2000).

The current study provided validation that the nurse/patient relationship enhances treatment compliance through the process of getting it, together. The current study sheds light on the dimensions of the relationship as well as the mechanisms for establishing and maintaining the relationship. The study also began to provide information on the impact that the relationship has on healthcare outcomes. Mental health nursing should lead the way; in fact, it has a responsibility to bridge the gap between the advances in bioscience and relationships with patients.

Ethically, it becomes important to protect nurse/patient relationships from cost-containment measures that disengage expert nurses from the direct interpersonal care of patients. Cost-effective care can only exist when patients are known and continuity of care is established (Tanner et al., 1993; Whittemore, 2000). Relationships with patients in the community mental health center, which have been fostered over time, will allow nurses to assess symptoms that are prodromal to more severe forms of the illness. Nurses can intervene in an appropriate manner, using nursing interventions to decrease the possibility of decompensation and costly hospitalization.

Patients with schizophrenia cannot be moved from nursing provider to nursing provider without impacting a wide array of treatment issues. The trend in mental health centers and with managed care is for nursing providers to be
interchangeable, with patients being treated by any nurse who may be available regardless of the established relationship. When nurses work in situations in which it is impossible to know their patients well enough to recognize relevant symptoms or to protect vulnerable patients, nursing care is undermined. In this case scenario, nursing practice is relegated to technology only, providing the high visibility tasks of giving injections and medication management (Tanner et al., 1993). Nurses become disillusioned and lose the essential practice of knowing the patient. Ethically, nursing practice in community mental health centers must be designed so that nurses can know their patients.

Knowing the patient is difficult to link to specific outcomes (Whittemore, 2000). One approach to outcomes could be exposing the cost of not knowing the patient. During one nurse/patient interaction, I observed the importance of the nurse knowing the patient and being able to intervene and avoid a costly hospitalization. This patient had been arrested for driving recklessly on the freeway and was charged with “driving under the influence.” The nurse was called by the patient’s mother regarding the arrest. The nurse responded immediately by bringing the patient in for an evaluation. While meeting with the patient, the nurse assessed that the patient was having increasing auditory hallucinations and delusions along with confusion and disorganization, which was the reason for the arrest. The nurse and the patient agreed that the patient was having increased symptoms of her illness. The nurse arranged for the patient to be given a crisis appointment with a psychiatrist that same day. The nurse and the patient also
agreed upon several situational supports to prevent further decompensation.

The consequences of not knowing patients can negatively impact them. Patients can be denied the thoughtful empathetic care from nurses who have firsthand knowledge of their issues. Patients can receive care by a trial-and-error approach or with decisions and interventions not tailored to their needs. Without a relationship with the nurse, recovery for the patient may not occur (Whittemore, 2000).

**Implications for Nursing Education**

The primary focus of this study was to understand the therapeutic process of the nurse/patient relationship from the perspective of nurses working in a community mental health center. Early in this study, it was evident that nurses approached and delivered care to patients with differing levels of treatment compliance but in a similar fashion. Knowing patients was most important in how nurses made decisions regarding treatment interventions and when to reschedule appointments with patients. Each interaction with a patient laid the foundation for the next interaction, with continued decision making moving towards treatment compliance and patient recovery.

Nurses in this study placed value on the significant connection that occurred during the nurse/patient interaction. The interaction was a powerful strategy in creating an atmosphere of normalcy, with an emphasis on healthy lifestyle, community integration, and recovery. The approach used by nurses promoted the interaction as a positive experience, with nursing interactions that encouraged
patients toward responsibility for their medication management and their mental health.

Other studies have also suggested that knowing the patient created collaborative relationships that were illustrative of the possibilities of sustainable, long-term relationships with patients living with mental illness in the community (Adams & Partee, 1998; Liaschenko, 1997; McCann & Baker, 2001; Muir-Cochrane, 1998; O'Brien, 2000). Therefore, in educating students, the focus was not only on understanding symptoms of schizophrenia but also on how to get to know patients as people. Knowing the patient was specific knowledge that was embedded in a particular historical, clinical context. Understanding patients is required for nursing care and clinical judgment (Tanner et al., 1993). Narratives of actual practice were required in order to transfer this knowledge to those who would be involved in nursing care of patients with schizophrenia.

