

Understanding the Therapeutic Alliance between Nurses and Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

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Certificate of Original Authorship

This thesis is the result of a research candidature conducted jointly with another University as part of a collaborative Doctoral degree. I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as part of the collaborative doctoral degree and/or fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Abstract

Introduction and Aims: The evidence informing the treatment of anorexia nervosa is limited. It is established that consumers with AN value professional interpersonal relationships with nurses, finding these relationships meaningful and therapeutic. A therapeutic alliance is associated with enhanced outcomes, and may be a promising aspect of the treatment for AN. However, therapeutic alliance is not well understood in the context of the inpatient setting. The aim of this research was to establish a greater understanding of the nature of the therapeutic alliance between nurses and consumers with anorexia nervosa, within the context of the inpatient setting.

Method: This study employed a mixed methods approach, two phase explanatory sequential design. The initial phase consisted of a quantitative investigation, involving both consumers and nurses in surveys. Surveys measured the perceived degree of alliance, and investigated other elements of ward context. The subsequent qualitative phase involved semi-structured interviews with both nurses and consumers. Interviews were focused on the relationships between nurses and consumers and the implications of ward context on those relationships. Interviews also developed a qualitative understanding for interpreting the quantitative findings.

Results: Consumers reported a relatively low perceived alliance with nurses, a relatively low perceived satisfaction with care, and a severe degree of eating disorder psychopathology. Nurses reported good attitudes towards consumers with acute mental illness. Consumers and nurses had a diverging perception of the alliance, as nurses perceived a higher strength of alliance compared to consumers. The interviews revealed that the alliance was valued and had positive environmental implications. However, anorexia nervosa as an illness was detrimental to the relationships between nurses and consumers. In developing a therapeutic alliance, nurses and consumers actively separated from the destructive implications of anorexia nervosa. Nurses' use of authority was influential over the development of the alliance. Multiple contextual factors within the ward influenced the therapeutic alliance between nurses and consumers.

Discussion and Conclusion: The way that nurses utilised their position of power determined the quality of the therapeutic alliance. A successful therapeutic separation and mutuality was dependent on confidence in the understanding that the orientation of power was employed to credit and protect the consumer. A balance of 'love and limits' developed a therapeutic separation, which preceded the mutuality of a therapeutic alliance. Contextual factors within the inpatient setting can be modified to enhance the capacity for nurses to develop therapeutic alliances with consumers.

Chapter One: Introduction

“Definitely if you have a nurse that is supportive, and you can tell, the best one genuinely somewhat cares... they would be like ‘you’re beautiful enough without like being so skinny, you don’t need it’... they’d be encouraging, like if we were eating they’d be like ‘well done, you did well then’” (Angela, consumer, aged 15).

“They make you realise how stupid sometimes it is just to ruin everything with an eating disorder...like they tell me about life and other things and it kind of makes you think about other things that you have to look forward to if you get out and if you just get over it, ... there’s this nurse called ‘Jan’ (pseudonym) and she’s really happy and she runs around, she’s always busy...I see her running around so much and I know that if, like, I were to do that and if I didn’t eat enough I wouldn’t be able to do that. And she looks so happy and healthy and I know that’s also because she’s healthy. So yeah, that motivates me” (Grace, consumer, aged 15).

The above quotes are excerpts from qualitative interviews, from a previous study of consumer perspectives (Zugai, Stein-Parbury & Roche, 2013, p. 2025). From this study, it was clear that nurses held a unique and intimate role in the treatment of anorexia nervosa, and the relationships between nurses and consumers were emphasised as an influential element of inpatient care. Through a mastery of interaction, nurses not only enhanced the inpatient experience, but also enhanced motivation and resolve towards achieving recovery. The study by Zugai, Stein-Parbury and Roche (2013) involved interviews with a small sample of eight consumers from an outpatient clinic. It was then necessary to expand from this previous project by consulting both nurses and consumers, with a larger sample from a range of hospitals. Research is also warranted in light of the severity of the illness and dearth of evidence based treatments. This chapter is an introduction to a research project that explored the nature of the

therapeutic alliance between nurses and consumers with AN, within the inpatient setting.

The Need for Evidence

Anorexia Nervosa (AN) is a psychological illness with severe physical and medical implications. AN has a high mortality rate mostly due to medical complications from the illness and suicide (American Psychiatric Association 2013; Birmingham et al. 2005). Compared to same aged populations, people with AN have a mortality rate five times higher, and are 32 times more likely to successfully suicide (Beumont 2000). In developed countries, it is the most common serious illness of adolescent females. In the US, the incidence of AN is estimated to range between 0.5%– 1.0% in adolescent females (Daigneau & Saewyc 2007).

In Australia, the prevalence of eating disorders is increasing (Hay et al. 2008). Approximately 9% of the Australian population is estimated to be affected by eating disorders (National Eating Disorders Collaboration 2012). From the most recently available research, approximately 400 diagnoses of AN are made each year, with approximately 5000 consumers affected by AN at any given time (Beumont 2000). In a more recent Australian study, the lifetime prevalence of AN is reported as 1.9%, and 2.4% for partial syndrome cases (those without amenorrhoea) (Wade et al. 2006). Unlike the DSM-IV the DSM 5 does not consider amenorrhoea a diagnostic feature (American Psychiatric Association 2013), and the lifetime prevalence is then more accurately expressed as 4.3%. The expense of caring for consumers with AN in Australia is burdensome: *“the expense of treatment of an episode of anorexia nervosa has been reported to come second only to the cost of cardiac artery bypass surgery in the private hospital sector in Australia”* (NEDC 2012, p. 15). For females aged between 15-24 years in Australia, AN is the 10th leading cause of burden of disease and injury (Australian Institute of Health and Welfare 2007). Given that this is the most recently available research, there is a clear need for evidence in the Australian context.

The outcomes for consumers with AN are often poor (Steinhausen 2002), and evidence for effective treatments is limited (Bulik et al. 2007); evidence for the use of formal therapies for the treatment of AN is neither strong nor abundant. In a randomised,

controlled trial focused on the treatment of AN, the efficacy of cognitive behavioural therapy (CBT), interpersonal psychotherapy and non-specific supportive management were compared (McIntosh et al. 2005). Unexpectedly, the non-specific supportive management approach was superior to the more formalised therapies. This was attributed to the emphasis on the development of a supportive and therapeutic relationship as a primary task of the non-specific management. Qualitative research has also emphasised the importance of therapeutic relationships in the treatment of AN. The consumer perspective (Westwood & Kendal 2012) and the nursing perspective (Ryan et al. 2006) both emphasise the importance of successful therapeutic relationships for effective care. This study is an investigation of the therapeutic alliance between nurses and consumers with AN, within the inpatient setting.

Therapeutic Alliance

Research has substantiated further interest in the role of interpersonal dynamics in AN care. The term therapeutic alliance refers to a particular type, or condition, of relationship between healthcare providers and recipients. Fundamentally, therapeutic alliance is an interpersonal relationship formed in the process of healthcare whereby the relationship contributes to healing in conjunction with, or independent of, specific or formal therapies. Intrinsic to the concept of therapeutic alliance is a rational and mutual collaboration towards agreed goals (Thurston 2003). Therapeutic alliance is embedded in the discipline, philosophy and practices of nursing; nursing being a profession defined by relationships with people who are ill or in need of care (Peplau 1991)(originally published 1952).

Therapeutic alliance is considered fundamental to mental health nursing (Welch 2005) and is associated with good outcomes for consumers with mental illness (Howgego et al. 2003). Therefore, nurses caring for and assisting consumers with AN may ensure better outcomes by facilitating a therapeutic alliance. However, nursing consumers with AN is considered challenging and emotionally exhausting (King & Turner 2000) and establishing a therapeutic alliance is difficult (Forsberg et al. 2013). Understanding therapeutic alliance in the context of AN care has the potential to improve consumer outcomes, especially considering that evidence for existing treatment in AN is weak

(Bulik et al. 2007). However, the dynamics of therapeutic alliance are not yet well understood within the context of nursing practice for the inpatient treatment of AN.

Therapeutic alliance has been conceptually developed within therapeutic contexts that operate on a one-to-one basis (the dyad), such as that in psychotherapy or counselling (Elvins & Green 2008). Nurses providing mental healthcare in the inpatient context also form therapeutic alliances with consumers, however these relationships do not conform to the traditional format of the dyad. Rather, these relationships are 'extra-dyadic'. The term 'extra-dyadic' is used in reference to the unique way that therapeutic alliance operates between multiple nurses who are interacting concurrently with multiple inpatients, and vice versa, the way inpatients concurrently interact with multiple nurses, as well as other inpatients. Because the therapeutic alliance that nurses facilitate with consumers in the inpatient setting is unique, it is important to understand how the context of the inpatient environment influences the therapeutic alliance between nurses and consumers. As such, this study focused on the extra-dyadic therapeutic alliance between nurses and consumers with AN, within the inpatient setting.

Originality of Research

It is clear that therapeutic alliance is associated with effective mental healthcare, and there is a developing base of literature that examines therapeutic alliance in relation to AN care. There is also a growing wealth of literature that considers the opinions of consumers regarding AN care, and research into the nursing perspective of AN care is also developing. This project is distinct in that it concurrently examined both the consumer and nurse perspective regarding therapeutic alliance in the inpatient setting with a mixed methods approach. The concept of therapeutic alliance is extensively documented and conceptually developed for the dyadic context. The implications of the inpatient context on the therapeutic alliance are relatively unexplored. Therefore, the dynamic interplay between therapeutic alliance and ward context was closely examined; contextual factors that impacted on the formation and nature of the therapeutic alliance were explored in depth. The ward routine, layout, staffing, attitudes and milieu are all elements of context that may carry implications for the nature of the therapeutic

alliance. The therapeutic alliance that nurses develop with consumers is then unique. Therefore, nursing must develop its own literature base in order to properly integrate and develop the concept of therapeutic alliance. This study addressed this gap in the literature by examining the ward environment, and by exploring consumer and nursing perspectives.

Summary

AN is a pernicious mental disorder, seriously affecting the lives of many young people. Due to the poor outcomes for consumers, research is required to enhance treatments for AN. Therapeutic alliance is considered an important element of AN care, and is associated with good outcomes. Therapeutic alliance, although well established in dyadic therapy, remains relatively under-examined in mental health nursing. This thesis details the course of a doctoral research study that examined the therapeutic alliance between nurses and consumers in the inpatient setting. This research specifically considers the way contextual factors of the inpatient setting influences the extra-dyadic therapeutic alliance.

Dissertation Structure

The chapters within this doctoral thesis are interdependent and are arranged in a logical sequence. This chapter orientates the reader with the meaning, aim and justification for this research project. The need for researching the nature of relationships between nurses and consumers with AN is made apparent. This chapter also provides a brief theoretical background, necessary for fully understanding the upcoming chapters.

Chapter Two is a thorough review of the concept of therapeutic alliance. Therapeutic alliance is a concept originally developed within the practice of psychoanalysis. Nursing has subsequently adopted therapeutic alliance into its contemporary theory and literature, from a long standing interpersonal professional identity. From the deinstitutionalisation in the United States, to the Consumer Movement, and in the context of the Recovery Movement, therapeutic alliance has become an integral concept in mental health nursing. Emphasising the importance of developing a nursing

literature base, the differences between the psychoanalytic dyadic context and the extra-dyadic, inpatient mental health nursing context are explored.

Chapter Three is a review of therapeutic alliance in the context of AN care. In this chapter, AN as an illness is outlined: its modern definition and history, aetiology, and physical and mental implications. Contemporary treatments for AN are discussed, leading to the emphasis of therapeutic alliance as a concept of interest for the treatment of AN. The complexity of AN and its implications on the nature of relationships between nurses and consumers is also explored. The consumer and nursing perspectives are examined, emphasising the importance of therapeutic alliance in the context of AN care.

Chapter Four thoroughly details the methodology of the study. The design and philosophical orientation of the study are described. As the study involves a mixed methods approach, details regarding quantitative instrumentation and qualitative interview structure are provided. Procedural matters and the overall conduct of the study are outlined in detail. For research involving a highly vulnerable population, ethical considerations and scrupulous conduct were critical for mitigating harm to all stakeholders.

Chapter Five reports the results of the study in two phases. Phase one pertains to the quantitative findings. The quantitative results are reported in text and visual tables, reporting consumer and nursing scores. Aiding interpretation, findings are compared to previous studies that utilised similar instrumentation. Findings requiring qualitative expansion are identified. Phase two pertains to the qualitative findings. The qualitative findings are presented as themes. The nature of the therapeutic alliance between nurses and consumers is described. The implications of AN, the rules of the eating disorder program, and the multiple contextual factors of the inpatient setting, are reported. The qualitative results also expand on the phase one quantitative results. Quotes are used for their explanatory and descriptive worth.

Chapter Six is a discussion of the results, and concludes the thesis. By interpreting the results of this study in relation to current literature, an enhanced insight into the nature of the extra-dyadic therapeutic alliance is gleaned. The unique context of the

inpatient setting, and the nature of AN as an illness, are highly influential over the nature of the therapeutic alliance between nurses and consumers with AN. With an enhanced understanding of the nature of the extra-dyadic therapeutic alliance, recommendations for practice are developed. The limitations of the study and future directions for research are outlined.

Following the discussion and conclusion, appendices are included. The appendices include information and consent forms for participants, quantitative instruments, documents regarding ethical approval, and information regarding the sample. Also included is a journal article produced during the course of candidature (Appendix A): 'Therapeutic Alliance in Mental Health Nursing: an Evolutionary Concept Analysis' (Zugai, Stein-Parbury & Roche 2015). All references are organised into a bibliography, adhering to Harvard (UTS) referencing format.

Key Terms

AN: Anorexia Nervosa

Analysand: A person undergoing psychoanalysis. This term is similar in meaning to the term 'patient' or 'client', however it is specific to psychoanalysis. 'Client' is the term typically used in more recent literature.

