The reasons why some patients suffering from schizophrenia miss clinic appointments

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The reasons why some patients suffering from schizophrenia miss clinic appointments

By

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I declare that the dissertation submitted for the degree, Magister Societatis Scientiae in Nursing to the University of the Orange Free State is my own independent work and has not previously been submitted for a degree to another university.

M.F. Mogodie

DEDICATION

This work is dedicated to:

- My parents for the gift of education they gave me, especially my mother who is still alive at the time of my study, for her support during stressful times.

- My daughters, Maud and Millicent for their encouragement and support through this long and demanding process.

- Again for their tolerance of limited attention from their mother because of study demands.

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INDEX

Page

CHAPTER 1: Statement of the problem

CHAPTER 2: Literature review

Page

Page

CHAPTER 3: Research methodology

CHAPTER 4: Presentation of findings

Page

List of figure

List of tables

CHAPTER 1

Statement of the problem

1.1 INTRODUCTION

Patients who suffer from schizophrenia require a long-term management approach including both medical and social treatment. Symptomatic and preventive drug treatment and the role of psychosocial intervention reduce relapse (Hawthorne & Burns, 1994:15).

Strong support from the family and the community and the relationship between caregivers and the community are priorities to enhance compliance by removing the stigma attached to mental illness (Hawthorne & Burns, 1994:16).

In most cases the patients can be successfully managed at home if they attend the clinic regularly for evaluation and treatment. Even though some symptoms may take weeks to respond, relapse is greatly reduced (Hawthorne & Burns, 1994:18).

Reasons for missed appointments, which is a world-wide problem, are not clearly defined in previous studies because of poor community involvement. If a strong relationship between the community and health care services could be maintained and services made available and accessible at all times, mental illness, like all other physical illnesses will be acceptable, and missed appointments will be reduced (Mdluli & Msomi, 1989:17).

Missed appointments, for whatever reason, are always a cause for concern because of their consequences to the patient, family, community and the

health services. The economy of the country is affected by increasing demands for funds for additional resources such as manpower, facilities, transport, medication and other necessities to meet the needs of relapsed patients who are readmitted (Mdluli & Msomi, 1989:18).

Berk (1993:48) states that the relapse rate for patients suffering from schizophrenia who do not keep clinic appointments may be as high as 50% at six months and 65% to 80% at 12 months if follow up measures are not taken. Regular patient's assessment and treatment intake is important to prevent the relapse.

1.2 PROBLEM STATEMENT

According to the internal policy of Botshabelo Primary Health Care Services (Circular No. 12 of 1990), the statistics for psychiatric patients at the clinics are compiled monthly to ensure clinic compliance. Patients who miss appointments, are visited at home one month after a missed appointment. The purpose is to encourage attendance and to prevent relapse. Letters are left for people who are not at home.

During the compilation of monthly statistics for all psychiatric patients who were seen at the clinic for the first time between January and March 1995, it was noted that those who are suffering from schizophrenia comprised the majority and missed clinic appointments were high among them. According to the statistics, the total number of all psychiatric patients who were seen for the first time at five selected clinics were 50 and those suffering from schizophrenia were 34. Further analysis of the statistics to detect missed clinic appointments for the 12 months period between January 1995 and January 1996, showed high rate of non-compliance among patients who are suffering from schizophrenia. Five patients missed clinic apointment once in 12 months period while 27 missed two or more clinic appointments. Only two patients showed compliance. Statistics to illustrate the situation are presented in Table 1.1 (see p.3).

TABLE 1.1: The statistics for January 1995 to January 1996

DIAGNOSIS	*First visit*				*Missed appointments*					*Total*	*Compliances or attendances*	*Releapsed and admission*
	January	*February*	*March*	*Total*	*x1*	*x2*	*x3*	*x4*	*x5+*			
Schizophrenia	13	7	14	34	5	2	8	5	12	32	2	4
Depression	2	3	2	7	-	4	1	-	2	7	-	-
Epileptic psychosis	-	-	2	2	1	-	-	-	-	1	1	-
Reactive psychosis	-	1	-	1	-	-	-	-	1	1	-	-
Other psychosis	-	4	-	4	-	1	-	-	3	4	-	-
Dementia	-	1	1	2	-	-	1	1	-	2	-	-
TOTAL	15	16	19	50	6	7	10	6	18	47	3	4

1.2.1 Missed clinic appointments as a world-wide problem

Missed clinic appointments as a world-wide problem has been reported by the Department of Health and Human Sciences of the United State of America. The statistics reveal that 30% to 55% of patients suffering from schizophrenia do not keep their clinic appointments. In order to encourage them, they should be reminded telephonically or by letter. These measures are expensive and time-consuming. Patients are routinely given appointment cards (Harmon & Tratnack, 1992:15).

According to Nicholas (1994:276) the hospitalization of 10% of schizophrenic patients may be due to missed clinic appointments and inadequate intake of medication. In some countries the large discrepancy between the number of attendances booked and the number of patients who actually arrived was a major problem. The Nuffield Survey revealed that in Britain the number of booked patients was 33% and 16% did not attend the clinics. In Los Angeles 20% of patients missed appointments while in Montreal the figure was 32% to 62%.

1.2.2 Missed appointments in South Africa

A research study conducted by the Department of Community Health of the Witwatersrand University in the Free State in 1994, revealed that missed clinic appointments among mentally ill patients is an ongoing problem (Freeman, Lee & Vivian, 1994:122).

1.2.3 The consequences of missed clinic appointments

According to the literature, missed appointments have consequences for the patient, family, health services and the community.

1.2.3.1 The patient

- The patient who misses clinic appointments may relapse and never regain his pre-relapse level of functioning. If the patient is admitted to hospital a sense of helplessness may result. Hospitalization generally represents a painful experience in an environment that may itself be highly stressful, away from family members who are well able to continue caring if they are given adequate support (Hawthorne & Burns, 1994:18).

- It is common for the relapsed patient to become depressed with suicidal risks.

- Some patients may suffer severe social consequences of another period of illness (Weiden & Havens, 1995:289).

- Mental deterioration may result in paranoia, demoralization, aggression and violence. The patient may be dangerous to himself and other people and this results in rejection (Weiden & Havens, 1995:289).

- The patient may experience a deficit in information processing, differentiating relevant and irrelevant stimuli and abstraction (Stuart & Sundeen, 1995:497).

- Socially, the patient may experience deficits in assertiveness, carrying on a conversation and understanding interpersonal messages (Stuart & Sundeen, 1995:498).

1.2.3.2 The family

- Dependency and financial burden on the family. A member of the family might have to stop working to care for the patient.

- Fears and anxiety due to the patient's behaviour. Some family members have to leave the house due to assault by the patient. (This has been experienced by the researcher in her practice.)

- Family disorganisation, such as separation between husband and wife, or divorce. (This is commonly seen in psychiatric nursing practice.)

1.2.3.3 Professional nurse

An increasing patient load at the clinics causes stress on nurses which may result in burnout. Absenteeism, repeated sick leave and poor work performance which results in poor patient care may take place (own experience).

1.2.3.4 Health services and facilities

- The running costs of health services increase affecting the economy of the country (Berk, 1993:48).

- Overcrowding. Facilities may be overcrowded and the nursing personnel experience pressure of work due to the increased number of relapsed patients (Berk, 1993:48).

- Extra medication will be required resulting in a financial burden on the government (Berk, 1993:48).

- Additional vehicles for home visits and nurses with drivers' licences, will be required. This is a problem because not all nurses have drivers licences (personal experience).

- Extra nurses will need to be employed to meet the needs of patients (Berk, 1993:48).

1.2.3.5 The community

The risk of violence, assaults, rape or other unacceptable behaviours may occur in the community due to mental disorders resulting from non-compliance (Nicholas, 1994:276).

1.2.4 Possible reasons for missed appointments

1.2.4.1 Characteristics of schizophrenia

The effect of the illness on the patient leads to inability to keep clinic appointments.

- Ambivalence. According to the literature, patients with schizophrenia experience ambivalent feelings which result in difficulty to make decisions. Positive and negative feelings about the illness cause confusion and reluctance to seek or accept help (Stuart & Sundeen, 1995:504).

- Hallucinations, delusions and inappropriate affect which are the primary symptoms of patients suffering from schizophrenia, cloud the patients' consciousness and they become disorientated to self, time and environment. Hallucinations such as hearing voices telling them not to go to the clinic or paranoid delusions of nurses wanting to kill them by means

of injection or tablets are the common perceptions which contribute to missed clinic appointments (Stuart & Sundeen, 1995:505).

- Social breakdown syndrome. Schizophrenic patients in long-term psychiatric treatment may experience progressive deterioration of social and interpersonal skills which causes them to become asocial, prefering to be alone and avoiding contact with other people. This also contributes to missed appointments (Stuart & Sundeen, 1995:505).

1.2.4.2 The patient

- Financial problems, for instance, not having money for public transport or medication.

- Physical illness which makes it difficult to go to the clinic.

- No improvement on medication, or refusal of medication due to fear of extrapyramidal symptoms such as a subtle akathexia.

- Forgetfulness.

- The patient may be feeling well and does not see any reason to go to the clinic (Caton, 1984:77; Freeman *et al.*, 1994:122).

- Refusal of treatment because patients who suffer from schizophrenia are unable to comprehend instructions or co-operate. This has been identified as a major source of discontinuity (Stuart & Sundeen, 1995:191).

1.2.4.3 Cultural influence

Mdluli and Msomi (1989:15) in their studies reported that cultural background is one of the contributory factors among black patients for missed appointments. Some patients visit the traditional healer or sangoma during the course of treatment and stop clinic visits. Historically, mental illness is related to witchcraft or ancestors in the black culture. Mentally ill persons are taken to the sangoma for the Twassa (traditional ceremony) treatment. This is supported by Gaborone (1990:11).

1.2.4.4 The family

- Lack of support due to ignorance. The patient's family may have no understanding of mental illness.

- Due to the cultural stigma the family do not accept the patient's illness as it degrades their dignity.

- Rejection or a poor relationship due to the patient's psychotic behaviour.

- Financial burden brought about by the patient when the breadwinner is compelled to give up his/her work to look after the patient (Mdluli & Msomi, 1989:15; Freeman *et al.*, 1994:125; Gaborone (1990:4).

1.2.4.5 Health services or clinic

- Long hours of waiting for evaluation and treatment.

- Long wait for an appointment. People want immediate relief and if they cannot see a doctor for weeks they search around for someone else (Caton, 1984:75).

- The clinic is not accessible. The patients travel a long distance and use transport. Money may be a problem.

- Negative attitude displayed by personnel. In most cases the manner in which patients are treated by caregivers at the clinics is not acceptable because of their negative attitudes, or because they label patients as mental cases. This behaviour contributes to missed clinic appointments (Caton, 1984:76).

1.2.4.6 The treatment

- Long-term medication and frequent assessment. The patient who has been on medication for a long time with little improvement may stop attending the clinic.

- Side-effects of medication such as stiffness of the body, tremors, salivation and other symptoms may cause fear contributing to missed clinic appointments (Nicholas, 1994:277).

1.2.4.7 The community and employer

The stigma attached to mental illness by the community and some employers contributes to the reluctance of patients to visit the clinic (own experience in psychiatric nursing practice).

1.3 CONCEPTUAL MODEL

The factors that influence the patient's ability to comply with clinic appointments and the consequences of missed clinic appointments are outlined in the conceptual model.

The conceptual model, which is based on the principles of systems theory, has been used to explain the possible reasons for missed clinic appointments among patients suffering from schizophrenia. According to this model the patient, as part of a system, is influenced by the environmental factors and the illness itself to stop visiting the clinic for treatment. Missed clinic appointments cause a break or cut between the patient and the clinic due to subsystems which play a negative role within a system.

The patient, as a central part of the system (being one of the subsystems), is surrounded by the environment consisting of subsystems. A positive and effective functioning of subsystems, including the patient as part of the system, results in acceptable functioning of the whole system, i.e. compliance with treatment and nursing activities.

A negative functioning of subsystems due to any disturbances within the system affect the normal functioning of the whole system and result in non-compliance or missed clinic appointments.

According to the conceptual model as a systems approach, each subsystem plays an important role in maintaining the normal functioning of the system. The following subsystems are involved in motivating patients to attend clinic or they contribute to missed clinic appointments are:

- Nature of the illness.
- Patient.
- Family.
- Community.
- Culture.
- Health services (clinic).

The influence of each of the above-mentioned factors will be explained in Chapter 2 (Fawcett, 1989:100).

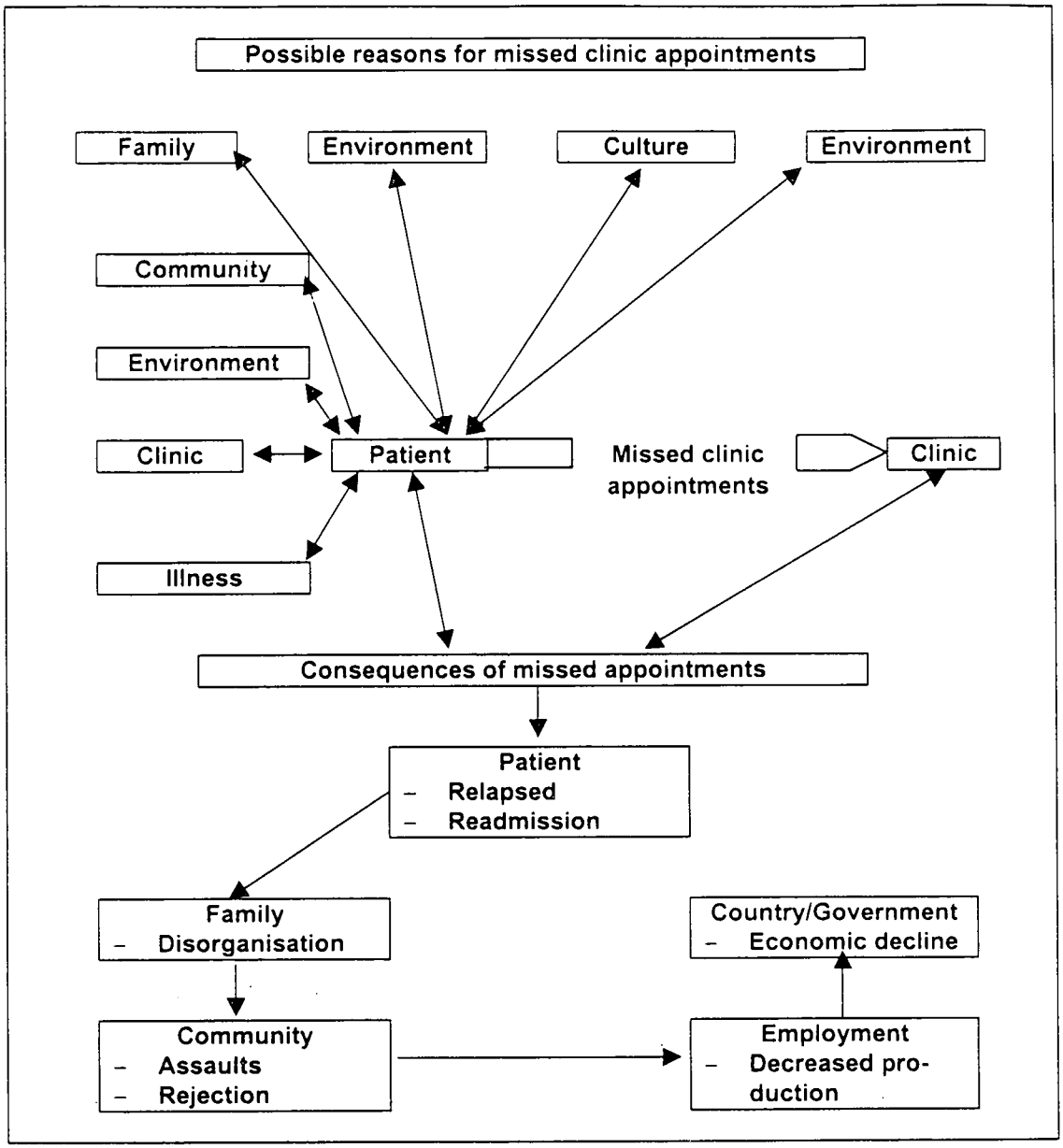

FIGURE 1.1: Conceptual model

1.3.1 Short description of the conceptual model

According to the model which represent a system, the patient who forms the central part of the system is influenced by the surrounding environment which consists of the family, community, health services (clinic) culture and the

nature of the illness to miss clinic appointments. The interrelations of the subsystems as indicated by arrows show the influence of the individual subsystem to one another including the patient, towards missed clinic appointments. Three stages which are involved in the functioning of the system (inputs, throughputs and outputs) are interrelated in this model and could not be divorced from one another.

Example: The nature of the illness on the patient, the family, the health services and the culture influence the patient to miss clinic appointments. The consequences of missed appointments on the patient also affect other subsystems mentioned.

1.4 CONCEPTUAL DEFINITIONS

1.4.1 Patient

According to Orem's self-care model the patient is defined as a person who receives help and care from a nurse, or someone who is under the care of a health care professional at a specific time and specific place (Fawcett, 1989:107).

Orem in Fawcett (1989:107) further explains that human beings are normally able to perform self-care which is defined as actions directed by individuals themselves or their environment to regulate their own functioning and development in the interests of sustaining life, maintaining or restoring integrated functioning under stable or changing environmental conditions, and maintaining or bringing about a condition of well-being.

A person who is unable to perform self-care requires assistance from a health professional as a patient (Fawcett, 1989:211).

King in Fawcett (1989:110) agrees with Orem in describing her conceptual model of interacting systems that a human-being interacting with the environment selects the positive ideas and roles to maintain and restore health. As soon as a person cannot cope and perform his usual activities he requires help (Fawcett, 1989:110).

In this study a patient is a person who is suffering from schizophrenia and requires treatment and nursing care.

1.4.2 Schizophrenia

The term schizophrenia was coined by the Swiss psychiatrist, Eugen Bleuler in 1911. The term derives from the Greek words schizo (to split) and phren (spirit), thus splitting of the mind, or splitting of psychic processes. This reflects Bleuler's view that a disharmony of psychic functions, other than a deteriorating course (as proposed by Emil Kraepelin [1898] who named the illness dementia praecox and believed that the illness affects people at an early age and develops faster with symptoms similar to those of dementia) is the characteristic feature of schizophrenia (Flack, Miller & Weiner, 1991:59; Kaplan & Sadock, 1998:488).

In this study the definition of schizophrenia will be described according to the DSM-IV Diagnostic Criteria.

The illness schizophrenia is characterized by two or more of the following symptoms which are present for a significant portion of time during one month period or less if successfully treated:

A. 1. Delusions
   2. Hallucinations
   3. Disorganised speech (frequent derailment or incoherence)

4. Grossly disorganised or catatonic behaviour
5. Negative symptoms, i.e. affective flattening, and avulation [a disturbance of drive or expression of will especially in the residual phase. Alogia such as poverty of speech, blocking and poverty of content of speech together with Anhedonia [few recreational interests, impaired intimacy] are some of the negative symptoms common in schizophrenic patients.

B. Social occupation dysfunction. Failure to achieve expected level of interpersonal academic or occupational achievements [Cromwell & Snyder, 1993:90; American Psychiatric Association, 1994:284].

C. The minimum duration of symptoms to subside is six to twelve months period.

1.4.3 Clinic

A clinic is defined as an organised place where physically or mentally ill, or hurt people who require health care assistance are seen for preventive, promotive, curative and rehabilitative measures [Caton, 1984:75; Hawthorne & Burns, 1994:16].

For this study a clinic in the primary health care is an organised place which brings health care as close to the community as possible.

1.4.4 Family

A family is one of the most important social institutions which forms an immediate supportive system for an individual.

A family is a group of persons directly linked by kin connections, the adult members of which assume responsibility for caring for the children.

A family is divided into two types which influence family relationships.

The nuclear family consists of two adults living together in a household with their own or adopted children. The relationship of the family is intimate and strong.

The extended family is defined as a group of three or more generations living either within the same dwelling or very close to each other. It may include grandparents, brothers and their wives, sisters and their husbands, aunts, uncles, nieces and nephews. The relationship may not be as strong as in the nuclear family (Giddens, 1990:384-386).

1.4.5 Community

A community is a body of people living in one place, district or country. In most cases this body of people have culture, religion, ethnic origin and interests in common. Like a family the community plays a supportive role to individual members during crisis situations such as illness, death or other activities which require support (Stanhope & Laucaster, 1992:103; Oxford Dictionary, 1996:167).

For this study a community refers to a body of people living in a specific area and utilizing specific available resources and facilities.

1.4.6 Culture

Culture refers to the whole way of life of the members of a society. It consists of the values the members of a given group hold, the norms they follow, and

the material goods they create. Values are abstract ideas, while norms are definite principles or rules which people are expected to observe. Norms represent the "dos and "don'ts" of social life (Giddens, 1990:31).

1.5 OBJECTIVES OF THE STUDY

1.5.1 To identify the possible reasons for missed clinic appointments among patients who suffer from schizophrenia in Botshabelo.

1.5.2 To suggest nursing guide-lines to enhance clinic attendance.

1.6 METHODOLOGY

1.6.1 Research design

The study type will be a quantitative one using descriptive and exploratory designs to gain insight into the contributory factors for missed clinic appointments among patients who suffer from schizophrenia.

The quantitative research approach is commonly chosen when the researcher wishes to identify the possible reasons for the problem, and to develop strategies to improve clinic attendance (Uys & Basson, 1991:38; Polit & Hungler, 1995:372).

Quantitative research is very valuable in nursing because it enables nurses to investigate a variety of research problems (Burns & Grove, 1993:372; Polit & Hungler, 1995:148).

1.6.2 Population

All people living in Botshabelo from the age of 19 years suffering from schizophrenia as well as a family member residing with the patient.

1.6.3 Sampling

Sampling is the process of selecting a portion of the population to obtain data regarding a problem. The main purpose of sampling is to make certain that the research study accurately reflects the population sample (Uys & Basson, 1991:87; Burns & Grove, 1993:235; Polit & Hungler, 1995:229; Talbot, 1995:241).

■ Sampling approach

Non-probability sampling will be used because of the type of problem identified.

The advantages of this type of sampling are as follows:

- It is less expensive, less complicated and allows the researcher to be more spontaneous when a research situation arises.

- It is commonly used in nursing research because it is feasible especially when records are used as in this study, where the problem was identified in the statistics and available patients' records (Polit & Hungler, 1995:235).

■ Sampling procedure

Purposive sampling or judgmental sampling will be used. The researcher will select the schizophrenic patients who missed clinic appointments.

■ Sampling criteria

Inclusive criteria:

- Patients who are suffering from schizophrenia with the following criteria will be included:
  * Admitted at the clinics between January 1995 and January 1996.
  * Males and females aged 19 years and above.
  * Missed clinic appointments twice or more in the 12 months period.
  * Selected from five specific clinics at Botshabelo. These clinics have been selected because they are the biggest clinics which cater for many patients.

