INSIGHT AND PSYCHOSIS: PSYCHIATRIC NURSES' PERSPECTIVES ON PATIENTS' LACK OF INSIGHT

by

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DEDICATION

This exploration is dedicated Ezra Bates Maxwell, who, at the age of about six, said to the world, “You’re not the boss of me.”
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ABSTRACT

INSIGHT AND PSYCHOSIS: PSYCHIATRIC NURSES’ PERSPECTIVES ON PATIENTS’ LACK OF INSIGHT

Kim G. Cox, Ph.D.
George Mason University, 2016
Dissertation Director: Dr. Renee Milligan

The purpose of this study was to explore psychiatric nurses’ clinical experience of a particular schizophrenia symptom, lack of insight. People with symptoms of schizophrenia sometimes lack insight into, or awareness of, their disorder. This circumstance is problematic and may present safety concerns in people with delusions, especially paranoia. Schizophrenia involves both positive (delusions, hallucinations, disorganized speech or behavior) and negative (e.g., avolition, diminished emotional expression) symptoms, in addition to cognitive deficits (working memory, executive function deficits) and affective symptoms (inappropriate affect). Functional limitations resulting from these symptoms range from mild to severe, even with optimal pharmacological treatment. Lack of insight into the disorder makes clinical intervention very difficult: the patient does not realize that she or he has problems, does not recognize or experience any need for assistance, and often actively resists treatment.
Productive clinical management of these patients is very challenging for both inpatient
nurses and outpatient case managers. The goal of this study was to provide clinicians
with psychiatric nurses’ perspectives on the patients’ experience when patients lack
insight, and to provide clinicians with potential implications of lack of insight on the
clinical relationship. Specifically, the research questions addressed how psychiatric
nurses experience the patients’ lack of insight, how the nurses believed the patients who
lack insight experience their own treatments, and how the nurses believed that poor
insight affects the nurse-patient relationship. Knowing how psychiatric nurses imagine
the patients’ experiences may provide important guidance regarding clinical
communication and the treatment challenges of caring for patients with schizophrenia
and poor insight.

I used a descriptive, qualitative research design to address three research questions:
1) What are psychiatric nurses’ experiences of poor insight in patients with
schizophrenia?
2) What are psychiatric nurses’ perceptions of the patients’ experience of impaired
insight?
3) What are psychiatric nurses’ beliefs about how lack of insight affects the nurse-patient
relationship? The research population was psychiatric nurses with at least three years of
current, direct experience providing care for patients with schizophrenia spectrum
psychotic disorders. A panel of nurses was purposefully selected using snowball
sampling. Eleven psychiatric nurses were interviewed by the researcher using a semi-
structured interview guide designed in a pilot study. Data collection included the nurses’
demographic data, audio-taped nurse qualitative interviews with field notes, and
descriptions of the institutional and programmatic contexts. Data analysis included
listening to, transcription of, and reading the interviews, and construction of interpretive
interview summaries. The interview summaries were sent to each participant to check
accuracy. The interview summaries were re-read, codes noted, and categories were
composed after all the interviews summaries were approved by each nurse participant.
Finally, seven themes were developed from the categories. The themes focused on the
nurses’ beliefs about how lack of insight affects the nurse-patient relationship. Interview
themes were discussed in the context of the conceptual framework, and conclusions
drawn with qualifications in regard to validity threats.
FOREWORD
STRUCTURAL OVERVIEW OF DISSERTATION RESEARCH STUDY
FIVE CHAPTERS

This research study is presented in five parts corresponding to the traditional structure of a dissertation. In Chapter 1, the research problem explored for this dissertation research on insight and psychosis is described. The phenomenon of insight, especially in the context of schizophrenia spectrum psychotic disorders is discussed, including why this topic is both clinically important, and problematic. The study goals and the potential implications of this study for clinical practice are explored. The research problems are presented as aspects of insight and psychotic disorders that are incompletely understood. This background provides an introduction to the research questions for this study and rationale supporting a qualitative, descriptive exploration of psychosis and insight.

In Chapter 2, literature on the problem of psychosis and insight, is organized as the theoretical and conceptual context for the research study questions. Qualitative research on the topic is explored. The literature review also includes rationale of the use of qualitative research approaches to carry out this particular exploration of psychosis and insight. My own experience as a psychiatric nurse is presented to provide perspectives on how psychiatric nurses currently approach care with people with psychotic disorders who lack insight. I provide my pilot research exploring nurses’ clinical experience of
schizophrenia and poor insight. This discussion develops the conceptual framework for the study.

In Chapter 3, the methods used for this study are explicated. Validity threats are identified, with the approaches used to limit threats and to enhance qualitative data collection and analysis. Ethical concerns regarding the conduct of research involving psychiatric nurses are addressed. Potential limitations to this study are also explored.

In Chapter 4, the results of the study are reported and discussed. Seven themes emerged from the data which focus on the nurses’ beliefs about how lack of insight affects the nurse-patient relationship.

In Chapter 5, the conclusions, implications, recommendations, limitations, and next steps are presented and discussed.
Schizophrenia Clinical Features

Schizophrenia is a psychiatric disorder that involves both positive (delusions, hallucinations, disorganized speech, and grossly disorganized, or catatonic behavior) and negative symptoms. (diminished emotional expression, alogia,\(^1\) avolition,\(^2\) asociality, and anhedonia). These are all clustered as Criterion A symptoms in the most recent 2013 edition of the American Psychiatric Association (APA) Diagnostic and Statistics Manual of Mental Disorders Fifth Edition (DSM-V). Psychotic disorders are categorically grouped in the DSM-V to reflect symptoms of psychiatric origin, and not secondary symptoms that arise due to a medical condition, or a disorder induced by substance use.

Functional limitations in work, interpersonal relations, or self-care resulting from the positive and negative symptoms of schizophrenia, or DSM-V Criterion B symptoms (APA, 2013), and range from mild to severe. This is the case even in those patients who have achieved optimal pharmacological treatment response. Functional difficulties for the person with schizophrenia include both personal and instrumental deficits. These

\(^{1}\)alogia: dysfunction of communication; restrictions in the fluency and productivity of thought and speech (Stahl, 2008)

\(^{2}\)avolition: reduced desire, motivation, or persistence; restrictions in the initiation of goal-directed behavior (Stahl, 2008)
limitations influence the individual’s ability for self-care, and impair the individual’s ability to socialize, attend school, maintain employment, and be involved in family life.

Chronic, severe psychiatric disorders, including schizophrenia, are associated with functional disabilities, and these impairments may present a safety risk to self or others. Impaired insight is associated with increased violent behavior and associated stigma, especially when the person is not taking medication and may also be using street drugs or alcohol; these problems occur in the context of “a failure of public psychiatric services” (Torrey, 2004, p. 252). Correctional facilities have been referred to as America’s alternative psychiatric hospital system, housing more psychotic people than psychiatric and general hospitals (Torrey et al., 1992). Approximately 1.25 million jail and prison inmates are reported to have mental health problems (U.S. Department of Justice, 2006).

**Schizophrenia as a Brain Disease**

In recent decades, biomedical psychiatric researchers have focused on understanding the biological underpinnings of mental disorders. The Library of Congress and the NIMH designated the 1990’s as the Decade of the Brain, to draw attention to the benefits of brain research, and to enhance public awareness of discoveries related to biologically-based brain disorders (Library of Congress, 2011). This view of psychiatric disorders as brain disorders is in stark contrast to previously held notions of psychiatric disorders as “functional” problems (Kleinman et al., 2011) that originated from and were maintained by psychodynamic or psychological “forces.” Research into the biological
mechanisms of brain disorders is helping advance treatments, reduce recidivism, and even probe preventative approaches to mental illness.

Presently, biological psychiatric researchers continue to explore the neurobiological underpinnings of psychosis; this has included recognition that the frontal lobes contribute to the insight deficits common in schizophrenia (Amador, Strauss, Yale, & Groman, 1991). People with schizophrenia may demonstrate executive function difficulties on neuropsychological testing and psychiatric assessment (Morgan & David, 2004); frontally-based deficits in judgment and insight are associated with lack of symptom awareness (Amador & Kronengold, 2004). Scientific data supporting a neurobiological basis of insight in schizophrenia is growing (Xavier & Vorderstrasse, 2016)

Advances in biological psychiatric research have led to a blurring of the distinctions between psychiatric and medical disorders. This, in turn, diminishes the artificial – and stigmatizing – boundaries between these categories of clinical and research endeavors. Despite indisputable evidence that schizophrenia is a brain disease, as long as people with psychotic disorders are perceived as “acting-out” psychological problems, they may be more easily held inappropriately accountable for their disabilities.

**Statement of the Problem**

At present, psychiatric clinicians sometimes approach psychotic people in ways that may distance, or even frighten the patients. The manner and attitude with which clinicians interact with patients contributes to the outcome of the interaction (Crisis Prevention Institute, 2005). A large body of clinical psychiatric literature, including
nursing literature, exists regarding psychiatric violence, restraint and seclusion, and their negative sequelae.

Psychotic symptoms such as paranoid delusions and interfering auditory hallucinations, as well as communication difficulties and deficits, are associated with the occurrence of violence in psychiatric settings (Canadian Institute for Health Information, 2011). Researchers have found that patients’ poor insight regarding symptoms has been a primary factor associated with psychiatric violence (Torrey, 2004).

People with symptoms of schizophrenia commonly lack insight into, or awareness of their disorder. That is, the person with schizophrenia does not recognize or necessarily experience the signs and symptoms of his or her own psychosis. This lack of insight presents treatment and safety concerns, especially in people with psychotic symptoms of delusions and paranoia.

Restraint and seclusion are associated with physical and psychological harm to both staff and patients (Institute of Medicine, 2006). More recent work focused on the reduction or elimination of restraint and seclusion has revealed an appreciation for factors that not only are associated with psychiatric violence, but may actually underlie reactive violence (Johnson, 2010). For example, inpatients may experience anxiety, fear, powerlessness and isolation (Alexander, 2006; Freuh et al., 2005) in response to staff members who inconsistently implement program rules and guidelines without communicating clear rationale (Brennan, Flood, & Bowers, 2006).

Psychiatric clinicians develop profiles of individual patients as a tool to facilitate the tracking of symptom response to medication and other treatments. This symptom
profile is a component of repeated psychiatric assessments over the course of treatment. If patients lack insight regarding the existence or impact of their particular symptoms, they naturally have difficulty communicating the experience of symptoms during this repeated interview assessment process. As a result, they may withdraw further into protective social isolation.

Some patients develop insight over the course of treatment, but this can take months or even years. Insight is much more likely to develop when antipsychotic treatment effectively targets this particular symptom or syndrome (Llorca, 2008; Pijnenborg et al., 2013). Without accommodation for the patient’s poor insight, clinical interventions may even unwittingly provoke fearful responses expressed as physical aggression or violence by the patient. In contrast, clinicians’ sensitivity to, and accommodation of the patient’s lack of insight demonstrates recognition of the importance of not challenging the patient’s perceptions directly. This sensitivity to the patient’s tolerance and vulnerability can promote a trusting clinical alliance, potentially enhancing the clinician-patient relationship.

**Background, Justification, and Significance of the Study**

**Costs and prevalence of severe mental disorders and schizophrenia.** In the Global Burden of Disease Study published in the year 2001, the World Health Organization (WHO World Health Report) reported that mental illness costs the equivalent of 15% of the established world market economies. This study also indicated that schizophrenia ranked seventh of all chronic disease categories, as measured by Years Lived with Disability (YLD), 2.8% of total YLD globally. In 2011, the National Institute
of Mental Health (NIMH) reported that severe mental health disorders were the leading cause of disability in the United States and Canada for people ages 15-44, affecting 6%, or one in 17 Americans, at the cost of approximately 300 billion dollars a year. Schizophrenia affects approximately 1%, or 2.4 million Americans, costing the United States $62.7 billion annually (NIMH, 2011).

**Study justification: Schizophrenia, lack of insight, and clinical implications.**

Lack of insight, or the inability to recognize one’s disease, is a common finding in people with schizophrenia: as many as 50 – 80% of people with schizophrenia have poor insight (Amador & Gorman, 1998). Previously, researchers have suggested that poor insight was one of the discriminating dimensions separating schizophrenia from other psychiatric disorders (Amador et al., 1991; Carpenter, Strauss, & Bartko, 1973). In contrast to the DSM-IV TR (APA, 2000), the DSM-V (APA, 2013) includes a discussion of lack of insight, or anosognosia, as an associated feature supporting the diagnosis of schizophrenia.

Lack of insight negatively affects treatment adherence, prognosis, and functional outcomes (Amador & David, 2007; Lincoln et al., 2007). Lack of insight into symptoms of one’s disorder makes clinical intervention very difficult: the patient does not realize that he or she has problems, does not recognize or experience any need for assistance, and often actively resists treatment. Given the chronic nature of schizophrenia, how clinicians approach interactions and maintain therapeutic relationships with patients who have poor insight are important factors influencing clinical outcomes.
Significance of the study. Productive clinical management of people with poor insight is very challenging for both inpatient clinicians and outpatient case managers. This is especially true when the clinicians are inpatient nurses, as inpatient hospitalizations involve extended periods of time when patients are most symptomatic. Examination of the nurses’ experiences may provide a means to understand whether nurses recognize lack of insight in the patient, and may be a means to elicit perspectives on how nurses interact with, and perhaps influence patients’ participation in their own medical-psychiatric treatment and nursing care.

The results of this study may increase understanding of, and thus provide practice implications regarding limited capacity for insight in patients with psychotic disorders. Exploration of the nurses’ experiences of patients’ lack of insight may provide direction for the development of non-threatening interpersonal techniques for use in clinical interviewing, assessment, and intervention design for patients with schizophrenia who lack insight. Understanding nurses’ impressions of patients’ experiences may provide a starting point in the re-alignment of more constructive and meaningful clinical relationships, with the ultimate goal of improving clinical outcomes for the patients, including the reduction of violence. This study may advance understanding of the impact of lack of insight on the nurse-patient relationship.

Purpose of the Study and Research Questions

The purpose of this study is to explore psychiatric nurses’ clinical experience of a specific schizophrenia symptom, impaired insight. The research questions are:
1. What are psychiatric nurses’ experiences of poor insight in patients with schizophrenia?

2. What are psychiatric nurses’ perceptions of the patients’ experiences of impaired insight?

3. What are psychiatric nurses’ beliefs about how lack of insight affects the nurse-patient relationship?

**Definition of Terms**

In this study terms are defined as follows:

*Psychosis:* grossly impaired reality testing and impaired mental functioning. The ability to evaluate the accuracy of perceptions and inferences about reality correctly is compromised. Impairment of mental functioning is manifested by delusions, hallucinations, confusion, cognitive / memory impairments. Social and personal functioning are severely impaired (APA, 2013; Sadock & Sadock, 2014, p. 1416).

*Schizophrenia spectrum psychotic disorders:* schizophrenia (Criteria A and B symptoms, described earlier in the study background section, lasting at least six months), schizophreniform disorder (symptoms lasting 1 to 6 months), schizoaffective disorder (mood symptoms occur for the majority of the presence of psychotic symptoms), delusional disorder (one month of delusions without other schizophrenia symptoms), psychotic disorder not otherwise specified (NOS) that may demonstrate symptoms of hallucinations, delusions, disorganized thinking or behavior, alogia, avolition, flat affect, and anhedonia, but not meet criteria included above (APA, 2013).
Schizophrenia: psychiatric disorder with a combination of symptoms of hallucinations, delusions, disorganized thinking or behavior, alogia, avolition, and flat affect lasting at least six months, with at least one month of active symptoms (APA, 2013).

Insight: awareness, understanding, and appreciation of one’s psychotic symptoms and their implications. Poor insight, impaired insight, or lack of insight, indicate significant lack of awareness of deficits, consequences of the disorder, and need for treatment (Amador & Kronengold, 2004; APA, 2013).

Anosognosia is a neurological symptom indicated by impaired awareness, understanding, and / or appreciation of implications related to the object of the insight. Anosognosia is demonstrated by unawareness of false beliefs, despite evidence to the contrary (delusions), and is associated with the cognitive deficits of schizophrenia, a biologically-based brain disorder (Amador & Kronengold, 2004; APA, 2013).

Patient: is the person for whom the nurse provides nursing care. From the Latin, patiens, meaning “the one who suffers.” It is this suffering that leads the patient to seek health care, including from nurses.

Nurse: is a psychiatric nurse having at least three years of current, direct experience providing care for patients with schizophrenia spectrum psychotic disorders (as defined above).

Conceptual Underpinnings of the Study

Interactive approach to qualitative research design. The conceptual and theoretical framework for this study will be constructed using Maxwell’s (2013)
interactive approach to qualitative research design (Figure 1, p. 18). This framework represents a model, explanation, or theory underlying the study phenomena (Maxwell, 2013). Maxwell further explained that the conceptual framework helps the researcher to assess and refine research goals, develop realistic and relevant research questions, refine research methods, and elucidate potential validity threats to the study conclusions.

Using this interactive approach, the research problem or what is actually and presently problematic, is incorporated with the study goals to justify the research study. Then, this justification is incorporated into and becomes part of the conceptual framework, in conjunction with the research questions. Maxwell explained that the conceptual framework is thus “…something that is constructed, not found” (p. 41).

Interactive research approach components. Maxwell described five research process components, and demonstrated the potential for dynamic relationship and interaction between these components. The components are each represented with a query.

- The purpose of the study: What do you want to accomplish?
- The conceptual framework: What do you think is happening?
- The research questions: What do you want to know and understand?
- The methods: What do you need to do to answer your questions?
- Validity: How will you approach threats?

The Design Map (Figure 1, p. 17) represents the application of Maxwell’s research design framework to this study. Using this approach, the study purpose and goals of this
study are described in the following section. Chapter 2 elaborates the conceptual framework, and Chapter 3 describes study methods and validity issues.

**Study purpose.** The research purpose elucidates the broad goals for the application of the outcomes of this study. The results of this study may provide clinicians with

1) nurses’ perceptions of the patients’ experiences when the patients lack insight and

2) potential implications of lack of insight on clinical relationships.

Thus, the purpose of this study was to learn about nurses’ perceptions and the clinical implications of those perceptions regarding the patients’ lack of insight.

These purposes and goals incorporate Maxwell’s five intellectual and three practical goals of qualitative research (2005). The five intellectual goals and their applications to this study were:

- *understanding meaning of experiences* – explore the participant nurses’ perspectives on what they believe the patients’ experiences are when the patients’ insight is poor; how nurses understand and make sense of those experiences, and how that understanding may influence their own behavior;

- *understanding contexts of experiences* – explore how situational context of the patients’ lack of insight influences what nurses perceive and do (inpatient care, outpatient care, planning care, nursing interventions);
• identifying and discovering unanticipated phenomena, influences and relationships – explore nurses’ perceptions of why patients act the way they do when nurses respond to and interact with them;

• understand processes rather than outcomes underlying events – explore nurses’ understandings of how their own actions interact with and influence the patients’ responses and antecedents;

• developing causal explanations – explore nurses’ perceptions of patients’ behavior and perceived factors influencing their behavior.

Maxwell’s three practical goals (2005, pp. 24-25) and their applications to this study are as follows

• To produce understandable and credible results – generate perspectives regarding the effects of poor insight on the clinical relationships relevant to all clinicians working with people who have schizophrenia spectrum disorders and who lack insight.

• To conduct formative evaluations to improve existing practice and understand underlying processes – specifically evaluate nurses’ perspectives regarding the patient lacking insight in relation to how nurses’ understanding affects interactions with patients and patient outcomes.

• To collaborate with research participants in the conduct of credible, ethical research – enhance patient care through research regarding a highly vulnerable psychiatric patient population using peer-research partnership relationships with psychiatric nurse interview participants.
Taken together, these intellectual and practical goals provided a foundation for this research of poor insight in people with schizophrenia spectrum disorders.

**Conceptual framework underlying the study.** The conceptual framework underlying this study on psychosis and insight is created (Figure 1, p. 17) in Chapter 2. It includes review of relevant literature, personal professional experience, and previous pilot study work. This conceptual examination of how lack of insight impedes treatment, how nurses who do not understand the role of insight in the treatment of psychotic disorders, may not help and may even harm therapeutic goals and relationships with patients, and how understanding and appreciation of patients’ insight problems may positively influence communication and care delivery, will provide guidance to this research examination of how psychiatric nurses use their understanding of the role of insight to approach care for patients with psychosis.

**Study research questions.** The research questions derive from the research purpose and conceptual framework. They are provisional and flexible, and may change as data are collected; Maxwell (2013) wrote that good research questions result from the use of the interactive design process and do not represent the starting point of the research process. The questions for this study addressed psychiatric nurses’ experiences with, and perspective on, insight of patients with schizophrenia.

**Study methods and validity.**

The methods of this study are explicated in Chapter 3, integrating the research questions, research design, approaches to enhancing validity and reducing validity...
threats, panel of research participants, data collection procedures, data analysis, and confidentiality considerations.
Design Map
Poor Insight in Schizophrenia Spectrum Disorders

Purposes/Goals
[Why are you doing this study?]
• Provide clinicians with nurses’ perspective on patients’ experience when patients lack insight
• Provide clinicians with potential implications of impaired insight on the clinical relationship

Conceptual Framework
[What do you think is going on?]
• Lack of insight impedes treatment
• Nurses who do not understand the role of insight may not help and may even harm therapeutic goals
• Understanding and appreciation of patients’ insight problems may positively influence communication and care delivery (Amador’s LEAP model, 2010)

Research Questions
[What do you want to understand?]
• What are psychiatric nurses’ experiences of lack of insight in patients with schizophrenia?
• What are psychiatric nurses’ perceptions of the patients’ experiences of impaired insight?
• What are psychiatric nurses’ beliefs about how lack of insight affects the nurse-patient relationship?

Methods
[What will you actually do?]
• Qualitative interview analysis of psychiatric nurses’ experience/interventions/perceptions/beliefs
• Nurse demographic data
• Institutional/programmatic culture descriptions for context

Validity
[How might you be wrong?]
• Ineffective interviews are not representational of the nurses’ personal/professional experience related to research questions and purpose – participant analysis review/revision; construct effective interviews
• Qualitative data not transferable due to validity problems identified – provide descriptive context and limitations; make researcher biases transparent via identification; discuss implications
• Implications of inaccurate diagnostic profiling – nurses will provide descriptions of patients’ symptoms in context of psychiatric diagnosis

Adapted from Maxwell, J. 2013. Qualitative research design. An interactive approach. SAGE: Los Angeles.

Figure 1.
Figure 1: Design Map Poor Insight in Schizophrenia Spectrum Disorders
**Personal and professional psychiatric experience.** My own thirty-five years of professional experience as a psychiatric nurse supporting the work of the biological psychiatric research of the NIMH Intramural Research Program in Bethesda, Maryland has influenced my perspectives on chronic mental illness, including my thinking on psychosis and insight. To enhance the integrity of my research, the influence of my experiences is discussed here.

**Biological underpinnings of mental illness.** Biology determines psychiatric disorders much as it does medical disorders. In my experience, psychiatric nurses may not understand that patients with psychotic symptoms are not able to understand that they have symptoms of a brain disorder. People with schizophrenia psychotic symptoms may have cognitive difficulties involving frontal lobe executive functions (LaroI, Barr, & Keefe, 2004). This frontal lobe dysfunction may affect the most human of capacities: awareness, and, especially troubling, self-awareness.

I have worked with psychiatric nurses who sometimes describe patients as willfully, volitionally, or choosing to, deny that they have symptoms of schizophrenia. These nurses may hold patients responsible for their symptoms, and may believe that patients are capable of recognizing and understanding the consequences of their symptoms; these nurses may believe that patients choose to actively resist treatment and help. This could lead to a very troubling dynamic between nurses and people with psychotic disorders. What the nurse clinician may deem as therapeutic interventions in these situations may provoke anxiety in the patient, and perhaps even worse, exacerbate fear, paranoia, and aggression.
Patients do not choose to be resistant, noncompliant, or aggressive (Amador, 2007). Psychiatric nurses have a clinically fiduciary responsibility to understand the diseases for which patients are being treated (American Nurses Association International Society of Psychiatric-Mental Health Nurses, 2014). Lack of appreciation for the limits of the patients’ capacity can produce inordinate clinical expectations that can become burdensome to the patients, and even psychologically or physically provocative.

I have worked with “therapeutic” programs and practiced in psychiatric health care cultures built on and maintained by misattributions regarding patients’ capacity for self-awareness. Healthcare leaders are accountable for maintaining currency in scientific developments, and offering staff education that translates scientific findings into relevant practice guidelines. Healthcare leaders overseeing psychiatric care programs are accountable to monitor, supervise, and evaluate the clinical competence and development of their staff (Goetz & Taylor-Trujillo, 2012).

**Summary Statement of Study Purpose**

In summary, the purpose of this study was to understand nurses’ knowledge and conceptualization of the role of insight in schizophrenia. In addition, the purpose was to understand how nurses believe that patients’ lack of insight affects the nurse-patient relationship.
CHAPTER TWO
REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Approach to Constructing the Conceptual Framework

The conceptual framework underlying this study on nurses’ perceptions of psychosis and insight was created in this chapter using a review of relevant literature, personal professional experience, and previous pilot study work. In Maxwell’s terms (2013), the conceptual framework organizes what you think is going on. To explore what I think may be going on between psychiatric nurses and patients who have poor insight and psychosis, this conceptual framework addresses the points listed in the Conceptual Framework section of my Design Map (Figure 1, p. 17)

- lack of insight impedes treatment,
- nurses who do not understand the role of insight in treatment of psychotic disorders may not help and may even harm therapeutic goals and relationships with patients, and
- nurses’ understanding and appreciation of patients’ insight problems may positively influence clinical communication and care delivery, and may provide guidance to this examination of how psychiatric nurses use their understanding of the role of insight to approach care for patients with psychosis.
Organization of the Literature Review: Psychosis and Insight

To organize the literature review, this chapter will include a discussion of concepts relevant to the conceptual framework for this study including

- description of insight and its role in schizophrenia and related disorders;
- qualitative description of how people live with the disease;
- goals and methods of both inpatient and outpatient treatment for people with schizophrenia and related disorders
- Framing the nurse-patient relationship in communication: Listen, Empathize, Agree, and Partner Model (LEAP).

The literature review thus leads into the development of a conceptual framework that included my professional experience and results from my previous pilot study on insight and psychosis. This conceptual framework then influenced the collection and analysis of data, and the formulation of implications from the research study.

Using the literature on psychosis and insight, I constructed a conceptual framework to investigate the problems and phenomena involved in psychiatric nurses’ clinical work with people experiencing psychosis. This framework referenced previous qualitative research addressing psychosis and schizophrenia and my own clinical experience. Amador’s (2010) Listen, Empathize, Agree, and Partner (LEAP) framework is also presented as an established approach to effective communication with people who have poor insight, and provides perspectives on the complexities of interacting with loved ones who believe that they do not need treatment. In reviewing the literature, I used the
original author’s/s’ terms when referring to or describing the patient, client, consumer, service-user, or loved one.

**Role of Insight in Schizophrenia and Related Disorders**

Commentary / review papers and quantitative research relevant to schizophrenia spectrum psychotic disorders insight were organized into many interrelated topics. Quantitative studies abound, and the explorative angle of my expanded search for insight-specific papers at the outset of my research study resulted in over 50 retrieved articles in my original literature search conducted in 2011. Although not the focus of this topical literature review, mention is made of the topics captured while exploring the subject of schizophrenia and lack of insight, to provide scientific context for this research. (To illustrate literature growth regarding psychosis and insight, the PubMed search I conducted in October, 2016 using the terms schizophrenia and insight produced 1,999 items.)

The quantitative researchers addressed insight in relation to attempts to define, assess, measure, and treat insight; describe and measure insight as a neurocognitive and executive function deficit; methodological problems in exploring insight; treatment non-adherence and associated costs; psychological dimensions of insight and psychosis; quality of life; the association of lack of insight with other symptoms of psychosis; the stigma associated with chronic mental illness disability; association of schizophrenia, insight and suicide; and perspectives on epidemiological data and treatment outcomes associated with lack of insight. Insight is complexly entwined within the still complicated brain disease of schizophrenia.
Qualitative study of insight phenomenon included exploration of insight formation in schizophrenia remission by Ko et al. (2006) and comparison of patient, friend, and clinician perspectives on insight and psychosis, with a special focus on socio-cultural factors by Tranulis et al. (2008).

Ko et al. explored how outpatients in remission viewed their illness experiences. The authors reported that the outpatients experienced loss of control and unbearable symptoms; that medications work by trial and error; and that awareness of illness may come with symptom relief over time.

Tranulis et al. found that while the patients and family members were able to represent each other’s experiences with relative agreement, great differences were found between clinicians and patient/family. How the clinician perceived the patient’s culture and background influenced clinician interpretation and attribution regarding psychotic symptoms, and clinician attachment of stigma to the patient’s severe, chronic mental illness. When the clinicians’ assessments were matched and compared one-to-one to family members’ perceptions, assessments revealed little clinician consideration of the clients’ insight-related issues and much more sensitivity on the family members’ perspectives regarding the influence of insight on the clients. Clinicians were fearful of provoking confrontations with clients, so did not explore divergent views. There was a sense that clinicians were unable to relate and communicate with their clients. With these limitations imposed on assessment data, the clinician may be apt to misappropriate the meaning of the data. Stigma may result; the patient may learn to withdraw and avoid interaction.
Qualitative Research and Schizophrenia: How People Live with the Disease

Given the vast and extensive commentary and research literature on schizophrenia and psychosis, the literature search was organized without time limits to explore the interrelated topics of insight, schizophrenia, and qualitative research. PubMed was searched using the keywords insight, schizophrenia, and qualitative research. The same keywords entered into CINAHL retrieved no publications in the original 2011 search I conducted, but schizophrenia combined only with qualitative research resulted in ten citations. Using the combined databases in October 2016, 18 bona fide qualitative research studies qualified for retrieval. Eliminating insight as a search term and broadening the topic to schizophrenia AND qualitative research was necessary to access any qualitative studies involving schizophrenia and schizophrenia spectrum disorder psychosis in the nursing literature index. Insight as a research focus was subsumed under schizophrenia and turned out to be the literature search-limiting factor.

With the exception of a single 1995 study, qualitative research regarding schizophrenia is limited to 16 other studies all published since 2003: one in 2003, one in 2004, two in 2005, two in 2006, two in 2007, three in 2008, one in 2011, two in 2012, one in 2013, and two in 2014. Qualitative research endeavors in schizophrenia are thus essentially less than fifteen years old. Of note, authorship of research reflects international interest in qualitative research investigations of schizophrenia with European nations, Canada, Australia, New Zealand, Ethiopia, India, and Taiwan represented. Only the 1995, 2011, and 2013 articles originated from the United States.
The qualitative literature review is organized to address how qualitative research has been used to explore schizophrenia. The sections in the following literature review include methods of qualitative research used, the topics studied, and the data-source persons tapped. Finally, I discuss the connections between perspectives discovered in the existing literature and qualitative interview study of psychiatric nurses’ experience of working with people lacking insight.

Types of qualitative research methods used to explore schizophrenia.
Fourteen of the seventeen studies used qualitative narrative or thematic analysis methods to explore topics relevant to schizophrenia (Baier 1995; Chur-Hansen et al. 2005; Corring & Cook 2007; Galasinski & Opalinski 2012; Gould et al. 2005; Higgins et al. 2007; Ko et al. 2006; Langan 2008; Moller & Zauszniewski 2011; Nordick & van Heugten 2014; Ogden 2014; Roe et al. 2004; Teferra et al. 2013; Tranulis et al. 2008; Vandyk & Baker 2012). The narratives were recorded and analyzed using notation, coding, and themes. Resulting themes were organized and reported using either conceptualizations gleaned by the researchers, or re-referencing participants’ own phraseology. Grounded theory was used by Nordick and van Heugten (2014); Noiseux and Ricard (2008) also used grounded theory methodology with open coding, axial coding, and selective coding guided by Glaser and Strauss. Kikkert et al. (2006) employed a complex mixed-methods approach which used concept mapping. Moller and Zauszniewski (2011) framed their research with van Kaam’s 1987 psycho-phenomenological method of analysis modeled after Edmund Husserl’s thinking. Vandyk and Baker (2012) used a constructivist paradigm modeled by Kumar in 2005 and Morse and Field in 1995. One remaining study by Andresen et al.
(2003) was actually a review of qualitative and theoretical research including published experiential accounts. This work should not be dismissed, as the authors underscored the importance and value of including consumer experiences in describing clinically relevant phenomena.

**Data-source persons.** Approximately half of the qualitative studies used actual consumers, patients, or service-users (United Kingdom term) as the sole data source. Qualitative methods are strengthened by triangulation and use of multiple perspectives, yet the fact that schizophrenia carries such profound stigma suggests the possibility of endemic avoidance of people with schizophrenia, including qualitative researchers. Consider that literature search engines find that qualitative research has only been carried out in the last fifteen years on the general topic of chronic schizophrenia: still rarer is qualitative research involving the people themselves who live with the symptoms of delusions, hallucinations, cognitive deficits, social withdrawal, and isolation. Nine of the studies included only patients as informants (Corring & Cook 2007; Gould et al. 2005; Ko et al. 2006; Langan 2008; Moller & Zauszniewski 2011; Nordick & van Heugten 2014; Ogden 2014; Roe et al. 2004; Vandyk & Baker 2012). Five studies included the patient, family member and/or clinician perspectives (Baier 1995; Kikkert et al. 2006; Noiseux & Ricard 2008; Teferra et al. 2013; Tranulis et al. 2008). The remaining three were focused on staff experiences and accounts (Chur-Hansen et al. 2005; Galasinski & Opalinski 2012; Higgins et al. 2007). Multiple perspectives can give strength and stability to qualitatively described phenomena, and the research reviewed here inherently
expresses the thematic need to give the person with schizophrenia a voice through research.

**Qualitative topics studied.** As my research will use qualitative methods to explore nurses’ perspectives on the patients’ experiences of psychosis and insight, qualitative studies are reviewed in this section. The following studies used qualitative analysis approaches to focus on rehabilitation and recovery and associated coping; clinical assessments; specific insight-oriented issues; and quality-of-life using qualitative analysis methods.

