INSTIGATING AN INDIVIDUAL FOCUS: DEVELOPING INTERPERSONAL RELATIONSHIPS WITH ADOLESCENTS WHO HAVE ANOREXIA NERVOSA

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ABSTRACT

Anorexia nervosa is a complex eating disorder that usually develops during adolescence. Individuals who have anorexia are known to refuse treatment and exhibit challenging behaviours. Many paediatric nurses can develop professional interpersonal relationships with these patients however some can find it difficult to establish these relationships. Although the literature is abundant with studies exploring anorexia and professional interpersonal relationships, there is no research on how nurses might develop this type of relationship with these patients. This modified grounded theory study aimed to identify how paediatric nurses develop professional interpersonal relationships with adolescent patients who have anorexia. Data was collected using in-depth interviews from ten Registered Division One paediatric nurses. Simultaneous data collection and analysis occurred, according to the Strauss and Corbin style of grounded theory. The findings revealed two foci of care; interacting with nurses and interacting with patients, and interrelated categories and strategies, and contextual factors that modified the process of how nurses developed relationships with patients who have anorexia. A core category highlighted the importance of instigating an individual focus when developing professional interpersonal relationships with these patients. Using this approach, nurses can gain a greater understanding of individuals experiencing the disorder and are better positioned to develop reciprocal relationships. This can then help nurses provide care which is more consistent with these patients' needs and assist with their recovery.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text, this thesis contains no material published elsewhere or extract in whole or part, from a thesis presented by me for another degree or diploma. No other person's work has been used without due acknowledgement in the main text of this thesis. This thesis has not been submitted for an award of another degree or diploma in any other tertiary institution.

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CHAPTER ONE:

INTRODUCTION

1.1 Introduction

Anorexia nervosa (here after referred to as anorexia) is an eating disorder, which is an important cause of physical and psychological morbidity that occurs mainly among adolescent females and young adult women (Muscari, 1998). Researchers have explored many areas relating to anorexia, as the illness is complex and difficult to understand. As a result of the condition, some paediatric nurses find it difficult to develop professional interpersonal relationships with these patients during their hospitalisation. This modified grounded theory study aims to identify how paediatric nurses develop professional interpersonal relationships with adolescents who have anorexia. This chapter will identify the problem statement, provide a background of the study, outline the aim and rationale for the study, and discuss its significance. Finally an outline of the thesis will be provided.

1.2 Problem Statement

The most difficult aspect of this researcher's first year as a Registered Nurse on a paediatric ward was attempting to develop professional interpersonal relationships with patients who have anorexia. Many of her colleagues agreed that it was difficult to develop professional interpersonal relationships with these patients. Professional interpersonal relationships are an important part of nursing as therapeutic effectiveness can be facilitated by the development of such relationships between nurses and patients (Williams, 1998). Developing professional interpersonal relationships with patients who have anorexia can be difficult however, as these patients are often reluctant to trust others and this behaviour can limit nurse-patient interactions on many levels.

Several authors (Cameron 1996; Grothaus, 1998; Kenny, 1991; King & Turner, 2000; Ramjan, 2004) agree that developing relationships with patients who have anorexia is complex, challenging and frustrating. The development and maintenance of a therapeutic relationship is not only difficult to accomplish, it requires continuous effort and knowledge (Muscari, 1998). Through the development of caring interpersonal relationships, patients who have anorexia can learn how to care for themselves and accept care from others (Anderson, 1997). Building trusting relationships can help adolescents who have anorexia understand

why they have difficulties with food, weight, and body image and may facilitate change in their behaviour (Thompson, 2004). This indicates that interpersonal relationships are a vital part of their recovery.

Although the above studies have explored professional interpersonal relationships and professional interpersonal relationships with patients who have anorexia, they have not explored how nurses develop these relationships. This prompted the researcher to explore how paediatric nurses develop professional interpersonal relationships with adolescent patients who have anorexia.

1.3   Background of the Study

Adolescence is a time for developing a positive self-image and gaining independence (Stephens & Hill, 1994). Adolescents face developmental changes related to autonomy, sexual development, cognitive functioning, intimacy, identity and achievement (Woodgate, 1998). It is also a period of biological and psychological change that is affected by family, media, cultural values, spiritual beliefs, and social influences (Millstein, Nightingale, Petersen, Mortimer & Hamburg, 1993). Adolescents are often concerned with how others perceive them, which often results in the development of their self images based on others' perceptions (Fairburn & Harrison, 2003). The media also influence adolescents' views of what is considered normal. The unrealistic images that are frequently displayed in the media may cause adolescents to have a naive view of how they should be (Stephens & Hill, 1994).

Anorexia is one of several eating disorders that predominately present during adolescence. Anorexia is characterised as a refusal to maintain normal body weight, a fear of gaining weight and body shape misinterpretation (Gordon, 2000; Lask & Bryant-Waugh, 2000). Other characteristics of anorexia are physiological manifestations, such as sleep disturbance, altered metabolism, amenorrhea, excessive body hair, and hypotension (Grothaus, 1998). Individuals who have anorexia have thought processes that are concrete and superstitious, and they also display behaviours such as impulsiveness, anxiety and manipulation (Muscari, 1998). Typically, individuals have difficulty identifying and expressing their emotions and feelings (Grothaus, 1998).

Hospital related admissions for people with eating disorders mainly focus on normalising eating patterns, restoring physical and nutritional health, helping patients make sense of the condition, and developing strategies to overcome the disorder (Grothaus, 1998). A critical factor in the treatment of anorexia is achieving a balance between psychological issues and biological alterations that result from weight loss and disturbed eating patterns (Grothaus, 1998). Given that nurses claim to provide holistic care and promote health, they are ideally situated to improve the wellbeing of patients who have anorexia through professional interpersonal relationships (Muscari, 1998).

1.4   Rationale for the Study

The internalised feelings experienced by patients who have anorexia can be expressed through professional interpersonal relationships they develop with nurses (Holyoake & Jenkins, 1998). However, given the complexity of anorexia, this has proven to be a challenge for nurses (Lindsay, 1997). Strategies for developing professional interpersonal relationships can increase nurses' understanding of these individuals and are valuable for providing care specific to their needs (King & Turner, 2000; Williams 1998). Nurses need to develop skills and gain insight into nurse-patient interactions and how to develop professional nurse-patient relationships in order to make therapeutic progress (Croom, 2000; Lindsay, 1997; Lotzkar & Bottorff, 2001; Morse, 1991; Rolfe, 1998).

1.5   Aim of the Study

The aim of the study is to describe the strategies paediatric nurses use to develop professional interpersonal relationships with adolescent patients who have anorexia.

1.6   Significance of the Study

The study is significant to nursing as the findings may help inform nurses of the strategies to use when developing professional interpersonal relationships with patients who have anorexia. The findings may guide less experienced nurses when attempting to develop relationships with these patients. In addition, the study may improve clinical practice and unit administration, may provide valuable information for undergraduate and in-service education, and be used to enhance and direct further research.

1.7   Organisation of the thesis

Chapter Two in this thesis will explore the literature related to anorexia and professional interpersonal relationships. Chapter Three will explain the methodology and method that was used to gather and analyse data. This chapter will also explore the ethical issues and rigour of the study. Chapter Four will present the findings of the study, while Chapter Five will discuss these findings. Lastly, Chapter Six will conclude the study.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

According to the grounded theory methodology that will be adopted in this study, the review of literature can occur prior to data collection and during analysis. This Chapter will explore the literature that was reviewed prior to data collection, to provide a rationale for the study, identify current gaps in knowledge, and help define unfamiliar terms. The Chapter will explore anorexia, general professional interpersonal relationships and professional interpersonal relationships related to anorexia.

2.2 Anorexia Nervosa

Anorexia is a complex but hazardous disorder during which young people, usually adolescents, endeavour to starve themselves (Rosenblum & Forman, 2002; Sloan, 1999). The disorder was first recognised in the 1870s, however it did not become widely reported until the 1970s, and by the mid 1980s anorexia was a well known disorder (Gordon; 2000; Sloan, 1999). The following will be discussed in order to develop an understanding of the illness: the diagnostic criteria of anorexia, incidence, aetiology, characteristics, treatment and prognosis.

2.2.1 Definition

Anorexia is defined in the Diagnostic and Statistical Manual of Mental Disorders, as:

> A refusal to maintain body weight over a minimal normal weight for age and height, an intense fear of gaining weight or becoming fat, even though individuals are under weight, an excessive influence of body weight or shape on self-evaluation, or a denial of the seriousness of their current low body weight, and in females, the absence of at least three consecutive menstrual cycles when expected to occur (American Psychiatric Association, 2000, p. 583).

There are two subtypes of anorexia: restrictive and binge-purge. Anorexia restrictive subtype refers to severe restriction of the amounts of foods consumed, and binge-purge subtype indicates ingesting large amounts of food and purging following this as a compensatory

measure to prevent weight gain (Thompson, 2004). Given these definitions, the condition is particularly complex to manage and treat as the affected individual exhibits both physical and psychological symptoms.

2.2.2 Incidence

Although anorexia can develop at any age, it is more common in adolescence (Anderson, 1997; Emans, 2000; Fairburn & Harrison, 2003). The approximate duration of the illness is five years, usually beginning in puberty and persisting through adolescence into adulthood (Beumont, Hay & Beumont, 2003). In Australia and New Zealand, the prevalence of anorexia is 0.2-0.5% (Beumont, Hay & Beumont, 2003).

2.2.3 Aetiology

The pathogenesis of anorexia remains elusive, although familial, socio-cultural and biological factors can be linked to the development of the condition (Emans, 2000; Fairburn & Harrison, 2003; Lask & Bryant-Waugh, 2000; Sloan 1999). The onset is usually triggered by interpersonal conflict, the development of secondary sexual characteristics, or physical or verbal assault (Sloan, 1999). These triggers can lead to low self-esteem, ineffectiveness and psychological dysfunction, and for whatever reason individuals believe they can solve these problems through restricting their food intake (Sloan, 1999). Interpersonal processes that are present in family systems may provoke an episode of anorexia (Sloan, 1999). Individuals who have the disorder are more likely to be part of families where they have learned to subordinate themselves to others, are unable to express themselves directly and assertively, and have not developed appropriate separation from their parents (Grothaus, 1998; Herzog, Kronmuller, Hartmann, Bergmann & Kroger, 2000; Sloan, 1999; Wechselblatt, Gurnick & Simon, 2000). As a result of disturbed family relationships, those who have anorexia may also exhibit abnormal or non-existent relationships with others and have difficulty developing their identity (McIntosh, Bulik, McKenzie, Luty & Jordan, 2000).

The social-cultural factors linked with the disorder, such as peer pressure and adverse media influence have been associated with increased body dissatisfaction (Stice, Maxfield & Wells, 2002). An example of peer pressure influencing the development of the body dissatisfaction is individuals being teased by their peers about their appearance (Berg, Wertheim, Thompson, & Paxton, 2002). The cultural factors apparent in Western cultures that pertain to

the development of anorexia include the changing female role, and a preoccupation with appearance, body image and weight (Gordon, 2000). The media have been considered a major factor in the development of anorexia. Given that young women and men are frequently exposed to advertising on television, in magazines, and in films, the media are believed to have a powerful influence on culture and how women's ideals of the perfect body are formulated (Andrist, 2003; Emans, 2000; Fairburn & Harrison, 2003; Gordon, 2000; Lake, Staiger & Glowinski, 2000; Stice, Maxfield & Wells, 2002). Not only are young women exposed to these media influences, adolescent men are also subjected to the pressures of conforming to the ideal body. When adolescents are unable to achieve these images, body dissatisfaction can occur and distorted eating may begin (Andrist, 2003; Stice, Maxfield & Wells, 2002).

There is evidence to suggest that neurochemical disturbances are present in individuals who have anorexia (Attia, Mayer, & Killory, 2001). The magnitude of brain abnormalities is associated with the degree of starvation (Katzman, Golden, Neumark-Sztainer, Yager, & Strober, 2000). Individuals who have anorexia have elevated neuropeptides which are amino acid clusters that reduce feeding and increase energy expenditure (Attia, Mayer, & Killory, 2001). These individuals have lowered levels of a gene, Leptin, which is involved in fat distribution and results in low percentages of body fat (Katzman, Golden, Neumark-Sztainer, Yager, & Strober, 2000). The biological influences associated with the disorder are hypothalamic dysfunction that is secondary to malnutrition and weight loss (Sloan, 1999). An abnormally functioning hypothalamus can result in biological stress and acute illness (Attia, Mayer, & Killory, 2001). Individuals who exhibit anxiety, rigidity and obsessional behaviours have increased levels of serotonin and are susceptible to developing anorexia, however once the disorder develops serotonin levels are lowered (Attia, Mayer, & Killory, 2001). Enlarged brain ventricles, which are associated with elevated cortisol levels are also evident in these individuals and can result in abnormal brain chemistry (Katzman, Golden, Neumark-Sztainer, Yager, & Strober, 2000).

2.2.4 Characteristics

Anorexia is a complex disorder that exhibits many behavioural and emotional levels as well as medical complications (Gordon, 2000). Distinctive signs include severe fasting and/or abuse of laxatives and diuretics, excessive exercise, self-induced vomiting, amphetamine ingestion and ritualistic activity such as cutting food into small pieces (Gordon, 2000; Lask & Bryant-Waugh, 2000). Physical consequences of anorexia can include frequent headaches, osteoporosis, amenorrhea, brittle hair, teeth erosion, heart failure, fatigue, increased body hair, and muscle loss (Grothaus, 1998).

As dieting is transformed from fasting into forced starvation, individuals exhibit psychological disturbances (Gordon, 2000; Sloan, 1999). They become obsessed with thoughts of food, details of dieting and calorie counting, and the sight of their own image in the mirror (Gordon, 2000). They can soon develop emotional patterns such as depression, anxiety, mood swings, isolation, obsessive-compulsive disorders, personality disorders and substance abuse (Fairburn & Harrison, 2003; Emans, 2000). Adolescents who have anorexia commonly have flat affect, are irritable, lack insight, and are disturbed interpersonally (Emans 2000; Lindsay, 1997; Pryor & Wiederman, 1998). They are usually perfectionists, overactive and persistent in attempting to reach their goal of thinness, and they view their severe weight loss as an accomplishment rather than a consequence (Fairburn & Harrison, 2003; Grothaus, 1998). People who have anorexia also find it difficult to express their inner worlds, have low self-esteem, and lack trust in others (Lindsay, 1997). Their severe exercise regimes and food restriction is believed to be an effort to ward off panic about being powerless (Grothaus, 1998; Lindsay, 1997). Individuals who have anorexia display a greater concern over self-concept, academic confidence and conformity to social expectations compared to those with other eating disorders (Pryor & Wiederman, 1998).

2.2.5 Treatment

There is general consensus that a multi-skilled and multidisciplinary holistic approach is required to successfully treat individuals who have anorexia (Beumont, Hay & Beumont, 2003; Beumont, Russell & Touyz, 1993; Rosenblum & Forman, 2002). An approach should be employed that incorporates comprehensive holistic assessments, multiple treatment modalities need to be explored (medication, nutrition, individual, group and family therapies), and multiple interventions (behavioural, cognitive-behavioural, psychodynamic, and

interpersonal therapies) should be considered (Katzman, Golden, Neumark-Sztainer, Yager, & Strober, 2000; Sloan, 1999). Despite the many approaches used to treat anorexia, no strategy is more effective than another, however general interventions can lower mortality rates compared to no treatment at all (Beumont, Hay & Beumont, 2003). Anorexia is often a chronic illness that may require years to overcome, with multiple hospital admissions (Beumont, Russell & Touyz, 1993).The most common, current regimes to treat the individual include nutritional rehabilitation, pharmacological intervention, psychotherapy (interpersonal and family), and behaviour modification techniques.

