

Effective Interaction With Patients With Schizophrenia: Qualitative Evaluation of the Interaction Skills Training Programme

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PURPOSE. *The purpose of this study was to describe experiences of caregivers with the Interaction Skills Training Programme, and to evaluate the training effects observed by caregivers.*

DESIGN AND METHODS. *A qualitative research design was applied. Semistructured interviews were conducted with 17 caregivers who had followed the training program.*

FINDINGS. *The research findings clearly confirm the value of the program. Positive effects of the training were reported in terms of: (a) awareness and insightfulness; (b) the attitude of caregivers; (c) the quality of the therapeutic alliance; and (d) job perception.*

PRACTICE IMPLICATIONS. *Training interactive skills may contribute to a better quality of care for chronic psychiatric patients. Based on the qualitative study, implementation of the skills training program can be recommended.*

Search terms: *Communication, nursing, schizophrenia, working alliance*

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Since the 1950s, researchers have written extensively about interaction and communication between patients suffering from schizophrenia and their social environment. The initial focus of the research was on the patients' family backgrounds. It was believed that the conditions in which patients with schizophrenia grew up were so pathogenic in nature that these were a contributory cause of their illness (e.g., Bateson, Jackson, Haley, & Weakland, 1956). The focus gradually shifted, however, toward research into the impact of family and interaction patterns on the course of the schizophrenic disorder (Barrowclough & Lobban, 2008; Goldstein, 1994; Liberman, 1994; Mueser & Gingerich, 1994; Willetts & Leff, 1997). The concept of *expressed emotion*, referring to the emotional response of family members to a patient's illness, received much attention in this context. The conclusion was that a high level of criticism, hostility, and emotional overinvolvement expressed within the patient's family

First received January 12, 2009; Revision received May 5, 2009; Accepted for publication May 6, 2009.

increased the risk of psychotic relapses. This insight formed the basis of new family intervention programs to lower the level of expressed emotion (Leff, Kuipers, Berkowitz, Eberlein-Vries, & Sturgeon, 1982).

Researchers have paid much less attention to interactions between patients with schizophrenia and their caregivers. There is, however, evidence from both research and practice that establishing a therapeutic relationship between caregivers and their patients is a complicated process (Frank & Gunderson, 1990; Willetts & Leff, 1997). Patients generally indicate that they attach much value to a good therapeutic alliance with their care providers (McCabe, Roder-Wanner, Hoffmann, & Priebe, 1999). Moreover, research has shown that there is a clear link between the quality of a therapeutic alliance and the results of the treatment given. Patients who entertain a positive therapeutic relationship with their caregivers make more efficient use of the treatment facilities available to them and are more drug compliant. These factors explain significantly the success rate of treatments, including the reduced occurrence of relapses (Frank & Gunderson; Hewitt & Coffey, 2005; Holzinger, Loffler, Muller, Priebe, & Angermeyer, 2002; Olfson et al., 2000; Speedy, 1999). Furthermore, as Melchior (1996) and Betgem (2000) observed, not only the patients, but also the care providers may well benefit from developing healthy therapeutic alliances: their job satisfaction levels increase and the risk of burnout decreases.

In the 1990s, the Dutch Interaction Foundation (*Stichting Interactie*) developed a training program to improve therapeutic interactions between care providers and patients suffering from a chronic psychotic disorder. This article describes the experiences of care providers who followed the training program. The two main research questions were: (a) How do caregivers experience and evaluate the Interaction Skills Training Programme? and (b) What training effects did caregivers observe concerning the therapeutic process and the quality of the therapeutic alliance with their patients?

Method

The study reported here was part of a more comprehensive project that explored the qualitative and quantitative effects of the Interaction Skills Training Programme (Megens, van Meijel, & Grypdonck, 2007). For the overall project, respondents were recruited from four large mental healthcare centers throughout the Netherlands.

A total of 102 care providers participated in the quantitative study. They were divided into eight training groups. The average age of the participants was 40 years ($SD = 10$); well over one third of the participants (37%) were male. Two thirds (67%) of the caregivers were active as nurses or social workers, 26% as (psycho)therapists, and the remaining 7% as occupational therapists.