Rehabilitation and recovery phenomena were specifically addressed in five studies. Higgins et al. (2007) used questionnaires to explore mental health nurses’ experiences of rehabilitation services offered in China and India and factors affecting rehabilitation success, particularly demographic factors and cultural beliefs. The authors’ literature search revealed a focus on Western culture practices; Eastern rehabilitation services were not described. To assess rehabilitation programming success in the Eastern cultures of China and India, the researchers clarified some basic factors including traditional medicine practices not used in Western schizophrenia treatments and gender preferences.

Noiseux and Ricard (2008) studied recovery as perceived by people with schizophrenia, family members, and health professionals. The core category coalesced into:

… a process involving intrinsic, non-linear progress that is primarily generated by the role as actor that the individual adopts to rebuild his or her sense of self and to
manage the imbalance between internal and external forces with the objective of charting a path through the social world and regain a sense of well-being on all biopsychosocial levels (Noiseux & Ricard, 2008, p. 1148).

The authors concluded that individuals’ inner attributes and resources explain the recovery response. They stressed the importance of focusing on the individual. Andresen et al. (2003) stressed the role of the consumer in describing the recovery process in hopes that treatment programs will be guided by actual consumer needs.

Post-psychotic adjustment process as a stage of recovery from a psychotic episode was examined by Moller and Zauszniewski (2011). The authors elucidated four elements associated with post-psychotic adjustment. Cognitive dissonance involved making sense of the experience, and was associated with medication efficacy. Insight represented the recognition of symptoms and that illness created serious problems. Cognitive constancy represented the ability to have relationships and participate in activities. Ordinariness was described as patients’ abilities to conduct their lives in a similar manner compared to before they became ill.

Importantly, Moller and Zauszniewski (2011) found that patients who had insight were able to initiate and sustain reality testing. Insight was associated with relative clinical stability and medication efficacy. The authors indicated that the development of insight took 6 to 18 months in treatment, and stressed that insight was associated with effective symptom response to medications. Patients with insight did not want others to know they were having symptoms of psychosis, and benefited most from effective medications that targeted their symptoms; family support; and the understanding of their
treatment teams. Sometimes, symptoms were only partially ameliorated by medications, and only over time were patients able to recognize their losses in terms of how their lives had changed. A final crucial point the authors made was how patients learned to recognize intermittent symptoms, and begin to make adjustments over time in spite of those symptoms.

Moller and Zausniewski (2011) were also able to describe the human experiences of adjustment to psychosis, in an effort to assist clinicians who support patients in a recovery process. They explained that clinicians need to understand that adjustment to psychosis is not an outcome of treatment, but rather a process of adjustment over the course of time and experience. They stressed the highly personal nature of adjustment, and the extensive and variable time the individuals’ adjustment process takes: they emphasized process-over-outcome, and cautioned clinicians not to place unrealistic expectations on patients.

Coping with everyday life was the subject of four studies. Gould et al. (2005) clarified a process of coping with the results of losses, addressing the clinical gap aimed at helping consumers (patients) get what they wanted and needed, to interrupt patterns of social isolation, limited activities, and work. Roe et al. (2004) explored coping strategies used to regulate activity and control stress to reduce symptoms; a confident hope came through the determination to imagine a good future. Baier (1995) described how the uncertain course and effects of schizophrenia result in attitudes of either opportunity or fear for patients. Vandyk and Baker (2012) explored everyday effects of medication-induced weight gain on people with schizophrenia and schizoaffective disorders; the
authors reported the patients’ concerns about eating well and exercising yet not having much energy or money to support a healthy lifestyle. Weight gain affected how the participants felt about themselves. The participants also worried about how their medications might affect their health over time.

How people with serious mental health conditions find meaning and value in life was addressed by Ogden (2014). She conducted multiple interviews with six older adults who had symptoms of schizophrenia to construct their personal historical narratives, or life stories. Only two of the participants were reported as having insight regarding their mental illness, yet despite this, all the participants had developed life stories and self-identities incorporating their experiences of schizophrenia. Ogden discussed the role of age and experience in the participants’ ability to make sense of symptoms and illness; she also emphasized that living in, or associating with a community of peers seemed to be socially and personally protective against stigma, in that a “shared narrative” existed among community members (Ogden, 2014, p. 1352). Participants with greater insight about their illness condition retained some sense of disability; one patient with clinical insight absorbed the stigma of his disability but could not repel it. He carried within himself a sense and identity of being disabled. Generally, however, Ogden concluded that these older people with schizophrenia could minimize damage to their sense of self because they had a group identity and belongingness.
Goals and Methods of Treatment for People with Schizophrenia and Related Disorders

Clinical assessments are relevant to this review, as insight is a highly complex phenomenon. Three studies looked at assessment processes. Langan (2008) assessed how mental health professionals assessed whether patients were a risk to others and the extent to which the clinicians involved consumers in the assessment process. The author also attempted to ascertain what consumers knew about the assessment process and how they perceived the risk assessment:

… the frankness with which professionals discussed risk to others with [patients] depended upon a complex interplay of factors such as quality of the relationship, extent of agreement about the risk, concern about harm to staff, fears for personal safety and confidence in approaching this subject (Langan, 2008, pp. 476-477).

While including the patient openly in clinical interviews may be the preferred method of assessing insight and psychosis, actual practice may vary. Chur-Hansen et al. (2005) found differences in how mental health nurses and psychiatrists approached their prognostic assessments of people with schizophrenia; these differences were associated with nursing and medical frames of reference. The nurses were concerned with caring for their patients’ needs and relationships, while doctors were focused on treatment of symptoms and symptom recurrence. Kikkert et al. (2006) explored factors influencing medication adherence to help professionals positively influence medication adherence by focusing on what is important from the patients’ perspectives. The researchers also emphasized the need to investigate discrepancies that were discovered between patients
and professionals in regards to views on non-adherence. These assessment processes give glimpses into what the issues are in working clinical relationships with people struggling, yet hoping, to live good lives.

Patients, their caregivers, field workers and health workers were interviewed by Teferra et al. (2013) in rural Africa to study reasons that underlie medication non-adherence in people with schizophrenia. The authors used results gleaned from focus group discussions and individual interviews to identify factors basic to everyday life needs and expectations that may be influencing people with schizophrenia to stop taking antipsychotic medication. These factors were likened to those found in developed nations with higher standards of living than those in rural Africa, where health resources and access to care are often limited. Reasons that patients, caregivers, and healthcare workers gave for treatment non-adherence included limited food availability (antipsychotic medications can spur appetite), and limited social and family support; social and financial factors were stressed as the most important factors related to medication non-compliance. Factors were found common to both developed countries and the poor, rural African area where this study was conducted; they included patients’ poor insight about the illness, poor response to treatment, medication side effects, stigma, and the caregiver’s attitudes toward the person with schizophrenia.

Role of Nurses in Treatment of Schizophrenia and Related Disorders

Clinicians’ views and attitudes may affect how their patients experience the need to receive treatment. To explore how psychiatrists describe the role of insight in schizophrenia, Galasinski and Opalinski (2012) interviewed psychiatrists who specialized
in the treatment of schizophrenia spectrum psychotic disorders. From their data, the authors reported that the psychiatrists had a medical view of mental illness in patients who have impaired insight, so that the psychiatrists viewed their patients with a *sense of illness*. This sense of medical illness affected and was associated with how the psychiatrists interacted with their patients; this attitude resulted in a form of interpersonal *criticism*. The authors posed that these interactions in turn may affect the patients’ *readiness to receive treatment*. Galsinski and Opalinski concluded that such perceptions and attitudes in psychiatrists, as clinicians, limited how the psychiatrists perceived serious mental illness, and that these clinical perceptions limited the exchange of views and experiences that are required to help patients with their needs and problems. The authors described the psychiatrists’ attitudes as “*imposing*” medicalization on people in distress” (p. 1465).

Nordick and van Heugten (2014) examined lack of insight in schizophrenia to explore the problems underlying treatment adherence. The authors asked patient participants how schizophrenia affects the participants’ lives and how insight develops. The participants had experience with the illness - they were middle-aged - and had what the authors described as good insight. The authors were especially interested in how the participants’ experienced psychiatric crises and reported that the participants developed insight in three stages: a *period of chaos*, a *dynamic period*, and a *period of wisdom*. The authors linked psychiatric crises thematically with dangerousness, both in relation to danger to the participants, and danger to the participants’ relationships with people who care about them. Repeated crises wear on relationships with family and social supports.
The authors’ “Theory of Dangerousness” connected the participants’ motivation to remain in treatment and stay well, to the participants’ wish to maintain their social and family relationships.

Corring and Cook (2007) explored the applicability of the quality-of-life construct to chronic schizophrenia. They concluded that existing models measured illness experiences in terms of symptoms and side effects, and did not sufficiently develop individual experiences related to illness burden or recovery processes. The authors stressed that people with schizophrenia only want what other people want, and generally come accept that they will do with less than what others have. They conveyed that patients must take action, and that clinicians can support their patients’ efforts by interacting in a meaningful way that accepts them as individuals with individual experiences and needs.

There are relevant perspectives for psychiatric nurses in almost all of the study findings described thus far. Patients want, and need, to be approached by clinicians who recognize them as individuals. They need nurse clinicians, especially in their intensive time of need while hospitalized during psychiatric crises and symptom exacerbations, to have the competence to provide effective nursing care – despite varying levels of insight about the patients’ illness condition. Psychiatric nursing standards of practice stress the need for research that describes clinical competence that is necessary to care for patients with chronic mental illness conditions (American Nurses Association, 2014).
Perspectives from the Literature: Prompts for the Qualitative Study of Impaired Insight Associated with Schizophrenia Spectrum Disorders

The qualitative research literature relevant to schizophrenia has been reviewed in terms of specific topics explored, study methods, and targeted data groups. The review revealed that people other than the persons with schizophrenia themselves are often used to explore life with schizophrenia. Clinical problems, such as medication non-adherence and the specific phenomenon of lack of insight, are explored and then described by clinicians, family members, and friends of the person with schizophrenia.

Some more direct research work has tapped the experiences of the person with schizophrenia. Studies including patients as participants explore insight phenomena only when the patient has gained insight and can report on their experience retroactively. This body of research falls short of actually describing the experience of unawareness while unaware. While this statement appears only logical, advancing understanding of actual patient experiences while in the throes of not sharing the same worldview as caring others do “for” them, could expand the clinician’s view of patients as non-compliant, uncooperative, resistive, and enigmatic.

Productive clinical management and care of people who lack insight is very challenging for both inpatient nurses and outpatient case managers. Phenomenological examination of the nurses’ experiences may provide a means of understanding whether, or how, nurses recognize lack of insight in the patient. Phenomenology may also provide a way to elicit perspectives on how nurses interact with and perhaps influence patients’ participation in their own treatment and care. Exploration of the nurses’ experiences of
patients’ lack of insight may be helpful in clarifying how to design non-threatening assessment approaches and interview techniques for patients lacking insight, especially for delusional patients with poor insight.

**Listen, Empathize, Agree, and Partner (LEAP) Model: Framing the Nurse-Patient Relationship in Communication**

In order to present the Listen, Empathize, Agree and Partner framework (Amador, 2010-2012) effectively, some background regarding the model and its author is useful. Over his thirty-five year career as a Ph.D. clinical psychologist, Xavier Amador worked with people with severe mental illness who had poor insight into their disorders. He was motivated to find ways to communicate more effectively with his older brother who was diagnosed with schizoaffective disorder when Amador was in his early twenties. His brother Enrique, “Henry,” was repeatedly hospitalized during periods of extreme psychosis when he was delusional, and had no insight into his psychotic symptoms. Henry would stop taking his medication as soon as he was discharged from the hospital, became unable to care for himself for periods, and was repeatedly arrested by the police and jailed. Amador had to commit his brother to psychiatric care numerous times against his brother’s will. Their relationship suffered, as they both individually had to live with the effects of having to, from the younger Amador’s perspective, force treatment on his brother, and from Henry’s perspective, be forced into psychiatric care he did not need (Amador, 2010-2012).

This story was the background and impetus for the development of Xavier Amador’s (2010-2012) framework, Listen-Empathize-Agree-Partner. Rather than argue
differences in perspective with a person lacking insight, the neurological condition termed anosognosia, LEAP-directed communication is focused on what both parties can agree on. Finding shared goals, for example staying out of the hospital, becomes the focus of communication rather than attempts to convince the person lacking insight that something is wrong with them. The book in which Amador described the framework is now in its third edition, 2010, after initially being published in 2000, followed by a second edition in 2007.

Amador is a leading researcher in the area of psychosis and insight. For this research study, however, I will focus on the work he has made accessible in his book (2010-2012) targeted for people with severe mental disorders, their families, and caring friends. Of note, Amador chose to use the term “loved one” when referring to patients with lack of insight to keep his focus on what matters to most of us: maintaining communication with someone you care very, very much about, the same person who resists your caring when that response is packaged in direct encouragement or direction to take medication, go to treatment, and admit or “face” illness.

At several points in the book (2010-2012) Amador posited that LEAP represents good communication, that it is simply an intuitive form of a caring endeavor focused on delivering messages in a way that the receiver lacking insight can accept and work with. When taking medication, day-in and day-out, is couched in the perspective that taking medication consistently keeps the loved one out of jail and hospitals, the person is more likely to find that approach less threatening than more direct instructions to take
necessary medications (2010-2012). The four elements of LEAP, listen, empathize, agree, and partner will be presented next.

**Listen.** Listening involves special listening, reflective listening (Amador, 2010-2012). The purpose of reflective listening is to gain access and perspective on the loved one’s point of view, not to give the listener the opportunity to find a pliable opening into poor insight about illness. It is intently focused on helping the other person open-up, so that the person lacking insight might share his/her perspective, how the person themselves, see things. Only when the loved one’s perspective is established, can a shared conversation take place. The listener has no other agenda than to help the person tell his or her story: only questions are allowed that support the development of that story, no comments or suggestions are to be offered that could be experienced as a challenge.

Amador (2010-2012) provides guidelines for reflective listening. He explained that the listener needs to “make it safe” (p. 77) for the person to talk when the listener is not presenting challenges, comments, or confrontations, so that the person does not have to defensively explain himself. Amador recommended at this early stage in the listening process to apologize for past times when listening did not occur, and to say that it is understandable that the loved one does not want to talk about anything anymore. This way, the person with severe mental illness does not have to avoid talking.

Amador (2010-2012) also wrote that knowing one’s own fears about reinforcing delusions, or dangerous and unhealthy behavior, is important. Psychiatric nurses, for instance, were previously taught and supervised to point-out that they did not share the patient’s experience or perceptions related to delusional beliefs, as if this would let the
patient know that what the patient was experiencing was not real, thereby avoiding reinforcing the delusion. This, however, is highly threatening – challenging – to people experiencing psychotic delusions, as those beliefs are the patients’ experiences, and not to be explained away by what is termed reality testing (presenting an alternative explanation for the same phenomenon).

Amador (2010-2012) also wrote that it is important to “stop pushing your agenda” (p. 77), that this is the very thing that is promoting the psychotic person’s avoidance of communication. Amador wrote, “Let it be” (p.77), leave the matter alone, do not attempt to rectify thought disorder and disorganized speech. Listen to the feelings, they are there, if we quiet down, listen, and are interested in them.

Amador (2010-2012) closed his section on listening by asking the readers to respect what they have heard from the loved one, not to react with one’s own point of view, not to provide any comment or criticism, so as to not create a reason for the patient to be defensive or to have to explain. He instructed the listener to “find workable problems” (p. 77): what is that problem according to the loved one, and does he think it needs fixing or does he want to work on it? Only when the problem is identified in the terms of the loved one can there be a shared focus regarding that problem. Amador finally recommended that once we have listened like this, we need to “write the headlines” (p. 77) as if we are journalists. We need to record the things that are important to the other person, as they expressed the issue, not what we think is the point. This way, a shared focus can exist, one that the person is motivated to stay connected to the listener around.
**Empathize.** The very feelings and perceptions the loved one finds most important are often the feelings that we resist and deny and try to reason away the most (Amador, 2010-2012). The person with severe mental illness is angry and scared, afraid that their past experiences with the mental health system and treatment will be forced on them again and again against their will. It is as if the person is not real, and that the person’s feelings and perspective are worthless to outsiders. The point of listening is to learn what these feelings and experiences are, and to maintain contact with those feelings through the expression of empathy. The listener is so interested in the experience of the loved one, that they can only care about (and agree with, surprisingly!) those feelings and experiences the person has had to pack away and attempt to live with.

Amador (2010-2012) brought up the most difficult situations family members, friends, and psychiatric professionals come across, the “Do you agree with me?” (p. 119) question, posed to the listener when the person needs or desires confirmation regarding their perspective on their experiences, treatments, and medications. He suggested that answering the question be delayed as long as possible, to diminish threat to the shared experience that is building between the loved one and the listener, in order to not weaken the development of shared perspective. Also, not providing any opinion unless the person asks for it is essential. When the person seeks perspective, focus on the patient’s desired outcome. If the question is forced, promising to provide that view later can be helpful, with the explanation that listening is more important at this point, and that loved one’s point of view is the most important thing to talk about. We can tell the person we will
share our views later, after we are really sure we understand the loved one’s point of view.

Amador (2010-2012) closed his points on empathy by suggesting we apologize that our view might feel hurtful or disappointing to the person. He said that we should acknowledge simply and clearly that we could be wrong, and that we need to agree to disagree without emphasizing the disagreement. Conveying the respect for the other person’s experiences and perspectives is the crux of empathy. Being open to our own feelings and putting them into words is important, without implying that the loved one should respond in kind. Expressing disappointment that we have perhaps hurt or offended the person is authentic disclosure.

Agree. Amador (2010-2012) offered six points to help the listener find aspects of the loved one’s experiences and perspectives with which to agree. Again, finding ways to agree helps turn the relationship into a safe, desirable, shared experience for both parties. In order to recognize and use opportunities to find areas of agreement, he said to normalize the experience, only discuss perceived problems or symptoms, review perceived advantages and disadvantages of treatment, correct the loved one’s misconceptions, reflect back and highlight perceived benefits, and agree to disagree. We can find ways to agree with the person, letting them know we would feel the same. We do not have to label experiences as psychotic or delusional, but rather describe how uncomfortable, scary, and disheartening these chronic problems are.

Helping the person clarify what is helpful or bothersome about treatment and medications and then agreeing with those perspectives is an opportunity to demonstrate
we are listening, we empathize, and we agree with the person – we are with them, not against them. Correcting misconceptions about medications and the origins of mental illness (often there is guilt about past behavior the person believes caused the disorder) is another helpful, supportive action. Finally, letting go of things not in agreement is important. Leave the other things alone. As the relationship develops and corrects, opportunities may arise later to explore other more entrenched differences, to be experienced in time as areas in which the parties can find common ground.

**Partner.** Partnering is what happens when listening, empathy, and agreement come together in a shared experience between the listener and the loved one (Amador, 2010-2012). Now there is common ground, agreement that both parties want the loved one to stay out of the hospital, that restful sleep is a good thing, that taking medication consistently is associated with, for example, a decrease in unrelenting, cruel voices (auditory hallucinations). In this relationship, parties share non-threatening goals, even supportive and caring communication processes. LEAP brings people together around apparently insuperable differences. The future of the relationship is the responsibility, and the shared success, of both parties.

The clinical relationship shared between patient and nurse is a partnership (Amador, 2010-2012). Goals and plans require agreement between patient and nurse to produce effective clinical outcomes. The LEAP framework provides a simple, sophisticated, and effective process to help locate the clinical relationship in a shared partnership, and the interpersonal communication means to effectively navigate the way through that special relationship.
Patients will not be accessed in this present study for feasibility reasons, nor will their relatives or friends. Psychiatric nurses will provide interview reports of their experiences working with people who have psychosis and poor insight, to take a first step in clarifying what the patients might be experiencing. This quintessentially personal experience that people with psychosis and who have impaired insight live with alone, might then be approached with due respect and appreciation.

**Pilot Study**

I composed and completed a pilot study six years ago to organize my research interests and purposes, to compose and test the questions of an initial interview guide, and to explore the feasibility of interviewing psychiatric nurses regarding insight and psychosis. For the pilot study interviews, I purposefully selected three highly experienced psychiatric nurses who had worked for years supporting research regarding psychotic disorders, based within inpatient programs. The inpatient research participants in these programs were patients with chronic schizophrenia spectrum disorder psychosis, and often demonstrated incomplete insight regarding their symptoms of psychosis.

Using the first section of the Psychosis and Insight Interview Guide (Appendix A), qualitative interviews with these three nurses resulted in three themes: the patients’ experience, how the nurses use their own experience, and the use of frameworks to guide their nursing practice.

**The nurses report on the patients’ experience.** Despite the ambiguity and challenge inherent in working with patients who lack insight, one of the most important findings of this pilot study was that all three nurses stated directly, and described
repeatedly through examples how they, and other people, cannot know for certain what patients are going through. The patient’s experience is their own: “I obviously can’t know what they experience … it’s such a profound thing to be 18 or 19 and have your whole life just literally ripped apart.” This was a validating occurrence: we cannot know directly another person’s experience, we can only aim to clearly understand those experiences in the manner intended by the other person. When describing what lack of insight is, one nurse said, “They’ll just very plainly state, ‘I don’t believe I have an illness … I know what I’m experiencing is real, nobody can tell me differently.’”

Despite the awareness that we cannot know another’s experiences directly, the nurses did describe how patients talk about their particular experiences. They also described how patients behave, interact, and respond in varying scenarios: “Their experience is often one of bewilderment. You can’t quite figure out how they got to this point in their life … things just don’t make sense …” They also described how they work to clarify and understand the patient and “meet them wherever they are” without being confrontational or expecting the patient to share their clinical perspective: “You can’t force a person to believe something they don’t believe.” One nurse recalled an older head nurse teaching her, “‘You have to go where the person is, and work backwards;’ and I said, what do you mean? [And she said] ‘Wonder why: Wonder what’s going on … find out where they are.’”

Patients try to make sense of what is happening to them, “…they come up with an explanation … they can accept and live with, at least for a while. It doesn’t make it go away; it just makes it bearable …”
Patients may react with anger, hostility, paranoia, withdrawal, avoidance, and despondency when faced with their own unrelenting psychotic experiences. The patients’ losses were voiced over and over by all three nurses:

… the reaction is to, to stop living … to not participate … just kind of cut yourself off … I don’t think it’s intentional … so much as a reaction … the more you cut yourself off, the more rusty your skills at socializing become, and you get really far behind.

The nurses described how patients are anxious, fearful, and easily intimidated by interactions and circumstance: “I think they are fearful” and “They are terrified.” The patients are overwhelmed and need compassion, understanding, and gentleness.

**How the nurses use their experience.** In response to the patients’ need for confident, caring responses, the nurses described how they, “… move closer … but in a way that’s not intrusive, a way that respects their integrity … it’s like reaching out, saying, ‘I’m here…I know you’re in there…’” Nurses’ authenticity was described in this communication process: “And there’s … no trickery to it … it is all safe … [no] enforcing the rules … [no] making people act normal …” The nurses described their process of “being with” the patients as “precious,” as “being present.”

They also described disturbing situations. One nurse recounted that some nurses are “… directive … bossy … telling them what to do.” They also described the “… abusive and unacceptable … arrogance …” of nurses who attempt to control patients. The participant nurses expressed accountability and responsibility when faced with these abusive situations:
Why do we think we are smarter than they are? … I understand what’s wrong with them, to some extent, although we know so little about it really, still … [we need to have] the humility to see them as … they are … [we must] extend a hand…it’s a matter of justice, fairness.

Another nurse expressed,

… you know that could be a family member, or that could be me … I’m humbled … to know all these things, secrets, all the information about another human being … The least that we can do as human beings is to respect each other and care for each other.

The nurses’ use of frameworks. Given the ambiguity and abstract nature of insight, the nurses referenced frameworks to help them put their keen observations to use:

“It’s hard to say what works and what doesn’t. … One of the big things … is having a framework or even having something to measure this by … [to] see what’s happening.”

(The two nurses with Master’s degrees both expressed notions about formal frameworks, while the bachelor’s prepared nurse did not.) Piaget was mentioned in the context of formal operations of adulthood, and, “If an adult is schizophrenic and is not able to think in those terms, I have to stop and think of what’s wrong and if it’s lack of insight … I’m thinking it’s got to be some frontal lobe problem …” Analogies were drawn to physiological conditions like diabetes or pain to help articulate and make more concrete the symptoms of an illness, to provide the person with psychosis a discernable reference point.
Conclusions from the pilot study. Although the patients themselves were not accessible for the study, nurse reports provided initial prompts for investigating how to think about psychotic states in which insight is limited. Without guidance from the literature, the designers of behavioral programs with well-intended ambitions, psychiatric treatment programs and their leaders, and clinical staff – especially twenty-four hour inpatient nursing staff – may fall into the very mishaps such as abusive, inappropriate, over-controlling behaviors and expectations described by the nurses in this study. The toxic, unsafe, and harmful conditions recounted in this small qualitative study may reflect the deleterious affects that clinicians short on time, and who lack knowledge or practice experience regarding psychosis, and who work in programs not designed to support the care needs of people with psychotic disorders, may have on people with psychotic disorders.

Surprisingly, using only three participants, much of the data regarding the nurses’ experiences overlapped and expressed recurrent themes. The choice of three especially experienced, gifted, and ultimately humane nurses may explain that occurrence. Nonetheless, exploring other nurses’ views, perhaps purposefully using less experienced nurses or seemingly less insightful nurses, may be useful to clarify more simply what not to do with patients who lack insight.

A more refined approach to this research project would include taking the interview scripts back to each nurse, thoughtfully reviewing the material, and developing the ideas with even greater analytic depth and clarity. This material is too rich and
leading, too full of clinical promise and potential benefit to clinicians and patients alike to leave it less worked.

**Summary**

Using the pilot results, my own psychiatric nursing experience, Amador’s (2010-2012) LEAP framework, and the literature on insight and psychosis, I explored these ideas in the conceptual framework

- lack of insight impedes treatment;
- nurses who do not understand the role of insight in treatment of people with psychotic disorders may not help and may even harm therapeutic goals and relationships with patients; and
- understanding and appreciation of patients’ insight problems may positively influence clinical communication and care delivery, and may provide guidance to this examination of how psychiatric nurses use their understanding of the role of insight to approach care for patients with psychosis.

The conceptual framework addresses crucial factors affecting nurses’ perceptions and experiences with patients with schizophrenia who lack insight, and provides an approach to investigate the nurses’ understanding of patients’ levels of insight. That is, do the nurses practice with an adequate understanding and appreciation of insight in people with schizophrenia? That is what this research study addressed.
CHAPTER THREE
METHODS

Research Methods Using Maxwell’s Interactive Research Approach

In the Interactive Research Approach, research methods include consideration of the processes related to data collection, establishing research relationships with study participants, site and participant selection, and data analysis approaches. Maxwell (2013) explained that unstructured design approaches support the investigation of particular phenomena, while structured approaches are more useful when the researcher wants to make comparisons and investigate differences between phenomena. Because this research study explores how nurses perceive the patients’ experiences, a relatively unstructured design approach is important, while a planned design approach will assist the implementation and next phases of what will be a program of research. This chapter on study methods will encompass an overview of the study, population and sample, data collection procedures, data analysis, confidentiality considerations, validity limitations of the research design, and summary.

Overview of the Study

Investigation of patients’ lack of insight using nurses’ experiences, perceptions, and beliefs will be thematically reported in Chapter 4: Results and Discussion, using qualitative data collected from interviews with nurse participants. Attention was paid to identifying and limiting validity threats inherent in qualitative interviewing. As a next
phase of this research, the design approach and results of this initial research study may ultimately be used to enhance the future development of non-threatening assessment approaches and interview techniques to assess impaired insight in patients with psychosis and delusions.

For the purposes of this research project, professional psychiatric nurses were asked to report their experiences. Qualitative interviewing provided the method to query the psychiatric nurses’ experience of working with patients lacking insight. Interpretation of the nurses’ experiences is discussed and implications are drawn using Maxwell’s (2013) interactive approach to qualitative research design.

To make inferences regarding the meaning of lack of insight in patients with psychosis, professional nurses were selected to provide reports of their experiences. Examination of the nurses’ experiences and perspectives provided a means of understanding how nurses may recognize lack of insight in the patient. It also was a way to elicit perspectives on how nurses interact with, and perhaps influence, patients’ participation in their own treatment and care. Knowing how nurses think about patients who lack insight, what nurses believe about what influences the patients’ behaviors, and what expectations nurses have of psychotic people lacking full self-awareness helped to clarify the processes nurse clinicians intuitively draw on in difficult clinical situations.

**Panels and Samples**

The purpose of this study was to explore psychiatric nurses’ clinical experience of impaired insight in patients with schizophrenia spectrum psychotic disorders. In order to best understand what the nurses thought was going on with the patients, I used the
approach indicated by Weiss (1994) regarding panels of informants versus samples of informants. Weiss indicated that *panels of knowledgeable informants* are selected by the researcher when the study questions address how something works and can provide different perspectives and inform aspects of the thing or phenomena being examined (1994). In the case of this study, Weiss’s panel approach was represented by gathering data from nurse participants who are experienced and knowledgeable, and who also represent a range of different perspectives on insight and psychosis in patients, and practice in varying types of psychiatric care programs. The panel approach was more apt to produce data that inform the research questions about what psychiatric nurses’ experiences are regarding lack of insight in patients than a sampling approach.

Alternatively, Weiss (1994) described an approach he termed a “sample of representatives” (p. 18). He wrote that this approach can produce data aimed at describing how participants are affected by specified phenomena. When considered together as a group, the sample participants represent a range of experiences. He explained that the panel of knowledgeable informants and sample of representatives can be combined in the same research study, but that the researcher is then combining two different, but related, studies. This combination can enrich the research study, but it is much more work (Weiss, 1994). For feasibility reasons, this study used a panel of nurses who provided knowledgeable information addressing the research questions, and that represented their experiences in varying practice contexts including community and university hospitals and clinics, and forensic facilities.
While all 11 of the psychiatric nurse participants expressed critical views about how to treat and approach patients when they are psychotic and have poor insight, one psychiatric nurse in particular turned out to be what Weiss (1994) called a key informant. Oprah was the tenth of 11 nurses to be interviewed; she demonstrated characteristics that Weiss described as “an informant on informants” (p. 20). Oprah wove her perspectives on how clinicians, psychiatric treatment programs, and the healthcare industry may contribute to making problems worse for psychotic people in crisis. Weiss described an “orienting figure,” as a panel member informant who is confident, candid, and comfortable with the interview process and research purposes (p.20). After reporting the thematic results of the study in Chapter 4, I provide sections of Oprah’s interpretive interview summary because of her openness, to actively summarize the study findings.

The Research Participants

Registered nurses who had at least three years of current direct clinical experience caring for patients with schizophrenia were drawn from the local metropolitan area. Snowball sampling was used to recruit 11 nurses from non-profit community and university teaching hospitals, state psychiatric and forensic hospitals, and private for-profit hospitals and clinics.

Finding and recruiting the research participants. I concentrated on finding nurse candidates who I thought would be good informants regarding my research questions focused on psychosis and insight. I presently work with some of the nurses I approached to be potential recruiters for research candidates to participate in this study. I did not ask these colleagues to participate in the study for professional and institutional
boundary (ethical) reasons. A recruitment script (Appendix D) was physically given to and then emailed to the nurses who expressed support for my project and wanted to help me find research participants. After explaining the purpose and process of the study, I also provided these nurses with the informed consent form (Appendix C) to provide them with the details of the study requirements to provide more specifics about the study in writing, although these nurse colleagues and other associates were not research participants themselves. I then asked if they were interested in recruiting nurse colleagues who might meet the criteria for the study. In this way, I used purposeful sampling (Weiss, 1994) to select nurses who had current direct clinical experiences with patients lacking insight into their disorders. Using this recruitment approach, I also respected the privacy and autonomy of potential candidates by not directly asking them if they were interested in participating in the research project. This approach also supported the recruitment of nurses, who despite demanding work and life schedules, were interested in the study topic and in participating in nursing research.

I did not approach any of the nurse candidates directly about participating in the study. Using the process described above, my colleagues provided the interview candidate with the copy of the recruitment form and informed consent, which provided background on the research project, without pressure or obligation to participate. My contact information was included in these forms, so that the candidate then contacted me directly, themselves. The nurse candidates’ all expressed interest in the study purpose and desire to help further research about psychosis and insight conducted by a nurse.
In addition to their interest in supporting research on psychosis and insight, the nurses were selected for varying levels of educational preparation and clinical experiences. This approach to selecting a panel of nurses was used to enhance data representing a possible range of nursing perspectives to address my research regarding psychosis and insight. They also represented different institutional and program contexts of providing care for persons with psychosis and impaired insight, i.e., had work experience in clinics and/or hospitals, in inpatient and outpatient psychiatric care.

Because of their interest in the research project and topic, the nurses became more than participants in a nursing research study. They became partners in the research study, research colleagues. They not only were asked to participate in the qualitative interview, but were also asked to review and critique the interpretive summary of their own interview in light of my research questions (see Appendix E, Letter to Participant – Interview Interpretive Summary).

**Data Collection Procedures**

**Interview guide: Development.** A semi-structured interview using 16 open-ended questions to learn about nurses’ experiences and perceptions was used (Appendix A: Psychosis and Insight Interview Guide). (During the proposal phase of my dissertation research, I considered including in the interview an assessment or additional questions about what nurses know about schizophrenia, insight, and treatment approaches. I decided against including questions that the nurse participants could even possibly experience as a “test” on insight; I did not want to potentially distance the nurses or infer in the context of the interview that they should have informational knowledge
about psychosis and insight. (See the following section addressing research partnership. I

did not want to infer that the nurses should know what insight is in the context of

schizophrenia; rather I took the approach of clarifying what the nurses meant when they
talked about insight in the context of the interview.)

The interview guide was developed using the pilot study data previously
described. The three nurses who participated in the pilot study confirmed that the
interview guide addressed their topics relevant to psychosis and insight, in relation to
psychiatric nursing practice. After the pilot study was completed, the guide was expanded
to incorporate the literature on insight and psychosis and my research questions as I
developed my dissertation proposal. The guide was further refined using suggestions
from two dissertation committee members who were experienced in qualitative methods,
interviewing, and data analysis.