Nutritional restoration is the primary intervention to treat people who have anorexia. Specially trained dieticians, who plan re-feeding programs, are involved in their implementation and patient education (Beumont, Russell & Touyz, 1993). The focus is for patients to reach a normal weight, consume everyday foods (no supplements) and regain socially acceptable eating behaviours (Beumont, Russell & Touyz, 1993). It is believed that with weight restoration, physical alterations, abnormal behaviours and psychological abnormalities, will also be corrected (Attia, Mayer, & Killory, 2001; Beumont, Russell & Touyz, 1993). Nutritional rehabilitation involving dietary planning and education can occur in hospital or in outpatient programs. Inpatient programs, preferably in specialised eating disorder units, are suited to patients who present in medical crisis who are experiencing rapid weight loss or exhibit physical deterioration (Beumont, Hay & Beumont, 2003; Beumont, Russell & Touyz, 1993). Outpatient programs are more suited to individuals with severe anorexia but not severe enough to warrant inpatient treatment. These programs are less intrusive and, as a result, have greater adherence compared to inpatient settings (Beumont, Hay & Beumont, 2003).

There have been many pharmacological interventions used treat patients who have anorexia. There is little evidence, however, to support treating patients who have anorexia with medications (Attia, Mayer, & Killory, 2001; Beumont, Hay & Beumont, 2003; Rosenblum & Forman, 2002). There are few studies that have reviewed the effectiveness of antipsychotic medications, however these have shown little improvements in symptoms and some have been associated with adverse side effects (Attia, Mayer, & Killory, 2001). There is also minimal evidence to support the use of antidepressants when treating anorexia, however they can be beneficial when preventing relapse (Attia, Mayer, & Killory, 2001; Rosenblum & Forman, 2002). Pharmacological therapy is only considered successful with antipsychotics or

anti-depressants for those patients who have a subset of psychosis or depression (Behrman, Kliegman & Jenson, 2000). Antipsychotics, such as small doses of chlorpromazine can be used for high levels of anxiety in the early treatment of people who have anorexia (Beumont, Russell & Touyz, 1993). Ineffective treatment with medication may be the result of the abnormal brain chemistry evident in individuals who have anorexia (Attia, Mayer, & Killory, 2001).

Interpersonal therapy has been empirically demonstrated to be effective for people who have anorexia (Haas & Clopton, 2003). Interpersonal therapy is a brief, time-limited psychotherapy that was initially developed for the treatment of depression (McIntosh, Bulik, McKenzie, Luty, Jordan, 2000). The goal of the intervention is to decrease depressive symptoms and to improve interpersonal functioning by enhancing communication skills in significant relationships (McIntosh, Bulik, McKenzie, Luty, Jordan, 2000). The four areas of this approach are: interpersonal disputes, role transitions, abnormal grief, and interpersonal deficits (McIntosh, Bulik, McKenzie, Luty, Jordan, 2000). Interpersonal therapy can help patients gain considerable control over problematic areas of their lives, such as their troubled interpersonal relationships, and may give people who have anorexia the confidence to overcome symptoms of their eating disorder (Gordon, 2000; Thompson, 2004).

Family therapy is considered just as effective as individual therapy in relation to weight restoration (Beumont, Hay & Beumont, 2003). Family therapy is an approach used to emphasise parental responsibility in response to the adolescent's crisis and conceptualise the family as a resource, not the problem (Geist, Heinmaa, Stephens, Davis & Katzman, 2000; Thompson, 2004). Patients with an early onset and who have had a short history of anorexia may benefit most from family therapy, while those with a later onset benefit from individual therapies (Beumont, Hay & Beumont, 2003; Eisler, Dare, Russell & Szmukler, 1997). Family therapies are considered particularly beneficial for adolescent patients due to their reliance on family systems (Beumont, Hay & Beumont, 2003).

Cognitive behavioural therapy (CBT) combines cognitive restructuring and behavioural strategies to reduce the frequency of abnormal eating patterns (Rosenblum & Forman, 2002). CBT has been reported to have brought about improvements in the severity of depressive symptoms and weight gain, compared to those receiving only dietary advice (Beumont, Hay

& Beumont, 2003). CBT techniques include having an empathetic therapist, providing education regarding malnutrition and how to restructure problematic thoughts, and practising assertiveness (Rosenblum & Forman, 2002; Sloan, 1999). A therapeutic relationship is essential for CBT and other therapies to be successful, as collaboration, guided discovery and empathy is important for assessment and treatment of patients who have anorexia (Geller, Williams & Srikameswaran, 2001; Sloan, 1999).

2.2.6 Prognosis

The majority of adolescents who have anorexia have a good prognosis, however it is unclear what treatments have contributed to this (Grothaus, 1998; Lask & Bryant-Waugh, 2000). According to Fisher (2003), approximately half of adolescents diagnosed with anorexia recover well whereas the others either recover reasonably (30%) or poorly (20%). Without treatment, 20% of affected individuals die, with treatment that number falls to 2-3% (Gordon, 2000). In some cases, the disorder is short-lived, and only requires brief interventions, however some individuals need intensive treatment (Fairburn & Harrison, 2003). Individuals with underlying psychiatric disorders and abnormal serology may be associated with poor prognosis, and those with extremely low weights may develop chronic anorexia (Finfgeld, 2002). In 10-20% of individuals, the disorder is intractable and unremitting (Fairburn & Harrison, 2003). The long-term outcomes for those who do not recover include abnormal relationships, fertility and reproduction abnormalities, medical problems, psychological and social dysfunction, and mortality (Finfgeld, 2002). Anorexia is associated with a raised mortality rate compared to other eating disorders and most of the deaths occur are a result of medical complications or suicide (Fairburn & Harrison, 2003; Finfgeld, 2002; Grothaus, 1998; Lask & Bryant-Waugh, 2000). Mortality rates are increased with chronicity and the passage of time (Gordon, 2000).

2.3　Professional interpersonal relationships

Many studies have been published regarding professional interpersonal relationships (Lotzkar & Bottorff, 2001; Morse, 1991; Peplau, 1991; Williams, 1998). Professional interpersonal relationships in this context, however, are defined as collaborative working partnerships, where recurring difficulties of patients' lives can be identified and managed by nurses and other healthcare professionals through mutual respect and understanding (Peplau, 1991). Interpersonal relationships are dependent on many factors such as the

duration of contact, patients' needs, the commitment of nurses, and patients' willingness to trust nurses (Morse 1991). Both nurses and patients consider the development of relationships as important, and that nurse-patient interactions determine the type and effectiveness of interpersonal relationships (Lotzkar & Bottorff, 2001). The individuals in the relationship do not have to like each other; the interactions are goal directed (to meet patients' needs), and healthcare professionals are expected to be non-judgemental and empathetic (Arnold & Boggs, 1995). Mutual trust is fundamental in any valued relationship, as patients need to feel that they have been taken seriously and that their judgements are respected (McQueen, 2000). It also involves being part of a partnership in a non-directive style of interacting where nurses attempt to give patients options and help them become more active in their own care (McQueen, 2000).

The move to holistic patient care has placed a great importance on relationship building between nurses and patients (McQueen, 2000). During these interactions, individualised care can be provided. Given that nurses have frequent contact with patients, they are considered to be ideally positioned to create positive interpersonal relationships (Anderson, 1997; King & Turner, 2000; McQueen, 2000). When nurses spend time with patients, the outcome of the hospital experience is likely to result in useful patient learning (Peplau, 1991). All relationships involve personal contact and a discovery of patients' needs, feelings, and ideas (Arnold & Boggs, 1995). Interpersonal relationships can be critical in providing information, support and comfort that is required to facilitate physical and technical procedures and behaviour change (McQueen, 2000; Morse 1991; Muscari, 1988; Robinson, 1996; Stubblefield & Mutha, 2002).

In order for nurses to develop a relationship with patients, they need to attempt to understand the individuals (McCann & Baker, 2001; McQueen, 2000). Positive, useful nursing actions result from an understanding of patients' situations (Peplau, 1991). Patients appreciate when nurses understand their situation and nurses gain satisfaction that inspires their work (McQueen, 2000). Being friendly, approachable and flexible and listening to patients, have been identified as strategies that can be used to develop interpersonal relationships and understand patients (McCann & Baker, 2001). Therapeutic relationships that are dependent on empathy, unconditional positive regard, and genuineness result in positive outcomes (Lindsay, 1997). Revealing ones-self, maintaining confidentiality and providing support for

patients are among other interventions that nurses can use to develop these relationships (McCann & Baker, 2001). Although both nurses and patients clearly contribute to the type of relationship developed, it is the nurse's role to encourage a therapeutic relationship (McQueen, 2000). Nurses' attributes, appearance, personal qualities, attitudes and confidence, all influence the development of interpersonal relationships (McQueen, 2000).

2.4   Professional interpersonal relationships and anorexia nervosa

The development of a strong therapeutic alliance between nurses and patients is an important element of treatment for patients who have anorexia (Sloan, 1999). In order for this to occur, healthcare professionals must be warm, positive, honest, empathetic and courteous (Sloan, 1999). There are many benefits associated with establishing professional interpersonal relationships with patients who have anorexia, however given the multidimensional characteristics of the disorder, many difficulties are encountered during the process.

2.4.1 Benefits of establishing professional interpersonal relationships

As anorexia consists of emotional and psychological components, these factors need to be addressed in order to facilitate recovery (Amara & Cerrato, 1996; Zipfel, Lowe, Reas & Deter & Herzog, 2000). The aetiology of anorexia, and clinical practice, highlight disturbed interpersonal relationships or difficulties with role transitions as central to the development of the disorder (McIntosh, Bulik, McKenzie, Luty & Jordan, 2000; Rosenblum & Forman, 2002; Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003). Self-psychology has emphasised the importance of interpersonal relationships in the development and maintenance of self-esteem and self-cohesion (McIntosh, Bulik, McKenzie, Luty & Jordan, 2000). Given the link between disturbed interpersonal relationships and the aetiology of anorexia, a focus on interpersonal functioning in treating the disorder is warranted (McIntosh, Bulik, McKenzie, Luty & Jordan, 2000).

Being understood and having supportive relationships are regarded as vital to recovery for patients with anorexia (Tozzi, Sullivan, Fear, McKenzie & Bulik, 1997). Individuals who have developed an interpersonal relationship with a parent or other adult, including a therapist, are able to develop more differentiated relationships, and are better positioned to manage stress, and cope with the social and physical aspects of the disorder (Wechselblatt, Gurnick &

Simon, 2000; Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003). Through professional interpersonal relationships patients can be educated about their illness and how they can recover (Amara & Cerrato, 1996). Professional interpersonal relationships can provide patients with an opportunity to express their feelings and work through any unresolved difficulties they may be experiencing (Holyoake & Jenkins, 1998). This approach to care can help individuals deal with a multitude of issues, such as grief and loss, addictive behaviour, manipulation, and family problems (Grothaus, 1998). One of the best treatments for individuals is to counsel them on how to manage relationships effectively (Thompson, 2004). In some cases, the development of interpersonal relationships can result in a diminished focus on food issues and can improve patients' self-concept (McIntosh, Bulik, McKenzie, Luty & Jordan, 2000).

As patients who have anorexia frequently interact with nurses during hospitalisation, the role of nurses is considered important in managing these patients (Lask & Bryant-Waugh, 2000). Nurses have a great advantage in the treatment of eating disorders due to their extensive background in physical assessment and their multidimensional approach to client care (Grothaus, 1998). The unique therapeutic relationships that can develop between patients and nurses can provide a foundation for meeting patients' goals and facilitating behaviour change (Lask & Bryant-Waugh, 2000). Nurses are encouraged to provide opportunities for patients to openly discuss concerns such as anxiety (Finfgeld, 2002). It is the behaviours and the attitudes of nurses that influence patients who have anorexia to recover, therefore it is important for nurses to be positive, supportive and accepting (Gordon, 2000; Lask & Bryant-Waugh, 2000).

Although establishing professional interpersonal relationships with patients is considered an important part of recovery for individuals who have anorexia, there is limited literature outlining how to develop these relationships with these patients (Finfgeld, 2002). It is vital that nurses receive adequate education prior to working with patients who have anorexia, and that their knowledge is regularly updated (Lindsay, 1997; King & Turner, 2000). Strategies for emphasising and developing nurse-patient relationships are valuable for nursing education, and can increase nurses' understanding of patients (Amara & Cerrato, 1996; Croom, 2000; King & Turner, 2000; Lindsay, 1997; Lotzkar & Bottorff, 2001; Rolfe, 1998; Williams 1998). Although research has helped nurses better understand anorexia, it has failed to provide

nurses with concrete interventions that have proved useful for successful relationship development (Grothaus, 1998). Nurses who are experienced in caring for individuals who have anorexia are considered ideally positioned to educate other nurses on how to develop professional interpersonal relationships (Fairburn & Harrison, 2003).

2.4.2 Difficulties in developing professional interpersonal relationships

Despite the known benefits of establishing professional interpersonal relationships with patients who have anorexia, it is often a challenging process (Fairburn & Harrison, 2003; King & Turner, 2000; Ramjan, 2004). Individuals who have anorexia can refuse treatment, may be manipulative and have difficulties trusting others (King & Turner, 2000; Ramjan, 2004). The entrenchment of the disorder drives patients not to cooperate with treatments and they often see healthcare professionals as the enemy (King &Turner, 2000; Ramjan, 2004). In order for patients to gain control of their surroundings and avoid treatment, they resort to negative methods to gain power, such as manipulation, deceit, and untruthfulness (King &Turner, 2000; Ramjan, 2003). Given these behaviours, individuals who have anorexia have problems trusting healthcare professional who want patients to adhere to treatment. As a result of the behaviours exhibited by these patients, nurses can become suspicious and untrusting. This can lead to nurses becoming frustrated and distancing themselves from patients (King & Tuner, 2000; Lindsay, 1997; Ramjan, 2003). Nurses who lack trust and are afraid of being manipulated by patients are apprehensive of entering into relationships with them (Morse, 1991). The possibility of developing interpersonal relationships is therefore diminished.

Healthcare professionals view individuals who have anorexia as intimidating, and are often challenged by these patients who refuse treatment and deny the severity of their illness (Gordon, 2000). Healthcare professionals' negative views of individuals who have anorexia, can adversely impact on the care they provide (Cameron, Willis & Ritcher, 1997; King & Turner, 2000). These professionals have voiced their feelings of fear and inadequacy when working with patients who have anorexia (Cameron, Willis & Ritcher, 1997; King & Turner, 2000). They can view these individuals in a negative way as patients are considered responsible for their illness (Cameron, Willis & Ritcher, 1997; King & Turner, 2000; Lindsay, 1997). As a result of harsh treatment and judgement from nurses, the possibility of developing interpersonal relationships is delayed (Lindsay, 1997). Not only do patients' symptoms and healthcare professionals' attitudes create barriers when forming professional

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interpersonal relationships, these patients are cared for according to rigid protocols (Cameron, Willis & Ritcher, 1997; King & Turner, 2000; Muscuri, 1998). This has caused added frustration and disconnectedness between patients and nurses (King & Turner, 2000). In addition, nurses' workloads and other factors can decrease patient contact and influence the outcome of nurse-patient interactions (McQueen, 2000).

2.5 Summary

There is a high incidence of anorexia among adolescent females in particular. The disorder is characterised as a refusal to maintain weight, excessive exercise and difficulty in establishing relationships. Several treatments have been used to overcome anorexia however none have been proven greatly effective in the absence of professional interpersonal relationships with healthcare professionals. Given that nurses have increased contact with hospitalised patients who have anorexia and have skills that facilitate the development of these relationships, they have an important role in establishing interpersonal relationships with these patients to help them recover.

CHAPTER THREE:

METHODOLOGY

3.1 Introduction

Methodology refers to the principles and ideas on which researchers base their procedures and strategies. A qualitative approach was employed in this study as it focuses on human experiences in a naturalistic setting. The study used a modified version of grounded theory; the approach being derived from symbolic interactionism, which explores the processes of interactions between peoples' social roles and behaviours. This chapter will outline the research design and rationale, sampling and access procedures, the method that was employed, and explain how data was collected and analysed during the study. It will also discuss ethical issues and the techniques used to ensure rigour.

