THE ORIENTATION PHASE OF THE NURSE-CLIENT RELATIONSHIP: TESTING PEPLAU'S THEORY

by

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DISSERTATION

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CHAPTER 1

Introduction

Establishing a therapeutic nurse-client relationship is a common goal and yet a common frustration for nurses working with individuals with chronic mental illnesses. It has been observed that the initial or orientation phase of the relationship may be prolonged with this population (Forchuk, Beaton, Crawford, Ide, Voorberg & Bethune, 1989; Peplau, 1973a) yet, little is known about factors related to the length of time in the orientation phase or factors that may assist nurse-client dyads to move more quickly through this difficult phase. This phase is critical in that it is a necessary prerequisite for identifying and working on client problems. A preliminary investigation found that chronically mental ill clients who took 11 or more months in orientation also tended to have much longer psychiatric hospital stays. These clients were hospitalized for 70.3 months over 5.7 hospitalizations compared to 10.9 months over 4.1 admissions for clients who completed orientation in up to two months (Forchuk, in press). It is possible that information that would facilitate movement through the orientation phase would also facilitate shorter hospital stays.

The general purpose of this investigation was to test Peplau's theory in relation to anticipated factors.
influencing progress in the therapeutic relationship during the orientation phase. It is hoped this information will assist nurse-client dyads to set realistic goals for the length of time in orientation. The ultimate purpose is to facilitate passage through this phase.

**Theoretical Implications**

**Peplau's Theoretical Framework**

Peplau is best known for her 1952 book entitled, *Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing*. The major emphasis of Peplau's work is the importance of the nurse-client relationship. The nurse-client relationship is the crux of nursing (Peplau, 1962; 1964; 1965). It "is educative and therapeutic when nurse and patient can come to know and respect each other as persons who are alike, and yet different, as persons who share in the solution of problems" (1952, p. 9).

Peplau's framework is complex due to the many concepts and subconcepts that are interrelated. To assist in clarification of the framework a numbering system has been developed by the author (Table 1) to illustrate relations among concepts and subconcepts. The traditional metaparadigm of nursing is indicated with alphabetical letters.
Table 1

Major Concepts and Subconcepts within Peplau's Theory

<table>
<thead>
<tr>
<th>Metaparadigm Concepts:</th>
<th>Other Concepts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Nursing</td>
<td>1.0 Interpersonal Relationships</td>
</tr>
<tr>
<td>B. Person</td>
<td>1.1 Nurse-Client Relationship</td>
</tr>
<tr>
<td>B.1 Patient/Client</td>
<td>1.11 Orientation</td>
</tr>
<tr>
<td>B.2 Nurse</td>
<td>1.12 Working</td>
</tr>
<tr>
<td>C. Health</td>
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<td>D. Environment</td>
<td>1.13 Resolution</td>
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<td>7.0 Competencies</td>
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<td>8.0 Anxiety</td>
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To assist in understanding Peplau's theory as it relates to the investigation, the concepts from the metaparadigm, and the phases of the relationship will be described:

A. **Nursing** is an educative instrument, a maturing force, that aims to promote forward movement of the personality in the direction of creative, constructive, productive, personal and community living (Peplau, 1952, p.16). Nursing involves the growth of the nurse and the client (Peplau, 1952; 1973a). It is an enabling, empowering, transforming art (Peplau, 1988).

B. A **person** is a human being who lives in an unstable environment (i.e., physiological, psychological and social fluidity) (Peplau, 1952). Both the nurse and the patient/client are persons. Each person brings unique experiences, beliefs, expectations, and patterns of relating to others into all interpersonal relationships (Peplau, 1952).

B.1 The **patient or client** refers to "sick and well individuals, groups, families, and communities for whom nurses provide direct nursing services" (Peplau, 1988, p.9).

B.2 The **nurse** is the medium of the art of nursing. "The unique blend of ideals, values, integrity, and commitment to the well-being of others, expressed in a nurse's self-presentation and responses to clients, makes each nurse a one-of-a-kind artist in nursing practice" (Peplau, 1988,
C. Health is a word symbol that implies forward movement of the personality and other on-going human processes in the direction of creative, constructive, personal and community living (1952, p.12). This definition underscores the idea of growth as inherent in health. Health is the primary goal of nursing (1952, p. 6).

D. Environment includes physiological, psychological and social fluidity (1952, p.82) The environment includes the context of the nurse-client relationship. Systems in the environment can be potentially illness maintaining or health promoting, depending on the interaction of patterns (1973g, 1987b).

Interpersonal relationships include the nurse-client relationship and other relationships:

1.1 The nurse-client relationship is the specific interpersonal relationship that develops between a nurse and a client. The relationship develops through interlocking and overlapping phases. These are: the orientation phase, the working phase (subdivided into identification and exploitation), and the resolution phase.

1.11 The orientation phase begins with the first encounter of the nurse and client. In this phase, the nurse and client come to know each other as persons and to understand the role and expectations of each other in the
relationship. Consistency and clarity is essential on the part of the nurse in giving and meeting the parameters of the nursing role. The client will need to test these parameters in order to establish that the nurse is a trustworthy person. A critical indicator that the orientation phase is completed is that the client can begin to identify problems and subproblems to work on in the relationship (Peplau, 1952; 1973b).

1.12 The working phase incorporates both the identification and exploitation subphases. Relationships may move back and forth frequently between these two subphases as new problems are identified and worked through (Peplau, 1973c).

1.121 Identification is the first part of the working phase of the relationship. The idea of "identification" is two-fold. The client begins to identify with the nurse and the nurse-client encounters, and also begins to identify problems and subproblems to be worked on in context of the nurse-client relationship. The nurse and client may plan the use of resources in this subphase, but the actual "doing" signifies a movement into the exploitation phase (Peplau, 1952; 1973c).

1.122 Exploitation is the subphase of the working phase where the client is able to make full use of the services of the nurse. After plans are fully implemented, the nurse-client relationship may involve the
identification of further issues to be worked on (i.e., return to identification) or the resolution of the relationship (Peplau, 1952; 1973c).

1.13 Resolution involves the mutual termination of the relationship. It includes the time from the implementation of all plans until no further nurse-client encounters occur. It includes planning for alternate sources of support, problem prevention, and the client's integration of illness experiences (Peplau, 1952; 1973d).

Peplau's definitions of other specific concepts to be studied are included later in the proposal as theoretical definitions.

The relations among the major concepts are depicted in Figure 1. The central focus of nursing (A) is the nurse-client relationship (1.1). Two people (B) are included in the diagram: the nurse (B.2) and the client (B.1). Imagine the multiple layers depicted in the figure to be three dimensional, such that the layers drawn at the "back" of the circles also touch the front.

The between-person phenomena include the nurse-client relationship (1.1), including the phases (1.11-1.13), communication (2.0), and pattern integration (3.0). The nurse-client relationship (1.1) impacts on the whole of both people (B), but the focus of the nurse (B.2) involves using all the concepts and processes (all numbers and letters) within the framework by employing specific roles (4.0).
Figure 1:
Peplau's Framework: Major Concepts and Their Inter-Relationships (C. Forchuk, 1989)
The ability to use these concepts, processes and roles is immediately dependent on the self-understanding (5.2) and competencies (7.0) of the nurse. The immediate focus with the client is the development of competencies (7.0) and, as a by-product, self-understanding (7.0) (note: this is not quite parallel - the nurse uses self understanding and competencies, the client develops these).

The next "layer" is the same for the nurse and client. Both are enabled and limited by their thinking, particularly preconceptions of each other, current learning, other relationships (past, present, real or illusory) and anxiety. The concepts found within this layer would be expected to influence the duration of the orientation phase of the relationship, as well as the other interpersonal phenomena.

The next "layer" for both individuals is also parallel. Both involve growth; the type of growth, however, will emphasize increased self-understanding in the nurse and improved health (which includes self understanding) for the client. If the circles on the paper can be imagined as three dimensional spheres, it can be seen that this layer would also touch the first one described (i.e., the nurse's ability to use concepts, processes and roles, and the clients' development of competencies).

The entire (1.2) nurse-client relationship takes place in the context of the (D) environment.

Peplau identified two "guiding assumptions" in her 1952
book. She stated these were the underpinnings to her framework. These are:

1. The kind of nurse each person becomes makes a substantial difference in what each client will learn as she/he is nursed throughout her/his experience with illness (p.xi).

2. Fostering personality development in the direction of maturity is a function of nursing and nursing education; it requires the use of principles and methods that permit and guide the process of grappling with everyday interpersonal problems or difficulties (p.xi).

Peplau emphasized the importance of the first assumption by stating:

A main Peplau contribution overall was to say the relationship (interaction) of nurse with patient was an influential factor in the outcome for the patient, i.e., participant observation was required; while, before that, the nurse was a spectator observer and the patient the "object" to be observed (personal correspondence, July 1989; March, 1991).

She further stated that the counselling and teaching functions flowed from the second assumption.

Within Peplau's theory, factors that may be expected to influence progress in the therapeutic relationship would include:
1. Preconceptions of the nurse and/or client of each other: Preconceptions of a person are conceptions prior to knowing that person. Both the nurse and client would be expected to have preconceptions of each other. These preconceptions could have a positive or negative influence on the developing relationship, depending on their nature (Peplau, 1952).

2. Other interpersonal relationships of both the nurse and the client: Previous and other current relationships of both the nurse and the client would be expected to impact on the developing nurse-client relationship. Successful relationships encourage further success in relationships, while negative experiences in relationships impede the development of the current nurse-client relationship (Peplau, 1952; 1973a).

3. Levels of anxiety in both nurse and client: Mild anxiety, in nurse and/or client provides an energy that can be channelled towards growth. At moderate levels of anxiety, growth may be impeded but is still possible. Severe and panic levels of anxiety block growth and the developing nurse-client relationship (Peplau, 1971a; 1973e; 1989).

4. Communication patterns of the nurse and client: Mutual (e.g., mutual withdrawal or mutual anger) patterns and complementary (e.g., domination-submission) patterns maintain the status quo and do not promote change or growth.
in relationships. Change is promoted through antagonistic patterns (e.g., angry client and investigative nurse) (Peplau, 1973g, 1987b).

5. Self understanding of the nurse and client: Peplau (1952) focussed primarily on the self understanding of the nurse and stated as an assumption that the nurse's self understanding is a necessary prerequisite to forming effective nurse-client relationships. Unlike insight-oriented therapies, self understanding of the client is not a goal. The relationship aims to develop interpersonal and problem solving competencies within the client. Through this process, however, clients may develop self understanding as a by-product (Peplau, 1973a). Self understanding of the client can facilitate development of the nurse-client relationship (Peplau, 1952).

6. Current level of learning of the client and nurse: Progress in the nurse-client relationship would be impeded by either participant being at the lower end of the eight point learning continuum described by Peplau (1971b). From a practical perspective it would more likely be the client who was operating at a more basic level. Specifically, if the client is at the first level of "to observe" and has not yet achieved the competencies required for the second phase, "to describe," that person would also have difficulty verbally identifying problems. Problem identification is an essential feature of the "identification" phase of the

The potential influences suggested by Peplau's theory are summarized in pictorial form in Appendix A. For the purpose of this investigation only the first three potential influences were considered relative to duration of time in the orientation phase. There was an anticipated interrelationship of these variables with time in orientation. Therefore, subjects who completed orientation by three months were anticipated to have more positive conceptions, more positive relationships with others, and less anxiety than subjects who were still in the orientation phase.

Hypotheses

The primary hypotheses focused on variables, measured at the beginning of the relationship, which within Peplau's theory, would be expected to impact on the development of the therapeutic relationship. These hypotheses are:

1. Clients' more positive preconceptions of the nurse will be related to greater progress in the development of therapeutic relationships.

2. Nurses' more positive preconceptions of the client will be related to greater progress in the development of therapeutic relationships.

3. Clients' more positive interpersonal relationships will be related to greater progress in the development of therapeutic relationships.
4. Nurses' more positive interpersonal relationships will be related to greater progress in the development of therapeutic relationships.

5. Higher levels of anxiety in the client will be related to less progress in the development of therapeutic relationships.

6. Higher levels of anxiety in the nurse will be related to less progress in the development of therapeutic relationships.

7. Taken together, clients' preconceptions of the nurse, level of anxiety and interpersonal relationships will be a better predictor of progress in the development of therapeutic relationships, than any one client variable alone.

8. Taken together, nurses' preconceptions of the client, level of anxiety and interpersonal relationships will be a better predictor of progress in the development of therapeutic relationships, than any one nurse variable alone.

In addition to these primary hypotheses, secondary hypotheses examined changes in each of the variables at three months into the nurse-client relationship. It was anticipated that preconceptions, interpersonal relationships and anxiety would be more positive among individuals who had completed the orientation phase in a shorter period of time.
Theoretical - Operational Definitions

All theoretical definitions were drawn from Peplau's work. Theoretical definitions are followed by operational definitions.

Interpersonal relationships encompass any processes occurring between two or more persons. Peplau included Sullivan's (1953) perspective in specifying that all but one of the persons involved may be illusory. "Such relations or connections are identified in terms of their nature (pattern), their origin (history), their function (intention, motive, expectations, purpose), their mode (form, style, method), or by integrations (patterns of two or more people which together, link or bind them)" (Peplau, 1987b, p.202). Nurse-client relationships are the specific relationships that develop between nurses and clients. These relationships progress through the identifiable phases of orientation, working (subphases: identification and exploitation), and resolution (Peplau, 1952; 1973a)

For the purpose of this study two types of interpersonal relationships were specified: interpersonal relationships other than the nurse-client relationship, and the nurse-client therapeutic relationship. The operational definitions related to interpersonal relationships are:

Other interpersonal relationships are social support, other than that within the nurse-client relationship, as measured by the ratings on the Personal Resource Questionnaire.
The nurse-client relationship is the specific interpersonal, therapeutic relationship that develops between a nurse and client, as measured by ratings on the Working Alliance Inventory (Horvath & Greenberg, 1986), and that progresses through identifiable phases, as measured by ratings on the Relationship Form (Forchuk et al., 1986; Forchuk & Brown, 1989).

The orientation phase of the nurse-client relationship is the initial phase of the nurse-client relationship. The major task of this phase is beginning the development of a therapeutic or working relationship. This phase begins when the nurse and client first meet. A hallmark of the passage through this phase is that the client can begin to identify problems and subproblems to work on with the nurse. The operational definition is: Time in the orientation phase is the number of weeks from the first meeting of the nurse and client until the nurse in the relationship and a clinical nurse specialist1 who is blind to other measures agree that the phase of the relationship, as indicated on the Relationship Form (Forchuk et al., 1986; Forchuk & Brown, 1989).

1 A clinical nurse specialist is a nurse with a masters or doctoral degree in a clinical nursing specialty who functions in the roles of expert practitioner, consultant, educator and researcher (Registered Nurses Association of Ontario, 1991). For the purpose of this study, the clinical nurse specialists' clinical specialty included psychiatric-mental health nursing with a sound understanding of Peplau's theory.
1989), is in the working phase.

Preconceptions in the nurse-client relationship are the nurse's and client's thoughts, feelings and assumptions about each other, early in the relationship before they come to know each other as unique persons. Preconceptions are generally formed through previous interpersonal relationships (Peplau, 1952, 21-30,123). The operational definition is: preconceptions in the nurse-client relationship are the nurses' and clients' ratings of each other on specified semantic differential scales.

Anxiety is an energy that is cognitively triggered by any real or imagined, internal or external threat to the security of an individual. Anxiety may also be triggered by empathic observation of another person's anxiety. Self views or established patterns cannot be changed without anxiety. Levels of anxiety range from mild anxiety (anxiety+), moderate anxiety (anxiety++), severe anxiety (anxiety+++), to panic (anxiety++++). All persons, including nurses and clients, are usually experiencing some anxiety. The absence of anxiety is euphoria (Peplau 1952; 1971a; 1973e; 1989). The operational definition is: anxiety is the rating on the Beck Anxiety Inventory (Beck, Epstein, Brown & Steer, 1988).

Summary

In this chapter the problem of establishing therapeutic relationships with individuals with a chronic
mental illness was introduced. Peplau's theory was reviewed to demonstrate that it provides an appropriate underpinning to the study. Specific concepts and hypotheses were identified. The hypotheses reflect factors within Peplau's theory that would be expected to influence the duration of the orientation phase of the relationship.
CHAPTER 2

Review of Literature

The review of the literature that follows gives consideration to the research tradition within Peplau's theory and other traditions related to therapeutic relationships. Major concepts within Peplau's theory that are predicted to influence the evolving nurse-client relationship were reviewed with a focus on nurses and individuals with chronic mental illnesses. These concepts are: other interpersonal relationships, preconceptions, and anxiety.

Peplau's theory

The research tradition within Peplau's theory has been largely confined to the use of case studies based on process recordings. Peplau recommended the use of "nursing process forms" to study the nurse-client relationship (Peplau, 1952, p.308). Manaser and Werner (1964) published a collection of instruments which could be used in analyzing process recordings in a manner consistent with Peplau's framework. These instruments tended to be used by students learning Peplau's framework. No examples of these instruments being used by researchers were found.

Several examples of single case studies can be found in publications by Burd and Marshall (1971) and Hays and Larsen (1963). The general purpose of these case studies was to illustrate the use of the theory. Examples of extensive case
studies using process recordings include those provided by Hays and Myers (1964) who analyzed 106 hours of nurse-client interactions with respect to the levels of learning described by Peplau (1971b) to demonstrate that clients moved sequentially through these levels. Another detailed example was provided by Lemmer (1988) who analyzed a series of 17 interactions and reported that Peplau's theory was clinically useful in a domiciliary care setting. A disadvantage of the case study approach is that it is usually limited to the study of a single nurse-client dyad, and generally no comparisons are made between dyads. An exception to this is provided by Thompson (1986) who compared two women receiving short-term individual therapy based on Peplau's theory. Thompson demonstrated that Peplau's theory can be successfully used in short-term counselling, since most of the earlier work focussed on long term relationships.

Forchuk and Voorberg (1991) reported on an evaluation of a community mental health program. The program was based on Peplau's theory. The evaluation examined client outcomes after a two year period. The method involved retrospective review of 92 client records by blind reviewers. The client outcomes included a decrease in hospital admissions, a decrease in social isolation, and improvement in activities of daily living. No comparison was made to other community mental health programs based on different theoretical
perspectives.

Using Silva's (1986) classifications for the use of theory in nursing research, the studies described above demonstrate inadequate use of nursing theory. This is because they assumed Peplau's theory was correct and did not test it with regards to its propositional statements. Silva (1986) found few nursing studies provided a test of nursing theory. This is particularly important when it is recognized that some findings which are predicted by Peplau's work are inconsistent with those predicted by some other nursing theories.

Theories such as those of Rogers (1970; 1980; 1986) and Parse (1981; 1987) claim that each nurse-client encounter is unique; this is inconsistent with Peplau's characterization of the nurse-client relationship as evolving through predictable, sequential phases evolving over a linear period of time. For example, Parse (1988) viewed Peplau's four phases of the nurse-client relationship as a contrast to her theory. Parse clearly rejected the idea that relationships move though similar phases and criticized Peplau's perspective as negating the uniqueness of each relationship.

Three surveys of psychiatric nurses have found Peplau's work to be the most common nursing theoretical basis of practice. For example, Martin and Kirkpatrick (1987; 1989), in two surveys of registered nurses at a Canadian tertiary care psychiatric hospital, found that approximately two
thirds of the sample used Peplau's framework. Similarly, in an American national survey of psychiatric nurses, Hirschmann (1989) found half of the subjects reported using Peplau's work as a theoretical basis. Considering the apparent wide use of Peplau's work in mental health-psychiatric nursing, very little empirical testing of her work on the nurse-client relationship has been done.

The Nurse-Client Relationship and Therapeutic Alliance

The research on Peplau's theory has focussed on the nurse-client relationship, and will not be repeated in this section. Lego (1980) reviewed nursing literature published on the nurse-client relationship from 1946 to 1976. The vast majority of these publications involved single case studies and "of 166 clinical papers 78 were written by students and faculty colleagues of Peplau" (p.81). There does not seem to be any open debate in the nursing literature related to Peplau's premise that the therapeutic relationship is of importance. Specific nursing theories, however, vary in the specific emphasis placed on this phenomena. Some nursing theories focus on client variables more than the interrelationship of nurse and client (e.g., Neuman, 1982; Orem 1985; Roy, 1970; 1984;). Others, like Peplau, focus more on the interrelationship (King, 1981; Orlando, 1961; 1972).

A prolonged orientation phase has been noted by nurses when working with clients with chronic mental illnesses

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(Forchuk, in press; Forchuk, Beaton, Crawford, Ide, Voorberg & Bethune, 1989; Peplau, 1973b). An early nursing investigation which examined the orientation phase was the work of Rector (1965). She examined the content of the initial nurse-client interview with three case studies and concluded the content (both what was said and what was avoided) at the initial encounter was very important to the developing relationship.

Forchuk (in press) examined factors related to the time in orientation with 72 community-based clients with a chronic mental illness. The length of time in the orientation phase was not related to psychiatric diagnosis, current age, age of entry to the psychiatric system, or gender. There was a significant (p < .05) correlation between time in orientation and both number of psychiatric hospitalizations and duration of psychiatric hospitalizations. Time in the orientation phase was positively related to length and number of psychiatric admissions. This is in contrast to findings reported by Frank and Gunderson (1990) and Allen, Tranoff and Coyne (1985) that length of initial hospitalization was inversely related to time in establishing a therapeutic alliance. This difference may be explained in that, in the Forchuk study, subjects had an average of approximately five previous admissions, while in the other studies, subjects were hospitalized for the first time.
Nakata (1964) examined a four year nurse-client relationship with a young client with schizophrenia. She highlighted the importance of self-reflection of the nurse and a focus on the client as a person, rather than a focus on symptoms.

Orlando conducted two major studies on the nurse-client relationship, focusing on communication between the nurse and client. The initial study was published in 1961. "The purpose of the project was to identify the factors which enhanced or impeded the integration of mental health concepts in the basic nursing curriculum" (Orlando, 1961, p. vii). Orlando reviewed over 2,000 nurse-client encounters and found they could be divided into two mutually exclusive groups: deliberative and nondeliberative or automatic nursing (essentially good and bad nursing). The difference between the two groups pertained to the process of validation. The nurse validated his/her perceptions, feelings and/or thoughts with the client with deliberative nursing, but not with nondeliberative nursing (Schmieding, 1983).