**Determining the interview location.** Interview location was determined by each
nurse’s availability and accessibility; each nurse participant determined the interview
location that was most convenient, comfortable, and private for them. (Five interviews
were conducted in the nurse participant’s home, three were conducted in the participant’s
work place, and three were conducted in public library private reading rooms.) The study
purpose, procedures, and participant selection were described and explained. Written
informed consent was obtained using the George Mason University Office of Research
Subject Protections Consent Form (Appendix C) approved by the Human Subjects
Review Board (HSRB) June 1, 2012. Risks and discomforts were described, with
emphasis that participation was voluntary and could be withdrawn at any time. I
emphasized that I would be contacting the participants with a follow-up request to read
and comment on the interpretive summary I planned to compose of their individual
interview (Appendix F: Interpretive Interview Summary – Letter to Participant).

Conduct of the interviews. Interviews did not generally exceed two hours in
length; one interview took longer in order to include two breaks, per the nurse
participant’s request. The time course of the interviews was dependent on the individual
nurse participant’s willingness to clarify and expand their responses, and on the
productivity of the interview. The interviews were based on broad, open-ended questions
regarding the nurse’s clinical experience with patients who lack insight. The questions
were crafted based on the study research questions in the qualitative interview tradition
(Weiss, 1994) with input from expert qualitative interviewers and reviewed by nurses
with clinical expertise working with patients with psychosis and impaired insight.

I interacted with the nurse participants as research colleagues involved in this
research study addressing the nurses’ experiences, perceptions and beliefs regarding
psychosis and insight. Each nurse participant demonstrated their collegial partnership by
spending time and effort to be interviewed and returning a completed demographic form;
they then spent more time and effort reviewing and critiquing the interview summary I
sent them when all the summaries were composed. Each of them expressed not only
support for the research project, but enthusiasm – even pride – that a nurse-peer was
conducting this research.

Audio-taped interviews, transcription, field notes, and demographic data.
The interviews were audio-taped and transcribed by the researcher verbatim to capture
voice inflection and nuance of expression soon after the interview was conducted. The transcription process was thus tied closely in time to the actual conduct of each interview. Field notes were written on the day of each interview to maintain data currency; these notes also provided a process audit of the interview data collection activities.

I transcribed the tapes myself, listening to the tapes using a play-back recorder. I started and completed the interview transcriptions one at a time, as the interviews were collected, and before the next interview. Interviews were conducted until the data collected became redundant, and little new information was being gathered, although any new information regarding insight and psychosis was included. The feasibility of time limits on my dissertation ultimately called a halt to interview data collection. Weiss (1994, p.21) addressed the problem of when to stop interviewing by concluding that the researcher must decide when more interviews “add little to the story.”

I collected demographic and work place/program descriptions using the Demographic Form, Appendix B. This informational data was used to provide context and depth to the interview data, in later data analysis. I provided each of the nurse participants the demographic form at the time of the interview, and also emailed the participants a copy of the form to complete and return to me. (All 11 participants returned the completed demographic forms.)

**Member-checking: Interpretive interview summaries.** Participant collaboration involved not only the in-depth interview, but also member-checking and the offer to share study results. After the interview process was explained, a request for follow-up contact permission was obtained from each participant. I explained that I
would email the participant with an interpretive summary of their interview, and I requested that they read the summary and comment on the accuracy of my interpretation. Thus, the follow-up was a validity member check regarding the interview data before formal analysis across the interviews. The interpretive interview summary gave each participant the opportunity to comment on and clarify the extent to which and how I had understood the meaning and intention of what the participant had said.

The individual interview summary also reflected back to each nurse participant how I had organized their experiences, perceptions, beliefs and views in the context of my research purpose questions. Seven of the 11 participants expressed pride in their work when they sent their reviews back to me. They seemed surprised and pleased that their views could be put in a meaningful context beyond their own individual, day-to-day practice as psychiatric nurses working with people who have serious mental illness.

Confidentiality

I described previously the process I used to find the research participants for this study. Contacting the research candidates through a colleague already familiar to the candidates, maintained their confidentiality and respected their privacy and autonomy.

Information regarding confidentiality procedures and what will be published (Weiss, 1994) was shared with each participant both in the consent form itself and in the consent conversation process I conducted before beginning an interview. Every nurse I approached using the recruitment method I described previously agreed to participate in the study. After discussing the study purpose, process, and requirements, each participant signed an informed consent approved by the George Mason University Humans Subjects
Review Board. The data in this study were and are kept confidential. When an interview participant or I inadvertently used the identifying name of the participant or the name of their workplaces, these identifiers were anonymously indicated using bracketed substitutions in the interview transcripts and data analysis report. The participant source of each interview was de-identified by assigning a fictitious name to the audio-recordings, transcripts, interpretive summaries, research files, and results report. (Before beginning the interview, I had each nurse participant select an alias that I used as a code name assigned to each audio-taped interview and interview transcript, and demographic form.) Demographic data were kept free of identifiers and anonymously coded. Audio tapes were kept in a locked cabinet, as was original data in its identifiable state. The data analysis files and notes that record the anonymous code assignments to the nurse interviews were also kept secured.

Through the use of the identification key, only the researcher was able to link each interview, transcript, demographic form, and interpretive interview summary to the identity of the participant, and only the researcher had access to the identification key. Potential identifiers were camouflaged in an effort to maintain confidentiality, as previously described. Any data published from this study will not identify the research participants, their workplaces, or references the participants made to people, places, or situations.

I will send the results report of this study to the nurse participants when my dissertation research is approved by my committee. Although I did not have time to collect the participants’ views on how I organized and interpreted their interview data
together, I will extend this body of work to them out of respect and gratitude for their time, effort, and support of nursing research. I will also inform the participants of any publications that might be produced from this study.

**Data Analysis**

**Interview process; field notes and interview memos.** Data analysis began with the actual interviews as they occurred. As the participants addressed the interview questions, I sometimes would clarify what the question was getting at as the nurse responded to the question. As Glesne explained, “the data you get is only as good as the questions you ask” (2011, p. 113). I wrote research memos soon after each interview to develop observations of how the interview generally related to my research questions and research process. These memos included the field notes compiled soon after the interviews. Review of each interview enabled me to become clearer on the breadth and meaning of the interview questions as prompts supporting my research purposes and questions.

I reviewed the first few interviews with two of my committee members who were experienced and expert in qualitative methods, interviewing, and data analysis. I incorporated their suggestions into my interview approach and responses to the participants. For example, one committee member commented on the importance of not leading the participant by indicating what my own preferences and biases might be, but to concentrate on eliciting their own perspectives and thinking.

**Transcription of the interview.** Transcribing the interviews was a deep initial exploration of each interview: using a foot pedal recorder as the mode of transcription.
provided not only an exacting content record, but also an interpretative record of the tone and context within which the participant provided their thinking. I played each section of the interview on the recorder after I transcribed it into the computer to review the interview, section by section, for accuracy.

**Data analysis: Procedures and approach.** As a novice qualitative researcher, I was highly aware of my need for guidance regarding the data analysis portion of my research study. Data analysis was the least practiced of my research skills. Through my Ph.D. program classes I had not only been exposed to, but had practiced using research approaches to develop and use research purposes, questions, designs, and methods – that is, to a certain beginning extent. I had confidence in my grasp of the overall field of knowledge regarding psychosis and insight; I had some confidence in how to design a study that focused on my interests about psychosis and insight, but little confidence in my ability to use the data I collected in a meaningful way to address my research purpose and questions. Because of this, I turned to the literature beyond what I had learned in my previous coursework for more concrete direction.

I found a useful resource in the journal of *Qualitative Research in Psychology* (Braun & Clarke, 2006). The authors addressed thematic analysis in psychology, which was an allied field to my psychiatric nursing specialty. They posited that thematic analysis is not only a tool which can be used to analyze qualitative data; thematic analysis is a research method or approach in and of itself. I had more confidence in their approach especially when they pointed out that despite the flexibility of thematic analysis as an
approach to data analysis, thematic analysis is not often well described in qualitative work. I required careful description of thematic analysis process as a neophyte researcher.

Braun and Clarke (2006) provided six phases of thematic analysis involving steps and processes as follows:

1. Familiarize yourself with your data (transcribing, reading, re-reading; note ideas);
2. Generate initial codes (coding interesting features, collating data for each code);
3. Search for themes (collating codes into potential themes, gathering all relevant data);
4. Review the themes (checking that codes work with themes; thematic map);
5. Define and name the themes (refining specifics of each theme in relation to the overall story of the analysis);
6. Produce the report (selecting examples that relate to the research questions/literature).

I used these steps and processes to guide my work through a tremendous amount of raw interview data, codes, categories, and ultimately themes based on my research questions set within the context of my design map addressing psychosis and insight (Figure 1, p. 17). The next sections follow these numbered steps (Braun & Clark, 2006).

1. **Familiarize yourself with the data.**

I finished the interviews and transcriptions as one process before beginning formal analysis (I had field notes, and research memos recording my ideas as I interviewed and transcribed the individual interviews.) I read the interviews, first without making notes at all. Then I re-read each interview and made notes in the margins of the
transcript while I used colored markers to highlight the sections of the interview pertinent to my research questions.

2. Generate initial codes.

I used these portions of the interviews to develop codes meaningful to the particular interview. I then created an interpretive interview summary to send to the particular interview participant for member-checking using my research questions as context. I repeated this process with each interview. As I worked through the interviews, I re-read and reflected on previous interviews, making other notes and connections between ideas I found within and among other interviews, an iterative process of generating meaningful codes.

3. Search for themes.

I organized the codes into large categories addressing each of my three research questions. After this step was done using all the interviews and their individual codes, I created categories within data pertinent to the three research questions. I continued to call these groups data categories within the three research questions. I labeled them with descriptive names, using cards to separate the categories, again using a reflexive process across the categories and themes.

4. Reviewing the themes.

I composed themes using the data categories, as links became apparent between the categories. At this point, I maintained the separate data themes and their subthemes or categories identified within each of the research questions. This way, I created three categories of themes and their sub-themes. As I formalized outlines of the themes and
their categories within each research question, I found similarities and overlap among the three research questions.

5. **Defining and naming the themes.**

Finally, I decided to combine and use the data from my first research question focusing on the nurses’ experience with psychosis and insight, and my second research question addressing the nurses’ perceptions of what the patients’ experiences might reveal about psychosis and insight. This way, I was able to provide context for my third research question and avoid thematic overlap and redundancy. I constructed a robust theme addressing how the nurses believed that impaired insight affects the nurse-patient relationship. While knowing that dissertation research projects usually provide discrete findings related to each identified research question, I took this step to coalesce the themes to address how the nurses relate to the patient after finding significant thematic overlap and redundancy among the three research questions.

6. **Producing the report.**

Ultimately, using this approach, I was able to organize the themes in the context of the research questions and conceptual framework, and I was able to provide the basis for discussion of the study results (Chapter 4) and their implications with my conclusions (Chapter 5).

**Validity**

Maxwell (2005) considered threats to validity as a specific, separable component of the Interactive Research Approach, recognizing validity as “…a goal not a product…” (p. 105) of research design. Qualitative research validity is focused on how data are
interpreted, and how those interpretations could be wrong or interpreted differently (Maxwell, 2005, 2013). The researcher must identify and communicate values and ideas that could influence the study in undisclosed or “biased” ways. Maxwell (2005) emphasized the concept of integrity or transparent communication of influences on data gathering and interpretation. Given these points, the data collection and analysis process for this study were constructed and presented in the context of identified validity threats.

**Validity threats, controls, and alternative explanations.** For this study, possible validity threats were identified, and approaches to controlling those threats were developed. These threats (see Figure 1, p. 17) included ineffective interviews with the nurses that would not accurately capture personal and professional experiences related to the research questions and purpose. I actively engaged each nurse participant during the interview to clarify the meaning of the nurse’s intention if the meaning was not clear to me. Participant analysis of the interpretive interview summaries, or member-checking, included the participant’s review and revision; this step also provided protection against this threat. Secondly, qualitative data may not be generalizable internally to the project itself, due to unforeseen validity problems that are identified during the interview process and analysis (Maxwell, 2013). To protect against this possibility, descriptive context was recorded in the form of my field notes, and I kept an audit trail of all research activities as I collected the interviews. Memos were written with each interview to develop ideas regarding the study aims and research questions; tracking the interviews both in content and process this way helped to discern research findings pertinent to my research questions. Also, some overlap between the research questions began to emerge even as I
accrued the interviews; I did not necessarily see this as a problem at the time. Only in the midst of the data analysis process did I see this as redundant, thinking that the data had to be organized into neat, separable concepts. I found that the data collection process and data analysis interacted in a reflexive manner with my research questions, consistent with Weiss (1994). This interaction induced me to focus on the nurse-patient relationship, so that I used the data produced through my first two research questions (nurse experience and nurse perception of the patients’ experiences) to provide context and background for my third research question addressing the influence of insight on the nurse-patient relationship.

Additional validity threats included my biases as a researcher that could influence how I interviewed the participants and my interpretive analysis of the data. I made my research biases (discussed previously, pp. 19-20) as transparent as possible by identifying them before I began the research project, including a careful discussion of the implications of those biases on the research process. Formalizing my biases and assumptions about psychiatric nursing practice related to psychosis and insight helped me keep these ideas in mind, both as I interviewed the nurses and as I analyzed the data. Writing memos during data collection and analysis helped protect against these biases; writing these ideas out helped me focus on the research questions and results of my interviews, not my own views prior to the study. Writing the interpretive summaries, sending them to the participants, and receiving them back with the participant’s own comments (usually approval) also focused me on the interpretation and organization of the study results.
Finally, I was concerned that nurses might be inaccurate when they report their experiences and perceptions of patients with poor insight beyond those people with schizophrenia spectrum psychotic disorders or schizophrenia. This could have possibly contaminated their experiential reporting. To control for this possible validity threat, I had the nurse describe and help clarify the patient’s symptoms and conditions. Sometimes, the nurses would catch the distinction themselves, and qualify that they were talking about a person with a personality disorder or affective disorder. I was then able to redirect the interview back to examples using patients with schizophrenia spectrum psychotic disorders when the interview became too broadly applied to other diagnostic groups of patients.

In summary, this application of Maxwell’s interactive design approach (2013) considers the research questions and methodology, and also integrates the research process. The concreteness and practicality of this approach to qualitative research assists in maintaining focus on the components, while helping to determine the best research methodology and how to approach threats to validity (Maxwell, 2013).

**Discovery Using Qualitative Methods**

In her commentary *Theoretical Dilemmas: To Justify or to Discover*, Smith (1990) urged nurses to go beyond the process of using research to justify nursing practice empirically. Instead, nursing science should move into the realm of discovery, using observed clinical patterns to refine established theories and frameworks. Discovery can move existing ways of thinking beyond their present boundaries. In this study, qualitative interviews were used to explore the intersection of the patient-nurse
relationship in the context of patients’ insight and insight deficits. This knowledge may expand present clinical thinking and experience regarding therapeutic relationships (Bochner, 2002; Fisher, 1989; Polkinghorne, 1988) to inform and sensitize clinicians to these highly vulnerable patients’ experiences.

Chapter 4 follows, with the presentation of the study results discussed as themes and process comments.
CHAPTER FOUR
RESULTS WITH DISCUSSION

Organization of the Study Results with Discussion

The results of the study are presented and discussed to answer the three study questions.

- Research Question One: What are psychiatric nurses’ experiences of lack of insight in patients with schizophrenia?
- Research Question Two: What are psychiatric nurses’ perceptions of the patients’ experiences of impaired insight?
- Research Question Three: What are psychiatric nurses’ beliefs about how lack of insight affects the nurse-patient relationship?

Before presenting the thematic results of the study, I will provide a descriptive synopsis of each nurse participant and key characteristics of the nurse’s interview as an introduction to the study results. Nurse participant demographic information is provided as Appendix D.

**Study results: Presentation.** In the data analysis, codes and categories coalesced into themes across the three research questions. Rather than address each research question separately, and in order to organize the data in a useful way, I combined the data from
Question One, the nurses’ experiences with lack of insight in patients with schizophrenia, and the data from Question Two, nurses’ perceptions of the patients’ experiences of impaired insight, to address the findings from Question Three regarding the nurses’ beliefs about how lack of insight affects the nurse-patient relationship. This way, I was able to use the inter-related nature of the data collected to tap thematic contiguity across the data set (Maxwell & Miller, 2008). I used this approach to address the crucial issue related to how the nurses’ believe lack of insight affects the nurse-patient relationship.

**Presentation approach: Rationale.** My rationale for this approach results from finding thematic commonality and overlap between the nurses’ reports of their experiences, what they perceive their patients’ experiences are, and the influence of poor insight on the nurse-patient relationship. Additionally, interview data results from both Question One and Question Two provided background and context in order to address Question Three, the nurse-patient relationship, in a more meaningful way.

**Presentation of results: Prologue.** I found discrete themes within the study data; however, there were threads that bind the themes to form the overarching experience of care for patients with schizophrenia. These threads relate to both the patient and the nurse, and the nurse-patient relationship. They include issues related to control, dignity, respect, relating, and recognizing the patient as an individual person. These thematic threads weave through and connect the seven themes. The phenomena reported in this study apply to many people who find themselves sick, and not only to patients with schizophrenia and poor insight.
**Seven themes emerged.** Seven themes emerged from the interview data collected from the eleven nurse participant interviews. The themes were organized across all the data collected under the three research questions.

- The nurses believed that a therapeutic relationship is required to care for the patients with psychosis and poor insight.
- The nurses believed that they needed to learn the patients’ stories to be helpful.
- The nurses identified key aspects of communicating with patients who have poor insight.
- The nurses identified certain important elements and dynamics that should be part of the nurse-patient relationship when the patient has poor insight.
- The nurses believed that they administer medications and patients take medications within the context of the nurse-patient relationship.
- The nurse-patient relationship affects the nurses professionally and personally.
- The nurses believed that the interview process affected how they think about their practice.

These seven themes emerged from the codes and categories organized through the interpretive summaries of nurses’ interviews. Each theme draws meaning from the experiences and perspectives of the nurses themselves, and individual quotes from nurses are used to illustrate the thematic findings.

Finally, excerpts from a single interview summary are provided to illustrate ways that the nurse understands the patient when the patient may have little awareness of or insight about what their experiences mean beyond themselves. This summary titled, Pulling It
All Together: Oprah’s Story, is provided to demonstrate how particular responses by the nurse may affect the patient’s experiences of safety and comfort, and of being understood and cared for by the nurse.

**The participants: Description of each nurse and their interview.**

A brief description of each nurse participant and key characteristics of their interview are presented in the order that the interviews were conducted.

**Molly.**

Molly’s most important point about lack of insight in schizophrenia is that the clinician needs to work to understand the factors are contributing to the patient’s poor insight before using treatment approaches to work on gaining insight into their illness and symptoms, and the need for treatment, specifically medication. Molly indicates that this is where so many of us go wrong: unless we know *what* specific areas the patient lacks insight in, and unless we understand *why* they lack insight, our approaches will not be effective in a lasting way. Without knowing in what areas the patient lacks insight related to their illness, symptoms, and treatments, we usually aim at the wrong target. Whatever approaches we use to meet patient treatment goals and outcomes will not work in the long run because we don’t have an accurate target to begin with. We are inadvertently working at odds with the patient.

**Rachel.**

Before the audio-taping of the interview began, Rachel commented, “It’s great: hardly any one pays attention to the nurses, does research for nurses.” She then went on to give one of the most comprehensive and in-depth interviews of the entire panel of
nurses who contributed to the research project. At the end of the interview, when I asked
her if she thought there were any other questions I should have or wished I had asked
about working with patients with poor insight, she talked about how being a nurse gives
her strength. She described how caring for patients as a nurse has influenced how she
sees things and how she lives her own life. She went beyond psychiatric nursing practice
to include all nurses: when friends tell her she is the strongest person they know, she tells
them it is because she is a nurse: “I am who I am because I am a nurse.”

Donna.

How Donna thinks about psychosis and insight as the interview starts appears to
be very clear. Initially, she shares that “from admission to discharge,” patients deny that
they are sick, deny that they are in the hospital because of schizophrenia - “denial from
start to finish.” Another way she determines that a patient lacks insight is when they
refuse medications “despite the education.” Early on, she says that her patients refuse
medications “despite confronting the patient.” She is quick, however, to adjust her
description to “telling them straight up” that the clinicians are observing symptoms of
psychosis.

As the interview progresses, Donna becomes clearer that her own particular
approach to caring for patients who lack insight is much more measured and sensitive and
less confrontational, than she initially indicates. Her clinical examples highlight patients’
poor insight and the repercussions of not having the capacity to even acknowledge
symptoms of psychosis.
Chanel.

Chanel’s interview is strongly characterized by her view of the patient’s perspective. She bases her thoughts about what she thinks the patient is experiencing with clear clinical examples. She recalls interactions with patients to describe how she guides patients who have experienced a “crisis” back to what she calls reality, and back to the patient’s own pre-crisis baseline. She expresses her personal and professional empathy and compassion in her own approaches to caring for patients. She comes out as a strong patient advocate when talking about how nurses should approach patients with psychosis and poor insight, denouncing nursing practice that does not include current knowledge about schizophrenia and psychosis. She is outspoken about the responsibility psychiatric nurses have to keep their professional practice current.

Sophia.

Sophia’s interview stands out because she provides views about psychosis and insight in the context of psychiatric treatment for people who are involuntarily and voluntarily committed to psychiatric care via a state legal system. She has practiced as a psychiatric staff nurse, nurse manager, and nurse executive so that her perspectives on providing direct psychiatric nursing care to patients are influenced by her many levels of responsibility to care for chronically mentally ill patients. While focused on the research topic of psychosis and insight, she responds to the interview questions thoughtfully, often asking questions of her own. This makes the interview more of a discussion about the issues involved in caring for people with psychosis, and enriches the data on what psychiatric nurses think about insight and psychosis. The other way Sophia’s interview is
different from all the others is her emphasis on the Recovery Model and how she integrates person-centered care into her facility’s program, and her every-day interactions with patients.

*Dee.*

Dee’s interview is characterized by a clear, simple message about how to relate to patients with all sorts of psychiatric problems and needs, especially patients who have schizophrenia and have limited or no insight into their symptoms and illness. Dee talks about her patients with compassion and emphasizes that nurses need to validate patients by treating them as normal people. She has a holistic view of how nursing care addresses the whole person - who the person is regardless of psychiatric symptoms. She works to articulate the means of her psychiatric nursing care, and the keys to knowing the patient as a person, and how to get to know them. Because of her non-threatening approach, patients respond positively to Dee - patients who often refuse medication, take medications from Dee. Dee is a nurse who other staff, “even the doctors,” say the patients love. As she works through the interview, Dee repeats her basic tenets of interpersonal compassion, normalcy, and validation, to describe her building blocks of rapport. She ultimately uses her rapport to educate the patient about self-care and taking medications to support the best life for the patient.

*Hunter.*

Hunter’s views on psychosis and insight center on the fundamentals of his psychiatric clinical practice. When he addresses many of the interview topics, his responses stem from his values regarding human relationships; those of being genuine,
compassionate, and fair. He relies heavily on who he is as a person and his own upbringing for guidance in his clinical practice. His nursing care also draws on his experience training and working with dogs, where his behavior must be consistent in order to communicate his message. While training dogs, his intentions are clear and his expectations meet the capability of the animal. Hunter lays responsibility on psychiatric nurses who are innately talented to keep up with changes in clinical care to benefit the patients. By keeping their practice current and fresh, he thinks that nurses can avoid burn-out and not become a drag on the treatment team. It is especially important to Hunter that nurses remain positive clinical role models for new nurses who are vulnerable to negative influence.

**John.**

John works in a state forensic psychiatric facility. The patients he works with are judged by the State court as not criminally responsible (NCR) for the crimes they have committed, secondary to their psychiatric illnesses. Most commonly these are psychotic disorders, and most patients hospitalized by court-order at this facility are diagnosed with schizophrenia spectrum or bipolar disorders.

The patients have committed violent crimes, including murder, while psychotic. The forensic program John works in is highly structured, and the policies regulating how the staff operates are guided by the need for safety. Because the environment is so safety-oriented, it is highly monitored for just, humane care, as patient freedoms are restricted. The staff walks a fine line, balancing psychiatric treatment for patients labeling
criminally insane, who have serious psychiatric illness, while maintaining a safe, supportive care environment.

John describes the patients’ length of stay as “six months to forever.” John has worked for his entire twelve year nursing career in forensic and jail settings, as both a staff nurse and a supervisory nurse. The overriding theme of John’s interview is maintaining a safe environment.

Van.

Van offers a unique point of view on patients who have schizophrenia and little or no awareness of their psychosis symptoms. She works the night shift at a state psychiatric facility that provides care for patients who are not guilty by reason of insanity (NGRI). She also cares for people without health care insurance, who were determined by the state judicial system to be a harm to themselves or others, or, who cannot take care of themselves secondary to psychiatric illness.

Van stresses the need for patients to take, and stay on, medication. This is among the strongest points that Van makes (and the other psychiatric nurse participants in this study) regarding psychosis and poor insight. She focuses on medication compliance from the perspective that medications improve the patients’ psychosis symptoms and help them function at a higher level. While Van offers mediations as one of the most important aspects of the care psychiatric nurses provide to their patients, she also stresses good sleep as healing.

The mission of this state facility is to help patients regain a level of stability and function that allows them to return to the community, and to be assisted there with mental
health support services. Returning to the community may mean living with family, living in a group home, or living independently, usually with support of community-based services. The facility that employs Van cannot discharge patients to the street.

*Oprah.*

Of all the nurse participants in this research study, throughout the interview Oprah focuses on the patient and how she imagines the patient feels. Empathy characterizes everything she talks about as she addresses the semi-structured interview questions. She says she comes naturally by her ability to relate to what she imagines other people are going through, and that her nonjudgmental attitude is not something that she picked up through her education in human relations (a combination of sociology and psychology) and then nursing.

It is almost as if Oprah speaks as the conscience of psychiatric nursing. She made observations about what psychiatric nursing practice might be with more appreciation of what the patients’ experiences are of our care, our treatments, our clinical relationships, our programs, and our healthcare systems. We use the word advocate often to describe someone who does the best they can to bring forth issues and see those issues through to benefit and help the patient. We use the word advocacy to describe the process of being able to represent the patient’s point of view and wishes for what they want for themselves (SAMHSA, 2012). Somehow, Oprah takes her experiences of working with people who have schizophrenia and poor insight and reads the human experience of those people with simple and sometimes disturbing clarity.
Oprah has a rare depth of perception beyond her own ability to read human situations. As I wrote this interpretive interview summary, I had to remind myself that Oprah did not know what the interview questions were before the interview occurred, because she responded to the questions with such immediacy and articulateness. She is calm and composed, not intense, and seems to be motivated to simply let me know what she imagines the patients’ point of views might be. It is as if her responses come out of her without effort, and that she has walked in the shoes of those people, the patients, who she is representing. It is an accident of fortune that I met Oprah and she agreed to participate in this study; I hope that I will be able to share Oprah’s perspectives with psychiatric nurses and clinicians beyond my dissertation research through publishing my research findings.

Dolly.

Dolly cares for her patients with psychosis and lack of insight with a sense of mission. Her mission is to support the efforts of the psychiatric treatment team to find the best medication regimen for the patient; and once that is achieved, to help the patient keep taking their medication. Dolly talks with pride of her past experience as a member of the U.S. Army; the sense of mission and loyalty she developed as a young woman in the military continues to influence her career as a nurse.

Next, the results of the study are presented as Themes I – VII.
I. Nurses Believed that a Therapeutic Relationship is Required to Care for Patients with Psychosis and Poor Insight

The nurse participants believed that a therapeutic relationship is required to care for patients with psychosis, especially when the patient is not aware of their psychosis as an altered state of being. The nurses described the therapeutic relationship in distinct ways, indicating that a specific type of collaborative relationship is required to work with a person who may not be able to fully acknowledge, recognize, or appreciate the implications of having psychosis symptoms.

The nurse works to establish a collaborative, helping relationship. Time and circumstance guide nurses’ interactions with patients who are psychotic. The nurse initiates interactions with the patient to understand the patient’s situation from the patient’s point of view, and then takes up the patient’s perspective to help guide the patient. Nurses may alienate the patient by telling the patient what the patient should do. When the nurse works to understand the situation from the patient’s point of view, the patient may perceive the nurse as a source of help in an uncertain situation. Molly described the relationship she works quickly to establish with the patient in the Emergency Room setting.

I think it’s important - it sounds very basic - that the patient is seeing me as an ally, and that they trust me, and it’s very hard to establish that in an emergency room setting, obviously, because we don’t have the time. But that’s important I think. It’s very elementary, but they have to see me as somebody who wants to
help them. And I try not to go in with - maybe less experienced people may go in with - a template of, ‘This is my prescription for you, this is what you need to do; good-bye.’ I feel like they need to understand that I am there to help them, and am trying to understand their situation, and work with them and what they think their situation is. Because if I’m just saying, ‘Well I think you should do x, y, z,’ it may not make any sense to them because I am superimposing how I think things should go based on maybe something that’s not a reality for them, … their housing situation, their support system, their ability to arrive at treatment facilities, etc. So I really try to get them to understand that I am there to help them, and not necessarily tick off a list of what I think that they should do.

Sophia explained how she uses patient-centered Recovery Model collaboration with the patient as a therapeutic partnership. Patient-centered care involves a collaborative relationship between the clinician and the patient. The person and the person’s needs are the main concern. These ideas reflect the tenets of the Recovery Model (SAMHSA, 2012) focused on the patient as a whole person and the patient’s living the best life possible. Recovery practices may be incorporated by clinicians or whole programs, and change the nature of the therapeutic focus from a medical model following physician or provider and treatment team directives, to a model in which the staff and patient share a partner relationship based on what the patient believes their needs and priorities are. Sophia connected how poor insight affects use of the Recovery approach; she described letting go of the “therapeutic” control clinical programs and staff used to impose “beneficently” on patients.
People have choices, people can make choices. Our goal is not to tell them what they can and can’t do. We can help guide them to make better choices, and obviously their lack of insight sometimes prevents them from making good choices; I think some clinicians are better at sitting with that than others. Some people get very upset about how we should be doing more, and restrict them from going out into the community because they are yelling at the person at the [quick-stop convenience market], or for fear that something may happen to them. But I think part of Recovery is for these individuals - if they are maintaining safety, they might not be making the best choices, but if they’re not putting themselves in imminent risk to hurt themselves or someone else - they need to be given the chance to be able to go where they would like to go. So here in our program we’re really trying to encourage individuals to work with the clinician and collaborate to come up with their goals, or what they want, not, obviously, what we want to do for them.

**The first aim of the relationship is to be safe and feel comfortable.** The initial and basic aim of the therapeutic relationship between the nurse and patient is to help the patient feel as safe and as comfortable as possible - despite the hospitalization. Safety and security may be gained more rapidly in situations where the patient is allowed to have as much control as possible.

A primary clinical aim of a therapeutic relationship is that the patient is comfortable with the nurse. Yet, feeling safe and secure may be difficult for patients who may not understand why they are in the hospital, unaware that they need medication,
treatment, and help because of their anosognosia and schizophrenia psychosis. As the patient’s helper, the nurse needs to be sure of what the patient perceives, and what the patient wants. The nurse solicits what the patient thinks the patient’s needs are, and takes the time to understand the situation from the patient’s point of view. This is one way a nurse shows that she is meeting the patient where they are. (It is important to note that Molly is not focused on what she thinks the patient needs, but what she believes the patient thinks or wants for themself.)

That they’re comfortable … what my goal is … well, my goal for them is for them to feel safe … non-threatened. And this might be a lofty goal, especially in the first day, for them to feel that I am a person there to help them, I am there to help them, that they feel safe; it’s non-threatening - that they do have some sense of control and dignity because I’m trying not to superimpose on them what I expect to happen; that they can still, if they so choose, not to want to talk to me, or not want me to sit down at that moment - maybe they’d rather go sit in the hallway. I really don’t know what they want, so that if they say to me, “Well, no I don’t want you to sit there, please sit there,” or, “I’d feel better if we went out into the hallway or go into my room and talk,” I’ll move so they feel comfortable where they are.

**The nurse must meet the patient where they are.** When patients are so psychotic that they cannot communicate, they sometimes need help to care for themselves. Nurses provide simple direction and structure to meet the patient’s physical needs. Molly provides an example of the supportive care she gives by helping her young
patient while the patient is so psychotic that she cannot sleep, eat, go to the bathroom, or bathe. Molly explained how discussion, or talking too much, can be provocative when the patient is severely psychotic.

At the point that the patient is unable to verbalize what is happening, I’m therefore looking at non-behavioral symptoms: I’m observing she’s not eating, she’s not sleeping, she’s not taking care of her ADLs, she needs help. So at that point I knew that I would not be able to engage with this person verbally, but I felt I needed to be totally directive at that point, because she was so impaired. … I need to be directive and assume responsibilities that she is not able to take care of. So I did that, I just kind of went, “Come on Debbie, let’s go to the bathroom.” There was no discussion like, “Debbie, would you like to go to the bathroom now?” because she was just so preoccupied, it was just be directive. … There couldn’t be any discussion, because I think that might have been more provocative for her, more complicated for her to understand. She did not understand her needs signals, and she’s getting verbal signals coming in on her. So I just kept it very simple. … So based on the non-verbal behaviors I then became very directive regarding what she needed to do in order to sustain herself. … I think that I always try to understand where they’re at based on verbal, non-verbal stuff, and I try to meet them where they are. And if the patient is very preoccupied with stimuli then I know I have to be very low key, very simple, and try to help them meet their basic needs.
The nurse directs and responds to feelings produced by not knowing what to expect. Knowing what to expect in situations is a component of interpersonal safety and comfort. When the patient and nurse first meet, they do not know each other. People with psychosis are already operating with perceptions that come from experiences most often not shared by other people. The nurse must find a way to meet the patient in a comforting manner that does not evoke potential anxiety. Patient anxiety is to be expected in new situations while in the hospital, and the nurse’s work is initially focused on making a person who is afraid and easily threatened as comfortable as possible by letting them know what to expect. Oprah describes what she thinks is going on both for the nurse and the patient in these initial interactions.