3.2 Research Design and Rationale

Grounded theory is a qualitative methodology that can offer insight, enhance understanding and provide a meaningful guide to action (Strauss & Corbin, 1998a). The main features of grounded theory are that theory can be generated from the data, and existing theories can be modified or further developed. The methodology is a particularly useful style of research when there is little prior information known about a topic (Strauss & Corbin 1998b). Other characteristics of the approach are the processes of induction, deduction and verification, which are unlike other qualitative methods (Clifford, 1997; Streubert & Carpenter, 1999). Induction uses a ground-up (from practice to theory) approach, to enter the field with none or little preconceived hypotheses or framework from the literature or elsewhere, and to be open-minded and flexible, so that the theory emerges from the data; this process moves from specific to general ideas (Strauss & Corbin 1998a). Deduction refers to a logical process where hypothesis are derived from theory; the process is from general to specific (Schneider, Elliot, LoBiondo-Wood & Harber, 2003). The data is tested through induction and deduction processes to verify the emerging categories and theory (Clifford, 1997; Streubert & Carpenter, 1999). Grounded theory also provides us with a picture of what people do, what their prime concerns are, and how they deal with these concerns (Crooks, 2001). The grounded theory approach was chosen for the study as it is used to explore and gain knowledge on the social processes that are present within human interactions (Streubert &

Carpenter, 1999), in this instance, how paediatric nurses develop professional interpersonal relationships with patients who have anorexia.

The theoretical framework for grounded theory is derived from symbolic interactionism, which focuses on the processes of interactions between people exploring human behaviour and social roles (Cutcliffe, 2000; Holloway & Wheeler, 2002, p. 153; Streubert & Carpenter, 1999). The researcher attempts to determine what symbolic meanings, gestures and words have for groups of people as they interact with one another (Crooks, 2001; Cutcliffe, 2000). It also concentrates on the actions and perceptions of individuals and their ideas and intentions (Crooks, 2001; Cutcliffe, 2000; Holloway & Wheeler, 1996). When making choices, people identify things that have meaning in the situation through a process of inward communication (Crooks, 2001). Therefore, the person does not respond without thought to situations, but rather guides action according to his or her interpretations of situations (Crooks, 2001).

Grounded theory was developed by Glaser and Strauss in the 1960's, to provide a rationale for theory that was grounded in data, legitimise qualitative research, and outline the methods of grounded theories (Strauss and Corbin, 1998b). Glaser believed that theory should be developed only from the data and that the researcher's views should not be used to analyse data, as the theory developed will not truly represent the phenomena. Strauss disagreed with this, and as a consequence he created an approach to grounded theory that was more structured and a useful process of data collection and analysis. The grounded theory style adopted by Strauss was chosen for the study as the researcher had a paediatric nursing background and she believed that incorporating her understanding in the study would enhance the data gathered. Given the limited scope of this honours thesis, however, a modified form of grounded theory was used. Some of the methodology's concepts were adopted to identify categories and the processes that evolved when exploring how paediatric nurses develop professional interpersonal relationships with adolescent patients who have anorexia.

3.3 Sampling and Access

Sample selection in grounded theory must begin with purposive sampling (Strauss & Corbin, 1998a). This means that the researcher will decide on a particular setting or group of individuals to provide information (Holloway & Wheeler, 1996). In the present study, Division

One Registered Nurses, who had a minimum of two years experience of working with adolescents who have anorexia, were initially interviewed. Participants were male and female and were employed either full-time or part-time. Once initial interviews had been undertaken and analysed, further participants were chosen using theoretical sampling (Strauss & Corbin, 1998a). This type of sampling involved selecting further participants on the basis of concepts that had proven relevant to the data collected thus far (Strauss & Corbin, 1998a). The researcher searched for further participants in order to fully understand the concepts that emerged (Cutcliffe, 2000). For example, some categories that initially emerged pertained to participants who had extensive nursing experience. To verify these concepts the researcher sought information from nurses with less experience to determine if these concepts were also relevant to them.

Given the scope of this Honours thesis, ten nurses were interviewed. The number was dependent on theoretical saturation of the main categories. Theoretical saturation means that no new information arises from the data (Strauss & Corbin, 1998a) and that the quality of the information gathered satisfies the research problem (Holloway and Wheeler, 2002). It also refers to the completeness of each category and to indicate that no new category can be formed or existing categories expanded (Streubert & Carpenter, 1999). The nurses who participated in the study were paediatric nurses who cared for patients who have anorexia on a paediatric medical ward in a major metropolitan hospital. Participants had cared for patients who have anorexia between 3 to 14 years and only one participant was male.

Once ethical approval was obtained from the hospital and Victoria University, participants were accessed at the hospital. The researcher asked permission to speak with staff during a regularly scheduled staff meeting, without the Unit Manager being present. The absence of the Unit Manager ensured there was no coercion to participate. During the meeting, the researcher explained the study and answered questions to the satisfaction of staff members, but did not actively seek to recruit participants in the meeting. A copy of the Plain Language Statement and Consent Form (Appendix A) were distributed to each staff member present at the meeting, and a copy was placed in the staff mailbox for individuals not present at the meeting. The final method of recruitment was a poster displayed on staff notice boards. Intending participants telephoned the researcher to indicate willingness to take part in the study.

3.4 Method

The study used unstructured and in-depth interviews to gather data. In-depth interviews are conversations with a specific purpose that exists between the researcher and the participant focusing on the participant's perception of self, life and experience, expressed in his or her own words (Minichiello, Aroni, Timewell & Alexander, 1990). In-depth interviewing was chosen for this study as it helped the researcher to understand the complex behaviours of individuals without prior categorisation that may limit the field of inquiry (Fontana & Frey, 1994). These in-depth interviews were unstructured, which means that there was minimal control by the researcher of the topics discussed during the interview, however the aim was to keep the participant speaking about his or her experiences (Minichiello, Aroni, Timewell & Alexander, 1990). The researcher chose participants from the unit were she was employed as the unit was considered the most experienced in the hospital at caring for patients who have anorexia. As the researcher had already worked with participants, this facilitated the development of rapport and trust in the interview process. Given that the researcher was affiliated with participants and patients who have anorexia, her views may have affected the study findings. The researcher kept a journal to ventilate her own feelings and did not include them in the study.

Interviews were conducted, audio-taped and transcribed by the researcher. They were undertaken at a time and setting that was agreed upon by the researcher and participants, and took place in private. The duration of the interviews was approximately thirty minutes to one hour. Given that the researcher was a novice at the interview process, she used an interview guide (Appendix B), which was a list of broad questions that kept the interviews focused on the aim of the study (Schreiber & Stern, 2001). Although the researcher used the guide, she followed the major concerns or points of view of the participants (Wimpenny, 2000). The researcher began each interview by asking participants an open-ended question such as, "Tell me about your experiences of developing interpersonal relationships with adolescent patients who have anorexia?" Further questions were asked during the interview only to obtain clarification or encourage participants to continue speaking. The researcher also asked questions based on responses given by participants, and to answer any queries from previous interviews or emerging concepts (Strauss & Corbin, 1998a). This ensured that the description given by participants was based purely on their own experiences.

3.5   Data Collection

Data collection in grounded theory incorporates multiple methods, such as interviews, observations in the field, diaries and even newspapers (Holloway & Wheeler, 2002). Given the limited scope of this thesis, data was collected using only interviews. During the initial steps of data collection, the researcher took cues from the emerging data to develop further interview questions and selected participants accordingly (Holloway & Wheeler, 2002; Wimpenny, 2000).   Subsequent interviews were also guided by analytical questions and initial hypotheses about the categories and relationships between them (Wimpenny, 2000). This enabled data collection to be more specific and focused as the gathering process developed (Holloway & Wheeler, 2002; Wimpenny, 2000).

In grounded theory, data collection and analysis occurs simultaneously (Holloway & Wheeler, 1996; Strauss & Corbin, 1998a). In the present study, during data collection and analysis the researcher remained theoretically sensitive, which means that she was responsive to concepts and themes that emerged from the data (Strauss, 1995). Being theoretically sensitive legitimises the researcher's creativity when concepts are formulated and increases the depth of understanding of the phenomena (Cutcliffe, 2000). This process also indicated that the researcher needed to differentiate between significant and less important data and have insight into their meanings (Holloway & Wheeler, 2002; Streubert & Carpenter, 1999). The researcher remained theoretically sensitive by her professional experience as a nurse, her personal experience of working with patients who have anorexia and reading relevant professional literature. The researcher also critically analysed situations, recognised her own biases, obtained valid and reliable data, thought abstractly, possessed excellent interpersonal skills, and was able to write with a high degree of accuracy, which are all attributes necessary for grounded theory researchers (Streubert & Carpenter, 1999).

During and following data collection and analysis, memo writing was employed to help formulate concepts. Memo writing involved the researcher storing analytical ideas and thoughts on paper (Strauss & Corbin, 1998a). Memos consisted of coding products, they provided direction for theoretical sampling, and allowed the researcher to sort out ideas (Strauss & Corbin, 1998a). They were used to remind the researcher of events, actions and interactions and triggered her thinking process (Holloway & Wheeler, 2002). Memo writing

went through stages and became more complex as the research progressed (Holloway & Wheeler, 2002).

3.6 Data Analysis

Simultaneous data collection and analysis occurred. Constant comparison was used throughout analysis, which means that the researcher compared each section of the data with every other and searched for similarities and differences (Holloway & Wheeler, 1996). This process also involved identifying categories in the data (Holloway & Wheeler, 1996). The researcher looked for relationships between concepts, such as patterns and links between categories (Streubert & Carpenter, 1999). This was a useful process for finding properties and dimensions of categories, and helped examine concepts critically when compared to new incoming data (Holloway & Wheeler, 2002). Data were analysed using a coding system, which means that concepts or themes were identified and named during analysis (Holloway & Wheeler, 1996). Each code represents the operations by which data are broken down, conceptualised and put back together in new ways (Strauss & Corbin, 1998a). There are three levels of coding in grounded theory: open, axial and selective coding (Strauss & Corbin, 1998b). An audit trial will be used to track the processes the researcher employed to develop categories in each level of coding. The coding processes occur together until categories are saturated (Strauss & Corbin, 1998a). This means that no new information seems to emerge during coding, or in other words no new properties and dimensions, actions or interactions, or consequences emerge from the data (Strauss & Corbin, 1998a).

3.6.1 Open Coding

Open coding is the initial type of coding whereby data is closely examined in order to develop provisional concepts (Strauss, 1995). It is known as open coding as the data is opened up to expose thoughts, ideas and meanings that exist within (Strauss & Corbin, 1990). There are several ways to undertake open coding however the method chosen by the researcher was *line-by-line* analysis. This involved close examination of data, phrase-by-phrase and sometimes word-by-word. The steps involved in open coding are fragmentation, conceptualisation and categorisation. The first step is to break or fragment the data (Table 3.1) into discrete parts, and closely examine them for similarities and differences in order to generate concepts (Strauss & Corbin, 1998a).

Table 3.1: Fragmentation of the data and application of a conceptual label

Data	Conceptual label
...if they feel... they are not being... listened to... then they will not trust you... Julie.	**Listening to patients' stories**

The next step is to conceptualise the data (Table 3.2) which is an abstract representation of an event, object, or action or interaction that the researcher identifies as being significant in the data (Strauss & Corbin, 1998a). The aim is to enable the researcher to group similar events, happenings and objects under a common heading or classification. Each concept is named according to an object that has meaning to it or the name may be taken from the respondents themselves (Strauss & Corbin, 1998a). The latter is often referred to as *in vivo codes.* As data is classified, the researcher responds to what strikes participants as relevant and classifies accordingly (Strauss & Corbin, 1998a).

Table 3.2: Conceptualisation of the category *Developing Trust*

Listening to patients' stories	Being friendly
Taking time	Being respectful
Being honest	Maintaining confidentiality
Being consistent	Self disclosing
Assisting with meals	Being clear

Data were examined more closely once conceptual labels were formed (Strauss & Corbin, 1998a). Concepts were then grouped under more abstract categories based on their ability to explain what is happening (Strauss & Corbin, 1998a). The researcher aimed to form categories where a range of potential meanings contained within the words used by participants were uncovered and developed further into dimensions. Categories are defined as events, occurrences, objects and actions or interactions that are found to be similar in nature or related in meaning that are grouped together (Strauss & Corbin, 1998a). Grouping concepts into categories was important as it enabled the researcher to reduce the number of units with which she was working. For example, the conceptual label "listening to patients' stories" was grouped with a number of other conceptual labels, and through the process of

abstraction, the category *Developing Trust* was identified (Table 3.3). The category then developed further into terms of properties and dimensions. Through the forming of categories, the researcher gave categories precision and differentiated them from other categories (Strauss & Corbin, 1998a).

Table 3.3 The category *Developing Trust* and related strategies

Category	Strategy
Developing trust	Listening to patients' stories
	Maintaining confidentiality
	Being honest
	Taking time

3.6.2 Axial Coding

Axial coding involves the 'intense' analysis of one category in order to identify the relationships that exist in a category (Strauss, 1995, p. 32). It is defined, as the process of relating categories to their subcategories. The code is called axial as the coding occurs around the axis of a category, linking a category at a level of properties and dimensions (Strauss & Corbin, 1998a). The process involves reassembling data that were fractured during open coding (Strauss & Corbin, 1998a). This occurs as categories are related to their subcategories to form a more precise and complete explanation of the phenomena. There are two levels of analysis in axial coding: actual words used by participants and the researcher's conceptualisations of these (Strauss & Corbin, 1998a). The latter refers to the researchers' interpretation of events (Strauss & Corbin, 1998a). During analysis, the researcher aimed to answer questions such as who, when, where, why, how, and with what consequences. This process enables the researcher to search for explanations and gain a better understanding of the data. The category *Developing Trust* was formed by examining how the conceptual labels related to one another and condensing similar concepts. The conceptual labels were further analysed to identify related subcategories known as strategies, which were 'listening to patients' stories', 'maintaining confidentiality', being honest', and 'taking time'. Forming subcategories under categories gave each concept greater explanatory power (Strauss & Corbin, 1998a).

3.6.3 Selective Coding

Selective coding is a process of integrating and refining theory with the purpose of discovering a core category, and systemically integrating the relationships that exist between the core category and other categories and validating those relationships (Polit & Beck, 2004; Strauss & Corbin, 1998a). The category *Developing Trust* was interrelated with other categories, *Building Rapport* and *Being Supportive*. The common link or relationship between theses categories was *Interacting with Patients*, therefore the focus of the same name was developed.

A core category was developed in this study by determining linkages between the foci and contextual factors that were identified. A core category represents the main theme of the research that has analytical power and is able to pull the other categories together to identify relationships between them and form an explanatory whole (Strauss & Corbin, 1998a). Through the development of a core category, a theory can also be formed. Theory comprises of a set of well-developed categories that are systemically inter-related through statements of relationship to form a theoretical framework that explains phenomena (Strauss & Corbin, 1998a). Theory provides a guide of action that can be used to explain and predict events (Strauss & Corbin, 1998a). Through examination of the relationships that exist, this study formulated a substantive theory (theory that applies to a specific area of investigation), *Instigating an individual focus* to guide action for nurses when they develop professional interpersonal relationships with adolescent patients who have anorexia.

3.7 Preconceived Ideas

The researcher's preconceived ideas were that nurses have great difficulty developing interpersonal relationships with patients who have anorexia, there are specific strategies always used to develop relationships with these patients, and many nurses hold negative views about patients who have anorexia. Although she had these ideas prior to data collection, the researcher did not allow these ideas to influence the data that emerged. The researcher achieved self-awareness by keeping a journal of her own feelings regarding the development of professional interpersonal relationships with these patients and did not include them in the study.

3.8 Ethical considerations

The study required ethical approval by the Human Ethics Committee of Victoria University and the hospital where participants were accessed, to ensure that the study was performed with the highest ethical standards. In the current study, participants were volunteers and were provided with information via the Plain Language Statement prior to signing the Consent Form (Appendix A). There were no risks associated with taking part in the study. Participants were informed that they could withdraw from the study at any time without explanation or penalty, and they could review or edit the answers they had given during the interviews upon request.