Her results were replicated in several later studies with diverse client populations (Anderson, Mertz & Leonard, 1965; Dumas, Anderson & Leonard, 1965; Dumas & Johnson, 1972; Dumas & Leonard, 1963; Gowan & Morris, 1964; Hampe, 1975; Harrison, 1966; Schmieding, 1987a, 1987b, 1988; Wolfer & Visintainer, 1975). Since "improvement" in this model is
determined by a change in the initial client behavior, the model is very easy to test and consequences are readily demonstrated. Orlando (1972) reported on the implementation of her theory in practice in her second book.

Unfortunately Orlando did not publish her work in the style of a study. Her books expanded the theory resulting from the study, but did not present the study itself. Although she stated she took a year to analyze her data, very sketchy information was presented on the process. The study itself was described very briefly and only in the forward. Even the total number of interactions analyzed was not reported. This information was reported only briefly in a later chapter by Schmieding (1983) based on personal contact with Orlando.

Another classic work on the nurse-client relationship is the qualitative study by Gwen Tudor. This work was originally published in 1952, and reprinted in 1970. Tudor used a broad qualitative data base and attempted to validate her interpretations in the practice situation. She employed a method similar to grounded theory for the identification of themes. The investigator was in the role of participant-observer for 6 months in a psychiatric unit. Analysis included review and validation with a sociologist external to the unit. Although Tudor included verbatim interactions, she did not rely exclusively on them. Data included discussions and observations with staff and
clients, as well as clinical records. Two nurse-client interactions were presented and analyzed in detail. She found clinical documentation of changes in client behavior accompanied changes in the nurse-client relationship. Confirmability was shown with examples of the raw data and descriptions of the decision making process. This process involved validation and discussions with a sociologist. The process could be clearly followed by others not involved in the analysis. Schwartz and Schockley (1956), a sociologist-nurse team, focused on similar interpersonal patterns in a psychiatric facility and also noted patterns such as the mutual withdrawal described by Tudor.

There have been several researchers who have developed instruments to measure some aspect of the nurse-client relationship. A social interaction inventory was developed by Methven and Schlotfeldt (1962) to measure elements of empathy, warmth and genuineness. This instrument was later used by Sethie (1967) who found that public health nurses in Ontario tended to be on the empathic, warm, and genuine ends of the scales.

An instrument to measure psychological aspects of nurse-client interaction was developed by Mathews (1962). This study included analyzing the responses of 122 nurses to written statements designed to represent client statements. Only 30% of the nurses' responses were client centered. Responses that were not client centered included responses
categorized as task oriented or rule oriented.

An instrument to measure core dimensions to improve interpersonal process was developed by Aiken and Aiken (1973). This instrument was based on the therapeutic style suggested by Carl Rogers and measured the facilitative level of interactions.

Forchuk, Beaton, Bethune, Ide and Voorberg (1986) developed an instrument to measure the phases of the relationship based on Peplau's theory. This instrument was used as part of the clinical record for community mental health clients. It was found to be clinically useful in assisting the nurse to identify the current phase of the therapeutic relationship and design and implement appropriate phase-specific interventions. The instrument includes a pictorial overview of the relationship phases.

Hays (1966) analyzed 100 student nurse-client interactions according to the therapeutic and nontherapeutic techniques categorized by Hays and Larson (1963). The major communication problems included: changing topics, requesting explanations, seeking reassurance, probing and stereotyped nurse responses.

Lego (1980), in a review of nurse-client relationship literature, identified that until the early 1970s nursing was embroiled in a debate about whether the psychotherapist role was appropriate for nurses. Peplau strongly advocated for the psychotherapeutic role of the nurse. To make her
position explicit, she changed her label for the role of the nurse from the more timid "counsellor" in her earlier writings to "psychotherapist" in later writings. Nursing has borrowed from other psychotherapy literature for the implementation of this role. An example of this is Peplau's use of Sullivan's work in relation to anxiety and the self system. In view of this, it is appropriate to also review other psychotherapy literature.

The therapeutic or working alliance between therapist and client has been examined in psychotherapy literature. The relative importance of specific techniques versus the relationship per se has been debated. The relative importance of therapist factors or client factors versus interrelationship factors has also been examined.

Difficulties in establishing therapeutic relationships with individuals with chronic mental illnesses have been reported in recent review articles (Goering & Stylianos, 1988; Gunderson, 1979; Jennings, 1987). Difficulties in establishing therapeutic relationships with individuals with chronic mental illnesses may have been a contributing factor to the move to a biological and psychopharmacological approach to chronic mental illnesses. Coursey (1989) stated:

The success of the biological revolution in our understanding of schizophrenia, along with the lack of convincing evidence for the efficacy of global approaches to individual psychotherapy with
schizophrenia, has lead to the virtual disappearance of research and theory in this area (p. 349).

Although Coursey (1989) contended there is a virtual disappearance of research and theory in this area, the practice of psychotherapy with individuals with chronic mental illnesses is still very common. McCarrick, Rosenstein, Milazzo-Sayre and Manderscheid (1988) reviewed trends in the use of psychotherapy in psychiatric inpatient settings in 1975 and 1980 /1981. There was an increase in the use of psychotherapy with individuals with schizophrenia across all settings. The actual percentage of such individuals receiving psychotherapy ranged from 65.7% in state and county mental hospitals to 95.3% in private psychiatric hospitals.

Psychopharmacology has been most effective in relieving the positive symptoms of schizophrenia (e.g., hallucinations, and delusions) and major affective disorders (e.g., as depression and mania). However, the negative symptoms, such as, apathy, lack of energy, and amotivation, are not effected by psychotropics. Similarly, issues of living with a chronic disorder and problems of everyday living are not relieved by medication alone. These continuing problems may point to the need for reexamining psychotherapy with individuals with chronic mental illnesses (Coursey, 1989; Katz, 1989).
The initial phase of the relationship has been most predictive of the outcome of psychotherapy with individuals with chronic mental illness (Frank & Gunderson, 1990; Hartley & Strupp, 1983; Luborsky, 1976) as well as individuals with neuroses (Kirtner & Cartwright, 1958; Saltzman, Leutgart, Roth, Creaser & Howard, 1976). Difficulty in establishing relationships with individuals from the chronic population have been related to poor outcomes in treatment (Horowitz, 1974; Luborsky, 1976; Orlinsky & Howard, 1978).

Frank and Gunderson (1990) studied the therapeutic alliance and treatment outcomes with 143 individuals with nonchronic schizophrenia. They found that the initial six months was a critical period. Although only 29.8% of the sample were able to establish a "good" alliance in this time, if dyads were unable to develop an alliance in this time, they did not tend to develop one at all. Only an additional 5.1% of dyads developed a "good alliance" over the next 18 months. Clients who were able to form a therapeutic alliance in six months had better treatment outcomes, including a lower dropout rate, less prescribed medication, greater compliance with medication, and fewer rehospitalizations over the next two years (p ≤ .05). Clients had been randomly assigned to an exploratory-insight-oriented therapeutic approach or a reality-adaptive-supportive approach. The treatment approach did not
significantly effect outcomes or therapeutic alliance. The quality of the alliance was determined through the Psychotherapy Status Report, a 15 item Likert scale, which focussed on the degree of active engagement in the therapeutic process.

Gehrs (1991) examined the relation of the working alliance and rehabilitation outcomes among 22 dyads in the early stage of their relationship. The clients were diagnosed as schizophrenic, and the dyads were recruited from an active community rehabilitation program. The attainment of rehabilitation goals was related to the establishment of a working alliance ($r$ ranged from .48 to .67). There was a high congruence of client and therapist perceptions on the Working Alliance Inventory ($r = .52$) and the Modified Goal Attainment Scale ($r = .72$). This study also found that the therapeutic relationship slowly developed over several months, with significant changes between data collection periods at the fourth and seventh months of the relationship.

Kirtner and Cartwright (1958) studied 42 initial client-centered counselling sessions. The sample was neurotic, young (mean age = 27.9) and half were students. The initial session was rated by 2 judges into one of 5 categories. This initial categorization was predictive of both the length and outcome of therapy.

Saltzman, Luetgert, Roth, Creaser, and Howard (1976) also
conducted a study examining the initial phase of psychotherapy. This study also involved a neurotic, young (median age = 22), university student sample. There were 91 subjects. The first 10 sessions were rated independently by clients and therapists. At the termination of therapy, clients and therapists completed outcome rating forms. The researchers found that they could discriminate those that would drop-out from those who would remain in therapy until completion by the third session. Early perceptions of therapists, but not clients, were related to outcome.

Marziali, Marmar, and Krupnick (1981) examined therapist and client contributions to the attitudinal-affective climate of the therapeutic relationship, and worked on the development of a therapeutic alliance scale. They found that it was important to separate the perceptions of the therapist and client, and that the clients' attitudes towards the therapeutic relationship, but not the therapists' attitudes, were related to outcome. This is in contrast to the study by Saltzman et al. (1988). Outcome was judged by two social workers rating audiotapes. The sample was relatively small (n = 25) and healthy (suffering from neuroses rather than psychoses).

There appears to be a debate in psychotherapy literature whether the relationship itself is the essential ingredient of psychotherapy. Other emphases include techniques, therapist variables, and client variables. The
issue is particularly clouded by difficulties in determining an appropriate outcome measure of psychotherapy (Strupp, 1978).

Lambert (1982) reviewed the relative importance of the therapeutic relationship within different schools of psychotherapy. He demonstrated that in the more traditional psychoanalytic school, the Alderian school and the Rogerian school, the developing therapeutic relationship is thought to be the primary focus. Brief psychotherapy was described as viewing the therapeutic relationship as important, but as a prerequisite rather than as an ongoing focus. Behavior therapists, family therapists and rational-emotive therapists put much more emphasis on the specific techniques to be employed and do not focus on the therapeutic relationship. Gestalt therapy was described as requiring an "authentic relationship" but also strongly reliant on specific techniques.

Bordin (1979) argued that the concept of the working alliance between therapist and client can be generalized across all psychotherapies, despite a varied emphasis on this concept. He stated that all psychotherapies involve some agreement between therapist and client on goals and tasks, and all psychotherapies require the establishment of some bonds. There are differences, however, in the nature of the specific goals, tasks and bonds between therapist and client depending on the type of psychotherapy.
The commonality of a therapeutic relationship has been used as an explanation for the phenomena that all psychotherapies seem to work to some extent. Bergin and Lambert (1978) reviewed almost two hundred studies examining the effect of various psychotherapies with various client groups. They concluded that generally psychotherapeutic treatment approaches are effective. However, the similarity in effectiveness across modalities may suggest a placebo effect. "Instead of controlling for them by adopting a spurious parallel with medical placebos, we may be dismissing the active ingredients we are looking for" (p.180).

Parloff, Waskow, and Wolfe (1978) reviewed just over two hundred studies involving research on therapist variables in relation to process and outcome. They concluded that the therapist's emotional problems may interfere with effectiveness. Most therapist variables considered in isolation from client variables were inconclusive. These included the therapist's gender, experience, style of interaction and use of empathy, warmth and genuineness. Studies examining the combined therapist and client variables found congruence of expectations tended to decrease drop-outs but was not necessarily related to other outcomes. Adequate client preparation tended to enhance outcomes. Areas that hold some promise for improving outcome include compatible personalities, values,
and cognitive styles between the therapist and client.

Luborsky, McLellan, Woody, O'Brian, and Auerbach (1985) examined therapist success. They examined differences in three different approaches: supportive-expressive psychotherapy, cognitive-behavioral psychotherapy and drug counselling with clients randomized to treatment approach. Differences were not found among the theoretical approaches, but rather, among specific therapists. Some therapists, within each treatment approach group, consistently had more positive outcomes than their colleagues. Using "pure" rather than eclectic approaches, as judged by videotaped sessions, was also correlated to positive outcomes ($r = .44$). Therapists tended to vary their "purity" in working with different clients. In other words, the same therapist might more consistently apply a theoretical approach with one client than with another. Even within the caseload of a given therapist more positive results were found when the therapist was theoretically consistent ("pure") rather than eclectic. A similar finding, that the individual therapist made the difference, was reported earlier by Ricks (1973).

Psychotherapy with individuals with schizophrenia has not been as successful as psychotherapy with other client groups (Gomes-Schwartz, 1984; Gunderson, 1979). Goering and Stylianos (1988), in a review of the literature, found that schizophrenic clients were more likely to respond to supportive versus more intensive psychotherapy. They
suggested that the recent success of rehabilitation therapy with this population is related to its similarity with supportive psychotherapy, and that this underlying similarity is related to the establishment of a working alliance.

Jennings (1987) suggested that four major psychotherapies (existential psychotherapy, psychoanalysis, client-centered psychotherapy, and family therapy) were changed after therapists from these schools began to work with individuals with schizophrenia. In particular, all increased an emphasis on interpersonal phenomena, particularly therapists' subjective responses to the client.

In summary, the nurse-client relationship has been seen as a major focus of nursing by some nurse theorists. Even though it has not been a recent focus of nursing research, there has been a great deal of nonnursing research on the therapeutic relationship that may be generalizable to the nurse-client relationship. The literature suggests that therapeutic relationships are complex phenomena. Although hundreds of studies have been conducted on this topic, much is still unknown. Psychotherapy with clients with chronic mental illnesses, such as schizophrenia, present particular challenges.

Preconceptions

Although stereotypes exist for both nurses and chronic psychiatric clients, very little research has been reported
on the preconceptions nurses and psychiatric clients have of each other.

Nurses have been portrayed in the entertainment media as unimportant and uncommitted (Hughes, 1980; Kalisch & Kalisch, 1986). With media examples, such as Nurse Ratchett from One Flew over the Cuckoo's Nest, the image of the psychiatric nurse may be even worse.

Kalisch and Kalisch (1981) studied the media portrayal of psychiatric nurses compared to other nurses through content analysis of full length films released between 1930 and 1980. Compared to other nurses, psychiatric nurses were portrayed as less physically attractive, having a great desire for and abuse of power, and lacking nurturance. Psychiatric nurses commonly served as an "antagonist to a positive, progressive, attractive psychiatrist" (p.119) and tended to do their clients more harm than good. Administrative psychiatric nurses were frequently portrayed as being mentally ill.

Reich and Geller (1977) examined the self-image of psychiatric nurses by administering Adjective Check Lists (Gough & Heilbrun, 1965) to 91 psychiatric nurses working at one of two large psychiatric hospitals in New York City. They found the psychiatric nurses generally had a positive self-image. Compared to female norms for the test, they scored significantly higher on the following: self-confidence, self-control, personal adjustment, achievement,
dominance, endurance, order, intraception, and counselling readiness. They scored significantly lower on: lability, succorance, abasement and total number of negative items checked.

Both qualitative (Estroff, 1981; Goffman, 1961; Plum, 1987; Teasdale, 1987) and quantitative studies (Cummings & Cummings, 1961; Durham & Weinburg, 1960; Neuhring, 1979; Scheff, 1966; Somer & Whitney, 1961) have reported that psychiatric clients generally experience stigmatization and stereotyping. Psychiatric clients have been reported as viewing staff as impersonal and/or indifferent to them (Goffman, 1961; Rosenhan, 1973), or as controlling and/or threatening (Goffman, 1961; Rosenhan, 1973; Nabosiak et al., 1957; Scott & Phillip, 1985; Staton & Schwartz, 1954).

On the other hand, a Canadian survey of 1090 respondents found public attitudes to psychiatric clients and facilities to be generally sympathetic and positive, and only a very small minority (5 respondents) were in opposition to them (Taylor, Dear, & Hall, 1979). This study was replicated in New York with 180 respondents and only 10 percent were in opposition (Rabkin, 1984).

Manis, Hunt, Brawer, and Kercher (1965) examined the conceptions of mental illness held by 1,183 randomly selected members of the general public and seven psychiatrists from the same community. Although the differences in subgroup sizes would be a limitation, it was
interesting that the two groups held similar beliefs. Both groups tended to perceive persecutory, bizarre or emotional behavior as more indicative of mental illness than manic, conformist, grandiose or depressive behavior. The hypothesis had been that troublesome or disruptive behavior would be interpreted as indicative of mental illness by the general public but not by the psychiatrists. In the findings, neither group held conceptions that equated such behaviors with mental illness.

Morrison, Smith, Fentiman, Madrazo-Peterson, and Boyagian (1979) studied the attitudes of community gatekeepers (family doctors n = 58, clergy n = 47, lawyers n = 52) and psychiatric social workers (n = 63) regarding mental illness. They found that the gatekeepers had more stereotyped attitudes than the social workers. There was little difference between the types of gatekeepers, except that, not surprisingly, the physicians were more likely to use a medical model of mental illness.

Scott and Phillip (1985) studied the attitudes of 208 psychiatric nurses and nursing assistants regarding treatment and clients. Questionnaires developed previously by Caine and Smail (1968) were used. Staff who were more educated, younger and male were less likely to be impersonal towards clients or favor physical methods of treatment. The group as a whole had more positive attitudes than those reported by Caine and Smail almost twenty years earlier.
Plum (1987) conducted a qualitative analysis of 20 autobiographical accounts of psychiatric clients. She found that ignorance and stigma were perceived to be the greatest hindrances to recovery.

Teasdale (1987) used a qualitative grounded theory approach to analyze the views of 21 clients in a day psychiatric treatment program. Struggle with the stigma of "madness" was a major theme that emerged. The label of schizophrenic was the most feared and resisted. Stigma was perceived by the clients to interfere with obtaining employment and maintaining social relationships.

Wahl and Harmen (1989) found that family members of individuals with chronic mental illness were very concerned about the stigma of mental illness. Of the respondents, 76.6% reported that stigma had affected their mentally ill relatives. In particular, relationships with other family members and self-esteem were thought to suffer as a result of stigma.

Langer and Abelson (1974) had forty mental health clinicians assess the behavior of an individual on the basis of a videotaped interview. Half of the clinicians were psychoanalytically oriented and half were behaviorally oriented. Half of the clinicians were told the individual was a patient and the other half were told he was a job applicant. Psychoanalytic clinicians who had been given the "patient" label tended to rate the individual as far more
disturbed. Clinicians with a more behavioral perspective rated the individual as well adjusted regardless of label. There were no significant differences between clinicians of various theoretical backgrounds in their ratings of the "job applicant." This study is interesting in demonstrating the potential interplay of labelling and theoretical orientation.

In 1971, Doherty reviewed two dozen research articles from the previous thirty years on social attraction and choice among psychiatric clients and staff. He concluded that a major theme was that staff's initial liking of clients was consistently related to positive therapeutic outcomes.

Stereotyping according to diagnosis has been found to be related to lack of empathy (Gallop, Lancee & Garfinkel, 1989). Gallop and her colleagues found that nursing staff had more negative responses to clients labelled as having a personality disorder compared to those labelled schizophrenic. The sample included 124 psychiatric nurses from 5 short term psychiatric units in Ontario, Canada. The nurses were asked to give likely responses to hypothetical situations. The hypothetical clients were diagnosed as either having a borderline personality disorder or schizophrenia. The clients with a personality disorder were more likely to receive belittling or superficial comments. Those with schizophrenia were more likely to receive
empathic responses. Gallop concluded:

If the individuality of the patient is lost to a stereotype and his or her behavior is prejudged, then it is not perplexing that the responses both of the nurses and patients follow a predictable and non-therapeutic pattern (1988, p.20).

Glazer (1981) examined the labelling of "good" patients. Eight consumers, three nurses and three physicians were included in this qualitative investigation. Responses given by two of three nurses included: asks questions, undemanding, and participates in self care. In contrast the physicians and consumers both most commonly responded that a good patient follows physicians' orders.

Gladstone and McKegney (1980) examined relations between perceived client behaviors and nurses' attitudes in a general medical ward. Clients perceived as manipulative or uncooperative were disliked. Staff felt drained by, or wanted to avoid, clients who were in pain, cried or seemed depressed. Positive client behaviors included the following: happy, calm, comfortable, satisfied, cooperative, reality testing, smiling and in contact with other clients.

Negative initial impressions of therapists by clients have been found to lead to higher drop-out rates (Kline, Adrian & Spevak, 1974). Clients who perceived the therapist to be uninterested, have been found to be particularly likely to drop out of treatment prematurely (Cain & Smail,
Using a questionnaire, Kline and others (1974) studied 432 clients' evaluations of their therapists and outpatient services after the first interview. The nature of the client sample was not described, other than stating that they were psychiatric outpatients. Those who prematurely ended therapy tended to perceive their therapists as uninterested, and about half of them chose to seek treatment elsewhere. Those who remained in therapy were generally complimentary about both the therapist and the outpatient services.

Lorr (1965) examined clients' perceptions of their therapists. A sample of 523 clients in individual therapy (32% had psychotic illnesses) rated client perceptions of their therapists on an inventory of 65 statements. Major dimensions were identified as understanding, accepting, authoritarian, independence-encouraging, and critical-hostile. The dimensions of understanding and accepting were found to be related to client perceived improvement.

Mental health workers supportiveness or nurturance has been mentioned as important to chronic mental health clients (Goering, 1988; Goldstein, Cohen, Lewis & Struening, 1988; Lamb, 1982). Goldstein et al. (1988) compared staff and client evaluations of the treatment environment. Five partial hospitalization programs in New
York were examined. There were 90 clients and 41 staff in the sample. Clients were chronic and two-thirds had schizophrenia. Clients considered a supportive, involved staff and program clarity to be the most important factors related to successful treatment.

In conclusion, both nurses and clients in the therapeutic relationship can be expected to have some unique preconceptions based on the interweaving of public stereotypes and personal experiences. However, the effect of these preconceptions on the course and outcome of the therapeutic relationship is unknown.

Other Interpersonal Relationships

Relationships can be examined through the construct of social support. Social support has been defined differently by different writers, but an emphasis on interpersonal relationships is a common theme. Norbeck (1982) proposed that the notion that social support is given in the context of a network of social relationships crosses theoretical understandings of this concept. In 1988 she summarized the assumptions she first identified in 1982:

(a) Social support refers to interpersonal interactions and relationships; (b) these interactions provide emotional support or actual help with tasks or problems; (c) this support is usually provided by members of the individual's social network, not by strangers, professionals,
or casual acquaintances; and (d) social support is both given and received by the members of the network, and the members try to share equally in the giving and receiving (p. 174).