Traditionally, case-study presentations and stories of nurses' practices (narratives) have been used to describe the connection between knowledge of symptoms and nursing skills. Narratives of nurses knowing patients as people, in addition to discussion of the model, Getting It, Together, are necessary to define and promote knowledge and skill related to knowing.

Narratives revealed the context of patients' situations in ways that could help students relate personally to situations. Narratives provided a level of detail that could bring knowing the patient as a person to life. The model, Getting It, Together, could act as a springboard to discuss specific narratives in relation to
each category, helping to sensitize students to the ethics of care in clinical situations. Student nurses could also be encouraged to share their own experiences of clinical practice and to learn from each other (Benner, Tanner, & Chesla, 1996; Foley, Minick, & Kee, 2000; Tanner et al., 1993).

Students introduced to caring for patients with schizophrenia need to have the opportunity to observe and work alongside expert nurses in the clinical setting. The opportunity to observe experts in clinical care is a valuable learning experience (Channell, 2002). In conjunction with the use of the model, Getting It, Together, structuring clinical experiences and narratives of clinical situations is vital. Students can observe specific activities, interventions, or interactions, as outlined by the model, that help to ensure that the clinical experience is purposeful. The complexity of the observation can be adjusted according to students' levels of training, thus helping to ensure progressive learning. Observation and participation in clinical settings provide further focus for discussion with expert nurses and also provide for a mentoring experience for students (Benner et al., 1996; Channell, 2002).

Mental health nurses need sufficient preparation of the knowledge and skills necessary to enter into nurse/patient relationships. Nurses need to develop specific therapeutic skills in order to provide specific interventions for treatment (McCann & Baker, 2001; O'Brien, 2000). The model, Getting It, Together, can provide the basis for evaluating nursing care, articulating the value of the interventions, and helping to understand resources needed to assist patients toward recovery.
Implications for Nursing Research

Further research should be conducted on knowing the patient, treatment compliance, and utility of the model, Getting It, Together. Additional patient care and diagnostic categories should be explored in order to expand the applicability of the model. Identifying variability in the model in other settings such as inpatient, residential, day treatment, and home-health nursing care can further add to understanding the model. Educational approaches to teaching and advancing clinical understanding can be analyzed for influence on effectiveness and outcome.

Research about patients' perspectives of being known and knowing their nurses is needed. The research would provide insight into the quality of care given and could also address issues regarding influence of training/educational utilization of the model, Getting It, Together. One possible qualitative study could involve interviewing patients regarding their perceptions of their care provided by nurses. They could evaluate the following hypothesis: To what extent does knowing the nurse make a difference from the patient’s vantage point in improving rapport and in increasing treatment compliance? Does knowing the nurse affect a lasting behavioral change?

Qualitative methods should also be applied in future studies. Research answering questions regarding the length of time and frequency of interaction necessary for nurses to know patients sufficiently to provide safe, effective, and efficient nursing care should be explored. Time-dimensional designs could be used to examine sequences and patterns of change, growth, and trends across time.
Research to demonstrate the importance of knowing the patient for organizational and economic constraints would also be important to explore (Whittemore, 2000). A careful retrospective analysis of not knowing the patient may uncover costly interventions that could have been prevented if consistent nursing care had been delivered. Reviewing hospitalizations and residential treatments correlated with nursing care could be evaluated.

**Conclusions**

This qualitative study was conducted with 5 expert nurses who worked in outpatient programs in a community mental health setting. These nurses were observed during nurse/patient interactions (15 patients) during their regular clinic visits. The nurses utilized a number of interventions to help patients understand the need for active participation in treatment and to assist patients toward their goals. Knowing the patient was the pivotal process in patients' nursing care.

A grounded theory model, Getting It, Together, was developed and is now available to nurses, educators, and others. The model could be used to guide future clinical and scholarly endeavors. The importance of the study for mental health nurses lies in the identification of, and nature of, the nurse/patient relationship as central to knowing the patient and assisting in patient recovery.

The expert nurse participants reinforced the perception that knowing the patient and treatment compliance were complex. The strategies used in the model, Getting It, Together, include socialization, normalization, and celebration with
patients of their accomplishments as nurses and patients walked the path together.