The confidentiality of participants was kept throughout the study. The researcher and principal supervisor were the only individuals aware of the identity of participants. Any personal or identifying information, such as names on consent forms, were kept separate from the data. Pseudonyms were used in the interview transcripts and recorded tapes. Pseudonyms were used to conceal participants' identity and place of employment. The data were securely stored in a locked filing cabinet and password protected computer during the study and was accessible only to the researcher. The principal supervisor will hold the data for 5 years after the completion of the final report as required by the National Health and Medical Research Council.

3.9   Rigour of the Study

Qualitative research studies are subject to criticism and questions concerning, validity, reliability and generalisability (Cutcliffe & McKenna, 1999). In grounded theory, the criteria for evaluation are referred to as fit, work, relevance, modifiability and scope (Schneider, Elliott, LoBiondo-Wood & Haber, 2003).

3.9.1 Fit

Fit is defined as the process of identifying characteristics of one piece of data and comparing them with characteristics of another (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). The constant comparative method used in grounded theory is considered reliable to the study findings as it searches for alternative cases that may challenge the emergent data (Clifford,

1997). This form of triangulation of data, along with the use of theoretical sampling, ensured the research findings were complete and confirmed (Cutcliffe & McKenna, 1999).

3.9.2 Work

Work pertains to the ability of the theory to be applied in practice (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). The theory developed can be used in similar environments, as the information obtained was from nurses working with patients who have anorexia.

3.9.3 Relevance

Relevance aims to describe the appropriateness of the study findings to the group under investigation (Polit, Beck & Hungler, 2001). The concepts portrayed participants' experiences as the words they used in dialogue were applied to code emerging concepts and the researcher returned to participants to confirm the accuracy of their transcripts. The researcher also kept a journal to ensure that her preconceived ideas did not influence the data collected and that the concepts developed truly represented the participants investigated.

3.9.4 Modifiability

Modifiability is defined as qualifying the study findings (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). An account is valid or true if it represents accurately those features of the phenomena that it is intended to describe or explain (Cutcliffe & McKenna, 1999). The researcher verified concepts in conjunction with her supervisor and returned to participants to review their transcripts. Memo writing helped formulate and direct concept development and an audit trail was used to display how concepts were developed and justified. The researcher ensured that the data represented the everyday reality of the phenomena, as diverse data were included in the findings and the study did not prematurely close the investigation (Streubert & Carpenter, 1999).

3.9.5 Scope

Scope pertains to the opportunity to use the finding in other settings (Schneider, Elliott, LoBiondo-Wood & Haber, 2003). The scope of the findings is limited as this was a small qualitative study. Nevertheless, the findings can be used to increase the knowledge of nurses

and other healthcare professionals when developing professional interpersonal relationships with patients who have anorexia in similar settings.

3.10 Summary

The study used a grounded theory approach to collect and analyse data. This method was appropriate to the study as it aims to discover the processes that determine actions in situations from participants' perspectives. Data was collected using audio-taped, unstructured, in-depth interviews. Data was analysed using a coding system, which identified categories, and their properties and dimensions. A core category and substantive theory was also developed. Confidentiality of participants was maintained at all times during data collection, analysis, and in the final report. Rigour of the data was ensured by constant comparison of data and identifying an audit trail of how concepts were developed.

CHAPTER FOUR:

FINDINGS OF THE STUDY

4.1 Introduction

This Chapter presents the findings of this study of how paediatric nurses developed professional interpersonal relationships with patients who have anorexia nervosa. The first part of the Chapter examines the contextual factors that influenced the way nurses developed interpersonal relationships with these patients. The second part of the Chapter describes the two foci that emerged from the data, which were 'interacting with nurses' and 'interacting with patients'. Each focus represents a set of categories and each category describes the strategies that nurses used to develop professional interpersonal relationships. Although the foci are discussed separately, the data showed that they intersected through the process of developing interpersonal relationships with patients. Lastly, the core category will be described.

4.2 Contextual factors

Several contextual factors were identified in the data that either negatively or positively influenced the development of professional interpersonal relationships with patients who have anorexia. Contextual factors are actions and interactions that occur in a specific setting under certain conditions (Chenitz & Swanson, 1986). This means that the variations and conditions that occurred in this study will be examined. The main contextual factors identified in this study included 'unit protocol', 'treatment plans', 'nurses' workloads', 'insufficient education for nurses' and 'nurses' perceptions of patients' (Figure 4.1).

4.2.1 Unit protocol

The unit protocol was a written document that provided a general framework of care of patients who have anorexia. Together, doctors, nurses and dieticians formulated the protocol. The protocol was mainly designed to meet the illness related needs of patients and it needed to be followed closely by participants and other healthcare professionals.

Figure 4.1: Contextual factors that affected the development of professional interpersonal relationships
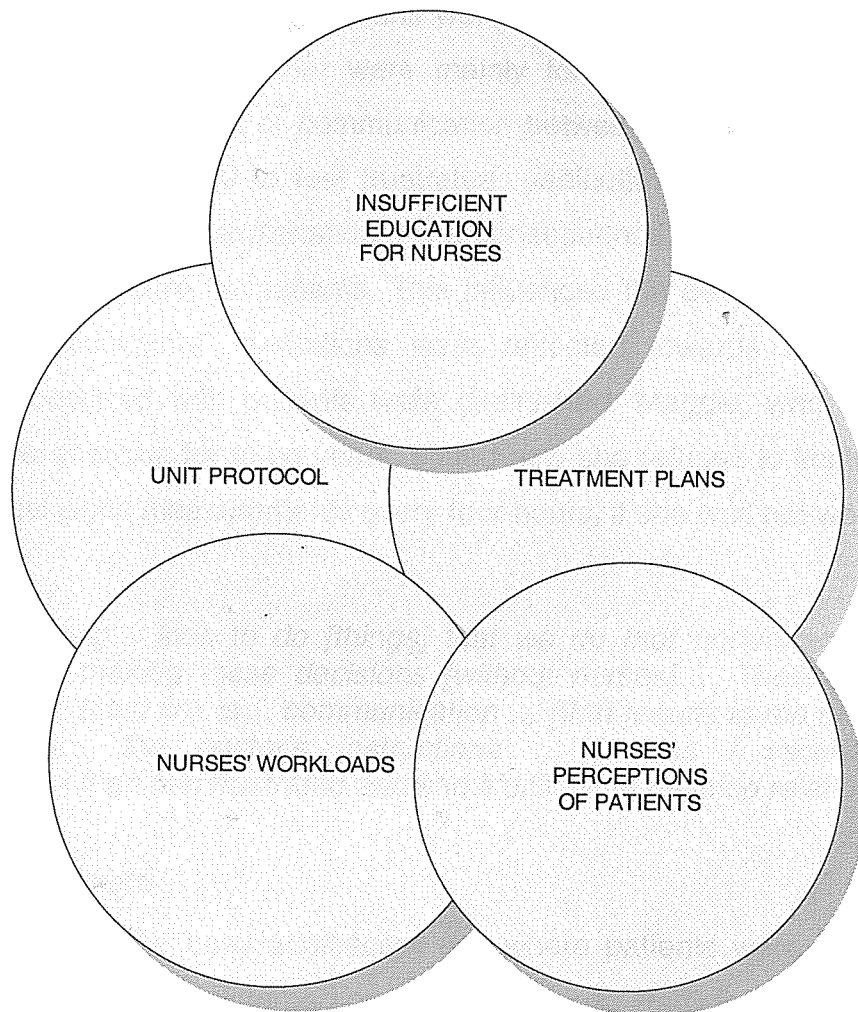
Participants described the protocol as inflexible due to the fact that participants were expected to strictly follow these guidelines. As a result, participants were restricted in the strategies that they could use to develop interpersonal relationships. Endora, who had been nursing patients who have anorexia for three years, stated that the protocol restricted her ability to develop interpersonal relationships with patients.

> [Patients]... see us as forcing things on them.... Often we [are] implementing things that other healthcare professionals have put in place.... and [nurses are] seen to be restricting things.... In most circumstances the relationships [are] more restricted... because that [is] the way we care for them.

4.2.2 Treatment plans

Participants stated that the treatment plans for patients who have anorexia were often not explained to them in detail. Treatment plans were an individualised outline of physical care for patients who have anorexia that were mainly formulated by doctors and dieticians. Participants stated that the lack of communication between healthcare professionals about treatment plans caused nurses to feel frustrated, particularly when they felt compelled to implement treatments without explanation. As a consequence, they felt as though they were not providing adequate care for patients. This influenced the development of interpersonal relationships as participants' frustrations were reflected towards the patients and the interactions that occurred with patients were diminished. Maggie, who had been nursing patients who have anorexia for three years, stated how she refused to implement treatments such as taking vital signs measurements every four hours, if she was not well informed.

> We are... forcing... kids to do [things] that we do [not understand].... [The doctors are]... making these decisions [without nurses].... There does [not] seem [to be] a direct link in... communication ... [that results in me not wanting to]... enforce... the doctor's instructions ... [unless I receive] more information.... I then feel frustrated and find it difficult to develop relationships.

4.2.3 Nurses' workloads

Participants stated that the busy adolescent unit where patients were cared for adversely affected the development of interpersonal relationships. Participants not only cared for patients who have anorexia, they were also responsible for acutely ill and chronically unwell patients who required a great deal of care. As a result, there was limited time available to spend with patients who have anorexia. The lack of time impacted on the development of interpersonal relationships as participants found it difficult to understand patients and build rapport. Julie, who had been nursing patients who have anorexia for five years, explained that time constraints contributed to the lack of availability for nurses to be with patients and, consequently, the opportunity to develop relationships was decreased.

> This is not an ideal place for most of our patients...because... we do not get to spend enough time with them... so it is difficult to form a relationship with them.

4.2.4 Insufficient education for nurses

Participants talked about the difficulties of developing relationships with patients who have anorexia as they had received little education on this group of patients in their undergraduate courses and in their workplace education. Participants had received no mental health training and relied on experienced staff members to help them develop relationships with these patients. Apart from one participant, no formal education had been undertaken about how to care for patients who have anorexia. This lack of education often resulted in discrepancies in how these patients should be managed and how relationships should be developed. The participant who received training stated that she was able to develop relationships with patients more easily as she had a better understanding of these patients and could instigate appropriate strategies. Some participants suggested that by gaining a better understanding of the condition, this would enable them to develop more suitable strategies to form interpersonal relationships. By gaining an understanding of anorexia, participants felt they would also be better able to accept some of the behaviours of patients and this in turn may assist them to developing professional interpersonal relationships. Candy and Kylie, who had been nursing patients who have anorexia for 14 and 5 years respectively, described this below:

I did [not] have an understanding [of] ... [anorexia].... when I first cared for [these patients]. [I later] did a course [about anorexia].... [It] helped me understand these kids. I found it a lot easier to look after [them] and form relationships.

Candy.

[You] can... look after a patient... for months... and never really... understand what is happening... to [them].... [It is]... good to be able to [understand what is going on,] ... [because it can]... help you develop... relationships ... [as] you can... approach the patient [better]... and... deal with the situation.   *Kylie.*

4.2.5 Nurses' perceptions of patients

Participants stated that the way they perceived patients who have anorexia influenced the development of interpersonal relationships. Participants acknowledged the presence of stigma associated with patients who have anorexia, however their focus was on the individual when attempting to develop relationships. This focus had a positive influence when developing relationships as patients were not labelled and could be seen as individuals. This awareness resulted in participants being able to identify patients' specific needs, the

interactions that had occurred between patients and participants improved, and the development of satisfactory relationships was more likely.

> *Everyone has their... opinions and values about anorexia nervosa... [For example,] they are considered more emotionally draining... Adopting an individualised approach, based on the person... is the way ... [to develop relationships].*
>
> *Kylie.*

4.3   Strategies used to develop professional interpersonal relationships

The strategies that participants used to develop professional interpersonal relationships were divided into two foci of care. The first focus, interacting with nurses, concentrated on the indirect strategies that participants used to develop interpersonal relationships with patients. This focus examined how interacting with nurses helped participants formulate professional interpersonal relationships with patients. The second focus, interacting with patients, investigated the direct strategies that were used to develop interpersonal relationships. These strategies were used when interacting with patients. Each focus had a set of categories and within each category a set of strategies was identified. The data showed that the two foci interconnected through the process of developing professional interpersonal relationships.

4.3.1 Interacting with nurses

The first focus of care, interacting with nurses, highlighted the importance of using indirect strategies when developing professional interpersonal relationships with patients who have anorexia. The data showed that the interactions that occurred between participants and other nurses helped the development of relationships with these individuals. The participants' ability to develop relationships with patients improved when they supported one another and shared information with nurses. Participants also used their own experiences when forming relationships (Figure 4.2).

Figure 4.2: Interacting with nurses
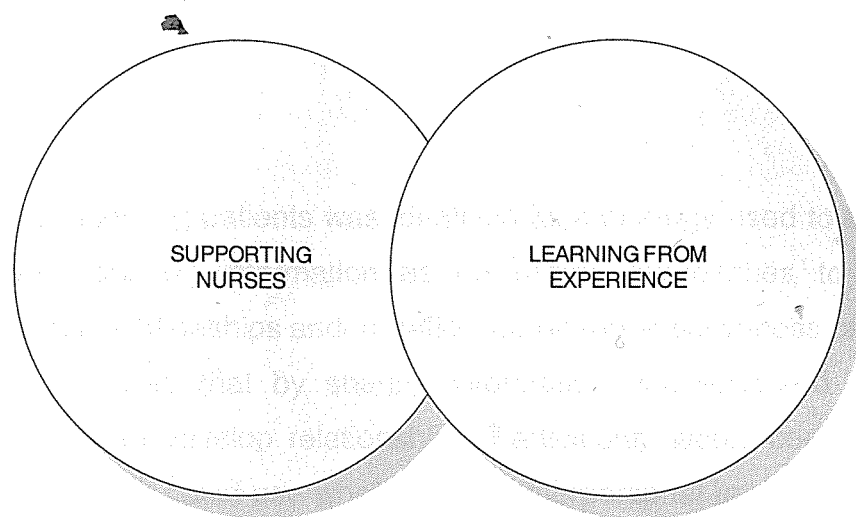
The categories identified from the data within this focus were: 'supporting nurses' and 'learning from experience' (Table 4.1). The category 'supporting nurses' along with the strategy 'sharing information', described how nurses relied on each other to develop relationships with patients, especially when having difficulties. Participants were also able to identify approaches to undertake when they learned from their experiences through reflecting on previous relationships they have had with patients.

Table 4.1 Interacting with nurses: Categories and strategies

Category	Strategies
Supporting nurses	Sharing information
Learning from experience	Reflecting on clinical experience

4.3.1.1 Supporting nurses

'Supporting nurses' was identified as an important category that was used to develop professional interpersonal relationships with patients who have anorexia. The data showed that participants required collegial support to identify the most useful strategies to use when developing relationships. It was also important for participants to be supported as a lack of support may have caused them to have negative perceptions of these patients. For example, participants who had received little support from their colleagues found it difficult to develop interpersonal relationships with patients and, as a result, they considered these patients as

challenging. The main way participants were supported or supported each other was by 'sharing information'.

Sharing information

Sharing information concerning patients was identified as a strategy used to support nurses. Participants described sharing information as discussing approaches to employ when developing interpersonal relationships and/ or reflecting on the effectiveness of currently used strategies. The data showed that by sharing information, individualised and consistent strategies could be used to develop relationships. Participants would consult other nurses regarding the strategies they could use when forming interpersonal relationships, particularly when they had encountered difficulties. For example, participants acknowledged that they may have difficulties forming interpersonal relationships with some patients and by consulting other nurses who had formed relationships with these patients they may overcome some of the difficulties. Through discussions with other nurses, suitable strategies can be identified, knowledge can be shared and the challenging behaviours sometimes displayed by patients could be managed. Through communication and working collaboratively, participants were able to focus their care based on patients' individual needs and form relationships more easily, as participants felt supported and were provided with direction and confidence when developing relationships and providing care. Rachael, who had been nursing patients who have anorexia for three years, explained how sharing information helped her develop interpersonal relationships by identifying suitable strategies and being more consistent:

> *[It is] good to talk to... staff ... [who have]... a lot of [experience].... because [they are] willing to share information.... This is important... to be consistent to help develop better relationships. [When we work as] one team...through ... good communication...and have the same... goals...it helps develop a good relationship.*

4.3.1.2 Learning from experience

The data showed that learning from experience was another approach that participants used to develop professional interpersonal relationships with patients who have anorexia. Participants had learnt from their previous relationships in the clinical environment and used similar approaches in current relationships. 'Reflecting on clinical experience' was the main strategy used to develop relationships with patients.