Social support was described by Kahn (1979) as encompassing affect, affirmation, and aid. Norbeck, Lindsay, and Carrieri (1983) stated such support is provided through the number of people in a social network, the duration of relationships and frequency of contacts. Norbeck (1988) differentiated between two main types of social support: psychological support (emotional support, trust, information, advice, and support for self worth) and tangible support (direct assistance including material goods or money). Cobb (1976) included information that leads to the belief that one is loved, esteemed and a network member. Weiss (1974) included the dimensions of intimacy, social integration, worth, nurturance and assistance.

Interpersonal Relationships and Clients with Chronic Mental Illnesses

Through both quantitative descriptive studies (Isele, Merz, Malzacher, & Angst, 1985; Schwartz, Robinson, Flaherty, Jobe, & Birz, 1986) and ethnographic studies (Estroff, 1981; Scheper-Hughes, 1981), individuals with chronic mental illnesses have been found to have few members in their social networks.

Pattison, Defransisco, Wood, Frazier, and Crowder
(1975) found psychotic individuals had four to five members, almost exclusively relatives, in their social networks. This is many fewer than the 20 to 30 members, including relatives and unrelated friends, found in the nonpsychiatric subjects in the same study. Similarly, Schwartz et al. (1986) found that 37 individuals with a chronic mental illness who attended a supportive out patient clinic had few social supports, but did have some support outside the clinic environment. Subjects listed the opportunity for "contact" with others as the most beneficial aspect of the clinic.

Tolsdorf (1976), in a descriptive study, found 10 individuals with psychotic illnesses tended to have a negative orientation (for example anger) to what few supports they did have. They were less likely to request help from their network members than the 10 individuals in the matched medical comparison group.

Correlational studies focussing on the negative quality of family interactions, have found high expression of emotions (a count of negative comments and criticisms during an interview) within the family to be related to relapse among people with schizophrenia (Hogarty, Anderson, Reiss, Kornblith, Greenwald, Javna & Madonia, 1986; Spiegel & Wissler, 1983; Spiegel & Wissler, 1986; Vaughn & Leff, 1976). Similarly, small networks have been related to increased hospitalization (Cohen & Sakolovsky, 1978).

Hogarty and others (1986) randomly assigned 103 clients
living with families with high expressed emotion (EE) to one of four, two year aftercare programs: (a) family education and chemotherapy; (b) social skills training and chemotherapy; (c) family education, social skills training and chemotherapy; or, (d) chemotherapy only. The first two groups had half (20% and 19%) the relapse rate of the group receiving medication only (41%). However, the third group which received a combined approach had no relapses (0%) during the study period. This study demonstrated that medication alone is not the answer to treatment for individuals with schizophrenia, and supported the use of an intensive treatment approach which considers interpersonal phenomena. The authors cautioned that their results could be interpreted as a delay in relapse rather than prevention of relapse.

Goldstein, Miklowitz, Strachan, Doane, Nuechterlein, and Feingold (1989) examined the reciprocal nature of high expressed emotion (EE) within families that included a member with recent onset schizophrenia. There were 45 families included in this study. The schizophrenic members belonging to high EE families consistently made critical comments about their family members. In contrast, the schizophrenic members of low EE families had few critical comments directed towards family members. There were only three families where this pattern was not found.

Serban (1975) examined factors related to the
functioning and rehospitalization of people with schizophrenia. The study included 125 subjects with acute schizophrenia, 516 subjects with chronic schizophrenia, and 95 normal control subjects who were followed over a two year period. Interpersonal relationships were strong predictors of rehospitalization. Among the chronic group, the factors related to rehospitalization were: antisocial behavior, interpersonal difficulties with the opposite sex, interpersonal difficulties with neighbors and lack of religious affiliation. Among the acute group, the factors related to rehospitalization were: interpersonal difficulties with parents, and difficulties with friends.

A quasi-experimental study (including a pretest, posttest, randomization to control or cohort group) found network therapy led to improvements in size and quality of networks (Schoenfield, Halevy, Hemley-van der Velden & Ruf, 1986). When the 20 subjects in the experimental group were compared to the 20 cohort subjects, the network therapy approach was found to reduce both number of hospitalizations, and days of hospitalizations over a two-year follow-up period.

Through correlational studies, lack of family support offered to individuals with chronic mental health problems has been related to the perceived burden of having a mentally ill relative (Crotty & Kulys, 1986; Noh & Turner, 1987). Yet there is not a simple causal relationship.
between chronic mental illness and lack of support or poor relationships. In a longitudinal, prospective study, Isele, Merz, Malzacher, and Angst (1985) found lack of support and general difficulties with interpersonal relationships preceded the onset of schizophrenia. This multiple site study was conducted in several European countries. It compared 69 subjects with first onset schizophrenia to 60 healthy subjects.

A study of 15 young nonchronic schizophrenic subjects suggested a biological basis for interpersonal difficulties (Seidman, Sokolove, McElroy, Knapp & Sabin, 1987). A relationship was found between enlarged lateral cerebral ventricles and fewer relationships, fewer types of relationships, and less independent living arrangements. The social network difficulties were not explained by demographic variables, length of illness, neuropsychological difficulties or lack of motivation.

The role of interpersonal relationships in the course of schizophrenia has been controversial. Prior to the popularity of a biological theory of schizophrenia, families, particularly mothers, were blamed for the onset of schizophrenia in their family members. Individuals or families thought to cause schizophrenia in others were called "schizophrenogenic." Thus family members who experienced this blaming may feel vindicated by the biological movement, and may tend to perceive any return to
a focus on relationships as suspect.

To summarize the literature on clients' social support: lack of social support and poor interpersonal relationships have consistently been found to be common, and highly significant problems among people with chronic mental illnesses. This consistency is across a wide variety of studies, employing different research approaches.

Interpersonal Relationships and Nurses

The concept of interpersonal relationships, other than therapeutic relationships, has not been studied very directly with nurses. Difficulty with interpersonal relationships on the job was cited by Cohen-Mansfield (1989) as a source of job dissatisfaction. This study included 30 staff nurses who described sources of satisfaction and dissatisfaction with their work.

Similarly, Mueller and McClowsky (1990), in developing and testing a nurses' job satisfaction measure among 320 nurses, found, in their factor analysis, a factor they called "interaction." This factor included issues related to friendship opportunity and social interaction both during and after work. Also, feedback from supervisors and peers was found as a factor they called "praise-recognition." McClowsky (1990), in another study involving 320 newly employed nurses, found that the interaction of autonomy (control over one's work) and social integration (defined as relationships with coworkers) was related to the nurses'
commitment to the organization. However, no information is
given in either study that would differentiate nurses'
interpersonal relationships from those of other groups.
Other recent studies examining job satisfaction do not
comment on the interpersonal dimension (e.g., Dolan, 1987;

Literature on nursing shortages and nurses' burnout was
also examined for information on nurses' interpersonal
relationships. Meltz (1988) found a shortage of nurses in
psychiatric hospitals in Ontario well above the provincial
average. Similarly, Dolan (1987) found that psychiatric
nurses perceived themselves to be more "burned out" than
general staff nurses or nurse administrators. She also found
a decrease in job satisfaction to be a reliable indicator of
burnout.

Many factors have been identified as contributing to
nursing shortages. These interrelated factors include:
nurses' wages, working conditions, lack of recognition and
respect, lack of administrative support, lack of
opportunities for career development, and the organization
of the health care system (Beurhaus, 1987; Chernecki, 1989;
Langill, 1989; Meltz, 1988; Rajkumar, 1990). The literature
would suggest that quality of worklife issues rather than
issues outside the workplace, such as non-job related
interpersonal relationships, are involved.

In summary, clients' interpersonal relationships have
been frequently studied and found to be problematic among individuals with chronic mental illnesses. However, the concept of interpersonal relationships, other than therapeutic relationships, appears to be rarely examined with respect to nurses.

Anxiety

Anxiety is a phenomenon of concern in many disciplines. Rollo May, (1950) in his classic book, The Meaning of Anxiety, reviewed philosophical, biological, psychological, psychoanalytic, and cultural understandings of anxiety. As a synthesis, he defined anxiety as "the apprehension cued off by a threat to some value that the individual holds essential to his (sic) existence as a personality" (p.180). May emphasized that anxiety is an emotion essential to the human condition. In a later work, he differentiated anxiety from stress by clarifying that stress, as used by Selye, is chiefly physiological rather than emotional. "Anxiety is how we handle stress" (1983, p.144).

The belief that anxiety is related to the perception of personal danger has also been the focus of cognitive approaches to anxiety; clients treated for anxiety have been found to identify cognitions related to personal danger (Beck, Laude & Bohnert, 1974; Hibbert, 1984).

Anxiety can be seen as a normal part of human life, but when it becomes severe and interferes with normal functioning it may be diagnosed as a psychiatric disorder.
Severe anxiety has been related to suicide, alcoholism, sexual dysfunctions and physical illness (Fink, 1988; Pasnau, 1988; Rahe, 1988; Schuckit, 1983). Higher levels of anxiety have been found as people get older (Gaitz & Scott, 1972; Kata, 1975), for women compared to men (Kalimo, Bice & Novasel, 1970; Kata, 1975; Phillips, 1962) and within individuals with less education (Gaudry & Spielberger, 1971; Kata, 1975).

High levels of anxiety commonly accompany almost all psychiatric disorders (Lader & Marks, 1971). In particular, strong associations between anxiety and depression have been found to the extent that individuals with diagnosed depression are not discriminated from those with diagnosed anxiety disorders on some anxiety scales (Dobson, 1985; Mountjoy & Roth, 1982; Riskand, Beck, Brown & Steer, 1987; Tanaka-Matsumi & Kameoka, 1986) such as the State-Trait Anxiety Inventory (Spielberger, Gorsuch & Luchene, 1970), Hamilton Anxiety Rating Scales (Hamilton, 1959), and Self-Rating Anxiety Scale (Zung, 1971).

Anxiety among nurses or therapists has not been frequently explored. Bergin (1966) found that therapists with more anxiety were less successful with their clients. Menninger (1990) examined anxiety among 88 therapists by asking them, through a survey, to list anxiety-provoking experiences. Anxiety was found to be an extremely common experience during therapy. Only one therapist listed "none"
for anxiety-provoking experiences, and all but 8 listed three or more examples.

Johnson (1979) explored the effects of anxiety on the disclosure between nurses and clients. This study examined anxiety with both nurses ($n = 70$) and clients ($n = 68$). The sample was drawn from psychiatric, medical, surgical, and critical care settings. Psychiatric nurses in this study reported less anxiety than the other nurses. Nurses with more experience and nurses with less education also reported lower levels of anxiety. As anxiety levels increased, nurses were less likely to self-disclose to clients. Clients on the psychiatric unit had higher levels of anxiety than other client groups. Level of client to nurse self disclosure was very low. Client self disclosure also decreased as anxiety increased.

In contrast to the previously discussed study, Jones, Janman, Payne, and Rick (1987) found psychiatric nurses to have a higher degree of job related stress and anxiety than other employed groups. Similarly, De Leo Magna, Vallerini, and Dal Palu (1983) found psychiatric nurses had higher anxiety ratings as measured by Taylor's Manifest Anxiety Scale (1953) and higher Zung (1965) depression scores than general hospital nurses. However, Johnson (1979) found the psychiatric nurses had lower anxiety than nurses in other settings.

Buckelew, Degood, Schartz, and Kerler (1986) found
psychiatric clients (n = 50) had higher anxiety scores than hospital employees (n = 50) or pain patients (n = 50). Anxiety was assessed through the Symptom Checklist-90-Revised (Degratis, Rickels & Rock, 1976).

In summary, anxiety is a common phenomenon. Both clients and nurses would be expected to be experiencing some anxiety. However, the impact of anxiety on the evolving nurse-client relationship remains unknown.

Summary

Peplau's theory, although commonly employed in practice by psychiatric-mental health nurses, has not been tested through research. The literature related to her theory is largely composed of case histories reporting use of the theory in practice. There is, however, a great deal of nonnursing research exploring the therapeutic relationship. Review of the psychotherapy literature highlights the complexities of the therapeutic relationship and difficulty in establishing therapeutic relationships with individuals with chronic mental health problems. Although the initial phase of therapeutic relationships appears to be related to a variety of outcome measures, there is still much to be learned about how to facilitate this initial phase.

Negative stereotypes have been found to exist for both psychiatric nurses and their clients. Although stereotypes may be changing, this is unknown since most of the studies examining them are at least a decade old. Initial therapist
and client impressions do appear to influence the developing relationship. However, samples studied tend to include non-nursing therapists and clients without chronic or psychotic mental disorders.

The social relationships and support of individuals with chronic mental illness have been frequently studied. These individuals tend to have small social networks and negative interpersonal relationships. Improving social support is emerging as a method for preventing or delaying relapse. However, no research was found which explored the relation between social support and the therapeutic relationship.

The literature on nurses' interpersonal relationships is almost non-existent. Interpersonal relationships, other than therapeutic relationships, are only mentioned peripherally in the literature in relation to nurses. No study was found related to psychiatric nurses specifically or the relation between nurses' other interpersonal relationships and the evolving therapeutic relationship.

Anxiety has been found to be a common phenomenon amongst psychiatric clients. Contradictory findings exist in regards to anxiety among psychiatric nurses. The potential influence of the client's and nurse's anxiety on the evolving nurse-client relationship does not appear to have been studied.

In summary, much is still unknown about the variables
studied in this investigation. The investigation addresses several gaps in the literature including the testing of Peplau's theory, exploration of the initial phase of the therapeutic relationship with individuals with a chronic illness, and the impact of both nurse and client preconceptions, social support and anxiety on the evolving nurse-client relationship.
CHAPTER 3
Research Methods

Design

This investigation employed a prospective, longitudinal panel design to allow study of passage through the orientation phase of the nurse-client relationship. The study was correlational and used the initial results for the independent variables (preconceptions, interpersonal relationships, and anxiety) to predict later results for the dependent variable (development of the therapeutic relationship). All independent variables were measured for both nurses and clients. More positive preconceptions, positive interpersonal relationships and lower anxiety were expected to facilitate development of the therapeutic relationship. Development of the therapeutic relationship was measured through the number of weeks required in the orientation phase noted on the Relationship Form, and client and nurse ratings of the therapeutic relationship on the Working Alliance Inventory (WAI).

The design is summarized in Table 2. Data collection took place at the beginning of the nurse-client relationship (time-1), three months later (time-2), and six months later (time-3). The exception was the current phase
Table 2

Research Design

<table>
<thead>
<tr>
<th>Time-1 (0 mo.)</th>
<th>Time-2 (3 mo.)</th>
<th>Time-3 (6 mo.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current phase of relationship (evaluated weekly)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working alliance</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Preconceptions/conceptions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Anxiety</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Other interpersonal relationships</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Demographics</td>
<td>x</td>
<td>some</td>
</tr>
</tbody>
</table>
of the relationship which was monitored weekly on the Relationship Form, by the nurse.

Sample

The investigation utilized nonprobability, purposive sampling of newly formed nurse-client dyads. Potential dyads were identified within selected long term programs serving the chronically mentally ill population within south central Ontario, Canada. Consent to participate was given by nurses before their clients were approached. Consent was then obtained from clients. Dyads were included only when with both nurse and client consented to participate. The slow turnover of clients in all settings necessitated sampling at multiple settings.

Inclusion criteria for nurses. Nurse subjects in the study met the following inclusion criteria:

1. Used a theoretical basis for practice consistent with Peplau's framework, including the use of regular therapeutic meetings with clients.
2. Consented to participate.
3. Were employed in a program defined as serving individuals with chronic mental illnesses.
4. Were part of a newly assigned nurse-client dyad.

Inclusion criteria for clients. Client subjects in the study met the following inclusion criteria:

1. Were over age 18.
2. Were part of a newly assigned nurse-client dyad.
3. Enrolled in a program targeted at individuals with chronic mentally illness.
4. Made informed consent.
5. Were proficient in English to the degree necessary to understand and complete interview.

Sample size. The initial sample size was set at 100 dyads. This was based on the following statistical constraints: (a) alpha level set at ≤ .05, (b) unidirectional hypotheses, (c) expected medium relationships (r ≤ .30) (d) power of .80, and (e) a 20% anticipated drop out rate (Cohen, 1977; Volicer, 1984). However, since the discharge rate was larger than initially anticipated, the sample size was increased to 124. Dyads were not included after discharge since the nurse and client were no longer meeting.

Of the 124 dyads included in time-1, 57 dyads were included at time-2, and 38 dyads at time-3. The reasons for dyads not participating at the later data collection periods are summarized in Table 3. From Table 3 it can be seen that the most common reason dyads were not included at time-2 and/or time-3 was the client's discharge. (Since this is a Canadian study, all clients had universal health care coverage. Therefore an early discharge would be generally indicative of improved functioning.)
Table 3

**Dyads Included at Each Data Collection Period**

<table>
<thead>
<tr>
<th>Reason for not including at</th>
<th>time-2</th>
<th>time-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client discharged (in orientation)</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Client discharged (orientation completed)</td>
<td>26</td>
<td>1</td>
</tr>
<tr>
<td>Client discharged (orientation unknown)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Client transferred</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Client declined further participation</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Client died</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nurse left program/sick leave</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Nurse declined further participation</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Discontinued after Time-1 and Time-2**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67</td>
<td>19</td>
</tr>
</tbody>
</table>

**Time-1:**
- Total in Study: 124 Dyads

**Time-2:**
- Total Remaining in Study: 57 Dyads

**Time-3:**
- Total Remaining in Study: 38 Dyads
Characteristics of Sample. Although 124 dyads were in the sample, some nurses were involved in more than one dyad. A total of 74 different nurses participated. Within the 124 dyads, 107 were Registered Nurses (including all of the community nurses) and 17 were Registered Nursing Assistants; 119 were female and 5 were male. Other descriptive data for nurse subjects are displayed in Tables 4 and 5.

Of the 124 initial clients, 83 were male, 41 were female. Psychiatric diagnoses were available on only 81 clients; these were schizophrenia (57), affective disorder (10), schizoaffective (4), personality disorder (4), and other psychiatric diagnoses (6). Other client descriptive data are displayed in Table 6.

Refusal Rate. An accurate refusal rate is difficult to determine, since clients and nurses were usually approached by the nursing supervisor or delegate about possible inclusion in the study before their names were forwarded to the investigator. However, 59 dyads referred to the study were not included (32.2% of 183 referrals). These were comprised of 51 client refusals, 2 nurse refusals and 6 dyads who agreed to participate but were not

2 similar to licenced practical nurses in the United States
Table 4

**Descriptive Data on Nurse Subjects**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>22 - 63</td>
<td>39.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Years in nursing</td>
<td>0 - 39</td>
<td>16.9</td>
<td>21.0</td>
</tr>
<tr>
<td>Years in psych. nursing</td>
<td>0 - 27</td>
<td>12.5</td>
<td>20.4</td>
</tr>
<tr>
<td>Familiarity with Peplau's theory</td>
<td>1 - 5</td>
<td>3.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Use of Peplau's theory</td>
<td>1 - 6</td>
<td>4.2</td>
<td>1.4</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Nurse-client relationship</th>
<th>77.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health teaching</td>
<td>38.8%</td>
</tr>
<tr>
<td>Therapeutic milieu</td>
<td>34.6%</td>
</tr>
<tr>
<td>Work with family/social support</td>
<td>30.9%</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>19.8%</td>
</tr>
<tr>
<td>Monitoring psychotropics</td>
<td>16.0%</td>
</tr>
<tr>
<td>Other</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

Note: Multiple responses were given by individual nurses.
### Table 6

**Descriptive Data on Client Subjects**

<table>
<thead>
<tr>
<th>Variable</th>
<th>range</th>
<th>mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>19 - 86</td>
<td>44.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Previous psychiatric hospitalizations</td>
<td>0 - 40</td>
<td>6.4</td>
<td>6.8</td>
</tr>
<tr>
<td>Last hospitalization duration (months)</td>
<td>0 - 456</td>
<td>35.8</td>
<td>78.4</td>
</tr>
<tr>
<td>Hospitalization status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalized</td>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/ transitional</td>
<td>29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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included. The reasons for not including the last 6 dyads were concerns that the client was not making an informed consent (i.e. did not understand the nature of the study) (4), client difficulty with English (1), and client difficulty with the concepts of agree and disagree (1).

An attempt was made to compare clients not included in the study to those who were included. However, only limited access of inpatient records to one hospital were available to the researcher. Of the 6 that agreed to participate but were not included, 5 were male and 1 female; 3 had an organic brain disorder and 3 had schizophrenia. It is interesting to note that none of the included subjects had an identified organic brain disorder as the primary psychiatric diagnosis, and only 2 had this as a secondary diagnosis. This suggests adequate cognitive functioning was required by clients to participate in the study.

Information was also obtained on 18 clients who declined to participate: they were comprised of 10 male, 8 female; 16 with schizophrenia, 2 with organic brain disorders; an average age of 52.7 (compared to 44.1 for those in the study); an average of 9.25 hospitalizations (compared to 6.4 for those in the study); and, an average 22.0 months (compared to 35.8) for the most recent psychiatric hospitalization.

**Instruments**

Theoretical and operational definitions were presented
in Chapter 1, which described the theoretical implications of the study. The variables in the study and the empirical indicators for each variable are listed in Table 7. Each instrument is described, with particular emphasis on reliability and validity.

Progress in the Therapeutic Relationship. This variable was measured with two instruments. These instruments were the Relationship Form, which measures number of weeks in the orientation phase, and the Working Alliance Inventory (WAI), which measures nurses' and clients' perception of the evolving therapeutic relationship.

The Relationship Form (see Appendix B) was developed by Forchuk, Beaton, Crawford, Ide, Voorberg and Bethune (1986) to measure the phases of the nurse-client relationship as described by Peplau. It is a seven point scale depicting four phases of the relationship and three intermediate points.