In my opinion, a person that is psychotic and has no insight into their illness is scared, and also scary. They don’t know what to expect of me, and they feel threatened, and they are scared because what is going through their mind is so real to them that they think that I am scary. Whereas I think that they are very unpredictable, they probably think that I am unpredictable, and they don’t know what to expect and they’re scared. So it goes both ways: I’m scared of them because they’re unpredictable, and I don’t know what they’re going to do, and in the same light, that’s what they’re thinking of me. So, it’s like taking two animals, and they’re going to go into a fight, and they’re feeling each other out, backing-up, and coming forward, dancing around, just trying to figure out what’s going to happen next.
The patient’s psychosis may produce anxiety in the nurse, especially when the nurse does not know the patient. When patients with psychosis do not know they are psychotic, and have symptoms of auditory hallucinations, paranoia, delusions, and disorganized cognitive processes, they do not usually directly talk about these experiences. Rather, these psychosis symptoms are expressed more behaviorally because the patients may have difficulty describing them verbally or they may be too anxious and afraid. This situation can make both the patient and the nursing team members anxious. Rachel is experienced with helping psychotic patients when they are anxious, but she gets anxious herself when the patient becomes agitated or impulsive, especially when someone could get hurt.

I’m new to my hospital but I’m probably one of the more seasoned psych nurses. In some acting-out situations I find nurses backing-off, where I will go and enter and talk to people and sometimes will be the nurse that will work with them because I am not afraid, because I know I can kind of pick-up pretty quickly what will work and what won’t, and what I need to do, to kind of prevent certain situations. It’s those situations that you can’t control: that’s where I tend to get anxious when the patient is agitated … especially in an acute setting when they’ve been off their meds, and they’re very crazy more or less; because you don’t know them. And when you don’t know them, you don’t know if they could impulsively act, and be violent, and you get hurt, and no one wants wants to get hurt physically or see anyone else get hurt.
Interacting with patients who have schizophrenia and lack insight can produce anxiety in both the clinicians and the patient. The anxiety is about not knowing what to expect, the unpredictability of the situation. The nurse does not know what to expect from the patient, and that lack of predictability can produce anxiety in the nurse. It is important to talk in a frank and succinct way with patients who are actively psychotic, who may be hearing voices, experiencing delusions, and may be fearful and paranoid. Here, Molly works to clarify what the patient’s perceptions may be.

I think most of the time the anxiety is related to not knowing what to expect, because I think there can be a wide spectrum of where people’s functional abilities are, based on the diagnosis. Like I said, I’m not just going to have an assumption because they have a diagnosis of schizophrenia that its going to be “X” symptoms. … I think the anxiety is mostly not knowing what to expect and then trying to make that determination pretty quickly to figure out how I’m going to approach the patient. I think that’s a lot of what my anxiety is about. But, I think if I’ve made the determination that they are psychotic, and lacking insight into their current situation, I just feel that it’s more of a burden to the patient for me to ramble on about what they should or should not be doing. … So I really try to minimize how much I’m communicating with them. Because if they are psychotic, in my experience, most of the time they’re pretty isolated and not wanting to interact with the unknowns, someone like me who would be an unknown for them, so most of the time I really try to communicate to them that I understand that. I usually say, ask them, are they hearing voices or seeing things?
‘You’re fearful, do you feel that maybe anybody may be out to harm you?’ that kind of general question. And generally I feel people tell me, “Yes, I’m hearing voices.” Yeah, generally I would say they do.

Nurses feel empathy in response to the patient’s fear and anxiety. Empathy is a personal attribute which influences the clinical, interpersonal relationship; thus, empathy may help the nurse understand that the patient may be anxious and afraid while the patient is experiencing altered thought processes and psychosis. The nurse’s empathy may help the patient avoid unknowing and not understanding, and prevent anxiety from becoming fear. Molly explained:

I don’t think it’s anything I’ve learned: I think it’s just empathy. I just feel like if that was me, psychotic, not knowing what’s going on, I would want someone to at least try to attempt to let me know what to expect, so they don’t build up all this fear, right? … Fears of what may happen to them… And I really just sit there and allow them to comprehend what I’m saying. … They may be so wrapped up in their own kind of psychotic world; in that case, I don’t think there is much you can do. Just communicate, let them know that that you know they are suffering.

Patients can become severely cognitively and functionally disorganized and disabled while delusional, paranoid, hearing voices, and not able to sleep or control their thought processes. Because of their withdrawal, agitation, and possible aggression in the midst of confusion, anxiety, and fear, the patient is highly vulnerable. Even though empathy cannot make the symptoms of schizophrenia go away, the nurse can provide the patient with comfort and understanding without placing demands on the patient in their
time of crisis and stress. Empathy emerges as an element of Molly’s experience of taking care of psychotic patients.

And empathy - I think I’m always, always, empathic of patient situations. ... and there’s another girl I’m thinking of that was at a hospital I worked with at an academic setting who also was very, very psychotic and couldn’t attend to her basic needs. And I think I might have had an all male staff on that day and I was the only female, and she was nineteen or twenty ... and she started her menses. I think, oh my God - and again, it’s my empathy - this poor kid. I mean, I have an all male staff; these guys really aren’t going to want to deal with this, they don’t even want to go in the room. I do think empathy is very, very important. ... If I was in that situation, of course I would want somebody to help me. Right: would I want to allow this young girl to be walking around the hall for all the other patients to see in that state?

Empathy and anxiety: do they interact? Empathy may influence the nurse’s experience of being with patients when the patients are so vulnerable in their psychosis. How empathy intersects and interacts with the uncertainty and anxiety that are part of caring for patients with severe psychosis is a puzzle. Each nurse’s experience may vary. Does empathy collide with anxiety? Does empathy diminish anxiety? Does empathy replace anxiety? Does empathy become the dominant affective influence for the nurse even when she is anxious? Molly connects her empathy with her anxiety. She thinks that her empathy may mitigate her anxiety, in her efforts to help the patient. Here is an excerpt from the interview between the researcher and Molly.
Researcher: So, when you’re feeling the empathy, Molly, does that influence your own experience of the patient?

Molly: You know Kim, I’ve never actually thought about that. I think that’s a really good question, because I don’t know. I’m not going to say is it good or bad to have anxiety. I just know that I get anxious, I do, and I’m aware of it, and I do try to temper it. And how do I try to temper it is a very good question, in that intellectually, I know that certain behaviors I have to demonstrate in order to mitigate it. But I never really thought of that as my empathy helping my anxiety, and I think it probably is. I never thought of that.

Researcher: Well, we both know that psychosis can be dangerous, so there is reason to be anxious.

The nurse-patient relationship: Treat the patient as a person, as a human being, giving them respect and control. A therapeutic relationship with the patient allows the nurse to be a reliable source of comfort and help to patients who have symptoms of psychosis without insight into their condition. John describes the therapeutic relationship, and how patients give back respect when the nurses show them respect.

Therapeutic relationship is not limited to the one-to-one, it’s whenever you are on the unit. You don’t raise your voice at them, you can agitate them doing that … When [your tone] is good, you are low-speaking, soft, not angry - they will respect you. Because you give them respect, they will give it back to you, yeah. But if you are yelling at them, you are going to have yelling from them … Yeah,
like when they come to us for something, they would be very polite. What I mean by polite: they will not raise their voices, and their eye contact will be respectful. But if they don’t respect you, they are going to raise their voice, they don’t care who you are; they will treat you like any other person. So that’s why I say you have to respect them: they give you back respect.

Healing relationships are founded on how clinicians treat patients, how they respect patients and treat them with dignity. Validation of each patient’s dignity is intended to penetrate through psychosis and poor insight: the person’s awareness of their symptoms and illness does not determine their humanity. The patient is aware of respect shown to them, and responds accordingly. The patient’s ability to acknowledge their symptoms, or whether the patient has good insight does not direct how Hunter approaches and relates to the individuals he cares for.

You treat someone decently: generally speaking you’re going to get that in return … I don’t think it matters one bit, sometimes … It’s just a matter if you’ve validated the person as a human being, you’ve treated them with respect, they know that! I don’t care who you are, or what you’re experiencing, you know that! Chanel talked about how she treats the patients “with respect - I think that’s the biggest thing, that I respect them.” She described how she normalizes her interactions and patient relationships to reduce the stigma of being in a hospital.

I don’t treat them funny. I don’t treat them like they’re sick. … I don’t try to talk to them in a different manner or try to speak to them on a lower level just because they are sick. I speak to them as if we are out somewhere; you are just speaking to
somebody, you just talk to them like there is nothing wrong with them. I don’t focus on the illness, I focus on the person. They know they are sick, I know they are sick, why do we need to harp on that? … One of the patients would always walk around totally covered by a blanket … All I did was walk up to him and say, ‘Hi, how are you doing?’ And I put my hand on his shoulder. And he was in a wheelchair, and the man started crying, and I was like, ‘Oh my God: what is going on? Are you okay?’ I thought something was wrong! … “You touched me. I haven’t been touched in so long, because people are afraid of me; no one, everybody thinks that I’m going to give them some thing, they don’t want to be near me. You touched me.”

Patients who are psychotic easily become anxious and uncomfortable. Psychiatric nurses purposefully carry themselves in as non-threatening a manner as possible to project their trustworthiness. The nurse can show respect for the patient by asking for their permission; asking permission also gives the patient some control in the clinical relationship. Molly gives the patients a sense of control, dignity, and respect as building blocks of a helping relationship. Molly asks the patient for permission to be with them, and does not impose herself.

I’m very respectful of people’s space. I always tell them who I am, what my purpose is. I am very soft spoken … non-threatening, and simple. I always try to let them have some ounce of dignity and control, in that I’m now in their space, even though they’re in the hospital: may I sit down with them, I’d like to talk with them, is that okay, asking for their permission for me to be in their space. I don’t
walk down the hall, and say ‘Hey, So-and-So, this is your room,’ and go in there, and check their belongings. I try to build-up a relationship with them that they know I’m somebody they can trust, and try to work with them …

Finding ways into patients’ thinking so that they are able to engage with the nurses and treatment team is a delicate interpersonal process. Working in a manner that is acceptable to the individual patient, and that results in their gradual participation in taking medications and caring for themselves, may be an alternative to forcing medications and treatment on patients. The weight of the clinical responsibility is on the nurses and other members of the treatment team to find an approach that resonates with the patient’s own experience of their circumstances and the meaning of their “symptoms.” This is not ‘complying with delusions’ as psychiatric staff formerly believed, but rather coming to understand the patients’ perspectives, based on their understanding of their circumstances. Rachel used a former patient as an example to explain how the psychiatric inpatient nurses she works with used this approach with a difficult patient:

One woman we had who … was an Ivy League graduate, pretty high functioning, but she had these delusions about basically every race out there, that if you were white, if you were blonde, blue eyed, white, she was comfortable with you, but if you were any other race, she wanted nothing to do with you, because she thought we were going to hurt her … she would not work with most people. … We ended up assigning her only the nurses that she liked - they were the ones to give her the medication. … If the good looking, blue-eyed nurse is who she wants to get her
medicine from, he’s going to be working with her. I think you’ve got to do what you’ve got to do to get them better, and if that works, then that’s what you do.

Psychiatric nursing interventions, at their core, are about clinical interactions and relationships with patients. At any given time, the intervention must fit the particular assessment the nurse has made regarding what the patient needs, and the patient’s readiness to cooperate with treatment. Further, each patient may demonstrate a different set of symptoms, in particular ways that require individual, specific approaches and interventions. Patients who lack insight about their symptoms may not be able to recognize their own experiences as symptoms. Rachel explains how she has learned to interact with patients with schizophrenia who lack insight, and who are not aware of what their symptoms may mean.

I think it helps the more experience you have; you quickly assess what will work, what won’t. Sometimes you can compromise; sometimes you can offer them choices and see what they feel comfortable with, and then based on that, work around it. I had a guy the other day: he was good at taking his meds, but I wanted to give him a PRN, because he was just so crazy and extra PRNs would have been helpful. … He wanted a Coke, so I said, ‘Sure, I’ll give you a Coke, just let me give you your medicine first,’ and he was like, “Okay.” So he took his medicine and then I gave him his Coke. You can kind of work with them, bargain with them, compromise, that kind of thing. But that doesn’t always work with everybody, it depends on the person. That’s the thing with schizophrenia, it’s just so different for every person.
Before approaching patients who are experiencing symptoms of psychosis, nurses need to consider the nature of the patients’ presenting symptoms. Dee interacts with patients who are anxious and paranoid depending on how secure she thinks they feel, and she is sensitive to how much control they need in order to interact with her. She gives an example of how she is non-reactive while being compassionate.

We have a male patient that when you look at him, he’ll look dartingly, he’ll turn back to see if you’re watching him, because he is so paranoid, you almost have to have a tabula rasa-like look on your face, and just be very matter of fact. But that is not saying you’re not compassionate - but you are not reactive.

Another aspect of the nurse-patient relationship that is especially important is how to interact with people with psychosis who are feeling threatened and act defensively and aggressively as part of, or in response to, their symptom experience. To avoid inducing more defensive behavior during behavioral and emotional escalation, skilled nurses make themselves and the staff as predictable to the patient as possible. They explain what they are doing and what they are going to do before they do it. Effective nurses explain both their behavior and their intent using concrete, simple language that the patient is able to process during levels of high excitement or defensiveness. The nurse removes a sense of pressure that the patient has to do something in a certain way or within a specific time frame. These interventions make the staff behavior less controlling and communicate supportive intentions to the patient. In this example, Hunter diffuses an escalating situation by engaging the patient and re-directing them; he makes himself predictable and non-threatening to the patient.
If I am walking down the hall, and someone is getting ready to blow up, if I have a connection with that person, then I can go to that person and say, ‘Listen, walk with me,’ and they can still be ready to tear the place up. … ‘As of right now, you are in total control: No one is going to touch you – walk with me, walk and talk, we can walk as long as we need to do that.’

Treating patients as people, as individual persons, with dignity and respect is basic to person-centered relationships. Sophia explains that even during psychiatric emergencies, the staff members work to maintain the person’s dignity.

I mean we still talk about dignity and respect, and people have the right to chose and make choices for themselves. So again, in regards to the insight, if they’re not a danger to hurt themselves or someone else, I think we still treat them as people, not as patients, and not all staff are really good at that … So when I think of dignity, I think of preserving that about a person: someone who takes off their clothes all the time, making sure we get a blanket so we help to preserve that person’s dignity.

**The nurses build trust with the patients.** Knowing a patient as an individual, as a person, is an aspect of a therapeutic clinical relationship. Knowing someone as a person within a therapeutic relationship, beyond their illness condition - and not only as a patient who receives care based on diagnoses determined by and treatments directed by clinicians - is especially important when the patient cannot acknowledge their experiences as symptoms of schizophrenia. If the clinician only has observations as a basis for clinical judgment, they know less about how the patient experiences their
symptoms, and how the patient makes sense of, and gives meaning to those experiences. And patients may avoid relationships with clinicians who cannot find ways to show that they are interested in, and to validate the patient’s version of their own experience. Donna explained why she purposefully treats her “patients” as individuals who she needs to get to know as people.

So just developing trust, that just-getting-to-know-them; knowing someone as a person, not as “my patient.” Especially someone with poor insight: they already resent the fact that they’re even a patient, so trying to just steer away from that “You’re a patient”: get to know them as a person - that helps.

Hunter is careful to consider that the patient’s behavior may come from the underlying disease, and is not usually volitional. He is concerned that his message is clear when interacting with patients, so that his caring intent is communicated to them. The intent of a nurse’s message can be misconstrued, and patients are vulnerable to any perception of negative appraisal. Hunter pursues clear communication by asking for the patient’s view, preferences, and feedback. He does this to enhance the patient’s trust and confidence in him.

If you can’t connect with someone, you can simply ask, ‘How can I best talk with you? Do you want me to go around the bush with the story? Or do you want me to be matter of fact? You tell me, and I’ll try to do what I can to give you the information in the best way that I can, but I need to know how you want to receive it.’ … And it comes back to me believing that if a person does not trust you, they are not going to talk with you …
The patient’s experience of the psychiatric nurse’s dependability is a key to the nurse’s ability to maintain a therapeutic alliance, much less to redirect psychotic escalations. The nurse is able to establish and sustain engagement with the anxious, fearful person during a crisis or escalation because the nurse previously showed themselves to be consistently helpful and caring, both in the particular relationship with the patient, and in general while working with other patients. The patient may recall past observations of how the nurse interacted with other patients who were anxious, defensive, or fearful. The patient has their own observations as a basis for their sense of what will happen next, whether the staff will help and support them, and how much decision making the patient will be given in the situation. These are the experiential elements of staff reliability and trustworthiness; Hunter describes how this process works.

If they’ve seen me work with someone in the day room, and he’s blowing up, and I told him exactly what was going to happen, very matter of fact, present the options, let them make some choice, and go down that road exactly like I’ve spelled out, it wasn’t because of patient A: patient A watched the whole thing happen. So now, the next day, patient A, same situation, when I talk with him, he knows, hopefully, based on observation, that I’m telling him exactly what’s going to happen, nothing else is going to happen, this is the way its going to happen.

In acute care psychiatric inpatient programs, nurses usually report that their first concern is safety. Safety is a concern for the treatment team members, for themselves and for the patients. A staff member can become the target of a patient’s psychosis symptoms in ways that are not known to the team, and thus not understood or appreciated by the
particular staff person; this then may create danger. On the other hand, Dolly talked about how trust between patients and staff members is essential, because “without it, you can do nothing” to influence positively the development of the patient’s attitudes about the care they need. She described how patients are more likely to talk about their symptoms and take medications, even medications they do not think they need, when they trust the nurse.

The number one thing I think about being on an acute care inpatient unit is safety, first: safety for myself, the safety of the patients. Because if you have a patient who is determined to dig something out of their head, you have to make sure the environment is safe so there is nothing available for them to be able to hurt themselves.

Psychiatric inpatient program safety maintenance is implemented by the staff team members in many ways. Dolly explained how “safety” is translated in her program: patients do not have access to eating utensils, not metal or even plastic, without asking the nursing staff for these items. To help the patient not feel singled out, everyone is treated the same way based on the safety policy. As a seeming oxymoron, Dolly presents these safety restrictions that make the patients so dependent on the staff members in the context of the need to build trust with the patients. The development of trust and rapport require multiple and consistent interactions between the patient and the staff members.

We monitor and collect forks and spoons! And you cannot get a fork or a spoon unless you ask. … Plastic, either! You must ask, and you must return it. You don’t get to throw it in the trash. … And we explain to all of our patients, like in a
group meeting, so they that they don’t feel like they are singled out. This is part of our unit policy, for safety, for everyone, because we know anything can be used to injure yourself or injure another person.

As a charge nurse, Dolly matches patient assignments to nurses who work well with particular patient populations and their needs. This purposeful staff and patient assignment promotes trust building by matching nurses who best understand particular patients. Trusting rapport provides the clinical context for an understanding of the patient. Dolly regards trust to be the interpersonal foundation of her clinical knowledge of the patient’s specific symptoms and needs.

If I have a patient that has schizophrenia and a staff that does well with schizophrenics, I make sure I assign them to them.

The nurses get to know and value the patient as an individual person.
Psychiatric nurses must know each of their patients as individuals, or else a generic, superficial relationship develops. Since the word “clinical” refers to needed treatment to improve health, nurses cannot deliver care that fits the particular patient without knowing them as an individual. The nurses described why they get to know and value each patient, and how knowing-the-person is the foundation of a therapeutic relationship.

The most important aspect of connecting with the patient as a person is to know them as an individual. To connect with the patient, the nurse must be genuine, use good timing, perceive what the person is asking for, and be flexibly responsive to their needs. Hunter explained how he helps the patient know that they are someone who matters to him by validating them.
The interaction itself is just to be genuine in your conversation. It’s to be sensitive to the questions you ask at the right time; it’s to be sensitive to what you perceive them asking for. … And you have to be able to pick up on that, and go with it! Again, it’s going to come back to, I think, that initial meeting, that initial genuineness: you want to know about this individual. They are not just somebody else, who just walked in the door. They are somebody who is important, someone who needs to be validated; that communication is not just about telling them what they should do, not do, why they are here. It includes some of that of course, depending on the nature of the conversation, but also, what I have to offer to them …

Especially when a patient does not think they are sick or needs help, nurses can use indirect approaches that do not challenge what the patient thinks about being asked to, or made to, stay in the hospital. The nurse can use these approaches to understand how the patient experiences taking medications and how they perceive what other people, including their clinicians, believe are symptoms of psychosis. The key to therapeutic relatedness is to know the person as a whole person, someone who is more than the sum of the parts of their psychosis symptoms. Sophia explained:

I think it’s really taking the time to form a relationship with the person and find out what they are capable of, and what they want to do. Working with people that way: what’s important to them, what their strengths are - everything about them, kind of their history, where they’ve been, what experience they bring to the table. So again, it’s really getting to know them as a whole person.
Getting to know the person is not being sneaky. The nurse can use a natural approach in order to not be threatening to the patient’s perception of themselves or their symptom experiences. To do this, the nurse needs to know what the patient is experiencing and what it means to them, even if the nurse perceives that the patient’s experience is a symptom of their schizophrenia psychosis. Evaluating the patient’s mental status in a natural interpersonal context, so that the nurse expresses interest in the patient’s experiences and views of those experiences, may feel more like a normal conversation to the patient. The nurse can then use this conversation with the patient as a psychiatric interview in a purposeful way. Donna intuitively takes this indirect, non-threatening means to get to know the patient as a person. Using a purposeful, clinical approach to engender conversation does not imply being sneaky - or does it?

No, not at all: it’s not sneaky at all. … Because using that approach, I’m generally getting to know the person, we’re having a talk - just small talk - about anything. And I’m getting to know them as someone who is with them here every day. So [the conversation] has a purpose. It’s not sneaky at all, not [sneaky] – no hidden agenda.

II. The Nurses Believed That They Need to Learn the Patients’ Stories to be Helpful

Clarifying a patient’s view of what they think they want and need is always important in a clinical relationship. Without the patient’s view, the clinician might be working at odds with what may be important to and a priority for the person. Whether wittingly or not, this leaves the clinician going in a different direction, and the patient is
less apt to experience the working relationship as a partnership with shared goals. The crucial issue in the nurse-patient relationship is that the nurse must discover what the patient thinks is the problem and what the patient wants for themselves despite their poor insight; the nurse then attempts to address the patient’s perceived needs, and uses approaches that make sense to the patient. This is especially important when a person has psychosis and does not have insight about that psychosis. Without a sense of a shared understanding, setting mutual clinical goals with the patient may be difficult if not impossible.

The nurses need to find out what the patients believe and experience to help them. Mutual understanding and goal setting may be complicated by the circumstances that bring the patient to the hospital or clinic for care. When patients are coerced by family members to be hospitalized or are forced into the hospital by legal commitment procedures, the patients may be all the more afraid of, and resistant to any attempts to care for them. The approach the nurse uses is crucial. Nurses have to find ways to build rapport with, and make the patient comfortable in order to learn what the patient believes and experiences regarding their illness. Here are nurse participants’ views on exploring the patient’s perception of their situation. Chanel described her approach this way:

First find out what the patient sees as the problem: again, I have to keep going back to what is individual to the patient, it’s not a one-shoe-fits-all - what the patient sees is the problem and work on that … we can only help when we know what’s going on. And I try to create a rapport with them so that they feel
comfortable and able to talk to me and open up to me about what’s going on, and then we start with the basics, and work on and build on that.

Rather than focus on the person’s diagnosis of schizophrenia, Hunter’s view of clinical treatment is based on knowing the patient as an individual person, what their strengths are, and relating to them as a human being. He is interested in knowing the patient well enough to understand their story about who they are beyond their diagnosis. Knowing the person this way allows him to help the person in times of crisis, because he is able to reflect back to the person what they have shared with him. He uses each person as their own reporter; this can be especially helpful if the person has some degree of insight and will work with the nurse around treatment issues.

Just because you’re diagnosed with a mental illness, that tells you a little bit, but it just tells you what this person’s been referred to as. You really don’t know who that person is, so you sit down and talk with them, if they’ll talk with you. You know there might be a barrier with that, but if you are able to do that, I’ve always found it’s just really neat to be able to put together a story that this person has lived. In fact, I have found that in doing so, if you do hit a crisis situation, you can go back in and draw on a conversation you may have had with that person … And from the feedback that I’ve gotten from folks where I have done that, it’s pretty interesting that they will acknowledge that. They will ask me, how do I know that? And then I will tell them how I know it: it’s because they told me. If you don’t do that, you can’t effectively work with someone. Do you always have a positive outcome? I say yes. It might not be the best, but it’s definitely better than
not having that information, not striving to get it. I do believe that the fun part of it also is learning about people, where they were from, what they experienced in life. I think also that going forward, it helps you see a little bit better perhaps why, because you might have someone who is treatment resistant, because they know where they came from, and they know where they are now. That’s for someone who has some insight. It’s a struggle, and that’s what I’ve been told by folks that I work with.

Learning the patient’s story is a step towards gaining a relationship with the patient, and knowledge of their strengths and abilities. This is not only what can make the nurse’s relationship with the patient therapeutic, but also, individual knowledge of the patient makes the nurse’s work more effective with the patient – and fun.

**Discover what the patient wants for themselves.** A fundamental aspect of a therapeutic relationship is working toward mutual clinical goals. Unless the nurse knows what the patient wants or is willing to do to improve the patient’s situation or condition, a shared direction and goal may be difficult to imagine, partner with, and make progress towards. This is also especially important in the case where a patient has poor insight about their illness condition and resulting needs. The nurses addressed the necessity of finding out what the patients want for themselves.

Rachel believes that if patients take their medicine, see their doctor, get their lab work done to fulfill the requirements to renew their prescription, then they will most likely stay out of the hospital. (It is when patients stop taking antipsychotic medications that they are often readmitted to the hospital in a psychotic crisis.) Rachel described how
coming to this partnership process works between the clinician and the person with schizophrenia and poor insight. The key is to find out what the person wants for themselves; what the patient wants may motive them. This excerpt from the research interview further explains Rachel’s thinking.

_Rachel:_ They might have enough insight to comply with their medicine, to stay out of the hospital - they might have that knowledge, insight to do that. … like [with the psychiatrist in the Clozaril outpatient clinic I worked with], all his patients know “If I comply with my medicine and see him and do my lab and take my medicine then I stay out of the hospital,” and that might be their only insight - which might be all they need. So maybe that’s all the insight they need.

_Researcher:_ How would that work?

_Rachel:_ Well then you try to get them to take their meds, and go get treatment.

_Researcher:_ Because they identified that is the way to stay out of the hospital?

_Rachel:_ Right, if they can identify that. So I guess if you try to find out what it is that they want, and work with what they want to get them to get the insight to do what they have to do to stay healthy, but sometimes it’s not easy to get them to figure out what they want. But if you can … help them figure it out … you have to know what they want, and use it as a motivating factor to maybe get the insight and to be able to perform, to do what they have to do.

Discovering what the patient wants for themselves is part of the Recovery Model. The Recovery Model is used extensively in the design structure and implementation of the particular state psychiatric program in which Sophia works. Giving the patients more
control, and giving the patients opportunities to make choices, gives clinicians new experiences of what it is like to work with patients who lack insight.

I think I work at a pretty unique place. I think we’ve taken Recovery, some people say to the extreme. I think … to the extreme? A good example is for people who just kind of stay in their rooms all the time. And we’re not … pushing; we are taking more risks than maybe more conservative providers wouldn’t take, really allowing people to take those chances and those risks. I think we’re pretty liberal on that end. … And so what if their insight is completely wacked. Are they hurting someone? No. Are they doing what they want to do? Yes. [Sophia pauses] … I think when I first started in psych it was very maternalistic, paternalistic … and I worked with kids and adolescents … “You need to do this;” “You need to do that;” “You need to do this;” “You should do this.” And there’s no room for people to grow their wings or take a chance … But I do think some people get it.

Nurse-Patient relationship: Necessary elements of privacy in a safe environment. People with symptoms of psychosis, with little or no awareness that their symptoms are part of a psychiatric illness, often display characteristics of self-protection. They withdraw socially and physically, find places where they feel most secure and are least exposed to possible harm. The nurse purposefully selects and designs environments and situations in which patients are apt to feel safe, and to experience at least some level of comfort. This interpersonal and physical environment can enable clinical observation, and provide the necessary conditions to get to know the person.
To care effectively for people with symptoms of psychosis, nurses use the physical environment to enhance interpersonal interventions. A combination of physical space and staff presence is used to make patients feel comfortable and secure. The nurse is observable by and easily accessible to the patients, so that the nurse is present without being psychologically intrusive. Nurses can provide physical space and not make patients feel crowded to enhance a sense of security and comfort. Here, Hunter described interventions nurses use to create a stable, calming interpersonal and physical environment.

If you’ve got a hallway, you use a hallway - you walk. If you have a dayroom, when there is no one in there, then you go to the dayroom. If you’re in the dayroom, I don’t have to talk: all I’ve got to do is say, ‘Sun shining through the window, there’s a chair, you might just want to take a break, relax. I’m going to sit down over here, all the way across the room: I don’t need to say anything to you; I am here if you need something. I’m going to get up and leave in a few minutes; I just want to make sure you are okay.’ Space: that’s one of the things I preach, and preach, and preach about. If you don’t have space, you have got to make space, you have to be innovative; you have to become creative.

Meeting privately on a one-to-one basis with the patient provides an interpersonal setting in which the patient can talk about their symptoms. John explained:

It doesn’t happen easily, like a one-time meeting with the patient, it takes several times, and I’ll be very patient. You should understand that these are people who are sick, you have to really convince them that they need help, and you do that by
meeting with them privately, on a one-to-one basis, having verbal interactions about their illness and giving them information about their illness, so they will understand. And their symptoms: they tell you what they’re experiencing, and from there, you can teach them about the kind of help they will need. … I call it subjective because they are the ones feeling it … when you meet with them one-to-one, it’s like they are talking it out … How do you have a conversation with them? … Your relationship has to be therapeutic … Yeah, therapeutic … You have to listen to the person attentively. Make eye contact with the patient. Give them a chance to express their feelings and concerns.

III. Communication with Patients Who Have Poor Insight: Key Aspects of Interventions and Style

Communication with people who are psychotic and do not know that their experiences are symptoms requires clinical knowledge, skill, understanding, and appreciation of what the individual person may be going through. Based on the nurse’s specific knowledge of the person’s symptom experience from clinical observation and interaction, nurses shape their approach to more active interaction with the symptomatic patient. The patient may feel challenged if clinicians interview them around a set of possible symptoms: the patient may not experience their perceptions as symptoms, but as normal perceptions, and feel put-off, or even frightened by this clinically direct symptom assessment. In this context, the nurses share fundamental considerations about being and communicating with people who have psychosis.
**Observe quietly and calmly.** Allowing the patient to come into the relationship with the nurse is also a part of establishing trust with the patient. Being patient, being quiet, and allowing silence; being observant and present without necessarily speaking, not having to provide well-meaning insights, all communicate the nurse’s interest in the patient and caring. Getting to know patients with psychosis may take time, as their behavior and needs are influenced by symptoms of psychosis that do not fit necessarily into logical cultural and social expectations. Further, patients with psychosis may be so cognitively disorganized or paranoid, that the patients are not able to communicate their thoughts and experiences verbally. Because behavior is not always logically directed or meaningful in usual ways, nurses may have to put together what the nurses think they themselves are seeing (what the patient is doing or not doing) and hearing (what the patient is saying or not saying) in new patient-specific ways that become meaningful only over time and when the nurse knows the patient well. Hunter borrowed an expression from his experience with animal training to explain how he interacts with patients who have psychosis.

You know, you *see with your ears and hear with your eyes*, and sometimes you need to be quiet, until the person can say what it is that they need, or, if they can’t, it doesn’t mean that you don’t know what it is that they need. All you’ve got to do is observe, and you’ll get there. [Italics added]

Molly observes patients’ non-verbal behavior to gauge their responses to her. If the patient appears comfortable then Molly is comfortable.
Most of the time I find that they are reassured by [telling them what to expect]: that they shake their head, that they understand. Usually, they are calm. … I think I judge a lot of it by their non-verbal cues. Are they able to make eye contact with me? Do they, are they able to lie still or sit still? Are they restless? Are they pacing? Are they telling me they want to leave? So I think I base it more on, again, their non-verbal behavior than what they’re saying because most of the times when the patients are very psychotic, they aren’t saying much; it’s more the behavior, so if they appear to be calm and wanting to stay in the place where I already met with them, then I’m usually comfortable … .

**Don’t hide anything.** Involuntary hospitalization processes often involve frightened and agitated people, both staff and patients. These admission processes must be carefully orchestrated to contain the anxiety and fear that can lead to overreactions by the staff and to resistance and even violence by the patient.

Molly described how she shares her impressions of what is happening with the patient as way to gauge the patient’s “resistance” to going to the hospital for care. Molly recognizes and understands the patient’s lack of control and fear. She uses a step-wise series of interactions to present involuntary admission to the patient. Molly invites interaction with the person and carefully gauges how they respond to her summaries of her understanding of their situation. In this way she also assesses their capacity to interact with her in the midst of their psychosis.

… ‘Is that your understanding of what happened? Tell me what brought you here.’ And I don’t try to hide my knowledge from them: ‘I understand this is what
happened; can you tell me a little bit about this? Am I missing anything here?’

And just trying to make sure we’re on the same page. And if they deny it, they’re not willing to explore it, they’re totally shut down and resistant, and I’ve tried many different ways to make them comfortable, then I will probably talk with them about their need for treatment based upon what I’m hearing.

**Assess symptoms indirectly, within the context of usual conversations and activities.** A nurse can show interest in the patient’s perception of the patient’s experiences without presenting, or imposing, the nurse’s own perceptions of those experiences. In this way, the nurse validates the patient’s perceptions of their symptoms. Donna does not bring up specific symptoms directly with patient when she assesses their mental status; she uses observation rather than direct interview. Donna elicits how the patients’ make sense of their own experiences and then avoids labeling those experiences as symptoms.

I just talk to them like we were just hanging out in a coffee shop chit-chatting. …

So by me just having small talk, and not saying, ‘So are you hearing voices today?’ and asking about symptoms, they’ll actually engage me in conversation so I can get a chance to evaluate them without them knowing. … I’m evaluating if the symptoms are increasing, decreasing, and, if they are taking meds, if it’s working; if their thoughts are a little more organized, if they’re still having symptoms.

Donna thinks that the patients react poorly to the nurses thinking that something is wrong with them when they perceive that they are being evaluated.
They probably would resent the whole therapy approach and not even participate. Because then, it’s saying once again that we think something’s wrong, and we need to evaluate it. So yeah, they probably wouldn’t even partake in it.