Reflecting on clinical experience

Participants described reflecting on clinical experience as utilising the knowledge and skills they had gained from previous interpersonal relationships and applying these to their current relationships with patients. Participants reflected on their earlier experiences of developing relationships and determined the strategies they would use in subsequent relationships. For example, James, who had been nursing patients who have anorexia for five years, described how his experiences had changed his willingness to trust patients.

> *I thought... I could trust her.... I only turned my back for a little moment... to fiddle with [a] machine and... it happened.... [She hid the sandwich]. So ... I [am] not as trusting as... I used to be.*

Participants also described how they had occasionally become emotionally over involved with some patients. This had caused them to become emotionally drained or unable to cope with some situations. Participants learned through experience that they needed to distance themselves from the patient and re-engage when they felt more comfortable to prevent this from occurring. When participants were able to cope with their feelings they would then return and engage with patients once again in order to re-establish the relationship.

> *I had [a] patient... who ... ran out the ward... crying.... during her lunch... I [did not] know how to cope with [her].... [What] I [have] learned from that [is]... [I need to]... take a ... step [back] for a while... and then... re-engage again later... but that comes with experience.* Rachael.

4.3.2 Interacting with patients

The second focus, 'interacting with patients', involved the direct strategies that nurses used to develop professional interpersonal relationships with patients who have anorexia. The direct strategies used were largely influenced by the indirect strategies, and the two foci overlapped and interacted. Participants stated that patients influenced the direct strategies that they used as each patient and situation varied, therefore the direct strategies that participants used to develop relationships were individualised. Three main categories that emerged from the data were 'building rapport', 'being supportive', and 'developing trust' (Figure 4.3).

Figure 4.3: Interacting with patients
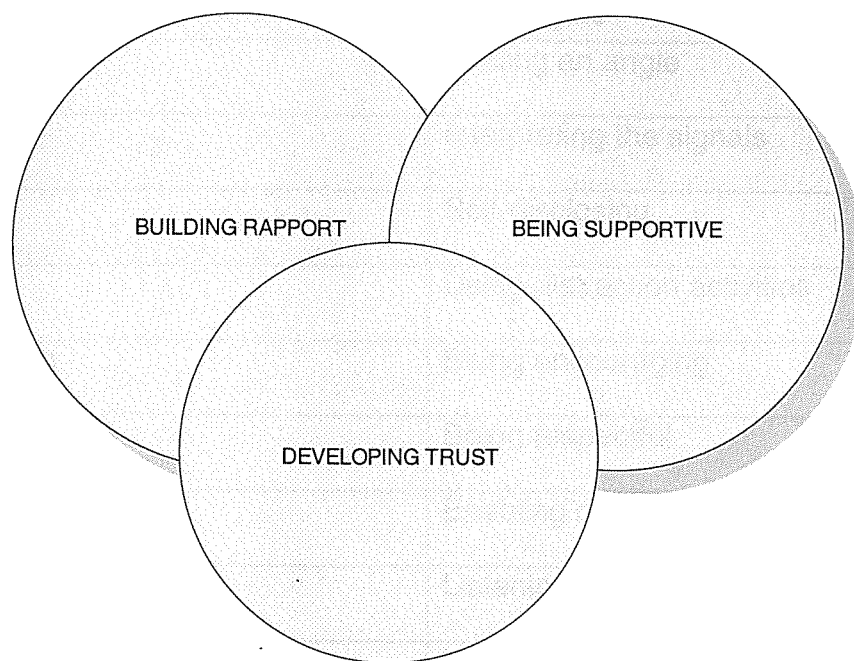
Each category represented a set of strategies as to how nurses developed professional interpersonal relationships with patients who have anorexia (Table 4.2). Each category and related strategy will be discussed next.

4.3.2.1 Building rapport

Building rapport was identified as a category in the development of professional interpersonal relationships with patients who have anorexia. Participants described building rapport as developing positive interactions with patients. This initially entailed participants and patients becoming acquainted and later progressed to participants being able to understand patients. By understanding patients, participants were able to provide care that was consistent with patients' needs. The strategies used to build rapport were: 'finding an angle', 'interpreting the signals', 'self-disclosing', and 'using distraction activities'.

Table 4.2 Interacting with patients: Categories and strategies

Category	Strategies
Building rapport	Finding an angle
	Interpreting the signals
	Self-disclosing
	Using distraction activities
Being supportive	Being encouraging
	Being respectful
	Enabling control
Developing trust	Listening to patients' story
	Maintaining confidentiality
	Being honest
	Taking time

Finding an angle

Finding an angle was identified as an important strategy that nurses used to develop relationships. Participants described finding an angle as discovering approaches they could use to understand the patient. They suggested that it was valuable to find an angle as it may help patients reveal their feelings. Participants described that they utilised various opportunities to find an angle in order to become successful at forming relationships. One way participants would find an angle was through examining the conversations they had with patients. Through conversations and examining these interactions, participants believed they were demonstrating that they wanted to know more about patients. This facilitated patients to express their feelings and, as a result, participants were able to gain a better understanding of them. Endora highlighted the importance of conversation in order to find an angle and gain an understanding of patients. Participants would also find an angle by being open. Being open was described as being receptive and attentive to patients. Participants also demonstrated that they were an interested in getting to know patients by being open.

Ensuring eye contact whilst speaking to patients was a way participants displayed their openness. Emma, who had been nursing patients who have anorexia for two years, explained how being open showed that she was attentive.

In general conversation I try and find something... that they have an interest in and... develop that further.... [So I have] some sort of an angle to... find out... what [is] going on... in their minds and thoughts ... [to get a] bigger picture of what [is] happening.
<div align="right">*Endora.*</div>

[I]...smile ... [to show I am] open ... [and I am]... there... to help them through the process.... I use eye contact to also show I am open and receptive... to answer questions.
<div align="right">*Emma.*</div>

Interpreting the signals

Participants disclosed that once they had developed an understanding of patients, their ability to interpret signals that patients were displaying improved. According to participants, interpreting the signals means nurses could identify how patients were feeling through patients' responses. For example, patients may have displayed that they wanted to disclose their feelings by responding openly to questions. By interpreting the signals, participants were guided by patients' responses and could initiate care accordingly. Participants stated that responding to the signals given by the patient showed that participants were attentive and were concerned about them. This aided the development of relationships, as participants appeared willing to understand patients and their situations.

[Sometimes it is]... the things they do.... [The way they] speak to you... the way they look at you, their face [and] their body language ... [indicate] ... [their response]. Sometimes their body language... indicates that... there [is] something [they want to] talk about.... Sometimes [it can be] a verbal thing [for example] "Can I talk to you?" but more often... it [is] just what you [interpret].I use this to determine the effectiveness of a strategy.
<div align="right">*Maggie.*</div>

Self-disclosing

Participants discussed the importance of self-disclosing when developing relationships. Self-disclosing was described as nurses revealing personal information about themselves to patients. Participants stated that self-disclosing was important as it helped the development of a reciprocal relationship where nurses and patients had an opportunity to share

experiences. Self-disclosing was considered valuable as nurses and patients were considered equal partners in the development of the relationship. This was also useful when forming interpersonal relationships, as participants were not seen as a threat and patients were, therefore, more likely to participate in the relationship.

I have talked about things going on in my life, in very basic ways.... Not that I give great details.... I think it [is] just a part of the... reciprocal... relationship... I think it... puts them on your level and helps develop a relationship.   *Julie.*

Although self-disclosure was identified as a strategy to help develop interpersonal relationships, sharing excessive amounts of personal information could have a negative effect. Participants disclosing large amounts of personal information could consequently result in patients avoiding expressing themselves due to the focus being shifted to the nurses. Participants therefore limited the amount of personal information they disclosed. The amount of information shared with patients was influenced by participants' level of comfort. Level of comfort was defined as the depth of interaction participants wished to have with patients, which was influenced by professional boundaries and the individual personalities of patients and nurses. For example, participants would only disclose information about themselves on a superficial level due to their professional roles and responsibilities. Participants who had similar personalities with patients would divulge more information about themselves compared to other patients

Every person has a level of intimacy that they want to [have] with... another person.... The patients who have similar personalities you will automatically feel you are... able to talk to them... about more ... personal [things]... So using your instinct ... or comfort level determines the depth of interactions.
Kylie.

Using distraction activities

Participants described how they used distraction activities to help form interpersonal relationships with patients. This approach was considered an important way to help patients focus less on their illness and concentrate on other aspects of their lives. As a result, patients were more likely to relax and express themselves. Using this approach also helped improve the interactions that occurred between participants and patients. Distraction activities were described as tasks or conversations that were used to divert patients' focus on their illness.

Some examples of distraction activities adopted by participants were the use of humour, art and music therapy. Participants talked about how humour helped patients become more comfortable with them, as it showed that they were interested in understanding patients as individuals. By focusing less on the illness, patients would become more relaxed and their ability to express their feelings improved. Humour was described as being able to say and perceive things as amusing. The main way participants were humorous was through improvisation. Participants also described the use of art and music therapy as means of helping patients express their feelings. Activities that aimed to externalise patients' feelings, such as drawing how the disorder began, increased participants' understanding of patients.

> *[She] used to wear a t-shirt that had an oriental symbol on the front and I... always said to her that is was... a shirt that had been lying on the road with a frog on it...[that] must have been run over.... Just something... silly.... to make them laugh ....so they do not think of themselves as an eating disorder the whole time and it can help form relationships.*   *Candy.*

> *I... talked about what feelings [one girl was... having... through]... some art therapy.... Encouraging her to express herself... through art... was beneficial when forming a relationship to gain an understanding of her feelings.*   *Maggie.*

4.3.2.2 Being supportive

Another category that emerged from the data was being supportive to patients who have anorexia. Participants defined being supportive, as providing practical and emotional assistance to patients when required. By being supportive participants were involved in patients' care. Participants stated that supporting patients through difficulties could help the development of professional interpersonal relationships as patients perceived that participants cared for them. The main strategies participants used to support patients were through 'being encouraging', 'being respectful', and 'enabling control'.

Being encouraging

Participants talked about supporting patients through encouragement. They described being encouraging as inspiring patients to recover. Being encouraging helped form interpersonal relationships, as participants showed that they were involved in patients' care and they aimed for recovery. The interactions that occurred between participants and patients were also

enhanced through being encouraging as it facilitated each other to take part in the relationship and patient care. Participants stated that the techniques they used to encourage patients were individualised, however a common approach used to encourage patients was by providing them with positive feedback about their progress. Positive feedback was provided for behaviours that were considered to advance patients' healing, for example compliance with treatment. Through positive feedback patients felt as though they were achieving goals and making improvements.

> *[Each] patient is different of how you support them.... [I will] encourage some patients... during a meal [by] giving positive feed back that they [are] doing really well... to let them know that they are getting better, and... they [are] achieving... little goals.* Kylie.

Being respectful

Participants described the effectiveness of being respectful when developing interpersonal relationship with patients who have anorexia. Participants described being respectful, as demonstrating thoughtfulness and consideration. By being respectful participants believed they appreciated patients and they displayed care. This approach helped develop interpersonal relationships, as patients felt that nurses valued them as individuals. By valuing patients as people they were more likely to take part in the relationship, comply with treatment and assist with their recovery. Valuing patients through respect was thought to enhance patients' personal development and patients would value themselves if participants valued them. Some of the ways participants showed respect was by maintaining privacy, not forcing patients to express themselves and focusing on aspects of patients' lives that did not include their illness.

> *[By] treating people [who have] anorexia with respect ...I... develop a better relationship with them... as they know I value them as a person.* Maggie.

Enabling control

Enabling patients to have control over some aspects of their care and treatment helped the development of professional interpersonal relationships. Participants described enabling control as allowing patients to have power and say in relation to their care. Enabling control could be achieved through patients having a choice about when they have their meals, for example, or the activities they took part in. Participants described how providing choices

showed patients that nurses believed they were able to make their own decisions. Participants provided assistance and guidance, when patients made decisions to ensure patients' safety was not compromised and that the outcomes were in the best interests of patients. Providing choices helped develop professional interpersonal relationships as participants were viewed as assisting patients to become more independent and progress in their recovery. Participants stated how informing patients about their illness or treatment helped patients gain control. Through this patients were considered better prepared and less anxious, and were more willing to take part in their care. Given that patients who have anorexia often refuse their primary treatment, to consume food, allowing them to have choices in other areas of their treatment could help avoid the difficulties faced with adherence to treatment. This helped form relationships, as participants believed it enhanced interactions between nurses and patients.

> *Trying to...support...their ability to make their own decisions is important to develop relationships with them.*   *Maggie.*

4.3.2.3 Developing trust

Developing trust with patients was identified as the final category when forming professional interpersonal relationships. Participants identified developing trust as a progression towards being confident that nurses and patients are truthful and reliable. Participants described that developing trust helped form professional interpersonal relationships, as patients were able to depend on the nurse to be honest about their care, treatment and progress. Participants also relied on the patients to be truthful about their feelings and behaviours. Trust was considered to form a connection between participants and patients, as each contributor was dependent on the other to help relationships improve and progress. Once trust was developed, participants claimed that patients' needs could be identified and dealt with appropriately. The strategies used to develop trust were 'listening to patients' stories', 'being honest', 'maintaining confidentiality' and 'taking time'.

Listening to patients' stories

Participants identified that listening to patients enabled trust to develop in relationships with those who have anorexia. Listening to patients' stories was described by participants, as being attentive towards patients past events and developments, as well as their current

situations. By concentrating on patients' verbal communications, they showed patients that their views and concerns had been heard. Not only was it important for participants to listen to patients' stories, the feedback given to patients was also important. Participants believed that clarifying patients' views, being non-judgemental and responding to their concerns, helped patients feel confident that they had been listened to. Through listening, participants were able to develop an in-depth understanding of patients and assist them when required. This helped form interpersonal relationships as a connection between participants and patients could be formed.

> *By listening to patients you can understand what has brought them... to be... where they are... This helps... get their trust and confidence in you.... [So] they can... share... and... talk about [things] with you.* Endora.

Maintaining Confidentiality

Participants described how maintaining confidentiality helped the development of trust. Participants defined maintaining confidentiality as not disclosing patient information to others unless the patient had consented. According to participants, patients were most concerned about nurses revealing personal information to their parents. Participants described that maintaining confidentiality resulted in patients expressing their feelings more often as they felt secure. It helped form a connection between patients and participants as patients' views and feelings were protected within the relationship. When patients were confident that participants would not disclose their personal information, they were more likely to discuss their feelings and were willing to develop relationships. This helped form a deeper understanding of patients and participants were able to gather more information about their needs.

> *Others... do [not] understand what [is] going on... because of confidentiality... so it [is] like... you have a secret with the... patient... and they know that you [are] not going to disclose [it] to anybody... A... bond... is formed in some ways... and they know ... you are going to protect them.* Maggie.

Being honest

Being honest with information about patients' progress and treatment was useful when developing professional interpersonal relationships with patients who have anorexia. Participants described being honest as ensuring clarity and consistency about the information

provided to patients or the actions of participants. When nurses were honest, patients were aware of what to expect with their treatment and care. They stated that patients were more likely to view their judgements and opinions as aiding their recovery, when they were honest. Participants identified communication, consistency and being clear as ways to ensure honesty, as patients were less confused about their treatments and progress. They indicated that in order for trust to develop, patients also needed to be honest with the nurses about their feelings and situation. Being honest helped form interpersonal relationships, as nurses and patients could be overt about care, treatment and progress. The increased understanding and willingness of patients to take part in relationships were enhanced through participants being honest.