Forchuk and Brown (1989) reported on the initial reliability and validity for the Relationship Form. Content validity was established by having Peplau review the form for accuracy as a measure of nurse-client relationships and consistency with her theory. In addition, a panel of three independent clinical nurse specialists (CNSs), who functioned from an extensive theory-based practice, reviewed
Table 7

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress in therapeutic</td>
<td>a) Relationship Form</td>
</tr>
<tr>
<td>relationship</td>
<td>Forchuk, Beaton,</td>
</tr>
<tr>
<td></td>
<td>Crawford, Ide,</td>
</tr>
<tr>
<td></td>
<td>Voorberg &amp; Bethune (1986)</td>
</tr>
<tr>
<td></td>
<td>b) Working Alliance</td>
</tr>
<tr>
<td></td>
<td>Inventory</td>
</tr>
<tr>
<td></td>
<td>Horvath &amp; Greenberg (1986)</td>
</tr>
<tr>
<td>Preconceptions</td>
<td>Semantic differential</td>
</tr>
<tr>
<td></td>
<td>scales adapted from</td>
</tr>
<tr>
<td></td>
<td>Osgood, Suci &amp;</td>
</tr>
<tr>
<td></td>
<td>Tannenbaum (1957)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Brandt &amp; Weinert (1981),</td>
</tr>
<tr>
<td>relationships</td>
<td>revised Weinert (1987)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Beck Anxiety Inventory</td>
</tr>
<tr>
<td></td>
<td>Beck, Epstein, Brown &amp;</td>
</tr>
<tr>
<td></td>
<td>Steer (1988)</td>
</tr>
</tbody>
</table>
the instrument. Interrater reliability was established by having an additional CNS act as a blind rater by reviewing clinical records and comparing her assessment of the phases to those determined on the form by the clinician in the nurse-client relationship. Agreement within one point of the seven point scale was 91%, but crude diagonal agreement was only 41%. A problem noted was, that in cases where disagreement existed, the CNS consistently rated the relationship one point higher than the clinician.

To counterbalance the clinicians' hesitancy to note a change in the relationship until it had persisted for several encounters, a secondary confirmation was used in this current study. The assigned nurse and a clinical nurse specialist (CNS) validated the current phase of the relationship. This was done through discussion and consensus with the assigned nurse. The CNSs were all experienced with practice from Peplau's framework, had at least 6 years psychiatric mental health nursing experience, and were blind to other measures. All CNSs who assisted in the rating reviewed two videotapes of simulated nurse-client encounters to enhance interrater reliability. The standard explanation for the relationship form is included as Appendix C and the memo sent to the CNSs is included as Appendix D.

The Working Alliance Inventory (WAI) was developed by
Horvath and Greenberg (1986) and is based on Bordin's concept of the working alliance (1979). It measures the quality and nature of the relationship from an interpersonal perspective. This instrument is a 36 item self report measure with parallel forms for therapist and client. It was developed as a "generic" instrument in that it can be used whatever the psychotherapeutic orientation of the therapist. It has three subscales: goals, tasks and bond. (See Appendix E for therapist form and Appendix F for client form.)

Initial testing of the instrument reported by Horvath and Greenberg (1986) used a relatively healthy sample: college students receiving counselling. Construct validity was established through working from the model of Bordin and comparing the items and scores to more established instruments such as the Relationship Inventory Form (Barrette-Leonard, 1978). Internal consistency, calculated by using Cronbach's alpha appeared reasonably high: .93 for the client form and .87 for the therapist form.

Horvath and Greenberg reported further work on the reliability and validity of their instrument. Three studies using therapists from a broad range of theoretical perspectives were summarized in 1989. High reliability results (Cronbach's alphas on subscales were .93, .87 and .93) continued to be achieved and the separate scales remained stable. Concurrent validity included moderate
similarities to the Relationship Inventory and the Counsellor Rating Form. Predictive validity on the WAI was superior to the other instruments when the various instruments were used to predict successful client outcomes \( p \leq .05 \).

A replication of the 1986 study was conducted in Toronto with a chronic mental health sample (Stylianos & Goering, in progress). Twenty-two therapists (including nurses) and 50 clients completed the Working Alliance Inventory (WAI) and the earlier Relationship Inventory Form (RI). Clients were able to complete the WAI in 40 minutes or less with minimal assistance. Apparently there was considerably more difficulty with the RI. Cronbach's alpha results on all subscales, for clients and therapists, ranged between .80 and .90.

For the current investigation, Cronbach's alpha for the entire sample was .94 for the total scale, .85 for the task subscale, .84 for the bond subscale, and .91 for the goal subscale. For the client group the results were .93 for the total scale, .82 for the task subscale, .85 for the bond subscale, and .79 for the goal subscale. For the nurse group the results were .95 for the total scale, .89 for the task subscale, .84 for the bond subscale, and .90 for the goal subscale.

Preconceptions. Preconceptions of nurses and clients were measured through two sets of semantic differential
scales. Semantic differential scales were developed by Osgood, Suci and Tannenbaum (1957) as attitude measuring instruments. Seven-point scales are used to separate bipolar adjective pairs.

Semantic differential scales were adapted for this investigation based on a preliminary survey and comparisons to descriptions found in the literature. A small convenience sample of 20 newly formed nurse-client dyads (mental health nurses and chronic mental health clients) were asked to give descriptions of each other. Responses given by more than one client are summarized in Table 8 and common descriptions from the literature are summarized in Table 9. Descriptions and specific adjective/phrase pairs that were used in the investigation are linked in both tables. Similarly, the nurses' descriptions of their clients are summarized in Table 10, and descriptions from the literature are summarized in Table 11.

The specific semantic differentials, drawn from the preliminary investigation and literature, are included as Appendices G and H. On the actual instruments used the direction (positive or negative) of the scales is varied. For example, good-bad, was followed by difficult-easy. However, in the scoring of the scales the negative end of the scale (for example bad and difficult) was given a value of 7 and the positive end of the scale (for example good and easy) was given a value of 1.
Table 8

Client Descriptions of Nurses

<table>
<thead>
<tr>
<th>Descriptions Used</th>
<th>Number of Clients</th>
<th>Bipolar Adjectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nice, good, not bad, bitchy, don’t give a damn</td>
<td>12</td>
<td>Good-bad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nice-not nice</td>
</tr>
<tr>
<td>Busy, doesn’t spend enough time with me</td>
<td>4</td>
<td>Busy-not busy</td>
</tr>
<tr>
<td>Can’t share feelings don’t mind sharing feelings with her, can share feelings</td>
<td>3</td>
<td>I can share feelings with nurse - I can’t share feelings with nurse</td>
</tr>
<tr>
<td>She helps me, a great comfort</td>
<td>2</td>
<td>Helpful-unhelpful</td>
</tr>
<tr>
<td>Descriptions Used</td>
<td>Source</td>
<td>Bipolar Adjectives</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Authoritarian, feel powerless, experience abuse, feel threatened, fear staff power</td>
<td>Scott &amp; Philip (1985)</td>
<td>Controls-let me control</td>
</tr>
<tr>
<td></td>
<td>Rosenhan (1973)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Goffman (1961)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Naboisek et al. (1957)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staton &amp; Schwartz (1954)</td>
<td></td>
</tr>
<tr>
<td>Depersonalizing &amp; indifferent, Impersonal</td>
<td>Rosenhan (1973)</td>
<td>Treats me as a person - does not treat me as a person</td>
</tr>
<tr>
<td></td>
<td>Scott &amp; Philip (1985)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Goffman (1961)</td>
<td></td>
</tr>
<tr>
<td>Feel stereotyped /stigmatized by staff</td>
<td>Cummings &amp; Cummings (1961)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durham &amp; Weinburg (1960)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scheff (1966)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Somer &amp; Whitney (1961)</td>
<td></td>
</tr>
<tr>
<td>Supportive</td>
<td>Lamb (1982)</td>
<td>Supportive - not supportive</td>
</tr>
<tr>
<td></td>
<td>Goering &amp; Stylianos (1988)</td>
<td></td>
</tr>
<tr>
<td>Nurturing</td>
<td>Goldstein et al. (1988)</td>
<td></td>
</tr>
<tr>
<td>Attraction &amp; liking</td>
<td>Doherty (1971) (summarizing 30 studies)</td>
<td>Attractive-not attractive I like nurse - I don't like nurse</td>
</tr>
<tr>
<td>Interest</td>
<td>Cain &amp; Smail (1968)</td>
<td>Interested in me - not</td>
</tr>
<tr>
<td></td>
<td>Goyne &amp; Ladoux (1973)</td>
<td>interested</td>
</tr>
<tr>
<td></td>
<td>Kline et al. (1974)</td>
<td>in me</td>
</tr>
<tr>
<td></td>
<td>Salvman (1970)</td>
<td></td>
</tr>
<tr>
<td>Descriptions Used</td>
<td>Number of Nurses</td>
<td>Bipolar Adjectives</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Difficult, easy</td>
<td>7</td>
<td>Difficult-easy</td>
</tr>
<tr>
<td>Feel empathy,</td>
<td>4</td>
<td>Feel empathy for-feel no empathy</td>
</tr>
<tr>
<td>feel sympathy,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for warmth, T.L.C.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No different than</td>
<td>4</td>
<td>Typical-unique</td>
</tr>
<tr>
<td>others, (refer to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnosis),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>different</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfying,</td>
<td>3</td>
<td>Satisfying-not satisfying</td>
</tr>
<tr>
<td>enjoyable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasant, likable,</td>
<td>3</td>
<td>Likable-not likable</td>
</tr>
<tr>
<td>lovely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>2</td>
<td>Good-bad</td>
</tr>
<tr>
<td>Cooperative,</td>
<td>2</td>
<td>Cooperative-uncooperative</td>
</tr>
<tr>
<td>uncooperative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggressive,</td>
<td>2</td>
<td>Safe-dangerous</td>
</tr>
<tr>
<td>violent,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dangerous,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nasty streak</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trusting, suspicious</td>
<td>2</td>
<td>Trusting-suspicious</td>
</tr>
</tbody>
</table>
Table 11

<table>
<thead>
<tr>
<th>Descriptions Used</th>
<th>Source</th>
<th>Bipolar Adjectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sympathy toward, empathy toward</td>
<td>Taylor et al. (1979) Gallop (1988)</td>
<td>Feel empathy for-feel no empathy for</td>
</tr>
<tr>
<td>Attraction &amp; liking</td>
<td>Doherty (1971) (summarizing 30 studies)</td>
<td>Attractive-not attractive I like client-I don't like client</td>
</tr>
</tbody>
</table>
Osgood et al. (1957) discussed the objectivity, reliability, sensitivity, comparability and validity of their scales based on evidence collected over a five-year period. On test-retest reliability with individual items the resulting coefficient was .85 with an N of 4,000 (p. 127). In other studies they found the scales accurate within a single unit (p. 131).

The validity of semantic factors was explored by Osgood et al. (1957) by having subjects make judgments of similarities and differences between concepts without the use of the semantic differential. Coefficients were .86, .90 and .36 when subjects were asked to choose the most similar of three concepts (p. 143-145). The last figure resulted from words being used that did not appear in Osgood et al.'s list. "However, when two identifiable factors were used to compute distances between concepts, and these distances were correlated across the two spaces, the resulting coefficient was .95" (p. 145).

Semantic differential scales have been frequently used in nursing studies (Woods & Cantanzaro, 1988, p.234-235). They appear to be widely accepted as attitude measuring instruments in both nursing and nonnursing studies. For this investigation, the semantic differentials completed by nurses at time-1 had an internal consistency (by Cronbach alpha) of .76, and those completed by clients a result of .83. The nurses' cronbach alpha at time-2 was .86 and
Interpersonal relationships. The Personal Resource Questionnaire (PRQ) was used to measure interpersonal relationships. The PRQ was developed by Brandt and Weinert (1981) and revised by Weinert (1987). It is a two part self report instrument designed to measure characteristics of social support. For this study only part two was used (see Appendix I).

Part two is a 25 item Likert scale based on Weiss's (1974) model of relational functions. Peplau (1987b) stated interpersonal relationships are identified in terms of their integrations, nature, origin, functions, or mode. Weiss's five dimensions are social integration, intimacy, nurturance, worth and assistance. Integrations are common to both models; intimacy, nurturance, worth and assistance are viewed as functions within Peplau's work (validated through personal correspondence, Peplau, March, 1991). The nature of relationships, according to Peplau (1987b), refers to the patterns that develop. The PRQ asks for information related to the nature of relationships by asking the respondent to indicate degree of agreement/disagreement with each of the items, e.g., "I can't count on my friends or relatives to help me with problems". The origin (history) and mode (form, style, method) are not included on the questionnaire or in Weiss's model. Peplau did not suggest that all components must be present to describe a
relationship. Therefore, it would appear that the second part of the PRQ is congruent with Peplau's concept of interpersonal relationships.

Part one, which was not used, asks respondents to list all possible sources of support in eight situations and indicate whether or not they have recently experienced these situations and their satisfaction with them. These items do not appear as congruent with Peplau's concept of relationships since they are situation-specific. They would give some indirect information about origins, but do not add to information related to mode. In addition, the complexity of these items makes them very difficult for many individuals with chronic mental illnesses to answer. This is due to the prevalence of thought disorders, which interfere with more abstract thinking. The respondent burden of asking for these additional responses did not justify the limited additional information that would be obtained.

Brandt and Weinert (1981) addressed the reliability and validity of the PRQ. The internal consistency, using Cronbach's alpha, was .89 for part two of the test. The internal consistency of the specific subscales was determined using Cronbach's alpha. The results ranged from .61 to .77. The subscales parallel to Weiss's five dimensions: social integration, intimacy, nurturance, worth and assistance. The investigators recommended that part two be used in full to reduce measurement error.
Several steps were taken by Brandt and Weinert to enhance the validity of their questionnaire. Three professors who were researchers in social support critiqued the PRQ for clarity and to ensure adequate representation of the domain. In addition, 25 graduate-prepared individuals categorized the items according to Weiss's dimensions; inconsistent items were deleted. In addition, community residents were asked to complete the questionnaire and comment on its relevance. The investigators noted revisions were made at each of these steps.

To determine predictive validity, the results of the PRQ were compared to results obtained on Pless and Satterwhite's (1973) family functioning measure, and two subscales from the marital adjustment scale of Spanier (1976). Moderate relationships were found.

Further testing of the instrument was reported by Weinert in 1987. Further evidence for the construct validity of part two of the instrument was demonstrated by inverse relationships with the Beck Depression Inventory (1967) \( (r = -0.33) \) and the Trait Anxiety Scale (Spielberger et al., 1970) \( (r = -0.39) \).

Two similar sample sets of middle aged adults were combined to obtain an adequate sample size \( (n = 282) \) for factor analysis. Cronbach's alpha for the two was .88; subscales produced alphas ranging from .62 to .75. Item to total correlations ranged from .29 to .70 (Weinert, 1987).
Factor analysis determined that the underlying dimensions of the instrument are a three-factor structure, rather than the five-factor structure proposed by Weiss. While the nurturance subscale consistently loaded on the same factor, there were overlaps between intimacy and assistance, and between integration and affirmation. The three-factor solution explained 44.4% of the variance. This three-factor solution was subsequently substantiated with a different sample of 164 middle-age men and women. Intimacy/assistance and integration/affirmation overlaps were again found. The nurturance subscale did not load on a single factor in the second analysis; a factor which appeared to reflect reciprocity rather than nurturance was found in this analysis. The three-factor loading explained 43.3% of the variance. Weinert (1987) concluded that the instrument has a three factor structure, but a few of the items are unstable and therefore additional item analysis must be conducted. The current scoring instructions are that only the total score be used.

The PRQ appears to have undergone considerable testing and has demonstrated reasonable reliability and validity. The possible instability of some items, that may load as a nurturance or reciprocity factor, would not appear to present a problem for this investigation.

Using the sample for this study, the internal consistency (Cronbach's alpha) was .93 for the entire group.
at time-1 and .94 for the entire group at time-2. The nurse alpha results were .88 for time-1 and .94 for time-2. The client alpha results were .87 for time-1 and .88 for time-2.

Anxiety. Anxiety was measured with the Beck Anxiety Inventory (BAI). The BAI is a 21 item self-report instrument that has been developed for measuring the severity of anxiety in psychiatric populations. It was developed by pooling items from several other anxiety instruments and reducing the number in the item pool through a number of analyses, including internal consistency and differentiation from depression. The BAI was found to have high internal consistency (Cronbach's alpha of .92) and test-retest reliability over a week (r = .75). The instrument was found to be more successful than previous anxiety scales in differentiating anxiety from depression (r = .25) (Beck, Epstein, Brown & Steer, 1988).

The BAI is conceptually similar to Peplau's levels of anxiety since each item is rated as mild, moderate or severe. Although it does not include a panic level, individuals in panic would not be expected to complete a questionnaire.

For this investigation the internal consistency (Cronbach's alpha) results were .91 for the entire group at time-1 and .89 at time-2. The nurse alpha results were .85 at time-1 and .68 at time-2. The client alpha results were .89 at time-1 and .87 at time-2. The lower alpha result at
time-2 for the nurse group reflects a greater diversity in responses for that time period. The alpha could have been raised to .70 if the item "dizzy or light headed" had been deleted. No other item deletions would have improved the alpha more than .01.

Demographic questions. A few demographic questions were asked to describe the sample: age, gender, psychiatric diagnosis, and the use of psychotropic medication. In addition, nurses were asked questions regarding their familiarity and use of Peplau's theory, and source of ongoing clinical supervision. Nurses were also asked how frequently they met with clients and for how long they usually met, since these would be possible confounding factors. The questionnaire used at the beginning of the relationship is presented as Appendix J. A shortened version, containing only items subject to change, was used for time-2 and time-3 (presented as Appendix K).

Data Collection

The sample was sought by accessing specific programs targeted at chronically mentally ill clients. The project was explained to staff at program meetings. Program managers/nursing supervisors/delegates supplied lists of nurses who were being assigned new clients. Nurses who met the inclusion criteria were asked to participate. When nurses agreed to participate, their newly assigned client(s) were approached, if they met the inclusion criteria for
clients, and were asked to participate. Only dyads (i.e., both nurse and client agreeing to participate) were included. Initial data collection took place prior to the third nurse-client therapeutic interview. This made it likely that subjects would focus on initial impressions. It is recognized that appointments might have been set, or brief introductions made, involving minimal interaction in addition to the therapeutic interviews. Separate data collection interviews took place for each nurse and client.

During a pilot study, subjects were asked whether they preferred an interview or questionnaire format; all but 2 of 20 clients preferred an interview. However, only 2 nurses had this preference. Therefore test materials were prepared so that they could be administered either way. If the subject opted for a questionnaire format, the interviewer remained present or available by telephone while the subject completed the questionnaire. A notation was made of the subject's format choice. All but four of the nurse responses were gathered by questionnaire; all but one of the client responses were gathered by interview. Data collection began in May 1990 and continued until the required time-1 sample was obtained in April 1991. Time-3 data collection was completed in Oct. 1991.

All data collection was the primary responsibility of the investigator. The investigator was assisted by fourth year undergraduate nursing students enrolled in a research
process course and research assistants hired by the nursing department at the hospital in which the investigator was employed. The instruments and protocol were reviewed with the students/assistants and mock interviews were completed prior to participation in data collection. When students/assistants were used, the same individual was used at all data collection periods for a given subject where possible. As described on page 70, the investigation also used CNSs to validate the phase of the relationship on the Relationship Form.

Protection of Subject's Rights

Subjects were under no obligation to participate in this study. Choosing to participate or not participate did not affect their treatment or employment (see Appendix L for standard explanation of study to potential subjects). Subjects could choose to omit any questions or items, and were informed of this right by having the investigator read them the consent form (Appendices M & N). Subjects' questions were addressed prior to requesting their signed consent, and during data collection. Anonymity was assured by instructing subjects not to sign their names on questionnaires and using coded identifying numbers on interview schedules. Anonymity was also protected by limiting requested demographic items to nonidentifying items.
CHAPTER 4

Results

Analysis was conducted on data collected from 124 initial nurse-client dyads, 57 at three months, and 38 at six months. Some subjects did not complete the WAI; only 46 clients completed it at time-2 and 26 at time-3. More items were missed or left blank by client subjects at time-3; when less than 10% of the items were missing on a scale the average of the other items was used for the missing items; when 10% or more were missing the entire scale was treated as missing and not included in analysis.

General descriptive data such as frequencies, ranges, and measures of central tendency were obtained on all variables. Multiple regression analyses were conducted to examine relations among the independent variables and progress in the therapeutic relationship. Specifically, clients' preconceptions of the nurse, nurses' preconceptions of the client, client anxiety, nurse anxiety, client interpersonal relationships, and nurse interpersonal relationships were the independent variables examined though multiple regression. Individual Pearson's $r$s for interrelationships among variables were calculated within this process. Changes in variables between data collection periods one and two were examined through use of $t$-tests. The Statistical Package for Social Sciences (SPSS-PC) was
used for data analysis. The significance level established for this investigation was $p < .05$.

In this chapter, a description of the results for each variable are provided, followed by summaries for each data collection period. Although findings are reported for time-3, due to the small sample at that point, comparisons are generally limited to time-1 and time-2. The results of the hypothesis testing are then reported.

**Progress in Therapeutic Relationships**

**Relationship Form.** Relationship Forms were completed for 94 nurse-client dyads: 51 who completed the orientation phase, 30 who discontinued the nurse-client relationship due to client discharge or transfer while still in the orientation phase, and 13 who remained in orientation after six months.

Among those who completed the orientation phase there was great diversity in the length of time taken. This ranged from 1 week to 30 weeks with a mean of 9.5 weeks ($SD = 6.96$). These measures of central tendency should be interpreted with caution since they do not include dyads still in the orientation phase, and therefore would not reflect an "average" time to complete the orientation phase for this sample, only average time for those who did complete it.

Three dyads completed orientation after the six month data collection (time-3). Nurses were not requested to
contact the investigator if this occurred, however, three nurses did. There were 32 dyads who completed the orientation phase prior to three months (time-2), and an additional 19 who completed the orientation phase after this period.