**Diffuse interpersonal tension: Focus the interaction on the patient’s concerns.** When patients are able to talk with staff and are cognitively organized, the patients may be able to engage with and be distracted by the nurses, despite being highly defensive. Focusing the patient on something other than the nurse can help to de-escalate and distract patient. Use of a white board can keep the conversation focused, concrete, and indirectly interactive; while the patient is focused on the board instead of the nurse, the interpersonal defensiveness that the patient might have developed during the escalation may be diffused. The patient has control in this situation and may sit or stand, leave or stay – the door is open. Hunter explained:

With someone who has schizophrenia for example, I tend to do a lot of picture, or circle, connect-the-dot type of thing, and just kind of lay out examples, and analogies and metaphors. And you just kind of figure out what works, you ask the person what would work. I have found that using a visual tool like a dry-erase board, you can take someone who is extremely angry, if you – they don’t have to sit down – they can stand up, the door is open, they can leave whenever they want … but it becomes more about watching the board than it is face-to-face. That’s what I do.

This use of the board to structure conversation during de-escalation of defensiveness may relieve tension between the nurse and the patient. Both the patient and
the nurse are looking at the same thing, but each from their own perspective – and perhaps importantly – not at each other. Even though their perspectives are different and may vary considerably, they are both looking outward but towards subject content, working toward a mutually important focus, and finding common ground in the process. When the patient and nurse are able to communicate around a process aimed at shared goal setting, confidence in a worthwhile interpersonal relationship may build.

**Awareness of judgment: Empathy in the face of frustration.** Patients may talk and open-up with nurses who are easily visible and accessible to them. The ready presence of the nurse can lend ease to the nurse-patient relationship, in that the nurse signals that they are someone who is there to offer help to the patient. The patient may be more apt to begin to relate to a nurse who makes themselves easily available to the patient. This can be an important aspect of the nurse’s interpersonal profile; psychosis symptoms that often others do not know about or understand may make patients feel vulnerable and anxious. Having the nurse relaxed, receptive, aware and readily available provides a safe, comfortable atmosphere that the patient needs in order to let down their guard so the nurse can get to know them.

Nurses may get frustrated working with patients with psychosis and poor insight. The nurse may try not to judge the patient’s response to their psychosis, especially when the patient does not want to take antipsychotic medication or goes off meds after leaving the hospital. The context of chronic mental illness and recidivism that is often part of the course of schizophrenia may lead to frustration or judgment by the nurse. Empathy with the patient’s condition may help ease this frustration.
Do not judge the patients: Nurses as social judges. Dolly believes that psychiatric nurses need to meet the patient with psychosis and poor insight into their symptoms “where they are.” She thinks it is important to take the time required to differentiate the forms and degrees of the patient’s psychosis. Her overall approach shows respect for the person, and reflects how she recognizes the person with dignity and is kind to the person. The patient is a person, after all; their identity is not limited to their race or legal status. Dolly gave the following example to emphasize that the patient is a person, “not an ethnicity!” to be judged according to nurses’ personal stereotypes.

I think the nurses should take it slow, and they should learn to meet the patient where they are. Some patients come in with psychosis, and it’s mild. But some come in and it’s very severe. You need to educate yourself, to know the difference, and meet them where they are. And be respectful; treat them with dignity, kindness. They are a person, they are a person. … These are the first remarks in the nursing report! “The Black Patient! Does he have a job?”; “The Spanish Patient! Does he speak English?”; “The Korean Patient! What’s he doing here? Does he speak English?” … And then one day, I told the nurses: ‘You will stop it! These are our clients! They are people, and I don’t want to hear it again! We are here for them! You don’t judge them.

The nurse is judgmental – it is natural to judge. But try to put yourself in their shoes: This is their life. Clinical knowledge alone does not necessarily make good psychiatric nurses. Psychiatric nurses are educated, trained, and sensitized not to be judgmental as a foundation of nursing care. But nurses may in fact judge patients; nurses
may be judgmental especially when they cannot share or imagine patients’ psychotic perceptions of the world. Despite the premise that psychiatric nurses must not be judgmental in response to patients, Donna observed that nurses do judge how their patients are conducting their lives; she emphasizes that consideration of the patient’s entire situation helps clinicians keep empathic perspective. Donna relates how her humility is key to the empathy she experiences working with people who have schizophrenia. Empathy deepens her perspective on all that the patients go through dealing with the effects of their medications in addition to their symptoms of schizophrenia.

You’ve got to put yourself in - I do try and put myself in - my patients’ shoes sometimes. … it actually brings my frustration level down sometimes … you know, after working with schizophrenics for five years … if only they can see what I’ve seen at the end of – but they just flat-out refuse: “I don’t want it” – and so it just kind of helps to bring my frustration level down, and humbles me just a little. … They just say, “Hey, the side effects are worse - I’d rather hear voices every day.” So I think we tend to, we judge. We may not verbalize it, but we do.

**Therapeutic mechanisms: How the nurses communicate caring attitude.** The nurses in this study described how they relate to and communicate with patients in order to initiate and engage in treatment-oriented relationships. The nurses describe and apply basic mechanisms of any constructive clinical relationship to the specific demands of interactions with people who do not know they are psychotic. These mechanisms are crucial, not just useful, in the context of a clinical relationship with a person who cannot
acknowledge their condition. These mechanisms include knowledge of the person’s particular symptom profile to avoid trespassing into their vulnerabilities; sensitivity to what makes the individual anxious and threatened; setting expectations and goals that match the person’s capabilities and strengths; and careful timing. The nurses provided examples using both general and specific circumstances, to demonstrate the necessary use of these communication mechanisms when interacting with people who have schizophrenia and poor insight.

*Do not push; it agitates the person and interferes with their comfort system.*

Psychiatric nurses learn how to approach patients who are anxious, insecure, and fearful as they become more practiced in observing and noticing signs of discomfort and distress. Nurses learn how to offer interaction, or how and when not to interact with patients who have psychosis. Pushing interaction onto the patient makes their anxiety and fear worse; the patient’s need to isolate and withdraw may increase. Pushing the patient into interaction can be provocative; even talking may produce agitation and heighten the patient’s need to defend themselves. Nurses learn over time to read the patient’s response to the nurse’s attempts to interact, and to the psychiatric environment in general. The patient’s response is used by the nurse as a gauge to assess and select which interventions may benefit the patient. Rachel talked about how to recognize and respond to patients’ needs without “pushing” and without telling patients “what they need to do.”

I guess I’ve learned through the years that you have to assess quickly how they are, and sometimes pushing them too much can make them agitated, and maybe make them worse because you’re interfering with their comfort system.
**Avoid power struggles: Provide options to increase the patient’s comfort.**

Approaching patients in a calm manner can be difficult if the nurse is frustrated, anxious, or scared. Nurses conveyed how they express feelings in different ways, and develop their own interpersonal styles to communicate with patients in difficult situations. Van explained that she is aware of an attitude she takes to help patients feel less threatened and scared: she communicates that she wants to provide help, does not get into power struggles, and she lets the patient know what options are available.

My way of approaching is being as calm as I possibly can, which can be very hard in some situations. But not getting in confrontations with them, not getting in power struggles, just setting limits, and I just try to make them feel comfortable where they are at. … For me it’s more like, ‘What can I do for you? … What can we do? You can’t stand here and rip apart the unit tonight, and we’re not a smoking facility, you can’t go out and have a cigarette;’ I just say, ‘but these are the options I have for you.’

**Gauge the patient’s level of engagement: Just keep going back.** Hunter includes essential elements of his therapeutic relationships with people who have psychosis and poor insight as keen observation, genuineness, being forthright and truthful, and discerning the patient’s level of engagement. He added that the nurse needs to be patient and gentle, and to persevere.

I think, first of all, you want to observe an individual. Second of all, once you start talking, it’s got to be genuine, it’s got to be - it’s got to be real, truthful. Third, you, ideally of course, you want that person engaged in the conversation,
verbally or non-verbally. And that may not happen the first time around, so you just keep going back.

*Make time for the patient; do not hurry or rush.* Ministering to the patient’s needs communicates that the nurse understands that the patient has needs and cares about them. By doing simple actions for the patient like pulling up their blanket, Dee communicates the patient’s worth non-verbally, allowing the patient to become more comfortable. Therapeutic rapport builds with repeated positive interactions, and can develop a foundation for interacting around difficult issues like taking medications.

I’m non-threatening, and I’m patient. I would say those are the keys … I have all day, I’m not rushing. Unless the patient is really regressed, or they’re not taking their meds, then I might guide them, but I never - I can use that term - I never try to present as hurried or rushed, or insensitive, … I’m being patient, I’m on their time schedule.

*Give the patient time to process information.* Giving a patient time think about what the nurse has discussed with them communicates to the patient that the nurse recognizes that the patient may want to process the information for themselves, and not just accept the nurse’s point of view. Giving the patient this time allows the patient to form their own understanding of the information until it means something to them. Johns explained:

You give them time to process the information, yeah … by telling them go think about it, and give them a time frame: ‘After a week, come and see me; we will
meet again and talk about it.’ … Some of them do. … You bring back the topic and let them express their feelings and perceptions.

Do not expect the patient to talk when they are highly symptomatic; provide validation non-verbally. Clear, unambiguous communication is important to establish and maintain a therapeutic relationship with the patient. If communication is not clear, the patient may find interacting with the nurse beyond their ability. This can be anxiety provoking for the patient who may be paranoid about others’ intentions towards them. Patients also may lack interpersonal confidence and be extremely sensitive to what they perceive as negative judgments from others about themselves. Dee explained how she interacts with patients using repetition and validation to communicate clearly, adding small acts of caring.

Yes, repetition, there it is: repetition. And validating using repetition, validating … to make sure that they’re on the same page with me. So I’m keying into them, and just clarifying … right, because they’ll nod affirmatively or say they are okay. Or, it’s just eye contact, because sometimes they’re so psychotic they’re not responding … they do something and then I always clarify with them: … ‘Do you want me to put your blankets up over you?’ just ministering to them. So, in an older man, an adult, and he was mostly mute, I just went in and gave him his meds - and I always give them my name - and tell them what I am doing. I am always - that’s the joke [the staff] makes: I’m always teaching, constantly teaching. So then I say, ‘Are you okay? These are your meds.’ I give them my
name, and say ‘Would you like me to pull the blanket up?’ And he just shook his head, and I pulled his blanket up.

*Do not take the patient’s perceptions from them. Believe the patient and they will believe you.* Donna described how she interacted with a patient who believed the patient smelled horribly. She describes the nurses’ attempts to help alleviate the patient’s olfactory sensation, and how these actions may have built trust with this patient. The patient only took the medication because she believed that Donna believed her.

I approached her, letting her know that I know that this smell that she is having is very real to her: she said, “Everyone always says I’m lying,” and I was like, ‘I wouldn’t say that; I would never say that this wasn’t real to you, the way that you are in such turmoil. It’s very real to you.’ So yeah, I would approach it that way. That kind of helped her: “You obviously believe me, so I’ll try your med, even though I know it’s not going to help, I’ll try your med.” But that’s the approach, yeah; … that kind of gave her some trust to say, “I’ll try the medication,” … but it was very real to her, very, very real to her.

Donna’s example may provide a lesson: believe the patient and their experience, and they may believe you about the need to take medication; believe the patient, and they may believe you. Donna’s story emphasized how real the symptom is to the patient; Donna’s focus was on the patient’s experience rather than her own experience as the psychiatric nurse.

*Ask their permission to share a different perspective from their own, to connect.*

*If not, “that is going to get their ears pinned-back.”* Especially in the midst of the crisis
that brought them to the hospital, patients are often responsive to nurses taking an interest in them as an individual. The nurse aims to connect with the person, and most importantly, the nurse shows the patient that the nurse wants to get to know the patient as an individual. Each patient is a person who is important, and who needs to be validated. Patients may be reactive to nurses’ suggestions and directions, as if the patients are perceived by the nurses as doing something wrong, incorrect, or inappropriate. The nurse’s sensitivity to the patient’s point of view is important and so is a respectful attitude, as in asking for the patient’s permission before offering alternative perceptions or interpretations to their own. Hunter explained how he approaches patients and asks permission before he shares his own perspective.

… And then I will ask for permission: ‘Can I give you some observational feedback right now?’ I find that extremely effective. If someone is going through a crisis situation or about ready to, maybe they lack insight, they can’t see what’s happening, and I will sit there and ask, ‘Do you mind if I give you some personal observational feedback? This is just what I’m seeing, nothing more, nothing less - you can do what you want with it.’ I will ask for that permission; I have never had anybody ever say no. Now, turn that around and just go up to someone and say, ‘Do you know what you are doing? Do you understand what it is?’ That’s not going to connect; sometimes, in fact, I think with that tone, that manner, their ears get pinned-back, they are not going to hear anything that you want to say. And the point is, you’re trying to connect with this individual.
**Do not blame them: How can you live this way?** People do not choose to be mentally ill. It can be easy to forget that a patient’s behavior is not necessarily in their willful control, but is an expression of their psychiatric symptoms. Blaming the patient, holding them responsible and expecting them to be able to explain what they are doing and why they are doing it, may be beyond the patient’s ability because of symptoms of poor insight. Further, patients may be in the hospital involuntarily, and have little say about directing their daily lives. Hunter commented on the importance of remembering that mental illness is not a choice and the negative effects of “blaming and shaming.”

You know, people don’t choose to be in this hospital necessarily. People don’t choose to born with a mental illness, or have one until they’re later in life. It is really sad, especially when you have someone who’s extremely successful, like at eighteen, twenty, twenty-two, twenty-four years old, and the whole bottom drops out. So then they’re slapped with a diagnosis that they’re schizophrenic, and in their mind all they know is what they’ve read, what they’ve heard, what they’ve seen, and that’s the end of it, when it doesn’t have to be.

**Don’t make them feel bad; ask those right questions, those furthering questions.** The key, maybe the key, to understanding and then meeting the patient where they are, is how the clinician recognizes and is aware of the patient’s lack of insight. Using this awareness, the clinician is more in a position to help the patient compensate for their anosognosia; the clinician is more able to respond to the patient’s needs using a clinical approach that is based on a realistic appraisal of the patient’s capacity for insight.

When asked about how she might apply her thinking about preserving the dignity of a
person in situations that are not dangerous, like the convenience store example, Sophia explained that she believes that redirecting patients by correcting them is hurtful.

I think it’s the approach which people use. Instead of saying, ‘You need to be quiet,’ it’s approaching them in a different way so that you’re not making them feel bad; … maybe they are responding to something: and are they scared? Are they? It’s asking those right questions, instead of telling them that their behavior is wrong; it’s asking them a furthering question – if they can answer it.

Asking “those right questions, those furthering questions,” may help clinicians provide assistance that the patient is ready and able to use. Exploring what the patient is experiencing and their point of view, understanding what the patient thinks the situation is and what it means to them: these are “furthering questions.” The nurse-patient relationship may deepen when the clinician responds in an open way, exploring what the patient’s experience is, and what they think about it. Especially because of limited awareness and impaired insight, people with chronic mental illnesses may not be able to acknowledge their behavior or what it means to others. How can a person take responsibility for their behavior if they are not even aware of the behavior, or if their capacity for insight is limited? Sophia commented, “It’s like a circle thing.”

**Be consistent: The trust-builder.** Consistency in approach and practice are elements that contribute to trust between nurses and patients. When the nurse is consistent, the nurse becomes more predictable and understandable to the patient. Being consistent and structured helps patients know what they can rely on the staff for: here,
John explained the most important aspects of how he interacts with patients who have psychosis and poor insight.

They have to build-up that trust for you. And how do you develop that trust?

That’s important. If you tell them tomorrow at ten o’clock I’m going to meet with you, be sure you meet with them at ten o’clock. … They will build-up that trust for you, yeah, by being consistent.

**Don’t be false: It’s the worst thing you can do. They know when you are interested or not.** Despite a patient’s poor insight into and perhaps even lack of awareness of their own symptoms, forming a clinical relationship as a foundation for eliciting the patient’s own story is key to any therapeutic work. The nurse must meet the patient where they are, and help the person to tell their own story, and then use the personal pieces of the patient’s own story to guide them along to possible healing within that clinical relationship. The patient’s willingness to enter into relationship with the nurse gives the nurse the opportunity to offer perspectives as the patient develops confidence in the nurse. Knowing the person as an individual and taking a real interest in them is the key to entering and maintaining this relationship. Hunter explained that the patients perceive when the nurse lacks genuine interest in them.

I think one of the worst things you can do is have a false conversation with someone. I think that’s why it is so important that when you are working with folks that you start to get a piece here, and a piece here, and you get a piece here, and you start putting the picture together. And then you talk about that picture with that individual; they know whether you are interested or not. You don’t walk
away from someone, you don’t smile at them and walk away and frown, you
don’t walk away when you are interested and you don’t continue to smile
effortlessly. People see that – I mean, they feel it, they experience it!

*Say you are sorry. It’s a two-way street – they will remember that conversation.*

Because the diagnosis of schizophrenia is associated with stigma, making the
therapeutic relationship “normal” is also an aspect of how Hunter interacts with people
with psychosis. Hunter normalizes his relationships with patients by sustaining a
conversation focused on who the patient is as a human being. An open, respectful
dialogue involves not only giving feedback to the patient, but inviting a two-way
interaction so the nurse can learn from the patient, where feedback goes both ways.
Making mistakes and misconstruing what a patient might have meant by what they said
or did is part of this relational learning process. When the nurse is able to apologize, to
say that they are sorry, they add strength and substance to the therapeutic relationship.
The person may remember the conversation and the nurse’s apology, as it is important to
them and makes the relationship more respectful, equal, and authentic.

You know, whether it is schizophrenia or not, it doesn’t make any difference to
me. I interact with them like they are normal human beings, in what I think is
normal. I don’t see a diagnosis. … You can have a very soft conversation with
someone to point out what you are seeing, how it might affect them, how it might
affect other folks. Again, it’s just being truthful in a way that is not blaming or
shaming: we’re just having a conversation, and also being open to the feedback
that that person may give me. Because, if you’re going to talk with someone, and
maybe give advice, or a recommendation, or observational feedback … You’ve got to be open for that person to give you some feedback also! … and you realize that you screwed-up, you get up, and you find that person, and you apologize, that’s what you do, because five years down the road they are going to tell you that they remember that conversation.

**Maintain confidentiality.** To build and maintain the patient’s trust and confidence, John never talks about individual patient’s treatments in a group setting. Only in one-to-one conversations will he discuss the patient’s care. Maintaining personal information in confidence demonstrates respect for the privacy of each individual. John comments on how his interactions with patients in an education session focus on the purpose of the group, without divulging personal treatment information.

… In a group setting … we never talk about the individual patient’s treatment, never! … About their problems? No, nothing in group – that happens in individual one-to-ones … about medication, in the medication group it’s going to be a generalized thing. Like today, I’m going to talk about Clozaril. Whoever is on Clozaril, I will talk about Clozaril in the group.

**Avoid the four Cs: How lack of communication, conflict, confusion, and chaos interlink.** Skill is required to assess when and how to interact with the patient in order to communicate effectively without making the patient anxious. Here, Dee provided her “mantra” regarding clinical communication, and how ongoing confusion can lead to even more problems for the patient and nurse.
… Well, my little mantra is: lack of communication leads to conflict, conflict leads to confusion, confusion leads to chaos - the four Cs… I use it particularly with the kids, and they usually embrace it and remember it. But you can use it for anybody.

*Treat the patient as a human being even when nothing seems to help.* When there seems no way out of the schizophrenia condition, for the patients or the nurses, Dee goes back to the origins of her way of being with the patients, no matter how chronic or severe their symptoms are. She is careful not to focus on aspects of the patient’s symptoms she cannot validate because they are beyond her experience, and belong to the patient; yet she does not deny the patient their own experience. She reminds caregivers that even when we cannot validate the patient’s internal experiences/symptoms of their psychosis cannot be validated, the patient as a human being with worth and dignity should be validated.

It doesn’t always work, right, because, if you have somebody who is psychotic there is nothing you can do. They’re going to be paranoid, they’re going to tell you that somebody was monitoring them with something in their tooth, or someone was speaking to them, or tracking them, they put a tracking device in them. So there’s no way that I can validate them or clarify with them because that is *the* 101: you’re not supposed to keep saying, no, it’s not true, it’s not true. But, here comes the key fact: I still can treat them as a human being [Dee raps the table with each word for emphasis]. And be compassionate – it’s just key – that’s it, and be patient, and give them as much normalcy as I can.
Don’t make them wait for you. Organize your work to anticipate and meet the patients’ needs: ‘I am happy to help you.’ When nurses anticipate what patients might need, they show the patients that they know and understand them, and appreciate them as individuals. Van plans her work so that she can focus on her patients’ needs over her entire shift, rather than reacting to developments that she does not anticipate. She talked about reviewing current documentation by other clinicians so that she is up-to-date regarding each patient’s clinical status; she prepares carefully for weekends when staffing may be thinner, and there is less program structure as fewer therapies are scheduled. She also purposefully manages transitions between shifts as a means to stabilize a less structured and potentially stressful time when nursing staff are changing shifts. Van organizes her work so that she can be out on the unit to interact with patients at change of shift, to meet – even anticipate – her patients’ needs. She emphasized that she does not make the patients wait.

I think the transition - the hardest time for the patients - is change of shift; … that usually is when a lot of things happen, because there is a lot more people in-and-out, there’s a lot of - probably with the medical units, too - it’s not even psych hospitals. … You have to be aware of the high times. You know what I do, I try to have all my paperwork wrapped-up early, so I will stay on the unit and interact with patients. … That is probably the best intervention. And I tell people, “Don’t make them wait for things!” They’re totally [dependent] – you have an adult here, and they are not children, and even though they have a mental illness they are not
children. … They don’t have the keys; … just respond to them before they get to the point of agitation.

*Care prevents a lot of aggression. Remember to look up when they ask for things: “I am here to help you.”* Van says that nurses should make eye contact: respond right away, give answers with options and reasons even if unable to give the person what they need, thereby demonstrating to the patient that the nurse is doing their best to solve their problem. This social interaction tells the patient that the nurse values them as an important person with individuality and worth, and that the nurse recognizes that they have given up much adult independence to be in the hospital. It is the nurse’s way of demonstrating faith in the person, in the patient, *the one who suffers*: Van demonstrated that she is there to help the patient, and that the patient is her partner in, and capable of using the hospitalization process to clinically stabilize. Her attitude is, “I am here to help you, and I am happy to help you.”

When a patient comes to the door, I try to - I look up: ‘What can I help you with?’ … And okay, they want a sandwich at night, and I’m like, ‘Okay, let me go look and see what we have.’ … You have got to set limits, set a little structure on them, like, ‘Okay, you can have a sandwich or milk, but this is it for snacks tonight.’ … yeah, and that you care about them. … If they see that the nurse cares about them, they are not going to, they’re not - that’s probably why I have never been hit. I’m not going to say that – [Van knocks on wood.] … It’s about preventing … I think care prevents a lot of aggressive events. I think you can prevent.
Use a comforting approach. But sometimes you can’t do your job – try one way and if that doesn’t work, try another. Before Rachel described how patients with psychosis and poor insight respond to her, she explained first how she treats them. She described her underlying approach and attitude as comforting, nurturing, soft, warm, open and that she provides choices without being demanding or controlling. She qualified that her approach is not always effective; she is not always able to use her approaches to influence her patients and their responses to her in the way she might like to. She especially said this in the context of doing her best to help the patients with psychosis take medications. When the patients will not take antipsychotic medications, despite Rachel’s frustration, she does not feel at fault. She turns instead to collaborate with the physicians who make decisions about future directions to try.

I think your approach definitely will help in you making someone comfortable. … It’s frustrating, because sometimes you can’t do your job. But with that being said … my motto nowadays is, “it is what it is.” So I just, I just keep trying. And if they refuse, for instance with medicines, if they refuse, and if I try a different approach just to get them to take their medicine, if I try it one way and it doesn’t work, I’ll try a different way, like maybe bargaining or compromising.

IV. The Nurses Believe that Certain Important Elements and Dynamics Should Be Part of the Nurse-Patient Relationship When the Patient Has Poor Insight

When patients do not know they have schizophrenia, the therapeutic relationship is constructed around the dynamic of trust, rapport, and interpersonal connection and involvement in ways that differ for patients who are able to acknowledge their symptoms
and conditions. Direct communication regarding symptoms may threaten and alienate the patient; the clinician must accentuate other aspects of the clinical relationship in order to engage the patient. The resulting relationship provides a foundation for the work of coming to understand and appreciate the patient’s experiences of their situation and condition. This shared understanding of the patient’s condition from the patient’s perspective is what the nurse clinician then can engage around and work with, in partnership with the patient.

This process of engagement and relatedness involves dynamics that the clinician recognizes and molds to benefit the patient. This relational relatedness becomes the foundation upon which patient and clinician may find common ground regarding goals and benefits. The nurses described several important elements and dynamics that are part of clinical relatedness that can be fragile and difficult to maintain – or even almost impossible to establish – without these important characteristics.

**Discover the patients’ interests and abilities: Normalize and connect.**

Normalizing interactions can reduce interpersonal anxiety in both the patient and the nurse when patients are experiencing schizophrenia symptoms. Expanding topics of conversations beyond a review of the patient’s symptoms can help cue the patient that the nurse is interested in them as a person. Being interested in the person enough to spend time to get to know them as an individual sends a caring signal to the patient. The nurse can extend the clinical relationship beyond the patient’s symptoms and incorporate this person as an individual. Again, the patient who is unaware that their behaviors or internal
experiences are symptoms of psychosis will have poor insight regarding having symptoms of schizophrenia.

**Normalize the nurse-patient relationship; go beyond the symptoms.** Dee explained that using humor and that just being herself are elements of her therapeutic approach which helps patients become comfortable with her and open-up. She describes how she interacts with patients as being normal and being humane.

So sometimes you just have to have a normal conversation with them, just interacting that way, and then they disclose of themselves, and it doesn’t have anything to do with their mental illness; you’re being humane.

**Connect through the patient’s interests to nourish them, so they can have some kind of happiness.** Therapeutic, interpersonal connection with patients occurs through interacting around what is specifically important to the person. Rachel talked about how she uses her relationships with patients to involve them increasingly in taking care of themselves, helping them to move away from previous isolation to greater social inclusion and normalcy. She gives an example of a patient’s particular talent and ability. Rachel relates to the patient’s abilities, not his disability, “to nourish and flourish his talent and his skills socially.”

… trying to find out what they’re connected to, whether it’s like a church or a certain activity, so they can have some kind of happiness in their lives, some kind of connection that might help keep them grounded, and give them reason to continue to take their meds, and eat, and bathe, and function more successfully in society … So like this artist, we would give him scrap paperwork, and crayons,
and markers, and all that kind of stuff. He was seen by pastoral care; pastoral care comes to our unit, they do a spirituality group, so he goes to that …

**Discover what factors are leading the person to not have insight into their illness and behaviors.** Phrases like “poor insight” or “lack of insight” can be used as unhelpful clinical labels unless the nurse goes on to explore and gather the patient’s experience of their own symptoms, from the patient’s own perspective. What clinicians label as symptoms of psychosis could then be described and given meaning from the patient’s point of view. In this way, the nurse could use the same words and a shared meaning in talking with the patient about their needs and proposals for treatment. Molly described how patient education, a common intervention nurses use to respond to or counter poor insight about symptoms, may be misappropriated by nurses in the hopes that the patient will be convinced they need to take antipsychotic medication and stay in treatment:

> So they may take that medication that day because I’m being persistent, encouraging them to take it, but in the long run, if they’re being discharged, let’s say a week from now, or two weeks from now, I’m not going to be there to be persistent with them, to remind them to take the medication. So I do think that it’s important to determine what factors are leading them not to have insight …

**Building rapport with the patient is a clinical investment to support symptom stability.** When asked to talk about the involuntarily hospitalized patient with no insight into their illness or symptoms, Chanel described a common inpatient scenario that
involves carefully building rapport using what the patient shares about their experience and symptoms. She explained that “You have to invest in them.”

Initially, I leave them alone, they’re so resistant. But after we do this enough times, with, “There’s nothing wrong with me, leave me alone,” I usually get a breakthrough with establishing rapport with them. And that usually is how it becomes successful, you get a breakthrough with establishing rapport with them, and then they start talking to you. And as they start talking to you, at this point, they are still thinking that there is nothing wrong with them. As they open up and start talking to you and telling you what their thoughts are, then you can form a better picture of what’s going on in their mind, and then you can start doing your reality orienting, and then as your rapport is forming with them, they will - and of course the trust is building - then they will start listening to you, and they will start processing and start thinking, okay, maybe I do need to take this medicine, there may be something wrong.

*The crisis aftermath as opportunity for relationship building: When the patient initiates.* Once the patient does get medications and begins to have an antipsychotic response, the patient may show beneficial changes. The patient may begin to initiate interactions with the nurse. A key indication of rapport, trust, and relationship building comes when the person initiates with the nurse. This shift in interpersonal dynamics is an opening to a shared relationship built on the patient’s trust; the nurse or other team member had been the one to extend help and support to the patient. In time, this offering may be reciprocated and the patient may initiate interaction or conversation with the
nurse. Hunter described how a patient began interacting with him after imposed medication administrations.

After a couple of incidents that involved, say, a medication administration, and finally getting some consistent meds on board, the next thing I knew, he would come to me and initiate a conversation. …It wasn’t superficial: I think the key thing was when he would initiate the greeting …

_Talking and relating to the patient to prevent escalation and crisis development._

The philosophy of a hospital should guide how the staff members relate to each other and to the patients, and how they implement the treatment program. In recent years, psychiatric hospitals have been working to change institutional philosophies to be more caring and patient-centered. At one State facility, the physical environment is designed to prevent use of objects as weapons; the interpersonal environment is guided by how the clinical staff members interact with patients, and is focused on preventing behavioral escalation through monitoring for early signs of anxiety and agitation, and then intervening early. Van talked about her facility’s approach to meeting threatening situations with the least restrictive method, a phrase that infiltrates updated psychiatric treatment program policies:

But our hospital’s philosophy is, you use, you always use, the least restrictive method, always. You catch them before a crisis happens, you talk to them; seclusion and restraints is the last measure. You have to be a danger to yourself or others to be put in restraints now; it used to be if you just get in an argument with a nurse. Now it’s like the last thing that you do … [no matter how much time or
effort it] takes to sit there and talk to them, and to reason with them, and to get them to stop. We’ll even let them sort of turn over furniture before we do stuff. Now my unit wised-up, and now we have these, about two hundred pound chairs and two hundred pound tables - they can’t move - and the only thing they can really damage is the TV and kick some doors. …

**How to have a dialogue with the patient who lacks insight: You have to be very skilled to have that conversation.** Hunter repeatedly referred back to and emphasized his admonition to “treat someone like a human being” to explain how he interacts with and maintains relationships with people who have psychosis and poor insight. He sees his approaches and attitudes about care as pragmatic. He described a nurse-patient relationship where the person, the patient, who may not be fully aware of, or have insight into their symptoms, is viewed as being in the wrong while the staff is in the right, so that the staff member stands as the authority on what is accurate. He then described a contrasting clinical relationship that is shared by the patient and the staff member, where perceptions become the basis of dialogue. He thought that nurses need to treat patients as human beings, always, no matter how severe the patient’s symptoms are, no matter what the patient’s level of awareness and insight is.

Hunter stressed that the nurse cares about the patient because the nurse’s work is inseparable from their compassion for the patients. Compassion gives the nurse resilience to maintain their caring perspective on the patient, to observe the patient perceptively, and discern what their needs might be. The nurse is responsive to the patient, and maintains an open dialogue that includes the patient’s perspective. The nurse does not
insist on authoritatively directing the patient. Hunter shared a lesson from working in business that “if the customer is not always right, you have to be very good at how you have that conversation.”

You have a person in front of you: see what the needs are. It’s amazing, that if you just sit down and talk with someone and ask them a couple questions – if they tell you to shut up, then shut up! Just let them know you’ll be around if they need you. Okay, don’t make an issue out of it. If you treat that person, that conversation that way, it goes a long ways – you know you don’t have to have a win-lose situation …

**Anosognosia and poor insight: Can you work with these symptoms?** Get a hook into where the person is. If a person is not aware of something, how can the person develop insight about the effects, repercussions, or implications of that circumstance?

Hunter differentiated anosognosia, lack of awareness, from lack of insight by explaining that he thinks the nurse can positively influence the patient’s poor insight within a therapeutic relationship. However, he did not imply the same in terms of the patient’s lack of awareness. He believes that a person is either aware or not, as if awareness is hard-wired. But interestingly, Hunter thinks that clinicians can work with lack of insight.

With lack of insight, I think you can work with that… Again, I think it comes back to taking the person, with where they are in front of you, what they’re presenting … so that they have something they can kind of get a hook into. And I think that starts, sort of like that road to whether it’s Recovery, or to getting
better, being able to hear what you are saying … Yeah, I want to get a hook in you so I can get you going with me, so we can talk.

The nurses’ source of hope: Belief in the patient. Psychiatric nurses must have hope, otherwise they can become burned-out. The cornerstone of Sophia’s perspective on working people who have psychosis and poor insight is founded on hope. She talks about whether her perspectives about psychosis and insight represent those of most psychiatric nurses:

I think sometimes people get very burned-out in this field, and I think … that prevents people from really having hope for some of these people, that they are going to get better. I think they get frustrated. … I do think most psych nurses have hope. I think you have to, to be in this field. It’s a hard field to be in; … it’s challenging on multiple, different levels. I think in order to be a good psych nurse you have to have some type of hope that you are able to instill in others …

The staff did not give up despite the patient’s chronic symptoms and lack of insight. In public State psychiatric facilities, patients have symptoms and disorders that are often treatment resistant, and result in chronic mental illness. Here Sophia described a patient she will never forget, a man who the program staff did not give up on. The team kept working with him even though “no one ever believed he would ever get better at all.”

These NGRI patients, we read all the packets that get sent, and you see the course of treatment. And there’s one individual who was manic and psychotic and ended up killing his mother, and every single time that it would come up to talk about
his index events, he would say he has no recollection of it, no recollection, no recollection, and he would come up with something about the offense. And finally one day he was in therapy with his therapist; it came up again about his index events, and he was able to actually say that he had actually killed his mother. … And I think with the relationship combined with medication, someone constantly just trying to work with him, we’ve seen him improve, and develop more insight into his mental illness and the disease process, and how medication would help, and when he is not on medications, how he cannot – he’s impaired all over the place.