A total of 118 patients, 58% male and 42% female, participated in this study. Their average age was 37 years ($SD = 11$). Nearly two thirds suffered from schizophrenia or a related psychotic disorder. Other diagnoses were mood disorders (9%), personality disorders (8%), and anxiety disorders (2%). For 19% of the patients, no diagnosis was available. Half of the patients were outpatients; one third were treated in a clinical treatment setting. The remaining patients were treated part-time or stayed in group homes/assisted living centers.

For the qualitative part of the study—the subject matter of this article—semistructured interviews were held with 17 caregivers (10 nurses, 6 [psycho]therapists, and 1 occupational therapist), who were asked to comment on their (learning) experiences during the training course and to indicate how the training had influenced the care process and the quality of the therapeutic alliances. The mean age of the respondents was 39 years (range 21–58). Eight men and nine women participated. The selection of caregivers was made on the basis of the changes shown in the overall scores on the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989; Vervaecke & Vertommen, 1993). This instrument was used in the quantitative part of the study to measure the quality of the therapeutic

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alliance. Both caregivers with significant changes in their WAI scores and caregivers with no reported changes were selected. The interviews took approximately 1 hr and were audio taped. The audio tapes were transcribed verbatim and analyzed descriptively with the aid of winMAX, a software program for qualitative text analysis (Verbi Software, Marburg, Germany). The analysis consisted of a first coding of the interview texts. Next, related codes were combined into five categories, which are described in the Results section of this article. The analysis procedures and the preliminary results were discussed extensively within the research team to ensure the reliability of the results and the conclusions drawn.

The Interaction Skills Training Programme

The training courses were given by certified trainers. A course consisted of seven sessions in which the participants discussed specific (problematic) interactions between caregivers and patients, and performed exercises. The skills trained during the course were the following: (a) observe and evaluate interactions; (b) assess one's position toward the patient's behavior; (c) create a basis for care and treatment; and, in the absence of any such basis, (d) use the least harmful intervention.

The training method used in the program is known as *The Mat*© (The Mat, Haarlem, the Netherlands), which literally involves a mat divided into two halves: one colored green, the other red. During the exercises, participants must take positions. Choosing green indicates their acceptance of the other's behavior, while red represents a lesser degree of acceptance. Therefore, the exercises in mastering interaction skills require participants to physically take positions relative to the other: the interaction and the interpersonal position is thus immediately clarified (Kuipers, 2002).

Results

The analysis of the qualitative interviews produced key dimensions for categorizing the views expressed

by the respondents: (a) awareness and insightfulness; (b) impact on attitude; (c) impact on professional relationships; (d) impact on job perception; and (e) training-related.

Whereas the individual elements of the interactive processes used to be indefinable or impalpable, the training course had provided them with the proper words to describe and analyze them.

Awareness and Insightfulness

Most of the interviewees (13) indicated that the training had sparked a process of awareness, particularly of the actual mechanisms involved in their interactions with patients. Whereas the individual elements of the interactive processes used to be indefinable or impalpable, the training course had provided them with the proper words to describe and analyze them. The caregivers had become more aware of their own positions in the interactions. Their levels of acceptance of the patients' behaviors played an important role. After the training, the interviewees could explain part of their interaction problems by recognizing their own nonaccepting attitudes toward patients and their behaviors. The caregivers began to realize that a troublesome therapeutic alliance could well benefit from a change in their own attitudes. This required an analysis of the interaction situation as such, as well as a more explicit definition of the responsibilities of both the caregivers and the patients. Analysis and more explicit definition resulted in a higher level of acceptance of the circumstances in which care was to be provided. It highlighted

the possibilities and limitations of the interaction process, which in turn facilitated a better adaptation of expectations and interventions to the actual situation. The following statement by one of the interviewees illustrates this point:

I don't believe that before the training, people were really aware of whether or not they accepted the situation surrounding a patient. What a difference that makes in dealing with the patient!

Impact on Attitude

Nearly all interviewees (16) told how—following the process of awareness—the training had influenced their attitudes in one or more caregiving situations. The training had taught the caregivers to reflect more, and with increased awareness, on the position of the patients and on themselves. The training had induced them to reflect on what moved the patients and why they exhibited specific behaviors. The caregivers were taught to do so by questioning themselves in concrete situations whether a patient was unwilling or (as yet) unable to meet (implied and/or expressed) expectations or agreements.