Data were examined to determine whether duration of the orientation phase was related to any items on the demographic questionnaire. To examine this, Pearson's $r$ was used for demographic variables at the ratio level, (see Table 12) and ANOVAs or $t$-tests were used to compare differences among groups for demographic data was at nominal categorical levels (see Table 13).

From Table 12, it can be seen that very few finding were statistically significant. The most significant finding was for duration of clients' previous hospital stay. The correlation between duration of previous hospital stay and weeks in orientation was .43. This suggests that clients who took longer in the orientation phase had longer previous hospital stays. Information on the previous admission was often missing from the questionnaire ($n = 31$), probably since it was unknown to the nurse. This is likely because client information is protected by the Mental Health Act of Ontario and cannot be obtained unless the client agrees to sign a specific form for the agency/hospital at which the client previously received services. When the previous
Table 12

Summary of Correlations for Ratio Level Demographic Variables and Weeks in Orientation

<table>
<thead>
<tr>
<th>Variables</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of nurse</td>
<td>-.07</td>
<td>NS1</td>
</tr>
<tr>
<td>Months of nursing experience</td>
<td>.04</td>
<td>NS</td>
</tr>
<tr>
<td>Months of psychiatric nursing experience</td>
<td>.00</td>
<td>NS</td>
</tr>
<tr>
<td>Time known client</td>
<td>-.11</td>
<td>NS</td>
</tr>
<tr>
<td>Meetings per month</td>
<td>.14</td>
<td>NS</td>
</tr>
<tr>
<td>Length of meetings</td>
<td>-.24</td>
<td>.05</td>
</tr>
<tr>
<td>Total time per month in meetings</td>
<td>-.24</td>
<td>.05</td>
</tr>
<tr>
<td>Age of client</td>
<td>.22</td>
<td>NS2</td>
</tr>
<tr>
<td>Number of previous hospital admissions</td>
<td>-.05</td>
<td>NS3</td>
</tr>
<tr>
<td>Duration of previous hospitalization</td>
<td>.43</td>
<td>.0074</td>
</tr>
</tbody>
</table>

Note n = 51 except as indicated
1 n = 44
2 n = 43
3 n = 35
4 n = 31
Table 13

**Summary of Analyses of Categorical Demographic Variables and Weeks in Orientation**

<table>
<thead>
<tr>
<th>Variables</th>
<th>t or F Results</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of registration (RN or RNA)</td>
<td>t = -0.05</td>
<td>48</td>
<td>NS</td>
</tr>
<tr>
<td>Setting (in-patient, transitional, community)</td>
<td>F = 0.73</td>
<td>2/48</td>
<td>NS</td>
</tr>
<tr>
<td>Role (e.g. primary nurse, case manager)</td>
<td>F = 0.46</td>
<td>5/45</td>
<td>NS</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>F = 0.99</td>
<td>5/43</td>
<td>NS</td>
</tr>
<tr>
<td>Nursing theory used</td>
<td>F = 1.65</td>
<td>13/20</td>
<td>NS</td>
</tr>
<tr>
<td>Psychiatric diagnosis</td>
<td>F = 0.24</td>
<td>4/36</td>
<td>NS&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Client medication</td>
<td>F = 0.83</td>
<td>4/21</td>
<td>NS&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Gender of client</td>
<td>t = -1.80</td>
<td>49</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Note.** n = 51 except as indicated
1 n = 41
2 n = 26
admission was to the present agency this information was available. The duration of nurse-client meetings and the total time spent in such meetings were also both significantly related to weeks in orientation.

From Table 13, it can be seen that time in orientation was not significantly different for various categorical demographic groups. There was a number of missing cases for both psychiatric diagnosis and client medication, which may have been unknown to the nurse on admission.

The results on the Relationship Form were compared to the results on the Working Alliance Inventory (WAI). A relationship was anticipated between the two, since both tools purport to measure aspects of the therapeutic relationship. This analysis was limited to dyads who completed orientation, and the WAI at time-2 (n = 35 nurses, 29 clients). Since the WAI is not to be given until dyads have been working together for at least two months, it was not used at time-1.

Pearson's $r$ was used to compare number of weeks in the orientation phase to WAI scores. Correlations for the therapist form of the WAI and weeks in the orientation phase were statistically significant for the total WAI and all subscales: total WAI (-.41), task subscale (-.42), bond subscale (-.28), and goal subscale (-.37). Similarly, results of the client form of the WAI were all statistically significant: total WAI (-.36), task subscale...
(-.51), bond subscale (-.70), and goal subscale (-.57). These results suggest that these two measures of progress in therapeutic relationships were similar, or interrelated.

Although the study did not pose any open ended questions, several nurses wrote in comments on the Relationship Form. With one exception, no comments were written on any other data collection forms. Interestingly, comments on the Relationship Form were only made by inpatient nurses, and generally to explain a lack of progress in the relationship. These comments were: that the client was inappropriate to the program and therefore discharged or transferred in the orientation phase (5), difficulty communicating with client due to language barriers (4), difficulty in meeting with client due to shift rotation (2), difficulty in seeing client since frequently reassigned to other clients (1), and, memory problems of client made it difficult to follow through on identification and working through of problems (1).

Working Alliance Inventory. The Working Alliance Inventory (WAI) was completed by 57 nurses and 46 clients at time-2, and 38 nurses and 26 clients at time-3. All subjects who completed the WAI at time-3 had also done so at time-2. The WAI was the last instrument in the package given to subjects. This position, as well as the length of this instrument (36 items), may have contributed to its omission by several clients. A summary of the descriptive

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data on the WAI are given in Table 14.

Although nurses tended to rate the relationship slightly lower than clients on each of the subscales and total, this difference was not statistically significant. There was a statistically significant positive correlation for the nurse and client scores within each dyad at time-2 (task .42, bond .27, goal .40, and total .42). In other words, nurses and clients had similar perceptions of the therapeutic relationship. The strength of these correlations for nurse and client scores on the WAI increased at time-3 (task .65, bond .47, goal .70, and total .66).

Data were examined to determine whether progress in the therapeutic relationship, as measured by the WAI, was related to any of the variables on the demographic questionnaire. To examine this, Pearson's $r$s were used for demographic variables at the ratio level, (see Table 15) and ANOVAs or $t$-tests were used to compare groups when the demographic data was at the nominal level (see Table 16).

From Table 15, it can be seen that several demographic variables were significantly related to WAI scores. Highest correlations were for length of the nurse's age, nursing and previous psychiatric experience, total time spent in nurse-client meetings per month, number of previous hospital admissions of the client, and length of time the nurse and
Table 14

Results on the Working Alliance Inventory

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time-2</th>
<th>Time-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 57 Nurses</td>
<td>Range</td>
</tr>
<tr>
<td></td>
<td>46 Clients</td>
<td></td>
</tr>
<tr>
<td>Bond</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>38-80</td>
<td>54.51</td>
</tr>
<tr>
<td>Client</td>
<td>37-83</td>
<td>65.02</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>28-74</td>
<td>58.53</td>
</tr>
<tr>
<td>Client</td>
<td>36-83</td>
<td>61.87</td>
</tr>
<tr>
<td>Goal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>31-76</td>
<td>55.89</td>
</tr>
<tr>
<td>Client</td>
<td>32-81</td>
<td>60.02</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>105-225</td>
<td>178.93</td>
</tr>
<tr>
<td>Client</td>
<td>115-241</td>
<td>186.22</td>
</tr>
</tbody>
</table>

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Table 15

Summary of Correlations for Ratio Level Demographic Variables and WAI

<table>
<thead>
<tr>
<th>Variables</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of nurse</td>
<td>.29</td>
<td>.021</td>
</tr>
<tr>
<td>Months of nursing experience</td>
<td>.26</td>
<td>.03</td>
</tr>
<tr>
<td>Months of psychiatric nursing experience</td>
<td>.32</td>
<td>.01</td>
</tr>
<tr>
<td>Time known client</td>
<td>-.27</td>
<td>.02</td>
</tr>
<tr>
<td>Meetings per month</td>
<td>-.04</td>
<td>NS</td>
</tr>
<tr>
<td>Length of meetings</td>
<td>.11</td>
<td>NS</td>
</tr>
<tr>
<td>Total time per month in Meetings</td>
<td>.32</td>
<td>.01</td>
</tr>
<tr>
<td>Age of client</td>
<td>-.24</td>
<td>.052</td>
</tr>
<tr>
<td>Number of previous hospital admissions</td>
<td>-.30</td>
<td>.033</td>
</tr>
<tr>
<td>Duration of previous hospitalization</td>
<td>-.16</td>
<td>NS4</td>
</tr>
</tbody>
</table>

Note. n = 54 except as indicated

1 n = 52
2 n = 48
3 n = 42
4 n = 32
Table 16

Summary of Analyses of Categorical Demographic Variables and WAI

<table>
<thead>
<tr>
<th>Variables</th>
<th>t or F Results</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category of registration (RN or RNA)</td>
<td>t = .36</td>
<td>53</td>
<td>NS</td>
</tr>
<tr>
<td>Setting (in-patient, transitional, community)</td>
<td>F = .73</td>
<td>2/53</td>
<td>NS</td>
</tr>
<tr>
<td>Role (e.g. primary nurse, case manager)</td>
<td>F = 1.01</td>
<td>5/51</td>
<td>NS</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>F = .40</td>
<td>5/50</td>
<td>NS</td>
</tr>
<tr>
<td>Nursing theory used</td>
<td>F = 1.19</td>
<td>20/20</td>
<td>NS</td>
</tr>
<tr>
<td>Psychiatric diagnosis</td>
<td>F = .66</td>
<td>4/42</td>
<td>NS^1</td>
</tr>
<tr>
<td>Client medication</td>
<td>F = .61</td>
<td>5/22</td>
<td>NS^2</td>
</tr>
<tr>
<td>Gender of client</td>
<td>t = -.20</td>
<td>55</td>
<td>NS</td>
</tr>
</tbody>
</table>

Note. n = 56 except as indicated

^1 n = 47
^2 n = 28

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client knew each other prior to working together. The nurse's length of psychiatric experience and total time spent with the client were positively related to development in the therapeutic relationship. On the other hand, duration of time the nurse and client knew each other prior to assignment and frequency of client admissions were negatively related to progress in the therapeutic relationship.

From Table 16, it can be seen that there were not significant differences in WAI scores for various demographic groups. As discussed earlier, there were a number of missing cases for the items of psychiatric diagnosis and client medication.

Preconceptions

Findings regarding nurses' preconceptions of clients are summarized in Table 17 and clients' preconceptions of the nurse are summarized in Table 18. These tables include all respondents for each data collection period.

There was a wide variety in both nurse and client responses, however, the responses were generally towards the positive end of the scales. The only exceptions were the easy-difficult and independent-dependent items completed by nurses. On easy-difficult, at each of the three time intervals, nurses' mean scores were slightly past the neutral response of 4. The independent-dependent item
Table 17

Nurses' Preconceptions of the Client

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time-1</th>
<th></th>
<th>Time-2</th>
<th></th>
<th>Time-3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 124</td>
<td>n = 57</td>
<td>n = 38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Good-bad</td>
<td>2.88</td>
<td>1.26</td>
<td>2.39</td>
<td>1.22</td>
<td>2.27</td>
<td>1.12</td>
</tr>
<tr>
<td>Easy - difficult</td>
<td>4.02</td>
<td>1.62</td>
<td>4.04</td>
<td>1.84</td>
<td>4.24</td>
<td>1.86</td>
</tr>
<tr>
<td>Satisfying-not satisfying</td>
<td>3.44</td>
<td>1.26</td>
<td>2.98</td>
<td>1.46</td>
<td>2.73</td>
<td>1.39</td>
</tr>
<tr>
<td>Cooperative- uncooperative</td>
<td>2.82</td>
<td>1.59</td>
<td>3.04</td>
<td>1.71</td>
<td>3.30</td>
<td>1.81</td>
</tr>
<tr>
<td>Unique-typical</td>
<td>2.63</td>
<td>1.28</td>
<td>2.63</td>
<td>1.52</td>
<td>2.70</td>
<td>1.73</td>
</tr>
<tr>
<td>Feel empathy for-feel no empathy for</td>
<td>3.42</td>
<td>1.55</td>
<td>2.16</td>
<td>1.08</td>
<td>1.97</td>
<td>1.12</td>
</tr>
<tr>
<td>Trusting-suspicious</td>
<td>3.75</td>
<td>1.54</td>
<td>3.54</td>
<td>1.79</td>
<td>3.35</td>
<td>1.89</td>
</tr>
<tr>
<td>Safe-dangerous</td>
<td>2.86</td>
<td>1.53</td>
<td>2.46</td>
<td>1.56</td>
<td>2.78</td>
<td>1.60</td>
</tr>
<tr>
<td>Independent-dependent</td>
<td>3.91</td>
<td>1.60</td>
<td>4.18</td>
<td>1.90</td>
<td>4.05</td>
<td>2.13</td>
</tr>
<tr>
<td>Attractive-not attractive</td>
<td>3.63</td>
<td>1.32</td>
<td>3.09</td>
<td>1.14</td>
<td>2.89</td>
<td>1.43</td>
</tr>
<tr>
<td>I like client-I do not like client</td>
<td>2.33</td>
<td>1.17</td>
<td>2.05</td>
<td>1.01</td>
<td>1.84</td>
<td>.76</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35.57</td>
<td>8.60</td>
<td>32.54</td>
<td>10.77</td>
<td>32.14</td>
<td>10.23</td>
</tr>
</tbody>
</table>

Note. possible range 11-77. Lower score indicates more positive rating.
Table 18
Clients' Preconceptions of the Nurse

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time-1 Mean</th>
<th>Time-1 SD</th>
<th>Time-2 Mean</th>
<th>Time-2 SD</th>
<th>Time-3 Mean</th>
<th>Time-3 SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good-bad</td>
<td>2.04</td>
<td>1.32</td>
<td>1.65</td>
<td>.93</td>
<td>1.56</td>
<td>.89</td>
</tr>
<tr>
<td>Interested in me-not interested in me</td>
<td>2.35</td>
<td>1.59</td>
<td>2.50</td>
<td>1.76</td>
<td>2.00</td>
<td>1.52</td>
</tr>
<tr>
<td>Treats me as a person-not treat me as a person</td>
<td>2.03</td>
<td>1.49</td>
<td>1.79</td>
<td>1.27</td>
<td>1.48</td>
<td>.89</td>
</tr>
<tr>
<td>Supports me -does not support me</td>
<td>2.74</td>
<td>1.87</td>
<td>2.21</td>
<td>1.60</td>
<td>2.33</td>
<td>1.90</td>
</tr>
<tr>
<td>Has time for me-too busy for me</td>
<td>2.57</td>
<td>1.92</td>
<td>2.35</td>
<td>1.90</td>
<td>2.63</td>
<td>1.86</td>
</tr>
<tr>
<td>Helpful-not helpful</td>
<td>2.16</td>
<td>1.69</td>
<td>2.06</td>
<td>1.91</td>
<td>1.46</td>
<td>.71</td>
</tr>
<tr>
<td>Nice-not nice</td>
<td>1.90</td>
<td>1.53</td>
<td>1.42</td>
<td>1.16</td>
<td>1.15</td>
<td>.36</td>
</tr>
<tr>
<td>Lets me control-controls</td>
<td>3.68</td>
<td>1.98</td>
<td>3.81</td>
<td>1.90</td>
<td>3.19</td>
<td>2.22</td>
</tr>
<tr>
<td>Attractive -not attractive</td>
<td>2.18</td>
<td>1.58</td>
<td>1.77</td>
<td>1.17</td>
<td>2.04</td>
<td>1.51</td>
</tr>
<tr>
<td>I like nurse-I do not like nurse</td>
<td>1.77</td>
<td>1.35</td>
<td>1.25</td>
<td>.70</td>
<td>1.22</td>
<td>.64</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23.41</td>
<td>10.40</td>
<td>20.81</td>
<td>8.24</td>
<td>19.07</td>
<td>6.02</td>
</tr>
</tbody>
</table>

Note. Possible range 10-70. Lower score indicates more positive rating.
was scored just past the neutral response of 4 at time-2 and time-3. The I like client-I don't like client item was the most positively ranked item by nurses, at each time interval.

Lets me control-controls was the most negatively ranked item by clients, for all time intervals. The item most positively ranked by clients was I like nurse-I don't like nurse for time-1 and time-2. This was the second most positively ranked item at time-3. The item most positively ranked at time-3 was nice-not nice. At time-3, all clients ranked their nurses with either a 1 or 2 on this item.

An analysis was completed for only those subjects who completed data collection at time-1 and time-2. This was to examine changes over time with the semantic differentials, without the influence of subjects no longer in the study at time-2. The semantic differentials remained quite stable over time. The mean difference on the nurse scores was 1.96, reflecting a very slight improvement in the preconceptions of clients over 3 months. Similarly, clients' mean difference was 2.50. Neither change was statistically significant using paired t-tests.

It was not possible to make direct comparisons of the nurse and client forms of the semantic differentials since different items are used. The only three items which appear on both forms are good-bad, attractive-unattractive and I like nurse/client-I do not like nurse/client. T-tests were
used to examine differences between the nurse and client groups on these three items. Clients' perceptions of nurses were more positive than nurses' perceptions of clients on all three items ($p \leq .001$).

The relationship between the nurses' and clients' preconceptions of each other was examined on the three items which appeared on both nurse and client forms. The correlations between nurse and client ratings were not statistically significant. The only exception was the good-bad scale at time-2 ($r = .30, p \leq .03$).

**Anxiety**

The results on the Beck Anxiety Inventory (BAI) for clients ranged from 0 to 49 at time-1, with a mean of 13.89 ($SD = 10.95, n = 124$). At time-2, client scores ranged from 0 to 40 with a mean of 10.49 ($SD = 9.57, n = 57$). At time-3, scores ranged from 0 to 29 with a mean score of 10.21 ($SD = 9.62, n = 38$). The standard deviations all appear large in relation to the means. This would suggest a large amount of variability within the anxiety scores. The means for the anxiety scores are similar to those reported by Beck and others (1988) for clients with a primary diagnosis of depression (mean 13.27, $SD = 8.36$). No norms were found for a schizophrenic group on this scale.

Client scores were examined for those in data collection at time-1 and time-2 ($n = 54$). The mean drop in anxiety on the BAI was 4.61. Using a paired t-test, the
difference was statistically significant ($p \leq .001$). This indicated that clients were less anxious at time-2. Since the initial data collection closely followed admission this change is not surprising.

The results on the BAI for nurses ranged from 0 to 22 at time-1, with a mean of 3.89 ($SD = 4.59, n = 124$). At time-2, the nurse scores ranged from 0 to 12 with a mean of 2.09 ($SD = 2.51, n = 57$). At time-3, the scores ranged from 0 to 9 with a mean score of 1.32 ($SD = 1.82, n = 38$). The standard deviations are all larger than the means, suggesting a skewed distribution towards lower anxiety scores. No norms for a healthy population on the BAI were available for comparison. However, as would be expected, the nurse scores are considerably lower than the client scores reported by Beck and others (1988).

Nurse scores were also examined for those in data collection at time-1 and time-2 ($n = 54$) and found to be not significant when tested with t-tests. Nurses would not be expected to have significant changes in their anxiety since the data collection periods would not be expected to coincide with major life events. This is in contrast to clients' situation which generally found the initial data collection period closely following a psychiatric admission. The results indicate nurses' anxiety scores were lower and more stable than clients' anxiety scores.

T-tests were also used to examine the differences
between nurse and client scores on the BAI. As might be expected, clients had higher anxiety scores than nurses at each of the data collection periods ($p \leq .0001$).

**Interpersonal Relationships**

Scores on the Personal Resource Questionnaire (PRQ) for clients ranged from 37 to 166 at time-1, with a mean of 116.31 ($SD = 24.52$, $n = 124$). At time-2, client scores ranged from 60 to 169 with a mean of 121.47 ($SD = 24.40$, $n = 57$). At time-3, the scores ranged from 88 to 146 with a mean score of 116.70 ($SD = 16.55$, $n = 38$). These results indicate a range of client scores that included both positive (above 100) and negative (below 100) perceptions of their interpersonal relationships. Means were more towards the positive end of the scale. However, the means were lower than any of those compiled by Weinert from 15 studies (personal correspondence, 1990). Means from these previous studies ranged from 125.4 to 149.2 for relatively healthy populations such as rural families and mothers.

Client scores were examined for change among those in data collection at time-1 and time-2. The mean improvement on the PRQ score was 6.53. Using a paired $t$-test, this difference was statistically significant ($p \leq .05$), indicating that clients' interpersonal relationships improved between time-1 and time-2.

Results on the PRQ for nurses ranged from 100 to 175 at time-1, with a mean of 152.29 ($SD = 13.75$, $n = 124$). At
time-2, nurse scores had the identical range as time-1 (100 to 175) with a mean of 153.98 ($SD = 17.16, n = 57$). At time-3, scores ranged from 117 to 150 with a mean of 135.57 ($SD = 7.60, n = 38$). Interestingly, with the exception of time-3, these means are higher than those for any of the 15 samples compiled by Weinert. These results indicate that nurses had positive interpersonal relationships; a score of 100 indicates a neutral rating and all scores higher than 100 are on the positive end of the scale. Changes in nurse scores were also examined for those in data collection at time-1 and time-2. It was anticipated that nurse scores should remain relatively stable throughout the study, since, unlike the clients, nurses were not expected to have undergone any major change in situation throughout the study. The changes between time-1 and time-2 were found to be not statistically significant when tested with t-tests.

T-tests were also used to examine differences between nurse and client scores on the PRQ. As might be expected, clients had lower PRQ scores than nurses at each of the data collection periods ($p \leq .0001$).