Consumer: In this thesis, the term 'consumer' will often be used in lieu of the term 'patient'. Outside of the inpatient context, the term 'patient' may imply a long term dependency on services, which is contrary to contemporary values. The term 'consumer' has been adopted in recognition of the empowerment, autonomy and independence rightfully inherent in people seeking and receiving mental healthcare (Our Consumer Place n.d.). However, the term 'patient' may be used in this paper when contextually appropriate for historical consistency when referencing earlier authors, a reflection of erstwhile parlance.

Deinstitutionalisation: Occurring in the United States in the mid 20th century, the deinstitutionalisation involved large numbers of once institutionalised consumers being discharged into community care. The financial burden of the large institutions and recent introduction of powerful psychotropic drugs made community based care

an economical and viable option. The deinstitutionalisation also occurred in response to socio-political pressures that demanded more humanistic care for people with mental illness.

DSM: The Diagnostic and Statistical Manual of Mental Disorders.

Dyad: A one-to-one clinical relationship, such as that in outpatient psychotherapy.

Ego-syntonic: AN is considered an ego-syntonic disorder, in that the illness pervasively adjusts the consumer's beliefs, attitudes and perceptions into a pathological orientation, thereby developing the illness as 'part of' the consumer.

Extra-Dyadic: The term 'Extra-dyadic' pertains to the way that relationships between nurses and consumers are unlike the traditional dyad. That is, the ward is a public and open space, where multiple consumers interact with multiple nurses.

Psychoanalytic relation: The term 'psychoanalytic relation' pertains to the nature of the relationship between a psychoanalyst and their client. The meaning of the term is broad and variable, as the philosophy of psychoanalysis has developed over the 20th century. According to the contemporary psychoanalyst Meissner, the psychoanalytic relation is tripartite, consisting of the real relation, transference/countertransference and the therapeutic alliance.

Chapter Two: Therapeutic Alliance

Introduction

A therapeutic alliance is characterised by an effective union between the work of therapy and an interpersonal, professional relationship; the tasks and goals of therapy are achieved and enhanced in the context of an interpersonal bond. Contemporary mental health care is characterised by an ethos of collaboration between clinician and consumer (Howgego et al. 2003; Priebe & McCabe 2008; Thurston 2003), that is, a therapeutic alliance. The positive and therapeutic consumer outcomes derived from the therapeutic alliance are particularly outstanding in the context of mental health care, and the therapeutic alliance is becoming recognised as a basis of therapy, rather than merely a complement to therapy (Priebe & McCabe 2008). The realisation and current understanding of therapeutic alliance as a concept in care has developed over more than a century, through clinical experience and observation, changes in healthcare philosophy and theoretical developments. Over this time, therapeutic alliance has become recognised for its healing qualities, and has been assimilated into clinical practice in a variety of contexts.

This chapter explores the theoretical history and development of the therapeutic alliance concept in the psychoanalytic discipline and nursing discipline. Each discipline is explored separately, and the concept's current philosophical apex is established. The socio-political influences that led to the widespread adoption of the therapeutic alliance concept are detailed. Finally, the implications of therapeutic context on the nature of the therapeutic alliance are explored.

Therapeutic Alliance: A Psychoanalytic Concept

In the late nineteenth and early twentieth century, Freud established the philosophy and practice of psychoanalysis. Psychoanalysis was founded upon the principle that repressed unconscious material led to neurosis (mental illness). In a controlled and guided manner, the psychoanalyst assisted the analysand to experience repressed unconscious material consciously, thereby making resolution of neurosis possible (Dean 2016). Freud introduced a new field of philosophy, with important therapeutic

potential: psychology. Foundations for the development of the therapeutic alliance concept originated from concepts developed in the early theory of psychoanalysis.

Originally published in 1912, Sigmund Freud's paper regarding the dynamics of transference in psychoanalysis (Freud 1958) is considered to be the first milestone in the conceptualisation of therapeutic alliance (Elvins & Green 2008; Howgego et al. 2003). The transference phenomenon results in a distortion of a present time relationship, due to replications of, and impressions from, formative or past significant relationships. In the psychoanalytic context, the analysand would typically ascribe an 'imago' of a significant childhood figure (such as a mother or father) on the therapist (Freud 1958). Freud established the imperative of understanding and interpreting the dynamics and implications of transference within the psychoanalytic relation (Freud 1958). Greenson (1965) defines transference as:

"...the experiencing of feelings, drives, attitudes, fantasies, and defences toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood".

(p. 156).

More recently, Levy & Scala (2012) define transference as:

"...a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships".

(p. 392)

Despite a central task of psychoanalysis being the therapist led observation and interpretation of transference, Freud later indicated the value of a reality based collaboration between the analysand and therapist as a medium for effective therapeutic work (Horvath & Luborsky 1993). In *Analysis terminable and interminable* (Freud 1937), Freud referred to the importance of maintaining the 'positive transference', the affectionate attitude that he considered the strongest motive for the analysand taking a share in the joint work of psychoanalysis. Freud also indicated

the necessary task of 'allying' and forming a 'pact' with the analysand's ego for an effective psychoanalytic collaboration. Although mentioned sporadically, Freud supported the therapeutic merit of a collaborative approach.

Following conceptual developments of the transference concept from previous psychoanalysts (Hausner 2000), Zetzel (1956) introduced the term 'therapeutic alliance' as a distinct element within the psychoanalytic relationship. Therapeutic alliance, a concept separate from transference, represented the rational capacity and autonomous participation of the analysand, necessary for productively understanding and internalising the therapist's transference interpretations (Horvath & Luborsky 1993; Zetzel 1956). This significant theoretical development led to increased emphasis placed on the collaborative relationship as a therapeutic medium. Subsequent to Zetzel, Greenson (1965) considered therapeutic alliance equally important as establishing the transference neurosis in psychotherapy, and stipulated clear characteristics of the therapeutic alliance in practice. Greenson indicated that the 'working alliance', synonymous with therapeutic alliance, represented the rational rapport between the analysand and therapist, and the capacity for the analysand to work within the analytic situation in an effective, motivated and co-operative manner. The absence of a working alliance was indicated as a common cause for psychoanalytic failure; without a therapeutic alliance, analyses were misguided, confused and efforts were ill-exerted (Greenson 1965).

With the emerging focus on interpersonal relationships as a therapeutic conduit, Carl Rogers eschewed formal or intellectual approaches to counselling, and instead emphasised the relationship as the critical element of the therapeutic process. Carl Rogers is attributed with leading the humanistic approach to dyadic therapy. According to Rogers (1961b) a relationship developed based on genuineness, understanding and acceptance was the key to growth, change and personal development for the client. Clients needed to be seen in their whole individuality as a unique person, rather than as a diagnosis. Whilst assisting the client, the therapist needed to be 'real' and also prepared for challenging personal growth. Care approaches that were aloof or detached lacked the humanity that made the interpersonal approach therapeutic. Supportive of his contention, Rogers cited studies that demonstrated the merit of his

emphasis on interpersonal relationships in therapy, although these studies were limited in quantity (Rogers 1961b).

With the emergence of a range of psychotherapies and a developing literature base, Bordin (1979) proposed the novel assertion that the working alliance could be generalised as the overall imperative element of all psychotherapies; successful therapy relied on the integrity of the working alliance regardless of specific techniques employed. Bordin further concreted the alliance concept by establishing its three core attributes, mutually experienced by the therapist and client: an agreement on goals, an agreement on tasks, and an interpersonal bond. Broadly applicable, the specific nature of these attributes was considered variable within each therapy type and context. Bordin's tripartite model remains esteemed, and is the basis of the measurement of the alliance in the Working Alliance Inventory (WAI) instrument (Horvath & Greenberg 1989). Of a sample of 79 studies conducted over 18 years, the WAI was the most commonly used in studies measuring the alliance (Martin, Garske & Davis 2000).

Despite firm scholarly establishment, the conceptualisation of therapeutic alliance is not without criticism. Brenner (1979) concluded that the 'alliance' concepts are not justifiably independent concepts, and are merely an aspect of the broader transference concept. Furthermore, theorists such as Brenner and Curtis suggested that focus on the therapeutic alliance potentially hindered the important psychoanalytic activity of interpreting transference (Horvath & Luborsky 1993). Regardless of whether the therapeutic alliance is simply a manifestation of transference, or whether it is a reality based interpersonal harmony that enhances psychoanalytic processes and therapies, a strong collaborative relationship between client and therapist is crucial; the majority of theorists agreeing that the establishment of a relationship is an important first step to successful therapy (Summers & Barber 2003).

In contemporary literature therapeutic alliance remains well-regarded, and has been clarified for application. Meissner (1992, 2007) provides a useful analysis and description of therapeutic alliance. By considering conceptual developments by Bordin

(1979) and Meissner (1992, 2007), therapeutic alliance can be outlined in a way useful for application. Meissner describes ten characteristics of the therapeutic alliance: the therapeutic framework, ethical considerations, responsibility, authority, autonomy, initiative, freedom, empathy, trust, and the therapist's stance of neutrality and abstinence. Neutrality and abstinence in this context refers to the therapist's deliberate effort to remain analytic in mental posture, rather than being influenced or strayed by counter-transference. The conceptual developments by both Bordin and Meissner are compatible, and both authors indicate the relevance of therapeutic alliance both within and outside of the psychotherapeutic context, and are therefore fit for nursing utilisation. Developed from contemporary psychoanalytic literature, therapeutic alliance can be summarized for application purposes.

Summary of the Contemporary Dyadic Alliance

In the context of an ethical relationship and an organised, negotiated therapeutic framework, a therapeutic alliance is determined by dynamic interactions and developments within the dyad, and the bi-lateral assumption of roles and responsibilities. As such, both client and therapist are responsible for fulfilling their respective roles within the work of therapy. Responsibilities include respect for both logistical matters, such as punctuality and payment, and participatory matters, such as concerted engagement in the work associated with therapy. As the facilitator of the process, the therapist possesses a degree of authority, utilising professional insight and experience to compliment the direction of therapy. However, as the alliance develops the client assumes a greater self-directed authority, and the therapist respectively assumes a role more participatory and supportive in nature. As a result of a therapeutic alliance, the client claims greater initiative in therapy and an increasingly autonomous role. So conceived, the outcome of the therapeutic alliance for the client is an increasingly independent state of wellbeing, developed with guidance from the therapist. Regardless of the power orientation within the therapeutic situation, it is essential that the client enters into therapy voluntarily; that is, a core element of therapeutic alliance is the freedom of participation. (Meissner 2007)

Mutual empathic attunement is the interpersonal state that permits effective communication and information sharing that is necessary for therapeutic work.

Empathy provides the therapist with an intimate awareness of the analytic situation, and the client the capacity to fully understand and appreciate the insights of the therapist. For effective therapeutic work, the client's development of a mature sense of trust, as opposed to an infantile trust, enhances their capacity for therapeutic participation and enables the client to adopt a more autonomous and responsible role in the analytic situation. Important for the therapist is the mental stance of neutrality and abstinence. That is, whilst being an empathic and caring therapist, the therapist maintains an objective, purposeful, reality based function of observation and reporting. The attributes described by Meissner provide a solid foundation for the development of Bordin's generalised tenets of a therapeutic alliance: a mutual agreement on goals, a mutual agreement on tasks for achieving goals, and an interpersonal bond (Bordin 1979; Meissner 2007).

As a concept, therapeutic alliance is in an advanced state of development. With the establishment of the core tenets of the alliance, methods of empirical measurement have been developed with a variety of scales available (Elvins & Green 2008; Summers & Barber 2003). Furthermore, empirical research has demonstrated that therapeutic alliance contributes to positive outcomes, validating therapeutic alliance as a credible care concept (Horvath et al. 2011; Martin, Garske & Davis 2000). Separate from the psychoanalytic discipline, nursing literature has also affirmed the importance of strong interpersonal relationships. Nursing has integrated the concept of therapeutic alliance, particularly in mental health nursing. Like psychoanalysis, nursing has an interpersonal tradition leading to the adoption of the therapeutic alliance concept.

Nursing and Therapeutic Alliance

From the psychoanalytic discipline, therapeutic alliance has been integrated into nursing theory. As evidenced by historical nursing texts, mental health nursing has a tradition of skilled interpersonal engagement, and modern mental health nursing theory continues to confidently illustrate the healing nature of relationships between nurses and consumers (Elder, Evans & Nizette 2013; Stein-Parbury 2014). Over the course of nursing theory, therapeutic alliance has become a significant concept in contemporary mental health nursing literature.

The Interpersonal History of Nursing

Theoretical and cultural developments in nursing have reified the capacity for interpersonal therapeutic interaction as an essential nursing aptitude. Historic nursing literature has focussed on the implications and importance of relationships between nurses and patients, laying foundations for current nursing theory. From the early tenets of nursing philosophy, the influence of interaction over wellbeing is documented. Florence Nightingale, often considered the founder of professional nursing, has made a significant contribution to the philosophy and art of nursing. Nightingale's book *Notes on Nursing: What it is, and what it is not* (Nightingale 1946) is primarily focussed on the practical aspects of nursing, such as the importance of good sanitation and hygiene. However, Nightingale also considered the way that interactions influenced wellbeing, albeit relatively briefly.

In the chapter titled *Chattering hopes and advices*, counter-productive forms of interaction are discussed. Nightingale considered attempts to provide false or superficial hope entirely unhelpful. Such interactions failed to 'cheer up' the patient and were instead experienced as demoralising. Nightingale also discredited 'lachrymose' or 'whining' interactions; to be overly sympathetic or mournful. Instead, a patient was more likely to derive joy, or at least variety, from hearing about factual developments in the lives of others (Nightingale 1946) (originally published 1859). The crux of Nightingale's *Chattering hopes and advices* is that interactions should not lead to an emphasis on the illness of the patient. Instead, interactions were most therapeutic when they led the patient to view the world and life outside of illness; life in all its joys and challenges, the way life is otherwise healthily experienced. The continuing development of nursing theory led to an emphasis on skilled interaction, interpersonal finesse being an imperative nursing attribute. This interpersonal aspect of the nursing identity was foundational for the adoption of therapeutic alliance into mental health nursing.