Benner, Kyriakidis, and Stannard (1999) related,

A good clinical grasp of the patient’s situation is central to expert clinical and ethical judgment. Learning to make qualitative distinctions, keep track of what has been done and what worked, recognize changing clinical relevance, and develop population-specific clinical knowledge are essential aspects in developing a good clinical understanding of patient situations. (p. 61)

This type of knowing needs experience. The model can be used as a strategy for the learner to become more proficient and attentive to what is needed to grasp the situation and to provide the care necessary to move the patient toward his or her goals.
### Table 3

**Controlled Studies Comparing Interventions With Standard Treatment for Patients With Schizophrenia**

<table>
<thead>
<tr>
<th>Author(s)/date</th>
<th>Site</th>
<th>Independent variable</th>
<th>Number in intervention group</th>
<th>Dose</th>
<th>Effect</th>
<th>Desired outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atkinson et al. (1996)</td>
<td>Glasgow · Schizophrenia, Education</td>
<td></td>
<td>73</td>
<td>20</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Delaney (1998)</td>
<td>Miami · Club house</td>
<td></td>
<td>NR</td>
<td>NR</td>
<td>+</td>
<td>Lower recidivism</td>
</tr>
<tr>
<td>Eckman &amp; Liberman (1990)</td>
<td>14 western U.S. sites, Cognitive behavioral medication education</td>
<td></td>
<td>160</td>
<td>15 to 20</td>
<td>+</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Favord (1993)</td>
<td>French environment · Cognitive behavioral medication education</td>
<td></td>
<td>19</td>
<td>32</td>
<td>+</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Frank &amp; Gunderson (1990)</td>
<td>Boston · Psychotherapy</td>
<td></td>
<td>95</td>
<td>NR</td>
<td>0</td>
<td>Treatment compliance</td>
</tr>
<tr>
<td>Guimon (1995)</td>
<td>Geneva · Medication education</td>
<td></td>
<td>10</td>
<td>8</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Hayward et al. (1995)</td>
<td>London · Compliance treatment</td>
<td></td>
<td>21</td>
<td>1</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Hogarty et al. (1991)</td>
<td>Pittsburgh · Family treatment combined with social skills training</td>
<td></td>
<td>20 Weekly for 2 years</td>
<td>+</td>
<td>Lower recidivism</td>
<td></td>
</tr>
<tr>
<td>Hornung et al. (1996)</td>
<td>Germany · Psychoeducation medication, Training + cognitive treatment</td>
<td></td>
<td>32</td>
<td>10</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td></td>
<td></td>
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Total = 74
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<th>Author(s)/date</th>
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<th>Independent variable</th>
<th>Number in intervention group</th>
<th>Dose</th>
<th>Effect</th>
<th>Desired outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hornung et al. (1998)</td>
<td>7 CMHCs in Germany</td>
<td>Psychoeducation medication, Training + cognitive treatment</td>
<td>84</td>
<td>14</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Kelly &amp; Scott (1990)</td>
<td>2 VAMCs in eastern United States</td>
<td>Family treatment</td>
<td>101</td>
<td>1</td>
<td>-</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Kemp &amp; David (1996)</td>
<td>NR</td>
<td>Compliance treatment</td>
<td>74</td>
<td>NR</td>
<td>+</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Kuipers et al. (1994)</td>
<td>Midwest United States</td>
<td>Cognitive behavioral medication education</td>
<td>32</td>
<td>6</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Linszen et al. (1998)</td>
<td>Amsterdam</td>
<td>Family treatment</td>
<td>37</td>
<td>NR</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>MacPherson et al. (1996)</td>
<td>Bristol Gloucester</td>
<td>Medication education</td>
<td>22</td>
<td>3</td>
<td>0</td>
<td>Medication compliance</td>
</tr>
<tr>
<td>Phan (1995)</td>
<td>New South Wales</td>
<td>Family treatment with clinic visits and phone calls</td>
<td>23</td>
<td>NR</td>
<td>+</td>
<td>Medication compliance, increased activities of daily living compliance</td>
</tr>
<tr>
<td>Schwartz et al. (1997)</td>
<td>Florida</td>
<td>Cognitive treatment with skill development</td>
<td>23</td>
<td>NR</td>
<td>+</td>
<td>Treatment compliance</td>
</tr>
<tr>
<td>Sharma et al. (1995)</td>
<td>VAMC southeast United States</td>
<td>Hospital visit by Therapist outpatient group visit</td>
<td>25</td>
<td>1</td>
<td>0</td>
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Table 3 (continued)