Summary of Each Data Collection Period

Results from each of the three data collection periods are summarized in Tables 19, 20 and 21, respectively.
### Table 19

**Summary of Time-1 Data**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Range</th>
<th>Actual Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconceptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>11-77</td>
<td>14-52</td>
<td>35.57</td>
<td>8.60</td>
</tr>
<tr>
<td>Client</td>
<td>10-70</td>
<td>10-58</td>
<td>23.41</td>
<td>10.41</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>0-63</td>
<td>0-22</td>
<td>3.89</td>
<td>4.59</td>
</tr>
<tr>
<td>Client</td>
<td>0-63</td>
<td>0-49</td>
<td>13.89</td>
<td>10.95</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>25-175</td>
<td>100-175</td>
<td>152.29</td>
<td>13.75</td>
</tr>
<tr>
<td>Client</td>
<td>25-175</td>
<td>37-166</td>
<td>116.31</td>
<td>24.47</td>
</tr>
</tbody>
</table>

*Note. n = 124 dyads*
Table 20

Summary of Time-2 Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Range</th>
<th>Actual Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconceptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>11-77</td>
<td>12-55</td>
<td>32.54</td>
<td>10.77</td>
</tr>
<tr>
<td>Client</td>
<td>10-70</td>
<td>10-44</td>
<td>20.81</td>
<td>8.24</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>0-63</td>
<td>0-12</td>
<td>2.09</td>
<td>2.51</td>
</tr>
<tr>
<td>Client</td>
<td>0-63</td>
<td>0-40</td>
<td>10.49</td>
<td>9.57</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>25-175</td>
<td>100-175</td>
<td>152.29</td>
<td>13.75</td>
</tr>
<tr>
<td>Client</td>
<td>25-175</td>
<td>60-169</td>
<td>121.47</td>
<td>24.40</td>
</tr>
<tr>
<td>Working Alliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>36-252</td>
<td>105-225</td>
<td>178.93</td>
<td>27.11</td>
</tr>
<tr>
<td>Client</td>
<td>36-252</td>
<td>115-241</td>
<td>186.22</td>
<td>34.61</td>
</tr>
</tbody>
</table>

Note. n = 57 dyads

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### Table 21

**Summary of Time-3 Data**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Range</th>
<th>Actual Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preconceptions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>11-77</td>
<td>11-53</td>
<td>32.14</td>
<td>10.23</td>
</tr>
<tr>
<td>Client</td>
<td>10-70</td>
<td>10-30</td>
<td>19.07</td>
<td>6.03</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>0-63</td>
<td>0-9</td>
<td>1.32</td>
<td>1.82</td>
</tr>
<tr>
<td>Client</td>
<td>0-63</td>
<td>0-29</td>
<td>10.21</td>
<td>9.62</td>
</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>25-175</td>
<td>117-150</td>
<td>135.57</td>
<td>7.60</td>
</tr>
<tr>
<td>Client</td>
<td>25-175</td>
<td>88-146</td>
<td>116.70</td>
<td>16.55</td>
</tr>
<tr>
<td><strong>Working Alliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>36-252</td>
<td>103-243</td>
<td>178.71</td>
<td>30.11</td>
</tr>
<tr>
<td>Client</td>
<td>36-252</td>
<td>142-241</td>
<td>194.00</td>
<td>28.35</td>
</tr>
</tbody>
</table>

*Note. n = 38 dyads*
Testing Hypotheses

The primary hypotheses predicted relationships between progress in the therapeutic relationship and specific nurse and client variables. The developing relationship was measured by the number of weeks in the orientation phase on the Relationship Form and scores on the WAI. Nurse and client variables were: preconceptions, interpersonal relationships and anxiety. Table 22 contains a correlation matrix for the time in the orientation phase and nurse and client variables. Table 23 contains a similar correlation matrix for the therapist form of the WAI, and Table 24 contains a correlation matrix for the client form of the WAI. In testing the specific hypotheses the therapist form of the WAI was used with nurse variables and the client form of the WAI was used with client variables.

It can be seen from examining these three correlation matrices that differences occur with some of the relationships. Each matrix represents a different cross section of the sample. The matrix for weeks in orientation describes dyads who completed orientation over the course of the study. The matrix for the therapist form of the WAI describes only those dyads still in the study at time-2. The matrix for the client form of the WAI also describes dyads in the study at time-2, but excludes dyads where the clients did not complete the WAI.
Table 22

Correlation Matrix for Weeks in Orientation and Independent Variables

<table>
<thead>
<tr>
<th></th>
<th>Weeks Orientation</th>
<th>Client BAI</th>
<th>Nurse BAI</th>
<th>Client PRQ</th>
<th>Nurse PRQ</th>
<th>Client Preconceptions</th>
<th>Nurse Preconceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client BAI</td>
<td>0.04</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse BAI</td>
<td>0.22</td>
<td>0.30*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client PRQ</td>
<td>-0.17</td>
<td>-0.33*</td>
<td>0.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse PRQ</td>
<td>-0.04</td>
<td>0.20</td>
<td>-0.31*</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Preconceptions</td>
<td>0.38*</td>
<td>-0.23*</td>
<td>-0.30*</td>
<td>-0.07</td>
<td>0.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Preconceptions</td>
<td>0.30*</td>
<td>-0.01</td>
<td>0.14</td>
<td>-0.23*</td>
<td>-0.17</td>
<td>-0.05</td>
<td></td>
</tr>
</tbody>
</table>

Note.  n = 51, * p < .05
Table 23

Correlation Matrix for Therapist WAI and Independent Variables

<table>
<thead>
<tr>
<th></th>
<th>WAI</th>
<th>Client BAI</th>
<th>Nurse BAI</th>
<th>Client PRQ</th>
<th>Nurse PRQ</th>
<th>Client Preconceptions</th>
<th>Nurse Preconceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client BAI</td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse BAI</td>
<td>.02</td>
<td>.28*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client PRQ</td>
<td>.24*</td>
<td>-.43*</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse PRQ</td>
<td>-.01</td>
<td>.16</td>
<td>-.31*</td>
<td>-.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Preconceptions</td>
<td>-.53*</td>
<td>-.10</td>
<td>-.13</td>
<td>-.31*</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Preconceptions</td>
<td>-.65*</td>
<td>-.01</td>
<td>.10</td>
<td>-.31*</td>
<td>-.18</td>
<td>-.20</td>
<td></td>
</tr>
</tbody>
</table>

Note. $n = 57$, * $p \leq .05$
Table 24

**Correlation Matrix for Client WAI and Independent Variables**

<table>
<thead>
<tr>
<th></th>
<th>WAI</th>
<th>Client BAI</th>
<th>Nurse BAI</th>
<th>Client PRQ</th>
<th>Nurse PRQ</th>
<th>Client Preconceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client BAI</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse BAI</td>
<td>-.08</td>
<td>.34*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client PRQ</td>
<td>.48*</td>
<td>-.17</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse PRQ</td>
<td>-.08</td>
<td>.26</td>
<td>-.34*</td>
<td>-.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Preconceptions</td>
<td>-.64*</td>
<td>-.22</td>
<td>-.22</td>
<td>-.31*</td>
<td>-.04</td>
<td></td>
</tr>
<tr>
<td>Nurse Preconceptions</td>
<td>-.39*</td>
<td>-.21</td>
<td>.20</td>
<td>-.22</td>
<td>-.17</td>
<td>-.07</td>
</tr>
</tbody>
</table>

*Note.* \( n = 46, \) \(* p \leq .05\)
Several moderate relationships were found between independent variables. There were inverse relationships between anxiety and interpersonal relationships, for both nurses and clients, except with the therapist form of the WAI. Clients with more negative interpersonal relationships were more likely to be viewed negatively by their nurses, and were more likely to have negative preconceptions of their nurses (on the WAI but not Relationship Form).

The power analysis calculated prior to the commencement of the study indicated that 83 dyads would be necessary for testing the hypotheses using Pearson's $r$. The initial data collection plan was to include 100 dyads. This was increased to 124 when it was realized that the number of client discharges and dyads not completing the orientation phase was larger than initially anticipated. Moreover, the data collection period was extended to six months (time-3) from the originally proposed three months (time-1 and time-2 only). With these expansions, the number of dyads who completed the orientation phase was 51; this is 19 more than if data collection had been terminated at time-2. Since this is below the number required to adequately test the hypotheses, the results of the Pearson's $r$ need to be interpreted with some caution. Specifically, the risk of type two error, that is, the risk of rejecting true hypotheses, is increased.

The first hypothesis was: Clients' more positive
preconceptions of the nurse will be related to greater progress in the development of therapeutic relationships. Pearson's $r$ for clients' preconceptions and the number of weeks in orientation ($n = 51$) was $0.37 \ (p \leq 0.004)$. The Pearson's $r$ for preconceptions and the WAI scores ($n = 46$), was $-0.38 \ (p \leq 0.004)$. The first hypothesis was therefore supported.

The second hypothesis was: Nurses' more positive preconceptions of the client will be related to greater progress in the development of therapeutic relationships. Pearson's $r$ for nurses' preconceptions and the number of weeks in orientation ($n = 51$) was $0.31 \ (p \leq 0.02)$. Pearson's $r$ for nurses' preconceptions and WAI scores ($n = 57$) was $-0.69 \ (p \leq 0.0001)$. The second hypothesis was therefore supported.

The third hypothesis was: Clients' more positive interpersonal relationships will be related to greater progress in the development of therapeutic relationships. Pearson's $r$ for clients' interpersonal relationships (PRQ) and the number of weeks in orientation ($n = 51$) was $-0.17$. Although this correlation is in the anticipated direction, it is not strong enough to be statistically significant. Pearson's $r$ for clients' interpersonal relationships (PRQ) and WAI scores ($n = 46$) was $0.48 \ (p \leq 0.0001)$. Therefore, although the third hypothesis received some support, the results are inconclusive.
The fourth hypothesis was: Nurses' more positive interpersonal relationships will be related to greater progress in the development of therapeutic relationships. Pearson's $r$ for nurses' interpersonal relationships and the number of weeks in orientation ($n = 51$) was $-0.05$. Pearson's $r$ for nurses' interpersonal relationships and the WAI scores ($n = 56$) was $0.00$. Neither of these correlations are statistically significant, therefore, the fourth hypothesis was not supported.

The fifth hypothesis was: Higher levels of anxiety in the client will be related to less progress in the development of therapeutic relationships. Pearson's $r$ for clients' anxiety and the number of weeks in orientations ($n = 51$) was $0.01$. Pearson's $r$ for the clients' anxiety and the client scores on the WAI ($n = 46$) was $0.09$. Neither of these correlations were statistically significant, therefore, the fifth hypothesis was not supported.

The sixth hypothesis was: Higher levels of anxiety in the nurse will be related to less progress in the development of therapeutic relationships. Pearson's $r$ for nurses' anxiety and number of weeks in orientation ($n = 51$) was $0.22$. This correlation was approaching significance ($p < 0.07$), but did not meet the minimum alpha level set for this investigation ($p < 0.05$). Pearson's $r$ for nurses' anxiety and the nurse scores on the WAI ($n = 56$) was $-0.08$. None of these correlations were statistically significant, therefore
the sixth hypothesis was not supported.

The seventh hypothesis was: Taken together, clients' preconceptions of the nurse, level of anxiety and interpersonal relationships will be a better predictor of progress in the development of therapeutic relationships, than any one client variable alone. Two multiple regressions were calculated (see Table 25 and 26). One analysis used weeks in orientation, and the other progress in the therapeutic alliance (WAI at time-2) as indicators of progress in the relationship.

Using weeks in orientation as the dependent measure, only clients' preconceptions of the nurse were independently, significantly predictive. The multiple $R$ of .42 ($R^2 = .17$) was only slightly greater than the simple $r$ of .37 for preconceptions. Thus, the multiple correlation supports the earlier findings that, with using weeks in orientation as the dependent measure, only clients' preconceptions were significant. The results of the multiple regression analysis are presented in more detail in Table 25.
Table 25

**Multiple Regression Analysis: Client Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Weeks in Orientation**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>1.38</td>
<td>.17</td>
<td></td>
</tr>
<tr>
<td>Preconceptions</td>
<td>.39</td>
<td>2.76</td>
<td>.01</td>
</tr>
<tr>
<td>Relationships</td>
<td>-.17</td>
<td>-1.16</td>
<td>.25</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.05</td>
<td>.30</td>
<td>.76</td>
</tr>
</tbody>
</table>

*Note.* Multiple $R = .42$, $R^2 = .17$
Table 26

Multiple Regression Analysis: Client Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Working Alliance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td></td>
<td>4.46</td>
<td>.0001</td>
</tr>
<tr>
<td>Preconceptions</td>
<td>-.31</td>
<td>-2.28</td>
<td>.03</td>
</tr>
<tr>
<td>Relationships</td>
<td>.45</td>
<td>3.46</td>
<td>.001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.07</td>
<td>.52</td>
<td>.61</td>
</tr>
</tbody>
</table>

Note. Multiple R = .58, R² = .34
Using client scores on the WAI as the dependent measure, clients' interpersonal relationships and preconceptions were both independently predictive. The multiple R was .58 ($R^2 = .34$) compared to the simple r's of .47 for interpersonal relationships and -.38 for preconceptions. This result supports the earlier finding that both preconceptions and interpersonal relationships are significant in relation to the results on the WAI, and clarifies that the contribution of each of the two variables is independent of the other. Therefore, the seventh hypothesis was partially supported.

The eighth hypothesis was: Taken together, nurses' preconceptions of the client, level of anxiety and interpersonal relationships will be a better predictor of progress in the development of therapeutic relationships, than any one nurse variable alone. Multiple regression analyses for these combined variables were also completed with weeks in the orientation phase (see Table 27) and nurses' results on the WAI at time-2 as the dependent measures (see Table 28).

Using weeks in orientation as the dependent measure, the nurse's preconceptions of the client was most predictive, but not statistically significant. The multiple R of .37 ($R^2 = .14$) is only slightly greater than the simple r of .30 for preconceptions. The only
Table 27

**Multiple Regression Analysis: Nurse Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Weeks in Orientation Phase**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>-.42</td>
<td>.68</td>
<td></td>
</tr>
<tr>
<td>Preconceptions</td>
<td>.28</td>
<td>1.86</td>
<td>.07</td>
</tr>
<tr>
<td>Relationships</td>
<td>.07</td>
<td>.47</td>
<td>.64</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.23</td>
<td>1.50</td>
<td>.14</td>
</tr>
</tbody>
</table>

*Note.* Multiple $R = .37$, $R^2 = .14$
Table 28
Multiple Regression Analysis: Nurse Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Working Alliance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>7.51</td>
<td>.0000</td>
<td></td>
</tr>
<tr>
<td>Preconceptions</td>
<td>-.68</td>
<td>-6.03</td>
<td>.0000</td>
</tr>
<tr>
<td>Relationships</td>
<td>-.11</td>
<td>- .91</td>
<td>.40</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.05</td>
<td>.43</td>
<td>.67</td>
</tr>
</tbody>
</table>

Note. Multiple $R = .66$, $R^2 = .44$
independently predictive variable was preconceptions, when
the WAI was the indicator of progress in the relationship.
The multiple $R$ of .66 was a negligible change over the
simple $r$ of .65 for preconceptions. This analysis supports
the earlier findings that, in relation to nurse variables,
only preconceptions were significant. Therefore, the eighth
hypothesis was not supported.

Table 29 contains a summary of findings testing the
primary hypotheses. Multiple regression analyses using both
nurse and client variables identified in the hypotheses
were also completed.

The results of the multiple regression analysis using
weeks in orientation as the dependent variable are presented
in Table 30. From Table 30 it can be seen that the
explanatory power resulting from using both nurse and
client variables was .38 ($R = .62$). This is considerably
greater than client factors alone ($R^2 = .17, R = .42$), or
nurse factors alone ($R^2 = .14, R = .37$) as predictors of
weeks in orientation. Client preconceptions appear to be
independently the most predictive of time in orientation and
within this analysis nurse preconceptions are no longer
significant. This would suggest an interaction of
relationship between client and nurse preconceptions.

An interesting finding with this multiple regression
analysis is that $R$ for nurses' anxiety is significant ($p < .
01$). The simple $r$ was only approaching minimal
Table 29

Summary of Results of Primary Hypotheses

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Weeks in Orientation</th>
<th>WAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client preconceptions</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>2. Nurse preconceptions</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>3. Client interpersonal relationships</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>4. Nurse interpersonal relationships</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>5. Client anxiety</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>6. Nurse anxiety</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>7. Combination of client variables</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>8. Combination of nurse variables</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

Note. yes = hypothesis supported, no = hypothesis not supported
Table 30

Multiple Regression Analysis: Nurse and Client Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Weeks in Orientation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client preconceptions</td>
<td>.48</td>
<td>3.43</td>
<td>.002</td>
</tr>
<tr>
<td>Nurse preconceptions</td>
<td>.24</td>
<td>1.71</td>
<td>.10</td>
</tr>
<tr>
<td>Client relationships</td>
<td>-.18</td>
<td>-1.18</td>
<td>.24</td>
</tr>
<tr>
<td>Nurse relationships</td>
<td>.09</td>
<td>.58</td>
<td>.56</td>
</tr>
<tr>
<td>Client anxiety</td>
<td>-.04</td>
<td>-.26</td>
<td>.80</td>
</tr>
<tr>
<td>Nurse anxiety</td>
<td>.40</td>
<td>2.57</td>
<td>.01</td>
</tr>
</tbody>
</table>

Note. Multiple R = .62, R² = .38
significance ($p \leq .07$), and anxiety was not significant on any other analysis in relation to the dependent variables. Nurses' anxiety was inter-related with other variables (nurses' other relationships and clients' preconceptions).

Results of the analysis using the WAI as the dependent variable are presented in Table 31 (for the therapist form of the WAI) and Table 32 (for the client form of the WAI). From Tables 31 and 32, it can be seen that the explanatory power for combined nurse and client factors was greater than that for only one person within the dyad. Client variables alone had a $R^2$ of .34 ($R = .58$), and nurse variables alone had a $R^2$ of .44 ($R = .66$). The regression analysis using a combination of nurse and client variables resulted in a $R^2$ of .61 ($R = .78$) for the therapist form of the WAI and a $R^2$ of .62 ($R = .79$) for the client form.

Some demographic variables were statistically significant in relation to progress in the therapeutic relationship. Length of nurse-client interactions and duration of clients' previous hospital stays were most strongly related to weeks in the orientation phase. Similarly, total time spent in nurse-client interactions, and nurses' psychiatric nursing experience were most strongly related to results on the WAI. Significant demographic variables were combined with significant variables from the hypotheses to determine predictive power.
Table 31

Regression Analysis: Nurse and Client Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Working Alliance (Therapist Form)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td></td>
<td>7.33</td>
<td>.0000</td>
</tr>
<tr>
<td>Client Preconceptions</td>
<td>-.42</td>
<td>-3.96</td>
<td>.0003</td>
</tr>
<tr>
<td>Nurse Preconceptions</td>
<td>-.59</td>
<td>-5.54</td>
<td>.0000</td>
</tr>
<tr>
<td>Client Relationships</td>
<td>-.05</td>
<td>-.40</td>
<td>.69</td>
</tr>
<tr>
<td>Nurse Relationships</td>
<td>-.14</td>
<td>-1.29</td>
<td>.20</td>
</tr>
<tr>
<td>Client Anxiety</td>
<td>-.10</td>
<td>.81</td>
<td>.43</td>
</tr>
<tr>
<td>Nurse Anxiety</td>
<td>-.05</td>
<td>-.47</td>
<td>.64</td>
</tr>
</tbody>
</table>

Note. Multiple R = .78, R² = .61
Table 32

Multiple Regression Analysis: Nurse and Client Preconceptions, Interpersonal Relationships and Anxiety as Predictors of Working Alliance (Client Form)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>4.93</td>
<td>.0000</td>
<td></td>
</tr>
<tr>
<td>Client Preconceptions</td>
<td>-.57</td>
<td>-4.66</td>
<td>.0001</td>
</tr>
<tr>
<td>Nurse Preconceptions</td>
<td>-.27</td>
<td>-2.14</td>
<td>.04</td>
</tr>
<tr>
<td>Client Relationships</td>
<td>.25</td>
<td>1.93</td>
<td>.06</td>
</tr>
<tr>
<td>Nurse Relationships</td>
<td>-.17</td>
<td>-1.31</td>
<td>.20</td>
</tr>
<tr>
<td>Client Anxiety</td>
<td>.07</td>
<td>.49</td>
<td>.63</td>
</tr>
<tr>
<td>Nurse Anxiety</td>
<td>-.25</td>
<td>-1.75</td>
<td>.09</td>
</tr>
</tbody>
</table>

Note. Multiple $R = .79$, $R^2 = .62$
The results of these regression analyses are presented in Table 33 (with weeks in the orientation phase as the dependent variable) and Table 34 (with the therapist form of the WAI as the dependent variable). It can be seen from Tables 33 and 34 that an increase in predictive power was provided by including the demographic items, but that these were not statistically significant. The demographics appear to correlate most significantly with nurse and client preconceptions. This again supports the concept of preconceptions as most independently predictive of progress in the therapeutic relationship.