Nursing theorists of the twentieth century thoroughly established the importance of caring relationships and skilled interaction. In 1952, Hildegard Peplau published *Interpersonal relations in nursing*, developing nursing theory and its practical application (Peplau 1991) (originally published 1952). Peplau depicted nurses as an

‘educational instrument’ and ‘maturing force’ that ultimately led to the effective provision of care. Central to her contentions, Peplau established interpersonal nursing as a professional skill. Peplau focussed on interpersonal nurse-patient relationships, the importance of psychodynamic nursing and the resolution of interpersonal difficulties. Through the nursing process of helpfully relating to a patient, both the patient and nurse were able to learn and develop throughout the experience of illness. Based on these principles, Peplau provided numerous recommendations for nursing conduct and interaction.

In sustaining the therapeutic nature of the relationship, it was necessary for the nurse to concurrently maintain an intimate self-awareness as well as an awareness of the patient and their needs. In addition to a powerful sense of awareness, Peplau established the importance and significance of interpersonal skills and therapeutic nursing roles: sensitivity, empathy, respectfulness, trust, good communication and interpretive skills, and the importance of patient advocacy and empowerment. Peplau also provided clear recommendations for effective conduct. For example, Peplau recommended that nurses maintained conventions of courtesy for forming an impression of positive regard and acceptance, important for the formation and maintenance of a productive relationship (Peplau 1991).

In structuring her theory, Peplau outlined four phases that encompassed the therapeutic nurse-patient relationship: orientation, identification, working and resolution. Peplau identified six roles that nurses fulfill to ensure the therapeutic merit of the four phases: stranger role, resource role, teaching role, counselling role, surrogate role and leadership role (Peplau 1991). In Peplau’s text, the ideal nurse-patient relationship was characterised by interpersonal engagement and a joint effort, with both nurse and patient collaborating as active forces in the restoration of health; the patient was not merely a passive recipient of care. Importantly, the four phases were dependent on bilateral therapeutic exertion from both nurse and patient. Recognition of the patient as an integral participant in the therapeutic relationship was an important theoretical foundation for the adoption of the therapeutic alliance concept in mental health nursing.

Following the tradition of Peplau, Joyce Travelbee further developed nursing theory, identifying nursing as an interpersonal process. Travelbee defined the role and purpose of the nurse beyond the mastery of technical skills and the scientific understanding of illness. Travelbee defined the role of the nurse by their function in assisting: to assist others to prevent or cope with illness and suffering, and, to assist others in finding meaning in illness if necessary. Travelbee focused on the concept of the human-to-human relationship, the establishment of this relationship being a fundamental task of the nurse. Travelbee deliberately avoided the terms 'patient-nurse relationship' so as to recognise the humanity of both parties. A meaningful relationship was not developed within the stereotyped roles of patient and nurse, but established when patient and nurse recognised each other as unique human beings. Although the relationship was not considered the purpose of nursing, the relationship was the means or conduit to achieving the goals of nursing and assisting (Travelbee 1971).

Travelbee described nursing as a balance of intellect and emotional finesse. Effective nursing required a disciplined and intellectual style of problem solving, in tandem with an interpersonal finesse. That is, a professional nurse relied on evidence, was objective, logical and disciplined, whilst also being self-aware, sensitive, empathic and compassionate. Travelbee stressed the imperative of nurses understanding therapeutic modes of interaction and communication. Fluency in the transmission and reception of both verbal and non-verbal communication was considered crucial. Throughout interaction, an effective nurse maintained a grasp of interpersonal skills and qualities to reach a therapeutic rapport. This required a well tempered and appropriate degree of sensitivity, empathy, sympathy, emotional involvement, and acceptance with a non-judgemental attitude (Travelbee 1971). Like Peplau, Travelbee firmly established the interpersonal foundation of the nursing profession, a precursor to the adoption of the therapeutic alliance concept.

In early nursing theory, skilled interaction and interpersonal relationships are stressed as an essential nursing capacity. Nightingale, Peplau and Travelbee clearly established the role nurses have in providing care that addresses more than somatic or physical illness. From these formative authors, the ethos and philosophy of nursing has

continued to embrace collaborative interpersonal relationships between nurses and patients. The authors Dexter and Wash (1995), Varcarolis (2014) and Murray & Huelskoetter (1991) provide guidelines and practical recommendations for effective mental health nursing. These authors represent the values and philosophy of mental health nursing of the late 20th century, and their acumen is relevant in the context of contemporary nursing practice. The authors unanimously emphasised the importance of a productive nurse-consumer relationship, and the recommendations the authors provide are congruous and complementary. From the early theory of nursing to the later developments in the 20th century, the interpersonal qualities of mental health nurses can be summarised.

Effective communication skills are considered an essential cornerstone to therapeutic interaction. Nurses must be effective communicators on both a verbal and non-verbal level and must effectively listen to and interpret others. In tandem with effective communication skills, nurses must possess interpersonal skills and qualities in order to facilitate meaningful and therapeutic interactions. Nurses must have a high degree of sensitivity, and have insight into how they are perceived and understood by others: a self-awareness. Nurses should project a non-judgemental and understanding nature, holding a consumer in an unconditional positive regard. Therapeutic interactions and relationships are characterised by trust, respectfulness, empathy, a genuine sense of caring and honesty, and acts of supportiveness and reassurance (Dexter & Wash 1995; Murray & Huelskoetter 1991; Varcarolis 2014). The philosophical orientation of mental health nursing has clearly been influenced by the humanistic work of Carl Rogers (Rogers 1961a).

The interpersonal history of nursing is well established, and is a longstanding aspect of the nursing identity. Following this tradition, therapeutic alliance has become an important nursing concept. The emphasis that previous scholars placed on interpersonal nursing relationships laid important foundations for therapeutic alliance in contemporary mental health nursing.

Contemporary Nursing and Therapeutic Alliance

Influential nursing authors such as Peplau and Travelbee thoroughly developed the interpersonal identity of nursing. From the work of these nursing authors, the professional nursing role engenders compassion and an adept interpersonal capacity, in addition to a professional sense of discipline and technical skill. It is nursing's interpersonal identity, and respect for evidence, scholarship and healthcare ethics that led to the emphasis placed on skilled and health focussed interaction. Thus, formative nursing theory is compatible with, and naturally preceded, the use of the therapeutic alliance concept. Cultural changes in healthcare and consumer expectations, in addition to supporting empirical evidence, compelled the nursing discipline to integrate therapeutic alliance as a concept from the psychoanalytic discipline. Subsequently, therapeutic alliance is now an important concept in contemporary nursing, and has been analysed for nursing applications (Doherty 2009; Madden 1990; Zugai, Stein-Parbury & Roche 2015). Therapeutic alliance has been thoroughly analysed in three nursing concept analyses.

The initial nursing concept analysis of therapeutic alliance by Madden (1990) was performed with the aid of very few nursing publications. Furthermore, the few available nursing references to therapeutic alliance were of little use for definitional purposes, as the concept was vaguely or improperly used. Subsequently, the formation of the nursing therapeutic alliance was essentially dependent on the theoretical underpinnings provided by the psychoanalytic discipline. By utilising theoretical foundations and findings from observational fieldwork within the community nursing setting, Madden (1990) developed a nursing definition of therapeutic alliance:

“Therapeutic alliance is a process that emerges within a provider-client interaction in which both client and provider are: 1) actively working toward the goal of developing client health behaviors chosen for consistency with the client’s current health status and lifestyle; 2) focusing on mutual negotiation to determine activities to be carried out toward that goal; and 3) using a supportive and equitable relationship to facilitate that goal” (p. 85).

Subsequent to Madden, Doherty (2009) performed a concept analysis of therapeutic alliance in the maternal-newborn nursing context. Unlike Madden, Doherty utilised a larger sample of nursing literature for theoretical development, and depended on retrospective accounts of women with a birthing experience with a midwife. Doherty developed a revised nursing definition of therapeutic alliance, applicable to nursing roles both within and outside the maternal-newborn context:

“Therapeutic alliance is a process within a health-care provider- client interaction that is initiated by an identified need for positive client health-care behaviors, whereby both parties work together toward this goal with consideration of the client’s current health status and developmental stage within the life span” (p. 45).

By utilising literature from a broad range of nursing contexts, and in consideration of the recovery movement, Zugai, Stein-Parbury & Roche (2015) performed an evolutionary concept analysis of therapeutic alliance specific for mental health nursing (Appendix A). As a result, three core attributes of the therapeutic alliance are established, each with particular meaning.

- Partnership: The process in which nurses negotiate goals and tasks with consumers, that depends upon and develops the interpersonal connection between nurse and consumer.
- Consumer Focus: That the partnership is focused on the individual consumer’s concept of wellbeing, and that care is suitably individualised.
- Consumer Empowerment: that the alliance ultimately empowers the consumer to realise their own idealised wellbeing, with support from the nurse.

The nursing analyses have notable similarities and differences, but combine to yield important developments in the nursing literature base. The definitions developed by Madden and Doherty are broadly applicable to nursing, however Zugai, Stein-Parbury & Roche (2015) developed an analysis specifically for mental health nursing. The nursing use of the concept of therapeutic alliance is essentially compatible with

psychoanalytic definition, that is, therapeutic alliance can generally agreed upon as: an interpersonal, mutual and negotiated collaboration necessitated by, and focussed on the resolution of, identified health goals.

Therapeutic alliance in nursing is then an outcome of an enduring interpersonal tradition with the adaptation of prominent psychoanalytic theory and empirical evidence. Therapeutic alliance has an indispensable role and a particular meaning in mental health nursing, with a growing literature base (Zugai, Stein-Parbury & Roche 2015). In acute mental healthcare, therapeutic alliance between a consumer and nurse is considered an influential and positive element of care, which makes a goal orientated collaboration possible (Thurston 2003). In an ideal therapeutic alliance, the consumer is not a passive recipient of care; rather, the consumer is motivated to fulfil health related objectives with support and care from nurses (Zugai, Stein-Parbury & Roche 2013).

The current conceptual position of therapeutic alliance in psychoanalysis and nursing did not develop spontaneously. The consumer movement, and subsequent recovery movement, have led to revised ethical standards and expectations, which have revolutionised the treatment consumers receive (Andresen, Oades & Caputi 2011); from the former paternalistic tradition, the philosophy of contemporary mental healthcare is focussed on ideals of collaboration and recovery. Antecedent to the adoption of therapeutic alliance as a mental healthcare concept was the revolutionary impact of the consumer/recovery movement.

A Revolution in Mental Healthcare

The rich theoretical history of therapeutic alliance did not develop in isolation from changing worldviews and political discourse. Primarily within the United States, multiple pressures and events between the 1950s and 1980s revolutionised mental healthcare leading to the current consumer orientated mental healthcare philosophy. The mass deinstitutionalisation of mental health inpatients in the 1950s was an important antecedent. Changes in mental health philosophy, attitudes and law led to the discredit of the large institutions. The institutions were considered a financial burden, with community care considered a more viable and ethical means of

treatment, particularly in light of the recent introduction of psychotropic agents. Thus, the deinstitutionalisation of mental healthcare led to a large number of patients abruptly discharged into community care programs. Unfortunately, the deinstitutionalisation process was inadequately supported and its implementation was problematic. After discharge, many were left without a viable alternative for care (Andresen, Oades & Caputi 2011; Lamb & Bachrach 2001; Paulson 2012).

Following the problematic deinstitutionalisation, the political and social activism of the 1960s not only intensified humanistic attitudes that partially led to the deinstitutionalisation itself, but also ushered in a zeitgeist of resistance against coercive authority; psychiatry was not immune to this emerging worldview. The ill-reputed arbitrariness of diagnostic practices and paternalism of psychiatry, in addition to emerging narratives of abusive and degrading treatment, led to widespread criticism towards psychiatry, from both ex-patients and authors within psychiatry itself. As a result of the combination of factors, the broad-based antipsychiatry movement emerged internationally, introducing a radical counter-philosophy (Berlim, Fleck & Shorter 2003; Whitley 2012). At an extreme, the existence of mental illness as dictated by psychiatry was rejected (Szasz 1960).

The antipsychiatry movement represents a rejection of psychiatry, condemning its practices, nosology and scientific basis (Berlim, Fleck & Shorter 2003). Emerging from the criticism of psychiatry were patient-based organisations/movements that sought advocacy, greater legal rights, and emancipation from custodial and paternalistic psychiatry. Various unifying terms were adopted by the activists of these organisations: 'ex-patient', 'consumer', 'psychiatric survivor/survivor', 'ex-inmate'. The terms chosen by activists have particular meanings with different political objectives, and engender varying degrees of collaboration with mental health professionals; the ideological commonality being a focus on empowerment.

The ex-patient movement was initially focused on the rights of those with psychiatric disabilities. Subsequent to the 'ex-patient' movement, the 'consumer' movement emerged in the 1970s. As an organisation of mental health service users, consumers claim control and choice over treatment, whilst tending to accept a medical model of

mental illness; consumers have a willingness to collaborate with healthcare professionals to enhance services for mutual and dignified mental healthcare. In contrast to the consumer movement, those who identify as 'survivors' or 'ex-inmates' are distanced from mainstream psychiatry, and instead opt for user led, self-help services (Andresen, Oades & Caputi 2011; McLean 1995; Tomes 2006).

As a result of consumer activism, consumer participation in the organisation of mental healthcare has developed from a dearth of rights, to an intimate role in the development of policy (Tomes 2006). The consumer contribution to policy development and mental healthcare has resulted in enhanced services and consequently greater outcomes for people with mental illness; from the successes of the consumer movement, consumer narratives of health and fulfilment emerged: recovery. Recovery, once being a rare exception, has become a common goal and expectation for many suffering from mental illness. Recovery is now a foundational concept ingrained in mental healthcare ethos and practice (Andresen, Oades & Caputi 2011), and is conceptualised from the mental health consumer's perspective.