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<tr>
<th>Author(s)/date</th>
<th>Site</th>
<th>Independent variable</th>
<th>Number in intervention group</th>
<th>Dose</th>
<th>Effect</th>
<th>Desired outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al. (1997)</td>
<td>NR</td>
<td>Cognitive behavioral medication education by gender</td>
<td>23 males</td>
<td>16</td>
<td>-</td>
<td>Treatment compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21 females</td>
<td>16</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Streicker et al. (1986)</td>
<td>Chicago</td>
<td>Medication education</td>
<td>40</td>
<td>10</td>
<td>-</td>
<td>Medication compliance</td>
</tr>
</tbody>
</table>

Note. 0 = no significant intervention effect, + = significant positive intervention effect, - = significant negative intervention effect, NR = not reported, CMHC = community mental health center, and VAMC = veterans administration medical center.
APPENDIX B

VALLEY MENTAL HEALTH ADULT

CLIENT INFORMATION
Valley Mental Health\textsuperscript{1} is a comprehensive mental health center serving Salt Lake, Summit, and Tooele Counties.

1. The community's mental health needs are being met by a dedicated staff of more than 800 employees.

2. During 1998, 15,933 individuals were seen for treatment; 57\% of these or 10,600 were adults.

3. Of the adults, 6,868 or 65\% were designated as \textit{seriously and persistently mentally ill}.

4. On any given day, approximately 2,300 persons receive treatment; 67\% of these or 1,500 were adults.

5. The agency operates more than 60 programs in Salt Lake, Summit, and Tooele Counties providing mental health services; 56 of these are adult programs.

\begin{itemize}
\item Adult/child/youth outpatient programs = 7
\item Adult employment programs = 3
\item Adult case management programs = 5
\item Adult clubhouse model program = 1
\item Adult day-treatment programs = 5
\item Adult in-home training services = 6
\item Adult residential treatment sites = 2
\item Adult in-patient contract = 1
\item Adult forensic programs = 3
\item Adult jail mental health program = 1
\end{itemize}

\textsuperscript{1}Adapted from Valley Mental Health Center Research and Evaluation (2000).
APPENDIX C

CONSENT FORMS
Consent and Information for Participation in an Investigational Study: How does the nurse/patient relationship influence treatment compliance for patients with schizophrenia? Karen S. Dearing, MS, APRN, Principal Investigator

Background Information: You are asked to participate in a study designed to explore how the experience of being in a therapeutic relationship with a patient with schizophrenia affects his or her compliance with prescribed treatment.

Study Procedure: If you agree to participate, first, you will be asked to fill out a demographic information form. Second, you will be observed by the principal investigator during three different individual counseling sessions with three different patients who have a diagnosis of schizophrenia in which you currently provide counseling. The counseling sessions will take the normal allotted time for an outpatient appointment (approximately 20-30 minutes) and with your permission will be audiotape recorded. Third, you will be asked to participate in an initial and follow-up interview with the principal investigator. During this interview, you will be asked to discuss how you make decisions regarding individual treatment for patients with schizophrenia. The interview will take approximately 30 minutes. With your permission, this interview will be audiotape recorded. The duration of the study will be approximately 12 months.

Risks: No significant risks are anticipated as a result of your participation in this study. There may be some inconvenience in spending the time necessary to complete the interview. If you become distressed by the observation, you can discontinue at any time.

Benefits: The information you provide may help healthcare providers provide interventions for other patients with schizophrenia. You may gain some benefit by having the opportunity to share concerns and experiences.

Alternative Procedures: You may choose not to participate in this study. If you choose not to participate, it will not affect your relationship with your employment at Valley Mental Health.

Confidentiality and Participant Rights: All information provided to the researcher will be kept strictly confidential. No names will be used in the study or subsequent publications. All forms, questionnaires, tapes, and transcribed interviews will be identified with a number. You are free to withdraw from the study at any time without prejudice.
Subject Disclosure: Should you disclose any actual or suspected abuse, neglect, or exploitation of a child, disabled adult, or elder adult, the researcher must report this abuse to the authorities, as required by federal and state laws.