This growing awareness created a more nuanced perception of the patients and their possibilities and limitations. The caregivers experienced a broadening of their own attitudinal options. They became more flexible and could more easily let go of their prejudices. This, in turn, enabled them to make a more well-considered choice in adapting their attitudes and professional conduct to the specificities of their patients.

Being able to adapt one's attitude to the possibilities, limitations, and wishes of the patients was one of the most notable effects of the training program. Virtually all care providers testified as much. The following statement is but an example of the various testimonies:

That was an eye-opener! It's just that you respond differently once you realise that it is not a matter of

unwillingness [. . .]. And that it's not simply for you to say: "I'm angry at you because I know you can do it. You just won't." In other words, you reflect more on what the patient *can* do and what kind of help you can offer.

Impact on Professional Relationships

Fifteen interviewees gave specific examples of how the training had influenced their relationships with patients. The effects basically involved improvements in their relationships and in the collaboration with the patients. The care providers observed that they were better able to be more relaxed in their attitudes toward patients exhibiting problematic behavior. Potential conflicts could be better contained. Patients were given more leeway, and there was an increased level of understanding of their motivations. The interviewees mentioned examples of lower irritation levels in their contacts with patients, a "clicking" with their patients, more eagerness by patients to cooperate, and a more open connection. As a result, specific problems that came to the fore during treatment could now also be discussed better. In addition, the increase in flexibility removed some of the pressure from the patients, so that the caregiver could take a more reactive stance. In other cases, depending on the possibilities and needs of the patients concerned, the caregivers were able to provide more (directive) support. One of the interviewees described this change in interaction as follows:

Before, I would have been more reserved, but now I'm a bit more outgoing, which has improved our interaction. He [the patient] has also noticed this and I can do more for him now. That boosts confidence. Our relation is better, he has become more inviting and we have fewer conflicts.

The interviewees also made statements about their relationships with fellow caregivers. A majority indicated that the training program had made it easier for them to discuss problem situations with coworkers

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who had also attended the training course. Participating in the course improved teamwork. The training had shown which problems their fellow caregivers encountered in practice and how these problems were handled, as a result of which they had become more acquainted with the work style of their colleagues. The threshold to discuss interaction problems and to give or request feedback was lowered. The training had created a common frame of reference. They could now share a clear and simple frame of language or, as one of the interviewees put it: "Interaction has been given a language." One or two words sufficed for the co-working caregivers to gain insight into the essence of a specific problem. The interviewees also declared that this improved communication had made it easier for all caregivers involved to agree on the best way to support a patient. The clear language and common frame of reference offered by the training program had thus become an instrument in forming opinions and making decisions.

Impact on Job Perception

Thirteen interviewees stated that the training course had contributed to lessening the perceived burden of working with the patients, specifically because they were better capable of defining and putting into practice the limits of their own professional responsibilities. They learned to manage their workloads better, which enabled them in a positive sense to distance themselves more from their patients and their patients' problems. They brooded less about problematic situations involving certain patients. One interviewee put it as follows: "It's easier for me now to take a position and be at peace with that."

The interviewees indicated that they harbored more realistic expectations of their patients, which led to fewer frustrations about (recurring) behavior so that it had become less wearying to deal with "troublesome" patients. In the words of one of the interviewees:

I can better accept now that there sometimes are limits to what we can do . . . that someone will not get very much farther than the point he has reached now. The energy I used to lose in frustration can now be put to work elsewhere.

About the Training

The (linguistic) frame of reference provided by the training course was considered very important to the effectiveness and "shelf-life" of the training. As stated before, the course gave the caregivers a language to reflect on interaction problems alone or with others, even months after the course had ended. The language was the instrument to deal with interaction problems in a different way. The language could be captured in a few simple phrases, such as "stop or go?" or "unwilling or unable?" This clarity made it easy to recall training experiences in day-to-day practice. One of the interviewees formulated this as follows:

It takes but one simple sentence to re-download the entire training course to the other person's mind. That is a lot for just one sentence. And what's so powerful in all this is that the sentence does not tell the other person what to do, but merely reminds him how to rearrange the thought process.