Recovery

Developed upon the foundation of the consumer movement, recovery in the context of mental health is a multi-faceted concept. Generated from the qualitative accounts of consumers, the principles of mental health recovery are determined based on the needs of those with mental illness. In this way, the recovery concept is novel in that consumers are considered experts by their mental health experience. Consumers may choose to accept a medical model of illness, but a medical definition of recovery is not as applicable to those with mental illness. The recovery concept has been thoroughly analysed yielding greater conceptual clarity (Leamy et al. 2011), and is largely recognised as the primary goal for those with long-term mental health needs. The foundational attributes of the therapeutic alliance of partnership, consumer focus and empowerment (Zugai, Stein-Parbury & Roche 2015) were developed in accordance with recovery principles.

Although a succinct, all encompassing definition of recovery is elusive (Chester et al. 2016), Jacobson and Greenley (2001) defined recovery as:

“the word recovery refers both to internal conditions—the attitudes, experiences, and processes of change of individuals who are recovering—and external conditions—the circumstances, events, policies, and practices that may facilitate recovery. Together, internal and external conditions produce the process called recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions” (p. 482).

In the definition by Jacobson and Greenley, the described internal conditions involve hope, healing, empowerment and connection. The external conditions involve human rights, a positive culture of healing, and recovery orientated services (Jacobson & Greenley 2001). These two sets of conditions are indicative of the way that the success of recovery focussed services are dependent on a humanistic, consumer focussed approach to mental healthcare. Effective mental health nursing practice will develop therapeutic alliances with consumers in accordance with these recovery principles.

In the context of mental healthcare, ‘recovery’ is not akin with terms such as ‘cure’ or ‘remedy’. Unlike a medically defined concept of health, mental health recovery is less a tangible or measurable outcome, but more an ongoing, non-linear personal journey of growth and fulfilment, with losses and gains throughout the process; a way of living to the greatest fulfilment one can realise despite challenges. Recovery is a self-directed and self-maintained state of well-being, and is determined by the needs and objectives of the individual consumer. Hope in the possibility of greater fulfilment and optimism for the future are aspirations rightfully pursued by consumers. Independence, empowerment and self-agency are key attributes of the recovery focused consumer: self-responsibility, self-determination, self-management and self-knowledge. Through recovery, consumers can form an identity with meaningful roles and purpose, overcoming stigma and setbacks. In developing identity, some may further find spirituality or meaning in their illness (Leamy et al. 2011; National Mental Health Commission 2013; Onken et al. 2007; Till 2007).

In adopting recovery principles, recommendations have been developed for services and the wider community. Mental healthcare services must transform to effectively

accommodate consumers with a wide range of pathologies. In assisting consumers, mental health professionals need to consider both the importance of clinical outcomes and personal recovery. Minimisation of force in care, availability of services and correct use of language are important elements of recovery orientated practice. In addition to culturally sensitive healthcare, connectedness and integration in the wider community is a part of recovery. This involves participation in community activities and social inclusion, opportunities for meaningful employment, de-stigmatisation and family support/involvement. This support from both healthcare services and the community will assist consumers in achieving an ideal self-agency and connectedness, in a way compatible with recovery ideals (Leamy et al. 2011; National Mental Health Commission 2013; Onken et al. 2007; Slade et al. 2014; Till 2007).

In a systematic literature review, Chester et al. (2016) establish recommendations for integrating recovery oriented practice into mental health services. The alleviation of stigma and the provision of recovery supportive responses are imperative for ensuring that consumers receive care conducive to recovery. Within the recommendations, Chester et al. (2016) underscore the importance of positive interpersonal relationships between consumers and mental healthcare providers. The relationships described serve as a medium for effective recovery services. This demonstrates the necessity of mental health nurses' capacity to develop therapeutic alliances with consumers.

In assisting consumers along the recovery journey, therapeutic alliance as a concept needs to be properly integrated into a range of health contexts, such as the inpatient setting. Most literature pertaining to therapeutic alliance is developed for the dyadic context. The extra-dyadic context is a unique context, warranting focused theoretical application. It is then necessary to consider the implications of context in applying therapeutic alliance.

Therapeutic Alliance and Contextual Implications

Therapeutic alliance is firmly established within mental health literature, and has an association with good consumer outcomes. However, empirical evidence regarding the outcomes associated with therapeutic alliance, such as the findings from meta-analyses (Horvath et al. 2011; Horvath & Symonds 1991; Martin, Garske & Davis 2000),

are focussed on the dyadic context (individual psychotherapy). It is essential to consider the generalisability of this evidence, as the concept of therapeutic alliance is applied in contexts outside of the dyad. It is necessary to consider the relationship between concept application and the dynamics of the context of care.

Therapeutic Alliance and Contextual Correspondence

Despite the conceptual genesis of therapeutic alliance being embedded in psychoanalytical theory and practice, therapeutic alliance is considered to be extant across a variety of settings and contexts, including the inpatient environment. Throughout various settings, therapeutic alliance is considered to maintain an analogous role (Meissner 2007). That is, the essence and role of the therapeutic alliance is a constant, despite variation in context. Historically, mental health nursing has incorporated cross disciplinary literature and conceptual developments. For example, Peplau recognised the occurrence of transference in the relationships between nurses and patients, thereby acknowledging psychoanalytic theory. However, the recognition and interpretation of transference is not necessarily an essential task in nursing, as it is in psychoanalysis. Nevertheless, Peplau recognised the implications of transference in nurse-patient relationships, and Peplau's contentions and theory were respectively influenced. Nursing has similarly incorporated the concept of therapeutic alliance, and it has subsequently been adopted as an important concept (Doherty 2009; Madden 1990; Zugai, Stein-Parbury & Roche 2015). It is essential to determine the way therapeutic alliance specifically applies to the nursing discipline, within its particular contexts.

Cross Disciplinary Comparison

In understanding the implications of context and concept application, it is useful to compare cross-disciplinary scholarship. The authors Meissner (2007) and George (1997) thoroughly discuss therapeutic alliance, establishing insight into its nature and application, drawing relevant theory from multiple scholars. However, the authors are of varying disciplinary origin; Meissner is a psychoanalyst primarily concerned with the dyadic context, whereas George specifically writes about therapeutic alliance in the context of nursing consumers with AN in the inpatient setting: the extra-dyadic therapeutic alliance.

Despite variation in discipline and context, their discussions are largely complementary. The work of these two authors is incorporated to develop a concise summary, which is made applicable to the inpatient nursing context for the treatment of AN. The summary demonstrates the ways therapeutic alliance is analogous in varying contexts, and also the ways context carries implications for the nature of therapeutic alliance. The works from Meissner and George were chosen for analysis in light of the specificity and relevance of their discourse for this study.

Therapeutic Alliance in the Dyad and in Nursing

It is important to consider the way that the therapeutic alliance applies to inpatient care for AN. Within the dyad, Meissner (2007) indicates that a therapeutic alliance is established within the context of a therapeutic framework, which involves the overall management and structure of care delivery, as well as other practical considerations. In the context of inpatient AN care, the therapeutic framework as described by Meissner would be established within the ward structure and routine. Designated meal times, the rules of the ward, staffing and skill mix, and other elements of ward organisation and protocols are all aspects of the therapeutic framework. In addition to the therapeutic framework, the facilitator of care must be both authoritative and responsible with care (Meissner 2007). In the inpatient environment, nurses have an inherent responsibility and authority in the nurse-consumer relationship, due to the involvement nurses have in facilitating care, and due to the implicit responsibility and authority nurses have as healthcare professionals in the hospital institution.

In order to establish and maintain a therapeutic alliance, nurses must be capable of employing interpersonal skills, and readily facilitate therapeutic interaction. In relation to the interpersonal aspects of the alliance, Meissner (2007) and George (1997) are complementary. Both Meissner (2007) and George (1997) consider empathy and trust important tenets for the successful establishment of therapeutic alliance. George (1997) indicates that it is important for nurses to remain responsive, genuine and consistent. That is, nurses must be prepared and be available to interact with consumers in an honest manner, with consistent expectations. George (1997) indicates that nurses must have positive attitudes and project a sense of positive regard towards consumers, providing non-judgemental responses. As a way of internalising and

understanding observations, Meissner (2007) recommends a mental stance of neutrality and abstinence. The 'neutral and abstinent' mental stance lends itself to a sense of objectivity, which precedes accurate interpretations and the calculation of appropriate therapeutic actions and interventions. Overall, both Meissner and George acknowledge the interpersonal nature of the therapeutic alliance.

Although similar, the works by Meissner (2007) and George (1997) do not entirely correspond. The alliance as described by George (1997) is strained by the resistance that characterises AN. The opposition between the nurse's therapeutic goals and the nature of the consumer's pathology carries implications for the nature of the alliance (George 1997). Consumers with AN are often highly ambivalent in relation to treatment due to the ego-syntonic nature of AN. Therefore, in the best interest of the consumer's physical health, freedom and autonomy may be suspended. Conversely, Meissner (2007) indicates that in a therapeutic alliance consumers are responsible for their participation in treatment, have freedom over the therapeutic process, and are autonomous and intuitive in the relationship. Meissner's principles may not then be readily applicable in the context of AN care.

According to George (1997) and Meissner (2007), the establishment of a therapeutic alliance is dependent on effective communication, sensitivity, self-awareness, and interpersonal skills. Therapeutic alliance is developed within a therapeutic framework, and within this framework, nurses are responsible, authoritative and considerate of ethical considerations and confidentiality. The therapeutic alliance between nurses and consumers is characterised by empathy, respectfulness, trust, and supportiveness. Nurses should be genuinely caring, non-judgemental and have an understanding nature, demonstrating a positive regard and acceptance towards consumers, whilst maintaining an objective mental perspective. Despite differences in disciplinary origin, Meissner (2007) and George (1997) provide largely complementary insight into the nature of the therapeutic alliance. That is, the interpersonal tenets of therapeutic alliance seem constant (trust, empathy, positive regard, etc). It is the context of therapeutic alliance that seems to be variable, carrying implications for conceptual application.

Therapeutic Alliance and Contextual Variation

It is important to consider the way that the concept of therapeutic alliance relates to its given context. The above passage has examined two distinct contexts in relation to therapeutic alliance; the traditional dyadic context and the inpatient mental health nursing context. The context of the traditional dyad is contrasted by the context of the inpatient setting. The acute inpatient mental health setting is a particular context, with implications for the development of the therapeutic alliance. When comparing the context of the traditional dyad to the context of the inpatient setting, clear distinctions are apparent, as seen in Table 1 Contextual Differences between the Traditional Dyadic Therapeutic Alliance and the Nurse-Consumer Therapeutic Alliance in the Inpatient Mental Health Setting (Extra-dyadic).

Table 1 Contextual Differences between the Traditional Dyadic Therapeutic Alliance and the Nurse-Consumer Therapeutic Alliance in the Inpatient Mental Health Setting (Extra-dyadic).

Dyadic	Inpatient Mental Health (Extra-dyadic)
<u>Setting:</u> The traditional dyad is often localised within the confines of a clement, private office setting.	<u>Setting:</u> Nurse-consumer relationships are developed within the inpatient setting, which is often a busy, chaotic, public and open environment.
<u>Persons of Influence:</u> The dyad is dominated and determined by only two people.	<u>Persons of Influence:</u> Nurses interact with a large group of consumers, and consumers interact with a varied set of nurses over the course of days and weeks. This means that nurses and consumers experience interactions and relationships on a highly varied and concurrent basis, completely unlike the traditional dyad.
<u>Structure and Order:</u> Interaction is scheduled, and is relatively controlled and predictable.	<u>Structure and Order:</u> Interaction is unscheduled, possibly occurring at any time of day or night. The inpatient setting for the treatment of acute mental illness can be highly unpredictable and is predisposed to intense interaction.
<u>Division of Attention:</u> Activities of the traditional dyad are absorbed in interaction.	<u>Division of Attention:</u> Nurses have varying duties and responsibilities in the inpatient setting. In addition to therapeutically interacting with consumers, nurses also attend to technical and administrative tasks, and engage with other healthcare professionals and families. Nursing interaction and attention with consumers is divided by competing responsibilities.
<u>Choice of Engagement:</u> In the traditional dyad, consumers are free to choose a therapist of their own preference. The consumer participation in care is of a voluntary nature.	<u>Choice of Engagement:</u> In the inpatient setting, consumers have very limited choice over the healthcare providers they interact with. In the acute mental health setting, admissions are often of an involuntary nature.
<u>Length of Participation:</u> The traditional therapeutic dyad may last many months or years. This relationship ends on the basis of a mutually formed agreement and resolution.	<u>Length of Participation:</u> The relationships between consumers and nurses in the inpatient setting are relatively transient compared to that of the traditional dyad. The relationship ends on discharge or transfer to other services or facilities.

The traditional dyadic therapeutic alliance is conspicuously different in context compared to the therapeutic alliance between nurses and consumers in the inpatient mental health setting. This contextual variation is liable to carry implications for the nature and operation of therapeutic alliance; assumptions based on dyadic literature

may not be entirely viable in the inpatient setting, despite the established areas of correspondence. This contextual variation warrants enquiry focused specifically on inpatient nursing relationships.

Ward Context: atmosphere and milieu

In considering the contextual factors that may influence the nature of the therapeutic alliance, the quality of ward atmosphere and milieu in the psychiatric setting is a longstanding focus of enquiry, with scales developed for empirical measurement (Moos & Houts 1968; Schalast et al. 2008). From a range of studies, it is clear that positive outcomes for consumers co-occur with a greater quality of ward atmosphere and milieu. A positive ward atmosphere and climate is associated with consumer outcomes such as engagement in treatment, satisfaction with care, the strength of the therapeutic alliance and lower levels of behavioural disturbance (Tonkin et al. 2012). In light of the well substantiated implications of ward context, the ward atmosphere and milieu for the inpatient care of AN is then a worthwhile focus of enquiry, which this study will explore.