> Being very clear... and communicating well... is important when developing relationships. It is difficult to develop relationships if [you are] ... [not] clear... as.... it is... confusing for patients ... and they lose trust.   Endora.

Taking time

Taking time to develop relationships with patients who have anorexia was considered important when forming relationships as it was a time consuming process. Through time and frequent interactions, patients and nurses could become more comfortable with one another. Participants stated that relationships developed over time were more likely to result in trusting relationships as nurses and patients had adequate time to interact and become acquainted. By allowing the relationship time to develop, participants could identify ways they could improve and form a more fulfilling relationship. Participants were aware that patients' needs could change frequently, therefore they required time to adjust and act if required according to these needs. Participants believed that patients required time to determine their needs and to whom they will disclose that information. Through time, a deeper understanding of patients could occur and patients were more likely to become active partners in relationships. By taking time to develop professional interpersonal relationships, the bond between participants and nurses could form naturally.

> I think trust... becomes... part of the relationship... If [I have] spent a few days with them... you can form... trust more easily.... [They can then] talk ... [and disclose their]... feelings.   Rachael.

4.4 Core category

The purpose of this substantive theory of how paediatric nurses develop professional interpersonal relationships with adolescent patients who have anorexia, comprised of a core category and interrelated foci, and contextual determinates that modified the process. The core category 'instigating an individual focus' (Figure 4.4) conceptualises how to develop interpersonal relationships with adolescents who have anorexia. The core category links the other categories together, and is premised on the following:

a) Participants instigated an individual focus when attempting to develop professional interpersonal relationships with patients who have anorexia. By adopting this approach they were able to understand the individual experiencing anorexia, which enabled participants to be better positioned to provide care that was consistent with patients' needs. The relationships developed were reciprocal, as patients felt valued and were more willing to actively participate in the relationship and accept assistance for their recovery.

b) The core category evolved by identifying the common themes and relationships between and among the foci, categories and strategies. The two key foci and related categories and strategies highlighted the importance of instigating an individualised focus when developing relationships with patients. The first focus, interacting with nurses, that explored the indirect strategies participants used to develop relationships, identified the importance of how supporting nurses by sharing information can be used to identify individualised strategies to develop relationships and determine the actions to take with patients. The category, learning from experience, and related strategy, reflecting on clinical experience, focused on how previous interpersonal relationships with patients who have anorexia helped determine the strategies participants used in current relationships. The second focus, interacting with patients, that pertained to the direct strategies that participants used in order to develop interpersonal relationships also emphasised the value of instigating an individual focus when developing professional interpersonal relationships. Building rapport, and related strategies, finding an angle, interpreting the signals, self-disclosing, and, using distraction activities, represented the participants' aim of developing an initial understanding of the individuals who have anorexia. The strategies highlighted the importance of instigating an individual focus by attempting to understand the individual, and interpreting and responding to the person who has anorexia. This

superficial understanding progressed to an understanding of patients' illness-related needs and how participants' attempted to meet their individual needs by adopting an individualised focus of care. The category, being supportive, and related strategies, being encouraging, being respectful, and, enabling control, described this phenomenon. The final category, developing trust, and associated strategies, listening to patients' stories, maintaining confidentiality, being honest, and, taking time, described how by instigating an individual focus to develop interpersonal relationships participants were able to advance the relationships by gaining an in-depth understanding of these patients through the development of trusting connected relationships.

c) Participants described the basic methods that they used to develop professional interpersonal relationships, however the effectiveness, utilisation and timing of the strategies was dependant on the response of each strategy on the individual experiencing anorexia. It was evident that in order to develop relationships, both participants and patients needed to be willing to participate in the relationship, contribute to its development and have a desire to do so. Participants held the main control over the development of relationships and they were developed primarily to benefit the patient during their current hospitalisation. Participants suggested that the main strategy to use when developing relationships with patients who have anorexia was to search beyond the illness and attempt to discover the individual. Once this approach was employed, the other strategies used to develop relationships should be successful. If participants were having difficulty developing relationships with some patients despite this approach, they were aware that they needed to accept this and attempt to establish relationships to the best of their abilities and/ or consult other nurses to aid them. Participants' perceptions and actions greatly affected the development of relationships, and were connected to how patients viewed themselves. For example, participants respecting patients and enabling patients to have some control helped patients value themselves and participate more readily in relationships. Those who instigated an individual focus that incorporated being non-judgemental, valuing patients, ensuring security of patient information, and taking time had the greatest success in developing professional interpersonal relationships with patients who have anorexia.

d) The key contextual determinants that moderated the way participants developed interpersonal relationships with patients were: unit protocol, treatment plans, nurses'

workloads, insufficient education for nurses and nurses' perceptions of patients. The unit protocol and treatment plans restricted participants' ability to instigate an individualised approach to develop relationships as they focused largely on the illness and participants were expected to strictly follow these guidelines. Nurses' heavy workloads limited their ability to develop relationships and, as a result, participants had decreased contact with patients and were less likely to instigate an individualised approach. The lack of education available to participants hindered their ability to adopt an individual focus to develop relationships, as participants had a decreased understanding of the illness the individual was experiencing. Participants' perceptions of patients who have anorexia positively influenced the instigation of an individualised approach to developing relationships.

Figure 4.4: Instigating an individual focus

CONTEXTUAL FACTORS

INTERACTING WITH NURSES

INTERACTING WITH PATIENTS

INSTIGATING AN INDIVIDUAL FOCUS
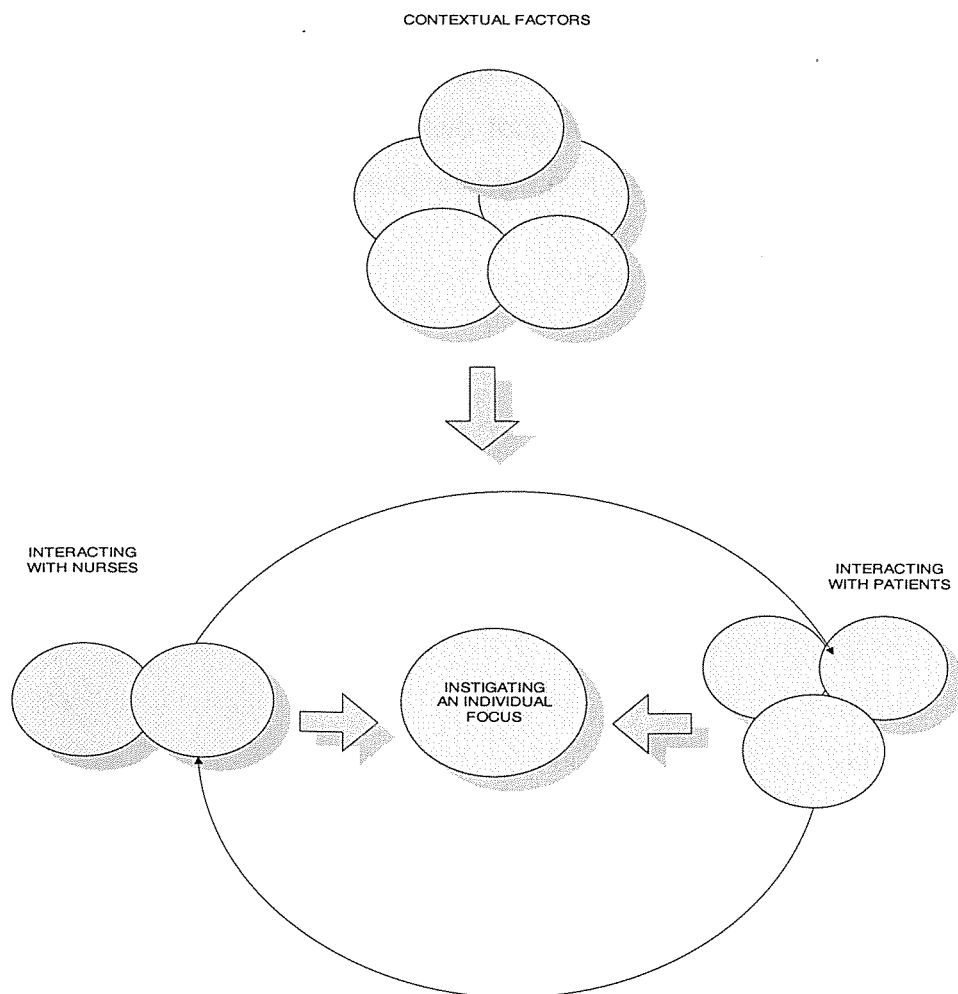
4.5 Summary

This chapter presented the findings of this study of how paediatric nurses developed professional interpersonal relationships with adolescent patients who have anorexia. Several contextual factors were identified: unit protocol, treatment plans, nurses' workloads, insufficient education for nurses, and nurses' perceptions of patients, that either negatively or positively influenced the strategies that participants used to develop relationships. The two foci that emerged from the data described how nurses developed relationships with patients using indirect and direct strategies. The first focus revealed that developing relationships with patients was affected by the interactions between the nurse participants and other nurses. Participants developed relationships by sharing information with other nurses and reflecting on their clinical experiences. The second focus examined the direct interactions participants experienced with patients that helped form relationships. The three categories identified in this focus: building rapport, being supportive and developing trust indicated that through understanding, assisting and connecting with patients, participants were able to form reciprocal interpersonal relationships. The core category, instigating an individual focus, was the common relationship that linked the two foci, which suggests that by focusing on the individual, professional interpersonal relationships can be developed with patients who have anorexia.

CHAPTER FIVE:

DISCUSSION

5.1　Introduction

This Chapter discusses the findings of this study of how paediatric nurses develop professional interpersonal relationships with patients who have anorexia. The foci, categories and strategies identified from the data will be discussed with reference to the current literature. The Chapter will firstly explore the contextual factors that were revealed in the data. Then the two foci, interacting with nurses and interacting with patients, and subsequent categories and strategies will be discussed. Finally, an examination of the core category will follow.

5.2　Contextual factors

The contextual factors that were identified in the current study either positively or negatively influenced the development of professional interpersonal relationships with patients who have anorexia. The actions and interactions that pertain to this setting were examined to reveal the main contextual factors: unit protocol, treatment plans, nurses' workloads, insufficient education for nurses, and nurses' perceptions of patients.

In relation to the first contextual factor, the unit protocol, participants stated that this protocol was inflexible and they were expected to strictly adhere to its procedures. Findings in the literature suggest that nurses are expected to follow and work within rigidly defined protocols, even when they are not convinced of their usefulness and that is inconsistent with their values (King & Turner, 2000; Ramjan, 2004). As a result, participants were restricted when developing interpersonal relationships with patients. This finding was supported by the King and Turner (2000), study. Protocols are most useful when nurses are educated on how to implement them and are able to provide continuous feedback regarding their effectiveness (Zaloga & Bortenschlager, 2004). There is also a need to improve hospital treatment programs and protocols to incorporate the development of therapeutic relationships (Ramjan, 2004; Zaloga & Bortenschlager, 2004).

With regard to the second contextual factor, treatment plans, participants described how these plans were often not clearly explained, therefore it caused them to feel frustrated, particularly when they felt compelled to implement treatments without explanation. If nurses cannot see the usefulness of treatment plans, they may begin to obstruct or dismiss them all together (King & Turner, 2000). Nurses' frustrations with treatment plans can be projected towards patients and, as such, can hinder the development of relationships. As a result of rigid treatment programs, nurses who are often the people implementing these treatments, are seen as taking control away from patients, as inflictors of punishment and as invaders of privacy (Ramjan, 2004). This can influence the development of relationships as nurses are seen as a threat and, as a result, the interactions between nurses and patients are reduced. Nurses, therefore, need to be more involved in assessing and restructuring treatment plans to promote patient care and to facilitate the development of relationships (King & Turner, 2000).

Nurses' workloads, was the third contextual factor that influenced the development of professional interpersonal relationships with patients who have anorexia. Participants stated that the busy medical unit where patients were being cared for adversely influenced the development of interpersonal relationships. Other studies concur with this finding that heavy workloads decrease the possibility of developing relationships with patients as they diminish the time that is available to interact with them (Greenglass, Burke & Fiksenbaum, 2001; Hagerty & Patusky, 2003; Lotzkar & Bottorff, 2001; McCann & Baker 2001; Williams, 1998). This can pose difficulties when attempting to develop relationships, as nurses may be unable to form an in-depth understanding of patients' experiences.

In relation to the fourth contextual factor, insufficient education for nurses, participants talked about the difficulties of developing relationships with patients who have anorexia as they had received very limited education on how to care for these patients either in their undergraduate courses or in workplace in-service education. It is not unusual for undergraduate courses to provide little information about eating disorders (Cameron, Willis & Ritcher, 1997). The lack of education often results in discrepancies about how these patients should be managed and how relationships should be developed (Ramjan, 2004). Education programs about the care of adolescents who have anorexia need to be developed and employed in order to support nurses (King & Turner, 2000). It is important that nurses caring for people who have anorexia receive training in mental health issues, and the healthcare system needs to take

responsibility for ensuring that nurses are prepared to care for these vulnerable patients (Ramjan, 2004). If nurses are not adequately educated, it is difficult for them to educate patients and facilitate change in their behaviour (Geller, Williams & Srikameswaran, 2001).

The final contextual factor, nurses' perceptions of patients, had an important influence on the development of interpersonal relationships with these patients. It has been claimed elsewhere that the development of a therapeutic relationship can be affected by nurses' perceptions (Morse, 1991). Many healthcare professionals perceive individuals who have anorexia in a negative context (Cameron, Willis & Ritcher, 1997; King & Turner, 2000; Newell, 2004). They are seen as unrewarding due to their long-standing illness and they are often considered responsible for the disorder (Beumont, Russell & Touyz, 1993). Without an understanding of the patients' situations, nurses may find it difficult to be empathetic and this may result in the formation of negative attitudes towards them (Ramjan, 2004). Nurses should also be aware that behaviours, such as lying, manipulation and deceit, that have been associated with patients who have anorexia, are evident in most adolescents and may be a normal part of their growth and development (King & Turner, 2000). The most common error nurses make is to have incorrect assumptions about patients' feelings, motives or experiences (Geller, Williams & Srikameswaran, 2001). Such assumptions reinforce negative opinions and prevent patients and nurses from understanding the true meaning of the illness experience (Geller, Williams & Srikameswaran, 2001). Participants in the present study acknowledged the presence of stigma associated with patients who have anorexia and the influence of this on their own perceptions about the illness, however their main focus when attempting to develop relationships with these patients was the individual experiencing the disorder. This awareness can result in positive interactions between nurses and patients and the development of relationships is more likely to occur (Newell, 2004). Through professional detachment and nurses being objective, people who have anorexia can be viewed as people with a difficult illness, rather than difficult people. Nurses should focus on viewing the whole person not just the illness or diagnosis during their assessments (King & Turner, 2000; Newell, 2004). They need to understand their own reactions to patients' behaviours in order to deal with them appropriately (Beumont, Russell & Touyz, 1993). Healthcare professionals who try to understand the difficulties faced by patients who have anorexia are just as real as any other patient, will find that caring for these patients is both interesting and rewarding (Beumont, Russell & Touyz, 1993).

5.3   Interacting with nurses

The first focus identified in the study, interacting with nurses, focused on the indirect strategies that participants used to develop professional interpersonal relationships with patients who have anorexia. This focus concentrated on the interactions that occurred between participants and other nurses. The ability of participants to develop relationships with patients was enhanced when they shared information with nurses and supported one another. It was evident that participants were also able to identify strategies to develop relationships with patients through reflecting on their own clinical experiences. Two categories were identified in the data that reflected this focus: supporting nurses and learning from experience.