In the training sessions, the caregivers were given extensive opportunity to practice with actual case studies. This gave them hands-on experience with changes in interaction resulting from a shift in position or a new style of communication. Of particular value to the caregivers was the acquired skill of dwelling on the difference between *unwillingness* and *inability* in everyday practice. Many interaction problems could be traced back to not making this distinction, which created a great deal of unclarity about what could be expected of a patient. Other significant skills improved during the training program were the ability to express one's own emotions and opinions in specific situations (using the first person) and the skill of continuing to ask

questions about the reasons why a patient was exhibiting specific behavior. Obviously, these skills were not entirely new to the caregivers. The added value of the training course was the ongoing explicit and consistent focus on these aspects of interaction and on these skills.

The interviewees named positive effects in terms of their relationships with the patients, their collaboration with other caregivers, the multidisciplinary teamwork, and their job perceptions.

Discussion

The qualitative interviews conducted indicated that caregivers perceived the Interactive Skills Training Programme to yield positive effects. The interviewees named positive effects in terms of their relationships with the patients, their collaboration with other caregivers, the multidisciplinary teamwork, and their job perceptions. These positive effects, however, were not confirmed by the results of the quantitative part of the research (Megens et al., 2007). We believe that this incongruence between the qualitative and quantitative research results was due to methodologic factors. The caregivers indicated in the interviews that the interactive changes mainly occurred in their relationships with patients with whom it was difficult to build up a therapeutic alliance. These were precisely the patients who were unable or unwilling to participate in our quantitative research. They simply could not, or would not, make the effort required. This implies that changes in therapeutic alliances presumably occurred on a

larger scale in “difficult” patients, who were not involved in the quantitative research. The caregivers explained that it was easier for them to connect to these patients after they had completed the training program. They were better able to understand the patients, their motives, and their capabilities and incapacities. The caregivers were also better able to interpret and control difficult situations, as the skills they had acquired during the training program enabled them to analyze the situations and determine their own positions and strategies.

At the (multidisciplinary) team level, the shared frame of language provided by the training program proved to be conducive to both communication and problem resolution. With the use of that shared frame of language, difficult patient situations could be analyzed more effectively and efficiently. It was easier to reach consensus among the team members about how to define the problem and what strategy to use to resolve that problem effectively.

Our research results largely conform to those of Willetts and Leff (1997, 2003). They made a quantitative analysis of the effects of a training program on mental health workers—who worked with a comparable group of patients as the group in our research—and concluded that the program had led to a significant increase in the knowledge and skills of the professionals. Even so, they did not find any significant reduction in the level of expressed emotion.

We recommend that further research be carried out specifically into troublesome therapeutic alliances that have a negative impact on the treatment results. The expectation is that the Interaction Skills Training Programme can improve precisely those alliances. Large-scale quantitative research is less appropriate to achieve the intended purpose because of the risk of selection bias and selective dropout. Moreover, the quantitative research instruments that are available are not suitable to provide an adequate understanding of either the exact nature of the alliances and the problems within the alliances or the changes the training program may trigger.

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A methodologic alternative might be to preselect therapeutic alliances that are identified as difficult and wearisome by the caregivers and/or the patients. In that methodology, the aim is not so much to include large numbers of respondents in a (quasi)experimental research design, but rather to conduct an in-depth study of a limited number of (problem) cases. The research design of choice will then be a multiple-case study combining quantitative data collection and analysis methods with qualitative analysis techniques. This may provide a better understanding and explanation of how therapeutic alliances develop and how training programs may influence that process. Qualitative techniques may take the form of interviews with patients and caregivers combined with direct observations of how alliances develop over time. This method of data triangulation enables a discussion of the different aspects, in both qualitative and quantitative terms, of how an alliance develops under the influence of training. The expectation is that this focused approach will facilitate a better charting of the effects of a training program.

Implications for Nursing Practice

Training interactive skills may contribute to a better quality of care for chronic psychiatric patients. Considering the positive results of the qualitative research, we believe that there is good reason to advocate a wider implementation of the training program, even though at the same time we are aware of the need for future research into its effectiveness.

Acknowledgment. This project was financially supported by Stichting tot steun VCVGZ, De Open Ankh, Stichting Interactie, Stichting Koningsheide, & INHolland University for Applied Sciences.

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