Summary

The concept of therapeutic alliance has a well documented evolutionary course. From the initial Freudian emphasis on the establishment of the transference neurosis and subsequent interpretation, contemporary literature considers effective mental healthcare to be dependent on the integrity of the therapeutic alliance (Priebe & McCabe 2008). The development and adoption of the therapeutic alliance concept was not spontaneous or arbitrary. The initial concept developments by Zetzel (1956) and Greenson (1965) were published at a time coinciding with the deinstitutionalisation in the United States (Paulson 2012), demands for increasingly equitable legal representation for people with mental illness (Eisenberg, Barnes & Gutheil 1980), and the anti-psychiatry (Szasz 1960), Ex-patient, and consumer movements (Andresen, Oades & Caputi 2011). These events, in the context of the social-upheaval of the 1960s, led to the demand that people with mental illness deserve, and are entitled to, dignity and choices regarding care. The subsequent recovery movement currently influences the ethics and policy of mental healthcare (Andresen, Oades & Caputi 2011;

Tomes 2006). International and domestic human rights principles now demand equality, dignity, respect and autonomy for people with mental illness, and legislation protects these liberties (McGuire 2009).

Therefore, from political developments and changes to healthcare ethics and law, mental healthcare has adopted a culture that eschews unnecessary paternalism instead relying on an ethos that preserves self-efficacy and autonomy for people with mental illness, in the form of a therapeutic alliance. Empirical evidence has further validated the establishment of therapeutic alliances in mental healthcare (Horvath et al. 2011; Horvath & Symonds 1991; Martin, Garske & Davis 2000). In maintaining ethical integrity, and with respect to developing evidence, nursing has adopted use of the therapeutic alliance concept. According to Bordin (1979) and Meissner (2007), therapeutic alliance is generalisable and applicable to a range of contexts. However, variations in context bring implications for the nature and application of therapeutic alliance. Nursing must therefore focus effort on the task of incorporating therapeutic alliance within its broad range of contexts. The inpatient setting for the treatment of AN is a particular context with implications for the nature of nurse-consumer relations.

Chapter Three: Anorexia Nervosa and Therapeutic Alliance

Introduction

AN is a mental disorder with serious implications for the health and wellbeing of individuals and their families. Correspondingly, healthcare services are responsible for ensuring that consumers receive the care they need. Treatment must be substantiated by a high standard of evidence due to the severity of physical and psychological symptoms. Despite ongoing research, a lack of evidence in relation to the therapeutic efficacy of treatments remains and consumers continue to have poor outcomes. This may be due to the focus of attention on therapeutic method alone, in the absence of consideration of the process of a therapeutic alliance. The concept of therapeutic alliance shows promise and virtue as a useful avenue for research, especially in light of the focus of contemporary mental health care on collaborative approaches with consumers.

In this chapter, AN and its position as a mental illness is established. Its definition, history, aetiology, prevalence and incidence, health implications and treatment are thoroughly described. The evidence for the treatment of AN is considered, leading to a focus on therapeutic alliance as a treatment approach of interest. In relation to therapeutic alliance in the context of AN care, research of consumer and nursing perspectives are explored, as well as research that reports on the outcomes that are associated with therapeutic alliance for the treatment of AN.

Anorexia Nervosa

As an illness, AN is distinct and particularly egregious due to its combination of severe psychopathology and life-threatening physical symptoms. By developing an understanding of AN the need for research is demonstrated, not only by considering the seriousness of the illness, but also by the inadequacy of evidence for treatments. In this section, the way AN is currently understood and defined is established, as well as the history and origins of AN. The health implications, both mental and physical, are

briefly outlined. This section will also briefly address common management strategies and therapies for the treatment of AN.

Contemporary Definition

The DSM-5 (American Psychiatric Association 2013) stipulates the definitive criteria for the diagnosis of AN:

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.
2. Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

The 12-month prevalence of AN in young females is 0.4% approximately (American Psychiatric Association 2013). The registered incidence rate is up to 8 per 100, 000 per year, however this is considered an underestimation of the true incidence (Hoek 2006). The overall incidence rate of AN has remained stable over the last several decades, however 15-19 year-old girls are an increasingly high-risk group. This may be a genuine indication of an increasingly lower age of onset, or screening practices have yielded greater detection of younger cases (Smink, van Hoeken & Hoek 2012). Clinical populations indicate a 10:1 female-to-male prevalence ratio (American Psychiatric Association 2013), however the actual prevalence of AN in males is likely much higher when including partial syndrome cases (Muise, Stein & Arbess 2003). Furthermore, disordered eating patterns and distorted body image is common in males, and is less likely to be recognised (Gila et al. 2005; Muise, Stein & Arbess 2003).

AN primarily occurs in post-industrialised countries, however AN is known to affect culturally and socially diverse populations, with potential variations in features of presentation according to culture. Eating disorders have long been considered a health concern unique to Western industrialised nations, however cases of AN are reported in many non-western nations, such as: the Caribbean Island of Curacao (Hoek et al. 2005), Ghana (Bennett et al. 2004), Iraq (Younis & Ali 2012), Kenya (Njenga & Kangethe 2004), Nigeria (Unuhu et al. 2009) and Singapore (Lee et al. 2005).

The crude mortality rate of AN is approximately 5% per decade (American Psychiatric Association 2013). During the 1990s, AN had the highest rate of mortality of all mental disorders (Harris & Barraclough 1998). Despite the developing literature base, published eating disorder statistics and correlates are potentially limited due to selection biases arising from the over representation of clinical samples in research. The majority of individuals with AN do not engage in mental healthcare, and are community dwelling (Hoek 2006). Individuals with eating disorders often eschew treatment, neither seeking nor receiving care. Other sub-populations may be even less likely to engage with services (such as males with eating disorders or those in remote areas) and are further underrepresented (Mitchison & Hay 2014).

History of Anorexia Nervosa

Eating disorders are often considered a relatively contemporary illness, developing in modern times and Western culture (Banks 1992). AN is considered a contemporary illness as there is a strong hypothesis that AN in the West is strongly associated with the modern Western ideals of thinness in women, in conjunction with widespread media pressure (Simpson 2002). Whilst it is true that modern influences have shaped and contributed to the development of eating disorders, and the way that they are currently understood and experienced, AN has a significant historical background.

The first medical description of anorexia nervosa is typically attributed to Richard Morton in 1689 (Pearce 2004). The name of the condition 'Anorexia Nervosa' was termed by a prominent British physician, Sir William Gull, in 1874 (Madden 2004). The first physician to fully recognise and describe AN as a condition is subject of debate, however the credit of the 'discovery' of AN is generally attributed to both Sir William

Gull and Charles Laségue, a Parisian neuropsychiatrist (Vandereycken & Van Deth 1989). Gull's description of 'anorexia nervosa' has notable similarities with the contemporary understanding and definition of AN; such as the way Gull described the age and gender distribution. Whilst Gull recognised the psychological aspect of AN, deep elucidation into the psychology of AN was not provided (Madden 2004). Pertinent and of further interest, in the early 19th century, Lord Byron's eating and exercise behaviour is well documented and is pathological by contemporary standards (Rössner 2013). Lord Byron is known for his strict and restrictive dieting, intense exercise, and bingeing and purging behaviour.

Prior to the recognition of self-starvation as a medical or psychological condition, voluntary and wilful self-starvation was performed in the spirit of religious purity and devotion. Examples of this 'pious' starvation are present in the Hellenistic and Renaissance era (Pearce 2004). The Saints and pious women that practiced self-starvation, or 'Holy-Anorexia', did so as a means of punishment for sins and expiation, and as a way of remaining ascetic (Griffin & Berry 2003; Russell & Treasure 1989). Interestingly, 'holy anorexia' was more commonly associated with women (Griffin & Berry 2003), which corresponds with the current gender bias of AN.

Aetiology

There is no clearly defined cause of AN, however there are multiple factors that are understood to contribute to the overall development of AN. Factors that predispose individuals to AN may involve genetics, developmental factors, neurodevelopment, personality traits, central neurotransmitters, the endocrine system, and socio-cultural and social factors (Fitzpatrick & Lock 2011; Klein & Walsh 2004; Woerwag-Mehta & Treasure 2008). Those with anxiety disorders or early obsessional traits in childhood are predisposed to the development of AN. Exposure to cultures, occupations and avocations that attribute value, or otherwise encourage thinness are associated with increased risk for AN (American Psychiatric Association 2013; Mitchison & Hay 2014).

Genetic factors are implicated in the development of AN, with first-degree biological relatives of individuals with AN at a greater risk. Twin studies indicate concordance rates higher in monozygotic twins compared to dizygotic twins, further demonstrating

a genetic nexus. Brain abnormalities are associated with AN, however it is unclear whether these abnormalities precede AN or arise as a complication of the starvation state (American Psychiatric Association 2013; Fitzpatrick & Lock 2011). There is little evidence to suggest an association between eating disorders and urbanicity, socioeconomic status, ethnicity, or education (Mitchison & Hay 2014). AN may develop as a coping mechanism to various stressors, such as challenging transitions or familial conflict, but may also occur in the absence of apparent antecedents (Morris & Twaddle 2007).

Anorexia Nervosa and Mental Health

AN carries serious consequences for mental health, and is associated with behavioural disturbances. AN is typically preceded by progressively restrictive eating patterns and excessive exercise that results in a persistent pattern of pathological eating and exercise. The eating and exercise behaviours associated with AN are reinforced by thought patterns that reward weight loss and punish weight gain. A person with AN will persist great lengths to sustain continuing weight loss, possibly deceiving family members and avoiding social situations. Irritability, poor concentration, fatigue, and indifference towards activities that were once of interest, are associated with AN (Klein & Walsh 2004).

AN is associated with multiple types of psychiatric comorbidities, such as mood disorders and anxiety disorders (Salbach-Andrae et al. 2008). People with AN suffer from a body image disturbance and psychopathological preoccupation with weight and shape, and from these ascertain poor self-worth. Due to the human brain utilising approximately 20% of caloric intake, the brain is particularly susceptible to the effects of starvation. Starvation shrinks the brain, which is associated with psychological and behavioural problems such as social difficulties, emotional dysregulation and cognitive rigidity (Treasure, Claudino & Zucker 2010). The seriousness of the psychological impact of AN is clear in light of the heightened risk of suicide for people with AN (Fitzpatrick & Lock 2011; Pompili et al. 2004).

Anorexia Nervosa and Physical Health

The physical effects of AN go beyond the appearance of extreme thinness, and are highly responsible for the lethality of the disorder. The physiological effects of AN on a

growing and developing adolescent body is particularly egregious, as AN can damage all organ systems. In addition to generalised thinness, commonly observed physical signs may include hypothermia and cold extremities, hair loss and the growth of lanugo, sunken cheeks, parotidomegaly, and other signs associated with extreme weight maintenance and the starvation state (Nicholls, Hudson & Mahomed 2011). The physical effects of starvation lead to a systemic process of reduction in metabolic expenditure (Klein & Walsh 2004). The risk of mortality is higher in low weight binge-purge individuals, compared to purely restrictive individuals (Morris & Twaddle 2007).

AN is associated with potentially fatal cardiac complications such as arrhythmias and may lead to structural damage to the heart (Katzman 2005). Bradycardia and postural hypotension may be present as a result of poor cardiac contractility (Nicholls, Hudson & Mahomed 2011). Electrolyte imbalances may manifest as a result of restrictive intake, vomiting, or other extreme means of weight maintenance (Treasure, Claudino & Zucker 2010). Bone health is compromised due to poor calcium and vitamin D intake, the effects of amenorrhoea, and frequent and intense exercise (Dominguez et al. 2007; Katzman 2005; LaBan et al. 1995). The gastrointestinal system may be affected by delayed gastric emptying, slowed motility, constipation and bloating (Nicholls, Hudson & Mahomed 2011). AN is also associated with changes in brain structure and function (Katzman 2005), such as cortical atrophy (Nicholls, Hudson & Mahomed 2011). Extreme weight maintenance measures, such as the abuse of diuretics or laxatives, and chronic vomiting and the use of Ipecac (a cardio-toxic emetic), have serious health implications (Nicholls, Hudson & Mahomed 2011).

Anorexia Nervosa and Clinical Care

Due to the serious medical and psychological implications of AN, treatment should be effective and implemented swiftly. The treatment of AN involves a multidisciplinary approach (Nicholls, Hudson & Mahomed 2011; Patel, Pratt & Greydanus 2003). An effective collaboration may require a range of healthcare professionals such as psychiatrists, medical doctors, dieticians, nurses, psychologists, occupational therapists and physiotherapists (Hay 2004). Care efforts must be adequately sustained and resourced, as recovery from AN may take five to six years from diagnosis (Morris & Twaddle 2007; Nicholls, Hudson & Mahomed 2011).

Nutritional rehabilitation and the restoration of physical health is an essential of care. This involves the correction of pathological eating and exercise patterns, and healthy weight gain (Yager & Andersen 2005). On presentation, a comprehensive nutritional and physical assessment must be conducted in order to establish a consumer history, the severity of the eating disorder and the physical state of the consumer (Nicholls, Hudson & Mahomed 2011). Nutritional treatment should be administered cautiously with vitamin and mineral supplementation and foods high in potassium, avoiding refeeding syndrome; a medical condition caused by the introduction of food to a starved body, resulting in severe electrolyte disturbances (Treasure, Claudino & Zucker 2010).

Whilst it is indisputable that an effective strategy of care will include nutritional rehabilitation and the detection and resolution of medical complications (Hay 2004), effective strategies will also include attention to the psychological aspects of the illness. As part of that, assessment of suicide risk is necessary due to the high suicide rate (Fitzpatrick & Lock 2011). Inpatient and outpatient management may involve a variety of therapies and strategies of care. These include: cognitive behavioural therapy (CBT), family therapy, psycho-educational interventions, psychotherapy and pharmacotherapy (Bowers & Andersen 1994; Bulik et al. 2007; Garner & Bemis 1982; Hay 2004; Patel, Pratt & Greydanus 2003).