With regard to the first category, supporting nurses, it was evident that collegial support among nurses was a useful approach to develop professional interpersonal relationships with patients who have anorexia. The strategy sharing information, enabled participants of the current study to identify individualised and consistent approaches to care and management. Through discussion and support from other nurses, suitable strategies were identified, knowledge was shared and, as a result, the challenging behaviours sometimes displayed by patients were better managed. A supportive team can strengthen nurses' ability to provide high quality and more efficient care (Ditcher, 2003). Through teamwork, nurses determine each others' strengths and weaknesses, and can better support and compensate one another (Ditcher, 2003). Supportive nursing teams can diminish stress levels and can facilitate the development of relationships with patients (Williams, 1998). Given the intensity of nurses' work, support as well as clinical supervision is necessary to protect nurses and individuals receiving treatment (Newell, 2004). Lack of support for colleagues may result in nurses holding negative perceptions of patients (Williams, 1998). For example, in the present study, participants who had received little support from colleagues found it difficult to develop interpersonal relationships with patients who have anorexia, and as a result, they considered these patients difficult to care for.

In relation to the second category, learning from experience, participants learned from previous relationships they had with patients and used similar approaches in developing current relationships. Reflecting on clinical experience was the main strategy used by

participants to develop relationships with patients. It is important to reflect and learn from previous experience and utilise the knowledge and skills gained from these interpersonal relationships and apply them to current relationships with patients (King & Turner, 2000). Nurses can obtain a different perspective on patients who have anorexia by considering past experiences (King & Turner, 2000; Ramjan, 2004; Williams, 1998). Participants in the current study described how they had occasionally become emotionally over involved with patients, which had caused them to become unable to cope with some situations. A consequence of this is that nurses may feel burnt out and may be unwilling to invest emotional energy into relationships with patients (Morse, 1991). Nurses need to distance themselves from patients when this occurs and re-engage when they feel more comfortable to protect themselves and patients (Morse, 1991). Nurses should be wary however, that prolonged distancing can result in diminished interactions between nurses and patients and may decrease the possibility of developing relationships (King & Turner, 2000; Williams, 1998).

5.4   Interacting with patients

The second focus evident in this study, interacting with patients, related to the direct strategies that nurses used to develop professional interpersonal relationships with patients who have anorexia. By interacting with patients, nurses are able to understand them, be involved in their care and develop a connection with them. The three main categories that emerged from the data were building rapport, being supportive, and developing trust.

With regard to the first category, building rapport, this was described by participants as enabling them to understand patients' experiences and situations. The strategies participants used to build rapport were finding an angle, interpreting the signals, self-disclosing and using distraction activities. The first strategy, finding an angle, was described as discovering approaches that participants could use to understand patients' feelings about their illness in order to relate to them and provide care that is consistent to their needs. Participants in the current study stated that they would find an angle through conversations and by being open. Conversing with patients can be used as a vehicle to facilitate patients to express themselves and this can result in nurses gaining a better understanding of their experiences (Hagerty & Patusky, 2003; Lotzkar & Bottorff, 2001; McCann & Baker, 2001). Collaborative relationships can be formed, by providing patients with opportunities to express themselves and developing an understanding of them (Woodgate, 1998). By being open, study participants

demonstrated that they were interested in understanding patients. Being open was described by participants as displaying they were receptive and attentive to patients' needs. One way of demonstrating openness is ensuring eye contact whilst speaking to patients (Morse, 1991).

The second strategy that was used to build rapport was interpreting patients' signals. This approach focused on assessing and responding to patients' responses. By interpreting the signals, nurses can be guided by patients' responses and can use individualised strategies to develop relationships (Lotzkar & Bottorff, 2001; Struthers, 1999). Through frequent interactions and ongoing assessments, nurses are better positioned to recognise and act on patients' responses (Raingruber, 1999; Williams, 1998). Nurses in this situation are empowered once they have developed this sensitivity and are able to read patients' messages (Kettunen, Poskiparta & Liimatainen, 2001). This approach aided the development of relationships in the present study, as participants appeared willing to understand patients and their concerns. When nurses and patients have worked together for some time they are able to read each others' responses with a greater understanding (Raingruber, 1999). As a result of sustained involvement with one another, nurses and patients are able to understand and communicate through the development of a shared language, where they are able to recognise, understand and respond to communication that has evolved from their previous interactions (Raingruber, 1999).

Self-disclosing was the third strategy that participants used to build rapport. Participants described self-disclosing as an approach that enabled the development of reciprocal relationships, where nurses and patients had an opportunity to share experiences. Self-disclosing was considered valuable as nurses and patients were viewed as equal partners in the development of relationships. Nurses are not seen as a threat and patients are more likely to engage in conversations (McCann & Baker, 2001; Morse, 1991; Peternelj-Taylor & Yonge, 2003). Although participants in the present study identified self-disclosure as a strategy that they used to help the development of interpersonal relationships, they acknowledged that sharing excessive amounts of information about themselves as nurses may result in patients having less opportunity to express their feelings. To gauge the amount of information shared with patients, participants used their own level of comfort, which was defined as the depth of interaction they wished to have with patients. The literature refers to this concept as an assessment of intimacy, where nurses and patients interact and share

experiences to varying degrees in order to develop rapport (Williams, 2001). The nature of intimacy comprises of disclosing information and communication (Williams, 2001). Intimacy is influenced by professional boundaries and the individual personalities of patients and nurses. It is recognised that nurses will develop closer relationships with patients who have similar personalities (Morse, 1991; Williams, 2001).

Using distraction activities was the final strategy that participants used to build rapport. The use of distraction activities, such as humour, art and music therapy, as means of helping patients express their feelings aided the development of relationships. It can be beneficial to use alternative approaches to facilitate patients' self expression when conventional methods are ineffective (King & Turner, 2000). Participants in the current study considered humour as an important distraction activity, as patients became more relaxed and this, in turn, enhanced their ability to communicate. Consistent with the findings of other studies, humour provides patients with a form of distraction and relaxation (Astedt-Kurki, Isola, Tammentie & Kervinen, 2001; Greenberg, 2003; Morse, 1991; Struthers, 1999; Woodgate, 1998). Nurses who use humour can be seen as less threatening and sympathetic and are better positioned to develop trusting relationships with patients (Greenberg, 2003; Lotzkar & Bottorff, 2001). As a result, patients are more able to express themselves, nurses' ability to understand patients improves, and closer rapport can be developed (Astedt-Kurki, Isola, Tammentie & Kervinen, 2001; Greenberg, 2003; Struthers, 1999). Humour can lead to discussion of sensitive topics, dissolve tensions related to differences of opinions and lighten patients' moods (Lotzkar & Bottorff, 2001). While other studies have supported the use of humour, they also cautioned its use as patients can differ in what they perceive as humour (Greenberg, 2003; Lotzkar & Bottorff, 2001; Struthers, 1999; Woodgate, 1998). Nurses should therefore assess patients' responses to humour and use non-humorous communication during initial interactions to determine whether humour would be a beneficial strategy to use (Greenberg, 2003).

In relation to the second category, being supportive, participants in the study believed that they showed their involvement in patients' care by being supportive. Participants stated that supporting patients through difficulties could help the development of professional interpersonal relationships as participants showed they cared for patients. The main strategies participants used to support patients were by, being encouraging, being respectful, and enabling control.

The first strategy, being encouraging, highlighted how this helped the formation of professional interpersonal relationships with patients. Through encouragement, patients are empowered as they learn about their illness, are supported, and are given the tools for making their own decisions (Kettunen, Poskiparta & Liimatainen, 2001; Lotzkar & Bottorff, 2001). Being encouraging is important as it can foster hope, adherence to treatment regimes, and increase patients' motivation to achieve their goals (Woodgate, 1998). Encouragement can only be effective through accepting and facilitating patients' autonomy, and nurses responding to patients' needs (Williams, 2002). Nurses are advised to evaluate patients' concerns, facilitate discussion and personalise interactions in order to develop a reciprocal relationship through encouragement (Kettunen, Poskiparta & Liimatainen, 2001; Lotzkar & Bottorff, 2001). Participants in the study used positive feedback to help encourage and support patients who have anorexia. Positive feedback was utilised by participants for behaviours that were considered to advance patients' recovery, such as active participation in treatment. Patients are supported and encouraged through feedback and, as a result, feel accepted (Kettunen, Poskiparta & Liimatainen, 2001). Encouraging and praising small achievements can also help them achieve larger goals. Although it is not uncommon for patients who have anorexia to refuse to eat, nurses need to work with patients and to try and resolve reasons why they may decline food (Geller, Williams & Srikameswaran, 2001).

The second strategy used by participants, being respectful, emphasised how this approach helped patients felt appreciated and valued. Along with respect comes a deeper concern for patients' individual experiences and an acceptance of their perspectives and feelings (Stein-Parbury, 2000). Moving beyond treating patients like an illness, showing an interest in other aspect of their lives, not forcing them to express themselves and acknowledging that each adolescent is unique, are important ways of showing respect (Kettunen, Poskiparta & Liimatainen, 2001; Lotzkar & Bottorff, 2001; Woodgate, 1998). Another way that respect can be displayed is by setting aside any personal judgements about patients and their experiences (Stein-Parbury, 2000). Mutual respect needs to be shown by nurses and patients in order to develop collaborative relationships (Lotzkar & Bottorff, 2001; McCann & Baker, 2001; Williams, 2002). Mutual relating and respect is a process of developing reciprocal relationships with patients that involves a shared understanding of the roles and responsibilities of nurses and patients (McCann & Baker, 2001). Once respect has been

developed, patients can freely express themselves and nurses can gain a greater understanding of patients (Stein-Parbury, 2000).

The final strategy used to support patients, enabling control, showed how patients are guided and encouraged to make their own decisions. As a result, the interactions that occur between nurses and patients are enhanced. Informing patients about their illness or treatment options and acting in accordance with their values helps them gain control of the illness process (Geller, Williams, Srikameswaran, 2001; Lotzkar & Bottorff, 2001; Woodward, 1998). Nurses act as patient advocates, protect and aid them, as necessary, in order to enable patient control (Morse, 1991). By incorporating a supportive and collaborative decision making process, this helps the development of trusting relationships and increases patients' wellbeing (Hagerty & Patusky, 2003; Latvala, Janhonen & Moring, 2000; McCann & Baker, 2001; Williams, 2002; Woodgate, 1998).

The greatest threat to the development of relationships and patients participating in their care is nurses' use of power over them (Latvala, Janhonen & Moring, 2000). The power imbalance that exists between nurses and patients can create barriers to communication and can result in the development of superficial or unilateral relationships (Hagerty & Patusky, 2003; Morse, 1991). Such an imbalance can arise through patient vulnerability and their lack of understanding (Lotzkar & Bottorff, 2001). By enabling control, this can lessen power imbalances that may exist and aid the formation of in-depth relationships (Hagerty & Patusky, 2003). The process of enabling control may, however, be difficult to achieve with patients who have anorexia, as they often refuse treatment, particularly concerning food (Ramjan, 2004). In the current study, participants minimised these behaviours and aided the formation of relationships by gaining support from other nurses, informing patients about their treatment and illness, and by allowing choice in other areas of care that did not involve food. If individuals who have anorexia do not have some control they will resort to negative behaviours, such as manipulation, to meet their needs (Surgenor, Horn & Hudson, 2003). It is also difficult to enable patient control when protocols and treatment plans and the perceptions of healthcare professionals are contrary to this approach (Williams, 2002). In order for treatment to be successful, a strong working alliance must be developed that facilitates patients' self-awareness, self-acceptance, and responsibility for change (Geller, Williams & Srikameswaran, 2001; Newell, 2004; Williams, 2002). Education about and evaluation of

currently used methods of facilitating patient autonomy needs to be undertaken to overcome some of the barriers (Williams, 2002). Patients not only benefit from being autonomous, job satisfaction among nurses can occur when they use their knowledge and experience to facilitate greater choice for patients (Woodward, 1998).

With regard to the final category, developing trust, participants claimed that this aided the development of relationships, as patients were able to perceive nurses as being honest about their care, treatment and progress. Trust was considered to form a connection between participants and patients, as each was dependent on the other to develop relationships. As such, the essence of nursing is connecting with people that are frequently in distress (Newell, 2004). Through the development of trust, patients divulge valid information, cooperate with treatment and accomplish their goals (Hagerty & Patusky, 2003; Lotzkar & Bottorff, 2001). The strategies that participants used to develop trust in the current study were: listening to patients' stories, being honest, maintaining confidentiality and taking time.

Listening to patients' stories was the first strategy that participants used to develop trust. Listening is a complex process that encompasses the skills of perception, reception and interpretation of input (Stein-Parbury, 2000). Effective listening is an active process of absorbing the information provided and is used to understand what is being expressed (Stein-Parbury, 2000). By listening to patients' experiences and responding to their needs, a trusting relationship can be developed as nurses show they are interested in attempting to understand patients (Geller, Williams & Srikameswaran, 2001; Kettunen, Poskiparta & Liimatainen, 2001; Lotzkar & Bottorff, 2001; McCann & Baker, 2001; Morse, 1991). Forming a deeper understanding of the reasons why patients develop the disorder, can help clarify any ambivalence about patients wanting to change (Geller, Williams & Srikameswaran, 2001). Nurses who listen to patients and their illness experiences are more likely to gain patients' trust. Patients also make their own assessments of nurses in order to determine whether nurses are dependable and whether they should disclose information about themselves (Lotzkar & Bottorff, 2001; Morse, 1991).

The second strategy, maintaining confidentiality, highlighted the importance of nurses respecting patients' right to not disclose any information about them and allow only those involved in their care to have access to this information. Participants reported that

maintaining confidentiality resulted in patients expressing their feelings more openly as a result of the trust that had been developed. It also helps the formation of professional interpersonal relationships with patients and enables nurses to gather more information about patients (King & Turner, 2000; Latvala, Janhonen & Moring, 2000). The development of trust is necessary for patients to feel secure and confident with nurses (Morse, 1991). Patients may decide not to speak about sensitive issues if they perceive that nurses may discuss this information with significant others (McCann & Baker, 2001). If patients are unable to trust nurses, they may manifest difficult behaviours or become withdrawn (Morse, 1991). Trust may not be easy to develop with adolescent patients, particularly those with anorexia, who are considered to have difficulties with trusting others (King & Turner, 2000).

The third strategy, being honest, helped the development of professional interpersonal relationships. By being honest, both nurses and patients are open about matters relating to care, treatment and progress (King & Turner, 2000; Newell, 2004; Woodgate, 1998). Patients are more likely to view nurses' judgements and opinions as aiding their recovery if they are honest. Honesty also helps patients deal with uncertainty and avoid collusion (McCann & Baker, 2001). Communication, consistency and being clear are ways to ensure honesty, as confusion, anxiety and feelings of losing control are decreased (Lotzkar & Bottorff, 2001; Muscari, 1998). Patient care should focus on creating a secure, predictable environment, where patients can relinquish some of their own internal controls (Vandereycken, 2003). Orderly, unambiguous communication strategies should be firmly implemented to prevent using conflicting approaches when dealing with the difficult behaviours that patients may sometimes display (Beumont, Russell & Touyz, 1993; Muscari, 1998). In order to develop trust, patients also need to be honest with nurses about their feelings and situations.

The final strategy, taking time, reinforces that relationships are processes that are developed over time (Hagerty & Patusky, 2003). By allowing time for relationships to develop, nurses can identify ways they can form fulfilling and trusting relationships. Taking time with patients and attending to their needs is more likely to aid the formation of trusting relationships as nurses have adequate time to interact with patients and learn about them as individuals (Lotzkar & Bottorff, 2001; Morse, 1991; Ramjan, 2004; Williams, 2002; Woodward, 1998). Through time and frequent interactions, patients and nurses also become more comfortable with each other, which can help form natural bonds between patients and nurses (Lotzkar &

Bottorff, 2001; Morse, 1991; Williams, 2002). The possibility of developing a relationship is delayed if the process is rushed or carried out in an inflexible manner (McCann & Baker, 2001). Nurses need to acknowledge that in some instances a trusting relationship may not develop even though a significant amount of time has been spent with patients (Lotzkar & Bottorff, 2001; Morse, 1991). In these circumstances, nurses need to develop an awareness of trust being absent and negotiate working relationships with patients in order for them to achieve their goals (Hagerty & Patusky, 2003). It is important, therefore, that the time spent with patients should focus on how nurses can enhance the use of these interactions (Hagerty & Patusky, 2003).