In addition to the primary hypotheses, secondary hypotheses examined changes in each of the variables at three months into the nurse-client relationship. It was anticipated that preconceptions, interpersonal relationships and anxiety would be more positive among individuals who had completed the orientation phase in a shorter period of time. Scores for variables for those who completed orientation compared to those who did not, using paired t-tests, is presented in Table 35. It can be seen that preconceptions of both nurses and clients were significantly more positive among those who had completed orientation. Anxiety was not significantly different between those completing or not completing orientation. Interpersonal relationships were more positive among nurses and clients completing orientation; this difference was statistically
Table 33

Multiple Regression Analysis: Selected Demographic Variables and Significant Variables from Hypotheses as Predictors of Weeks in Orientation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>.45</td>
<td>.69</td>
<td></td>
</tr>
<tr>
<td>Client preconceptions</td>
<td>-.36</td>
<td>-1.19</td>
<td>.28</td>
</tr>
<tr>
<td>Nurse preconceptions</td>
<td>.60</td>
<td>2.00</td>
<td>.09</td>
</tr>
<tr>
<td>Duration hospital stay</td>
<td>.39</td>
<td>1.27</td>
<td>.25</td>
</tr>
<tr>
<td>Length of interactions</td>
<td>.24</td>
<td>.70</td>
<td>.51</td>
</tr>
</tbody>
</table>

Note. Multiple R = .76, R² = .57
Table 34

**Multiple Regression Analysis: Selected Demographic Variables and Significant Variables from Hypotheses as Predictors of WAI (Therapist Form)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>7.41</td>
<td></td>
<td>.0000</td>
</tr>
<tr>
<td>Client preconceptions</td>
<td>-.21</td>
<td>-1.82</td>
<td>.08</td>
</tr>
<tr>
<td>Nurse preconceptions</td>
<td>-.60</td>
<td>-4.74</td>
<td>.0001</td>
</tr>
<tr>
<td>Client relationships</td>
<td>.03</td>
<td>.24</td>
<td>.81</td>
</tr>
<tr>
<td>Total time interactions</td>
<td>.23</td>
<td>1.92</td>
<td>.07</td>
</tr>
<tr>
<td>Psych. nursing experience</td>
<td>.09</td>
<td>.76</td>
<td>.46</td>
</tr>
</tbody>
</table>

*Note. Multiple R = .85, R² = .71*
Table 35

Differences in Preconceptions, Anxiety, and Interpersonal Relationships at Time-2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preconceptions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses completing orientation</td>
<td>25.5</td>
<td>8.4</td>
<td>-5.97</td>
<td>.000</td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses in orientation</td>
<td>39.8</td>
<td>8.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client completing orientation</td>
<td>16.57</td>
<td>5.50</td>
<td>-3.28</td>
<td>.002</td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients in orientation</td>
<td>24.83</td>
<td>9.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses completing orientation</td>
<td>2.58</td>
<td>3.22</td>
<td>1.23</td>
<td>.23</td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses in orientation</td>
<td>1.61</td>
<td>1.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients completing orientation</td>
<td>11.14</td>
<td>10.35</td>
<td>.76</td>
<td>.45</td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients in orientation</td>
<td>8.95</td>
<td>7.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 35

Differences in Preconceptions, Anxiety, and Interpersonal Relationships at Time-2

(continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Interpersonal Relationships</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses completing orientation at 12 weeks</td>
<td>159.16</td>
<td>13.40</td>
<td>1.86</td>
<td>.07</td>
</tr>
<tr>
<td>Nurses in orientation at 12 weeks</td>
<td>150.00</td>
<td>19.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients completing orientation at 12 weeks</td>
<td>130.90</td>
<td>20.32</td>
<td>2.32</td>
<td>.03</td>
</tr>
<tr>
<td>Clients in orientation at 12 weeks</td>
<td>115.21</td>
<td>22.43</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
significant for clients, but only approached significance for nurses. Therefore, findings for secondary hypotheses mirrored those for primary hypotheses, in that those pertaining to preconceptions were supported, those for interpersonal relationships were partially supported, and those for anxiety were not supported.

A further analysis was completed by subtracting the difference between the time-1 and time-2 scores. The purpose of this was to reduce the influence of the initial scores. When this was done, none of the differences between groups completing and not completing orientation were significantly significant. This would suggest that the differences between these groups were influenced by the initial scores. In other words, differences reflect initial differences between these groups rather than change over time. Differences between those who completed orientation and those who did not, were also examined on the WAI. The results are reported in Table 36. Individuals who completed orientation had significantly more positive scores on the WAI.

**Summary**

The results of the investigation yielded information regarding variables related to, and not related to the duration of the orientation phase and general progress in the therapeutic relationship. The descriptive findings
Table 36

Differences in Working Alliance Inventory at Time-2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
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</thead>
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<tr>
<td><strong>Total WAI</strong></td>
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<tr>
<td>Nurses completing orientation</td>
<td>195.15</td>
<td>18.50</td>
<td>5.48</td>
<td>.000</td>
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<tr>
<td>at 12 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses in orientation at 12 weeks</td>
<td>160.82</td>
<td>25.31</td>
<td></td>
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</tr>
<tr>
<td>Clients completed orientation</td>
<td>209.95</td>
<td>19.79</td>
<td>6.37</td>
<td>.000</td>
</tr>
<tr>
<td>at 12 weeks</td>
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<td></td>
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<tr>
<td>Clients in orientation at 12 weeks</td>
<td>159.75</td>
<td>28.20</td>
<td></td>
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</tbody>
</table>
provided information related to the evolving nurse-client relationship. The major findings are summarized at the beginning of chapter 5 which also includes a discussion of the findings.
CHAPTER 5
Discussion

Major Conclusions

The findings of this study support some of the tenets of Peplau's theory, but not others. This has implications for further theory development or refinement, research and practice.

Preconceptions held by nurses and clients of each other appear to be extremely important. These preconceptions exist early in evolving relationships. The first data collection period was targeted to follow the first or second meeting of the nurse and client. Subjects did not have difficulty identifying and sharing their initial impressions. These preconceptions were significantly related to the duration of the orientation phase, as measured by the Relationship Form, and the general progress in the evolving therapeutic relationship, as measured by the Working Alliance Inventory. These results are consistent with, and supportive of Peplau's theory. Peplau described the early existence of preconceptions in the relationship, and the influence of preconceptions during the orientation phase (1952/1988 p. 10, 1973b). Negative preconceptions would be expected to adversely effect progress in an evolving relationship.

It is particularly supportive of Peplau's theory that
both the nurse and client preconceptions were significantly related to relationship parameters. Peplau's work emphasizes the importance of self awareness and self reflection of the nurse, and discourages assessment of the client in absence of a nurse's self assessment.

An important finding in the study was the stability of initial preconceptions over time. In three months there was almost no change in preconceptions nurses had of clients or that clients had of nurses. Considering that the possible range on the instrument allowed for a maximum difference of 66 points, it is interesting that over three months nurses' and clients' perceptions of each other only varied by approximately two points.

Another interpretation for the stability of preconceptions over time may be that change in the preconceptions occurred, but the semantic differentials were not sufficiently sensitive to this change. However, it should also be noted that the instrument to measure the nurses' and clients' preconceptions was developed specifically for this study, using the established method of semantic differential scales. Through use of a pilot study of 20 dyads, the investigator was able to use nurses' and clients' own words as anchors for the semantic differential scales. This should have allowed for more precision in the measurement of the phenomena under study and more relevance to the subjects. The other independent variables were
measured with broader pre-established instruments. This issue of sensitivity to change could be dealt with through further study, particularly with populations or circumstances that are likely to experience or promote change in mutual perceptions.

The relative importance of other interpersonal relationships, as measured with the Personal Resource Questionnaire, received inconclusive, mixed support. Nurses' PRQ results were not related to the time in orientation or the results on the WAI. It is possible, based on these results, to argue that nurses' interpersonal relationships are not at all important to progress in evolving therapeutic relationships. It is also possible that the concept of interpersonal relationships needs to be more narrowly defined, or that the PRQ was too broad a measure. These possibilities are discussed in subsequent sections on implications for theory development and implications for research.

Clients' PRQ results were significantly related to the WAI results, suggesting a relationship between clients' general interpersonal relationships and the specific therapeutic relationship. This correlation was not significant when using the other measure of progress in the therapeutic relationship, duration of time in the orientation phase. However, clients who completed the orientation phase were found to have significantly higher
scores on the PRQ.

The combination of client PRQ scores and preconceptions was predictive of progress in the relationship as measured by the WAI. Clients' preconceptions alone was a better predictor when progress in the relationship was measured by the Relationship Form.

The importance of anxiety, as measured by the Beck Anxiety Inventory, to progress in the evolving nurse-client relationship received no support from the findings of this investigation. With the exception of one multiple regression analysis, whether the anxiety was that of the nurse or client, or whether initial anxiety was examined or the anxiety scores at three months was examined, anxiety scores were simply not significant statistically in relation to the WAI or Relationship Form. This has implications, which will be discussed under the appropriate sections, for nursing theory development and research.

Interesting results related to the developing nurse-client relationship were found in the descriptive findings. Only 51 of the 124 dyads were confirmed as actually completing the orientation phase according to results of the Relationship Form. This finding confirms earlier findings which found a prolonged initial phase in the development of a relationship with clients with a chronic mental illness (Forchuk, in press; Frank & Gunderson, 1990; Gehrs, 1991).

Factors that were significant varied somewhat with the
two different measures of progress in therapeutic relationships. This could be expected since each instrument measures a different aspect of the therapeutic relationship. Both measures found the total time spent per month in interactions to be positively related to progress in the relationship. Both measures found aspects of the hospitalization history to be significant: Number of hospital admissions was significantly related to the WAI and duration of hospital stays was related to weeks in orientation. This is similar to earlier findings of Forchuk (in press), which also used the Relationship Form. In this study of community based dyads in which the clients had a chronic mental illness, the only demographic items significantly related to time in orientation were frequency and duration of previous hospital admissions.

Duration of nurse-client interactions was significantly related to the Relationship Form, but not the WAI. Longer nurse-client interactions were related to shorter orientation phases. Additional demographic items which were significantly related to WAI scores, but not the Relationship Form were: the time the nurse and client knew each other prior to being assigned (those who knew each other longer, took longer to establish a relationship), the age of the client (older clients progressed more slowly) and the age, general nursing experience, and psychiatric nursing experience of the nurse (older, more experienced nurses
progressed more quickly).

Implications for Nursing Theory

A stated purpose for this investigation was the testing of an established nursing theory. This in itself has implications for nursing theory, since such theories are seldom tested (Silva, 1986). Peplau's theory has been widely used in psychiatric mental health nursing practice (Hirschmann, 1989; Martin & Kirkpatrick, 1987; 1989), however, it has not undergone rigorous testing through research.

The concept of a therapeutic nurse-client relationship is a focus of Peplau's theory and other nursing theories, such as Orlando, Travellbee, and King. Information which contributes to understanding therapeutic relationships can therefore enhance the development and testing of nursing knowledge beyond Peplau's theory.

The current investigation used two different instruments to measure aspects of the therapeutic relationship: the duration of the orientation phase, as measured by the Relationship Form, and progress in the therapeutic alliance as measured by the Working Alliance Inventory. These two instruments were found to be significantly related to each other, suggesting that progression through the orientation phase is related to progress in establishing of a therapeutic alliance. This finding is consistent with earlier studies which found the
initial phase of the therapeutic relationship to be significantly related to client outcomes (Frank & Gunderson, 1990; Gehrs, 1991; Hartley & Strupp, 1983, Horowitz, 1974; Luborsky, 1976; Orlinsky & Howard, 1978). If the duration of the orientation phase is related to progress in the development of the therapeutic relationship, then it is logical to develop and test strategies to facilitate passage through the orientation phase. Further testing might explore whether or not these strategies also facilitate progress in the therapeutic alliance.

The concept of preconceptions, and its relative importance in the evolving therapeutic relationship received considerable support through the findings of this investigation. Findings for the first two hypotheses about nurse and client preconceptions support some of the most essential propositions of Peplau's theory.

The finding that both the nurses' and clients' preconceptions were significantly related to progress in the therapeutic relationship supports an interpersonal approach. Some nursing theories focus on the client, rather than the nurse-client relationship, as the unit of attention. Although the importance of the contribution of the nurse and larger social systems may be acknowledged in these theories, their focus is on the client. Examples include theories proposed by Orem (1985), Roy (1970; 1984), and B. Neuman (1984). In contrast, Peplau's theory

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recognizes that the nurse must use awareness of between-person phenomena, and self reflection as vigilantly as assessment of the client situation. This study found nurses' preconceptions to be significantly related to progress in the relationship. If a nurse focussed only on the client this important dimension could be easily missed.

The importance of the concept of other interpersonal relationships received some support in relation to clients, but was not supported in relation to nurses. Peplau's theory views the individual as developing in the context of a myriad of interpersonal relationships. The nurse-client relationship is but one of these potential relationships. Since individuals are seen in some ways as a sum of their relationships with others, other relationships would be expected to influence the current nurse-client relationship. This was not supported by the findings of this investigation.

Social relationships are particularly problematic among clients with chronic mental illnesses (Estroff, 1981; Isele, Merz, Malzacher, & Angst, 1985; Pattison, Defranscisco, Wood, Frazier & Crowder 1975; Schepер-Hughes, 1981; Schwartz, Robinson, Flaherty, Jobe, Birz, 1986). Although there was a wide range of scores on the PRQ, the low mean score in relation to those found in other studies using the same instrument, is consistent with earlier studies which found poor social supports with this population.
During the pilot phase, the Norbeck Social Support Questionnaire (NSSQ) was used with 20 dyads. It was not used in the study since clients found it to be too long and difficult.) None of the 20 clients in the pilot study reported more than 5 support persons; one, who listed 2 supports, included a pet. It is not surprising then, that among the client group, other relationships were significant predictors of progress in the therapeutic relationship. It may be that by using an instrument that emphasized the quality of relationships rather than the number of relationships more diverse findings were found within the client group.

In contrast to clients, nurses generally had quite high scores on the PRQ. The lowest score at any time interval, for any nurse was 100; this is the exact midpoint, neutral score. The means for time-1 and time-2 were higher than any reported in previous studies, suggesting the possibility of a ceiling effect. A nurse who has poor interpersonal relationships may have difficulty developing therapeutic relationships, but since there were no nurses in the study who reported unsatisfactory relationships this was untestable. The lack of diversity among nurses with regards to this variable, in addition to the sample size problem, may have impeded adequate testing of this hypothesis.

It may be that interpersonal relationships of the client are more important than those of the nurse in
predicting progress in the therapeutic relationship. Since clients are the persons in the relationship seeking assistance, it may be that only their interpersonal relationships are important in this regard. This would imply the need to change or refine Peplau's theory to acknowledge differences between nurse and client in the importance of their other relationships.

There may be some difficulty with the conceptualization of "other interpersonal relationships," in terms of breadth. "Other interpersonal relationships" can be envisioned as a constellation comprised of all relationships, past and present, of the individual. In that constellation "stars" in closer proximity to each other would exert a greater influence on each other than the more distant stars. This is quite different than viewing relationships as a totality in predicting a specific relationship. For example, while a nurse (or client) may have a totality of generally positive relationships, the nurse (or client) may have had specific negative experiences with clients (or nurses) perceived to be similar to the current client (or nurse). It may therefore be prudent to test the influence of a more narrow range of other interpersonal relationships within nurses' other relationships.

The anxiety of both nurses and clients were not significantly related to progress in the therapeutic relationship in this study. Within Peplau's theory, anxiety
is depicted within many contexts (Peplau 1973a; 1989). Anxiety is depicted as developing in response to a perceived threat, and as transmitted interpersonally. It can develop at varying levels within the nurse-client relationship, but can also occur at other times independent of the nurse-client relationship.

The Beck Anxiety Inventory is a measure of global anxiety. The instructions direct the subject to consider the previous week in the completion of the form. As a broad measure, the BAI is congruent with Peplau's theory; moreover, it uses the levels of mild, moderate and severe just as Peplau does.

Sample size problems resulting from fewer dyads completing orientation and more clients discharged in orientation than anticipated, limited the testing of the hypotheses. However, the absence of significant findings related to anxiety (except for one multiple regression analysis) suggests that global anxiety is not related to the evolving nurse-client relationship. It is not known whether the specific anxiety in context of the nurse-client relationship is related. Since Peplau's theory describes anxiety generally, as well as in context of the relationship, further testing using a more narrow conceptualization is needed. If further study finds no support for the influence of even a more narrowly defined anxiety, the theory would need to be revised to de-
emphasize the relative importance of anxiety.

Implications for Research

Measurement issues. The reliability of the semantic differential scales, PRQ, BAI and WAI were all sufficiently high for the samples in this investigation. Some clients did not complete the WAI; although their generally stated reason was that they had "had enough," it is unclear whether this was related to the length of the instrument (36 items and the longest questionnaire in the package) or its position as last in the package. Future studies with similar populations may need to examine these possibilities.

Clients stated a clear preference for an interview rather than questionnaire format during the pilot test of 20 nurse-client dyads. Rationale were that it was easier to both hear the interviewer and see the questions and that it was faster to have someone read it. This is particularly interesting since the data collection instruments were designed as questionnaires, not interviews, and previous studies did not report difficulty with that format.

In contrast, nurses in the pilot study found the questionnaire format faster, especially with someone present. The purpose of the having the person present was to legitimize the activity and reduce interruptions, rather than to read or clarify the questionnaire. Having someone present, but not reading, reduced the nurse's time to approximately 20 minutes from 40 minutes for having the
nurse complete the questionnaire alone. This is an extremely important consideration in clinical research since less nursing time away from client care potentially increases the administrative support for a project. With very few exceptions, nurses' and clients' preferences in the pilot study, were the same for the full investigation.

The semantic differential scales, PRQ and WAI all used seven point scales. Some clients had difficulty with the nuances in these scales. For example, on the PRQ, subjects frequently chose either "agree" or "disagree" and tended to avoid the "somewhat" or "strongly" qualifiers. This was countered by having the interviewer check with the client the degree of agreement or disagreement. Had these instruments had been given as questionnaires there may have been a problem with response variability and thus less precision with regards to outcomes.

The semantic differential scales, PRQ and WAI also all used a format where the direction of positive or negative responses varied among items. For example, on the semantic differential scales "too busy for me - has time for me" was directly followed by "nice - not nice" which reverses direction. This is a common strategy in instrument development and assists in encouraging the subject to think about each response independently thus reduce response bias. However, many clients found this confusing and requested that items be reread when these changes in
direction occurred. If the instruments had been given as a questionnaire, without an interviewer, the accuracy of the client responses would probably have been compromised.

The significant correlations between the Relationship Form findings and two forms of the WAI provides evidence for the concurrent validity of the Relationship Form. Previous study of this form (Forchuk & Brown, 1989) addressed only the construct and face validity.

Scores on the WAI were very similar to those reported by Gehrs (1991) with a similar sample of clients with a chronic mental illness. Scores around three months averaged 173.6 for the therapist form of the instrument, compared to 178.93 in this investigation. These results are higher than those reported by Horvath and Greenberg (1986) for a healthier sample in counselling at a university clinic (mean = 137.48, SD = 18.05) for the therapist form.

Scores for the client form of the WAI averaged 185.4 in Gehrs (1991) study compared to 186.22 in this investigation. Again, Horvath and Greenberg's study found lower scores with a mean of 139.38 (SD = 23.63). The only other study found which used the WAI with a chronic population (Stylianos & Goering, in press) presented reliability results and did not report means.

The higher WAI scores with a more chronic sample as compared to a university clinic sample are particularly interesting since they suggest that clients with a chronic
mental illness are better able to establish therapeutic alliances. However, the Horvath and Greenberg results for the university clinic were obtained one to two months earlier in the development of the relationship than the current investigation or the Gehrs study. It is also possible that there may be some problem with the validity of the WAI. Further study of the WAI with a variety of client groups are needed to determine the validity of the instrument.

Beck et al. (1988) reported norms for the BAI for only three groups: (a) clients with anxiety and no secondary diagnosis, (b) clients with anxiety and a secondary diagnosis, and (c) clients with a primary diagnosis of depression. Client scores in the current investigation are similar to those reported by Beck et al. for clients with a primary diagnosis of depression.

The current study found a time-1 client mean of 13.89 (SD = 10.95) compared to the depressed group mean of 13.27 (SD = 8.36) reported by Beck et al. (1988). As would be expected, mean scores for the study sample were lower than the samples with anxiety as the only diagnosis (mean 24.59, SD = 11.41), or anxiety as the primary diagnosis (mean 25.39, SD = 11.48). The higher standard deviation indicates more variation in the current investigation. Means on the BAI for nurses were considerably lower, with a mean of 3.89 (SD = 4.59), than those reported by Beck et al. The standard
deviation higher than the mean suggests a distribution skewed towards lower scores. The use of the BAI with various subject groups would assist in developing of a wider range of norms for different populations.

Weinert (personal correspondence, 1990) reported means for 15 studies using the PRQ. These means range from 125.4 to 149.2 (SDs 13.9 to 25.8). The samples were all relatively healthy, such as rural families, and mothers. It is therefore not surprising that the clients in this study scored lower than any other group previously reported (time-1 mean = 116.31, SD = 24.47). It is interesting that the nurses in this sample, with the exception of the scores at time-3, scored higher than any other group for whom results on the PRQ are available (time-1 mean = 152.29, SD = 13.75).

It should be noted that all samples described by Weinert (1990, personal correspondence) had a mean closer to the positive end of the scale (i.e., above 100). This reflects either a problem with the instrument's sensitivity to negative interpersonal relationships or lack of diversity in previous samples. Further study with the PRQ should include a broader selection of subject groups to allow for comparisons and to further develop the validity and sensitivity of the instrument.

Direct comparison of nurse and client preconceptions of each other was hampered by the use of different items on the
two forms of the semantic differential scales. Only three items appeared on both the nurse and client form. This was based on different descriptions of initial impressions given by nurses and clients during the pilot phase. Further study could attempt to identify additional items that are relevant to both nurses and clients so that more direct comparisons can be made.

Future research. The findings of this investigation indicates the need for future research to continue testing Peplau's theory. Since not all hypotheses were supported, the results, in concert with further research, have the potential to enhance further theory development and refinement of this nursing theory.

Future research should test the concept of other relationships more narrowly defined, for example in terms of other nurse-client relationships. In addition, future research should test the influence of anxiety that is specific to nurse-client interactions on the development of therapeutic relationships.

Nurses' and clients' preconceptions of each other were generally identified as the most important factors influencing the duration of time in the orientation phase. However, very few studies have examined the nature of preconceptions. Further investigations might explore the basis upon which preconceptions are formed and under what circumstances they can be changed.
Demographic factors that were found to be significantly related to the duration of the orientation phase might form the basis of experimental studies directed at shortening the orientation phase. For example one could study the effects of lengthening the duration of nurse-client interactions, or testing strategies to improve negative preconceptions.

Implications for Nursing Practice

Negative preconceptions of both nurses and clients need to be identified and worked through expediently in order to allow the therapeutic relationship to develop. If preconceptions are not amenable to change, a therapeutic transfer to another nurse needs to be considered.

The finding that numerous clients were discharged or transferred while still in the orientation phase raises clinical concerns. This occurred only with hospitalized clients (i.e. no community clients were discharged in the orientation phase). The 30 clients who discontinued the relationship with their nurse in orientation constituted almost 1 in 3 of the hospitalized clients in the study. Thus a large group of clients were discharged or transferred without establishing trust with their nurses or identifying problems to be worked on during their hospitalization. This process is a potential source of frustration for nurses and clients alike, since it interferes with psychiatric rehabilitation and mutual goal setting.