CBT aims to treat the emotional, behavioural and cognitive aspects of AN. CBT motivates adherence, corrects illogical perceptions regarding food and nutrition, and attends to the psychological elements of AN associated with weight maintenance behaviours (Hay 2004). CBT is reported to potentially reduce relapse rates for AN from 53% down to 22% (Espindola & Blay 2009). Family therapy is an ideal way to treat adolescent AN (Fishman 2006). Adolescent consumers have greater motivation to change with the presence of good parental relationships (Zaitsoff & Taylor 2009). The Maudsley method, in which parents are responsible for refeeding and challenging behaviours of AN, is a well supported and promising model of care delivery for treating adolescent AN (Attia & Walsh 2007). This is continued until behaviour modification and weight restoration are achieved. The responsibility of wellness is then imparted on the adolescent (Rhodes et al. 2005).

Pharmacotherapy for the specific treatment of AN is considered ineffective and largely unsubstantiated (Bulik et al. 2007; Fitzpatrick & Lock 2011; Patel, Pratt & Greydanus 2003). Antidepressants and the appetite stimulating effects of antipsychotics have been experimentally utilised for the treatment of AN, and have not yielded sufficiently convincing evidence (Morris & Twaddle 2007). In pursuit of effective pharmaceutical options, alternative medicines have been considered; such as cannabinoid-1 receptor agonists (Andries & Støving 2011) and cortisol supplements (Wheatland 2002).

Care and Consent

AN is typically treated on an outpatient basis, which is the most cost effective and least invasive means of care. However, with particularly severe presentations, if suicide risk warrants, or if outpatient care has failed to adequately effect positive behavioural and weight-gain outcomes, legally compelled inpatient care may be necessary. Life threatening AN may require compulsory treatment and lengthy hospital admissions. Adolescents with AN are considered particularly vulnerable. Adolescents with AN are less likely to effectively apply sound reasoning or logic in relation to their illness (Turrell, Peterson-Badali & Katzman 2011). Adolescents with AN therefore have a reduced capacity to consent to or refuse care. The inpatient setting may provide an intensity of care more effective in the context of severe AN (Fitzpatrick & Lock 2011; Williams, Goodie & Motsinger 2008). However, legally compelled inpatient care is potentially experienced with perceived coercion, is associated with poorer outcomes for consumers, and the exposure to other inpatients with eating disorders may hinder therapeutic progress (Morris & Twaddle 2007). Legally compelled care must then be carefully countenanced.

Continuity of Care and Social Support

The resources and interpersonal support within the inpatient setting assists consumers with the challenges of recovery. Although the inpatient setting establishes an effective intensity of care, the sudden loss of previously dependable close nursing support and structure on discharge may threaten the consumer's ongoing wellbeing (Cockell, Zaitsoff & Geller 2004; Offord, Turner & Cooper 2006). In achieving a safe and therapeutic discharge, parents of consumers need to be prepared to handle care on return home (Turrell et al. 2005). Relapse is less likely to occur for consumers

discharged into a socially supportive environment (Federici & Kaplan 2008), which parents could be better prepared to establish with prior nursing support. Nurses may be instrumental in preparing the parents of adolescent consumers (Bakker et al. 2011). If well prepared, siblings may also provide recovery support for consumers with AN (Bezance & Holliday 2013). For adult consumers not being discharged into parental care, a strong relationship with a partner (i.e. husband) is considered a driving recovery factor (Tozzi et al. 2003). Therefore, preparing a consumer's partner may be supportive of recovery.

Developing Evidence for the Treatment of Anorexia Nervosa

Despite the multiple therapies available, there is no single treatment or therapy that will definitively facilitate recovery for people with AN (Bodell & Keel 2010). The majority of research into the treatment of AN has been focused on specific techniques such as CBT, psycho-education and pharmacotherapy, and none of these treatment approaches are supported by sufficient evidence of therapeutic efficacy (Bodell & Keel 2010; Bulik et al. 2007). Despite multiple therapies and techniques, many consumers relapse and regress to maladaptive behaviours (Carter et al. 2004; Cockell, Zaitsoff & Geller 2004; Garner & Bemis 1982), leading to the assertion by Fairburn (2005) that an evidence based approach to treating AN is 'barely' possible.

Research is limited and often produces evidence of questionable quality due to methodological limitations, such as small sample sizes and high dropout rates. The paucity of evidence may be attributable to the difficulty of engaging consumers with AN in research, the implications of the nature and medical complications associated with AN, and the unwieldy task of conducting research in the context of complex care settings (Focker, Knoll & Hebebrand 2013; Morris & Twaddle 2007). In addressing the dearth of evidence, consumers and nurses have been consulted in research. Nurses and consumers possess novel insights that may enhance care delivery, enhancing consumer outcomes.

For example, consumers are more likely to relapse if care is perceived as exclusively behaviourally focussed, neglecting psychological, interpersonal and emotional development (Federici & Kaplan 2008; Tierney 2008). Although weight restoration is

strongly associated with enhanced psychological outcomes (Accurso et al. 2014), consumers with eating disorders place greater value on improvements to self-esteem, the improvement of body experience, problem solving skills and motivation to recover (Federici & Kaplan 2008; Vanderlinden et al. 2007). For the treatment of AN, therapeutic alliance is well regarded by both consumers and nurses (Bakker et al. 2011; Westwood & Kendal 2012).

Therapeutic Alliance: Consumer and Nursing Perspectives

For consumers with eating disorders, the most influential determinant of perceived quality of life is the sense of belonging derived from relationships with family, partner and friends (de la Rie et al. 2007). In the inpatient setting, the absence of family, loved ones and friends, combined with the intimate and ubiquitous presence that nurses have on the ward, serves to compel consumers to engage with nurses in a way that gratifies the need for a sense of belonging. In this way, the therapeutic alliance is an effective mode of care as it engages consumers in a manner appealing to their interpersonal need for intimacy and meaningful relationships. That is, with the development of meaningful relationships, consumers engage in care in order to maintain and reinforce their relationships with nurses (Zugai, Stein-Parbury & Roche 2013).

The qualities in interactions that are associated with therapeutic alliance are considered to be highly constructive by consumers (Federici & Kaplan 2008; Roots, Rowlands & Gowers 2009; Sly et al. 2014; Swain-Campbell, Surgenor & Snell 2001; van Ommen et al. 2009; Zugai, Stein-Parbury & Roche 2013). Sensitive interpersonal skills, and effective communication and listening skills are considered essential by consumers (Colton & Pistrang 2004; Offord, Turner & Cooper 2006; Reid et al. 2008; Roots, Rowlands & Gowers 2009; Tierney 2008; Tozzi et al. 2003; van Ommen et al. 2009; Zugai, Stein-Parbury & Roche 2013). Carers must be supportive (Colton & Pistrang 2004; Espindola & Blay 2009; Federici & Kaplan 2008; Offord, Turner & Cooper 2006; Reid et al. 2008; Tierney 2008; Tozzi et al. 2003; van Ommen et al. 2009), and have an understanding and non-judgemental nature (Colton & Pistrang 2004; Federici & Kaplan 2008; Reid et al. 2008; Roots, Rowlands & Gowers 2009; Tierney 2008; Tozzi et al. 2003; van Ommen et al. 2009).

Carers need to demonstrate a commitment to care, by being emotionally involved and available (Colton & Pistrang 2004; Espindola & Blay 2009; Reid et al. 2008; Swain-Campbell, Surgenor & Snell 2001; Tierney 2008; van Ommen et al. 2009). Consumers value an empathic (Colton & Pistrang 2004; Reid et al. 2008; Tierney 2008), respectful (van Ommen et al. 2009), and trusting relationship with carers (Swain-Campbell, Surgenor & Snell 2001; van Ommen et al. 2009). Autocratic or dictatorial carers are considered unhelpful. An effective approach to care will instead rely on collaboration and equality (Colton & Pistrang 2004; Offord, Turner & Cooper 2006; Reid et al. 2008; Sly et al. 2014; Swain-Campbell, Surgenor & Snell 2001; van Ommen et al. 2009; Zugai, Stein-Parbury & Roche 2013). Consumers have a clear preference for therapeutic interaction.

Nursing perspectives are similar to consumer perspectives, in that nurses also consider the therapeutic alliance to be positively influential. Nurses who specialise in the treatment of eating disorders consider supportive and empathic relationships with consumers to be a highly positive way to beneficially influence the wellbeing of consumers with AN (Bakker et al. 2011; Ryan et al. 2006). Effectively nursing consumers with AN requires firm guidance, genuine care and empathy, understanding, supportiveness and the gradual development of trust and the return of self-responsibility (Bakker et al. 2011; Ryan et al. 2006). The nursing perspective of what constitutes effective AN care remains relatively under-researched.

The strength of the therapeutic alliance is a key determinant of the perceived quality of care (Sly et al. 2014; Swain-Campbell, Surgenor & Snell 2001), and consumers that feel more satisfied with their care experience are less likely to relapse post-discharge (Federici & Kaplan 2008). Therefore, in addition to enhancing the inpatient experience, the therapeutic alliance contributes to the maintenance of health after discharge (Cockell, Zaitsoff & Geller 2004).

Anorexia Nervosa and Implications for Therapeutic Alliance

Despite the emphasis placed on developing the therapeutic alliance, it remains well established that nurses often find it difficult to facilitate and maintain strong relationships with consumers with AN (King & Turner 2000; Ramjan 2004). Nurses

believe that the difficulty in establishing therapeutic relationships is due to experiences of deceit and manipulation, a misunderstanding of the condition of AN, the constant struggle for control, the inability to be non-judgmental, and the continuing emotional challenge, frustration and exhaustion from the demands of nursing consumers with AN (King & Turner 2000; Ramjan 2004). The challenge in developing a therapeutic alliance with consumers may lie in the complexity of AN as an illness, and the way that AN influences interaction.

The way that AN affects consumers' mental health and behaviour presents challenges and obstacles that influence the inpatient context, and may consequently impair the development of a therapeutic alliance. The difficulty of establishing a therapeutic alliance lies partially in the ego-syntonic nature of AN. That is, AN is characterised by values, attitudes and beliefs that pervasively ingrain the illness into identity, and consequently direct behaviour. As a result, people with AN may deny their illness, be ambivalent about participation in care, and are inclined to enable and perpetuate their illness. The treatment for AN is then challenging. Consumers with AN may attempt to sabotage treatment and relapse after treatment is common (Guarda 2008; Higbed & Fox 2010; Meguerditchian et al. 2010; Tierney 2008). The ego-syntonic nature of AN presents a barrier to effective nursing and the establishment of therapeutic alliance. How is a mutual collaboration and agreement on health goals possible when a consumer actively promotes their illness?

Formative literature regarding the alliance stresses the importance of collaboration with the 'non-neurotic', rational aspect of the consumer (Greenson 1965); a relationship should be focused on and built in collaboration with the healthily operating aspect of the consumer's mind. Therefore, in caring for consumers with AN, therapeutic alliance is possible when consumer and nurse mutually find allies within each other, and the opponent within the AN. Despite the challenges in establishing a therapeutic alliance, research has examined the importance and efficacy of therapeutic alliance in a range of therapeutic contexts for the treatment of AN.

Anorexia Nervosa, Therapeutic Alliance and Variations in Evidence

Within the paucity of evidence, ongoing research develops a greater understanding of AN and its treatment. With multiple specific therapies considered unsubstantiated, therapeutic alliance in the treatment for AN may be an effective aspect of care. The effect of therapeutic alliance in the treatment of AN has been examined in a range of formal therapies, such as in family based therapy (Ellison et al. 2012; Forsberg et al. 2013; Forsberg et al. 2014; Isserlin & Couturier 2012; Pereira, Lock & Oggins 2006), CBT (Brown, Mountford & Waller 2013; Stiles-Shields et al. 2013), and inpatient care (Bourion-Bedes et al. 2013; Gallop, Kennedy & Stern 1994; Sly et al. 2013; Sly et al. 2014).

By reviewing the outcomes studies, there is clear variation in the findings. In studies of the inpatient setting, higher scores of therapeutic alliance were associated with greater retention in treatment (Gallop, Kennedy & Stern 1994; Sly et al. 2013), and a higher early alliance was predictive of a shorter period of time to reach target weight (Bourion-Bedes et al. 2013). In studies examining CBT however, therapeutic alliance scores were not predictive of treatment completion, and weight gain was indicated as a greater predictor of the alliance, rather than alliance being a predictor of weight gain (Brown, Mountford & Waller 2013). This raises the possibility that outcomes result in the development of an alliance, rather than the alliance eliciting good outcomes.

The association between therapeutic alliance and outcomes in family therapy has been relatively more researched, and considerable variation of findings is apparent. In a study by Ellison et al. (2012), a stronger mother-therapist alliance was significantly associated with greater weight gain, whereas a stronger father-therapist alliance was significantly associated with lower weight gain. However, in Forsberg et al. (2014) parental scores of alliance were not predictive of outcome, the difference between mothers' and fathers' scores were not predictive of recovery, and the difference between parent and adolescent scores were not predictive of recovery. Isserlin & Couturier (2012) indicate that a higher parental alliance is associated with weight remission at the end of treatment. Despite the specific investigations into mother-father alliance, it is worth considering that the traditional family model, consisting of

both a mother and father, is not applicable in all familial situations; many same sex couple families and single parent families also seek mental healthcare.

Considerable variation in findings across the outcomes studies is clearly apparent. The context of care has implications for the way that therapeutic alliance contributes to consumer outcomes. In understanding the variation in the findings across the studies, it is necessary to consider that the different studies measured therapeutic alliance with varying instrumentation, and at different times in the stages of therapy. Much is yet to be understood about the way therapeutic alliance interacts with outcomes for the treatment of AN.