- Other selected respondents are as follows:
  * One immediate family member who lives with the patient, and whose name was identified in the patient's record as a parent or guardian.
  * All respondents are residents of Botshabelo.

1.6.4 Data collection instrument

A semi-structured interview with the aid of a questionnaire will be used to collect data from the respondents. The questionnaire will consist of open-ended and closed questions.

> *"A questionnaire is a printed self-report form designed to collect information that can be obtained through written response of the subject"* (Burns & Grove, 1993:368).

■ Advantages of a questionnaire

- It is less expensive and a large number of subjects can be involved.

- Through closed questions, objectivity can be maintained and it avoids extra information being added by the researcher. The answer is either "yes" or "no".

- Open-ended questions enable the researcher to identify the core of the problem, such as possible reasons contributing to missed clinic appointments. The respondents are free to give the information required in their own words (Uys & Basson, 1991:65; Burns & Grove, 1993:368).

1.6.5 A pilot study

A pilot study is a small version or trial run done to prepare for a major study (Burns & Grove, 1993:373; Polit & Hungler, 1995:288).

A pre-test of the questionnaire will be performed to determine the clarity of questions, effectiveness of instructions, completeness of data collection during allocated time, and the success of the data collection technique.

The respondents for the pilot study will be similar to those selected for the main study to acquaint the researcher with the instrument, and to ensure reliability and validity. Corrections to the instrument made during the pilot study will be taken into consideration before the same instrument is used for the main study.

The respondents selected for the pilot study will not be included in the main study. Two patients and two family members will be interviewed for the study (Burns & Grove, 1993:373; Polit & Hungler, 1995:288).

1.6.6 Data collection

Data will be collected from all the respondents (patients and family members), by using a semi-structured interview aided by a questionnaire with closed and open-ended questions. The questionnaire which will be translated by the researcher during the interview from English to South Sotho, will also be completed by the researcher to counteract the problem of illiteracy. South Sotho is the language spoken by the majority of people in Botshabelo.

Data will be collected in privacy at the respondents' homes. The patients will be interviewed in privacy away from family members to avoid influence. The same procedure will be carried out in the case of the family members who will also be interviewed in private. Consent for participation in the study was obtained from the respondents before the interviews.

1.6.7 Reliability and validity

Reliability and validity are the important issues in the evaluation of the findings of a research study. The researcher in any research project attempts to avoid as many errors as possible because accuracy is the key point in reliability and validity. The reliability and validity of the data collection instrument and the whole procedure of undertaking the study will be evaluated after the pilot study (Uys & Basson, 1991:80; Burns & Grove, 1993:373).

■ Reliability

Reliability is concerned with how consistently the measurement technique measures the concept of interest. If the subject is weighed by using a scale, the results obtained at first are expected to be obtained again when the same subject is weighed using the same scale immediately. Consistency of the

results proves reliability (Uys & Basson, 1991:75; Burns & Grove, 1993:339) (see discussion in Chapter 3).

Validity

Validity refers to the degree to which an instrument measures what it is supposed to measure. For example, a questionnaire in a research study is considered to be an instrument to collect data (Uys & Basson, 1991:80; Burns & Grove, 1993:342; Polit & Hungler, 1995:353).

There are different types of validity which are tested in the research studies to ensure accuracy of the instrument. The following types will be discussed in Chapter 3:

- Content validity
- Predictive validity
- Construct validity (Uys & Basson, 1991:83; Burns & Grove, 1993:344; Polit & Hungler, 1995:357; Talbot, 1995:387).

1.6.8 Data analysis

Statistical analysis is a method for rendering quantitative information meaningful and intelligible. Interpretation of quantitative data collected during the research study would be difficult without the aid of statistics. Statistical procedure enables the researcher to reduce, summarize, organize, evaluate, interpret and communicate numerical information. Analysis of data in this study will be done by means of a computer to save time and to obtain correct and accurate results (Burns & Grove, 1993:497; Polit & Hungler 1995:379; Talbot, 1995:320) (see Chapter 3).

1.6.9 Processing and data interpretation

Completed interview schedules will be coded by the researcher and the data processed by the computer. Data will finally be interpreted by means of tables and graphs (Burns & Grove, 1993:498; Polit & Hungler, 1995:379).

1.7 ETHICAL CONSIDERATIONS

Ethical considerations are important in research studies to protect the human rights of subjects. Subjects should be protected physically, mentally, psychologically and socially. It is the right of the subjects to participate willingly without being forced even though they might benefit from the research study. The following ethical considerations were followed in this study:

- Permission for conducting the study was obtained from the appropriate authorities
- Informed consent was obtained from the respondents
- Privacy and confidentiality were maintained
- Attention was paid to the rights of persons with diminished autonomy
- The right to protection from discomfort and harm was respected

In this chapter a short description and discussion of the ethical considerations are given while more discussion will take place in Chapter 3 (Uys & Basson, 1991:98; Burns & Grove, 1993:95-97; Polit & Hungler, 1995:125; Talbot, 1995:36).

■ Obtaining permission

Permission for the research study was obtained from:

- The superintendent and management of the hospital. This is the first step to allow the use of patients' records, and to interview patients.

- The District Facilitating Committee of Botshabelo to interview members of the community (family members of the patients, and the patients as respondents.

- The Ethics Committee of the Faculty of Health Sciences, University of the Orange Free State (see Annexure A).

■ Informed consent

Voluntary consent will be obtained from the respondents (patients and family members) after they are informed of the purpose of the study. The designed consent form which was translated into South Sotho will be signed by the respondents and the researcher (Burns & Grove, 1993:95; Polit & Hungler, 1995:127) (see Annexure B).

■ Privacy and confidentiality

The respondents will be promised that the information obtained would not be publicity reported. Their names will not appear on the questionnaire. Privacy will be maintained by collecting data from individuals in a private room (Burns & Grove, 1993:372; Polit & Hungler, 1995:125).

■ Persons with diminished autonomy

Some patients suffering from schizophrenia and other types of mental illness are incapable of giving informed consent due to abnormal perceptions which affect their thinking process. In such situation the willing members of the family will be involved to give consent and to answer on behalf of the patients (Uys & Basson, 1991:98; Burns & Grove, 1993:97; Polit & Hungler, 1995:127).

■ Right to protection from discomfort and harm

The respondents will not be kept for long during the interview to avoid fatigue and discomfort. Physical harm will be avoided as no treatment will be introduced as in experimental studies. Comfort will be maintained as interviews will be conducted at the respondents' homes where individuals will be relaxed and free to answer questions (Burns & Grove, 1993:94; Polit & Hungler, 1995:128).

The interview will be stopped if a respondent experiences any discomfort.

1.8 CONCLUSION

Research that involves human subjects requires effective ethical consideration to protect their rights. Thorough explanation of the study and the procedures involved should be made clear and the researcher ensures that everything is understood by the respondents (Burns & Grove, 1993:95; Polit & Hungler, 1995:129; Talbot, 1995:36).

CHAPTER 2

Literature review

2.1 INTRODUCTION

In studying the reasons for missed clinic appointments among patients suffering from schizophrenia, one has to obtain information about different views of the factors influencing missed clinic appointments.

According to the Conceptual Model which is based on the principle of systems theory discussed in Chapter One, the following factors might influence missed clinic appointments among the patients under review:

- Nature of the illness (schizophrenia)
- Patient reasons
- The family
- Culture
- Health Services
- Other reasons influencing compliance

Missed clinic appointments are a world-wide problem which requires a strong relationship between the health services personnel and the community to promote compliance (Mdluli & Msomi, 1989:17).

The problem of missed clinic appointments is common among patients with schizophrenia because of their mental disorder which affects their thinking processes and personalities. Abnormal perceptions such as hallucinations and delusions, including ambivalent feelings, result in difficulty in making decisions, and cloud their consciousness so that they become disorientated to self, time

and environment (Hawthrone & Burns, 1994:6; Stuart & Sundeen, 1995:505).

Schizophrenia is probably the major mental health problem facing contemporary society. The emotional, social and economic costs of the disorder are enormous. Approximately one in every 100 of the population world-wide will suffer from the illness (Barrowclough & Tarrier, 1992:1; Uys, Pietersen & Middleton, 1994:36).

Berk (1993:48) states that the relapse rate for schizophrenic patients who do not keep clinic appointments may be as high as 50% at six months and 65 - 80% at twelve months if follow up measures are not taken.

2.2 DIFFERENT VIEWS OF THE POSSIBLE REASONS INFLUENCING MISSED CLINIC APPOINTMENTS BY PATIENTS SUFFERING FROM SCHIZOPHRENIA

The conceptual model in Chapter One illustrates the possible reasons which are interrelated and function like a system. A person as part of the system is influenced by the environmental factors and the illness itself to stop visiting the clinic for treatment. Missed clinic appointments result in a break or cut between the patient and the clinic due to the subsystem which plays a negative role within the System (Fawcett, 1989:67). The possible reasons for missed clinic appointments are as follows:

2.2.1 Nature of the illness schizophrenia

2.2.1.1 Historical view

The word "schizophrenia" was first coined in 1908 by a Swiss psychiatrist, Eugen Bleuler, to describe a group of mental disorders characterized by splitting (schizo) of the mind (phrenia). Bleuler's concept of schizophrenia was mainly based on a description of a group of mental illnesses, called dementia praecox by a German psychiatrist, Emil Kraepelin in 1896. According to Kraepelin, the illness normally starts relatively early (praecox) in life, during or shortly, after adolescence and tendes to become chronic, with mental deterioration (dementia). From the description of the illness by Kraepelin, Bleuler proposes the word "schizophrenia" to include patients showing symptoms of dementia praecox and paraphrenia (term paraprenia is used as synonym for paranoid schizophrenia) (Kaplan & Sadock, 1998:460). He extended Kraepelin's concept of dementia praecox and listed the main manifestations of the splitting of mind as characteristic thought disorders, emotional blunting and an impaired relationship with the external world. Bleuler considered that thought disorders and emotional blunting were fundamental or primary symptoms of schizophrenia and that hallucinations and delusions were secondary to the primary symptoms (Ackner, 1971:138; Tsuang, 1982:11; Flack, Miller & Weiner, 1991:2).

2.2.1.2 What is schizophrenia today?

Schizophrenia is one of the mental disorders which stem from a physiological malfunctioning of the brain. Specifically schizophrenia appears to result from chemical imbalances in the brain and results in disordered thought processes with difficulty in communication, interpersonal relationships and reality testing. The patient's negative feeling about the illness causes confusion and reluctance to seek or accept help (Stuart & Sundeem, 1995:504). The

reality of these patients is distorted, changeable and often frightening. Their sensory perceptions may be distorted by hallucinations of which auditory hallucinations are the most common. Their thought processes are often confused so that they find it difficult to "think straight" or focus on, or engage in problem-solving. The thought content is often also abnormal, delusions being common. Emotional expression is usually inappropriate. The symptoms of these patients are sometimes divided into positive and negative symptoms. Positive symptoms are associated with acute episodes and include confusion, delusions and hallucinations. Negative symptoms are related to the chronic syndrome and include flatness of affect, social withdrawal and poverty of speech. (Uys, Pietersen & Middleton, 1994:312).

Schizophrenia is a very important illness for a number of reasons. It attacks people in the prime of their lives and in most cases it is not possible to effect a total cure of the patient. The disease therefore has a long-term course. The disease also has a high incidence so that it forms a large portion of the work of psychiatric nurses (Uys *et al.*, 1994:312). Schizophrenia is often confused with a "split personality". The split means a split between the affect and the thoughts and behaviour of the patient, and not a split into multiple personalities (Uys *et al.*, 1994:313).

In this study the definition of Schizophrenia cannot be specified or explained like other physical illnesses caused by a specific micro-organism. The definition will be described according to the DSM IV Diagnostic Criteria in the next pages (Flack *et al.*, 1991:34; Kaplan & Sadock, 1998:470).

2.3 EPIDEMIOLOGY

Approximately 1% of the population develops Schizophrenia during their life time. Men and women are affected equally, although men tend to become ill in their twenties, while women become ill in their thirties.

In South Africa patients with a diagnosis of schizophrenia make up between 28% and 44% of psychiatric in-patients and between 20% and 46% of out-patients (Uys *et al.*, 1994:313).

Children of schizophrenic parents have a 10% chance of developing Schizophrenia compared to the 1% risk of persons in the general population (American Psychiatric Association, 1994:283).

In addition the following table represents the prevalence of schizophrenia in specific populations.

TABLE 2.1: Epidemiology

POPULATION	PREVALENCE %
General population	1.0
Non-twin sibling of a schizophrenic patient	8.0
Child with one schizophrenic parent	12.0
Zygotic twin of a schizophrenic patient	12.0
Child of two schizophrenic parents	40.0
Monozygotic twin of a schizophrenic patient.	47.0

2.4 AETIOLOGY

It is not clear what causes schizophrenia although it seems that genetic factors produce a vulnerability with environmental factors precipitating the acute episodes of disease. Although schizophrenia is discussed as if it were a single disease, the diagnostic category can include a variety of disorders that present with similar behavioural symptoms. Schizophrenia probably comprises a group of disorders with heterogeneous causes and includes patients with varied clinical presentations, treatment responses, and course of illness.

2.4.1 Contributory factors

Even though the course of schizophrenia is not known there are contributory factors to the cause of the illness. These will be discussed under the following headings:

- Biological factors.
- Genetic factors.
- Psychological factors.
- Stress-Diathesis model.

2.4.1.1 Biological factors

The cause for schizophrenia is not known. Some studies have indicated that a "pathophysiology in certain areas of the brain (including limbic system, the frontal cortex, and the basal ganglia) may contribute to the development of schizophrenia. Dysfunction in one area may involve primary pathology in another area, because of the brain's interconnections". Research studies have revealed that the limbic system is the potential site for the primary pathology in the majority of schizophrenic patients (Kaplan & Sadock, 1998:462).

More extensive studies are needed to explain the mechanism during the time a neuropathological lesion appears in the brain and the interaction of the lesion with environmental and social stressors and the development of schizophrenia. Under biological factors it appears that the major brain areas implicated in Schizophrenia are the limbic structures, the frontal lobes and the basal ganglia. The thalamus and the brain stem have also been implicated because of the role of the thalamus as an integrating mechanism, and the brainstem and the midbrain as the primary locations for the ascending aminergic neurones (Kaplan & Sadock, 1998:463). Some theories specify that schizophrenia results from too much dopaminergic activity which might be

caused by some drugs such as amphetamine. Other drugs such as hallucinogenic substances that affect serotonin e.g. lysergic acid diethylamide (LSD) may cause psychotic symptoms similar to those of schizophrenia (Kaplan & Sadock, 1998:463).

2.4.1.2 Genetic factors

Some genetic studies have found that a person is likely to have Schizophrenia if other members of the family suffer from it. This depends on the closeness of the relationship. If both parents suffer from schizophrenia, the chances of the child suffering from the illness is 40% whereas if one parent suffers from schizophrenia the chances of the child's suffering from the illness are 12% (Kaplan & Sadock, 1998:463).

The literature indicates that the genetic factor is not influenced by the environment. Research was conducted on monozygotic twins of schizophrenic parents who were raised by adoptive and biological parents. One twin who was raised by adoptive parents developed symptoms of the illness (schizophrenia) at the same rate as the twin raised by the biological parents. This indicates that the genetic factor is powerful and outweighs the environmental influences (Kaplan & Sadock, 1998:463).

2.4.1.3 Psychological factors

The psychological trauma affecting an individual at an early age due to interpersonal difficulties between the infant and the mother may contribute to schizophrenia. (The mother and child relationship is very important). Some theories state that if the environmental stressor exceeds a threshold determined by the individual's level of vulnerability, an episode of the illness may be triggered. (Flack *et al.*, 1991:34; Kaplan & Sadock, 1998:464). Psychoanalytic theorists such as Sigmund Freud state that schizophrenia

results from fixations in development that occurred earlier than those that result in the development of neuroses. The reason is because the presence of an ego defect contributes to the symptoms of schizophrenia as it affects the interpretation of reality (Kaplan & Sadock, 1998:464).

2.4.1.4 Stress-diathesis model

This model explains the integration of biological, psychological and environmental factors. It seems that genetic factors produce vulnerability in a person that, when acted on by some stressful environmental factors, precipitate the acute episodes of the illness. In the stress-diathesis model, the stress can be biological environmental, or both. The environmental component can be either biological like an infection, or psychological such as a stressful family situation or bereavement. The biological basis of vulnerability can be influenced by substance abuse, trauma or psychosocial stress (Kaplan & Sadock, 1998:465).

2.4.2 Theories regarding the individual patient

The literature indicates that regardless of the controversy regarding the causes of schizophrenia, it remains a condition that seriously affects individual patients, each of whom has a unique psychological makeup (Kaplan & Sadock, 1998:465). Psychodynamic theories regarding the pathogenesis of schizophrenia assist the clinician to understand how the disease may affect the patient's psyche.

2.4.2.1 Psychoanalytic theories

Sigmund Freud postulated that schizophrenia results from fixations in the development that occurred earlier than those that result in the development of neuroses. Freud also believed that the presence of an ego defect

contributes to the symptoms of schizophrenia. Freud's ideas regarding schizophrenia were coloured by his lack of intensive involvement with Schizophrenic patients [Kaplan & Sadock, 1998:465]. In contrast, Harry Stack Sullivan who engaged schizophrenic patients in intensive psychoanalysis concluded that the illness results from early interpersonal difficulties, particularly those related to a poor mother and child relationship. The general psychoanalytic view of schizophrenia hypothesizes that the ego defect affects the interpretation of reality and the control of inner drives such as sex, and aggression. The disturbances occur as a consequence of distortions in the reciprocal relationship between the infant and the mother. In addition, Margaret Mahler describes that the child is unable to separate and progress beyond the closeness and complete dependence that characterizes the mother-child relationship in the oral phase of development [Kaplan & Sadock, 1998:465].

2.4.2.2 Psychodynamic theories

"Genetic studies suggest that schizophrenia is an illness with an underlying biological basis". Some studies of monozygotic twins repeatedly show that environmental and psychological factors have some importance in the development of schizophrenia, since many twins are discordant for the illness.

"Psychodynamic views of schizophrenia have differed from Freud's complex model". Theorists regard the constitutionally based hypersensitivity to perceptual stimuli as a deficit. In Kaplan and sadock [1998:465] some research studies suggest that patients with schizophrenia find it difficult to screen out various stimuli and to focus on one piece of data at a time. The defective stimulus barrier creates difficulty throughout every phase of development during childhood and places particular stress on interpersonal relatedness. Generally, psychodynamic approaches operate from the premise that psychotic symptoms have meaning in schizophrenia. For example,

patients may become grandiose after an injury to their self-esteem [Kaplan & Sadock, 1998:465].

2.4.2.3 Learning theories

According to learning theorists in Kaplan and sadock [1998:466] children who later have schizophrenia learn irrational reactions and ways of thinking by imitating parents who may have their own significant emotional problems. The poor interpersonal relationships of schizophrenic persons develop because of poor models from whom to learn during childhood.

2.4.3 Theories regarding the family

The literature indicates that any specific family pattern plays a causative role in the development of schizophrenia. Some schizophrenic patients come from dysfunctional families. It is of clinical relevance to recognize pathological family behaviour, since such behaviour can significantly increase the emotional stress that a vulnerable schizophrenic patient must cope with [Kaplan & Sadock, 1998:466]. This appears that the family plays an important role in the prevention of mental disorders, including schizophrenia [American Psychiatric Association, 1994:283].

2.4.3.1 Double bind theory

Even though this is an old theory, it has contributed in the explanation of probable contributory factors to schizophrenia. Gregory Bateson formulated the theory to describe a hypothetical family in which children receive conflicting parental messages regarding their behaviour, attitudes and feelings. Within that hypothesis, children withdraw into their own psychotic state to escape the unsolvable confusion of the double bind [Kaplan & Sadock, 1998:466].

2.4.3.2 Social theories

Social theorists have suggested that industrialization and urbanization are involved in the causes of schizophrenia or the severity of the illness (Kaplan & Sadock, 1998:466).

2.4.4 Diagnosis

■ Diagnostic criteria

It has been noted in Kaplan and Sadock (1998:467) that black patients are often inappropriately given a diagnosis of schizophrenia. This might relate to cultural beliefs which are misunderstood by Western health care workers, or it may be the result of communication problems and the process of translation. It might also be related to inadequate attention being given to eliminate other conditions with similar symptoms as schizophrenia (Kaplan & Sadock, 1998:467; Uys *et al.*, 1994:371).

"DSM-IV criteria required for the diagnosis of schizophrenia are:"

A. Psychotic symptoms present during the acute-phase - under either 1, 2 or 3 for at least one week.

1. Two of the following symptoms:
   - Delusions,
   - Prominent hallucinations,
   - Incoherence or marked loosening of associations,
   - Catatonia,
   - Flat or grossly inappropriate affect.

2. Bizarre delusions

3. Prominent hallucinations of a voice keeping a running commentary or two voices having a conversation.

B. Functional level markedly below the highest premorbid level.

C. Related conditions and organic factors have been ruled out.

D. Continuous sign of the disturbance for at least six months.

"Subtypes of schizophrenia are identified by the predominance of certain signs and symptoms in addition to the diagnostic criteria. These are:

- **Catatonic:** Catatonic stupor, catatonic negativism, catatonic rigidity, catatonic excitement, catatonic posturing.

- **Disorganised:** Incoherence and marked loosening of associations or grossly disorganised behaviour, flat or grossly inappropriate affect.

- **Paranoid:** Preoccupation with one or more systematized delusions or with frequent auditory hallucinations on a single theme - without gross thought, affect or behaviour disorder.

- **Undifferentiated:** Prominent delusions, hallucinations, thought disorder or disorganised behaviour, but does not meet the criteria for one of the above types.

- **Residual:** Continuing evidence of the disturbance, without prominent psychotic symptoms.

In Kaplan and Sadock (1998:468) some theorists state that the diagnostic criteria include the following features: Hallucinations, delusions and thought disorder characterized by four A's such as Associations, Affect, Autism, Ambivalence (Kaplan & Sadock, 1998:468; American Psychiatric Association, 1994: 278-279).

2.4.5 Specific clinical features and characteristics of schizophrenia which may influence compliance

2.4.5.1 Hallucinations

Hallucinations, delusions and inappropriate affect which are primary symptoms of patients suffering from schizophrenia cloud the patient's consciousness and they become disorientated for self, time and environment. The patients might hear voices commanding them not to go to the clinic, or experience paranoid delusions which might brings fears that the nurses want to kill them by means of injection or tablets. These abnormal perceptions contribute to missed clinical appointments (Hawthrone & Burns, 1994:6; Stuart & Sundeen, 1995:505).

Grandiose delusions may cause patients to present themselves in a manner inconsistent with reality. Because of abnormal perceptions which cloud the patient's consciousness, he may believe that he is not ill, but has special healing powers as a doctor. As a result the patient wil not go to the clinic for treatment. This gross change in behaviour may convince the family of the need for treatment at the clinic (Hawthorne & Burns, 1994:16; Stuart & Sundeen, 1995:505).