5.5 Core category

The core category, instigating an individual focus, highlighted the importance of concentrating on the individual experiencing the illness in order to successfully develop professional interpersonal relationships with patients who have anorexia. By adopting this approach participants were better positioned to understand the individual experiencing anorexia and to provide care that was more consistent with their needs. When conducting assessments and providing care, nurses need to focus on the whole person, not just the illness (Newell, 2004; Beumont, Hay & Beumont, 2003). The relationships that are developed are reciprocal, as patients feel valued and are more willing to actively participate in the relationship and accept assistance for their recovery. Focusing on individuals' conflicts, concerns and needs, through nurse-patient relationships, can help the development of reciprocal relationships and assist in recovery (Holyoake & Jenkins, 1998). The effectiveness, utilisation and timing of a strategy are dependant on the response of the individual experiencing anorexia. In order for nurses to respond appropriately to patients, an in-depth understanding of them is required (Raingruber, 1999). When developing relationships, both nurses and patients needed to be willing to participate in the relationship and contribute to its development (Ramjan, 2004). When patients participate in their care, this can help the formation of better collaborative relationships, enhance dialogue, and enable nurses to adequately support patients (Latvala, Janhonen & Moring, 2000). In the present study, participants held the main influence over the development of relationships, which were developed primarily to benefit the patients during their hospitalisation.

Participants suggested that the main strategy to use when developing relationships with patients who have anorexia was to search beyond the illness and attempt to discover the individual. Those who instigated an individual focus that incorporated being non-judgemental, valuing patients, ensuring security of patient information, and taking time, had the greatest success in developing professional interpersonal relationships with these patients. Strategies, such as providing support, encouraging, establishing a sense of control, and assisting patients with their individual needs, can be used to form relationships (Anderson, 1997; Woodgate, 1998). With connected professional relationships, nurses are able to view patients as individuals (Morse, 1991). If participants in the present study were having difficulty developing relationships with some patients, despite this approach, they attempted to establish relationships to the best of their abilities and or consult other nurses to aid them.

5.6 Summary

This chapter discussed the findings of the study with reference to the current literature. Most of the studies supported the negative effects of unit protocols, treatment plans, nurses' workloads, and insufficient education for nurses, when developing interpersonal relationships with patients who have anorexia. The positive influence of participants' non-conventional perceptions of patients who have anorexia promoted the development of relationships with patients, as they were more likely to feel valued as individuals. The strategies used to develop relationships with patients who have anorexia, according to the two foci, categories and strategies, suggest that by understanding the individuals with the illness, assisting and connecting with them, professional interpersonal relationship can be established.

CHAPTER SIX:

CONCLUSION

6.1 Introduction

This study identified the strategies that paediatric nurses use to develop professional interpersonal relationships with adolescent patients who have anorexia nervosa. The study was undertaken on a medical ward where ten paediatric nurses were interviewed to collect data. The study employed a grounded theory approach to data collection and analysis incorporating in-depth, unstructured interviews. The study was carried out as a requirement of the researchers' Honours degree. This Chapter will summarise the findings, and outline the limitations and implications of the study. Lastly, a concluding statement will be provided.

6.2 Summary of the findings

The aim of the study was to describe the strategies paediatric nurses use to develop professional interpersonal relationships with adolescent patients who have anorexia. The two foci identified in the data captured the related categories and strategies participants used to develop relationships. The first focus, interacting with nurses, highlighted the importance of using indirect strategies to develop relationships. The category, supporting nurses, described how participants relied on other nurses to identify the strategies to use when developing relationships, especially when they encountered difficulties. Nurses could also identify approaches to undertake in order to form interpersonal relationships through reflecting on positive encounters with these patients. The second focus, interacting with patients, concentrated on the direct strategies participants used to develop relationships with patients. The first category, building a rapport, and related strategies, aimed to assist the nurse to understand the individual experiences of patients with the illness. Being supportive and associated strategies was the second category identified in the data. This category highlighted the importance of assisting patients with their individual needs in order to form relationships. The final category, developing trust and related strategies, highlighted that through the development of trust, an in-depth understanding of patients' individual feelings and needs could be achieved and reciprocal connected relationships could be developed. A

core category was identified as a result of further analysis of the data and identifying common relationships between and among categories. The core category, instigating an individual focus, explored the importance of concentrating on the individual when developing professional interpersonal relationships with patients who have anorexia. Participants who adopted this approach were better positioned to form relationships with patients, irrespective of the strategies they used. As a result of focusing on the individual, participants were better able to understand patients and could implement care consistent with their needs. Reciprocal relationships were also developed as patients felt valued, and as a result, were more willing to participate in the relationship and accept assistance to facilitate recovery. The contextual factors identified in the study influenced the process of developing professional interpersonal relationships with patients who have anorexia. The unit protocol, treatment plans, nurses' workloads and insufficient education for nurses were perceived by participants to hinder the formation of interpersonal relationships. Focusing primarily on the person with the illness, rather than the disorder, had a positive influence on nurses' perceptions of patients and helped them form relationships with them.

6.3   Limitations of the Study

Given that this was a small qualitative study, the findings cannot be generalised to other settings. The data collection and analysis method that was used reflected grounded theory methodology, however only one approach to data collection, in-depth interviews, was used in this Honours degree study. As the researcher worked on the unit where the study was conducted this may have influenced participants' responses during the interviews. Participants may have withheld or not fully explained their responses as they may have thought the researcher understood their responses. To avoid this, the researcher discussed individual transcripts with half the participants to verify the accuracy of their own responses. Apart from one participant, all the interviews were conducted in a meeting room on the unit. Despite informing participants that the interviews would be private and confidential, the unit environment may have adversely affected some participants' responses. Nevertheless, the study findings provide a useful framework for the development of professional interpersonal relationships with patients who have anorexia.

6.4 Implications of the Study

The findings of they study have implications for treatment, clinical practice, undergraduate and in-service education, unit administration and further research. The study reinforces the need to implement treatment within the context of professional interpersonal relationships and instigate an individual focus of care in order to aid recovery. The findings highlight the need to continually update and review existing treatments and protocols that are being used to manage patients who have anorexia, and to incorporate nurses' views during the procedure. Given the importance of forming relationships with patients who have anorexia and the impact of unit protocols and treatment plans during this process, the findings draw attention to the need for unit protocols and treatment plans to be consistent with the development of reciprocal professional interpersonal relationships between nurses and patients. Treatment plans and unit protocols should also provide enough scope for nurses to be able to incorporate patients' individual needs. In relation to clinical practice, the findings can be used to refine or further develop the skills of less experienced nurses who are caring for adolescents who have anorexia, particularly when attempting to develop relationships with them. The findings can provide them with valuable knowledge and direction if they encounter difficulties when forming these relationships. The study draws attention to the increasing workloads of nurses and the lack of time available for them to interact with patients and develop interpersonal relationships. By reviewing treatment plans, protocols and modes of caring for these patients, this will assist in identifying patients' real needs and help nurses to focus on the important elements of care. The study emphasises the need for further education and training for nurses who are caring for these patients. The findings can be used in undergraduate and in-service education programs to guide those with limited experience of caring for adolescents who have anorexia. The importance of nurses' perceptions of patients who have anorexia, and how these views can hinder the development of interpersonal relationships, are also highlighted in the study. The need for nurses to be non-judgemental and care for patients who have anorexia in an individualised manner is warranted when developing interpersonal relationships and can ensure adequate care is being provided. In light of the limited research that explores the development of relationships with patients who have anorexia, further research needs to be conducted to explore other fields of inquiry. Some of these areas include: patients' perceptions of developing professional interpersonal relationships with nurses, how mental health nurses develop professional interpersonal

relationships with patients who have anorexia, how do nurses overcome difficulties when developing professional interpersonal relationships with patients who have anorexia, and how is the process of developing relationships with patients who have anorexia affected by the type of clinical setting, such as specialised eating disorder units.

6.5   Concluding Statement

The theory of 'instigating an individual focus' provides a framework to guide the development of professional interpersonal relationships with adolescent patients who have anorexia. Despite the challenges faced by nurses when developing these relationships, the findings of this study indicate that relationships can be developed if nurses are willing to look beyond the illness and attempt to understand the individual experiencing the disorder.

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APPENDIX A: INFORMATION STATEMENT AND CONSENT FORM

Hospital Logo

VICTORIA
UNIVERSITY

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Project Number:
Version: Four
Date: 09/10/03

Title of Project
Developing interpersonal relationships with adolescent patients who have anorexia nervosa

Thank you for taking the time to read this Information Statement.
This information statement is <u>five</u> pages long. Please make sure you have all the pages.

For people who speak languages other than English:
If you would also like information about the research and the Consent Form in your language, please ask the person explaining this project to you.

You are invited to participate in a Research Project that is explained below.

What is an information statement?
These pages contain information about a research project we are inviting you to participate in. The purpose of information is to explain to you clearly and openly all the steps and procedures of this project. The information is to help you decide whether or not you would like to take part in the research.

Please read this information carefully. You can ask questions about anything in it. You may also wish to talk about this project with your parents or guardians, friends or health care worker. When you understand what the project is about, you can sign the consent form attached if you wish to take part. You will be given a copy of this information and the consent form to keep.

What is the Research Project about?
Previous research has shown that it is difficult to develop interpersonal relationships with adolescent patients who have anorexia nervosa. Despite this, many experienced nurses are able to form successful relationships with these patients. Developing interpersonal relationships with patients who have anorexia is important, as it can lead to improved patient compliance and a better understanding of the condition. However no research has been done to show the strategies used to develop such relationships. The aim of this study is to describe how experienced nurses develop interpersonal relationships with adolescent patients who have anorexia nervosa. We hope to interview around 10 Division One Registered Nurses who have a minimum of 2 years experience caring for adolescents with anorexia nervosa.

Who are the Researchers?

Associate Professor Terence McCann is a lecturer in the School of Nursing and Midwifery at Victoria University. He is an experienced researcher and is supervising this project.

Ms Valentina Micevski is a Registered Nurse in the Adolescent Unit at the Hospital. This project is part of her Honours in Nursing Degree.

Why am I being asked to be in this research project?

We are asking you to take part in this study as you have at least two years of experience working with patients who have anorexia nervosa.

What do I need to do to be in this research project?

We would like you to take part in an interview. We will ask you about how you develop interpersonal relationships with patients who have anorexia. The interview will be recorded on a audiotape so that we can review what you tell us. The interview will take between 45-60 minutes. The interview will take place in a quiet private room in on the ward in the Hospital or somewhere private where you feel comfortable. The interview will happen at a time that is convenient to you.

Is there likely to be a benefit to me?

There are no direct benefits to you. However many people appreciate the chance to express their views and experiences.

Is there likely to be a benefit to other people in the future?

The results of this project may be used to help guide inexperienced nurses about how they can develop interpersonal relationships with patients who have anorexia.

What are the possible risks and/or side-effects?

It is possible you may feel some distress when recalling your experiences of developing interpersonal relationships with patients who have anorexia nervosa. It may be more difficult for you if you have, or have had, an eating disorder

If you do feel any distress in the interview, we will stop the interview and let you to decide whether you wish to continue. We can also refer you to The Staff Support Officer at the Hospital if you require further debriefing (Tel.).

You do not have to answer any question that you do not wish to answer. You can request to review and edit any of your answers. You can also withdraw from the study at any time during the interview without explanation.

What are the possible discomforts and/or inconveniences?

The only inconvenience is the time it will take to complete the interview.

What will be done to make sure the information is confidential?
You may have concerns about confidentiality of data and study findings. In this study
(i)   Your responses will be confidential, except as required by law;
(ii)   Participation is voluntary;
(iii)   You can request to review, edit or delete responses;
(iv)   You have the right to withdraw without explanation or penalty; and
(v)   Withdrawal from the study has no implications for your continued employment.

Your name will not be used in the transcribed data. We will give you a confidential number or symbol to replace identifying information. This means your identity and place of employment will be kept confidential. Only the researchers involved with this study will be able to access your information. During the study data will be securely stored in a locked cabinet in the School of Nursing and Midwifery, Victoria University. At the end of the study, data will be stored in a safe in the School of Nursing and Midwifery, Victoria University. At the end of the study your information will be kept for 5 years. After this time it will be destroyed.

The information collected will be presented as a thesis, which will be accessible in the Victoria University library. You will not be identified in the thesis or any publications or conference presentations arising from this study.

Will I be informed of the results when the research project is finished?
We will write to you when the study is finished. A short report will be available to you and the participating ward. If you would like a copy of the report, we will tell you how you can get one.

You can decide whether or not to take part in this research project. You can decide whether or not you would like to withdraw at any time without explanation.

You may like to discuss participation in this research project with your family and with your doctor. You can ask for further information before deciding to take part.

If you would like more information about the study or if you need to contact a study representative in an emergency, the person to contact is:

Name: Terence McCann
Contact telephone: (03) 9365 2325

What are my rights as a participant?

1. I am informed that except where stated above, no information regarding my medical history will be released. This is subject to legal requirements.

2. I am informed that the results of any tests involving me will not be published so as to reveal my identity. This is subject to legal requirements.

3. The detail of the procedure proposed has also been explained to me. This includes how long it will take, how often the procedure will be performed and whether any discomfort will result.

4. It has also been explained that my involvement in the research may not be of any benefit to me personally. I understand that the purpose of this research project is to improve the quality of medical care in the future.

5. I have been asked if I would like to have a family member or a friend with me while the project is explained to me.

6. I understand that this project follows the guidelines of the National Statement on Ethical Conduct in Research Involving Humans (1999).

7. I understand that this research project has been approved by the Hospital Ethics in Human Research Committee on behalf of its Health Board.

8. I have received a copy of this document.

If you have any concerns about the study, and would like to speak to someone independent of the study, please contact Consumer Liaison, Clinical Support Services Team at the Executive Office, at the Hospital on Telephone… (Monday to Friday 9am-5pm).

<u>Or</u>

The Secretary, Faculty of Human Development Ethics Committee, Victoria University, PO Box 14428, MC, Melbourne, 8001. Telephone. (03) 9688 4710 (Monday to Friday).

Hospital Logo

CONSENT FORM

Title of Project:
Developing interpersonal relationships with adolescent patients who have anorexia nervosa

Principal Investigator(s):
Terence McCann and Valentina Micevski

I, _____ voluntarily consent to take part in this research project, which has been explained to me by _____.

- I have received a Participant Information Statement to keep and I believe I understand the purpose, extent and possible effects of my involvement
- I have been asked if I would like to have a family member or friend with me while the project was explained
- I have had an opportunity to ask questions and I am satisfied with the answers I have received
- I understand that the researcher has agreed not to reveal results of any information involving me, subject to legal requirements
- If information about this project is published or presented in any public form, I understand that the researcher will not reveal my identity
- I understand that if I refuse to consent, or if I withdraw form the study at any time without explanation, this will not affect my access to the best available treatment options and care from the hospital
- I understand I receive a copy of this consent form

SIGNATURE _____   **Date** _____

I have explained the study to the participant who has signed above, and believe that they understand the purpose, extent and possible effects of their own involvement.

RESEARCHERS SIGNATURE _____   **Date** _____

Note: All parties signing the Consent Form must date their own signature.

APPENDIX B: INTERVIEW GUIDE

Interview Guide

Research Project: Developing interpersonal relationships with adolescents who have anorexia nervosa

INTRODUCTION
Introduce myself
Outline the aims of the study
Answer questions to their satisfaction
Ensure consent form has been signed
Explain the interview process

DEVELOPMENT

Tell me about your experiences of developing interpersonal relationships with adolescent patients who have anorexia nervosa?

Tell me how you develop interpersonal relationships with adolescent patients who have anorexia?

Tell me about the factors that help you develop interpersonal relationships with adolescent patients who have anorexia nervosa?

Tell me about any difficulties, if any, that you experience when developing interpersonal relationships with these patients and how you overcome these difficulties?

CLOSURE
Debrief participant
Thank participant