A pertinent question is what should or could be done
about the number of clients discharged while in orientation? Should hospitalizations be longer for the chronic mental health population to allow adequate time for the completion of the orientation phase? Should staff somehow work more diligently or effectively in the limited time available to establish relationships? Should goals for hospitalization be changed so that therapeutic relationships are not expected to develop and relegate this expectation to community settings?

It is important for nurses working with clients with chronic mental health problems to recognize that, although there is a great deal of variability, it often takes a long time to complete the orientation phase. Only one dyad in the sample completed orientation in the first week, and 13 remained in orientation beyond six months. Nurses who had previously worked with other populations may have had unrealistic expectations about how long it takes for clients with a chronic mental illness to begin to trust and identify problems with their nurse. The researcher wondered whether some of the discharges of clients in the orientation phase were related to unrealistic expectations, especially when accompanied by comments of the client "not fitting the program."

There was great diversity in length of time in the orientation phase. This ranged from 1 to 30 weeks, with 13 dyads not completing orientation. A great deal of this
diversity was related to preconceptions. These findings suggest that flexibility and openness to individual differences is required on the part of the nurse, and on the part of programs geared to individuals with chronic mental illnesses.

Frank and Gunderson (1990) examined evolving therapeutic relationships with 143 individuals with nonchronic schizophrenia over a two year period. They found dyads seldom (only 5.1%) established a therapeutic relationship when it did not occur in the first 6 months. Yet, in this study, 3 nurses of the 16 dyads still in orientation at 6 months, contacted the investigator after 6 months with the information that the orientation phase was finally completed. This occurrence was particularly surprising since nurses had not been requested to do so. This provides some hope that a therapeutic relationship can be established even after a prolonged (6 month) period.

There were several demographic variables which were related to the duration of the orientation phase. Some, such as client age, cannot be altered. Others, however, are possible to change in the clinical setting. The duration, but not frequency, of nurse-client interactions was significantly related to time in the orientation phase. This finding has implications for the planning nursing care. It suggests that one 30 minute meeting is better than three 10 minute meetings. In some hospital settings nurses
seem to feel they must "check in" with clients at least daily for ten minutes or so. By the time all assigned clients have been seen and routine tasks have been completed, there is little time for a meeting of greater duration. Organizational changes could support less frequent but longer meetings.

The findings suggest that nurses need to be aware of their thoughts and feelings towards their clients. Both negative and positive preconceptions seem to exist very early in the relationship and undergo very little change. Yet, they have a significant relationship to the duration of the orientation phase. This also suggests that more consideration needs to be given to both nurse and client preferences in nurse-client assignment.

Limitations

Limitations of this investigation concern threats to internal and external validity. Threats to internal validity relate to the ability to control variance within the investigation (Wilson, 1985). These included:

1. History: An external event during the course of the study could have influenced results (e.g. change in existing programs, policies). This was controlled for by having dyads with both relatively short and long orientation phases included, and dyads from a number of programs in the sample.

2. Threats due to multiple testing (such as increasing
familiarity and comfort with test items and testing process at successive data collection periods) was a potential problem that was minimized by spacing the testing intervals three months apart.

3. Evaluation apprehension among the participants may have been an issue for both nurses and clients. Nurses may have felt their practice was being evaluated. Clients may have had difficulty trusting the motives of the investigator. A nonjudgmental attitude and measures to ensure anonymity were used to counter some of these threats.

4. The use of multiple sites may have introduced unknown and/or unmeasurable factors such as differences in program philosophies, staff and client expectations, personnel or staffing policies, and client screening policies. The investigator attempted to minimize this by visiting all sites and speaking to both managers and staff about general operating procedures that might create idiosyncratic differences in evolving nurse-client relationships. One potential program was excluded from the study because nurses' initial meetings with clients were always in the presence of a psychiatrist. Other programs were excluded that used intake groups rather than individual interviews.

5. Hypothesis guessing, or subjects conforming to what they believed was the expected behavior, was a potential problem in this investigation. The specific theory testing aspect, and the specific variables being examined were not revealed.
in the consent form or explanation. However, many of the nurse subjects were familiar with the investigator's program of research and/or recognized the Relationship Form as based on Peplau's theory. When questions were asked related to this, the investigator emphasized the exploratory nature of the investigation and the importance of the phenomena evolving naturally.

6. The process of asking questions about a relationship may have changed it, probably in a positive direction. It is likely that this was counter balanced in that there was a similar effect on all participants.

Potential threats to external validity are factors that may impede the generalizability of the findings (Wilson, 1985). These included:

1. Mortality was a large problem with this chronic population, particularly over multiple data collection periods. Drop outs were anticipated to be largest among clients that took longer in the orientation phase since, by definition, they had not yet engaged with their nurses. A particular mortality problem with this investigation was having 30 clients discharged while still in the orientation phase. This problem would have only been partially countered by getting as large of a sample as possible.

2. The sample of subjects completing orientation (51) was less than the minimum number suggested by power analysis (83) to adequately test the hypotheses. This increased the
risk of type two error, that is, the risk of rejecting a true hypothesis.

3. Experimenter expectancy was a potential issue which was balanced by having blind validation by CNSs of the phase of the relationship rather than having the investigator participate in this process.

4. Not all the potential influences identified by Peplau were measured in the investigation.

5. The use of mentally competent volunteer client subjects, while ethically necessary, limits the generalizability of the findings.

Summary and Conclusions

This investigation tested Peplau's theory, particularly her predictions about variables related to progress in the nurse-client relationship. The sample consisted of 124 nurse-client dyads in programs targeted at individuals with chronic mental illnesses. Variables examined were preconceptions, other interpersonal relationships, and anxiety. These variables were measured for both nurses and clients at the beginning of their relationship, and at three and six months into their relationship.

Preconceptions of both the client and nurse were found to be related to progress in the therapeutic relationship. Other relationships of clients but not nurses were found to
be related to development of the therapeutic relationship. Anxiety was not found to be significantly related to this relationship. The investigation, therefore, supported some tenets of Peplau's theory, but not others. This provides direction for future research and theory refinement.

It is expected that continued investigation of the orientation phase of the nurse-client relationship will yield information that will assist in realistic goal setting regarding progress in therapeutic relationships and will ultimately facilitate transition through the orientation phase of the relationship.
Appendix A

RELATIONSHIPS SUGGESTED BY PEPLAU

progress in nurse-client relationship

measured:

- low anxiety
- social support
- +preconceptions

not measured:

- client level of learning
- pattern integration
- verbal & nonverbal communication
### FIGURE
Community Mental-Health-Promotion Program Phases of Nurse-Client Relationship

<table>
<thead>
<tr>
<th>Date of Visit</th>
<th>Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Orientation Phase</th>
<th>Identification Phase</th>
<th>Exploitation Phase</th>
<th>Resolution Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conveys educative needs.</td>
<td>Begins to be aware of time.</td>
<td>Identifies new goals.</td>
<td>Aspires to new goals.</td>
</tr>
<tr>
<td>Shares preconceptions and expectations of nurse due to past experience.</td>
<td>Recognizes nurse as a person.</td>
<td>Exploitative behavior.</td>
<td>Maintains changes in style of communication and interaction.</td>
</tr>
<tr>
<td></td>
<td>Increases local attention.</td>
<td>Develops skills in interpersonal relationships and problem-solving.</td>
<td>Exhibits ability to stand alone.</td>
</tr>
<tr>
<td></td>
<td>Changes appearance (for better or worse).</td>
<td>Displays changes in manner of communication (more open, flexible).</td>
<td></td>
</tr>
<tr>
<td><strong>Nurse:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give parameters of meetings.</td>
<td>Exhibits ability to edit speech or control focal attention.</td>
<td>Most needs as they emerge.</td>
<td>Promote family interaction.</td>
</tr>
<tr>
<td>Explain roles.</td>
<td>Testing maneuvers decrease.</td>
<td>Understand reason for skills in behavior.</td>
<td>Assist with goal setting.</td>
</tr>
<tr>
<td>Gatter data.</td>
<td>Unconditional acceptance.</td>
<td>Initiate rehabilitative plans.</td>
<td>Teach preventive measures.</td>
</tr>
<tr>
<td>Help patient plan use of community resources and services.</td>
<td>Assess and adjust to needs.</td>
<td>Identify positive factors.</td>
<td>Teach skill.</td>
</tr>
<tr>
<td>Practice non-directive listening.</td>
<td>Provide experiences that diminish feelings of helplessness.</td>
<td>Facilitate forward movement of personality.</td>
<td></td>
</tr>
<tr>
<td>Focus patients energies.</td>
<td>Do not allow anxiety to overrule patient.</td>
<td>Deal with therapeutic impasse.</td>
<td></td>
</tr>
<tr>
<td>Clarify preconceptions and expectations of nurse.</td>
<td>Help patient to focus on cues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Help patient develop responses to cues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use word stimuli.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: Phases Are Overlapping

---

Appendix C:

Subject No: ______

Explanation for Relationship Form:

The Relationship Form plots the phases of the relationship by identifying important nurse and client behaviors. For this study it is important to know how many week are spent in the orientation phase. This phase begins with the first formal meeting of the nurse and client and ends with the behaviors listed under the "identification" part of the form. Most important is that in the identification phase clients can begin to identify problems to work on, and there begins to be some continuity from session to session.

It can be difficult at times to determine when the relationship has completed the orientation phase and moved to identification (the first part of the working phase). To assist in the accuracy of this determination, please contact __________________ at __________________ when you believe the relationship has completed orientation, or if you are not clear about this determination.

Date of first formal meeting = ____________
Date completed orientation = ____________
Number of weeks = ____________
Confirmed with clinical specialist ________

Return To: C. Forchuk

(or give to researcher at 3 or 6 month contact period)
Appendix D:

memo:
To: clinical nurse specialist
From: Cheryl Forchuk
Re: relationship study

The following nurse(s) have been given your name to validate the number of weeks in orientation:

<table>
<thead>
<tr>
<th>Nurse:</th>
<th>Program:</th>
<th>phone:</th>
<th>3 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>months</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

Please contact them by the 3 and 6 month period if they have not contacted you.

Thank you
PLEASE NOTE

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165-172
Preconceptions Of Nurse

The following includes opposite ways you might feel about your nurse. Put an "X" at the point between the two words to indicate how you feel. For example if you were given the scale:

fat __ __ __ __ __ __ __ __ thin

and you thought the nurse was extremely fat, you would check it off as follows:

fat _X__ __ __ __ __ __ __ thin

If you thought the nurse was slightly thin you would check it like this:

fat __ _X__ __ __ __ __ __ thin

There are no right or wrong answers. Your opinions are important.

Now, thinking of your nurse, fill out the following:

good __ __ __ __ __ __ __ bad

interested in me __ __ __ __ __ __ __ not interested in me

treats me as a __ __ __ __ __ __ __ does not treat me as a person

does not support __ __ __ __ __ __ __ supports me

too busy for me __ __ __ __ __ __ __ has time for me

helpful __ __ __ __ __ __ __ not helpful

nice __ __ __ __ __ __ __ not nice

controls __ __ __ __ __ __ __ lets me control

attractive __ __ __ __ __ __ __ not attractive

I like nurse __ __ __ __ __ __ __ I do not like nurse
Appendix H

Preconceptions Of Client

The following includes opposite ways you might feel about your client. Put an "X" at the point between the two words to indicate how you feel. For example if you were given the scale:

fat __ __ __ __ __ __ thin

and you thought the client was extremely fat, you would check it off as follows:

fat _X __ __ __ __ __ thin

If you thought the client was slightly thin you would check it like this:

fat __ __ __ __ _X __ __ thin

There are no right or wrong answers. Your opinions are important.

Now, thinking of your client, fill out the following:

good __ __ __ __ __ __ bad

difficult __ __ __ __ __ __ easy

satisfying __ __ __ __ __ __ not satisfying

uncooperative __ __ __ __ __ __ cooperative

unique __ __ __ __ __ __ typical

feel empathy for __ __ __ __ __ __ feel no

empathy for __ __ __ __ __ __ trusting

suspicious __ __ __ __ __ __ trusting

safe __ __ __ __ __ __ dangerous

dependent __ __ __ __ __ __ independent

attractive __ __ __ __ __ __ not attractive

I like client __ __ __ __ __ __ I do not like client
PLEASE NOTE

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

175-176
Appendix J:
Demographic Questionnaire for Nurses
at Beginning of Relationship

Subject Number_________

1. RN/grad _____ male___ age ___
   RNA/PNA _____ female____

2. Setting: in-patient____
   transitional (hospital to community)____
   community____

3. I have been in nursing for ____ years and in mental
   health/psychiatric nursing for____ years.

4. The nursing role with this client is:
   assigned nurse____
   primary nurse____
   case manager/coordinator_____
   other (please specify) _________

5. I have known this client for ____ weeks.

6. The client and I usually meet _____ times per week (or if
   less than once a week ___ times per month). Each time we
   meet, our sessions usually last approximately ____ minutes.

7. Clinical supervision in working with this client:
   No____
   Yes____, if yes, peer supervision___
   clinical specialist___
   psychiatrist_____
   supervisor____
   other____, specify_________________

   Clinical supervision with this client is received____ times
   per month.

8. Clinical supervision in working with any other client:
   No____
   Yes____, if yes, peer supervision___
   clinical specialist___
   psychiatrist____
   supervisor____
   other____, specify________________

   Clinical supervision with all other clients is received____
   times per month.

8. How familiar are you with Hildegard Peplau's framework
   for nursing practice?

very familiar ___ ___ ___ ___ ___ not familiar
9. How consistent is your nursing practice with Peplau's framework?

always use ___ ___ ___ ___ ___ Peplau

never use _____ _____ Peplau

Don't know Peplau's work well enough to answer ______

9. I believe the essence of mental health/psychiatric nursing is:

monitoring psychotropics____

health teaching____

nurse-client relationships____

work with families/social support____

therapeutic milieu____

activities of daily living____

other____ specify_____________________

10. Nursing Theories used in practice:

___ King _____ Neuman,Betty ___ Reihl

___ Leininger _____ Newman,Marg. ___ Rogers

___ Orem _____ Parse ___ Roy

___ Orlando _____ Peplau

___ Other (specify)____________________________

11. Are you on any medication that might reduce anxiety?

Yes____

No____
12. Client Information:

gender: male___ age____
    female___

psychiatric diagnosis: schizophrenic____
schizoaffective___
affective disorder____
organic brain disorder____
personality disorder____
other___,
specify____________________

psychotropic medication: (please check all that apply)
antipsychotic____
antianxiety___
antidepressant___
lithium____
hypnotic___
Other, (specify) __________________________

Number of previous psychiatric hospitalizations____

Most recent hospitalization was for ____ months (if less
than month, ____ weeks)

Current hospitalization status: Hospitalized____
    LOA____
    Community____
Appendix K:
Demographic Questionnaire for Nurses
at 3 and 6 months into relationship

Subject Number________

1. The client and I usually meet _____ times per week (or if less than once a week ___ times per month). Each time we meet, our sessions usually last approximately ____ minutes.

2. Clinical supervision in working with this client:
   No_____, if yes, peer supervision
   clinical specialist____
   psychiatrist_____
   supervisor____
   other ____, specify___________________

   Clinical supervision with this client is received ____ times per month.

3. Clinical supervision in working with any other client:
   No____
   Yes____, if yes, peer supervision
   clinical specialist____
   psychiatrist_____ 
   supervisor____
   other ____, specify___________________

   Clinical supervision with all other clients is received ____ times per month.

4. How familiar are you with Hildegard Peplau's framework for nursing practice?

   very familiar __ __ __ __ __ __ not familiar

5. How consistent is your nursing practice with Peplau's framework?

   always use Peplau ______ never use Peplau

   Don't know Peplau's work well enough to answer ______

6. I believe the essence of mental health/psychiatric nursing is:

   monitoring psychotropics____
   health teaching____
   nurse-client relationships____
   work with families/social support____
   therapeutic milieu____
   activities of daily living____
other (specify)_____________________

7. Nursing Theories used in practice:
   ___King
   ___Leininger
   ___Orem
   ___Orlando
   ___Other (specify)________________

   ___Neuman,Betty
   ___Newman,Marg.
   ___Parse
   ___Peplau
   ___Roy

8. Are you on any medication that might reduce anxiety?
   Yes____
   No____

   ________________________________

9. Client Information:

   psychiatric diagnosis: schizophrenic____
   schizoaffective____
   affective disorder____
   organic brain disorder____
   personality disorder____
   other____,

   specify_________________________

   psychotropic medication: (please check all that apply)
   antipsychotic____
   antianxiety____
   antidepressant____
   lithium____
   hypnotic____
   Other, (specify) __________________________

   Current hospitalization status: Hospitalized____
   LOA
   Community____
Hello. My name is Cheryl Forchuk. I am a doctoral student in the College of Nursing at Wayne State University and a clinical nurse specialist at Hamilton Psychiatric Hospital. Part of my course work involves research. I am conducting a research study entitled "The Relationship Study". The purpose is to examine how nurses and clients work together and to look at some of the things related to how they work together. For this project I need nurses and clients who are just beginning to work together. I understand that you have just begun to work with _____________. Let me tell you a bit of what I will be asking of people who volunteer to participate in this study so you can decide if you would like to participate.

You would be asked a series of questions about yourself and your feelings towards your client/nurse at the beginning of your relationship, and again after you have been working together for about three and six months. It will take approximately 30 to 45 minutes to answer these questions each time. Your client/nurse will also be asked questions about you and your nurse-client relationship. The answers will only be available to the researchers and will not be shared with others. The only exception will be a life threatening situation - such as planning suicide.

You are under no obligation to participate in this study. Whether or not you choose to participate will not affect your treatment/employment. You may choose to not answer any questions or items or to withdraw at any time. Your name will not appear in any related reports, and only a code number will be written by the answers instead of your name.

In the unlikely event of any injury resulting from the research, no reimbursement, compensation or free medical care is offered by Wayne State University. You can ask questions about your participation at any time and will receive a signed copy of the consent form. The consent also has my phone number and the number of the committee at the university that ensures research subjects rights are being respected.

Any questions? (Answer questions)
Would you like to participate?
(if no) Thank you for your time
(if yes) Thank you. I'll just go over this consent with you that summarizes what I just told you....
APPENDIX M

CLIENT CONSENT TO PARTICIPATE IN STUDY

I am being asked to participate in the research study entitled "The Relationship Study" conducted by Cheryl Forchuk (phone: [redacted]). I understand that the purpose is to examine how nurses and clients work together and to look at some of the things related to how they work together. It is hoped that people in similar circumstances will benefit through my participation.

I will be asked a series of questions about myself and my feelings towards my nurse at the beginning of our relationship, and again after we have been working together for about three and six months. It will take approximately 30 to 45 minutes to answer these questions each time. My nurse will also be asked questions about me and our nurse-client relationship. My answers and my nurses answers will only be available to the researchers and will not be shared with others. The only exception will be a life threatening situation—such as planning suicide.

I understand that I am under no obligation to participate in this study. Whether or not I choose to participate will not effect my treatment. I may choose to not answer any questions or items or to withdraw at any time. I understand that my name will not appear in any related reports, and only a code number will be written by my answers instead of my name. I can ask questions about my participation at any time and I will receive a signed copy of this consent form.

In the unlikely event of any injury resulting from the research, no reimbursement, compensation or free medical care is offered by Wayne State University. The Human Investigation Committee (HIC) can be reached at [redacted] as a research subject.

Date________________
Signature_______________________
Witness________________________
APPENDIX N
NURSE CONSENT TO PARTICIPATE IN STUDY

I have agreed to participate in the research study entitled "The Relationship Study" conducted by Cheryl Forchuk. I understand that the purpose is to examine how nurses and clients work together and to look at some of the things related to how they work together. It is hoped that people in similar circumstances will benefit through my participation.

I will be asked a series of questions about myself and my feelings towards my client at the beginning of our relationship, and again after we have been working together for about three and six months. It will take approximately 30 to 45 minutes to answer these questions each time. My client will also be asked questions about me and our nurse-client relationship. My answers will only be available to the researchers.

I understand that I am under no obligation to participate in this study. I may choose to not answer any questions or items or to withdraw at any time. I understand that my name will not appear in any related reports, and only a code number will be written by my answers instead of my name. I can ask questions about my participation at any time and I will receive a signed copy of this consent form.

In the unlikely event of any injury resulting from the research, no reimbursement, compensation or free medical care is offered by Wayne State University. The Human Investigation Committee (HIC) can be reached at [contact information].

Date ____________
Signature _________________________
Witness _________________________
References


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ABSTRACT
THE ORIENTATION PHASE OF THE NURSE-CLIENT RELATIONSHIP:
TESTING PEPLAU'S THEORY

CHERYL FORCHUK

May, 1992

Advisor: Dr. Laurel Northouse
Major: Nursing
Degree: Doctor of Philosophy

This investigation used a prospective design to examine the orientation phase of the nurse-client relationship. One hundred and twenty-four newly formed nurse-client dyads constituted the sample; Client subjects were individuals with a chronic mental illness. The following variables predicted by Peplau's theory to be related to development of the therapeutic nurse-client relationship were examined: nurses' preconceptions of their clients, clients' preconceptions of their nurses, other interpersonal relationships of clients and nurses, and anxiety of clients and nurses. Variables were measured for both nurses and clients at 0, 3 and 6 months into their relationship.

Preconceptions of both clients and nurses were related to the duration of the orientation phase and development of the therapeutic alliance. There was support for the importance of other interpersonal relationships with clients but not nurses. Anxiety was not found to be significantly related to the development of the therapeutic relationship. Findings therefore support some tenets of Peplau's theory,
but not others. This gives direction for future research and theory refinement.
Autobiographical Statement: Cheryl Forchuk

Personal Information: Born in Brantford, Ontario, Canada. Married to Ian Gerald T. Smits, with two sons, Ian Forchuk Smits and Robin Forchuk Smits.

Current Position: Clinical Nurse Specialist at Hamilton Psychiatric Hospital and Associate Clinical Professor (on leave while completing studies), School of Nursing, McMaster University, Hamilton, Ontario, Canada.


Research: Participated in several research projects as Principle Investigator, Co-principal investigator or Co-Investigator. Research programs include study of the nurse-client relationship, sexuality issues related to individuals with developmental handicaps and/or chronic mental illnesses, and issues related to the delivery of quality nursing services.