2.4.5.2 Social breakdown syndrome

A schizophrenic patient in long-term psychiatric treatment may suffer a progressive deterioration of social and interpersonal skills and relations, and presents with withdrawal and a split personality (Malone, 1990:7). The patient prefers to be alone and avoids mixing with other people. The relationship with the family also changes and the patient may become aggressive and violent. Such behaviours may cause fear and rejection by family members. The family may show lack of support, for instance by not accompanying, the patient to the clinic or reminding him about his appointment dates thus resulting in missed clinic appointments (Hawthorne & Burns, 1994:15; Stuart & Sundeen, 1995:505).

2.4.5.3 Ambivalence

According to the literature, patients with schizophrenia experience ambivalent feelings which result in difficulty in making decisions. Positive and negative feelings about the illness cause confusion and reluctance to seek or accept help (Stuart & Sundeen, 1995:504).

2.4.5.4 Thought disorders

The patient experiences alien thoughts that are recognised as not his own. The patient hears his/her thoughts spoken out loud or believes the thoughts are broadcast so that other people can hear them. With thought block or withdrawal, the patients experiences a sudden unexpected stopping of thoughts which is not due to anxiety or emotional state. The patient may feel that thoughts have been removed from his/her head (Barrowclough & Tarrier, 1992:6-7). According to Andreanse (1979:34) a type of thought disorder commonly seen in schizophrenic patients is "derailment". This is defined as a pattern of spontaneous speech in which ideas slip from one track onto

another that is clearly but obliquely related, or onto one that is completely unrelated. Within derailment the linear goal directed nature of speech is disrupted by frequent divergence from the semantically meaningful goal (Cromwell & Snyder, 1993:23).

In the process of starting the thought, there is a slippage of topic that may be only partial, in which case the next thought fragment seems somewhat related, or may be complete. Meaning is lost from speech because the main topic cannot be referred to constantly. This problem influences clinic attendance because when the thinking process is disturbed the patient is unable to remember the appointment date, and the perceptions which he/she experiences cloud the consciousness so that he/she is unable to think relevantly (Cromwell & Snyder, 1993:24).

2.4.5.5 Disturbance of self

These are the most characteristics of schizophrenia's symptoms: the feeling of changes in one's own personality, internal splitting, lack of command of thoughts and feelings, the feeling that others take command of one's acts, or that thoughts are taken away, and that other alien thoughts are inserted. This disturbance of self, influences clinic attendance as the patient becomes forgetful, unable to think clearly and reality is disturbed (Flack *et al.*, 1991:36; American Psychiatric Association, 1994:279-281).

2.5 COMPLIANCE AND NON COMPLIANCE

The terms "compliance and non-compliance" will be discussed and indicate their contributory factors.

2.5.1 Treatment compliance

The term "compliance", which means acquiescence, is a goal which is not reached easily unless three elements are maintained.

- **Cognition:** The patient's knowledge about medication and its benefits and risks. This means that the patient and family should be educated about the plan of treatment and its side effects.

- **Attitude:** Assist the patient to develop a positive attitude towards his/her illness. This is only possible if the patient has insight into his/her illness and the importance of completion of treatment, including the long-term medication process.

- **Behaviour:** If the patient is well informed about his/her illness and the treatment process, his/her behaviour will change from denial to acceptance and show capability of self-care in the process of after-care management. Training and education of patients and families will result in positive behaviours of compliance (Falloon, Boyd & McGill, 1987:295; Crane, Kirby & Kooperman, 1996:8).

2.5.2 Non-compliance

2.5.2.1 Forms of non-compliance

Non-compliance will be explained under the following factors:

■ Failure to have prescription filled

The patient may be unable to afford his medicines due to a financial problem. It is estimated that about 20 percent of prescriptions are never presented for

dispensing especially if the patient feels no pain or discomfort (George, 1995:16).

■ Failure to take enough medicine

This is a common form of non-compliance. Studies suggest that patients are inconsistent in their medicine-taking behaviour. Some will take not more than two doses of medicine per day and others will take not more than two tablets at a time. This requires education on the importance of regular medication intake.

■ Failure to observe the correct intervals between doses

Misunderstanding is a common cause of doses taken at the wrong intervals. Instructions, such as three time a day, mean very different things to different patients. Some patients, despite instructions may take two tablets at a time instead of taking one tablet twice a day (own experience).

■ Taking additional medication

Almost all systematic studies on drug compliance have shown that some patients regularly exceed the prescribed dosage. This may be due to frequent pain or discomfort which is not relieved by the prescribed dosage (George, 1995:18).

- **Failure to observe the correct duration of treatment**

In general, the longer the period of treatment required, the greater is the level of non-compliance. This is common among patients with schizophrenia due to long-term medication (George, 1995:18).

2.5.3 Strategies for improving patient compliance

2.5.3.1 Introduction

Compliance is an important factor in achieving beneficial effects from medication. It is a popular topic in health research which requires teamwork between patients, family members, nurses, doctors and the community (Ross, 1991:89; George, 1995:16; Crane *et al.*, 1996:8).

Several studies have shown that patients whose expectations are met, and who feel satisfied with the information that they receive are likely to comply with treatment.

2.5.3.2 Strategies for improving compliance

- Simplification of the scheme. A less complex scheme by which the patient takes fewer tablets or is treated once a week or monthly may improve compliance (George, 1995:16; Crane *et al.*, 1996:9).

- Tailoring the scheme to the routine of the patient. Medicines with sedative effect are best taken at night (George, 1995:16; Crane *et al.*, 1996:9).

- Involvement of the patient in monitoring his condition. If the patient is well-informed about the treatment and aware of the consequences of non-compliance the level of compliance improves (Crane *et al.*, 1996:9).

- Feedback about drug levels. If the patient is informed about blood levels that indicate a low concentration non-compliance may be improved (Crane *et al.*, 1996:10).

- Programmed learning. Programmed learning about medication, improves knowledge and the patient may keep to his schedule (Crane *et al.*, 1996:10).

- Prompting by alarms and reminders: Forgetful patients may be prompted by the use of alarms or calendars (George, 1995:24).

2.5.4 Other factors which could contribute towards missed clinic appointments

2.5.4.1 Introduction

Patients with schizophrenia who stop attending the clinic must be followed up by health personnel to identify the reasons or factors contributing to such behaviour. According to the literature, clinical practice and several research studies, there are many contributory factors some of which will be discussed as follows.

- The characteristics of schizophrenia as an illness.

- Patient reasons such as:
  - Physical illness.
  - Denial of illness severity.

- Financial problems.
- No apparent reasons.

- Family reasons
  - Lack of support.
  - Rejection or poor relationship.
  - Illness stigma.
  - Financial burden.

- Cultural influence

- Medication:
  - No improvement.
  - Fear of side effects.
  - Prolonged duration of medication.
  - Dissatisfaction of patient with medication.
  - Inconvenient dose scheduling.
  - Lack of medication education group therapy.

- Health services reasons
  - Location of the clinics.
  - Long wait for an appointment.
  - Long waiting periods in a queues.
  - Health workers' attitudes.
  - Shortage of nurses.
  - Amalgamation of psychiatric services in Primary Health Care.
  - Unavailability of drugs.
  - Shortage of competent psychiatric specialists.

- General or other reasons.
  - Lack of public transport.

- Unpredictable weather conditions.
- Curtailed use or lack of telephone (Stuart & Sundeen, 1995:505).

2.5.4.2 The characteristics of schizophrenia

As explained in the previous pages these contribute to missed clinic appointments. This is because of the abnormal perceptions which cloud the patient's consciousness to become disorientated to self, time and environment, and ambivalent feelings which prevent the patient from making decisions for self-care as a responsible person (Stuart & Sundeen, 1995:505).

2.5.4.3 Patient reasons

■ Physical illness

Physical illness prevents the patient from going to the clinic due to the following:

- Difficulty in walking, especially if the clinic is far from home.
- Old age, general ailments, or defects, i.e. blindness, arthritis etc. (Freeman, Lee & Vivian, 1994:59).

■ Denial of illness severity

Lack of insight into mental illness and the prognosis when not complying with the medication (Crane *et al.*, 1996:10).

■ Financial problems

Transport may not be affordable if there is no income. (Freeman *et al.*, 1994:116).

■ No apparent reason

The patient may stay at home without any relevant reason. This is common if the patients are not well-informed about their illness (Crane *et al.*, 1996:15).

2.5.4.4 Family reasons

Most psychiatric patients live with their families. If a close family member is diagnosed as having schizophrenia and this involves having to care for that person over the long-term it places an enormous objective and subjective burden on the family. An objective burden involves problems such as financial hardship and the disruption of family functioning, while a subjective burden refers to the psychological distress caused by the disease, such as the stigma attached to mental illness. Family members often experience mental health professionals as blaming, critical and unsympathetic instead of supportive (Uys *et al.*, 1994:326).

■ Lack of support

The family may neglect the patient due to ignorance. If they are not well-informed about the importance of after care services and the poor prognosis due to non-compliance, the family support of the patient will be poor.

■ Rejection or poor relationship

The patients psychotic behaviour may cause family disorganisation which may result in rejection of the patient by the family, and lack of assistance regarding clinic attendance (Mdluli & Msomi, 1989:15; Launer, 1997:10).

■ Illness stigma

The family deny the illness because of the stigma attached to mental illness. The family feels emotionally and psychologically distressed. The illness also degrades the family dignity and results in lack of support of the patient. If the patient is unable to go to the clinic alone he decides to stay at home (Mdluli & Msomi, 1989:14).

■ Financial burden

The patient may be neglected due to the financial burden and stress brought about by the fact that the bread-winner had to give up his/her job to look after him/her. This situation may cause poor relationships and family disorganisation (Mdluli & Msomi, 1989:15; Freeman *et al.*, 1994:125).

2.5.4.5 Cultural influence

Mdluli and Msomi (1989:15) reported that cultural beliefs influence the black psychiatric patient's view of illness, help seeking behaviour, subsequent treatment and follow-up. To support this information, Gaborone (1990:3) states that culture as the total way of life people provides the primary frame of reference for all. The cultural background is one factor which determines if and when a patient will look upon himself as ill or in need of help from his immediate environment. In most cases the immediate environment for providing help for psychiatric patients is traditional or faith healers.

Historically, mental illness among black people is viewed as being caused by an evil spirit, a provoked ancestral spirit or witchcraft. In accordance with the culture the patient improves after the "Thwasa" treatment and training. (Mdluli & Msomi, 1989:16; Gaborone, 1990:11; Andrense, 1992:47-48).

2.5.4.6 Medication

■ No improvement on medication

Failure of immediate response and improvement on long-term medication such as Fluphenazine may contribute to missed clinic appointments. The patient and the family may decide on alternative measures to seek help. Black psychiatric patients are commonly influenced by culture to visit traditional or faith healers for immediate help (Mdluli & Msomi, 1989:15; Gaborone, 1990:4).

■ Fear of side effects

A patient who develops stiffness of the body, tremors or other abnormalities after taking the medication may stop visiting the clinic. This is common for patients who are on Fluphenazine injection or other psychotropic drugs which cause severe extrapyramidal side effects (Caton, 1989:77; Malone, 1990:7; Poggenpoel, 1993:35).

■ Prolonged duration of medication

Patients with schizophrenia are put on long-term medication for a few months or years. The patient feels tired and looses interest in taking medication for such a long time. This is the response usually obtained from patients who are on Fluphenazine injections which are usually given for an indefinite period despite the patient appearing to be well controlled (George, 1995:22). About

80% of schizophrenic patients are on Fluphenazine injections which cause severe side effects.

■ Patient dissatisfaction

If the patient dislikes the type of medication prescribed for his/her illness he/she may stop attending the clinic. The patient may prefer tablets instead of an injection even if there are no side effects (George, 1995:24).

■ Inconvenient dose scheduling

Nurses and doctors do not always listen to the plea of the patient about scheduling the medication (Crane *et al.*, 1996:10). Patients who are working may prefer to attend the clinic at weekends. This is impossible for clinics which function for eight hours a day and only from Monday to Friday. In Botshabelo, only three out of 13, are open during weekends. This is one of the problems (Own experience, Crane *et al.*, 1996:10).

■ Medication education group therapy

Lack of medication education group therapy where patients are free to discuss their problems with peer groups and exchange their experiences and fears of the side effects of drugs (Malone, 1990:7).

2.5.4.7 Health services reasons

■ Location of the clinics

Long distance that must be travelled by the patient to obtain services (Bush, 1994:259) may result in non-compliance.

■ Long wait for an appointment

Patients want immediate relief, and if they cannot see a doctor for weeks they search around for someone else (Gillis & Egert, 1993:93). Usually the patients visit traditional doctors or stay at home.

■ Long waiting periods in queues

Patients who wait longer than 30 minutes at the clinic before being seen by a nurse may stop attending the clinic as this may cause hunger, boredom or irritability (Freeman *et al.*, 1994:59).

■ Clinic times

Patients who are working may prefer to attend the clinic during weekend (Saturday to Sunday) for treatment. This is impossible for the clinics which function for five days (Monday to Friday) and close during weekends. At Botshabelo, only three out of 13 clinics are open during weekends. This is one of the problems (own experience).

■ Health workers' attitude

Poor Interpersonal relationships displayed by health personnel towards patients, and labelling them as mentally ill persons may result in reluctance to attend the clinic (Caton, 1984:76; Crane *et al.*, 1996:10).

A shortage of nurses to provide outreach services (Bush, 1994:259). Mobile clinics and more staff will be required.

Little or poor quality of instruction. Nurses may fail to provide patients with adequate information about their illness and follow-up management (Malone, 1990:7; Weiden & Havens, 1995:289; Crane *et al.*, 1996:10).

■ Amalgamation of psychiatric service with primary health care

In 1994 when psychiatric Services were changed from being a speciality and combined with other services to form a comprehensive service, psychiatric patients in general began to be neglected and no longer received individualised and intensive care. The reason is that most Professional nurses in the clinics are not qualified in psychiatric nursing and lack the skills required to nurse the psychiatric patients. Good communication, listening and interpersonal skills influence compliance (Crane *et al.*, 1996:15).

- Unavailability of drugs at the clinic due to a long procedure for ordering from the central dispensary. According to the research study by (Freeman *et al.*, 1994:66) this was one of the reasons for missed clinic appointments.

- A shortage of competent psychiatric nurses required to provide quality patient care and counselling of defaulters. (Freeman *et al.*, 1994:66).

2.5.5 Non-compliance in general

- Lack of public transport. The patient may be able to afford transport which is not always available.

- Unpredictable weather conditions. Patients may fail to go to the clinic in rain or cold weather (Bush, 1994:259).

- Curtailed or lack of telephone services to communicate with health services personnel or visa versa. However this service may be expensive.

2.5.6 Employment reasons

Patients who work may fear loss of employment especially when the employer is not co-operative due to lack of insight into the patient's illness. Generally patients hide their illness from their employers due to fear of loosing their jobs. If the patient is not officially off duty, he will not go to the clinic (Freeman *et al.*, 1994:65; Crane *et al.*, 1996:15).

2.6 THE CONSEQUENCES OF MISSED CLINIC APPOINTMENTS

According to the literature, missed clinic appointments have consequences for the patient, family, health services, community and the country. Because mental illness carries such a strong stigma, secrecy and shame, parents may blame themselves for their defective child wondering what they did wrong. Since the largest number of schizophrenic patients live with their families, family members often take on the role of caregivers. The stress of caring for a severely mentally ill person may strain a marriage, interfere with normal social life, take an emotional toll on siblings, and drain the family's resources (Malone, 1990:7).

2.6.1 On the patient

The effects of missed clinic appointments on the patients are as follows:

2.6.1.1 Relapse and readmission

A patient who misses clinic appointments relapse and may never regain his pre-relapse level of functioning. If the patient is admitted to hospital a sense of helplessness result and may suffer severe social consequences or another period of illness. It has been found that fewer than half of the patients regain their pre-relapse level of functioning after 12 months (Crane *et al.*, 1996:9). Hospitalization generally represents a painful experience in an environment that may itself be highly stressful, away from family members who are as well able to continue caring if they are given adequate support (Hawthorne & Burns, 1994:18).

The relapse rate of patients who do not keep to a regular intake of medication may be as high as 50% at 6 months and 65% - 80% at 12 months if there is no follow up (Berk, 1993:48).

2.6.1.2 The problem of polypharmacy

Prescribing more than one drug for a patient who relapsed due to missed clinic appointments may results in severe side effects caused by drug interaction (Stuart & Sundeen, 1995:708). An evaluation of mental health services in the Free State revealed the high rate of relapse among schizophrenic patients who form a high percentage (52%) of all mental disorders (Freeman *et al.*, 1994:40).

2.6.1.3 Extra medication

Extra medication may be required for patients who need more than one type of medication to control their conditions. This affects the budget of the government (Berk, 1993:48).

2.6.1.4 Suicidal risks

Most patients who suffer from schizophrenia become depressed and attempt suicide which is successful at some stage. The statistics revealed that about 50% of all patients with schizophrenia attempt suicide at least once in their lifetimes, and 10-15% die by suicide during a 20 year follow up period (Kaplan & Sadock, 1998:458; Weiden & Havens, 1995:289).

2.6.1.5 Aggression and violence

Abnormal perceptions e.g. hallucinations and delusions may change the patient's behaviour and result in aggression, violence, paranoia and demoralization. The patient may become dangerous to himself and other people, and the patient may be unable to differentiate between relevant and irrelevant stimuli (Malone, 1990:5).

2.6.1.6 Deficits in assertiveness

Socially the patient may experience deficits in assertiveness carrying on a conversation and understanding interpersonal messages. He may also have a problem of using effective coping mechanisms and problem-solving techniques (Stuart & Sundeen, 1995:498).

2.6.2 The family

The family as a supportive system may be greatly affected by the patient's illness.

2.6.2.1 Dependency and financial burden

The patient may depend financially on the family for total basic needs. A member of the family may have to stop working to care for him/her thus affecting the income of the family (Freeman *et al.*, 1994:62).

2.6.2.2 Fears and anxiety

The abnormal behaviour of the patient due to abnormal perceptions may cause disruption in the family which may result in rejection. The family members may leave the patient alone in the house due to his/her uncontrolled behaviour, aggression and violence (Stuart & Sundeen, 1995:510-516).

2.6.2.3 Family disorganisation

Separation of husband and wife or divorce due to the patient's prolonged illness is possible. Some families prefer that the patient should be kept in an Institution for an indefinite period (Freeman *et al.*, 1994:123).

2.6.3 The health services

2.6.3.1 The running costs of health services

The running costs of health services increase affecting the economy of the country. To hospitalize patients and provide individualized intensive care to relapsed patients is expensive (Berk, 1993:48).

2.6.3.2 Overcrowding

Facilities may be overcrowded and the nursing personnel experience pressure of work due to the increased number of relapsed patients (Berk, 1993:48).

2.6.3.3 Need for vehicles

Additional vehicles for home visits and nurses with drivers' licences will be required. This is a problem because not all nurses have drivers' licences.

2.6.3.4 Employment of extra nurses

The employment of extra nurses with a psychiatric nursing qualification will be a priority to manage the increased number of patients who suffer relapses (Berk, 1993:48).

Suicidal patients require close observation which requires extra nursing time that could be used for other purposes. Withdrawn and mute patients who refuse meals require intensive care to improve physical and nutritional status. All these types of patients cause stress to care givers. (Janosik & Davies, 1989:550; Stuart & Sundeen, 1995:510).

2.6.4 The community

The risk of violence, assaults, rape and other unacceptable behaviour may occur and affect the community due to the patient's psychotic symptoms. This is possible because about 60% of psychiatric patients roam around unemployed or unoccupied. Lack of day centres and occupational therapy centres are the problem (Nicholas, 1994:276).

2.6.5 The government and the country

The building of extra institutions and the extension of existing buildings to accommodate the relapsed patients may be required thus causing a financial burden on the government and the country (Nicholas, 1994:277).

2.7 CONCLUSION

Missed clinic appointments which seem to be a major problem among patients suffering from schizophrenia as compared with other mental disorders were indicated in the statistics in Chapter One of this study. According to the literature the factors contributing to this problem are personal and environmental. The impact of the illness on the patient makes it difficult for the individual to perform a self-care role like a physically ill patient who could easily be a self-care agent and able to make decisions about what to do during his illness and to perform care measures (Fawcett, 1989:211-212).

The consciousness of a patient with schizophrenia is often disturbed by abnormal perceptions and thought disorders which makes it difficult for him/her to know right from wrong. The patient becomes dependent on the family which is expected to assist him/her in therapeutic self-care (Fawcett, 1989:212). Family interaction in the treatment of the patient is important to prevent non-compliance which has an impact on the patient, family, health services, government and the country (Falloon *et al.*, 1987:83; George, 1995:16).

The conceptual model in the form of a system used to identify the possible reasons for missed clinic appointments indicates that the factors which assist in the maintenance of compliance such as the family, may also be a risk factor for non-compliance and be affected by the consequences of non-compliance. Family-oriented therapy is useful in the treatment of Schizophrenia. Because

patients are often discharged in an only partially remitted state, a family to which the patient is returning can often benefit from a brief but intensive course of family therapy. Education given to the patient and the family about the patient's illness is a priority as well as training of the patient in strategies to cope with unwanted side effects (Falloon *et al.*, 1987:295; Kavanagh, 1992:254; Kaplan & Sadock 1998:484). Teamwork in the management of patients suffering from schizophrenia is of the upmost importance to prevent missed clinic appointments, and user-friendlines of the health services will attract patients as respected consumers of health care (Falloon *et al.*, 1987:94; Kavanagh, 1992:269; George, 1995:16).

CHAPTER 3

Research methodology

3.1 INTRODUCTION

Missed clinic appointments in Chapter One has been defined as a failure to attend the clinic according to the appointment dates written on the patient's card. A discrepancy between the number of patients booked and the number of patients who actually arrive at the clinic occurs. This has been identified in the statistics.

In this study, missed clinic appointments apply to patients suffering from schizophrenia who missed clinic appointments twice or more during a twelve month period of referral to the clinic. Missed clinic appointments results from several possible reasons:

- The nature of the illness,
- Patient reasons,
- Family reasons,
- Health Services,
- Medication,
- Culture,
- Employment.

The consequences of missed clinic appointments have an impact mainly on the patient who relapses and is readmitted (Gills & Egert, 1993:30; Stuart & Sundeen, 1995:504; Crane, Kirby & Kooperman, 1996:8).

3.2 AIM OF THE STUDY

The aim of the study was to determine the possible reasons for missed clinic appointments among patients suffering from schizophrenia in the Botshabelo area.

3.3 OBJECTIVES OF THE STUDY

The objectives of this study were:

3.3.1 To identify the possible reasons for missed clinic appointments among patients suffering from schizophrenia in Botshabelo.