Person to Contact: The researcher will answer any questions you might have about the study. If you have questions regarding this research, your rights, or related matters, please call Karen Dearing at (801)566-4423 (24 hours).

Institutional Review Board: If you have questions regarding your rights as a research subject, or if problems arise that you do not believe you can discuss with the investigator, please contact the Institutional Review Board Office at (801)581-3655.

Medical Treatment or Compensation for Injury: “In the event you sustain injury resulting from your participation in the research project, the University of Utah can provide to you, without charge, emergency and temporary medical treatment not otherwise covered by your own insurance. If you believe you have sustained an injury as a result of your participation in this research program, please contact the Institutional Review Board, phone number (801)581-3655. By signing this document you are not giving up your right to pursue legal action against any and all parties involved with this research, in accordance with the Utah Government Immunity Act, Section 63-30-1:63-30-34 Utah Code Ann. 1953 (as amended).”

Voluntary Participation: Participation in this study is voluntary. You may decline to participate at any time, and you may decline to answer any questions that you do not wish to answer. A refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

Unforeseeable Risks: As with any research, there may be unforeseen risks that may occur as a result of your participation.

Right of Investigator to Withdraw Subject: Your participation in this study may be ended without your consent if the investigator believes this is necessary.

Cost to Subjects: There is no cost to you, other than time, as a result of participation in this study.

New Information: Any new information pertaining to this research that becomes available that may affect your willingness to participate in the study will be shared with you.

Number of Subjects: Approximately 20 people will participate in this study.
Consent: I have read the foregoing, and my questions have been answered. I desire to participate in this study and accept the risks and benefits. I give permission for the information gathered in the study to be released to the researcher. A copy of the consent document has been given to me.

_________________________   ____________
Signature of Research Participant   Date

_________________________   ____________
Signature of Witness   Date
Patient Consent Form

Consent and Information for Participation in an Investigational Study: How does the nurse/patient relationship influence treatment compliance for patients with schizophrenia? Karen S. Dearing, MS, APRN, Principal Investigator

Background Information: You are asked to participate in a study designed to explore how meeting with your nurse at the mental health center affects your compliance with treatment.

Study Procedure: If you agree to participate, a routine counseling appointment with your nurse will be observed by the principal investigator. With your permission, this interview will be audiotape recorded. Your chart will also be reviewed for specific demographic information. The chart review will include age, gender, race or ethnic background, DSM-IV diagnosis, total number of years in mental health treatment, total number of years treated by your registered nurse, type of psychosocial treatment programs prescribed, and classification of medications prescribed.

Risks: No significant risks are anticipated as a result of your participation in this study. There may be some inconvenience with being observed during your routine counseling appointment. If you become distressed by the observation, you can discontinue at any time.

Benefits: The information gathered from observations may help nurses provide care for other patients with schizophrenia. You may gain some benefit by having the opportunity to share concerns and experiences.

Alternative Procedures: You may choose not to participate in this study. If you choose not to participate, it will not affect your relationship with Valley Mental Health, your nurse, any clinic personnel, or follow-up care you choose to receive.

Confidentiality and Participant Rights: All information provided to the researcher will be kept strictly confidential. No names will be used in the study or subsequent publications. All forms, questionnaires, tapes, and transcribed interviews will be identified with a number. You are free to withdraw from the study at any time without prejudice.

Subject Disclosure: Should you disclose any actual or suspected abuse, neglect, or exploitation of a child, disabled adult, or elder adult, the researcher must report this abuse to the authorities, as required by federal and state laws.
Person to Contact: The researcher will answer any questions you might have about the study. If you have questions regarding this research, your rights, or related matters, please call Karen Dearing at (801)566-4423 (24 hours).

Institutional Review Board: If you have questions regarding your rights as a research subject, or if problems arise that you do not believe you can discuss with the investigator, please contact the Institutional Review Board Office at (801)581-3655.

Medical Treatment or Compensation for Injury: "In the event you sustain injury resulting from your participation in the research project, the University of Utah can provide to you, without charge, emergency and temporary medical treatment not otherwise covered by your own insurance. If you believe you have sustained an injury as a result of your participation in this research program, please contact the Institutional Review Board, phone number (801)581-3655. By signing this document you are not giving up your right to pursue legal action against any and all parties involved with this research, in accordance with the Utah Government Immunity Act, Section 63-30-1:63-30-34 Utah Code Ann. 1953 (as amended)."