*This is the life they are given. She was out for a week, but it was the greatest week.* Sophia described her personal sadness as she witnesses the patients who are tortured by psychosis symptoms and suffering. She contrasted her sadness with joy: Sophia tells a story about a patient who went out on pass for a week after years of living in a public mental institution.

One woman we have here who is so, so, so sick, and she’s refractory. And every day someone assaults her, someone is hurting her, someone is doing this or that. It’s a really scary world, very scary … Personally, it’s just sad. There’s another guy over here who is refractory also, and chants, and cries, and wails. It’s just - and this is the life they are given. … We see a lot of people recover and get better, and when I say recover and get better, it may not be what we think is optimal. There’s a woman who has been here for years, and she decided she wanted to get discharged one day, and she was out for a week. But that week was
the greatest week: she was able to go out and be out of the hospital and then things went down hill, and she was able to come back on her own, and say, “I need help now.”

*The patient’s response to treatment influences hopefulness in the nurse – or hopelessness.* Donna arrives at her expectations that patients will begin to characterize their experiences of their symptoms as schizophrenia more out of hope than from her actual experience working with patients over time. She hopes that they develop some insight by the time they are ready for discharge from the inpatient treatment. She described her hope that given repeated exposure to inpatient treatment, patients will make some progress regarding their level of insight but for some patients she is hopeless.

From working with some patients, I don’t even have expectations for [getting insight]; like I said, we just know that they will be back. And hopefully one of these admissions they will, but for some patients I don’t have any [expectation that they will respond].

In this interchange with the researcher, Donna says she would be open to trying a different approach to helping the patient stay on antipsychotic medication if she knew about it.

*Researcher:* If we had a way, an approach - not necessarily to convince or impose insight on these guys, but an approach that you felt was worthwhile - that gave you a handle on how to think about how to interact with these guys, would you try it?

*Donna:* um – hum … yeah.
The nurse’s passion for their work influences the nurse-patient relationship.

The Recovery process shifts the clinical view from “treating the patient” to one where clinicians form a clinical partnership with the person as an individual, with their own experiences, points-of-view, and desires, and goals. In private and community hospitals, patients stay for short periods of time, and brief stays can limit the development of the clinical partnership between nurse and patient. Also, when the patient stays in a facility for years, as they may in public programs, remaining hopeful about patient progress can be a challenge. Length of stay, long or short, may influence nurses’ perspective regarding the possibility of their patients making progress. Additionally, Sophia talked about how professional “passion” influences nurses’ attitudes towards patients with chronic mental illnesses:

I wonder if part of it has to do with our state setting. We have people for a long time. And it’s different from a private facility where you have what, seven days, five days … to form that relationship; and here we really get to know someone quite well. And I’m not sure if that makes a difference … I don’t know. I think it depends on the person and how they feel about what they do. I love what I do, I’m still passionate about what I do, so to me this is important … I look out there and I can tell you, who it’s important to and who it’s really not, and who’s just here for a paycheck … It’s definitely a mixed bag.

Out-patient settings give the nurse time to get to know the patient as a whole person. Generally, nurses who only work with patients in hospitals work with patients for brief periods. Out-patient clinic experience can provide the nurse different
perspectives on who the patient is, as the nurse interacts with the patient in the context of the patient’s larger life – beyond the hospital. Knowing the patient over time in an out-patient setting may influence the clinical relationship between the nurse and the patient.

**Out-patient settings: Over time you get to see their whole life.** In contrast to the experiences she shares with other psychiatric nurses caring for people with psychosis and poor insight, Rachel sees some differences between her perspectives and other nurses’ on what those experiences mean to her - what she thinks is going on with patients and what they need. She emphasized that her experiences across inpatient and outpatient care settings gives her a different view of what is going on with patients with poor insight and how to support them.

I think my outpatient experience, because I got to know patients over years and have relationships with them, allowed me to see the limitations and the insight of how the disease really worked, because I knew the patients so well - not just the in-patient crisis intervention - but because I worked with them every week, every month, and saw them day-in, day-out, year-after-year, once per week or month. I got to see beyond how the mental illness played a role. … So you got to see their whole life, so I guess that played a role in me better understanding the limitations and insight of how these people operated.

**What nurses expect of the patients with poor insight may influence the nurse-patient relationship.**

**Establish patient-centered goals; determine what are the patients willing to do.**

When people with psychosis lack awareness of and insight into the implications of their
symptoms, what is important to the person can challenge the treatment team’s planning process to support the person’s adjustment and reincorporation into the community.

Being able to communicate in a way that is meaningful to the patient requires a deep knowledge of what the person values. That connection is maintained through a line of individualized communication which requires not only knowing what the patient wants, but how their logic works in respect to those aspects of their life in the community.

Sophia gave an example of how person-centered communication can support discharge planning, involving literally, “meeting the patient where they are.”

We have someone who is chronically homeless and they don’t want to live in an apartment, they just want to live in the woods … and they don’t have the insight to know it would be safer to go live in an apartment. So what we’ve tried to do is then, okay, so, they’re going to be out there, and then work with them on what they are willing to have, to be done for them, like PACT services. [Program for Accessible Community Treatment]

_We can make the mistake of going beyond the patient’s capacity._ To make clinical progress with the patient, nurses need find the common ground in the patient’s interests and abilities, and pay attention to the patient’s response to these conversations. The patient needs understanding and empathy; the nurse must perceive and appreciate these needs. These basics also include assessing the patient’s capacity, that is, what they can do, what they are capable of, and what they can succeed at while experiencing psychosis symptoms. Hunter explained:
I think it’s the root for any relationship if you’re going to work with someone. You validate them, you’re honest with them; don’t try to go over the head with something. … You go a long ways with the basics. If you don’t have the basics, you cannot move up the next level. Once you have those foundations in place, then you can start stretching-out [or extending]. I think sometimes we take for granted that we can stretch-out [or extend our expectations] because someone is an adult, or someone was okay: but they’re sick now.

*The treatment team struggles with determining and responding to patient behavior: Willful? Or not in the patient's awareness or control?* Clinical teams struggle with determining what the patient is actually capable of, especially in the realm of purposeful, willful behavior. Paranoid (and often delusional) patients with poor insight may be construed by the staff as making a “choice” to avoid social contact, inferring that the patient is capable of social contact and interaction. The treatment team may see this social avoidance behavior as self-determined, a choice. In general, giving patients choices is a positive and supportive intervention, and the perception that “allowing patients to make the decision not to go to treatment” assumes that the patient is actually capable of what they are choosing to not do, in this case, be exposed to and interact with people. Is the patient “deciding” to not go into treatment, or are they avoiding interaction secondary to their fear and anxiety, associated with the schizophrenia symptoms of paranoia and possible other delusional beliefs?

This example could be reframed to provide another perspective on this clinical scenario, a clinical demonstration where the patient’s positive (paranoia, delusions)
symptoms interact with their negative (amotivation, avolition) symptoms, which results in the patient’s avoidance of social stress. Then the team’s question would change: what expectations could the patient successfully meet without undue stress or exacerbation of their paranoid feelings and beliefs? Sophia provided a realistic example of how the staff team discovers a target symptom that went undetected in a patient.

We’ve had someone who I just saw recently in the hallway today who is diagnosed with paranoid schizophrenia and would be up in his room all night, sleeping all day. And I think they did some med changes, but he didn’t get why he should really probably go to sleep, and get on a good sleep cycle. Well, it comes to find out, he was completely paranoid: his meds weren’t working. So they adjusted the meds. But now I saw him out of his room in the hallways today, and I do think it was that continued check-in with staff, and that relationship - and yes, the medication adjustments - but finally, just waiting it out and he finally came out of his room. And whether that is impaired judgment, impaired insight into I need to leave my room because there are other things going on in the hospital? … We struggle with this, we do … some of the nurses don’t understand that.

Perhaps this patient’s medication regimen came to match his symptom of paranoia effectively; after time on medication, and the staff waiting it out, he was able to tolerate social presence and interaction. His social avoidance was abated by medication adjustments that more matched or targeted his symptoms: he can now sleep at night, and he does not need to avoid social interaction during the day when the social environment is active. This is an example of setting achievable goals and expectations based on the
capacity of the patient, matched with successful staff interventions: medicinally target the paranoia if possible, and monitor for changes in sleep and social tolerance. To give the patient choices, the clinician needs to find something that is both worthwhile to, and achievable by, the patient.

*Reality orientation can agitate the person, so wait until they are medicated.* One way to approach a clinical conversation and not agitate a person with persistent delusions is to add basic, less threatening dimensions to the dialogue without confronting the person with facts. If, however, a patient’s delusion becomes dangerous or targets the staff member, the nurse needs to lead the conversation back to a more reality-based perspective. Van explained how to use clinical timing to provide redirection as the patient gains insight, especially when antipsychotic medication has started to work.

You don’t want to agitate people. … If their delusions are going to take them down to a place where they are not safe, then you definitely need to redirect or lead them back to reality. But you try to do that type of thing when they are medicated and they are starting to get back to that point where they can hold that reality-based conversation. … Sometimes we will take them to reality, more reality.

*The nurse expects the patient to have “some approach to reality,” but never full insight.* Donna’s goal and expectation for her patients is that they start treatment - take antipsychotic medications - with the outcome that they develop some insight so that they connect their illness conditions with the need to take medication. In the specific example of the woman who has olfactory hallucinations, however, and who believes she is foul-
smelling, Donna expected this patient to develop insight when the test results come back normal. In other words, Donna thought that this patient should then “entertain the idea” that the basis of her olfactory experience is part of a schizophrenia condition.

My biggest expectation’s that once they start treatment, some insight will develop. And that’s the biggest part, is getting them to start treatment. That’s usually my main goal, “I know you don’t believe it now, but let’s have this conversation again at discharge.” … And for her, my expectation was that she would see, once we ruled-out all the disorders that she thought she possibly could have had, and we deemed, nope, you are actually healthy, perfectly healthy, nothing is inside of you, … Yeah, I never expect full insight. When it happens, it’s great, but I never expect full insight: just to entertain the idea that maybe the things you’re experiencing are because you have something called schizophrenia.

**Is insight necessary? It may depend on how much the level of deterioration affects the patient’s life.** Rachel thinks about capacity for insight in the context of schizophrenia in practical ways. She accepts that helping the patient gain insight is difficult, and is not always a useful clinical goal. She thinks that insight is not necessarily a tractable aspect of treatment. Targeting insight with interventions to improve insight may not be constructive or practical if the patient lacks the underlying capacity for developing insight. Rachel arrives at the conclusion that not having insight is okay if the deficit is not interfering in the patient’s life

You could try and help them gain the insight, but it’s just so hard. How do you do that when they have a fixed, false belief that they are not going to change? So I guess it
depends on their level of deterioration and how much it affects their life. … They might have enough insight to comply with their medicine, to stay out of the hospital - they might have that knowledge, insight to do that. … With the psychiatrist in the Clozaril outpatient clinic I worked with, all his patients know, “If I comply with my medicine and see him and do my lab and take my medicine then I stay out of the hospital” and that might be their only insight, which might be all they need. So maybe that’s all the insight they need. (Italics added)

V. The Nurses Administer Medications and Patients Take Medications Within the Context of the Nurse-Patient Relationship

The situational context for nurses to give antipsychotic medications to patients is that the nurses attempt to give antipsychotic medications to patients who do not believe that they need the medications. Anosognosia combined with poor insight creates complex clinical interaction that may be complicated by the patient’s limited ability to describe what they are experiencing and thinking. How the nurses perceive their role in administering necessary antipsychotic medications to patients who do not know they need them is taken apart and put back together in the sections that follow. The nurses’ perceptions of the patients’ experiences regarding the need to take medications and actually taking them are addressed.

The nurse-patient relationship: Interactions involving getting the patient to take medication. Sometimes the nurse does use interactions and conversations with a patient in a directive way. In order for this approach to succeed with the patient’s cooperation, the treatment team members must not intimate or increase the patient’s
anxiety. The patient may not share an understanding of the treatment goals with the team. If the patient does not understand or agree with the goals set by the clinical staff, the patient may perceive the goals and intervention plan to achieve the goal as an imposition, an attempt to control them and take them over, rather than as part of a shared clinical partnership. The patient has to have confidence that the clinical care team will meet their needs in a way that does not exceed the patient’s sense of security. This is where rapport with the patient is essential: without confidence and trust between the patient and the treatment team, the patient may experience being co-opted by the staff, rather than being the pivotal partner in their own care.

*Getting the patient to take medication; setting goals which consider patient needs, their readiness, and their responses to the nurses.* When the patient has poor insight about their symptoms of psychosis, the patient may not experience or recognize the need to take antipsychotic medications, and may resist taking them. In this example, Hunter talked about one of the most difficult areas of treatment, the patient taking psychiatric medications. He guides the patient to become clearer about what the treatment goals are.

If you stick with the basics, you’ll get a lot further because you can’t go from one to five and skip two, three, and four. That’s one of the things I’ll see with treatment plans where you’ll have goals that are just too broad, but the interventions are also too broad … You need to back up and … establish some rapport with that person …
**I can use their hopes and dreams to convince them why just taking this one simple pill twice a day can help these dreams take place.** Donna explained previously how and why she sometimes avoids making direct reference to symptoms of mental illness when she interacts with people who have schizophrenia and poor insight. She arrives at the conclusion that the person’s hopes and dreams can give them a future - their own particular future - despite mental illness, and that taking medications is the way to make that future possible.

I like to observe while I’m talking; *and I get a lot without asking one question about mental illness, I get a lot.* … I get information on their level of intelligence, just as far as the topics that they decide to talk about … just in life in general … because if you take away the mental illness, and if there’s some sort of motivation for their life, and hopes for their life, and dreams, and they want, they seek some sort of future for themselves: I can use that to convince them why just taking this one simple pill twice a day can help these dreams take place. (Italics added)

**Be matter of fact when giving meds. Return – come back – don’t expect the patients to take meds if you don’t have a relationship with them.** Patients are responsive to Dee’s interest in them as individuals. In contrast, appearing as hurried and preoccupied and rushed can make nurses seem insensitive and lacking in compassion from the patient’s perspective. The patients sense this from the cues that nurses give. Patients who are already highly vulnerable because of delusions, auditory hallucinations, paranoia, and cognitive deficits may withdraw further. They may refuse to take the antipsychotic medications that are the best hope of remediating their symptoms.
A lot of times you’ll have patients who are so psychotic, they’re just not going to take their meds, and they don’t have a relationship with you, and they’re going to give you all their delusional, their whole intact delusional system is coming forth, and presenting itself as to why they’re not taking them, and … you’re just matter of fact … Sometimes they’ll come back and they’ll say, “Okay, I’ll take this one,” or “I’ll take that one;” they’ll say, “Just give me this med,” you see it a lot of times …

*Transform the interaction from getting them to take meds to giving them my time.* The nurses are perplexed when Dee succeeds in giving patients medications that other nurses have not been able to. Her “style” includes patience and treating people as if they are normal.

People say it sometimes, “Oh, you got them to take their meds! How do you do that?” … I always try to have normalcy, even if it’s the most psychotic patient, I don’t differentiate, treat anybody differently; I have the same level of respect for everybody. … I’m giving them my time; I’m there, I’m patient, and I’m talking to them, trying to talk to them with as much normalcy as I can. … You want them to take their meds because as far as my knowledge base, and my experience, that’s … beneficial to them to actually be able to survive. That’s how I look at it: to survive and function in the world.

As a nurse, Dee intends the cajoling and distracting she provides as a means of forming a bond with the patient so that she can make the patient feel comfortable and have confidence in her, so that the person can rely on her. She develops a therapeutic
bond this way in order to work around the lack of insight and symptom unawareness. She cannot take away the symptom of anosognosia. She wants the patient to take their medication because she believes that the medications ultimately affect the patient’s ability to function and survive in the world.

*Use the nurse-patient relationship to do what is important to the patient - they may never develop insight regarding the need to take medications.* A goal of public mental health systems is to return the people with chronic mental illness to the larger community as safely and as comfortably as possible. For patients with psychosis and poor insight, Sophia goes beyond the patient taking medications; she thinks that what is important is to discover what is personally important to the patient. Working toward that, she bases her expectations, outcomes and rationale for returning to community living and functioning on the Recovery Model, i.e., what the patient wants.

Developing the basics of how to live in society is our goal and to get people back into the community. So for someone to live in the community, they need some basics about what’s right and wrong; medications obviously come up a lot here and I think some people that we have here never get the insight into their mental illness, and never realize that they could get better if they would just take their medication. … What we expect is not going to work for them, so it’s really about and what they can do with impaired insight.

*Trusting the nurse, or, “doing it for you.” The patient may take meds because of the relationship with the nurse.* Ultimately Donna hopes that insight will come with sustained time on meds. She urges the patient to figure out that the problems that bring
them repeatedly to the hospital could get better by taking medications: “You can benefit from staying on meds long term. Do you see what being off medications causes you to do?” Her credibility as a nurse may bring the patient to say, “You know, if you think so, I’ll try” taking the medicine. The patient’s rapport with the nurse may motivate the patient to keep taking medication despite not having insight about their psychosis condition.

I appreciate that a patient feels like they can trust me, or feels that in my position as their nurse, that I may know a little more of what I’m seeing and why I’m saying that this would help, so I appreciate that they would take the medication for me initially, and then with the hopes that they would see it on their own after. But that’s big: not every patient will trust in you, and they say, “You don’t know what you’re talking about.” But every now and then you get a patient who says, “You know, if you think so, I’ll try.”

*The nurse’s view: I appreciate your trust but I will not be there to help you when you leave.* Simply because of trust and rapport between the patient and nurse, the patient may be willing to take medications. The patients may offer a clinical détente around the symptoms and medications and say they will try the medications for *the nurse.* Donna described that even though some patients continue to deny that they have psychosis symptoms, they trust her. Donna expresses appreciation for their trust, but reminds the patients that she will not be there to give them encouragement after they leave the hospital.
I feel like I get through to some patients - that they’re not always angry - they definitely aren’t. They’ll continue to deny the symptoms, however. I’ll have a patient that will say, “Okay, well, if you think this is going on, I trust you and I’ll take it.” And though I say, ‘I appreciate you having this trust in me; that’s not going to help you when you leave here, so I need you to come to that on your own, because I will only help you, when you, while you are here with me.’ … Yeah, I have some patients say, “This is what you or the doctors think is what’s going on: I’ll give it a try,” kind of attitude, never really saying, “You know what? You’re right.” But I’ll have that kind of doing-it-for-me kind of thing, “If you say so.”

Use reality orientation until the patient is able to understand they need to take **meds**. For the patient with poor insight or little to no awareness of their symptoms, developing insight about treatment and medication compliance can be problematic. Chanel discussed reality orientation as an approach she believes helps patients develop insight over time in relation to taking medications.

That’s where we all come in and work together to help the patient to gain insight into the situation – you can’t just leave the patient out there and expect them to heal themselves, it’s not going to work. We all have to work together and help the patient – I don’t care how many times we have to do reality orientation – we just have to just continue to do it until the patient is able to understand, ‘Oh maybe that didn’t happen, maybe I was paranoid, maybe I thought …’ If the patient starts
to open up, and talk, and as they stabilize on whatever medication they are giving them, or as the therapies work, then the patient will be able to understand …

The nurse-patient relationship: We may not know how patients experience taking medications, or being restrained and held for IM medication administration. Getting patients who are psychotic to accept medications may take many different attempts and approaches. When PRN medications are given by injection, the patient may require temporary positional restraint by the staff. The nursing staff may experience this sort of physical restraint as supporting the patient, but it is hard to know what the patient’s experience of this “support” intervention is, especially when the patient has already refused the offer of oral antipsychotic medication. Rachel described a medication administration event.

… the Security [Officer] came up, he was just kind of holding her to give her support - like holding her hand, … she wasn’t fighting or anything. They were kind of holding her more at this point for support - not necessarily for positional restraint … how she interpreted it, I don’t know …

Use of the nurse-patient relationship: Transform medication administration from physical restraint to the provision of support. The clinician needs to have the patient’s perspective on what they want, what they think they need. Without this perspective, the nurse works within a treatment approach that may not match the patient’s own needs and preferences, or be suited to their level of insight and awareness of their needs. In the case of people with schizophrenia who decompensate, who cannot care for themselves adequately and are a potential harm to themselves or others, who lack insight
regarding the effects of their symptoms, and need antipsychotic medications to diminish symptoms of psychosis but do not want to take medications, physical restraint may be used to administer medication. Physically holding patients to give intramuscular antipsychotic medication when the patient has have refused to take medications “by choice,” creates a potential interpersonal crisis between the nurses and the patient. Hunter explained how he taps the trust he has established previously with the person who needs medication to attenuate the person’s experience of nurses using power and force to make the patient take medicine against their will.

We’re talking about someone with schizophrenia … who has decompensated, has lack insight, and they need medications, and you’re going to have to do a physical restraint to do a medication. … I have learned that based on your relationship with that individual, they may not want that medication, and they are going to sit there and tell you they are not going to take it, and that there’s going to be a fight over that medication. I have learned that if you’ve established a relationship with that individual, and this is something that I do consistently: I talk to that person up-front, I tell them exactly what’s going to happen, why it’s going to happen, what the options were, what the options are now, and that if we do have to do a physical restraint there will be nothing more than a physical restraint to support that person to administer the medication, and we will immediately release the individual, … That’s where the trust comes from … You don’t even get into a physical restraint: it’s more just being a physical presence and support.
A forensic treatment approach: Release to the community in exchange for taking medication. In order to work with seemingly intractable lack of psychiatric symptom awareness, this forensic treatment team uses education meetings with the patient to talk about treatment and discuss the patient’s viewpoint. But also, in this case, the treatment team does not only solicit and focus on the patient’s own experience of their symptoms. John explains that the forensic team tells the patient what they think is going on, using a reality-orientation approach, rather than solely validating the patient’s experience.

For somebody who doesn’t believe that he’s supposed to take medication? We will tell them what is going on, what we are seeing. Some of those things are objective. We see them talking to themselves in the hallway, we see them smiling by themselves like that, having conversations with themselves … We have to confront them and tell them, ‘This is what the problem is and, you have to agree or you disagree, it’s your right, but we think that you need medication.’

The situation described above is seen clinically and objectively from the team’s perspective, not the patient’s perspective. John indicates that the patients are sick, and not processing normally; he emphasizes that he must accept their subjective experience. The staff “confronts” the patient with behavior they observe, and the team members reframe this behavior as the reason why the patient requires medication treatment. The team does ask the patient what they are experiencing, and, if they are taking medications, about medication side effects. Because of safety concerns and the need for consistent clarity of purpose, care delivery involves a carefully organized interdisciplinary team approach.
John describes how the patient responds when they are told by the team that the patient needs to take medication.

We all have … to convince them that, ‘Look, Mister, this is what’s going on, you need help; this is the way you can benefit if you take medication. You can move on in the system from one unit to the other, from a more restrictive to a less restrictive area, yes; that can give you more freedom. That’s one of the benefits that could actually lead to your release in the community.’ So that’s something they are looking forward to, big time. They want to go back into the community, but they have to agree to take treatment.

*I tell you, medication works!* John’s description of how the team presents treatment options to the patient is focused on the goal of being released back into the community. Both short term medication compliance and long term symptom improvement goals focus on the patient’s motivation to be released, to leave the forensic hospital, and return to the community. Some patients agree that they need help and will take medication after talking with each professional in the education meeting. But what is the patient’s agreement like? Compliance is one thing, but agreement expressed as continued participation in treatment is another. As a nurse serving the needs of chronically ill forensic psychiatric patients, John sees the patient’s agreement with treatment come in small but important ways, especially after the patient is on medication.

But … agreeing: … it’s that they’re seeing that they are going to have some benefits from taking medication … And some of them they come back when we have interviewed them, yes, and they say that they need help, medication has let them sleep
well at night … Yes, and that their mind is clear, and they can think right – they tell us this! It’s unbelievable! … That’s why I tell you, medication works! They come back to us and tell us: “This is what I’m thinking now, you see my mind is clear, yeah, I can think right now; before I wasn’t thinking right. I don’t hear voices anymore. I’m not seeing things like before” … They become less paranoid … They talk about that … Paranoia, that’s a tough one! It’s hard to [describe changes in paranoia and] see that … If they were to [become less paranoid, they might say that] that another patient wanted to attack them in the past, they didn’t like them; after they start taking treatment, they become friends. We’ve seen that before. Yes, yeah: it’s amazing.

VI. The Nurses Believe that the Nurse-Patient Relationship Affects Them Professionally and Personally

Patients who have schizophrenia and poor insight require nurses to use therapeutic relationships in adaptive ways due to the perceptual divide that is created between the patients’ anosognosia and poor insight, and the nurses’ professional perspective on the patients’ need for treatment. Psychiatric nurses use themselves – “therapeutic use of self” - as the foundational means of caring for patients. When the nurses need ways to meet the patients where the patients are, the nurses enter a realm of interpersonal relationship that is not completely clear in its structure and boundaries; psychiatric nursing education does not often specifically provide training related to interacting with people who do not recognize that they have a psychiatric condition, the anosognosia and poor insight of
schizophrenia. The nurse participants share how caring for people who do not know they are sick and need treatment affects them as both healthcare professionals and as people.

**Clinical relationship boundaries: Therapeutic balance.** Over the course of repeated hospitalizations, nurses become familiar with and get to know the person and their illness profile. In the sections that follow, nurses talk about the difficulty of balancing professional relationship boundaries while interacting with the patient as a person rather than as someone who is “sick.” Helping someone in a locked psychiatric facility feel comfortable and non-threatened, and yet have the clear perception that the nurse is there to help them professionally, can be a dilemma. The patient’s perception about the basis of the relationship may be problematic: “Help with what? There is nothing wrong with me.”

*The nurse needs to know the types of patients they work best with and work with them.* Inpatient programs admit people with many diagnostic disorders. Chanel emphasized that psychiatric nurses should know their own practice abilities and limitations, if they are to help patients:

*Chanel:* Some nurses are more comfortable with different types of diseases … Work with the people with the diseases you are comfortable with, because if you are comfortable working with the bipolar population, and you know your own limits, and if you are afraid of a schizophrenic patient, that’s a problem because how can you approach them? They are going to know that you are apprehensive and have some fear, and you’re not, that’s not being open and nonjudgmental! That’s going to impact the nursing care that you are able to give to the patient…
Researcher: How do you know when you, or when people you are working with, are good at working with population specialties?

Chanel: … People should - the person should - be able to tell you that themselves.

Researcher: Should?

Chanel: Should. If the person doesn’t know, they’ll learn it when stuff keeps happening, when there is always a conflict with a certain population.

The nurse-patient relationship in therapeutic balance: Going both ways – are we getting each other? I made some significance in her life that day. Sometimes patients provide little indication that the nurses are having an impact on them. Here Dee described a clinical relationship that is validated both ways: from the nurse’s perspective and from the patient’s perspective, with a patient who had not been talking much.

She had chronic [schizophrenia]. At the end, I had to be her one-to-one all day.
She kept crying because they were going to put her in a nursing home because she was starting to have dementia - but she was schizophrenic also. And then she said she loved me … And she really wasn’t that clear, she didn’t talk that much. So I was kind of taken aback. Because sometimes you don’t think that they are really paying attention … Are they getting it, are we getting each other? And so she had developed a comfort level with me … It made me feel … that it was of some meaning to her, that I gave her some meaning…

Maintaining boundaries while not threatening the patient with their condition:

How do I do that? Boundaries can be problematic for Donna; she is not sure how to re-balance the relationship if patients want to become more personal. Donna would
appreciate help to organize her interactions with her patient to make clear that she perceives the patient as an individual beyond their mental illness while she maintains the relationship as clinical and therapeutic.

I just try to not make reference to them being a patient often, because then they say, “You just think I’m crazy, and you just think I’m not normal.” I just try to stay away from those terms, and make them feel comfortable. And it’s tough because then sometimes … they try and take the relationship to another [level]. I just kind of ‘remind you actually that I’m your nurse, and you’re my patient.’ So sometimes they get so comfortable that it’s tough to try and make someone in a locked facility where you are wearing this big nurse badge, and hey, “How’re you doing today?” like we’re here for, you know …

*The nurse looks for a way to maintain boundaries and communicate therapeutic intent.* In this balance of being interested in the patient in order to get to know them as a person, the nurse has to find ways to organize their approach and communicate therapeutic intent to the patient clearly and consistently. When asked if she would use and take advantage of an approach that helps the nurse show clinical caring while not threatening the patient, or alternatively, getting close in ways the patient who has poor insight may experience as part of a personal relationship, Donna expressed agreement.

*Researcher:* … if there were a way to organize your own approach so that it really helped you stay clear all the time on what people call boundaries in a psychiatric, therapeutic relationship, you’d take up a way to sign-post yourself?
**Donna:** Yeah. uh-huh, [Donna nods yes]. Oh yeah, oh yeah [emphatically].

A question that comes out of this discussion is: what are ways to approach patients without threatening or challenging their experiences, while providing another view of those experiences? Amador’s view (2012) is to find something you both can agree on and share as a goal, the A for agree in his LEAP model. That way, the nurse can maintain clinical boundaries while creating a shared goal with the patient, bridging what the patient needs from the nurse’s perspective and what the patient wants from their own perspective.

*This nurse wants to lead the patient out of their psychosis within her therapeutic relationship.* Chanel explained how she interacts openly with patients. She also expressed self-doubt about her way of being with patients; she wondered if it is clinically acceptable. She shared her own experience wanting to lead a particular patient out of their psychosis within the context of her relationship with the patient.

… ‘Let’s do this together – put me in there so I can help you, and maybe we can do some type of matrix thing and I can hold your hand and help you come out of this’ … So I can help bring them out of it, it might not be the established thing to do… So I can help bring them out of it. I feel like at that point ‘you’re doing this by yourself, and now I’m here to help you, I feel like I was called to this, really: now I’m here to help you. … I feel like let’s get there, let me get there with you, don’t be afraid, open up to me, let me help you.’

*Is that okay to say? Dee, the patients love you!* In order to reach the patient in their present state of mind, to relate to them while they are psychotic, the nurse must be
present to what the patient shares with them. There is material to grasp within illogical talk that can lead the nurse to know more about who the patient is, and what their experiences have been. Listen to the psychosis. The nurse can then use this as interpersonal common ground with the patient, reflecting back to the patient that the nurse knows something about who they are as a person. This shared knowledge can then become the basis of a clinical rapport: the nurse knows the patient in ways the patient finds credible – and caring. Dee shared cautiously how secure the patients feel with her, as if somehow the patients’ deep feeling for her makes her comforting, non-threatening approaches clinically illicit or improper, and lacking boundaries.

Because this is very different: if we can talk about this – this is very different!

You must understand, at my age - past 40 - I’ve had people question me, ask me silly things. The doctors, they’re like, “Dee’s here - you’re going to be here; oh the patients love you.” Can I talk now? … I mean, is that okay to say that? Right! But you can’t always say that. The doctors will say, “Dee, all the patients love you – they love you! The patients love you.” I’m just being me!

*They become part of you in a way. Whether you are able to help or not is another thing: it is beyond your control. You just have to know where the boundaries are.* Rachel puts boundaries between her work and the rest of her life to keep perspective on the limits of what she can do to help her patients, knowing that she is doing her best to help her patients with a devastating illness:

Discussing all these situations and these people makes you realize you are helping people; whether you are helping them is hard to say, and whether you’re going to
see that you are helping. … And you’re playing a role in their care, and they’re involved with your lives, and your lives in their lives, so they become a part of you in a way. Although, you may be the best nurse you can be and do all this wonderful stuff, and it’s not going to mean anything because they’re not going to be able to follow through or get better because of the obstacles or their illness, cognitive ability, and their insight or whatever, but it just kind of makes you feel good that you’re at least contributing to society, and to people, and trying to help - whether you’re able to or not, is another thing; it is beyond your control - so, as long as you don’t take that personally, and get too involved … And you just have to know where the boundaries are, and where you say, okay, I’m doing the best I can.

*Some of these people are dealing with terrible things: It helps you keep perspective.* Rachel thinks that being a nurse gives her strength and that working with the chronically mentally ill people gives her helpful perspectives and insight on her own life. The perspective she has gained through working beside her patients who have to contend with so much makes her see things differently, and is helpful to Rachel.

My friends say, “You’re the strongest woman I know.” I have to say, I think it’s because I’m a nurse. … I see what some of these people are going through; so many more mentally and physically sick people out there that have insight or don’t have insight. Even if they have the insight, they’re still dealing with terrible, terrible things, and they’ve got to function in life. So it gives you perspective in your own life, and
your own view of your own life and how you perceive other people, and how you perceive the world and situations. It helps you keep perspective.

VII. **The nurses believed that the interview process influenced how they think about their practice.**

Only one of the eleven nurse participants reported that the interview did not influence their thinking about how they practice related to patients with psychosis and poor insight. When asked the last interview question, if the interview process in and of itself influenced his views on psychosis and insight, John simply said, “No.” He had allotted personal time for the interview and wanted to end the interview at that point.

The other ten nurse participants remarked on the interview process in various ways. The nurses’ views range from the interview process influencing the nurse to think about their practice in an organized way, to the interview process having a significant affect on how the nurse thinks about psychosis and insight, to the extent that the nurse produced their own questions related to the role of insight in clinical practice. Some of the nurses reported a significant effect on how they think about psychosis and insight, with possible influences on their future practice.

Interacting with the nurses in the interviews made me think about how talking about something changes it - going from intuition, to thinking, to talking, to organized explanations. The interviews provide examples of how talking about something can change thinking, and make intuitive nursing practice communicable and thus transferable and applicable beyond the individual clinician to nursing as a practice
discipline. The interview process itself may induce the nurse to arrive at clinical insights. Here, I report the nurses’ perspectives.

**Molly**

Clinicians sometimes use formal rating instruments to structure intake interviews with patients. Molly uses a mental status rating form in her own Emergency Room clinical interviews, and wonders about the accuracy of her “checkbox” assessments related to the patient’s insight. She also commented on how, in the past, she has left the patient out of the process of setting treatment goals. She connected that talking with the patient about what they want for themselves, their own goals, might be a good way to get some perspective on how they see the situation that brought them to the Emergency Room, in other words, to initially assess their awareness of symptoms and insight into their condition. She ends the interview by asking questions of her own about how she assesses people with limited awareness of psychosis symptoms and poor insight.