3.3.2 To suggest nursing guide-lines to enhance clinic attendance.

3.4 RESEARCH METHODOLOGY

3.4.1 Research design

This study was a quantitative one and used descriptive and exploratory designs to gain insight into the contributory factors for missed clinic appointments among patients suffering from Schizophrenia. The quantitative research approach is chosen when the researcher wishes to identify the possible reasons for a problem and to develop strategies to improve the situation (Polit & Hungler, 1987:147; Uys & Basson, 1991:51; Burns & Grove, 1993:135, Polit & Hungler, 1995:372).

Quantitative research is very valuable in nursing research because it enables nurses to investigate a variety of research problems.

In quantitative research, the problem identifies an area of concern and the purpose reflects the type of study to be conducted.

Several characteristics of quantitative research are outlined as follows in the literature:

■ It is well defined

This means that the method is simple, the topic easily clarified and the researcher is easily able to formulate the purpose and the objectives of the study.

■ It is a reductionistic approach

Most of the questions used to collect data are of the closed ended type. This makes it easy for the researcher to analyse the statistics, either by hand, calculator or by using a computer.

■ Objectivity is maintained

If a questionnaire is used to collect data through closed or open-ended questions there is a possibility of maintaining objectivity because the researcher or the respondent fills in what is required without the addition of extra information. In most cases there is only scope for a "Yes" or "No" answer to closed questions, or a few lines for required information to open-ended questions. The researcher is expected to observe objectively and only to report what he / she obtained.

- Through quantitative research the researcher is able to determine the cause of the problem and effect or consequences of the identified problem.

■ Logically deductive

The researcher is able to use general ideas and facts to get an answer to the problem.

■ Generalization

The findings obtained from the sample may be generalised to the population. If the study is repeated using other samples in different geographical areas, and the findings are similar to those originally obtained the findings would be accepted to be generalisable (Uys & Basson, 1991:88).

- Numerical data is used to group similar categories before data is analysed. This is a time saving method unlike qualitative research in which answers to open ended questions are first sorted, coded and then analysed (Uys & Basson, 1991:51; Burns & Grove, 1993:135; Polit & Hungler, 1995:14).

Research using a quantitative approach generally:

- Focuses on a relatively small number of specific concepts;
- begins with preconceived hunches about how the concepts are interrelated;
- uses structured procedures and formal instruments to collect data;
- collects the information under controlled conditions;
- emphasizes objectivity in the collection and analysis of data;
- analyzes numerical data through statistical procedure as mentioned on the previous page (Polit & Hungler, 1995:15).

3.4.2 Linking quantitative and qualitative research

Even though quantitative and qualitative studies are completed independent of one another they are somehow linked. Each study makes an important and unique contribution to theory building. In the literature it is generally stated that "qualitative methods are only used for discovery and theory building, while quantitative methods are only used for verification or theory testing". Clearly this is not always the case because quantitative methods have also been used in theory building and qualitative methods often involve theory testing [Morse, 1997:231].

The literature explains that qualitative research provides the ground breaking work for beginning a program of research. In most studies quantitative methods are used to support or extend the results of qualitative research, whether theoretical frameworks, newly identified concepts, hypotheses or theory. It is suggested that quantitative researchers should be encouraged to take advantage of the growing body of qualitative research as a basis of their investigations [Morse, 1997:231].

Leininger, [1985:27 in Uys & Basson, 1991:48], states that the investigator uses quantitative research to identify selected variables of interest from a theoretical scheme, and then systematically examines these variables.

Quantitative research has been chosen for this study because as a "hard science" it is perceived as rigorous, systematic, and objective, focusing on numerical data and using statistical analysis. It controls in an attempt to eliminate bias. Quantitative research, as mentioned in previous pages emerges from logical positivism, which contends that the researcher must be truly objective and that precise measurement is essential. When indicated it seeks to establish relationships between variable and causal links. This method is suitable for nursing research because of its simplicity and clarification. It is

economical and saves time (Brink & Wood, 1989:162; Uys & Basson, 1991:51; Burns & Grove, 1993:135; Talbot, 1995:87; Morse, 1997:117).

One part of the questionnaire for both groups of respondents was conducted in a qualitative manner because it contained open-ended questions. Analysis of this part was also done in a qualitative manner.

3.5 POPULATION

A population is a group whose members possess specific attributes that the researcher is interested in studying (Burns & Grove, 1993:47; Polit & Hungler, 1995:229).

There were two groups of respondents. The first group consisted of all psychiatric patients suffering from schizophrenia, who were referred to the clinic between January 1995 and January 1996, males and females, ages 19 years and over, who had missed clinic appointments twice or more times in the twelve months period.

The second group consisted of one immediate family member residing with the patient, and whose name was identified in the patient's records. All respondents lived in the Botshabelo area.

3.5.1 Sampling

3.5.1.1 Definition

Sampling is the process of selecting a portion of the population to obtain data regarding a problem. According to Talbot (1995:241) a sample is a portion of the population selected to represent the population of interest. The main purpose of sampling is to make certain that the research study is efficient

[Uys & Basson, 1991:87; Burns & Grove, 1993:235, Polit & Hungler, 1995:229; Talbot, 1995:241].

3.5.1.2 A respondent

A respondent is a single member of the population under study, or the basic unit about whom information is collected. In this study a respondent was a patient suffering from schizophrenia who missed clinic appointments twice or more in a twelve months period. The other respondent was an immediate family member of each patient selected for the study [Talbot, 1995:242].

3.5.1.3 Sampling approach

Nonprobability sampling was chosen because of the type of problem identified. The disadvantages of using nonprobability sampling become obvious when one considers that the sample may not be representative of the large population and the results may not be generalized beyond the sample studies. The advantages of this type of sampling are that it is less expensive, less complicated and allows the researcher to be more spontaneous when a research situation arises. Nonprobability sampling is commonly used in nursing research because it is often feasible, economical, timely and ethical for for collecting a sample of the population under study. The subjects were not randomly selected. All subjects who met the criteria for inclusion in the study were used. [Polit & Hungler, 1995:235, Talbot, 1994:251].

3.5.1.4 Sampling procedure

■ Purposive sample

Purposive sampling or judgmental sampling was chosen in which the researcher identified the problem and used her knowledge and expertise to

select the elements of the study. This type of sampling is commonly seen in qualitative research, but can also be used in quantitative research. The researcher purposely selected all schizophrenic patients who missed clinic appointments twice or more times in the twelve months between January 1995 and January 1996. A sample of 32 adult psychiatric patients suffering from schizophrenia and missed clinic appointments twice or more in 12 months period was chosen from five main clinics situated in Botshabelo. Those five clinics chosen from 13 clinics were the main clinics which had more new patients who missed clinic appointments.

The second group of thirty-two family members was selected by using patients' records to identify the immediate family member as a next of kin (Burns & Grove, 1993:246; Polit & Hungler, 1995:235, Talbot, 1995:255).

Multiple biases which are believed to be common in purposive sampling were not experienced because the researcher prepared the respondents psychologically by introducing herself, not wearing a nurse's uniform and conducting interviews at the patient's homes. All respondents were free to answer questions.

3.5.2 Inclusion criteria

3.5.2.1 First group

The sample, as explained in the previous pages, included patients suffering from schizophrenia, admitted between January 1995 and January 1996 and who missed clinic appointments twice or more in twelve months period.

- Patients were selected from five main clinics in Botshabelo which cater for many patients and had great numbers of patients who missed clinic appointments.
- Ages were nineteen years and over, both males and females.

3.5.2.2 second groups

One immediate family member residing with the patient and whose name was identified in the patient's record.

3.5.3 Exclusion criteria

- Psychotic patients who could not give relevant information. This included patients who were disorientated for self, time and environment caused by acute psychotic episodes of hallucinations., delusions and thought disorders.

- Patients who did not live with their families because, information was required from both patient and family member.

- Patients or family members who could not be contacted due to wrong addresses or not being available at the time of the interview.

3.5.4 Representativeness

Representativeness means that the sample must be like the population in as many ways as possible. It is important that the sample be representative in relation to the variables being studied and other factors that may influence the study variables. In this study, as the aim was to determine the possible reasons for missed clinic appointments among patients suffering from schizophrenia, the sample was representative of the distribution of patients who missed clinic appointments. The five main clinics from which the patients were selected are geographically scattered in the Botshabelo area (Burns and Grove, 1993:237; Polit & Hungler, 1995:240).

3.5.5 Sample size

Sample size is the number of subjects selected for the study. There are no simple formulas that indicate how large a sample is needed to attain representativeness in a given study but the larger the sample, the more representative of the population it is likely to be. Some factors are used in deciding the appropriate sample size for a chosen study, for example, time, money and availability of subjects are some of the common factors. The time required for a study will decide whether the required sample size will be obtained. Money is involved in selecting the sample. The larger the sample the more expensive it is, and vice versa. The availability of subjects is the most deciding factor affecting the sample size. If the subjects required for the study are estimated to be fifty (50) and only twenty (20) subjects are obtained, the sample size will be small, thus affecting representativeness. In this situation sampling errors will result. Sampling error refers to the difference between a sample statistic and a population parameter. A large sampling error occurs if the sample does not provide a precise picture of the population, including the number of subjects selected (Burns & Grove, 1993:237; Polit & Hungler, 1995:258; Talbot, 1995:240).

In this study, representativeness and sample size appear to be adequate. Patients suffering schizophrenia who missed two or more clinic appointments during a 12 months period were interviewed. The researcher expected to obtain an adequate sample in five clinics out of 13 because they were the main clinics which had large number of new referrals unlike in other smaller clinics some of which had no new patients. The sample size was 37% of the population. The researcher consulted a statistician (Dr van Zyl at the department of mathematical Statistics, University of Orange Free State for a second opinion in this regard (Burns & Grove, 1993:247; Polit & Hungler, 1995:258; Talbot, 1995:240).

3.6 DEVELOPING A QUESTIONNAIRE

3.6.1 Introduction

A questionnaire is a printed self-report form designed to collect information that can be obtained through written response of the subject (Burns & Grove, 1993:368).

The information obtained through questionnaires is similar to that obtained by interview, but the questions tend to have less depth. Questions are presented in a consistent manner and there is less opportunity for bias than in interviews.

Advantages of a questionnaire

- A questionnaire is less expensive and a large number of subjects can be involved.

Characteristics

- A questionnaire may consist of closed-ended or open-ended questions. In closed-ended questions a series of possible answers are given for the respondent to make a choice. In open ended questions a respondent can formulate his own answers (Uys & Basson, 1991:65; Burns & Grove, 1993:368).

3.6.2 Development of a questionnaire

■ The first step

The desired information must first be identified. A blueprint is developed to identify the essential content to be covered by the questionnaire.

■ Second step

The next step is to search the literature for a questionnaire of a similar study or to contact the authors of a study and request a copy of their questionnaire. Researchers are encouraged to use questions in exactly the same form as those in previous studies to facilitate comparing results between studies. No suitable questionnaires could be found for this study (Burns & Grove, 1993:376).

For this study the researcher developed her own questionnaire from information obtained from literature and knowledge from own experience.

TYPES OF QUESTIONS USED

■ Closed-ended questions

The questionnaire designed for patients consisted mainly of closed-ended questions in which a specific list of alternatives was provided from which to select an answer. Some questions consisted of a Yes / No option. For some response categories "don't know" and "uncertain", were included. Each question clearly instructed the respondent how to respond (i.e. choose one, or mark all that apply) (see Annexure C).

■ Open-ended questions

There were only two open-ended questions in the patient's questionnaire, and three questions for the family members to indicate the possible reasons for missed clinic appointments and abnormal behaviour of the patients. In both questionnaires open-ended questions were placed last because their response required more time than closed-ended questions.

As the questionnaires were designed in an orderly manner demographic data was placed first in both, as was the relationship of the family member to the patient in the second questionnaire (see Annexure D).

■ Number of questions in the questionnaires

Patient questionnaire: Consisted of 31 questions and the family questionnaire eight questions.

A PILOT STUDY

A pilot study is a limited version or trial run done to prepare for a major study.

A pilot test of the questionnaire was performed to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire and success of data collection technique. The respondents selected and techniques used for the pilot study were similar to those planned for the main study to acquaint the researcher with the instrument and to ensure reliability and validity. Corrections made to the instrument during the pilot study were taken into consideration before the same instrument was used for the main study.

The respondents selected for the pilot study were not included in the main study. Two patients and two family members were interviewed [Burns & Grove, 1993:373; Polit & Hungler, 1995:288].

The main reasons for conducting the pilot study were to:

- determine whether the proposed study was feasible [e.g. availability of subjects, time required for the study];
- identify problems with the design;
- determine whether the sample was representative of the population, and whether the sampling was relevant to the study;
- refine or further develop the data collection instrument;
- examine the reliability and validity of the research instrument;
- refine the data collection and analysis plan;
- give the researcher experience with the subjects, setting, methodology and methods of measurement;
- try out data analysis techniques [Burns & Grove, 1993:48; Polit & Hungler, 1995:35];

■ The results of the pilot study

During the pilot study the researcher identified some problems which require attention and corrections were done before the main study.

♦ *Data collection instrument*

The questionnaire was simplified and some of the questions were rephrased. Question 13.1 on the patient's questionnaire was rephrased to test orientation of the respondents for self, time and place. Reliability and validity of the instrument was tested to ensure that the information required will be obtained.

- ***Time allocated for interviews***

When the researcher realized the lengthy time spent during interviews she increased the time from 15-20 to 20-30 minutes.

- ***Experience gained during pilot study***

The researcher during the main study was confident and calm when asking questions because of the experience she gained with the subject during the study.

- ***Data-analysis techniques***

Regarding the type of information collected, the researcher had tried out different data analysis techniques relevant for the study.

- ***Representativeness***

The researcher was able to determine whether the sample was representative of the population. The information required for possible reasons of missed clinic appointments were obtained (Burns & Grove, 1993:48).

3.7 DATA COLLECTION

A semi-structured interview with the aid of a questionnaire was used by the researcher to collect data. Both closed and open ended questions were included. The purpose of using open-ended questions was to obtain information in the respondents' own words regarding a description of the situation, the behaviour of the patients who stopped treatment and to determine the

possible reasons of missed clinic appointments (Burns & Grove, 1993:49; Polit & Hungler, 1995:258; Talbot, 1995:265).

The questionnaires were translated from English into South Sotho during the interview and completed by the researcher. The purpose of translating the questions from English to South Sotho was to counteract the language problem as the respondent had little or no understanding of English. Illiteracy was also taken into consideration. The same procedure was used for both groups of respondents.

3.7.1 The interview process: patient interviews

The researcher arranged to conduct interviews at the patients' homes in the morning and late afternoon with the hope that they would be at home. On arrival, the researcher introduced herself to the patients and their families and explained the purpose of the study. Before the interviews were conducted consent was requested from the respondents and they were were assured of confidentiality. They were assured that their identity would not be divulged as no names would appear on the questionnaire. Their permission to be interviewed was also sought.

- The researcher requested a room that would ensure privacy and be free from interruptions and disturbances.

- The patients were first interviewed in privacy away from family members to avoid their being influenced.

- Questionnaires were numbered 1-32 to identify the respondents.

- The researcher built rapport between herself and the respondents to put them at ease and to enable them to feel free to answer questions.

- The researcher asked the questions in South Sotho, which is the language used in Botshabelo, and gave respondents enough time to think clearly before answering.

- The time spent on each respondent varied between 25 - 35 minutes to accommodate slow thinkers.

- More time was spent on open-ended questions due to varied responses from the respondents.

- During the interview the researcher explained the questions and the respondents gave the required introduction in an atmosphere of mutual trust.

- The researcher completed the questionnaires to maintain uniformity and to counteract the problem of illiteracy.

- No problems were encountered in obtaining information from closed-ended questions.

- At the end of the interviews the researcher expressed her appreciation and thanked the respondents for their participation.

- Throughout the interviews the researcher used communication skills such as reflecting, validating and open-ended questions.

3.7.2 The interview process: interviews with the family members

- Before the interview each family member was given a full explanation of the research project and was asked for permission to be interviewed.

- They were also assured of confidentiality and those who were interviewed participated freely.

- The respondents were also interviewed in privacy and the questionnaire completed by the researcher to counteract the problem of illiteracy.

- Family members were more relaxed and willing to give information about the patients.

- The questions were asked in South Sotho which is the language spoken by the rest of the community in Botshabelo.

- Time spent by the researcher with each family member was shorter compared with the time spent with patients (20 - 25 minutes).

- None of the family members wanted to know what the patients had said concerning missed clinic appointments.

3.8 RELIABILITY AND VALIDITY

3.8.1 Introduction

Reliability and validity are important issues in evaluating the findings of a research study. In any research project the researcher attempts to avoid as

many errors as possible because accuracy is the key point in reliability and validity. In this study the researcher used a semi-structured interview with closed and open ended questions to obtain data. Open-ended questions were designed to elicit true feelings from the subject as closed ended questions restrict answers to "Yes" or "No".

The reliability and validity of the data collection instrument and the whole procedure of the study were evaluated during the pilot study (Uys & Basson, 1991:80; Burns & Grove, 1993:373).

■ Reliability

Reliability is concerned with how consistently the measurement technique measures the concept of interest. For example, if one were using a scale to obtain the weight of subjects, one would expect the scale to indicate the same weight if the subject is weighed again. In this study a questionnaire collected reliable and valid data because it was tested for reliability and validity during a pilot study. Questions which were asked during the interviews were clearly phrased and simplified. All respondents were asked the same questions to prevent bias. The reliability of the open-ended questions was established by a pre-test as the instrument used for the pre-test on two patients and two family members gave the same results when used on different respondents. This indicates the consistency and accuracy of the instrument (Uys & Basson, 1991:75; Burns & Grove, 1993:339; Polit & Hungler, 1995:347).

To ensure reliability and validity the questionnaire was submitted to the following professionals:

- Clinical experts in Nursing i.e. competent qualified psychiatric nurses with experience in community psychiatric nursing.

- The Ethics Committee of the faculty of Health Sciences at the University of Orange Free State.

- The Nursing Research Committee at the University of Orange Free State.

- The researcher who is competent, qualified in psychiatric nursing and has 23 years' experience in community psychiatric nursing.

Validity

Validity refers to the degree to which an instrument measures what it is supposed to be measuring. For example, a questionnaire in a research study is considered to be an instrument to collect data [Uys & Basson, 1991:80, Burns & Grove, 1993:342; Polit & Hungler, 1995:353].

It is difficult for the researcher to predict the validity of an instrument. Three primary types of validity are used to test an instrument.

Content validity

Content validity focuses on a higher degree of balance and representativeness of questions in the instrument to give relevant results to the problem. Even though respondents during the research study answer questions differently due to individuality, the information obtained should give the same picture of the problem of missed clinic appointment.

The validity of the instrument was maintained by evaluating the questionnaire in a pre-test to obtain information required in the main study by using the same type of questionnaire. The same researcher completed the questionnaire for the pilot study and the main study. Content validity was checked by submitting the questionnaire to the professionals mentioned on [previous pages] to test

validity as well as reliability. Content validity is used to test the reliability and validity of data (Burns & Grove, 1993:339).

■ Predictive validity

Predictive validity is the most powerful type of validity. A test that can be used predict an event that will occur in the future or to predict the type of response from respondents, is said to have predictive validity. If there is a high correlation between predicted behaviour or response and actual response, the instrument is said to have predictive validity. The questionnaire for this study obtained some of the information which the researcher expected from the respondents to be one of the contributory factors towards missed clinic appointments such as the side effects of drugs (Uys & Basson, 1991:82; Burns & Grove, 1993:344).

■ Construct validity

Construct validity examines the fit between the conceptual definitions and operational definitions of variables. Theoretical constructs are defined within the framework (conceptual definitions). The conceptual definitions provide the basis for the development of operational definitions of the variables. Operational definitions (methods of measurement) need to reflect the validity of the theoretical constructs.

The examination of construct validity determines whether the instrument actually measures the theoretical construct it purports to measure. Both questionnaires designed for the patients and family members obtained the required information concerning the possible reasons for missed clinic appointments (Uys & Basson, 1991:82; Burns & Grove, 1993:344; Polit & Hungler, 1995:356). The information obtained from the family was related to the information obtained from the patients.

Reliability and validity are the basic characteristics of a data collecting instrument which enable the researcher to collect reliable data. In both qualitative and quantitative research the data collecting instrument and recorded data are crucial to discover the cause or possible reasons for the problem (Uys & Basson, 1991, 83, Burns & Grove, 1993:344; Polit & Hungler, 1995:357; Talbot, 1995:287).

3.9 DATA ANALYSIS: DESCRIPTIVE STATISTICS

3.9.1 Introduction

Statistical analysis is a method of rendering quantitative information meaningful and intelligible. Without the aid of statistics, the quantitative data collected in a research project would be difficult to interpret. Statistical procedures enable the researcher to reduce, summarize, organize, evaluate, interpret and communicate numerical information. Statistics are classified as either descriptive or inferential. Descriptive statistics are used to describe and synthesize data. Averages and percentages are examples of descriptive statistics. When such indexes (statistics) are calculated on data from a population, they are referred to as parameters. A descriptive index from a sample is called a statistic (Burns & Grove, 1993:335; Polit & Hungler, 1995:371, Talbot, 1995:317).

Analysis of statistics is done by means of calculators and computers. Statistics are seldom calculated by hand nowadays.

In this study the computer has been used to arrange, analyse and process data which will be presented in the form of graphs, tables and histograms (Uys & Basson, 1991:135).

3.9.2 Levels of measurement

A system for categorizing different types of measurement have been developed by scientists. The following levels of measurement are used in data analysis:

- Nominal measurement
- Ordinal measurement
- Internal measurement
- Ratio level measurement

In quantitative research such as this study nominal measurement is the lowest level of measurement to classify characteristics into categories. Variables related to a nominal scale include gender, nursing speciality, religion and others. In this study this type of measurement has been used to analyse data for gender (Polit & Hungler, 1995:372).

■ Ratio level measurement

Ratio level measurement are the highest form of measure and meet all the rules of other forms of measurement. According to Burns and Grove (1993:372) is it advisable to use high level of measurement to analyse data.

3.10 PROCESSING AND INTERPRETATION OF DATA

Completed interview schedules were coded by the researcher. Data from close-ended questions was processed by the Computer Centre at the University of the Orange Free State. The SPSS-X data processing package was used. Frequencies of all variables were first requested. The researcher used these statistics to familiarise herself with the data set, as well as to describe the different variables. Although sufficient attention was paid to the level of measurement of variables to allow for inferential analysis, this

processing was for closed-ended questions. For the interpretation of results tables, histograms, and pie graphs were used.

For the analysis of open-ended questions the researcher coded data according to the similar themes, which were grouped together and interpreted by means of tables (Burns & Grove, 1993:497, Polit & Hungler, 1995:379; Talbot, 1995:320).

Data analysis is the most important stage in research for obtaining results. Using a computer for data analysis saves time and gives correct and accurate results. The frustration of using a calculator or calculating by hand is avoided as in most cases incorrect results may be obtained due to poor concentration.