Summary

AN is a serious mental illness, and research is required in order to address the dearth of evidence based recommendations. The efficacy and nature of therapeutic alliance is well established in the context of the traditional dyad, however is relatively unexplored in the inpatient mental health setting: the extra-dyadic context. The significant contextual variations that polarize traditional dyadic relationships and extra-dyadic relationships are likely to have implications for the nature and operation of the therapeutic alliance. Furthermore, AN as an illness itself likely contributes a complexity to the alliance, which further warrants focussed research. Despite difficulty in its establishment, the therapeutic alliance is considered by nurses and consumers to be therapeutic in the context of inpatient nursing care for consumers with AN (Ryan et al. 2006; van Ommen et al. 2009). Whether delivered voluntarily or otherwise, treatment for AN is best delivered through a collaborative relationship, which must be garnered and developed throughout the course of treatment (Morris & Twaddle 2007).

There is considerable variation in the findings of studies that examine therapeutic alliance in the context of eating disorders care (Brauhardt, de Zwaan & Hilbert 2014), suggesting that therapeutic alliance poses varying effects depending on the given context of care. This suggests that research of therapeutic alliance must be focussed to establish an understanding of therapeutic alliance as it relates to a specific context. To better understand how nurses can more effectively facilitate therapeutic alliance with consumers with AN in the inpatient setting is particularly important, as severe and

chronic cases of AN account for the majority of admissions to the inpatient setting (Wiseman et al. 2001). The therapeutic alliance between nurses and consumers in the inpatient setting is relatively unexplored, despite nurses being highly influential for consumers in the inpatient setting. The nature of these relationships would be better understood through specific and focused research. This study addressed this ambiguity.

Chapter Four: Method

Introduction

This chapter details the methodology and conduct of this research project. The aims of the research and study design are established. The procedures and practical considerations for the progression of the study, such as recruitment and data collection, are described. The instruments and means of data collection for this study are explained and their selection is justified. The process of analysis that yielded the findings of this study is outlined. The ethical integrity of this study is also demonstrated. Relevant documents such as letters of approval and instruments are included as appendices.

Aim

The aim of this study was to investigate the nature of the therapeutic alliance between nurses and consumers being treated for AN, in the context of the inpatient setting.

The objectives in meeting this aim were to:

1. Establish a greater understanding of the nature of therapeutic alliance within the context of the inpatient setting between nurses and consumers with AN.
2. Measure the strength of therapeutic alliance between nurses and consumers with AN in the inpatient setting.
3. Understand the consumer perspective of therapeutic alliance with nurses in the context of the inpatient setting.
4. Understand the nursing perspective of therapeutic alliance with consumers in the context of the inpatient setting.

Design

In achieving the aim and objectives of this study, a mixed methods 'Explanatory Sequential Design: Follow-up Explanations Model' was employed (Creswell & Plano Clark 2007). This model is distinguished by the sequential collection of quantitative and

qualitative data, whereby the initial quantitative phase enhanced the subsequent qualitative phase. The initial phase of the design involved the collection and analysis of quantitative data. The second phase involved further follow-up investigation through qualitative data collection. The final stage was a synthesis of the qualitative and quantitative results (Creswell & Plano Clark 2007).

The study design followed a sequential order, as outlined in Figure 1.

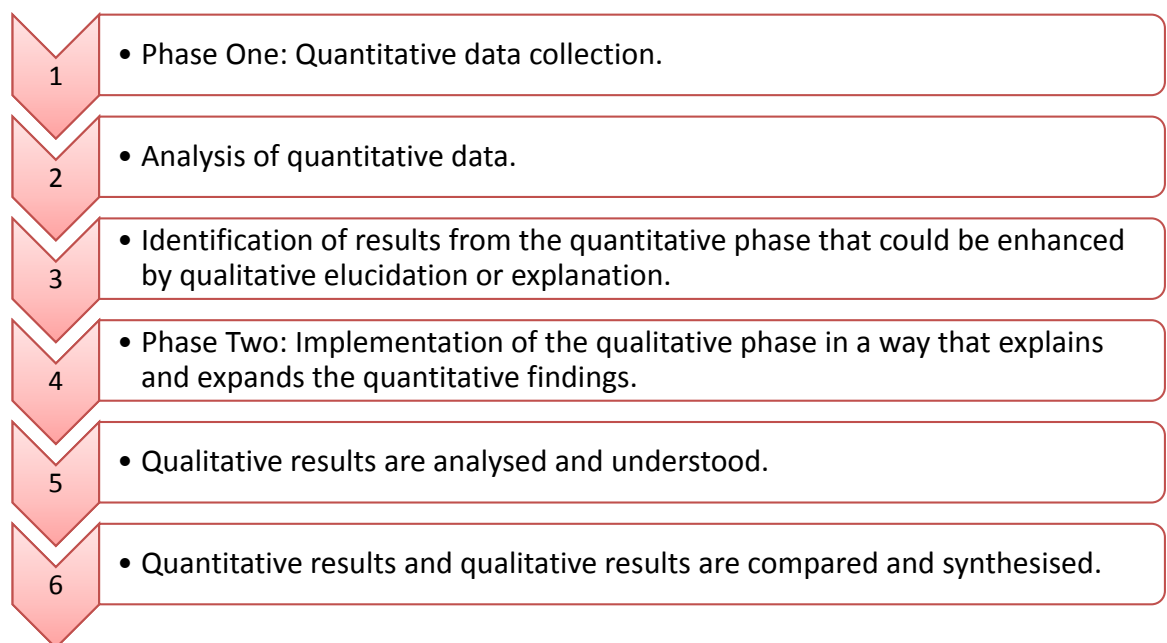


Figure 1 Visual Model of Study Design

In this study, data gathered during the quantitative phase established useful descriptive statistics, offering insight into the dynamics of the inpatient context. Findings from the quantitative phase provided an understanding of contextual factors that influence the therapeutic alliance between consumers and nurses: the strength of the alliance, ward climate, consumer satisfaction with care, eating disorder psychopathology and nursing attitudes. Following analysis of the quantitative data, statistical anomalies or findings of interest were identified for qualitative expansion. The qualitative phase expanded on the quantitative results, and established a more

person centred understanding of how the inpatient context influences and relates to therapeutic alliance.

Research Design

The aim of the study and selected research design is compatible with the philosophical foundation of the pragmatic world view, as there is a clear research problem that could be better understood by employing a mixed methods approach to research; a methodology involving a combination of research strategies and techniques.

Pragmatism is a worldview focussed on 'what works' in understanding problems and issues. Pragmatist researchers are focussed on a particular research question, and will utilise whatever means available to enhance and develop current knowledge (Creswell 2009). This project utilised a mixed methods approach in order to establish well evidenced conclusions and to develop readily applicable recommendations, thereby making pragmatism an apt worldview.

The pragmatic worldview is primarily associated with mixed methods research, as pragmatism is concerned with the consequence of research rather than strict adherence to either quantitative or qualitative assumptions (Creswell & Plano Clark 2007). A mixed methods approach mitigates some of the limitations of implementing either a solely quantitative or solely qualitative approach (Creswell & Plano Clark 2007). The quantitative and qualitative data generated from this project were examined sequentially in order to exploit the full virtue of the mixed methods approach. The quantitative and qualitative data were complementary and of consequence to each other, as opposed to an analysis of independent sets of quantitative and qualitative data.

Participants

This study recruited both consumers and nurses from multiple inpatient care facilities in the Sydney region. Six wards from five hospitals contributed participants; two of the facilities were private institutions, the remaining three were public hospitals. Two of the public hospitals were paediatric hospitals. Non-probability convenience sampling was utilised, and was justified by the need to sample from a specific population from specific

locations (Schofield 2004). Specific inclusion criteria determined the suitability of both nurses and consumers for participation. All participants were required to be fluent in speaking, reading and writing in English. Those not fluent in English were excluded from this study, as their needs could not be accommodated within the limited resources available for this project. In the presence of a language barrier, the means of data collection and process of gaining informed consent are compromised.

Consumer Participants

Both males and females were accepted for participation. Within the group of consumer participants, the expected ratio of females to males was 10:1. This estimate was determined by considering the typical gender distribution in AN. The participating consumers were required to be over 12 years old, and have experienced inpatient care specifically for the treatment of AN regardless of subtype or co-morbidity. Consumers were required to have experienced a minimum of 1 week within the participating ward, not inclusive of time spent in other wards within the given facility or time from prior admissions. Participating consumers were required to be medically and cognitively stable, to the degree that their participation was viable. The principal researcher liaised with the treating team in ascertaining the medical and cognitive stability of participants.

Nursing Participants

Within the group of nursing participants, it was expected that female nurses would represent the majority of the sample. Participating nurses were required to have been currently working in a ward which had a specialised program for the treatment of AN. Nurses of varying designation (Assistants in Nursing, Endorsed Enrolled Nurses and Registered Nurses) and experience level were all accepted for participation, as the diverse skill mix is inherently an element of ward context.

Phase One

The maximum overall sample size for the quantitative phase was 90 nurses and 90 consumers in total (15 nurses and 15 consumers from each participating ward), with a minimum of 54 nurses and 54 consumers in total (9 consumers and 9 nurses from each participating ward). The maximum sample size was achievable on condition that the participating wards had admitted sufficient numbers of consumers with AN, with a high response rate from both nurses and patients. The sample size for both participant

groups was limited as most inpatient units seldom have more than 8-10 inpatient consumers with AN at any given time, and there are relatively few nurses experienced in caring for consumers with AN. Furthermore, the consumer turnover in inpatient units is slow, as admissions can last weeks or possibly months. The minimum sample size was achievable with a response of around 50% of nurses from each ward and a slightly higher rate amongst consumers.

The minimum sample size ensured that the quantitative phase was adequately weighted with data. Most of the quantitative instrumentation for this study has been previously used in research with relatively small sub-samples: the I-TAS (Kerfoot, Bamford & Jones 2012; Rise et al. 2012), the CAT (Priebe et al. 2006), and the ATAMHS-33 (Baker, Richards & Campbell 2005; Foster et al. 2008). The developers of the EssenCES specify that a sample of 8-10 participants per ward is sufficient (University of Duisburg-Essen n.d.). In light of the small sample, the quantitative data were not to be used for inferential analyses, and instead provided descriptive information to inform and enhance the qualitative phase. A relatively small sample size was therefore not detrimental to the validity of the study (Greenwood 2004).

Phase Two

For the qualitative aspect of this study, a minimum of 5 nurses and 5 consumers from each of the wards that were involved in data collection was deemed to be sufficient to generate enough interview data to develop an understanding of the experiences and perceptions of both consumers and nurses. Interviews were ceased at the point of data saturation, when no new themes or ideas arose from data collection (Llewellyn, Sullivan & Minichiello 2004).

Procedure

Specific procedures and conduct over the course of data collection supported the feasibility, scientific validity and ethical integrity of the study. Upon receiving all required ethical and governance approvals, recruitment and data collection for this project commenced 16 May 2014 and concluded 12 February 2015. Prior to and during data collection for both phase one and phase two, the principal researcher liaised regularly with the treating teams at each facility, and arranged times and dates for

data collection, typically via email. The treating team supported the principal researcher to work within the ward where he made initial contact with potential participants. Specific procedures were used to collect data from nurses and consumers.

In gathering data from nursing participants, the principal researcher liaised with the Nursing Unit Manager (NUM) or other senior nurse (Clinical Nurse Specialist (CNS) or Clinical Nurse Educator (CNE)) of the respective ward to negotiate the means of data collection. The NUM/CNS/CNE supported the project by introducing the project to nursing staff and assisted the principal researcher with distributing surveys to the staff (Appendix B). Nursing staff were given the option to either complete the survey at home or whilst on the ward, thereby minimising the degree of disruption to ward duties. In addition to the survey, the nurses were provided with an 'Initial Contact Letter' (Appendix C). This letter provided a brief overview of the project, participation, and contact details of the principal researcher. All efforts were made to burden nurses as little as possible, as well as ensuring that participation did not compromise the care that patients received. Upon completion of the survey, participating nurses either returned the completed survey to the NUM to be stored securely in a filing cabinet or sealed envelope, or the nurses placed the completed survey in a secure drop-box left on the ward, which was then collected by the principal researcher at a later date.

For consumer participants, a member of clinical staff familiar with the study made initial contact with the potential participant, with the principal researcher present. If the consumer expressed interest in the study, the principal researcher then introduced himself and the study. The study and its required commitments were verbally explained and viable participants were offered an initial contact letter to keep (Appendix D) and a survey form to complete (Appendix E). The principal researcher remained in the presence of participants completing surveys in order to address any concerns or questions. Consumers were only recruited at times that did not interfere with care. Consumers were usually approached during a rest period after the afternoon meal. In this way, important therapies and other important activities were not interrupted and consumers were not otherwise distracted. Completed surveys were personally collected by the principal researcher.

Phase one data collection facilitated recruitment for phase two. The last page of the survey booklets (Appendices B & E) offered participants the opportunity to participate in a follow-up interview at a later date. If a participating nurse wished to further their participation in the form of an interview, the survey booklet requested contact information for the purposes of follow-up. The principal researcher then individually contacted nurses who agreed to participate in order to arrange a time and place for an interview, at the convenience of the nurse. If a consumer wished to further their participation in the form of an interview, the consumer indicated their interest by writing only their name in the last page of the survey package. The principal researcher then liaised with the treatment team at the given facility and arranged contact with the consumers who agreed to participate in order to arrange a time for an interview, at the convenience of the consumer. The last page of the survey booklet was separated to maintain confidentiality. In the event of a consumer recruitment shortfall for phase two, the principal researcher utilised the outpatient clinics of the participating facilities to recruit consumer participants. Whilst conducting the qualitative phase of the study, specific procedures were employed that ensured scientific validity and ethical integrity. Interviews were one-to-one, audio recorded on two Dictaphones, and conducted in a private room/area of the respective facility. The consumer participants were welcome to have a parent or other trusted person present in the interview if desired.