In the ER I do Mini Mental Status exams, I check a box: they have insight, they don’t have insight … It has fair, poor, or good, and how am I making that determination? Or am I just randomly checking the box? So, just to really think more about that when I make that assessment and also, as a psych nurse in the profession, is it something that we’ve done? Is it? Are we taught really how to assess that? What kind of questions do I ask, how do we make that determination? … The other thing is: my goals for the patient. … I think this is what the patient should do, or wants, but I’m not really involving the patient in that. And that
really would be a good way for me to make the determination about their insight … So I’m going to make that connection, as a result of this interview.

Molly analyzed her thinking as she talked about psychosis and insight throughout the research interview. She connected her own anxious response to the uncertainties involved in caring for patients with schizophrenia psychosis with her empathy for patients’ vulnerability when she asked, “Does my empathy then mitigate my anxiety, and help me be a better practitioner?” Finally, she extended her personal exploration of her practice with the hopes that research about psychosis and insight will influence nursing education and clinical practice development.

… I’ve always I’ve been aware of my own kind of anxiety in certain situations, and then I also I think I am a pretty empathic person … does my empathy then mitigate my anxiety, and help me be a better practitioner? And I’ve never quite thought of that, and I think it does. And is it something that is automatic, or how that occurs, I’m not quite sure, so I’m probably interested in exploring that as well. So I do think that this interview, and research, has helped me as a practitioner, and I’d love to find the results and see if that can help our education in the future, to be better practitioners, so thank you.

Rachel.

Talking in the research interview about her nursing practice brought Rachel recognition of what she knows; she expressed ideas that she had never thought about before. She reflected that nurses can be so busy that they do not stop to think about their practice and the things that might underlie problems for both themselves and the patients.
Because you can get so busy caught up with doing [what you have always done in] the past … it’s kind of helpful [to talk about it]. I think it’s helpful in the sense that it makes you just stop and look at the whole picture, and kind of see where people are at, because you sometimes are so busy doing your job and your tasks that you don’t really look at where people are at, at least we sometimes forget to.

*Donna.*

Having the opportunity to talk about psychosis and insight did not change the way Donna thinks, but it clarified what Donna thinks about psychosis and insight, and she is pleased with her thinking.

I usually just don’t get to talk about this stuff. You work, and then you’re supposed to leave it, then go home and forget about it until the next day. So I usually don’t talk it out like this. So that was – it was pretty interesting to see the things that I did think about, … because I usually don’t talk about it to this extent, so that was pretty cool.

*Chanel.*

Thinking and talking about psychosis and poor insight made Chanel want to concentrate more on her “favorite” patients.

It made me more aware of, it brought it back to life for me, and helped me realize personally that I need to get back into what I enjoy doing, working with the schizophrenic patients, and the emergencies that I really enjoy working with. … It energized me! Oh yeah, schizophrenia is my favorite area to work in with the psychiatric patients.
**Sophia.**

Intuitively doing something does not necessarily require that a nurse previously have thought about – analyzed and synthesized – the aspects of that practice activity. Thinking about something does not require the organized cognitive effort that talking about it does. When Sophia was asked about whether or not the interview process influenced her views on psychosis and insight, she explored what she thinks insight is in relation to psychosis and how she thinks insight relates to schizophrenia psychosis.

It made me think about it differently, I’ll be honest. … Tomorrow, I’ll be like, ‘I wonder how your insight is?’ … it’s interesting, it is, because … it’s kind of a hard topic to talk about … I found myself saying, ‘Judgment, well, insight’…and then, ‘Insight into your illness?’ ‘Insight into your behavior?’ … It’s interesting, it’s hard, it’s challenging … but, what is insight? What is, as a nurse, what’s your definition of insight? … It’s just not something we think about all the time and it’s in our conversations, and it’s in what we do, but to really pick it apart and think, think, think about it the way we did, it’s hard.

**Dee.**

When we discussed if the interview itself influenced Dee’s perspectives on psychosis and insight, she found the process rewarding but overwhelming. The interview questions and process addressed aspects of psychosis and insight that required Dee to talk about her practice in ways beyond intuition.

It enlightened me! To really think about my daily routine, and my self as a professional, yeah, my ethics, it’s all there, but to really process it. So it was
enlightening for me, it was rewarding. … But it just shows how complex it is, because we are moving into the twenty-first century.

Dee wanted to add her own questions about using touch with psychotic patients to my list of research questions. She is interested in how touch and spirituality fit into and can be used to care for patients.

Asking, I think if that could be part of the interview, what people think about touch with psychotic patients that don’t have insight, just to see people’s professional, nursing professionals’ theory on that, the power of touch … the touch and the spirituality, that’s just me.

Hunter.

Hunter shared his thinking, experience, and perspectives on psychosis and poor insight in the interview. Hunter needs time to think about and process the interview. He may use this interview experience in ways he is not yet aware of. He is confident that the principles, the fundamentals of interpersonal relationships are the most important things to utilize when helping people with psychosis and poor insight. He also believes that continued learning and new knowledge must be used in conjunction with, and connected back to, fundamentals of therapeutic communication: respect, empathy, and compassion for the person with psychosis. If not, knowledge gained through actual practice may not be of use to the nurse.

I will now probably go home and talk to the windshield. … I’ll have to sit down and kind of just think it through, and say, Where is the opportunity for me to bring something out of that, either to give it to somebody, or to go read up on something
that I can incorporate and still give to somebody, or, wait for the opportune time
to do that. I know I will do that!

*Van.*

Van simply appreciated the opportunity to share her experiences regarding the
patients she works with; she did not think the interview influenced her views on
psychosis and insight.

Because I have been a psych nurse so long, I don’t think anything could really
influence me [Van laughed], to be honest. I have been a psych nurse sixteen
years, so I think it is nice to share my experiences.

*Oprah.*

Intuitive action involves a personal, internal process without necessary conscious
cognitive awareness. It is synthetic, not analytical. In the research interview on psychosis
and insight, Oprah had to think first in order to describe what she does, how she does it,
and why she does it. The interview process took Oprah beyond intuition; even though she
said her views were not influenced by verbally expressing what she does every day in her
work, Oprah’s approach can now be shared and communicated to others.

Well, I think the only influence the interview had, was it made me think about
what I do, rather than just do what I do. That’s the only way I think that it’s
influenced me, because I really had to sit down last night and think, okay, what do
I do? … I don’t think [the interview influenced me.] Because what I think, what I
do, is naturally me, and whether I thought about what I do, I just act naturally
because that is who I am.
Dolly.

Dolly described her interview experience positively. She ended the interview with a summary of some of the points she made earlier. She thinks it is important to wait until the patient is organized enough to talk about their illness. For Dolly, talking about how she cares for people with psychosis and poor insight validates her work as purposeful and worthwhile. She reflected that she was able to think and then talk about what she does beyond going to work every day and doing the best she can. She remarked that she has never thought about her practice as a whole.

It influenced me in a positive way because I did not realize what I was doing when I am getting the patient to trust, that all the little things that I do, from making them comfortable, to talking about hobbies or things, to wait for their mind to become organized where we can talk about the illness itself, and details of what we can do: I did not realize all the things I do, because you are just doing them in the moment, and you’re not thinking about what you are doing. You know your outcome, you know what your goal is, but you don’t think about all the little pieces that go in to make that goal. So it’s helped clarify to me, I do do something! Because sometimes you think you’re just going to work every day. It helped me clarify that I do make a difference in people’s lives, and maybe make a difference for the long term, and for their families, and our community. But I never thought about it that way; I thought about it as going to work, and doing the best you can, and not thinking about it day-to-day, as a whole. I never thought about it as a whole.
How Poor Insight Affects the Nurse-Patient Relationship: Pulling It All Together.

Oprah’s Story

A portion of one nurse interview summary is provided as a thematic summary for all three research questions addressing the nurses’ experiences related to psychosis and poor insight, their perceptions of what the patients’ experiences are, and how poor insight affects the nurse-patient relationship. Oprah described how she uses her own perspective as a professional nurse, to focus on gaining the patient’s perspective. She described her thinking as a means of catching a glimpse of how her compassion enters the territory of the patient’s experience and perspective, without losing her own perspective. She recounted how she uses her perspective on the patient’s situation and condition to partner with the patient’s perspective. Her practice stands out as an example of how the nurse’s clinical attitudes can affect the patient’s experiences of safety and comfort, and of being understood and cared for by the nurse.

The nurse-patient relationship requires time – precious time away from the electronic medical record. Unpredictability is psychiatric nurse-speak for dangerousness. People perceive danger the more a situation feels unpredictable to them. Dangerous situations can be experienced by the staff when a patient’s behavior is deemed as not predictable, or, by the patient when they cannot easily predict staff behavior or know what to expect from the staff. The more unpredictable a situation is to the staff or the patient, the more danger it holds for the staff members and the patient. Conversely, when patient behavior is predictable, the staff members think they know what to expect; the clinical team members may be more apt to assess the patient’s needs accurately, and
design care and implement interventions that support patient healing and progress.

Patients and staff alike need to know what to expect of each other, and the more predictable both the staff and patients are to each other, the calmer and more therapeutic the atmosphere and environment are.

A basic way for people to become predictable to each other is to get to know one another. When people know each other, they become more predictable to each other. To know each other, the nurses and the patients have to be with each other, visible and accessible. The patients can observe and interact with the staff with less effort and greater psychological ease when the nurses are out among them in the treatment milieu, visible and easily accessible. Patients do not have to ask for the staff members when they are in their midst, and not in the nursing station. Oprah commented on one factor that affects how much time she has to interact with patients in the milieu, beyond the time she spends with them in nursing tasks like medication administration and documenting in the electronic medical record system.

… We have gone to a new computer system - all of our system’s hospitals - which is supposed to, in my opinion, it looks very good to the public, the electronic medical records. You know it is a propaganda that makes our hospital system look like it’s way more technology-advanced than other hospitals. But in fact what it has done in my unit is create enough computer work that it takes away patient-nurse time; it decreases the patient-nurse time, and increases the nurse being in the nursing station behind a computer. So, we don’t have as much time as we would like anymore, but we used to.
Time: We don’t get to know the patients very well anymore, except for giving meds. Electronic medical record systems may appear sophisticated and advanced, but more nurse time spent on documentation is time not spent with patients. Less time spent with patients results in less opportunity to get to know the patients well - outside of task-based interactions like giving medications - and less time for the patient to get to know the nurse. If medication administration is the time the nurse spends with the patient as an individual, the nurse-patient interaction is then couched most consistently in medication administration by the nurse, and medication taking, by the patient. Oprah describes the interpersonal nurse-patient situation this way:

We don’t get to know them very well anymore, unfortunately. My contact with the patient now is: I will make rounds in the morning of my assigned patients, and just check-in with them, and make sure they are breathing, and alert, standing, not falling on the floor, and just make sure that things are copasetic for the time being. And then at ten o’clock, I will make a med round, and during that med administration, I’ll ask questions about, ‘How are you doing today? How was your sleep last night? Are you still hearing the TV talk to you? What is it saying?’

Getting to know patients is limited to group interactions and giving meds. There is limited time, and therefore, limited opportunity and investment in getting to know the patient as a person, as an individual. Interactions in group settings are another way Oprah gets to spend time with her patients and get to know them. Beyond interactions around giving and taking medications, the sum total of the interaction with
patients, then, is Oprah’s initial check-in time at the outset of the shift, and seeing the individuals in therapy groups.

… Sometimes I’ll be assigned to a group. We try to have three groups a day – I learn more about my patients during group … I’ll learn more about all the patients at that group, so we learn a little bit more, because we will ask the patient to tell why they are here - if they want to share - why are you here, what brought you here, and what do you want, what do you think you should work on today, what is your goal that you would like to set just for the day. And then, that basically, besides a few other med administrations at other times during the day, that’s all the interaction I have with my patients.

Shooting the breeze with the patient, you learn a lot that way. But we don’t have time for that kind of thing anymore. The average length of a hospital stay in Oprah’s in-patient psychiatric treatment program is about one week. This time can range from two to three days at the shortest, to about a month at the longest. Before the introduction of the new documentation system and related responsibilities, Oprah used to construct other ways to interact naturalistically with her patients, to create more opportunity to spend time with and get to know them as individuals.

Well, I would say the average stay is about a week. You know, we have some patients that only stay two or three days, and we have a few that end up staying a month, but those are usually placement issues or disposition after discharge issues. So no, I think that we definitely need more time with our patients, definitely. Just more time to sit around and maybe do a simple task together. You
know, like, “Can you help me fold these towels?” And as we are folding the towels, we’re just like shooting the breeze. You learn a lot that way, but we don’t have time for that kind of thing anymore.

This apparent, non-purposeful, non-goal oriented interaction - busy work - is a means to establish the important personal relationship with an individual patient. The goal of this more personal relationship is to get to know the patient as a person. Nurses work with patients’ strengths and unless the nurses get to know each patient from their own perspective, the nurse is left to work with generic, prescriptive, program-based interactions like giving and taking medications. If the only time a nurse spends with a patient is when giving them medication or interacting with them in a group setting, the nurse-patient relationship may not withstand the challenges of poor insight, where the patient must have confidence in the nurse to allow the nurse to positively influence them.

The nurse learns more about the patient in a peer-to-peer, friend-to-friend relationship but we don’t have time for those interactions anymore. Patients with psychosis and poor insight may not want to take medications or receive clinical treatment because they experience no need for medication or treatment. Knowing a patient as an individual person, from their own perspective, and what the patient describes as their interests, hopes, strengths, and past experiences is especially important when working to gain the patient’s confidence. In order to have a positive influence on the patient, the patient must have confidence in the nurse. The patient with schizophrenia who lacks awareness of and insight into the effects of their symptoms may be difficult to clinically influence; a substantial therapeutic relationship is essential in order to engage the patient.
in their own treatment. Oprah relies on her ability to learn about patients as individual persons when she is “shooting the breeze” with them.

When you are shooting the breeze? You can learn a lot of things, because you share – it is more of a peer-to-peer kind of relationship at that point, and they will tend to share more about their background and what is going through their minds, and what their beliefs are, and what their wants are, than when they are formally interviewed as a nurse-to-patient kind of relationship. It is more of a friend-to-a-friend, so they are more open. I think you learn the most during those kinds of interactions, but we don’t have very much time for those interactions anymore.

**Just passing time with the patient: You learn more that way.** The more time the nurse spends with the patient, the more the nurse learns about the patient. When the nurse is unable to spend much time with the patient individually, they may not learn much about what is important to the patient, and how the patient perceives their own experience. Nurses need the patient’s point-of-view to work with, especially to keep track of what makes them anxious, afraid, and reactive. Without time to observe and be with the patient, the nurse has limited information about the patient and the patient has limited interactional experience with the nurse; these limitations may affect the development of therapeutic relatedness. Oprah explores why spending unstructured time with patients is so important to her ability to know what the patients’ experiences are.

Well, I think that when somebody is not guarded - when your patient is not guarded because they’re not being interviewed, they’re just passing time with you, focused on something else, like you’re folding towels, or you’re counting
pencils and putting them in boxes, or whatever the rote task is - then you can share more of your personality, and you learn a lot more that way. A person is apt to tell you why, why he did what he did, because you’re not, you’re accepting, and you’re non-judging, and you’re like friend-to-friend, and you’re also sharing a little bit of yourself. So it’s some give and take, a peer-to-peer kind of thing. You learn more about the motivations, and what exactly the psychosis is, and what the outcome might be, based on what they’re thinking and doing.

**Knowing the patient’s thinking goes a long, long way to help you make them feel not threatened and relaxed. You’re going to be more effective.** Oprah is describing an interpersonal process that allows her to make predictions about immediate and perhaps more distant, future possible options and behaviors the patient might engage in. This is what she means by “what the outcome of the psychosis might be,” implying that the patient is more apt to talk about what they are experiencing and what they think those experiences mean and how the experience may be affecting them, in a less structured, goal-oriented conversation with the nurse than in a formal interview. In this way, Oprah not only gains important assessment information about the person’s potential for aggressive, reactive behavior, but she also learns about the things that are personally important to the patient. She gains therapeutic perspective, and potentially, interpersonal leverage interacting this way with the patient. Here is an example of how Oprah gains a view of and uses the patient’s experience and perspective.

… I want to use this TV example because that seems to be more common! If a person thinks that there’s a newscaster on TV that’s giving him messages of what
to do, if you can find out what the latest messages have been, if the newscaster has been talking about that kid in Boston that killed all those people at the marathon, if he’s been hearing messages about that, and he’s thinking, Okay, so I’m supposed to be doing that, you could pretty well predict that his behavior is going to be something in the violent range, rather than going to the desert and trying to extract water out of the cacti – that’s not the messages he’s been receiving. … I also wanted to add that if you can establish kind of a peer-to-peer relationship by spending time with that patient, the next time that patient acts-out, you’re going to be way more effective at controlling the behavior, maybe controlling that patient’s thought process, making the patient feel relaxed and not threatened, and safe. You know, I think that goes a long, long way.

Conversation is necessary with people who have psychosis and little insight. The more conversation the nurse has with the patient, the more information the nurse has about the patient’s experiences and perceptions, and what the patient thinks their experiences mean. This gives the nurse information about the patient’s cognitive and delusional processes, their logic, and how they perceive things are connected. When the nurse has a conversational relationship with the patient, the nurse is more apt to be able to validate the patient’s perceptions, or at least aspects of their perceptions that have a basis in reality. If the nurse can validate even aspects of the patient’s experience or perception, the patient may feel more secure with the nurse, and gain confidence that the nurse is interested in and understands them. This may create more authentic influence by the nurse and heighten trust in the nurse-patient relationship, based on the nurse knowing the
patient as an individual person. This therapeutic relationship may enable the patient to return and interact with the nurse again, to get follow-up, to receive care, including medication and symptom monitoring.

**Talk to them as a friend or a peer rather than as their jailer.** The nurse must have a therapeutic relationship with the patient based on knowing them as a person. This relationship is what makes interaction around the patient’s symptom experiences possible when the patient needs help, when the patient is in their most alien, psychotic realm of experience that other people cannot share. They are experiencing their own psychotic experiences, perceptions, and beliefs that separate them from others. The patient requires a relationship to withstand the challenges of this seemingly unbridgeable cognitive, emotional, and psychological divide. If the patient has confidence in the nurse, the patient may take direction from the nurse, and allow the nurse to guide them even when they have poor insight into their illness and symptoms. While the patient is still vulnerable because of their symptoms, Oprah describes how she uses her relationship with the patient to help the patient open-up to reality testing; she explains that the nurse must relate to the patient as an equal, a whole person worthy of respect, and not as a

… professional-to-locked-in-person. Because I am sure that they just feel that they are locked in, and, “I can’t get out of here, I don’t know why; they’re my jailers.” But if you are more on a friend-to-friend, or peer-to-peer kind of basis, they are also more willing to accept the fact that maybe what that voice is telling them, maybe that is something that is sort of a trick-of-the-brain, rather than something that is really real. … Because if you are talking to them as a friend or
as a peer - rather than their jailer trying to cram beliefs into their head - they might be more accepting of what you are saying, and maybe, a little more introspective: “Maybe what they are saying is true, maybe I am not really hearing that. Maybe, maybe, I just think I am hearing that.”

**Two people on the same level; we are the same.** Describing the nature of and motivation underlying the therapeutic relationships Oprah develops with her patients is crucial because her relationships are the basis of her influence on the patient and the context for her therapeutic patient advocacy. The patient is a person to Oprah, a person whose identity is not limited to being a patient, a sick person. She is interested in who the patient is as a specific person, and she gets to know each of them as a person, not a patient. First and foremost, Oprah is interested

… in them as a person. … Non-judgmental, on the same level, two people on the same level, speaking with each other. You’re not bad, and I’m not good. We are the same. Just share your experiences with me, and I will share my experiences with you in a non-judgmental kind of way.

**They don’t need to feel like a sick person, and I don’t want to feel that I am a level above them in any way.** Psychological and emotional boundaries are a cornerstone of clinical relationships. Boundaries are used to focus the therapeutic relationship on meeting the patient’s needs, and not the professional’s. This is the case in all clinical relationships, and especially psychiatric clinical relationships where the therapeutic use of self is a tool of interpersonal healing. Emotional boundaries also help the patient stay focused on their own needs and not become enamored with the nurse. The patient is
vulnerable to experience the nurse as a personal friend beyond the clinical relationship because they feel safe, understood, and cared about. Oprah bases her ability to positively relate to vulnerable people who have psychosis and poor insight on how she relates to them as peers or friends, and how she relates to their psychotic symptoms as real experiences for them. This is how she establishes and maintains her authenticity as a person and her genuine interest in the patient’s needs, and not her own needs. In this interesting explanation, Oprah contrasts what she thinks about boundaries as commonly characterized in psychiatric clinical practice and how she uses boundaries to help people with psychosis at their most vulnerable time, when they think they are not “sick,” but may be very anxious, scared, and alone.

The boundary thing? … I am very bad at maintaining boundaries. I will approach a patient on a more personal level. I am known to hug a patient, touch a patient’s hand, or put my arm around a patient. I will share things from my own personal experiences that are similar to what they might be experiencing, just to show that I have the ability to understand. I try to empathize with their feelings: ‘Oh that must be really scary, I can’t imagine how scary that would be to feel that way.’ I don’t really maintain good boundaries at all. I will share more of myself probably than I should. … Well, they tell you in psychiatric nursing that you really have to - I don’t really know how to put that. … Well, you really shouldn’t share an emotional relationship with your patient. You should be more clinically separated from the patient. I don’t really know how to put it. I share more of my emotional self, and more of my own experiences, emotional experiences, than I should. I
don’t maintain that ‘I am your nurse, you are my patient - I ask the questions.’ I don’t maintain that boundary. … Well, I am referring to the psychiatric training that I’ve had, and studying for my certification. And all these textbooks and experts imply that you must maintain your boundary. You are the nurse, the professional; the patient is the sick person. I – they don’t want to feel like a sick person, and I don’t really want to feel like I am the professional, that I am a level above them in any way. So I don’t behave that way. I don’t know. … I just do it. I don’t know that I think about it. … I don’t even think about that – it is just the way that I naturally approach things.

Paradoxically, Oprah is describing not poor boundaries, but boundaries drawn to focus on the patient’s need for validation and normalcy. She draws boundaries to give the patient access to her own experiences as a way to validate their experiences of being scared, alone, and not understood. She reflects back to the patient her own empathic experience that they are not alien and alone, and helps the patient feel and know that they are having experiences akin to other people. Oprah relates to the aspects of the patient’s experience that she can genuinely share, and then as patient and nurse, as two people, they share this experience as therapeutic, communal property. Only a clinician who keenly perceives the patient’s need for understanding, validation, and interpersonal safety can meet the patient’s needs on this level without trespassing professional boundaries.

**Instill hope; do not refute what the patient shares.** Another way that Oprah helps patients to feel understood while they are psychotic is to not refute their experience, but rather, explore their experience so she is more confident that she understands what
they are going through before she addresses their symptoms in any way. She normalizes
the person’s experiences, relating that the situation is serious enough to bring them to the
hospital. Without labeling their symptoms, she lets the person know that what makes
them different makes people uncomfortable. She instills hope in the patient that this
situation can change so that other people are not threatened by them. Here is another
example of Oprah’s natural, non-judgmental approach to help the patient feel that they
are normal even while they may experience tremendous alienation during their psychosis.

Well, I try to be, and I naturally am very non-judgmental. I don’t refute what they
share with me. I try to understand how it feels to be like they are. I try to give
them the sense that everyone is different in their own way, and that the
differences that they are experiencing may have been severe enough to bring them
to the hospital. But, I try to give them hope that that is not the way it is always
going to be for them. I try to impart the knowledge that [Oprah pauses] - because
they are, their particular difference from other people makes other people
uncomfortable - that there is something that can be done so that they don’t make
other people threatened. They can continue what they - this is so hard –

**Be gentle and forthright about why people think they need to be segregated
from others; the focus of therapy is to control the thoughts that threaten others.**

Oprah’s gentleness is matched only by her forthrightness. She lets her patients know that
everyone is different, and by generalizing their differences from those of other people,
Oprah makes their psychosis symptoms less untouchable. Oprah reframes the symptoms
of psychosis as “differences that can change.” This normalizes the “differences” of
people with psychosis from those of other people. She explains to her patients that symptom control is an entryway back to belonging to life.

I don’t know - they can control what it is about them that makes people uncomfortable and feel like they need to be segregated from others. And in that way, I feel like I am not criticizing their differences. But that I am just giving them hope that they won’t, they don’t always have to be [Oprah pauses] seen as so different that they don’t always have to be locked-up. They have just the same rights and the right to have the feelings and the thoughts they have, as everybody else does, but that - I don’t know how to say this - since their thoughts are so different, or so threatening to other people, that they just need to be controlled. No, they just need to learn to control them, so that they won’t end up in the hospital again.

**Identify with the patient: This is how to interact.** Oprah explains to her patients that something can change to make other people more comfortable with them again. She does this without ostracizing or criticizing them, without making them out to be the problem, or putting them off. She does not indicate that there is something “wrong” with them; she does say that there is something about them that makes other people uncomfortable, so that they are sent to the hospital and segregated from others. She lets the patient know that these things that have made others uncomfortable and brought them to the hospital are controllable. If the patient is cognitive disorganized, Oprah is careful to clarify what the patient is saying, or more importantly, what they mean. This is an example of how Oprah interacts with people who have delusions and paranoia.
Well, I guess I try to identify with them. You know, I can say, ‘I know you think that everybody is trying to poison you; I don’t know of any reason why anybody would want to poison you - and I certainly don’t want to poison you - so, what do you think would make your fear go away, that people are trying to poison you?’

Well, I usually get an answer like, “Well” [Oprah takes a long pause], “I honestly can’t come up with an answer to that.” … And in a case like that, I will sit and I will try to figure out what it is they are trying to say. And then I will say, ‘Did you just say that “blah, blah, blah;” am I understanding, is that what you are saying? Did I understand that right?’ And then they will say something else, totally unrelated, right?

**Just two people together: How to show sensitivity to the patient’s anxiety and support in silence.** When patients struggle to verbally express themselves, this may indicate that they are cognitively disorganized or are not aware that what they are experiencing is a symptom, a delusional perception. This is a key indication that the person is not aware of their experience as a symptom; this is what anosognosia and lack of insight are. If the nurse asks questions that are beyond the patient’s ability to follow and understand, or challenge the patient’s perceptions, the patient may become uncomfortable and anxious, and withdraw. Oprah stops talking if she senses the patient is struggling, or she will re-organize and rephrase what she thinks the patient may be getting at. If the patient responds with a whole other line of thinking or changes the subject, Oprah takes this as a sign of anxiety and backs-off. She then uses a quiet, comforting silence as her response:
Usually I will just back-off for a while; a lot of times you just have to support in silence. You know, sometimes you just have to sit there with them, not challenge them to answer a question; just to be comfortable, you don’t have to say anything, I don’t have to say anything - let’s just be two people together. No challenges. … I use the word okay a lot, or ‘That’s alright,’ ‘Okay, that’s alright,’ when they have a threatened look in their eye, or a scared look in their eyes, and they can’t explain what it is: ‘It’s okay, it’s alright,’ just in kind of a comforting tone, “You will be alright.”

“Supporting in silence” infers that Oprah is not challenging the patient with further questions, and by “backing-off” she is being clear that the patient does not have to answer her questions. She is letting the person know that she does not mean to make them uncomfortable, and she makes it clear to the patient that the conversation is controlled and guided by both of them, not only herself as the nurse clinician. The goal of the interaction is simply to be “two people together,” presenting no challenge to each other, just to be comfortable together.

**Let it be: Monitoring the patient to know when to leave it alone.** In situations where the patient is so disturbed by internal stimuli that they cannot tolerate being around people, they may withdraw to protectively isolate themselves. Oprah takes social pressure off the person by interacting only briefly and when necessary, offering to help the patient with what they may need or want. If the patient does not answer, Oprah “backs off,” and monitors them unobtrusively. Here, Oprah gave an example of how she interacts with a young man who chronically experiences threatening auditory hallucinations.
Well I can tell you we have a patient on the unit right now, a male, a young male maybe thirty years old, who has been pretty much non-functional all his life. He still lives with his parents, and the latest voice that he hears is the voice of his mother, describing sexual acts between herself and him. And it is freaking him out. And I can tell by the way he is moving around, isolating himself from other people, he is trying to find areas that have less environmental stimulation. He tends to hang-out in the darkest, least inhabited, quietest area of the unit, and he is just pacing. I can approach that situation, and I did approach that situation and I said, ‘How are you doing?’ And he didn’t answer, but he was still pacing. ‘Is there anything I can get you?’ Still pacing, not answering. So I just backed away, and went where I could still see him, but I wasn’t communicating with him, I was just sitting there. I think actually I had a clipboard in my hand, so I started doodling, just so I could keep an eye on him, but I wasn’t challenging him. So sometimes I just leave it alone; I mean, I make sure he is not going to hurt himself or anybody else, but I just, you know, let it be.

*Let them come to you.* Any interaction can be a challenge or a threat to a person who is psychotic and pacing. Pacing is an agitated behavior that the patient may not be able to express or route in any other way. Having to socially, especially verbally, interact is effortful, and can be stressful, challenging, and threatening in these instances. If the clinician speaks to the patient when they are psychotic and pacing, the patient may react as if the clinician is provocatively challenging them; the clinician may lack sensitivity and not perceive that this is all too much for the patient. The clinician may not be aware
of or know about the particular strain the patient is under, secondary to their symptom experiences. The patient may be working to maintain self-control and is agitated: leave them alone and monitor them; let the patient come to you. Oprah described how she monitors and responds to an overwhelmed patient who cannot verbally interact – she lets the patient observe her, and come to her in his time.

Well, that particular patient, I don’t know, after about five or ten minutes, left the area where he was, and came and sat across from me in a chair. So we were sitting across from each other in the hall. And he didn’t say anything and I didn’t say anything. … So, in a way, I think what I did was comforting to him, because he was no longer pacing. He was able to sit.

**Instill hope: Segregation is the community’s “fault” not the patient’s.** Oprah seems to understand how anosognosia can affect people with schizophrenia. In order to be able to establish a therapeutic relationship with the patient, Oprah is motivated to accentuate and relate to the patient’s personhood, not their symptoms. Oprah instills hope through her relationships with patients: she creates and maintains that a healing relationship can be shared with the clinician and the patient who lacks insight into their psychosis. She does this by focusing on the patient as a person, and their personhood, and not their illness or symptoms - she does this rather than focusing on “wrong” thinking or “sick” thinking. She does not expect the patient-person to realize that they have symptoms in the short time they are experiencing a psychiatric crisis in the hospital. What she does not do is as important as what she does do. Oprah does not threaten her patients with their symptoms, she does not challenge them with the expectation that they
come to recognize they have psychosis symptoms, or to see themselves as the clinicians see them. She works positively with people who have psychosis and may not have the brain-based ability to understand that their experiences are symptoms of psychosis. Oprah moves the responsibility for the patient’s “segregation” in the hospital from the patient “to the patient’s community” this way:

And I think that’s what I was trying to get at: I want them to know that there’s hope that things will get better. Not because they are a bad person, or that their thinking is wrong, or their thinking is sick. It is just that their thinking is just different enough to make the rest of their own society - their own community - whether it be their relatives or the people they work with or live with, to feel that they need to be segregated. Well, the segregation is the end point, and that is what you want to avoid. So, if all you have to do to avoid being segregated is take one of these pills three times a day, hey, that’s easy to do. And then you don’t have to suffer the consequences of these other people thinking that you have to be segregated from them. It takes the fault, off of the patient and puts it on to the patient’s community.

We are in cahoots because we are friends. Goals in reverse: Make them feel that they are not sick; the outcome is that they may take meds and then stay out of the hospital. The goal of Oprah’s relationships with her patients is that the patient comes to trust Oprah, and the hoped-for outcome of that relationship is that the patient trusts Oprah enough to take medications and stay on medications to keep out of the hospital. She focuses on making the patient feel like they are not “sick.” She explains that her
relationship dynamics work to achieve the outcome of the patient taking medication and staying out of the hospital because she relates to the patient as a person, as a friend. The patient learns to trust her, and is able to use Oprah’s point of view regarding how things work in a way that the patient can manage, and benefit from:

Well I think my goal, my process, is to establish enough trust between that patient and myself, that even if it is illogical to him to take these pills three times a day, he and I are in cahoots enough that he trusts when I say, ‘If you take these pills three times a day, they are not going to send you back here,’ that he will remember that, and go, “I don’t really need to take these, but if this is going to keep me from coming back to the hospital, I will do what [Oprah] says and see if that works.” And go home and be compliant: that’s my goal. I mean, establishing trust I think is the key and making them feel like they are not sick, is the goal, and then the outcome is that they will comply with medication, because they trust you enough that you have instructed them what to do, not to end up back in here again. Because we are friends: “[Oprah] wouldn’t have told me that; I’ll bet you maybe this is going to work, because she, she said that.”

Reversing perspective: How Oprah came to understand that we are the ones who are different. Making patients with schizophrenia take medications when they have anosognosia and poor insight may be detrimental to the development of a trustworthy clinical dependency on the nurse and the ultimate outcome of the patient taking medications and staying out of the hospital. The patient may experience that they have been forced (psychologically or physically) to take medications and may reasonably
develop avoidance and even resentment when this occurs; they may have had repeated
exposure to psychiatric clinicians urging them to take medications or having psychiatric
medications forcibly administered when they see no reason for taking the medications.
Oprah shares a personal story to relate why she thinks that making patients take
medication when they have poor insight is generally a wrong clinical action.

Well you know, I think it is because I grew up with very authoritarian parents.
And I think that’s a very bad way to parent because I knew I had to do what they
told me, but I didn’t understand why. And that builds a lot of resentment. You
know if I understood why, then maybe I could go, ‘Oh, yeah, okay, well I need to
do that.’ And the clinician-versus-the-patient relationship, most of the time, we’re
telling them what they need to do. And we basically force them to do that while
they were in the hospital. But they don’t understand really why, because they
don’t have any insight into being any different – we are the ones that are different.
They are the ones that are normal: we are the ones that are different. So when they
leave, of course they’re not going to be compliant. I think it has to do with
understanding, and peer-to-peer, and being friends together, and being trusted,
not, ‘I say this; you have to do this.’ I don’t think that works.