It is advisable to consult a statistician to help and guide data analysis. In this study the researcher consulted a statistician at the University of the Orange Free State as mentioned previously, to check the questionnaire in order to determine the possibility of using a computer for data analysis (Burns & Grove, 1993:498; Polit & Hungler, 1995:379; Talbot, 1995:320).

3.11 ETHICAL CONSIDERATIONS

Ethical consideration is important during research studies to protect the human rights of subjects. Subjects should be protected physically, mentally, psychologically and socially. Even if the subjects might not benefit from the study they should be willing to participate after the research project has been clearly explained. The following ethical considerations were maintained:

- Obtaining permission
- Informed consent
- Privacy and confidentiality
- Persons with diminished autonomy
- Right to protection from discomfort and harm.

3.11.1 Obtaining permission

A letter was written to the management of Botshabelo Hospital, asking for permission to use the patients' records and to interview them. Another letter was written to the District Facilitating Committee of Botshabelo asking for permission to interview the members of the Committee, for example, family members of patients included in the study, as well as the patients suffering from schizophrenia who missed clinic appointments. Permission was also obtained from the Ethics Committee of the Faculty of Health Sciences, University of the Orange Free State [see Annexure A and B].

3.11.2 Informed consent

The subjects were informed about the research project and the reason for obtaining information. Both patients and family members were asked to sign the consent form if they were willing to participate. All respondents were informed that if at any time during the interview they wished to stop the interview or withdraw their permission they were free to do so [Burns & Grove, 1993:95; Polit & Hungler, 1995:127].

3.11.3 Privacy and confidentiality

The subjects were promised that the information obtained would not be publicity reported. They were assured that their names would not appear on the questionnaire, or in the discussion of the results. Privacy was maintained by collecting data from individual subjects in a private room. Only required data was collected. The name of the clinic was not mentioned, instead numbers were allocated to clinics i.e.1, 2, 3, 4, and 5. The self-respect and dignity of the patient was maintained during data collection [Uys & Basson, 1991:98; Burns & Grove, 1993:372; Polit & Hungler, 1995:125].

3.11.4 Persons with diminished autonomy

It is common that due to mental illness or cognitive impairment certain patients, are incapable of giving informed consent. In this situation the researcher usually involves a willing member of the family to answer on behalf of the patient and to give consent. In this study all patients were capable of giving consent. No physical or mental discomfort was detected (Uys & Basson, 1991:98; Burns & Grove, 1993:97; Polit & Hungler, 1995:127).

3.11.5 Right to protection from discomfort and harm

Interviews were not long to avoid fatigue and discomfort. Physical harm was avoided as no treatment was introduced such as in experimental studies. Comfort was maintained for the subjects because interviews were conducted in their homes (Burns & Grove, 1993:94; Polit & Hungler, 1995:128).

3.12 CONCLUSION

Research that involves human subjects requires careful consideration of the procedures to protect their rights. Most studies involve informed consent to provide subjects with sufficient information and to allow voluntary participation. In this study the patients and family members who were selected as respondents were willing to participate because they had insight into the purpose of the study and were willing to be assisted towards compliance (Burns & Grove, 1993:95; Polit & Hungler, 1995:129; Talbot, 1995:36).

CHAPTER 4

Presentation of findings

4.1 PATIENTS AS RESPONDENTS

4.1.1 Introduction

In this chapter the results of the study will be presented according to the questions as designed in the semi-structured interview guide and the discussion will be made at the end of each individual findings.

Questions 1-6 are concerned with the biographical detail of the patients as respondents.

4.1.2 Composition of a sample in terms of gender

The majority or respondents were males (62.5%) and 37.5% were females.

4.1.3 Composition of sample in terms of age

The graph in Figure 4.1 shows that the biggest category which missed clinic appointments were between ages 29-38 years (25%) and 49-58 years (25%). Respondents between 39-48 years and 59-68 years form 12.5% of the sample. Ages from 69 years and above form 3.1%. This is the lowest percentage. Ages between 19-28 years form 21.9%.

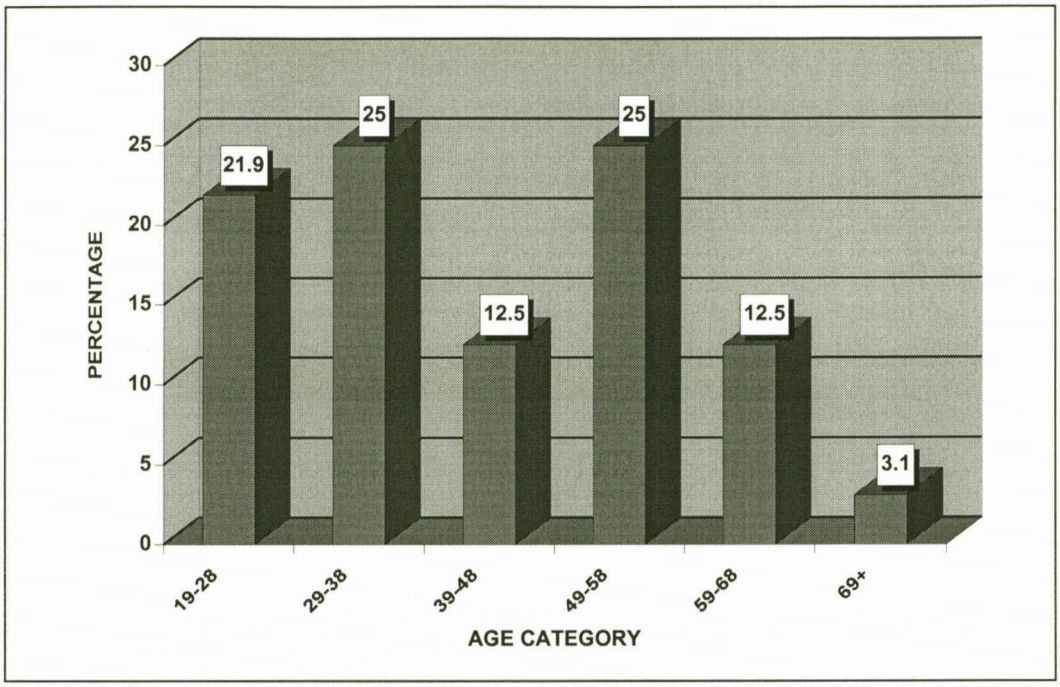

FIGURE 4.1: Composition of sample in terms of age

4.1.4 Composition of sample in term of marital status

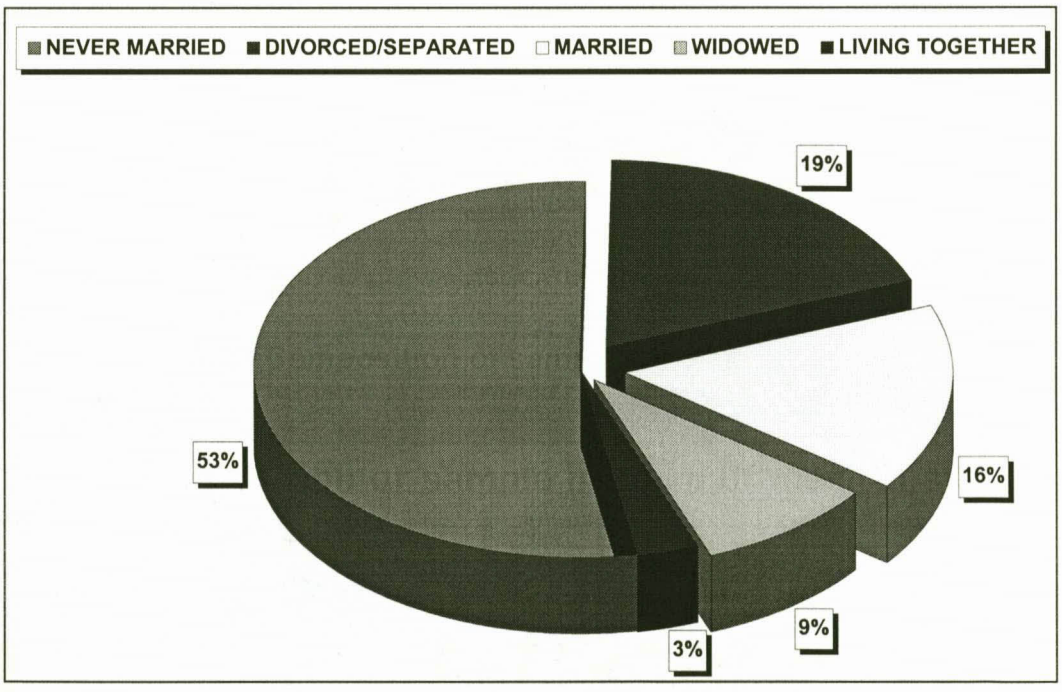

FIGURE 4.2: Composition of sample in terms of marital status

Most of the patients were never married (53%) which is more than half of the sample. Nineteen percent were divorced or separated, 16% married, 9%

widowed and only 3% were living together. This appears to be against cultural norms of black people who generally value marriage and expect to marry.

The majority of patients who are suffering from Schizophrenia are asocial and prefer to be alone especially when experiencing acute psychotic episodes. Literature supports the above information (Mdluli & Msomi, 1989:17; Berk, 1993:48; Stuart & Sundeen, 1995:490).

4.1.5 Educational status of respondents

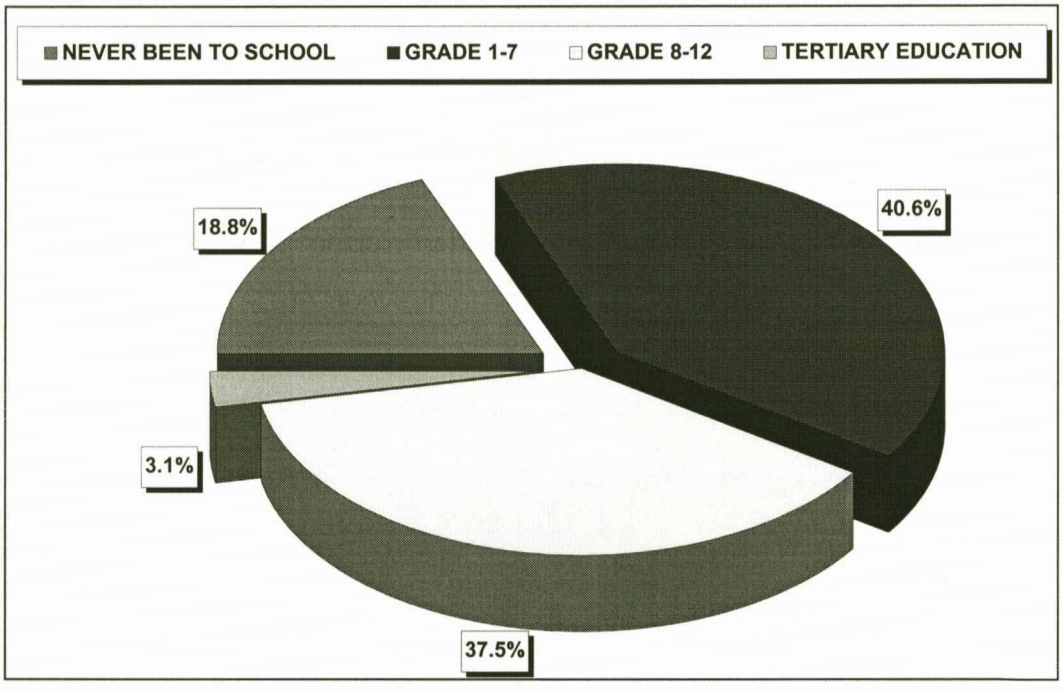

FIGURE 4.3: Educational status of respondents

A large number of respondents left school between grades 1-7 (40.6%) followed by secondary school education between grades 8-12 (37.5%). Only 3.1% completed tertiary education. Respondents who had never been to school form 18.8% of the sample.

The illiteracy of 18.8% of the sample did not influence the collection of data because the questionnaire was completed by the researcher for all respondents.

4.1.6 Employment status of respondent

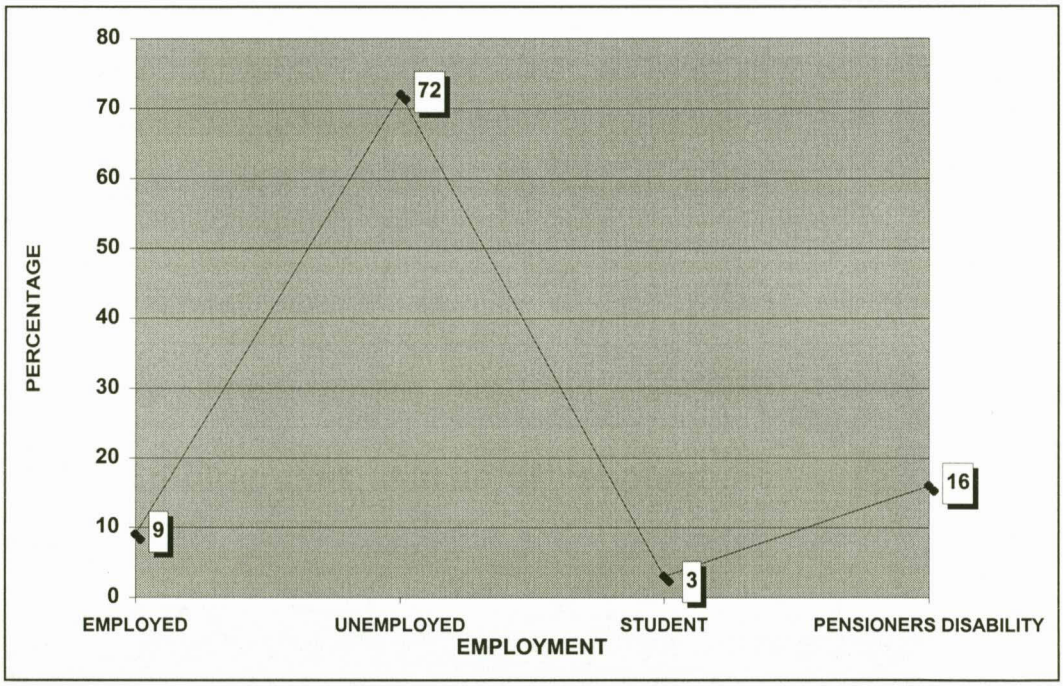

FIGURE 4.4: Employment status of respondent

The majority of respondents were unemployed. Seventy-two percent at the time of the study were unemployed when compared to 9% employed. The pensioners and those who were getting a disability grant formed 16%, and the students 3% of the sample.

The high unemployment rate may have been due to the nature of the illness. According to the literature the majority of Schizophrenic patients fail to stay at

4.1.7 The sample in terms of family size

The findings indicate that 57% of the respondents have one or two children, 13.9% three or more and 29.1% found to have no children.

Questions 7-9 test a general knowledge, awareness and responsibility of the respondents towards the illness.

4.1.8 Duration of treatment

Half of the sample (50%) indicated that they had been treated for the illness for eight to 12 months. Respondents who were treated for four to seven months formed 40.5%, and 9.5% were treated for less than four months.

4.1.9 Medical care as a source of help

The majority of respondents (81.2) appear to know that the illness required medical assistance, while 9.4% preferred traditional/faith healers, and 9.4% responded by saying: *"I don't know"*.

4.1.10 Keeping to the appointment

Forty-four percent of the respondents appear to be well-oriented for clinic appointment dates even though they failed to comply. Respondents who had to be reminded every month about clinic appointments formed 34% of the sample. Twenty-two percent had to be reminded sometimes.

4.1.11 Possible reasons for stopping clinic visits

4.1.11.1 Abnormal perceptions

About 37.5% of respondents reported hearing voices of unseen people frequently commanding them not to go to the clinic. Those who reported occasionally hearing voices formed 34.4% of the sample, and 28.1% denied hearing voices. These findings are similar with what Stuart and Sundeen (1995:505) indicated concerning abnormal perceptions experienced by schizophrenic patients.

4.1.11.2 Improvement or non-improvement on medication

Seventy-two percent of the respondents indicated the positive effects of the treatment and believe that a person could improve when taking the treatment. Twenty-eight percent responded negatively claiming that the treatment was not effective, but made their condition worse. Despite 72% of the respondents who knew that the treatment was effective for the illness, their actions of non-compliance contradicted their knowledge.

4.1.11.3 Ambivalent feeling

Seventy-five percent of the respondents complained of headaches, heaviness in the head and inability to make decisions at times. Only 25% reported ability to make decisions and to solve most of their problems. According to the literature an ambivalent feeling is one of the common abnormalities which prevents schizophrenic patients coping with the demands of their health care activities. Headaches and heaviness in the head which are common among schizophrenic patients could be somatizating of emotional problems which is

common among black people (Uys *et al.*, 1994:48; Stuart & Sundeen, 1995:504).

4.1.11.4 Orientation of the respondents

When testing for orientation, 71.9% of the sample found to be well-orientated for self, time and place. The respondents were able to name the day, month and the year. Fourteen percent were able to remember either the day and the month, or the day, month or year only, while 14.1% were totally disorientated. The findings indicate that a large percentage was well-orientated. This is not a major problem for missed clinic appointments in this study.

4.1.11.5 Social interaction

Most of the respondents (81.3%) were found to be coping well with their relationship with other people and having friends. Only 18.7% reported not having friends. High percentage of good social interaction contradicts the literature that the majority of schizophrenic patients are unable to socialize (Freeman, Lee & Vivian, 1994:117; Stuart & Sundeen, 1995:505).

4.1.11.6 Physical illness

Only 28.1% of the respondents indicated that physical illness most of the time prevented them to go to the clinic, while 37.5% denied physical illness as the cause of missed clinic appointments. Even though schizophrenic patients are not always aware of physical illness 34.4% reported that at times they become physically ill after been given an injection. Maybe referring to stiffness of the body after Fluphenazine injection (side-effects).

4.1.11.7 Stigma attached to mental illnesses

Embarrassment which was believed to be one of the possible reasons for stopping clinic attendance as indicated in the questionnaire shows low percentage of 15.6% of respondents who did not feel free to go to the clinic because their friends were laughing at them. The 84.4% which is the highest percentage did not feel embarrassed to go to the clinic.

4.1.11.8 Alternate source of help

Fifty-nine percent reported that they had consulted doctors at the hospital not at the clinic during acute episodes of the illness. Thirty-two percent consulted traditional healers because they are available in the community anytime when needed. Another advantage was the intensive treatment given to the clients by giving them emetics to induce vomiting, enemas to remove "Sejeso" which is a poisonous subject caused by witchcraft, several consultations and immediate relief of headaches by using snuff. Only 9% reported having consulted private doctors first. These findings show that the community is still in favour of health services even though the percentage of those who consulted traditional healers is relatively high. Some researchers have indicated these findings in their studies (Gaborone, 1990:2; Freeman *et al.*, 1994:57).

4.1.11.9 Family support

According to the findings the majority of the respondents are getting support from the family during illness (93.8%) where as only 6.2% indicated lack of support. Despite such high percent of family support, missed clinic appointments remain an issue.

4.1.11.10 Respondents accompanied to the clinic

According to the question asked concerning the family accompanying the respondents to the clinic, 34,4% report "yes" that they were accompanied by one of the family members when going to the clinic. The same percentage of respondents (34.4%) stated that "sometimes" they needed somebody to accompany them if they were not feeling well and 31.3% indicated that they went alone to the clinic without been accompanied.

4.1.11.11 Use of transport

The majority of respondents (93.8%) indicated that they do not use transport when going to the clinic because the clinic is accessible and located within 1-3 kilometres from the community. Those who use transport formed 6.2% of the sample. Among respondents who use transport, 78.4% of 6.2%) reported that the transport is not affordable financially except after getting a disability grant which they sometimes only receive after their clinic appointment dates. According to the results, transport contributed to missed clinic appointments for some patients. These findings are supported by some literature (Bush, 1994:259; Crane, Kirby & Kooperman, 1996:6).

4.1.11.12 Length of time spent in queues

Due to shortage of qualified psychiatric nurses at the clinics, and the fact that comprehensive services are provided simultaneously to clients means that patients have to wait in queues before seen by the nurses. Findings are indicated in Figure 4.5 (see p.10) below.

According to the findings those who indicated having to wait for 30 minutes to one hour form 52% which is the highest. Thirty-five percent waited for a shorter period of 30 minutes or less, while a low percentage i.e. 13% waited

for longer than an hour. To some people especially if there are no activities to keep them occupied, 30 minutes to one hour is a long time which causes discomfort and other problems. This might contribute to missed clinic appointments. The same information has been found in literature (Gillis & Egert, 1993:93; Freeman *et al.*, 1994:59).

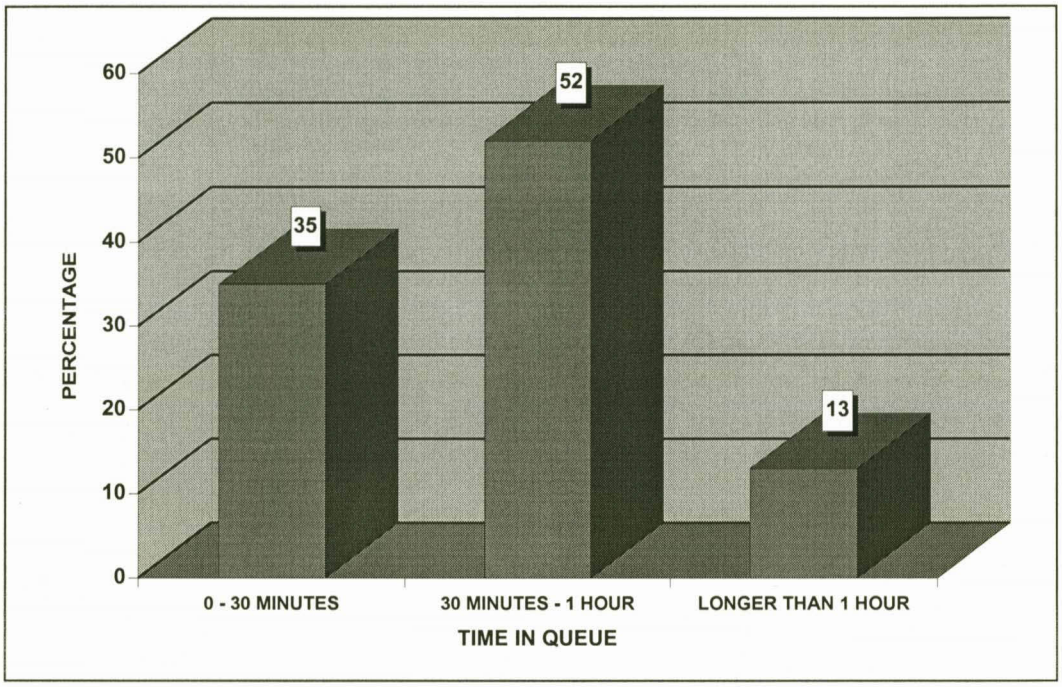

FIGURE 4.5: Length of time spent in queues

4.1.11.13 The effects of waiting procedure

Despite different length of time spent in queues only 21.9% indicated that the waiting time caused problems like hunger, boredom, tiredness. The majority of respondents (80.1%) reported not to be affected by waiting. Only seven respondents who were affected by waiting time five were between ages 49-58 years, one 61 years and one respondent was 35 years.