Voluntary Participation: Participation in this study is voluntary. You may decline to participate at any time, and you may decline to answer any questions that you do not wish to answer. A refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

Unforeseeable Risks: As with any research, there may be unforeseen risks that may occur as a result of your participation.

Right of Investigator to Withdraw Subject: Your participation in this study may be ended without your consent if the investigator believes this is necessary.

Cost to Subjects: There is no cost to you, other than time, as a result of participation in this study.

New Information: Any new information pertaining to this research that becomes available that may affect your willingness to participate in the study will be shared with you.

Number of Subjects: Approximately 20 people will participate in this study.

Consent: I have read the foregoing, and my questions have been answered. I desire to participate in this study and accept the risks and benefits. I understand that sections of my medical notes may be looked at by the principal investigator where it is relevant to my taking part in research. I give permission for the principal investigator to have access to my records and for the information gathered in the
study to be released to the researcher. A copy of the consent document has been given to me.

_____________________________  ______________________
Signature of Research Participant  Date

_____________________________  ______________________
Signature of Witness  Date
APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE:
NURSE PARTICIPANT
1. Age: __________

2. Gender: __________

3. Race or ethnic background:
   - Asian or Pacific Islander
   - African American
   - Caucasian
   - Hispanic/Latino
   - Native American
   - Other: ________________________________

4. Highest education level and year graduated:
   - Associate’s degree (___)
   - Bachelor’s degree (___)
   - Master’s degree (___)

5. Number of years in nursing: __________

6. Number of years practicing psychiatric/mental health nursing: __________

7. Number of years practicing at the community mental health center: __________

8. Number of patients in primary caseload: __________

9. Number of patients with a DSM-IV diagnosis of:
   - Schizophrenia
   - Schizoaffective disorder
   - Psychosis NOS [not otherwise specified]
APPENDIX E

DEMOGRAPHIC QUESTIONNAIRE:

PATIENT PARTICIPANT
1. Age:  

2. Gender:  

3. Race or ethnic background:  
   ____ Asian or Pacific Islander  
   ____ African American  
   ____ Caucasian  
   ____ Hispanic/Latino  
   ____ Native American  
   ____ Other:  

4. DSM-IV diagnosis:  

5. Total number of years in mental health treatment:  

6. Total number of years in treatment with the same nurse:  

7. Number and type of psychosocial treatment programs prescribed:  
   ______________________  ______________________  ______________________  
   ______________________  ______________________  ______________________  

8. Number and classification of medications prescribed:  
   ______________________  ______________________  
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APPENDIX F

PARTICIPANT OBSERVATION GUIDE
1. Describe the setting.

2. Describe the human social environment.
   a. Describe characteristics of the participants.
   b. Describe patterns, frequencies, and directions of the interaction.
   c. Describe decision-making behaviors. (Who initiates it? Who ultimately makes the decision? What is the nature of communication regarding the decision?)

3. Describe activities and behaviors that take place.
   a. Describe who initiates the activity.
   b. Describe the verbal and nonverbal reactions.
c. Describe who is involved.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

d. Describe how this activity is related to other observed behaviors.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

4. Describe any informal interactions or unplanned activities.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

5. Describe language used by the participants.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

6. Describe the nonverbal communication.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

7. Describe what did not happen or other surprise findings.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
APPENDIX G

INTERVIEW GUIDE
I am interested in how the nurse/patient relationship might influence treatment compliance for patients with schizophrenia.

1. Tell me about the relationship with ________. How did it develop?

2. What do you consider about your patients when you work with them?

3. Can you tell me about the decisions you made regarding specific treatment interventions used?

4. What signs or symptoms were your patients exhibiting that led you to this decision?

5. What other interventions might you recommend for your patients? Can you give me an example?

6. How did you decide when to schedule another appointment with your patients?
7. What do you do if your patients miss a scheduled appointment?

8. How do you respond if your patients have been in crisis?

9. How is treatment compliance an issue with your patients’ care?

10. Are treatment interventions different based on your patients’ symptoms or characteristics?
REFERENCES


Kramer, M. K., & Chinn, P. L. (n.d.). *Nursing fundamental patterns of knowing* [Handout from authors]. Salt Lake City: University of Utah, College of Nursing.