Telling patients “what they need to do” while they are in the hospital is a kind of
force imposed on the patients by the staff. Oprah consistently focuses on how the patient
perceives the nurses and hospital staff and the hospitalization experience to limit sources
of force. While psychiatric clinicians see the patient’s point of view as illogical, as a
symptom, Oprah reverses the logic by transplanting herself into what she imagines the
patient’s experience of the hospitalization might be. She works to understand the patient’s experience and view of the treatment experience: this is her clinical response to the patient’s need for understanding and trust. She clarifies the patient’s perspective and works with the patient’s perspectives before she introduces the notion that taking “these pills three times a day” will keep them out of the hospital.

**Force makes things worse. Understanding why something (like taking meds) is important.** Oprah does not know if her use of the patient’s own delusional symptoms, e.g., being poisoned, as a rationale to take the medication continues to sustain the patient’s compliance with medications after discharge from the hospital. But using her approach, the patients do begin to take medications while in the hospital without being psychologically or physically forced to do so. Oprah does not put the rationale for taking medications in the usual clinical terms. Oprah thinks that her use of the patient’s own symptoms as a rationale to accept medications – “People won’t want to poison you anymore” – influences the patient to cooperate with taking medications. She thinks that the patient can understand the reason for taking the medication when it is couched in their own experience, and framed in the way they understand the world to work. When we understand the reason for doing something, we are more apt to cooperate. Oprah makes the reason for taking medication reasonable to the patient; she uses the patient’s logic to offer a rationale in the terms of their own experience.

I use my own personal experience. I will, I would be way more apt to do something when I understand the reason for it, than just because someone told me I had to do that. … There are a lot of nurses - well some nurses I can say - I’m
sure a lot of nurses get into a power struggle with the patient: “You do this because I told you to do this.” You know, I don’t think that works at all – I don’t think that works at all. That makes it worse. You may be able to take down a patient [in a physical restraint hold] and [physically] force medication on them, but that is not going to make them any more willing to take medication the next time, unless the medication is that effective the first time, you know.

Oprah thinks that we need to work to understand what the patients understand before we start instructing, teaching, guiding, forcing or cajoling the patients to “comply” with psychiatric medication and treatment. We need to understand what the patient understands, first and foremost. Once we think we understand what the patients are experiencing, then we can begin to understand their perspectives, and how they see things, how they experience things. To positively influence a patient, clinicians need to understand the world as the patient understands the world; clinicians need to show the patient that they understand what they are going through by validating their experiences. By doing so, the clinician shows the patient that they understand what is important to the patient, what the person’s values are, and that the clinician will not take over the clinical “friendship” relationship in a controlling way. Within a shared clinical relationship, the clinician and patient can work together toward what the patient sees as important, including taking medication for reasons that may make sense to them.

**Oprah’s egg story pulls together the who, what, where, when and how to help psychotic patient and poor insight.** One of Oprah’s most memorable experiences working with a person with psychosis and poor insight involves eggs. Her egg story
describes how Oprah is careful to not only approach the patient just to administer medication, but to spend time to get to know this person and how she thinks about the things that happen to her. Oprah shows respect for this person by taking an interest in what she thinks about and how she arrives at her perspectives on situations, like the eggs.

Well, we did, and this actually wasn’t this long ago, we had a schizoaffective patient. She wasn’t really elderly, she was probably in her mid-sixties - that’s getting younger and younger all the time to me [Oprah jokes] - but she had been dysfunctional enough that she was in assisted living. And she had been in assisted living for years, and she got kicked-out of the assisted living because she was throwing eggs in the breezeway of whatever the facility this is. So they sent her to the hospital, they had her temporarily detained [through the court]; they sent her to the hospital, and they were not going to allow her to come back to that facility anymore. And she was really angry when she got there. And she wasn’t going to take her meds: ‘That’s okay, alright; you don’t want to, maybe you will want to later.’ So I would approach her at different times during the day, and it was not always about the meds. Sometimes I would go up and say, ‘Well what are you watching now?’ because she would be watching TV, ‘What’s going on?’ that kind of thing. And she would react angrily, you know: “Oh - oh, I don’t know, it’s none of your business!” or, “What are you asking me that for?” or whatever. So eventually I started approaching her saying, ‘You know you really seem like you are angry with me. Is it something I did? Something I said?’ And she said, “No I threw eggs.” I said, ‘You did?’ She said, “Yes, but there were only two of them
and they were brown.’ [Oprah laughs with the researcher heartily.] I said, ‘Okay, is that why you are here?’ ‘I guess so.’ ‘Okay,’ [said Oprah]. So the next time I approached her, I said, ‘Why did you throw eggs, anyway? What made you throw the eggs?’ She said, ‘They gave me three green ones, and I wanted pinks.’ I said, ‘Oh, three pink what?’ ‘Never mind!’ ‘Okay, well I guess that was disappointing if you got what you didn’t want, and you didn’t get what you did want.’ She said, ‘You’re not kidding me, you’re not telling me.’ So we just sort of danced around, you know, we were just having a little conversation in little tiny tidbits, like every couple of hours or so. I think she got so used to me coming up and asking her questions, and she would tell me something angrily. And I would go, ‘Oh yeah, it would make me mad too.’ Finally she started expecting me to come up and ask her questions. So I started coming up to her and sitting down and talking with her with the most crucial of the pills. When they come into the hospital, they will get a multivitamin, and a vitamin B, and potassium, and then their antipsychotics, and their blood pressure pill. I decided I was going to start with one blood pressure pill and one antipsychotic. [We both laugh.] I said, ‘Well you know, I decided that maybe you didn’t want to take all your pills, but would you consider taking these two?’ She wanted to know what they were. I said this is this, and this is this. And she picked up it up, and she went, ‘Oh! I haven’t seen you in a long time! How have you been!?!’ So she took that one with water, and then she picked the second one up out of the cup and she made some comment about it, and she took the second one. And I said, ‘That’s good, that’s great; so how are you doing?’
You know, and I just approached her very much like an acquaintance would come up and say, how are you doing? You know, I didn’t force her to do anything. I gave her space. When I felt like she couldn’t tolerate my presence anymore, I backed-off. If she seemed receptive to talking, then I would keep on talking. I would change the subject to something that had nothing to do with being here or taking her meds or, I would say something about the weather is really nice outside, but it is good you are in here because it is so hot! You know people are out there getting whatever that is - heatstroke - just something that didn’t have anything to do with why she was here. And see, that’s the way it kind of works with me. I kind of make them my friend, and then they are just way more liable to do what I ask. That’s how it works, that’s how it works for me.

Oprah does not psychologically threaten, force, criticize, challenge or otherwise back the person into a corner. She does engage, reassure, calm, compliment, and show interest in the person. Even when she distracts the patient from focusing on taking medication to talk about the weather, Oprah reframes the extremely hot summer outside as a good reason to be in the cool air conditioning inside. Oprah changes the subject to diffuse the possible tension related to the situation between “patient and nurse” in the more classical formulation of a clinical interview conversation.

**Oprah’s “how”: The humanity of it all.** Oprah makes herself approachable and relatable to the person. She provides the patient with choices and follows their lead. She will leave a subject alone, then go back often, being friendly and inviting without soliciting medication administration. She is friend-like. It is very hot outside; Oprah
showed in this exchange how she asks the patient conditionally, how she uses “would you like” and offers not just water, but cold water with medications:

Yeah, I don’t challenge them, don’t back them into a corner. … If you give them choices - that seems to work: ‘Hey, would you like this pudding? No - okay.’

Then go back a little later: ‘Hey, I’ve got two pills here; would you be, would you want this? I’ve got cold water you can take with it.’ You know, I don’t know if I am just being friendly…

When I asked Oprah about what was significant to her about the “egg story,” she said that it was memorable to her

… because of the way she picked up those pills and addressed each one like it was an old friend; because it was funny. … And then also the thing with the “three pinks and the three greens” - I never did find out what the greens and the pinks were about. … I just validated her feelings: ‘Well, that would make me mad, too!’

“I wanted the pinks, not the greens,” you know. … Three pinks and two greens, I think. … Three pinks and two greens! She was so funny!

**Patient violation: The two-edged sword of medication-over-objection.** Care approaches are not always well timed or matched to meet the patient’s needs, and Oprah indicates that the nursing staff will implement or impose the treatment program in a general way on all the patients without individualizing expectations for the patients “a lot of times, yeah.” Despite this, she also indicates that patients are not forced to participate in activities, especially if they are highly symptomatic. The exception to this approach is medication administration. Oprah has a particularly poignant view on forcing medication
on patients. She counters that medications do not have to be insisted onto people or imposed on them. She suggested that using the “soft” validation approach she described previously, i.e., to know the patient well enough in the midst of their psychosis experience to clarify their perceptions about their situation, and reflect back to them that the pills will make those things better, is what nurses should be doing with patients who are psychotic and are not aware of their symptoms.

A lot of times, yeah - I have to say, most of the time - because if there is a patient like that, we won’t, we do not force them to, we don’t force them to do anything, but we get really, the only thing we get really insistent with is medications. Well, eventually, usually, they start taking medications - just with the soft approach.

There is also a, I don’t know, it’s an injunction or something that is called medication over objection – oh I hate that – … “Medication over objection” where the magistrate will rule that yes, they must be forced to take medication.

And I always think that, that’s a two-edged sword: yes, they’re probably going to improve, their psychosis is probably going to decrease, in light of the fact that they’ve had several administrations of this medication. But on the other hand, on the other hand, I can’t imagine how traumatized they are, just by the physical administration itself. You know, you really feel, and I’m, I would imagine they feel, I feel like I’m violating them, and they must feel violated. [Oprah pauses.]

**Oprah is not typical.** Oprah believes that the patient is traumatized by physically administering intramuscular medications against their will. Oprah not only imagines that the patient feels violated, she feels that she is violating them herself. [Trauma Informed
Care approaches include the realization that trauma is widespread; that recognition of the signs and symptoms of trauma in patients, families, staff, and others is necessary to prevent inflicting further trauma via treatment; and that mental health professionals must respond to the trauma experience by integrating knowledge related to trauma into clinical policies, procedures, and practices; and that professionals actively resist re-traumatizing the patient (SAMHSA, 2015).] She commented that her strategy is not a typical approach to clinical interaction and treatment with psychiatric patients, rather, it is the way she meets people where they are while they do not recognize the symptoms of their psychosis.

Well, I don’t necessarily think that my strategy, my approach, is typical of everybody - that is just my approach.

They duck your head down to get you in the car. When asked if her experiences represent typical situations psychiatric nurses deal with, Oprah says that, “Yes, I do, I think my experiences are typical of all mental health experiences, in-patient experiences.” But the effect of Oprah’s experience of those “typical psychiatric situations” leads her to describe hospitalization-by-handcuffs, where patients may be following the law, yet when the police are called to intervene, the patient is brought to the hospital in handcuffs, a physical and possibly humiliating experience. The patient is brought to a place they do not know, cannot get out of, and all while surrounded by people telling them what to do. Trying to see the situation as the patients might, she described this as a terrible and scary experience.
Yeah, you know many of these people are brought in, in handcuffs. Can you imagine? How frightening that must be? [Oprah pauses.] Um! [Oprah pauses.]

You know, eh, I can’t image. I think that maybe I’m being Pollyannaish, but most people are upstanding citizens who follow the law, and don’t try to do things unlawful or wrong. Just because you are psychotic doesn’t mean that you don’t fall into that category. When you get picked-up from home, or wherever you are, and a cop puts your hands behind your back, and puts handcuffs on you, and they actually do duck your head down to get you in the car, I mean, it’s rather physical! I mean, why is that necessary? It is - not only are you putting your hands on somebody, but it’s kind of humiliating, you know. And then they are brought in, and to a place where they know they can’t get out, and people are telling them what to do: it’s um, it’s humiliating, it’s scary, it’s just, I’m sure, a very terrible experience for them. I don’t feel you do anything but try to gain their trust and be very gentle with them. That - you know - that’s what we should try to be doing – we should try to see it from their perspective. Try to put ourselves in their place, and try to imagine how they feel, and try to behave as if we would want others to behave towards us. [Oprah pauses.]

**Oprah is different. What can we learn from her?** Oprah admonishes psychiatric staff to try and see the hospitalization experience from the patient’s view, from the patient’s perspective. As a sensitive witness to the patient’s experience as she understand it, Oprah does not separate her experience from her perspective on how she thinks psychiatric nurses should interact with and respond to patients. She thinks we
should try to gain their trust and be gentle with them. She comments that she thinks that her perspectives on psychosis and insight do not represent those of most psychiatric nurses.

No, probably not. I always, in life, I guess, I’m very nonjudgmental. And I try to see other people’s perspectives as well as my own. I think I’m different in that way. Yeah, most of the people I am exposed to … are very judgmental. [They say things like,] “Do you believe he did that? You - I can’t believe -” Well, so, try to put yourself in that other person’s place: I can believe he did that, or, I can believe he said that. Just try to think how he’s feeling. I think I’m different in that way, because most people look at me like: you are such a weany. [Oprah laughs out loud.] I think I am different in that way.

**Summary of Chapter 4, Results with Discussion**

Oprah’s story provides segue to Chapter 5, Conclusion and Implications, Limitations, Recommendations, and Next Steps of this research on psychosis and insight. Her perspectives on human interpersonal fundamentals, those of sharing respect, dignity, equality with the patient, and to give the patient whatever meager control she can while the patient is in the hospital, set the stage for discussion of the clinical, educational, and research implications of this research addressing clinical relationships with people who have psychosis and impaired insight.
CHAPTER FIVE
CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS, LIMITATIONS, AND NEXT STEPS

This final chapter includes the study conclusions with implications.
Recommendations for clinical, education, policy, and research; limitations of the study, and a final statement regarding next steps in this program of research addressing psychosis and insight are described.

Conclusions

The purpose of this study was to understand nurses’ knowledge and conceptualization of the role of insight in schizophrenia, and nurses’ beliefs about how patients’ lack of insight affects the nurse-patient relationship. The literature review and my professional experience as a psychiatric nurse contributed to the creation of the conceptual framework for the study. This framework included the ideas that lack of insight impedes treatment; nurses who do not understand the role of insight may not help and may even harm therapeutic goals; and that understanding and appreciation of patients’ insight problems may positively influence care delivery. Qualitative interview analysis resulted in seven themes that described how the nurse participants believed that impaired insight affects the nurse-patient relationship.

The qualitative research literature on psychosis and Amador’s (2010-2012) Listen, Empathize, Agree, and Partner model intersect with the results of this study. As
discussed in the results section, the nurse participants described how they listen to, and empathize and agree with patients in order to partner with them in patient-centered care. Links between the themes discovered from the nurse interviews and the LEAP model are described next.

Themes I (the nurses believe that a therapeutic relationship is required to care for the patients with psychosis and poor insight), II (the nurses believed that they need to learn the patients’ stories to be helpful), and III (the nurses identified key aspects of communicating with patients who have poor insight), addressed how the nurses listen to, and empathize and agree with the patient. Theme IV (the nurses identified certain important elements and dynamics that should be part of the nurse-patient relationship when the patient has poor insight) revealed how the nurses gain access to the patients’ perceptions of their experiences through the development of rapport, and how the nurses use trust to help patients with their perceived needs. Theme V (the nurses believe that they administer medications and patients take medications within the context of the nurse-patient relationship) described the experience the nurses share with the patients around giving and taking medications, and how this interaction depends on the extent to which the nurses and patients Agree and Partner to address patients’ goals and desires.

Use of nursing interventions that interpret and support good listening, communicate empathy, help to forge agreements, and engage in patient-centered partnerships, actively focus on goals that the patients clarify with the clinician via the nurse-patient relationship. The LEAP framework is validated by the results of this study in how the nurses use aspects of their communication with the patients to elucidate
patients’ perceptions; how the nurses and patients bring together shared goals, despite differences in how the clinician sees the patients’ needs, and how the patients experience their own needs.

The results of the study also emphasized that nurses identify patients’ strengths, not only their vulnerabilities or weaknesses. The nurses conveyed the message to not address the patients’ weaknesses when the patients are vulnerable and symptomatic. The nurses chose not to challenge the patients’ perceptions when they are vulnerable. In this way, they helped the patients to build strength, and a sense of ability and willingness to engage as symptoms of psychosis stabilize.

Theme VI (the nurse-patient relationship affects the nurses professionally and personally) addressed how the nurses experienced their clinical work in the context of their own human experience, both as nurses and people. The nurses needed to maintain reasoned psychological boundaries when working with patients who have psychosis and impaired insight. This helped them focus on the patients’ needs.

Theme VII (the nurses believed that the interview process affected how they think about their practice) described how the nurses thought and talked about insight and psychosis, resulting in a formalization of their clinical practice that they were able to recognize and perhaps carry forward into future practice applications. This knowledge and these practices may be more accessible to the nurses who participated in the study, and be used by the nurses to clinically enhance their nursing care for patients with psychosis and poor insight. The nurses thought deeply about the interview questions, to enable them to articulate aspects of their practice that are usually not in conscious
awareness. They explained that they did not think about what they are doing much of the time. Rather, they intuitively practice interventions based on their experiential knowledge of what approaches succeed when interacting with and caring for patients with psychosis and poor insight.

**Implications**

Overarching threads reported in this study included dignity, respect, control, relating, and recognizing the patient as an individual person; these threads connect the seven themes, and relate to the nurses’ experiences of psychosis and impaired insight, the nurses’ perceptions of the patients’ own experiences, and the nurse-patient relationship. These phenomena apply to many people who are sick, especially the chronically ill, and not only to patients with schizophrenia and poor insight. And many of the interactions and interventions that the nurses described in the study are common to people who are sick. But it is the level or degree to which these fundamental aspects of nursing care become essential when the nurse cares for patients who do not recognize their illness or need for treatment. The nurse must create and maintain strong clinical relationships with patients to support the patient’s ongoing involvement in their own care. These clinical relationships must withstand the challenges of the nurse and patient not necessarily sharing experiential realities. The patient’s sense that the nurse understands them as an individual person may interact with, and may even determine, how and whether patients with psychosis and poor insight remain in treatment over time, and through illness exacerbations.
Weaving the threads of empathy, control, respect, dignity, and treating the patient as a person into the nurse-patient relationship may support more effective nursing care for patients with psychosis and impaired insight. The goal is not to impose clinical treatment on patients, but to collaborate in productive clinical partnerships with patients. The creation and maintenance of these partnerships requires time investment and nursing expertise. The partnership approach may keep the patient coming back and engaged in their care. This maintenance relationship might provide more consistent monitoring for changes in symptoms, aimed at the prevention of symptom downturns and psychiatric crises. Treatment approaches could be modified to possibly avoid re-hospitalization. Medications could be adjusted, frequency of visits increased, and phone follow-up could support ongoing engagement despite times of stress and crisis. The patient’s connection with their clinical carers could be maintained (Amador, 2010-2012).

The themes revealed in this study also comingle and parallel many aspects of Recovery Model principles (SAMHSA, 2012), paraphrased here:

1. Recovery emerges from hope,
2. Recovery is person-driven,
3. Recovery occurs via many pathways,
4. Recovery is holistic,
5. Recovery is supported by peers and allies,
6. Recovery is supported through relationship and social networks,
7. Recovery is culturally-based and influenced,
8. Recovery is supported by addressing trauma,
9. Recovery involves individual, family, and community strengths and responsibility, and,

10. Recovery is based on respect.

The themes of the research support hopeful, respectful, person-driven care, within the context of clinical relationships aimed at knowing the patient as an individual person, with particular strengths, hopes, and desires.

**Recommendations for Clinical Practice, Education, Policy, and Research**

**Clinical practice.** The results of this study indicate that practitioners can use Amador’s (2010-2012) Listen, Empathize, Agree, and Partner model to care for patients with psychosis and impaired insight. Integration of the LEAP model concepts into clinical programs and practice may assist programs to develop and apply expectations that match patient capacity, and support patients’ engagement in their own treatment.

Inpatient nursing care should include the awareness that nurses must create and maintain strong clinical relationships with patients to support patients’ ongoing involvement in their own care. In turn, patients may be more willing to accept treatment for symptoms and conditions that they do not necessarily believe they need.

Outpatient nursing care should also underwrite and incorporate the LEAP elements as fundamental in order to develop and maintain ongoing partnership with the patients as they live with schizophrenia, taking medications and receiving clinical treatments through hospital after-care and community-based programs.

**Education.** Nurse educators can use the LEAP model to provide clinical education for nurses. The LEAP framework could be integrated into Baccalaureate level
curricula to address the special needs of psychiatric patients with psychosis and impaired insight. At the Masters and advanced-practice level of nursing education, didactic and clinical instruction could include both LEAP and Recovery Model concepts in nursing curricula and practice standards and guidelines. Didactic and clinical practicum professors of psychiatric nursing practice could lead and mandate these changes in curriculum design. Supervised clinical practice integrating these concepts could provide application of the concepts to patients with chronic, severe psychosis who have impaired insight about their condition and need for treatment.

(The current, definitive guide to advanced-practice psychiatric nursing by Tusaic and Fitzpatrick (2016), *Integrating Psychotherapy, Psychopharmacology, and Complementary and Alternative Approaches Across the Life Span* does not address the special communication needs of patients created by anosognosia and impaired insight in patients with psychosis. Integrating the use of LEAP and other concepts relevant to the needs of patients with impaired insight could enhance clinical relationships with and treatment for patients with psychosis and poor insight.)

**Policy.** Using the nurses’ accounts reported in this study, hospital stays are typically three to seven days for patients in psychotic crisis. (Current literature reports on psychiatric inpatient hospital length of stay indicate that reports on inpatient stays are one to two decades old, and indicate that twenty years ago, the length of stay was just under ten days (Cheng, Shumway, Leary & Mangurian, 2016; Tullock, Fearon, & David, 2011)). Patients have often stopped taking antipsychotic medication, and a crisis results. When the patient has psychosis and also lacks insight about symptoms and their illness
condition, time is required for the nurses to get to know the patient in the context of psychotic crisis. To support decreased recidivism and to enhance symptom stabilization and patient engagement, longer hospital stays should be coded (i.e., permissible and paid for by insurance) based on the patient’s particular symptom profile and time for medication treatment. This change in coding and reimbursement might occur through research that supports identifying patients with anosognosia, with care provided focused on patient-specific goals, care plans, and outcome measures aimed at enhancing communication and partnership with patients who have impaired insight.

**Research.** The patients who have psychosis and impaired insight should be included in research studies examining insight and psychosis. Without the patients’ perspectives, treatment approaches will continue to be applied – imposed – on the patients when, from their perspectives, they do not require treatment.

Research should integrate the clinician, family, and patient perspectives to explore holistic, effective, and acceptable, support programs that address and benefit the patients’ perspectives on how psychiatric treatment fits into the best life for each patient.

As nurses are among front-line clinicians in hospital care, research should identify and explore factors affecting the nurse-patient relationship when the patient has psychosis and impaired insight, to support patient and family engagement in treatment while in the hospital, and in ongoing treatment.

**Limitations**

Specific limitations of this research include the constraints of time. To make the study feasible as a dissertation research project, the number of nurse participants had to
be limited. Including more nurse participants may have expanded the findings regarding the research questions addressing nurses’ experiences with psychosis and insight; the nurses’ perspectives on how patients’ experience psychosis and impaired insight; and how the nurse-patient relationship is affecting by poor insight. The nurses who did participate in the study were generous: recruiting nurses is difficult due to nurses’ variable work schedules, family responsibilities, and sometimes, also due to involvement in advanced educational activity.

I conducted this study myself, under the guidance of professors who helped me with the design of the study and analysis approaches. I did not have collegial partners to possibly enrich the thinking supporting my approaches to the research. I shared the codes and categories extracted from the interpretive summaries of the nurse interviews with a Ph.D. nurse who runs a large private practice caring for persons with chronic schizophrenia. She read and reviewed these data extracts, but did not contribute to the analysis, per se. The data analysis is limited to my own impressions.

As a qualitative researcher, I am a beginner. I did not create a thematic map as part of my data analysis strategy. A thematic map might have further changed or clarified how the themes and sub-themes were constructed and related to one another. Alternative explanations or organizations of the data might have resulted if I had composed an exacting thematic map using the data. Thus, not producing a thematic map is a limitation of the study analysis.

External generalizability (or “transferability” in qualitative terms) was not necessarily an intention of this study design (Maxwell, 2013) which involved the
exploration of psychosis and insight relevant to clinicians, particularly nurses working in inpatient and outpatient settings. Rather, processes, i.e., how insight affects nurse-patient relationships, were the point of this study (Maxwell, 2013). Variability in how impaired insight affects patients, clinicians, and how treatment programs are designed and implemented was expected. The literature findings support the results of this study, as discussed previously.

**Next Steps: A Program of Research**

This research was limited by the scope of the study itself. To appreciate the implications of insight on nurse-patient relationship and interactions, patients must be included directly in the research process. The focus and process of this dissertation research project with psychiatric nurses was an initial step of a program of research. As such, the focus of the current study was on one part of the nurse-patient dyad. Eventually, the research will be extended to include interviews with patients regarding their experiences of their clinical relationships and interactions with nurses. In addition, this research can only indirectly affect clinicians’ understanding of people with schizophrenia as non-compliant, uncooperative, resistant, and enigmatic. Patients were not been given their own voice, and ultimately, that is what this research is all about.
APPENDIX A
PSYCHOSIS AND INSIGHT INTERVIEW GUIDE

What is it like to work with a person with schizophrenia who does not demonstrate insight into the symptoms of, or actions due to, their illness?

How do you determine when a person with schizophrenia does not have insight into their symptoms or illness? (What did the person do that gave you the impression they lacked insight? Give examples please.)

What are the main things you think about when interacting with people with psychosis and poor insight?

How do you interact with patients with schizophrenia who lack insight?

How do these patients respond to you? Please give examples from your actual practice of how the patients responded to you.

What expectations/patient outcomes or goals do you formulate for these patients? How did you arrive at these expectations/outcomes (What was your rationale for…?)?

Specifically, what successful interventions do you use when interacting with these patients?

Can you recall a memorable experience about caring for a patient who lacked insight?

What do you imagine the patient (who lacked symptom/disorder-insight) was experiencing?

What did you feel – your affective response – clinically and personally toward these patients?

Please describe the program you practice in.

What approaches do you think nurses should generally take when interacting with these patients?

Do you think your experiences working with patients who lack insight represent typical situations psychiatric nurses deal with?
Do you think your *perspectives* on psychosis and insight represent those of most psychiatric nurses?

Did this interview process in and of itself, influence your views on psychosis and insight? If so, how did it influence you?

Are there any other questions you think I should have or wish I had asked you regarding working with patients who lack insight?
APPENDIX B
INSIGHT AND PSYCHOSIS DEMOGRAPHIC FORM: PERSONAL AND WORKPLACE

(Coded) Name: _____________________________

Age: _____________________________

Gender: _____________________________

Ethnicity: _____________________________

# Years as a registered nurse: ______________

# Years as a psychiatric nurse: ______________

# Years working with inpatient programs: ___ # Years working with outpatient clinics: ___

# Years working with people with psychotic disorders: _________

All degrees held/year: ____________________________________________________________

Type/s of institutions employed at:

Private hospital/clinic: _____________________________

Number of psychiatric beds/clients: ______________

Community non-profit hospital/clinic: _____________________________

Number of psychiatric beds/clients: ______________

Program information:

Inpatient/Outpatient (specify): _____________________________
Diagnostic groups: ____________________________________________

Length of stay (range/frequency): _______________________________

Program structure: Include general treatment approaches, groups, etc.:
__________________________________________________________________

Frequency/duration of seclusion or mechanical/positional restraint: ________
APPENDIX C
INFORMED CONSENT FORM

Insight and Psychosis: Exploring Psychiatric Nurses’ Perspectives on the
Patients’ Experience of Lack of Insight

INFORMED CONSENT FORM

RESEARCH PROCEDURES
This research is being conducted to explore psychiatric nurses’ clinical experience of a
specific schizophrenia symptom, impaired insight. If you agree to participate, you will be
asked to provide demographic data about yourself and a description of your work place.
You will be asked to participate in an audio-taped interview conducted by the
investigator for up to two hours. The audiotape will be transcribed, and the investigator
will compose an interview summary and send it to you. You will be asked to check the
interview summary for accuracy and return it to the researcher with your comments. As a
participant in this research project, you should expect to spend up to a total of four hours
over two weeks time: two hours in the interview, and 2 hours checking your interview
summary and writing or discussing your response with the researcher.

______ I agree to audio (video) taping.

______ I do not agree to audio (video) taping.

RISKS
There are no foreseeable risks for participating in this research.

BENEFITS
There are no benefits to you as a participant other than to further research to explore
psychiatric nurses’ clinical experience of a specific schizophrenia symptom, impaired
insight. In addition, this research may produce knowledge about how psychiatric nurses
approach interactions and maintain therapeutic relationships with patients who have poor
insight, which could improve clinical care for people with symptoms of schizophrenia.

CONFIDENTIALITY
The data in this study will be confidential. Your audio-taped interview will not record
your name or the name of your workplace. Names will not be included on the tape or
transcription of your interview. An alias name code will be assigned to your audio-taped
interview and interview transcript. Through the use of an identification key, the
researcher will be able to link your interview and transcription to your identity, and only
the researcher will have access to the identification key. A transcriptionist may assist the researcher to produce a written record of your taped interview. Any data published from this study will not identify the research participants or their workplaces.

**PARTICIPATION**
Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party.

**ALTERNATIVES TO PARTICIPATION**
You may elect to not participate in this study or withdraw from the study at any time. Your data will not be used and the audio-tape will be erased and your written interview transcript will be destroyed if you choose to withdraw your consent to participate.

**CONTACT**
This research is being conducted by Kim G. Cox, M.S.N., R.N., a Nursing PhD candidate under the supervision of Dr. Renee Milligan, Ph.D., R.N. at George Mason University Department of Nursing. Ms. Cox may be reached at 703-709-9187, and Dr. Milligan may be reached at 703-993-5035 for questions or to report a research-related problem. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

**CONSENT**
I have read this form and agree to participate in this study.

__________________________________________
Name

__________________________________________
Date of Signature

Version date: 06.01.2012
APPENDIX D
RECRUITMENT SCRIPT

Insight and Psychosis: Exploring Psychiatric Nurses’ Perspectives on Patients Lack of Insight

I am conducting a research study for my nursing Ph.D. dissertation at George Mason University in Fairfax, Virginia. My study will explore psychiatric nurses’ clinical experience of a specific schizophrenia symptom, impaired insight. You were referred to me as a possible study participant by a colleague or friend. To participate in the study, you must be a registered nurse with at least three years of current direct clinical experience caring for patients with schizophrenia, and be working in a non-profit community or private for-profit hospital or clinic.

This research may produce knowledge about how psychiatric nurses approach interactions and maintain therapeutic relationships with patients who have poor insight. The research findings could possibly influence care for people with symptoms of schizophrenia.

If you are interested in finding out more about this study, please contact me at 703.709.9187, or email me at kcox7@gmu.edu.

Thank you.

Kim G. Cox, MSN, RN
George Mason School of Nursing Ph.D. Candidate
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APPENDIX F
LETTER TO PARTICIPANT: INTERPRETIVE INTERVIEW SUMMARY

Insight and Psychosis: Exploring Psychiatric Nurses’ Perspectives on the Patient’s Experience of Lack of Insight: Interview #___—Code Name of Participant, Date of Letter

Dear Name of Participant,

I am getting back to you now that I have all the nurse interviews for my study completed and transcribed. I have composed summaries of the interviews, and I am asking each research participant to validate the summary I made of their own interview. This step of the research is very important. Once I know that I am interpreting the interviews in the way each participant intended, I can begin formal data analysis using all of the nurse interviews.

I have composed and attached my summary of your interview. I need you to evaluate, frankly and comprehensively, if you think I captured the main points you made in our interview. What I need most is that you let me know if I accurately characterized the meaning of what you said – this lets me more confidently use your interview data as evidence to address my research questions.

I have enclosed the transcript of our original interview and my summary. I need you to review the summary I composed based on our interview. Please think about the purpose of my study and research questions as you review the transcript and my interpretive summary:

The purpose of this study is to explore psychiatric nurses’ clinical experience of a specific schizophrenia symptom, impaired insight. The research questions are:

1. What are psychiatric nurses’ experiences of lack of insight in patients with schizophrenia?
2. What are psychiatric nurses’ perceptions of the patients’ experiences of impaired insight?
3. What are psychiatric nurses’ beliefs about how lack of insight affects the nurse-patient relationship?
Please email me back and let me know what you think about the interview summary. If you have specific points, please type your thoughts within the body of the summary. If you would prefer to talk on the phone, please call me at 703.709.9187; leave your phone number and I will call you back at your convenience. I will take notes as we discuss your thoughts. Also, I inadvertently left out ethnicity on the Demographic Form you filled out. Will you please tell me how you want me to fill that item in for you?

Thank you so much for your participation in this research project. I hope to thank you further by completing my dissertation this year! It is because of you and the other nurse participants that I can do this research.

Sincerely yours,

Kim
REFERENCES


Noiseux, S. & Ricard, N. (2008). Recovery as perceived by people with schizophrenia,


Ogden, L. P. (2014). “My life as it is has value”: Narrating schizophrenia in later years. *Qualitative Health Research, 24*(10), 1342-1355.


BIOGRAPHY

Kim Cox is a registered nurse, serving as a Clinical Nurse Specialist at the National Institutes of Health Clinical Research Center in Bethesda, Maryland. For 35 years she has supported biomedical clinical research conducted by the National Institute of Mental Health, and more recently, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute of Drug Abuse. She is a member of the American Psychiatric Nurses Association, and is a conference planning committee member for the annual APNA Clinical Psychopharmacology Institute. Kim is a member of Sigma Theta Tau International Nursing Honor Society, Epsilon Zeta Chapter, and is a recipient of the STTI research award. She is a master level instructor of the Crisis Prevention Institute® International Association of Certified Nonviolent Crisis Intervention Certified Instructors. Her professional experiences include intensive psychiatric inpatient care in a private psychiatric hospital, support of psychiatric research at the NIH Clinical Research Center, and providing nursing home consultation for special dementia care programs. She has provided program support for inpatient clinical research involving schizophrenia spectrum and affective disorders in adults and children, Alzheimer’s disease, and addiction disorders. Kim has been a Combined Neuroscience Institute Review Board member for over ten years at the NIH.