4.1.11.14 Nurse-patient relationship

The majority of respondents (87.5%) reported that the nurses treated them well, while 12.5% expressed dissatisfaction at the manner in which they were treated at the clinic. Fifty percent of 12.5% explained that the nurses were shouting at them without a sign of respect. Twenty-five percent reported that the nurses treated them badly by not addressing them properly by using their names. Some of the nurses used words like *"Hey you"*. Some of the respondents reported that they decided to stay at home because of the nurses attitudes. Nurse-patient relationship is very important to encourage clinic attendance.

4.1.11.15 The type of current treatment

Three quarter (75%) of the respondents reported to be on intramuscular treatment (injection). Those who were on tablets formed 18.7% and only 6.3% were not on treatment. Depot treatment like Fluphenazine injection is preferable for patients who are suffering from schizophrenia because of its long-term effect and it ensures compliance unlike tablets which the patient may not take. The injection may contribute to non-compliance due to side-effects which are common if the patient is on high doses.

4.1.11.16 Frequency of taking medication

The majority reported to be getting injection once monthly (90.6%) and only 9.4% who are on tablets were taking treatment daily.

4.1.11.17 Side-effects

Most patients who were on treatment reported side-effects like stiffness of the body and tremors. Other abnormalities experienced have been reported as indicated in Figure 4.6 [see p.12] below.

According to the findings in Figure 4.6 stiffness of the jaws and salivation was reported by 41.2% of the sample, headaches which are common form 18.5%. The patients who reported hallucinations form 10.3% of the sample. Physical illness which is seldom expressed by schizophrenic patients, abnormal sleeping pattern and tiredness form 8.3%, overeating forms the lowest percentage of 3.1%.

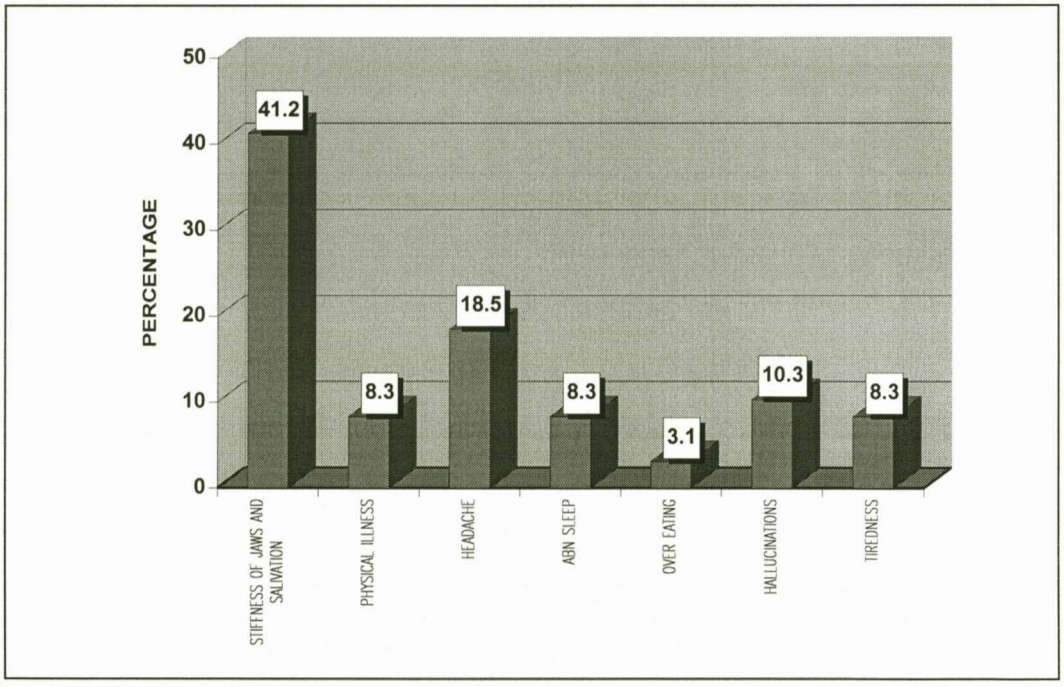

FIGURE 4.6 Side-effects

4.1.12 Perceived changes since stopping treatment

The majority of respondents reported feeling well when not taking medication (40.6%). This may have been due to the side-effects of the medication having subsided.

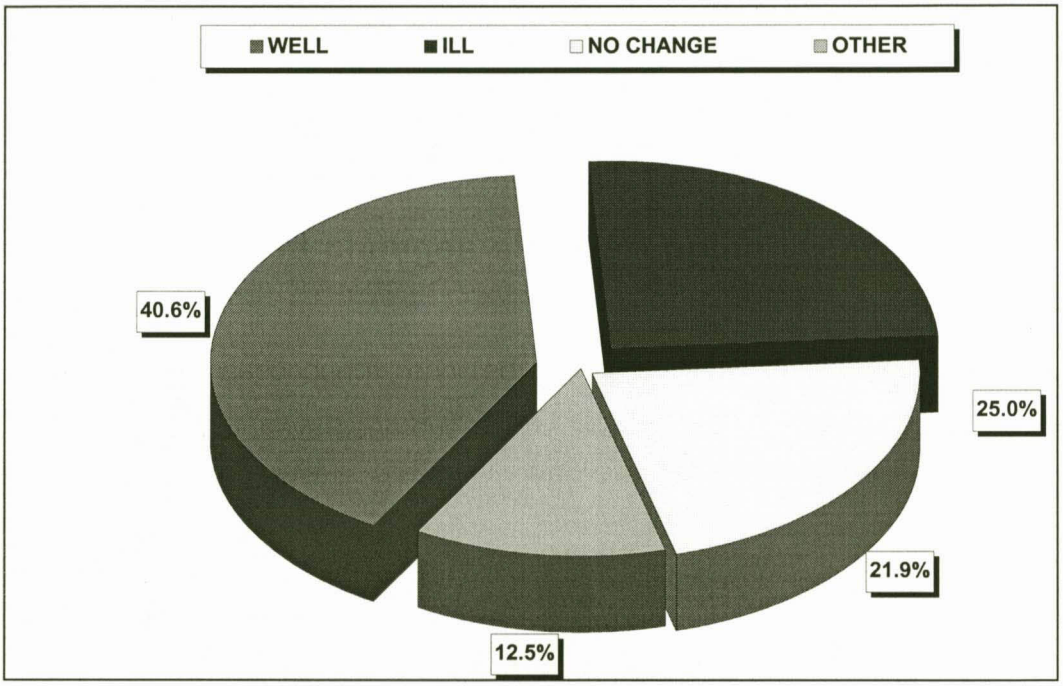

FIGURE 4.7: Perceived changes since stopping treatment

According to the findings in Figure 4.7 one quarter (25%) of the sample indicated that they felt ill after stopping treatment, but still failed to go to the clinic, 21.9% felt no change, while the remaining 12.5% reported different feelings such as, good appetite, sleeping pattern improved, energetic and able to do house work, reduced smoking because treatment was encouraging them to smoke heavily.

4.1.13 Admission to institution

Most of the patients (respondents) were admitted to the hospital when the illness started (96.9%). Only 3.1% have never been admitted but treated as

outpatient clients. On discharge 95.7% of the respondents were given referral letters to take to the clinic for follow-up treatment, while 6.3% were not given referral letters. For those who were given letters 90.6% knew where the clinic was situated, while 9.4% did not know where the clinic was and were accompanied by their family members to the clinic.

The findings show that on discharge from the institution, patients were given letters for after care services. According to the statistics the majority of respondents visited the clinic after been discharged from the hospital, then later stopped attending the clinic.

4.1.14 Employment factors

The majority of respondents (67%) who were employed reported that their employers were aware of their illness while 33% stated that they did not inform their employers about their illness with fear of might be discharged from work.

Fifty percent of the employed respondents indicated that their employers were supportive and gave them a day-off to go to the clinic, while 50% reported that they did not get support from their employers and were not paid for the days which they were taking for attending the clinic. The waiting time for patients in queue ranges between 30 minutes to one hour depending on the number of nurses available and the patients to be seen.

4.1.15 Information about the illness

A high percentage (78.1%) of respondents indicated that they need more information about their illness. Some of the respondents showed no interest for more information (15.6%). They indicated to have been given health talks at the clinics on every visit. A small percentage of 6.3% (only two

respondents] were reluctant to ask for more information about their illness because they could not read and write.

4.1.16 Reasons affecting clinic attendance or compliance

To obtain the respondent's own experience, open-ended questions were designed to obtain information about possible reasons which contributed to missed clinic appointments. Seventy-five percent of respondents reported that there were several reasons that prevented them going to the clinic. The interpretation of the results will be done in a table form. As each respondent indicated more than one reason, all similar responses were grouped together and coded by the researcher. Explanation of each point will be done at the end of the table.

■ Bad weather

When it is very cold or raining most of the patients do not attend the clinic especially if they have to walk a distance.

TABLE 4.1: Reasons affecting clinic attendance

	N	%
Bad weather (cold, rain)	2	8.3
Headaches	4	16.6
Forgetfulness	2	8.3
Physical illness	2	8.3
Side-effects of drugs	8	33.0
Dislike injection	2	8.3
Afraid of loosing job	1	4.1
Feels well	4	16.6
Looking after the children	1	4.1
Financial problems	3	12.5
No clean clothes	1	4.1
Looking after a sick mother	1	4.1

■ Headaches

Headaches seem to be a problem to some patients, especially those who are on injections. It is not clear whether this is a side-effects or due to physical illness.

■ Forgetfulness

This appears to be common among chronic schizophrenia and elderly patients. Unless they are reminded by family members to go to the clinic they miss clinic appointments.

■ Physical illness

Even though it is accepted that the patients who are suffering from schizophrenia do not complain of physical illness even when they feel pain, there are those who identified physical illness as a possible reason for missed clinic appointments. Some literature supports these findings (Crane *et al.*, 1996:11).

■ Side-effects of drugs

As most of psychotropic drugs cause side-effects, patients who have experienced such abnormalities, especially stiffness of the body, tend to develop fears towards medication and are inclined to stop attending the clinic. These results are supported by the literature (Malone, 1990:7; Poggenpoel, 1993:34).

■ Dislike injection

Patients who developed side-effects (as mentioned on the above paragraph), after having had an injection, apparently made an autonomous decision not to attend the clinic in future (George, 1995:18).

■ Afraid of loosing job

One respondent explained that his employer does not give him time off to go to the clinic. If he goes for treatment for a day, he forfeits a day's payment.

■ Feeling well

Four respondents explained that generally they felt well and consequently saw no reason to attend the clinic.

■ Looking after the children and a sick mother

According to the findings, it appears that the respondents are more concerned about their families than their own health. Some of them decided to stay at home looking after the children and sick mothers.

■ Financial problem

Some respondents indicated that they cannot afford public transport because of financial problems. They only managed to go to the clinic, after receiving their disability grant. Mdluli and Msomi (1989:15) explained that lack of transport is one of the common contributory factors for non-compliance.

■ No clean clothes

Poor personal hygiene is common among schizophrenic patients. This may be due to abnormal perceptions such as hallucinations and delusions which cloud the patient's consciousness. Voices commanding the patient not to go to the clinic for treatment and threatening death are also likely to persuade the patient to remain at home.

According to the findings on Table 4.1, 33% of the respondents did not go to the clinic, because they were afraid of the side-effects of drugs. Some of the literature has indicated the problem of side-effects as a crucial issue which requires immediate attention (Caton, 1989:77; Malone, 1990:7; Poggenpoel, 1993:35; George, 1995:22).

4.2 FAMILY MEMBERS AS RESPONDENTS

4.2.1 Introduction

The results of the family members as respondents will be presented according to the questions as designed in the semi-structured interview guide. Questions 1-7 are to determine the relationship of the respondents to the patients, who are also respondents in this study.

4.2.2 Family members as related to the patients

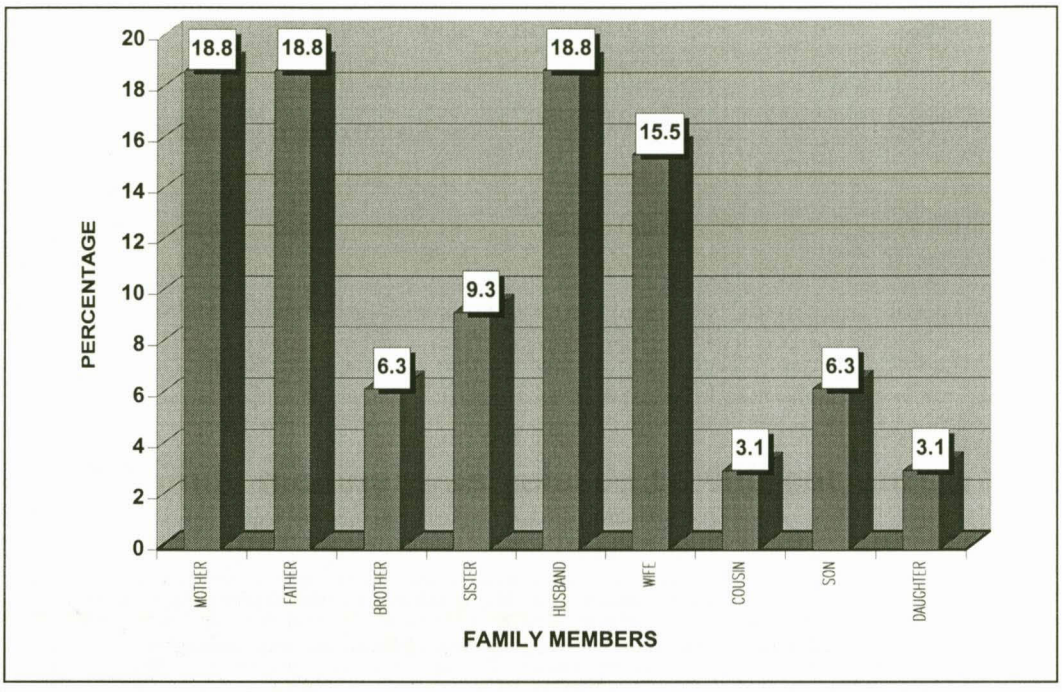

FIGURE 4.8: Family members as related to the patients

The findings show that the members of the family who stay with the patients and act as a support system are parents, children and extended family members e.g. cousins. Mothers, fathers and husbands form 18.8% of the sample, wives 15.5%, brothers and sons 6.3%, sisters 9.3% and the lowest percentage is for daughters and cousins which is 3.1%.

All the above-mentioned members of the family who were interviewed indicated that they stay with the patients and are the supportive system during the recovery process.

4.2.3 Duration of time when realised that the patient is ill

According to the findings 56.3% of respondents realised that the patient was ill for days before seeking medical or an another source of help. Other 43.8%

of respondents said that they detected abnormal behaviour on the patient's part for months before referring them for treatment.

4.2.4 Sources of help

As the clinics around Botshabelo are situated in the community 49% of the respondents referred the patients to the clinic, while 40% referred the patients to the hospital and only 4.5% to the private doctors and 6.5% to the traditional healers. Those who referred the patients to the traditional healers, later referred them to the clinic when their condition did not improve.

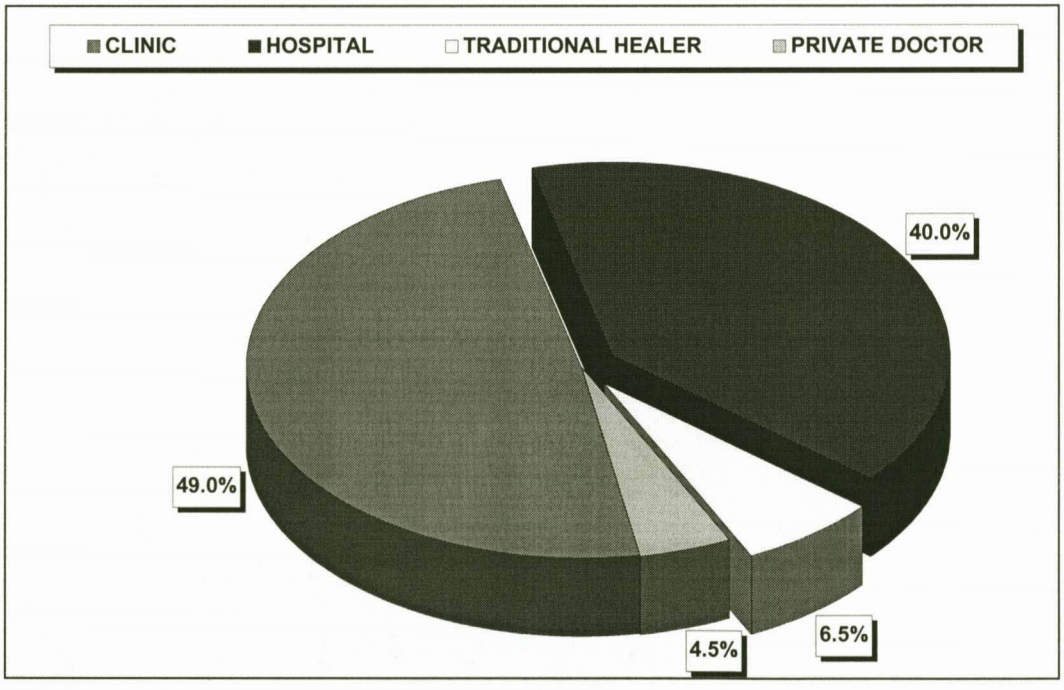

FIGURE 4.9: Sources of help

The findings show that the health services are utilized by the community as a priority during the illness (clinic 49% and hospital 40%).

4.2.5 Admission to the institutions

Most patients according to the respondents have been admitted to the hospital (93.8%) while only 6.2% were never admitted.

4.2.6 Duration of admission

Fifty percent indicated that the patients were admitted for months, 31.3% for days, while 18.7% had in the past, been admitted for a lengthy duration e.g. years. The findings show that patients are no longer admitted for a long time in the institutions. Outpatient departments and clinics are utilized for aftercare services thus motivating self-care among patients.

4.2.7 Referral system

Seventy-five percent (75%) indicated that patients were given letters on discharge to take to the clinic for follow-up management. According to 18.8% of respondents patients were not given referral letters. Respondents who were not sure whether the patients were given letters on discharge because they came home alone from the hospital formed 6.2% of the sample. The findings indicate that on discharge, patients are given referral letters.

4.2.8 Awareness of non-compliance

Most of family members were aware that the patients were no longer attending the clinic (78.1%). The respondents who were not attending the clinic formed 21.9% of the sample.

4.2.9 Perceived changes since the patients stopped clinic attendance

Sixty-six percent of the respondents indicated that they were experiencing problems since the patients had stopped clinic attendances. Thirty-four percent reported that they were not to be experiencing problems.

4.3 TYPES OF PROBLEMS EXPERIENCED BY THE FAMILY

An open-ended question was designed to obtain the subjective experience of family members regarding patients who stopped clinic attendances. Results will be interpreted in a graph form and then discussed.

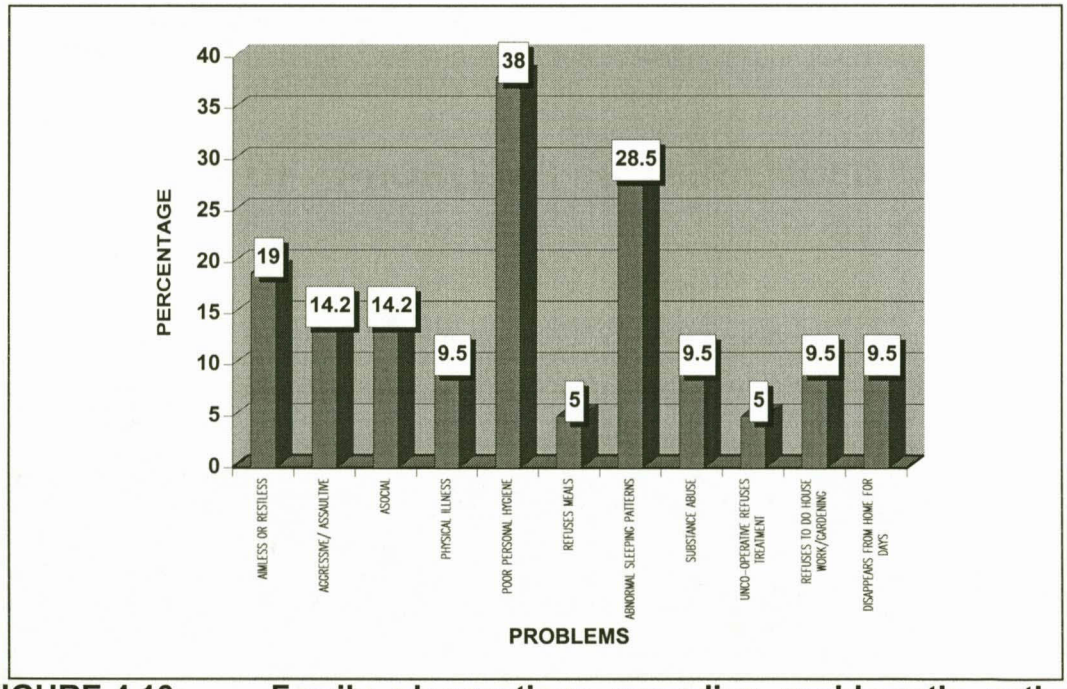

FIGURE 4.10: Family observations regarding problematic patient behaviour

According to the findings, high percentage (38%) of respondents indicated that the patients' personal hygiene is poor. They refuse to wash and also to

wear clean clothes. The patient only will wash if coaxed or physically forced to do so.

- Aggression and violence with assaultive behaviour occurs. One of the patients assaulted his aunt by hitting her on the ear causing partial deafness (14.2% no of respondents three).

- Abnormal sleeping patterns like sleeping late or waking up very early is a problem. This disturbs members of the family (28.5% no of respondents six).

- Some patients are restless and spend most of the time aimlessly roaming around (19% no of respondents four).

- Physical ailments is a rare complaint expressed by some patients. Schizophrenic patients rarely complain even if they are sick, unless observed by another person. Only two respondents (9.5%) reported physical illness on defaulted patients.

- Substance abuse and disappearing from home for days form 9.5% of the sample and those patients who were uncooperative and refused treatment formed 5% of the sample.

- Some patients refuse to do house work or simple work like gardening (9.5% i.e. two respondents).

Respondents mentioned more than one problem which were grouped together and coded by the researcher to interpret the results (see Table 4.2, p.23).

4.4 THE POSSIBLE REASONS FOR MISSED CLINIC APPOINTMENTS

An open-ended question was designed to obtain the individual's opinion about the possible reasons contributing to missed clinic appointments on the part of the patients. The respondents mentioned different reasons according to their experiences. Table 4.2 will be used to explain the possible reasons mentioned.

TABLE 4.2: The possible reasons for missed clinic appointments (to be continued)

REASONS	*N*	*%*
• **Side-effects of drugs especially for patients who are getting the injection. Body stiffness, tremors salivation are common. In most cases the patient is unable to do anything for him-/herself.**	9	28.4
• **The patients claimed to be feeling well after stopping the treatment. Some researchers have found the same findings in their studies (Malone, 1990:7; George, 1995:24).**	4	12.6
• **No improvement on the treatment. The patient decided to seek for help from other sources like traditional healer. Gaborone (1990:9) and Freeman *et al.* (1994:59) agree with the findings.**	2	6.2
• **No apparent reason. The patient refuses to go to the clinic without any reason. This is common if patients are not well informed about their illness. Crane *et al.* (1996:15) indicated this information in their studies.**	3	9.4
• **Physical illness. Difficulty in walking especially in old age. This problem has been identified in some studies (Freeman *et al.*, 1994:116).**	3	9.4
• **Influence from friends, labelling patients mentally ill persons. The patient felt embarrassed to go to the clinic. Crane *et al.* (1996:10) found the same results in their studies.**	2	6.2
• **Substance abuse: The patient drinking alcohol and smoking dagga are easily influenced by the environment and friends.**	2	6.2
• **Laziness: The patient reported to be feeling tired and lazy to go to the clinic. Freeman *et al.* (1994:59) found the same reasons of non-compliance.**	1	3.1
• **Financial problem: The patient may have no money for the transport to go to the clinic, especially if they depend on a disability grant. The same findings were indicated in some studies (Freeman *et al.*, 1994:116).**	1	3.1
• **Employment: The patient who is working may have no time to go to the clinic especially if the employer is uncooperative (Freeman *et al.*, 1994:65; Crane *et al.*, 1996:15).**	2	6.2

TABLE 4.2: The possible reasons for missed clinic appointments

REASONS	N	%
• **Poor nurse-patient relationship: Negative attitudes of nurses toward patients: shouting at them, addressing them disrespectfully, and speaking harshly to them. This was indicated by patients and their relatives (Falloon, Boyd & McGill, 1987:295; Crane *et al.*, 1996:8)**	2	6.2
• **Nobody to accompany the patient to the clinic when family members are working. Some patients are dependent and cannot go to the clinic alone (Freeman *et al.*, 1994:65)**	1	3.1

4.5 CONCLUSION

A similar open-ended question as on Table 4.2 was designed for the patients as respondents. Similarities of the responses from the two groups of respondents [the patients and family members] were detected concerning the possible reasons for missed clinic appointments. According to the findings, patient and family respondents concurred in citing the side-effects of the psychotropic drugs as the most common and principal reasons for missing clinic appointments. Some authors and researchers have also identified the reason of side-effects of drugs as the main and common problem causing missed clinic appointments or non-compliance [Caton, 1989:77; Malone, 1990:7; Poggenpoel, 1993:24; Freeman *et al.*, 1994:86].

4.6 SUMMARY OF RESPONSES TO QUESTIONS, NUMBER OF RESPONDENTS AND PERCENTAGE PRESENTED

Question 1-7 below are concerned with the biographical details of the respondents [patients].

DEMOGRAPHIC DATA

TABLE 4.3: Question 1-7

Question 1	*Gender*	*N*	*%*
	Male	12	37.5
	Female	20	62.5
Question 2	*Age*	*N*	*%*
	19-28	7	21.9
	29-38	8	25.0
	39-48	4	12.5
	49-58	8	25.0
	59-68	4	12.5
	69+	1	3.1
Question 3	*Marital status*	*N*	*%*
	Never married	17	53.1
	Married	5	15.6
	Divorced/separated	7	18.8
	Widowed	3	9.4
	Living together	1	3.1
	Other	-	-
Question 4	*Educational status*	*N*	*%*
	Never went to school	6	18.8
	Primary Grades (1-7)	13	40.6
	Secondary Grades (8-12)	12	37.5
	Tertiary	1	3.1
Question 5	*Occupation*	*N*	*%*
	Employed	3	9.3
	Unemployed	23	72.0
	Student	1	3.1
	Pensioner/disability grant	5	15.6
	Other	-	-
Question 6	*How many children do you have?*	*N*	*%*
	None	9	28.1
	1-2	15	47.0
	3-5	7	21.8
	More than 5	1	3.1

TABLE 4.4: Question 7-9: General questions to test patients' knowledge, insight and responsibility towards the illness

Question 7	*How long have you been treated for this illness?*	*N*	*%*
	0-3 months	3	9.3
	4-7 months	10	31.2
	8-12 months	13	41.0
	More than one year	16	18.5
Question 8	*Are you aware that you are ill and require medical help?*	*N*	*%*
	Yes	26	81.2
	No	3	9.4
	Do not know	3	9.4
Question 9	*Do you have to be reminded for your clinic appointments?*	*N*	*%*
	Yes	11	34.0
	No	14	44.0
	Not always	7	22.0

TABLE 4.5: Question 10-17: To determine possible reasons for missed clinic appointments (to be continued)

Question 10	*Do you at times hear voices commanding you not to go to the clinic?*	*N*	*%*
	Yes	12	37.5
	No	9	28.1
	Seldom	11	34.4
Question 11	*Do you believe that your condition will improve when attending the clinic for treatment?*	*N*	*%*
	Yes	23	71.8
	No	9	28.1
	Do not know	-	-
Question 12	*Do you at times feel heaviness in the head which affects your decision making?*	*N*	*%*
	Yes	24	75.0
	No	8	25.0
Question 13	*Do you know what is the day of the week, month and year?*	*N*	*%*
	Yes	23	71.9
	No	9	28.1
Question 13.1	*If yes, state the following*	*N*	*%*
	1. Day correct	15	46.9
	2. Month correct	8	25.0
	3. Year correct	9	28.1
Question 14	*Do you have friends?*	*N*	*%*
	Yes	26	81.3
	No	6	18.7

TABLE 4.5: Question 10-17: To determine possible reasons for missed clinic appointments

Question 14.1	*If yes, how often do you visit one another?*	*N*	*%*
	Daily	17	53.1
	Weekly	5	15.6
	Monthly	3	9.4
	Other	1	3.1
	Anytime day or night	6	18.8
Question 15	*Does physical illness prevent you from going to the clinic?*	*N*	*%*
	Yes	9	28.1
	No	12	37.5
	Sometimes	11	34.4
Question 16	*Do you feel embarrassed to go to the clinic because of your illness?*	*N*	*%*
	Yes	5	15.6
	No	27	84.4
Question 16.1	*If yes, please explain why*	*N*	*%*
	• Not mentally ill	1	3.1
	• Afraid of infection	2	6.2
	• My friends rejected me	1	3.1
	• People are afraid of me	1	3.1
Question 17	*Which other places have you visited to seek help for your illness*	*N*	*%*
	No where	-	-
	Private doctor	3	9.5
	Traditional/faith healer	10	31.2
	Other: Hospital	19	59.3

TABLE 4.6: Question 18-20: To determine lack of family support and transport as possible reason for missed clinic appointments (to be continued)

Question 18	*Do you get support from your family during your illness?*	*N*	*%*
	Yes	30	93.8
	No	2	6.2
Question 19	*Does any member of your family accompany you to the clinic?*	*N*	*%*
	Yes	11	34.4
	No	10	31.2
	Not always	11	34.4
Question 20	*Do you have to use transport to go to the clinic?*	*N*	*%*
	Yes	2	6.2
	No	30	93.8

TABLE 4.6: Question 18-20: To determine lack of family support and transport as possible reason for missed clinic appointments

Question 20.1	*If yes, is the transport affordable financially?*	*N*	*%*
	Yes	2	6.2
	No	-	-
	N/A	30	93.8
Question 20.2	*Is the transport always available? General question to all respondents*	*N*	*%*
	Yes	4	12.5
	No	3	9.0
	Not always	3	9.0
	Other	22	68.9

TABLE 4.7: Question 21-29: Health services and medication as possible reasons for missed clinic appointments (to be continued)

Question 21	*Do you have to wait for along time before seen at the clinic?*	*N*	*%*
	Yes	4	12.5
	No	28	87.5
	At times	-	-
Question 21.1	*If yes, how long do you wait?*	*N*	*%*
	Less than a hour	24	75.0
	More than a hour	8	25.0
Question 21.2	*If yes, does the waiting procedure cause any problems?*	*N*	*%*
	Yes	7	22.0
	No	25	78.0
Question 21.3	*If yes, please explain*	*N*	*%*
	• Feels tired	2	6.2
	• Boredom	2	6.2
	• Becomes hungry	2	6.2
	• Expected to go to work	1	3.1
Question 22	*Do the nurses treat you well at the clinic?*	*N*	*%*
	Yes	28	87.5
	No	4	12.5
Question 22.1	*If no, please explain*	*N*	*%*
	• They shout at us	2	6.2
	• Do not like me	1	3.1
	• Some nurses do not address us correctly	1	3.1
Question 23	*What type is your current treatment?*	*N*	*%*
	Injection	24	75.0
	Tablets	6	19.0
	None	2	6.0
	Other	-	-

TABLE 4.7: Question 21-29: Health services and medication as possible reasons for missed clinic appointments

Question 24	*How regularly do you have to take medication?*	*N*	*%*
	0-2 weekly	3	9.4
	Monthly	29	90.6
	Other	-	-
Question 25	*Do you at times develop tremors and stiffness of the body when taking medication?*	*N*	*%*
	Yes	28	87.5
	No	4	12.5
Question 26	*Do you experience other symptoms besides stiffness of the body?*	*N*	*%*
	Yes	25	78.0
	No	7	22.0
Question 26.1	*If yes, please explain*	*N*	*%*
	• Side-effects	10	31.2
	• Physical illness	3	9.3
	• Headache	4	12.5
	• Sleepy/drowsy	2	6.2
	• Overeating	1	3.1
	• Hallucinations	5	15.6
Question 27	*How do you feel when taking medication?*	*N*	*%*
	No change	7	21.9
	Well	13	40.6
	Ill	8	25.0
	Other	4	12.5
Question 28	*Have you ever been admitted to the hospital for the same illness?*	*N*	*%*
	Yes	31	96.9
	No	1	3.1
Question 28.1	*If yes, on discharge were you given a letter to take to the clinic for the next appointment?*	*N*	*%*
	Yes	30	95.7
	No	2	6.3
Question 28.2	*If yes to 28.1, did you know where the clinic was?*	*N*	*%*
	Yes	29	90.6
	No	3	9.4
Question 29	*If working, is your employer aware of your illness?*	*N*	*%*
	Yes	2	67.0
	No	1	33.0
	Do not know	-	-
Question 29.1	*If yes, is your employer supportive by making time available for you to go to the clinic?*	*N*	*%*
	Yes	1	50.0
	No	1	50.0
	Other	-	-

TABLE 4.8: Question 30-31: Other possible reasons for missed clinic appointments

Question 30	*Do you need more information about your illness*	*N*	*%*
	Yes	25	78.1
	No	5	15.6
	Other	2	6.3
Question 31	*Are there any reasons preventing you from going to the clinic?*	*N*	*%*
	Yes	24	75.0
	No	7	21.9
	Other	1	3.1
Question 31.1	*If yes, give reasons*	*N*	*%*
	1. Weather conditions	1	3.1
	2. Headaches	4	12.5
	3. Forgetfulness	1	3.1
	4. Physical illness	2	6.3
	5. Side-effects	6	19.0
	6. Does not want injection	2	6.3
	7. Employment conditions	1	3.1
	8. Feels well	2	6.3
	9. Looking after children	1	3.1
	10. Financial problems	2	6.3
	11. No clean clothes	1	3.1
	12. Looking after sick mother	1	3.1

4.7 FAMILY MEMBERS AS RESPONDENTS

Question 1-7 are to determine the relationship between the respondent and the patient.

TABLE 4.9: Question 1-7: Relationship between the respondents and the patient (to be continued)

Question 1	*What is your relationship with X*	*N*	*%*
	Mother	6	18.8
	Father	6	18.8
	Brother	2	6.2
	Sister	3	9.4
	Other:		
	• Husband	6	18.8
	• Wife	5	15.6
	• Cousin	1	3.1
	• Aunt	2	6.2
	• Uncle	1	3.1

TABLE 4.9: Question 1-7: Relationship between the respondents and the patient (to be continued)

Question 2	*Does X stay with you?*	*N*	*%*
	Yes	32	100.0
	No	-	-
Question 3	*When did you first realized that X was getting ill?*	*N*	*%*
	Days	18	56.0
	Months	14	44.0
	Years	-	-
Question 4	*What did you do at the time of the illness?*	*N*	*%*
	Took X to the clinic	18	56.0
	Took X to the private doctor	1	3.0
	Took X to the hospital	13	41.0
	Took X to the traditional healer	-	-
	Other	-	-
Question 5	*Has X ever been admitted to the hospital for his/her illness?*	*N*	*%*
	Yes	30	93.8
	No	2	6.3
Question 5.1	*If yes to 5., how long was X admitted?*	*N*	*%*
	Days	10	31.0
	Months	16	50.0
	Years	6	19.0
Question 5.2	*On discharge was X given a letter to take to the clinic?*	*N*	*%*
	Yes	24	75.0
	No	6	19.0
	Do not know	1	3.0
	Other	1	3.0
Question 6	*Do you know that X is not attending the clinic?*	*N*	*%*
	Yes	25	78.0
	No	7	22.0
Question 7	*Do you experience any problems with X when not taking treatment?*	*N*	*%*
	Yes	21	66.0
	No	11	34.0
Question 7.1	*If yes to 7., explain and give examples*	*N*	*%*
	• Aimlessly restless	4	19.0
	• Aggressive, assaultive fights people	3	14.2
	• Asocial, sits alone, talking to him-/herself	3	14.2
	• Physically ill	2	9.5
	• Poor personal hygiene, refuses to wash	8	38.0
	• Refuses meals	1	5.0
	• Abnormal sleeping patterns, sleeps late, wakes up early	6	28.5
	• Substance abuse	2	9.5
	• Unco-operative, refuses to go to the clinic	1	5.0
	• Refuses to do housework or gardening	2	9.5
	• Disappears from home for days	2	9.5

TABLE 4.9: Question 1-7: Relationship between the respondents and the patient

Question 8	What do you think are the possible reasons for the patient to miss clinic appointments?	N	%
	• Poor nurse-patient relationship (some nurses are shouting at them)	1	3.1
	• Side-effects: Injection causes tremors	9	28.1
	• Patient feels well	4	13.0
	• No improvement on treatment	2	6.2
	• Physical illness (difficulty in walking)	2	6.2
	• Influence from friend labelling them "mad persons"	2	6.2
	• Smokes dagga	2	6.2
	• Laziness	1	3.1
	• No apparent reason	3	9.3
	• Patient claimed to be discharged	1	3.1
	• Working (no time to go to the clinic)	2	6.2
	• No money for transport	1	3.1
	• Old age (unable to walk)	1	3.1
	• Nobody to accompany the patient to the clinic	1	3.1

4.8 CONCLUSION

According to the findings, the information which was obtained from the patients and the family members (respondents) regarding the possible reasons for missed clinic appointments revealed some similarities when the following contributory factors were indicated:

- The nature of the illess
- Physical illness and abnormal behaviour
- Financial background of the family
- Cultural beliefs and the stigma attached to the illness
- The health services which include the medication (side-effects), the health workers attitudes and the length of time waiting in queues which exceeds a hour
- The employers who are not supportive
- Other general factors e.g. influence from friends

Missed clinic appointments appear to be a problem which requires teamwork including the healthworkers, the patient, the family and the community as a whole. Informative sessions about the mental illnesses and the management might improve compliance.

CHAPTER 5

Conclusions and recommendations

5.1 INTRODUCTION

The findings of this study highlighted several aspects that influence missed clinic appointments among patients who are suffering from schizophrenia.

5.2 POSSIBLE REASONS FOR MISSED CLINIC APPOIONTMENTS

5.2.1 Most common possible reasons

TABLE 5.1: Most common possible reasons

REASONS	*N*	*%*
Side-effects of medication	9	28.1
Stopped treatment after feeling well	4	12.5
No apparent reason	3	9.3
Physical illnesses and difficulty in walking to the clinic	3	9.3
Influence from friends not to go to the clinic due to the stigma attached to mental illness	2	6.3
Substance abuse (alcohol and dagga)	2	6.3
Employment (no time provided to go to the clinic)	2	6.3
Poor nurse-patient relationship	2	6.3
No improvement on the treatment	2	6.3

5.2.2 Less common possible reasons

TABLE 5.2: Less common possible reasons

REASONS	N	%
Financial problems for the transport	1	3.1
Lack of family support to accompany the patient to the clinic	1	3.1
Lack of motivation to go to the clinic	1	3.1

There are other reasons which were mentioned together with the above possible reasons by the same respondents which could have contributed to missed clinic appointments such as:

- Bad weather (raining or cold weather)
- Forgetfulness
- Dislike injection
- Looking after children and sick family members
- No clean clothes to wear

The above-mentioned possible reasons for missed clinic appointments which resulted into the problems, need nursing interventions which could make it possible to attain the set objectives.

5.3 THE SOLUTIONS TO THE POSSIBLE REASONS SEEM TO FALL INTO A FEW CATEGORIES

TABLE 5.3: Solutions (to be continued)

CATEGORY	NURSING GUIDE-LINES
Education	I The patient ➢ Programmed learning about medication and its side-effects. ➢ Involvement of the patient in monitoring his/her condition (knowledge about side-effects of medication will build tolerance and strive for improvement). ➢ Education regarding the course of mental illness, including early signs and symptoms, and also management. ➢ Give information about the consequences of stopping the treatment which may cause a relapse and readmission. ➢ Provide information about the importance of injection (for those who dislike injection), to ensure compliance. ➢ Organise group discussions and give health education to patients who are waiting to be seen at the clinic. ➢ Use audio-visual aids for information. II The family ➢ Education of the family regarding mental illness, management, and side-effects of drugs. ➢ Give information about the importance of taking medication regularly and after care services to prevent relapse. III The nurses ➢ Organise meetings and workshops to discuss the importance of positive attitude to encourage clinic attendance. ➢ In service training on the necessary nursing skills of communication, listening, observation and interpersonal relations to improve good nurse-patient relationship

TABLE 5.3: Solutions (to be continued)

CATEGORY	*NURSING GUIDE-LINES*
Aspects in the clinic	I Waiting time ➢ Organise group discussion about health promotion matters. ➢ Health education through video, overhead projectors, slides, pamphlets, personal talks or audio cassettes. II Availability of drugs ➢ Ensure that enough medication is ordered and kept in stock at the clinics. ➢ Individualize treatment to meet the needs of the patient e.g. sedatives to be taken at night to avoid droopiness during the day. ➢ Oral medication for patients who dislike injection, depending on the state of mental illness. ➢ Regular evaluation of patients who are on treatment for early detection of side-effects. ➢ Avoid exceeding the dosage of drugs. ➢ Avoid pharmacotherapy unless the need arises ➢ Administration of anti-Parkinsonisms drugs immediately when the side-effects of medication is detected or when the patient is given high dose of Fluphenazine Injection. ➢ Simplification of the scheme. Less complex scheme where the patient is given few tablets or treatment once monthly. Many packets of different tablets may cause confusion and non-compliance. III Staff attitudes and nurse-patient relationship ➢ Promote job satisfaction among personnel by listening to their problems and obtain solutions. This would increase motivation and performance. ➢ Community involvement in the health activities and promotion of good interpersonal relationship between the staff and community. ➢ Incentives for personnel in the form of certificates, merit awards performance appraisals and promotions.

TABLE 5.3: Solutions

CATEGORY	*NURSING GUIDE-LINES*
Support	➢ Organise support group for nurses to assist with the management of patients even if a person is not a trained psychiatric nurse. An inservice training would improve an individual's skills and knowledge in mental health. ➢ Organise support group at the clinics by involving the community. Voluntary workers may be utilized to keep the patients occupied by means of activities, group discussions, and to encourage compliance. ➢ A support group may be allocated to do home visits to motivate patients to attend the clinics as indicated on the appointment card. ➢ Encourage family support by involvement in the education of patient's management. ➢ Encourage the community to accept mental illness like any other physical illness, and assist in the utilization of health services as relevant source of help. ➢ Encourage employers support by planning orientation sessions to inform them about the importance of after care services for their employees. ➢ Maintain good interpersonal relationship between the health personnel and the employers. The psychiatric nurse should act as a middle man between the employer and the patients. ➢ Encourage the family to support the patient financially for the public transport if it is needed to go to the clinic. ➢ Recommendation for disability grant if the patient qualifies for the grant due to the illness. ➢ Community participation to encourage compliance. Organisations and churches should be used to remind people about clinic appointments. ➢ Media like radio, loudspeaker to remind people and pamphlets would be useful. (This is a general reminder.)
General factors	➢ To improve interest and motivation recognition of patients who comply for medication by means of awards e.g. certificates, small trophies yearly for the best patient. ➢ Organise openday celebration involving patients to participate in activities such as music, role players and sports. ➢ Organise trips for recreational purpose to game resorts or entertainment centres annually. ➢ Maintain suitable temperature in the waiting area depending on the climate (warm in winter and cool in summer) ➢ Home visits to motivate clinic attendances. Voluntary workers to be utilized. ➢ Arrange for rehabilitation sessions for patients who misuse alcohol and drugs. ➢ Encourage utilization of health se5rvices for physical illnesses and not wait for the appointment dates for mental health. ➢ To remind the patients for appointment dates, use calendars, and diaries. ➢ Appointment cards to be clearly written. Coloured pen to be used.

5.4 LIMITATIONS

Some information which could have been omitted, and reluctance of the respondents to give the required information might have decreased generalizability of the findings.

5.4.1 General limitations

5.4.1.1 Patients as respondents

- **Nature of the illness**

The characteristics of the illness could have influenced the respondent's ability to participate fully during the interview. The following characteristics are common:

- Hallucinations and delusions
- Thought disorders (asocial behaviour)
- Social breakdown syndrome
- Ambivalence
- Disorientation
- Poor cognitive functioning

Some of the mentioned characteristics could have influenced collection of required information. A problem with cognitive functioning of the patients who are suffering from schizophrenia influences communication and understanding of the patients and might interfere with a collection of required information.

■ Forgetfulness

During the interviews when referring to Question 9 [in the questionnaire format] which tested the memory, 9 [28.1%] of the respondents aged between 58-69 years were forgetful and could not remember dates for clinic appointments.

■ Hallucinations and delusions

The respondents might have been preoccupied with auditory hallucinations or delusional thoughts and therefore, might have limited their ability to participate fully in the research interview. Three percent of the sample reported heaviness in the head which was affecting their thinking ability.

■ Ambivalent feelings

It may be difficult for the patient to make a choice when answering question which consist of "yes" or "no" response. Decision-making is affected.

■ Disorientation

According to the questionnaire, question number 13 to test orientation, indicated that some of the respondents [28.1%] were disorientated for time only. The majority were orientated for self time and place.

5.4.1.2 Family members as respondents

- **Cultural influence**

In responding to the question regarding the preferred source of help, one of the respondents strongly believed that mental illness is related to witch craft, and the patient could only be cured by the traditional healers. Cultural influence limited the respondent to think objectively to answer the question in the questionnaire.

5.4.2 Methodological limitations

5.4.2.1 Sample size

Sample size might have been too small to generalize the characteristics of the population geographically. Five clinics out of 13 clinics at Botshabelo have been selected, which might not generalize the results. Other areas except Botshabelo were not included.

5.4.2.2 Data collection instrument

During the interviews a questionnaire may have not collected all the required information as it has been indicated that other respondents (patients and family members) were reluctant and showed no interest to give information regarding certain questions e.g. Question 8 some of the patients showed denial about the illness.

Many close-ended questions in the patients questionnaire might have limited the information which could have indicated the possible reasons for missed

clinic appointments. Most of the questions asked were answered with "yes" or "no" response.

Subconscious non-verbal communication from the interviewer could have influenced the interviewee as the interviewer and the researcher were the same person.

5.5 CONCLUSION

The findings of this study indicated that the major reason for missed clinic appointments among patients who are suffering from schizophrenia, is a fear of medication side-effects. The patients who have been on psychotropic drugs and experienced side-effects, stop attending the clinic for continuation of treatment.

The other possible reasons for missed clinic appointments indicated to be related with the environment, the family, community, health services and the nature of the illness which affects the patient psychologically, physically, socially and financially. Involvement of the family and the community in the prevention of mental illness, and providing support to the patient would enhance compliance.

SUMMARY

THE REASONS WHY PATIENTS SUFFERING FROM SCHIZOPHRENIA MISS CLINIC APPOINTMENTS

M.F. Mogodie

SUPERVISOR: **Dr. Lily van Rhyn**

CO-SUPERVISOR: **Miss Idalia Venter**

Missed clinic appointments among the patients who are suffering from schizophrenia has been identified through the statistical records at Botshabelo psychiatric clinic. Missed clinic appointments remain a world-wide problem which results from the nature of the illness, the patient, the family, health services, culture, employment and other environmental factors.

A conceptual model which is based on the principles of the system theory has been discussed and indicated that the patient as part of the system is easily influenced by the environmental factors and the illness itself to stop visiting the clinic for treatment. During missed clinic appointments there is a break or cut between the patient and the clinic due to subsystems which play the negative role within a system (Fawcett, 1989:63).

The purpose of the study was to determine the possible reasons for missed clinic appointments for patients who are suffering from schizophrenia and to suggest nursing guidelines to enhance clinic attendances.

Quantitative research methodology using descriptive and exploratory designs was chosen. **The population** consisted of the patients who are suffering from schizophrenia referred to the clinics between January 1995 and January 1996, and missed clinic appointments twice or more within a period of 12 months, both females and males, ages from 19 years and above were included.

Sampling procedure was purposive consisting of two groups. Group A were patients who are suffering from schizophrenia and missed clinic appointments twice or more and Group B consisted of one immediate family member for each patient who was identified in the patient's record, and who live with the identified patient.

A pilot study was done to test the reliability and validity of the data-collecting instrument. Two patients and two family members were selected for the pilot study and were not included in the main study.

To verify reliability and validity of the instrument some of the experts were contacted as follows:

- Nursing Research Committee at the University of the Orange Free State.
- Ethics Committee at the Faculty of Health Sciences, University of Orange Free State.
- Computer Science personnel at the same university.
- Clinical psychiatric nursing personnel who are experienced in the psychiatric field.
- The researcher herself who acquires necessary skills in psychiatric nursing and experience played an important role to ensure reliability and validity of the instrument.

Data collection was done using a semi-structured interview aided by a questionnaire. Both closed and open-ended questions were designed to obtain

the required information. Questionnaires used were completed by the researcher to counteract illiteracy among the respondents. Data was coded by the computer centre at the University of Orange Free State. Analysis and interpretation of data was done by the researcher using graphs and tables.

Ethical consideration was maintained. Informed consent was obtained from the respondents. Privacy, confidentiality, person with diminished autonomy and right to protection from discomfort and harm was maintained throughout the study.

The results indicated that the major reason for missed clinic appointments among patients who are suffering from schizophrenia, is a fear of medication side-effects. This occurs to the patients who have been on treatment before, and experienced side-effects of medication (28.1 %).

The other reasons which appear to be caused by a lack of knowledge about the importance of aftercare management are as follows:

- Feeling well when not on treatment
- The patient stayed at home with no apparent reason
- Poor nurse-patient relationship
- Substance abuse
- Stigma attached to mental illness

All these reasons remain problem, which require immediate and long-term solutions.

Recommendations to address these problems were made by the researcher and the nursing guide-lines as explained.

OPSOMMING

'N ONDERSOEK NA DIE REDES WAAROM PASIËNTE WAT AAN SKISOFRENIE LY NIE HUL KLINIEK-AFSPRAKE NAKOM NIE

M.F. Mogodie

PROMOTOR: **Dr. Lily van Rhyn**

MEDE-PROMOTOR: **Miss Idalia Venter**

Versuim om kliniekafsprake na te kom is deur middel van statistiese rekords by die Botshabelo psigiatriese kliniek geïdentifiseer. Hierdie versuim is 'n wêreldwye probleem en is die gevolg van die aard van die siekte, die pasiënt, die familie, gesondheidesdienste, kultuur, werk en ander omgewingsfaktore.

'n Konseptuele model wat op die sisteemteorie gebaseer is, is bespreek. Dit het aangedui dat die pasiënt, as deel van die sisteem, maklik deur omgewingsfaktore en die siekte self beïnvloed word om op te hou om die kliniek vir behandeling te besoek. Kliniekafsprake wat nie nagekom word nie, veroorsaak 'n breuk tussen die pasiënt en die kliniek weens subsisteme wat 'n negatiewe rol binne die sisteem speel (Fawcett, 1989:63).

Die doelstelling van die studie was om die moontlike redes vir afsprake wat nie deur pasiënte met skisofrenie nagekom word nie, vas te stel. **Die doelwit** van die studie was om die moontlike rede vir afsprake wat nie

nagekom word nie, te bepaal en om strategieë vir beter kliniek bywoning voor te stel.

'n Kwantitatiewe navorsingsmetodologie met die gebruik van beskrywende en verkennende ontwerpe is geselekteer. **Die populasie** was die pasiënte met skisofrenie wat tussen Januarie 1995 en Januarie 1996 na die kliniek verwys is en wat twee of meer keer binne 'n periode van 12 maande versuim het om hul afsprake na te kom. Mans en vroue van 19 jaar en ouer is ingesluit.

Doelgerigte bemonstering met twee groepe is gebruik. Groep A het bestaan uit pasiënte met skisofrenie wat twee of meer keer nie hul afsprake nagekom het nie en Groep B uit een gesinslid van elke pasiënt wat in die pasiëntrekord geïdentifiseer is en wat saam met die pasiënt gewoon het.

'n Loodsstudie is uitgevoer om die betroubaarheid en geldigheid van die data versamelingsinstrument te toets. Twee pasiënte en twee gesinslede wat nie aan die hoofstudie deelgeneem het nie, is vir die loodsstudie geselekteer.

Die volgende kundiges is genooi om die geldigheid en betroubaarheid van die instrument te verifieer:

- Die verpleegkundige navorsingskomitee aan die Universiteit van die Oranje-Vrystaat
- Die etiekkomitee van die Fakulteit van Gesondheidswetenskappe aan die Universiteit van die Oranje-Vrystaat
- Die personeel van die rekenaarsentrum van bogenoemde universiteit
- Ervare kliniese psigiatriese verpleegpersoneel
- Die navorser, wat die nodige vaardighede in psigiatriese verpleegkunde verwerf het, het self 'n belangrike rol gespeel om die betroubaarheid en geldigheid van die instrument te verseker.

Data is deur middel van 'n semi-gestruktureerde onderhoud met behulp van 'n vraelys versamel. Beide geslote en oop-einde vrae is ontwerp om die verlangde inligting te bekom. Die vraelys is deur die navorser ingevul weens die ongeletterdheid van die respondente. Die data is deur die rekenaarsentrum aan die Universiteit van die Oranje-Vrystaat gekodeer. Die navorser het die data met behulp van grafieke en tabelle geanaliseer en geïnterpreteer.

Etiese oorwegings is voor oë gehou en ingeligte toestemming is van die respondente verkry. Privaatheid en vertroulikheid en die reg tot beskerming teen ongemak en skade is deurlopend verseker, ook van diegene met verminderde outonomie.

Die resultate dui daarop dat die hoofrede vir die mis van kliniek afsprake wat vrees vir die newe-effekte van medikasie. Dit gebeur met pasiënte wat op behandeling was en newe-effekte ondervind het in 28.1 % van gevalle.

Die ander redes wat dui op 'n gebrek aan kennis oor die belangrikheid van nasorg is as volg:

- Die pasiënt voel goed wanneer nie op behandeling
- Die pasiënt bly tuis sonder rede
- Swak verpleegkundige- pasiënt verhoudings
- Substans misbruik
- Stigma gekoippel aan psigiatriese siekte

Alle redes bly probleme wat onmiddellike en langtermyn oplossings vereis.

Voorstelle om die probleme aan te spreek, is gemaak deur die navorser en deur die verpleegriglyne soos verduidelik.

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ANNEXURE A
Letter

THE UNIVERSITY OF THE ORANGE FREE STATE

FACULTY OF MEDICINE
BOX 339 BLOEMFONTEIN 9300 REPUBLIC OF SOUTH AFRICA
TEL (051) 405 3012 FAX(051) 480-967

25

Mrs Niemand Tel 4053004 23rd September 1997

MRS MF MOGODIE
SCHOOL FOR NURSING
U O F S

Dear Mrs Mogodie

ETOVS NUMBER 195/97
RESEARCHER: MRS MF MOGODIE
PROJECT TITLE: MISSED CLINIC APPOINTMENTS AMONG PATIENTS SUFFERING FROM SCHIZOPHRENIA.

The abovementioned project was approved by the Ethics Committee during their meeting held on the 23rd September 1997.

Your attention is kindly drawn to the requirement that a progress report be presented not later than one year after approval of the project.

Would you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries.

Yours faithfully

for DIRECTOR: MEDICINE ADMINISTRATION
/hs

UOVS

ETHICS COMMITTEE

FOR MEDICAL RESEARCH

ATTENDANCE LIST OF THE MEETING HELD ON 23 SEPTEMBER 1997

FACULTY MEMBERS (CLINICAL)

Prof PH Wessels	**Chairman** M.B.Ch.B.,M.Med. (O.et G.)(UOFS), F.C.O.G. (SA) Department: Obstetrics and Gynaecology	Present
Prof BB Hoek	**Vice-chairman** M.B. Ch.B. (Pret), M.Med. (Paed.) (UOFS), D.G.G. (UOFS) Department: Paediatrics and Child Health	Absent
Prof L Goedhals	M.B. Ch.B. (U.C.T.) M.Med (Rad.T.) UOFS Department: Oncotherapy	Present
Prof MVJ v Vuuren	M.B. Ch.B. (Pret) M. Prax. Med. (Pret) MRCGP (London) Dip. Forensic Med. (SA) Department: Family Medicine	Present
Prof BJS Diedericks	M.B. Ch.B. (UOFS), M.Med (Anes) (UOFS) FCA (SA), B.A. (UNISA) Department Anaesthesiology	Present
Prof R Barry	M.B. Ch.B. (Stell.), M.Med. (Surgery) (UOFS) Department: Surgery	Absent

EX OFFICIO MEMBERS:

Dr Vossie Pienaar	B.Ch.D. (Pret.), DGA (UOFS) Chief Medical Superintendent, Pelonomi Hospital	
Dr WH Kruger *(Secundus)*	M.B. Ch.B.; M.Med. (UOFS) Dept. Community Health Temporary: Acting Medical Superintendent Pelonomi Hospital	Present

Dr L Fouché (Lady)	M.B. Ch.B., (Pret) Senior Medical Superintendent: Universitas Hospital	Absent

RELIGIOUS MEMBER:

Rev D Keta (Coloured)	B.Th. (University of the North) B.Th. (Hons.) (UNISA) Department Biblical Studies	Present
Rev MG Pienaar *(Secundus)*	M.A., B.Th. (Pret) Chaplain at the Universitas Hospital, Bloemfontein	

LEGAL MEMBER:

Dr H Oosthuizen	B.Iur., LL.B., LL.D. (UOFS) Department: Criminal Law	Present
Dr CP vd M Fick *(Secundus)*	P.T.C (Paarl) B. Iuris, LL.B., LL.D., (UOFS) Department of Criminal Law and Medical Law.	

NURSING REPRESENTATIVE:

Prof M Mulder (Lady)	Hons B.Soc.Sc Nursing (UOFS) M.Soc.Sc.Nursing (UOFS) D.Soc.Sc. Nursing (UOFS) Department of Nursing	Absent

LAY MEMBER:

Mrs F Mogorosi (Lady) (Black)		Absent
Ins P Mothabeng (Black) *(Secundus)*	Matriculation N.Dip. Police Administration Southern Free State Co-Ordinator on Community Policing / FORA	Present

for DIRECTOR: MEDICINE ADMINISTRATION
/hs

ANNEXURE B
Informed consent form

INFORMED CONSENT FORM

STUDY TITLE: **The reasons why some patients suffering from Schizophrenia miss clinic appointments**

RESEARCHER: **M.F. Mogodie**

Mrs. Mogodie is a registered nurse studying the **problem** of missed clinic appointments among the patients who are suffering from Schizophrenia at Botshabelo. **The purpose** of this study is to determine the possible reasons for missed clinic appointments among patients who are suffering from Schizophrenia. This study will benefit you by providing information that might improve clinic attendances. The study procedure involves no foreseeable risks or harm to you or your family (potential risks). Participation in this study will take approximately 20 minutes. You are free to ask any questions about the study. Your participation in this study is **voluntary**; and you are under no obligation to participate. You have the right to withdraw at any time. The study data will be coded so there will be no link to your name, your identity will not be revealed while the study is being conducted, or when the study is reported or published. All information will be collected by Mrs. Mogodie, stored in a secure place and not shared with any other person without your permission.

I have read this consent form and voluntarily consent to participate in this study.

SUBJECT SIGNATURE	**DATE**
RELATIONSHIP TO SUBJECT	**DATE**

I have explained this study to the above subject and have his/her understanding for informed consent.

RESEARCHER'S SIGNATURE	**DATE**

INFORMED CONSENT FORM

STUDY TITLE: **Dipatlisiso tsa ho tseba hore hobaneng bakudi ba lefu la hloho (Schizophrenia) ba sa ihlahisi kliniking ka letsatsi leo ba le baletsweng**

MOHLAHLOBI: **M.F. Mogodie (Mooki dikliniking tsa Botshabelo)**

Sepheo sa boithuto bona ke ho fumana mabaka a etsang hore bakudi ba schizophrenia ba hlolehe ho ihlahisa kliniking ka letsatsi leo ba le baletsweng. Boithuto bona bo tla le tswela molemo ka ho le fumantsa hlahiso leseding eo ka yona dipalo tsa ba tlang kliniking mohlomong di ka nyolohang. Ha ho na kotsi kapa mathata ao ka kopanang le oona ka ho kenela boithuto bona. Ke feela metsotso e mashome a mabedi ee hlokehang ho motho ea nkang karolo boithutong bona. Ke boikgetelo ho nka karolo boithutong bona ha ho motho ea qobelloang. U na le tokelo ea ho emisa ho tswelapele ka boithuto bona nako e nngwe le e nngwe. Boithutong bona ha hona mohla lebitso la hau le tla hlahelang hobane ho tla sebediswa dinomoro. Tsohle tse fumanweng ke mofumahali M.F. Mogodie, di tla bolokwa ka hloko mme ha di na ho bolellwa mang kapa mang ntle le tumello ea hau.

Ke badile tsohle tse ka hodimo mme ka boithaopo ba ka ke dumela ho nka karolo boithutong bona.

MOITHAOPI	**MOHLA**
OA LELAPA	**MOHLA**
DIKAMANO	**MOHLA**

Ke hlalositse boithuto bona ho moithaopi ea saennang ka hodimo mme u utlwisisa tsohle tseo.

TSHAENO EA MOHLAHLOBI	**MOHLA**

ANNEXURE C
Patients: Questionnaire form

THE PROBLEM OF MISSED APPOINTMENTS AMONG THE PATIENTS SUFFERING FROM SCHIZOPHRENIA IN BOTSHABELO

PATIENTS: QUESTIONNAIRE FORM

For office use only

N.B.: MAKE A CROSS IN THE APPROPRIATE BOX

Subject No. [ ][ ][ ] 1-2

1. Gender

Male	1	
Female	2	3

2. Age

19-28	1	
29-38	2	
39-48	3	
49-58	4	
59-68	5	
69 +	6	4

3. Marital status

Never married	1	
Married	2	
Divorced/Separated	3	
Widowed	4	
Living together	5	
Other (specify)	6	5

4. Educational status

Never went to school	1	
Primary (Grades 1-7)	2	
Secondary Grades 8-12)	3	
Teriary (specify)	4	6

5. Occupation

Employed	1	
Unemployed	2	
Student	3	
Pensioner/Disability	4	
Other (specify)	5	7

For office use only

6. How many children do you have?

..... 8-9

7. How long have you been treated for this illness?

0-3 months	1
4-7 months	2
8-12 months	3
More than 1 year	4

10

8. Are you aware that you are ill and require medical help?

Yes	1
No	2
Don't know	3

11

9. Do you have to be reminded of your clinic appointments?

Yes	1
No	2
Not always	3

12

10. Do you at times hear voices commanding you not to go to the clinic?

Yes	1
No	2
Seldom	3

13

11. Do you believe that your condition will improve when attending the clinic for treatment?

Yes	1
No	2
Don't know	3

14

12. Do you at times feel heaviness in the head which affects your decision-making?

Yes	1
No	2

15

13. Do you know what is the day of the week, month and year?

Yes	1
No	2

16

13.1 If YES, state the following:

1. Day 17-18
2. Month 19-20
3. Year 21-22

For office use only

14. Do you have friends?

Yes	1		
No	2		23

14.1 If YES, how often do you visit one another?

Daily	1		
Weekly	2		
Monthly	3		
Other (specify)	4		24

15. Does physical illness prevent you from going to the clinic?

Yes	1		
No	2		
Sometimes	3		25

16. Do you feel embarassed to go to the clinic because of your illness?

Yes	1		
No	2		26

16.1 If YES, please explain why:

..... | | | 27-28

17. Which other places have you visited to seek help for your illness?

Nowhere	1		29
Private doctor	2		30
Traditional/faith healer	3		31
Other (specify)	4		32

18. Do you get support from your family during your illness?

Yes	1		
No	2		33

19. Does any member of your family accompany you to the clinic?

Yes	1		
No	2		
Not always	3		34

For office use only

20. Do you have to use transport to go to the clinic?

Yes	1	
No	2	35

20.1 If YES, is the transport affordable financially?

Yes	1	
No	2	36

20.2 Is the transport always available?

Yes	1	
No	2	
Not always	3	
Other (specify)	4	37

21. Do you have to wait for a long time before seen at the clinic?

Yes	1	
No	2	
At times	3	38

21.1 If YES, how long do you wait?

Less than a hour	1	
More than a hour	2	39

21.2 If YES, does the waiting procedure cause any problems?

Yes	1	
No	2	40

21.2 If YES, plese explain:

..... 41-42

22. Do the nurses treat you well at the clinic?

Yes	1	
No	2	43

22.1 Please explain:

..... 44-45

For office use only

23. What type is your current treatment?

Injection	1		46
Tablets	2		47
None	3		48
Other (specify)	4		49

24. How regularly do you have to take medication?

1-2 weekly	1		
Monthly	2		
Other	3		50

25. Do you at times develop tremors and stiffness of the body after taking medication?

Yes	1		
No	2		51

26. Do you experience other symptoms besides the stiffness of the body?

Yes	1		
No	2		52

26.1 If YES, please explain:

..... | | | 53-54

27. How do you feel when not taking medication as prescribed?

No change	1		
Well	2		
Ill	3		
Other (specify)	4		55

28. Have you ever been admitted to the hospital for the same illness?

Yes	1		
No	2		56

28.1 If YES, on discharge were you given a letter to take to the clinic for the next appointment date?

Yes	1		
No	2		57

For office use only

28.2 If YES, to question 28.1 did you know where the clinic was?

Yes	1		
No	2		58

29. If working, is your employer aware of your illness?

Yes	1		
No	2		
Don't know	3		59

29.1 If YES, is your employer supportive by making time available for you to go to the clinic?

Yes	1		
No	2		60

30. Do you need more information about your illness?

Yes	1		
No	2		61

31. Are there any reasons preventing you from going to the clinic?

Yes	1		
No	2		62

31.1 If YES, give reasons:

1.			63-64
2.			65-66
3.			67-68
4.			69-70
5.			71-72
6.			73-74

THANK YOU FOR HAVING GRANTED THIS INTERVIEW!

ANNEXURE D
Family members unstructured questionnaire

THE PROBLEM OF MISSED APPOINTMENTS AMONG THE PATIENTS SUFFERING FROM SCHIZOPHRENIA IN BOTSHABELO

FAMILY MEMBERS UNSTRUCTURED QUESTIONNAIRE

For office use only

N.B.: MAKE A CROSS IN THE APPROPRIATE BOX

Subject No. [ ] [ ] [ ] 1-2

1-25

1. What is your relationship with X?

Mother	1	
Father	2	
Brother	3	
Sister	4	
Guardian	5	
Other (specify)	6	[ ] 3

2. Does X stay with you?

Yes	1	
No	2	[ ] 4

3. When did you first realized that X was getting ill?

Days ago	1	
Months ago	2	
Years ago	3	[ ] 5

4. What did you do at the time of the illness?

Took X to the clinic	1	
Took X to the private doctor	2	
Took X to the hospital	3	
Took X to traditional healer	4	
Other (specify)	5	[ ] 6

5. Has X ever been admitted to the hospital for his/her illness?

Yes	1	
No	2	[ ] 7

5.1 If YES, how long was X admitted?

Days	1	
Months	2	
Years	3	[ ] 8

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5.2 On discharge was X give a letter to take to the clinic?

Yes	1	
No	2	
Don't know	3	
Other (specify)	4	9

6. Do you know that X is not attending the clinic?

Yes	1	
No	2	10

7. Do you experience any problems with X when not taking treatment?

Yes	1	
No	2	11

7.1 If YES, explain and given examples

..... 12-13

..... 14-15

8. What do you think are the reasons for X stopping clinic attendances? Explain:

..... 16-17

..... 18-19

THANK YOU FOR HAVING GRANTED THIS INTERVIEW!