Data Collection

Phase One

During the initial quantitative phase, data were collected with five separate instruments that reflected both consumer and nursing perspectives. Each instrument provided unique insight into a particular element of the inpatient setting and overall context. The combination of instruments provided a thorough investigation of different factors within the inpatient setting, which had implications for the overall context of the therapeutic alliance between nurses and consumers. The strength of the therapeutic alliance, ward climate, consumer satisfaction with care, eating disorder psychopathology, and nursing attitudes towards mental health were measured. These results provided useful

information regarding the participants and the context of care. Some of the instruments were modified to enhance their use in the context of this study. All alterations to instruments were made with the permission of the creators of the instruments and are detailed below.

Instruments

The Inpatient Treatment Alliance Scale: The I-TAS

The I-TAS (Appendix E) was used in this study to ascertain the strength of therapeutic alliance between consumers and nurses, from the consumer perspective. Many scales have been developed in order to measure therapeutic alliance (Elvins & Green 2008), particularly in the outpatient setting where a consumer and therapist form a dyad. Therapeutic alliance in the inpatient setting, where multiple consumers interact concurrently with multiple caregivers, has been relatively unmeasured and unexamined. In light of this, the I-TAS was designed to empirically measure alliance dynamics from the consumer perspective, in the inpatient setting. The I-TAS does not measure therapeutic alliance in the context of a single dyad, but rather measures therapeutic alliance between consumers and their multiple caregivers (Blais 2004). This made the I-TAS a useful instrument for this study.

The I-TAS is a ten item self-report instrument scored on a seven point Likert scale. The ten items of the I-TAS reflect three major aspects of therapeutic alliance: bond (3 items), collaboration (4 items) and goals (3 items). The mean of the ten items is calculated to provide a single overall measure, with a range of 0 to 6. The initial use of the I-TAS was in an outcomes measurement program in an inpatient psychiatric unit (Blais 2004). In that study, consumers completed the instrument twice over four months: first in the early stages of treatment and second at discharge. The I-TAS was shown to have strong psychometric properties; the instrument displayed sound internal consistency (Cronbach's alpha of 0.94 [n=140] and 0.91 [n=72]), adequate test-retest reliability ($r= 0.61$, $n=73$, $p<0.0001$) and item-to-scale correlations ($r= 0.58$ to 0.94 , $n=140$). Furthermore, the I-TAS is associated with important outcome variables such as length of stay and patient satisfaction (Blais 2004).

For the purposes of this research project, the instrument was modified in order to specifically assess the degree to which consumers experienced therapeutic alliance with their nursing team. Items with the term 'Treatment Team' were replaced with the term 'Nursing Team'.

The Essen Climate Evaluation Schema: The EssenCES

Initially developed for use in the forensic setting, the EssenCES (Appendix B & E) is an instrument that measures the quality of the inpatient climate in mental healthcare settings (Schalast et al. 2008). Ascertaining the ward climate is important for understanding the overall context of the inpatient setting, where consumers and nurses constantly interact. The ward climate may have implications for the way therapeutic alliance exists between nurses and consumers. Originally a German language instrument, the EssenCES has been translated for use in English speaking environments, and subsequently validated (Howells et al. 2009; University of Duisburg-Essen n.d.).

The instrument consists of 17 items scored on a five point Likert scale, and was administered to both consumer and nursing participants. The instrument has two items, the first and last, which are not scored; the first item is an 'ice-breaking' question, and the final item is used to positively conclude the survey (Schalast et al. 2008). The instrument consists of three subscales each with 5 items (15 items in total). As each subscale consists of 5 items, and each item is scored 0-4, the raw score per subscale can range between 0-20 (University of Duisburg-Essen n.d.). The subscales measure three dimensions, which are:

- 1) Therapeutic Hold: This dimension essentially refers to the degree to which therapeutic alliance exists between nurse and consumer; the care and concern nurses have for consumers.
- 2) Patient Cohesion and Mutual Support: This dimension specifically refers to the quality of relationships between inpatients.
- 3) Experienced Safety: This dimension regards the overall feeling of being physically safe within the ward; the degree to which one feels threatened by potential aggression or violence. (Schalast et al. 2008)

During an initial validation study the EssenCES was trialled in 46 wards across 17 hospitals in Germany. In this trial, internal consistency was good, with Cronbach's alpha scores ranging from 0.73-0.87 for each of the three subscales. The three factors were confirmed via factor analysis and item total correlations were satisfactory (range 0.49-0.75). The instrument was found to be concordant with other, more burdensome, tools (Schalast et al. 2008). Similarly, a large study indicated that the English-language EssenCES had satisfactory internal consistency and maintained stable psychometric properties across a broad range of settings (Tonkin et al. 2012). The measurement of therapeutic hold is particularly useful for this study, as this subscale will offer insight into the association between the consumer and nurse quotient of the perceived alliance. For this study, the EssenCES was modified; items pertaining to ward climate in relation to staff have been altered to specifically address nursing staff. To this end, the term 'nursing staff' is used in lieu of the more general term 'staff'.

The Client Assessment of Treatment Scale: The CAT Scale

The CAT scale (Priebe et al. 2009) (Appendix E) provided a measure of consumer satisfaction with care. Understanding the client view of treatment and satisfaction with care was pertinent to this study. In the context of inpatient AN care, therapeutic alliance is perceived by consumers as a positive element of nursing care (Zugai, Stein-Parbury & Roche 2013), and has implications for the perceived satisfaction with care. Furthermore, consumers reporting greater satisfaction with treatment have better outcomes and adherence to treatment (Chue 2006). Consumers with AN often experience lengthy and involuntary hospitalisations, which are related with lower levels of satisfaction (Greenwood et al. 1999). In light of the importance of understanding consumer satisfaction and the lower levels of satisfaction associated with involuntary hospitalisation, the importance of understanding the perspectives of inpatient consumers with AN is apparent.

The CAT consists of six items, each item being rated along a 100mm analogue scale numbered 0-10, mean score used (Priebe et al. 2009). The scale is easy for participants to understand and suitable for use with populations receiving inpatient mental healthcare (Richardson et al. 2011). It has a good internal consistency (Cronbach's alpha= 0.90) (Priebe et al. 2009). A study of involuntary patients across three European

nations (England, Spain and Bulgaria) provided good support for the factorial validity of the CAT and its consistency across samples (Richardson et al. 2011). The scale has been used in several studies involving inpatient mental healthcare (Kallert et al. 2007; Priebe et al. 2011; Priebe et al. 2006; Richardson et al. 2011).

The Eating Disorder Examination-Questionnaire: EDE-Q

Consumers experience varying degrees of eating disorder psychopathology. The degree to which eating disorder behaviours and cognitions interfere with wellbeing is an important factor to ascertain for the effective treatment of AN. The EDE-Q (Appendix E) is an effective self-report instrument for measuring the severity of eating disorder behaviour and cognitions (Berg et al. 2012). The use of the EDE-Q was necessary for this study, as the overall severity of illness within each ward is an influential factor over ward context, and the association of severity of illness and other factors being measured in this study were examined.

The EDE-Q instrument used in this study consisted of 39 items, and was the youth version of the instrument, adapted from Goldfein, Devlin & Kamenetz (2005) and Fairburn & Beglin (1994). The version submitted for this study is the instrument used at a major paediatric tertiary referral hospital in Sydney for determining eating disorder severity, and the EDE-Q is considered the gold standard for assessing eating disorder psychopathology. The instrument features four subscales for measuring cognitive features of eating disorders: 'eating concern', 'shape concern', 'weight concern', and 'restraint'. Eating disorder behaviours such as binge eating, vomiting, excessive exercise, and laxative and diuretic misuse are also measured. The instrument measures the severity of eating disorder symptoms in relation to the previous 28 days. Within the four cognitive sub scales, test–retest correlations range from 0.66-0.94. Test-retest correlations for the behaviour items range between 0.51-0.92 (Berg et al. 2012).

The Attitudes towards Acute Mental Health Scale: The ATAMHS-33

The attitudes of healthcare providers working in mental healthcare may influence the experience consumers have in the inpatient setting. The attitudes of healthcare professionals can be negative, and consumers have suffered from stigma and poor service due to negative attitudes associated with mental illness. In response to this,

the ATAMHS-33 (Appendix B) was developed to measure staff attitudes (Baker, Richards & Campbell 2005). The ATAMHS-33 added an important understanding of the inpatient context in this study, as nurses' attitudes have implications for the therapeutic alliance.

The ATAMHS-33 is a 33 item instrument that measures the attitudes of nurses in relation to acute mental healthcare. Items 1-25 are scored on a seven point Likert scale and items 26-33 are scored on a semantic differential scale. Items are summed for each of the five subscales that were derived through factor analysis (Baker, Richards & Campbell 2005): 'care or control' (12 items), 'semantic differentials' (7 items), 'therapeutic perspectives' (6 items), 'hard to help' (4 items), and 'positive attitude' (4 items). Items in the ATAMHS-33 were developed from previously validated questionnaires in addition to literature and experience, suggesting good content validity (Baker, Richards & Campbell 2005). The instrument has acceptable internal consistency, as indicated by a Cronbach's alpha of 0.72 (Baker, Richards & Campbell 2005). This instrument has been used in studies that have examined nurses' attitudes in the UK (Munro & Baker 2007) and in Fiji (Foster et al. 2008).

Phase Two

The collection of qualitative data augmented the quantitative findings to provide rich subjective understanding and insight from nurses and consumers regarding therapeutic alliance and the inpatient context. Qualitative data were gathered through interviews with nurses and consumers. These semi-structured interviews allowed participants to express and introduce topics freely, and allowed the interviewer the capacity to follow-up and explore ideas introduced by the participants. The interviews focussed on the therapeutic alliance between consumers and nurses, in relation to contextual factors of the inpatient setting. The interviews were guided by a prescribed interview schedule (Appendices F & G), which was enhanced by findings from the quantitative phase. Semi-structured interviews were an appropriate means of data collection in order to capture person centred data (Minichiello et al. 2004).

Data Analysis

Phase one provided an indication of the strength of therapeutic alliance (I-TAS), whilst also providing insight into other contextual factors such as the ward climate (EssenCES), consumer satisfaction with care (CAT), the severity of eating disorder psychopathology of consumers (EDE-Q), and nursing attitudes towards mental health (ATAMHS-33). The analysis of the quantitative data then provided a description of the ward context, which influenced and enhanced the direction of the qualitative phase. The qualitative phase expanded on phase one findings, and addressed the aims of this project by establishing findings that could not be determined through quantitative means. The mixed methods employed in this study thereby resulted in an understanding of the unique context in which therapeutic alliance develops between nurses and adolescent consumers with AN, in the inpatient setting, by exploiting the full virtue of both quantitative and qualitative assumptions. Figure 2 Instruments and Analytical Approach provides a visual display of the data organisation and analysis.

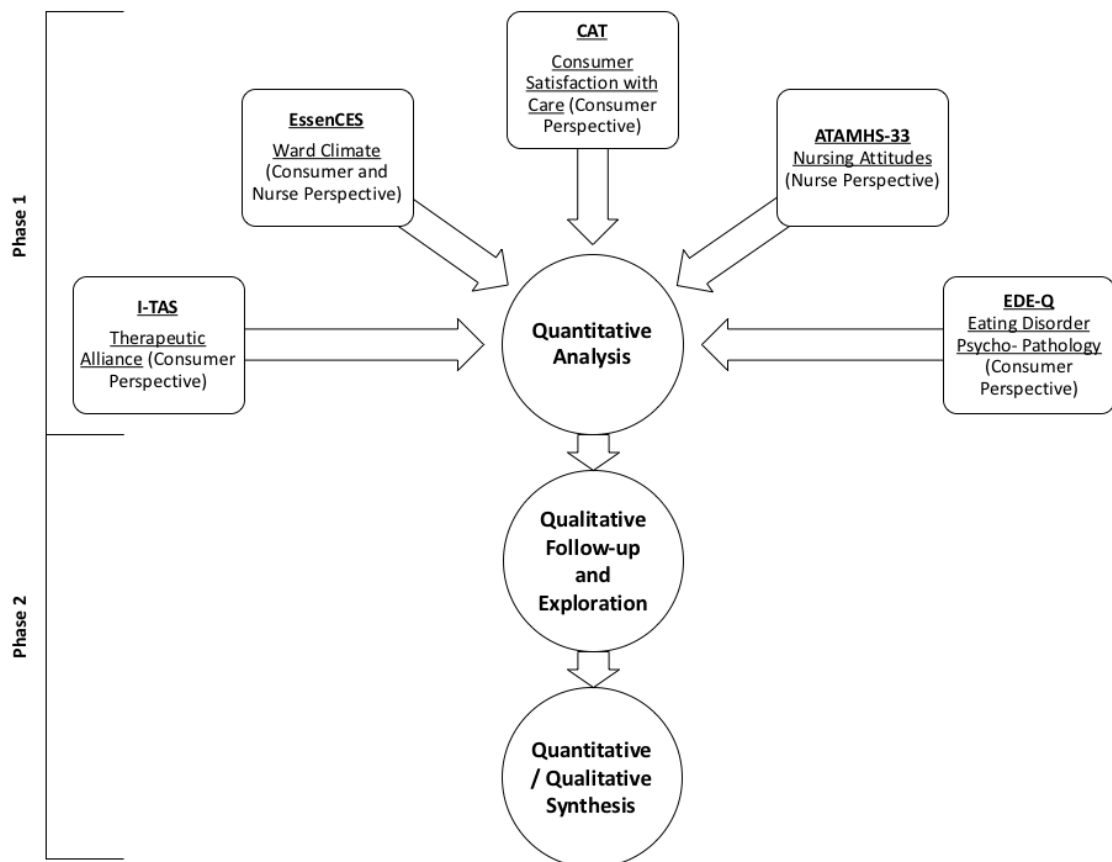


Figure 2 Instruments and Analytical Approach

Phase One Data Analysis

Quantitative data were entered directly into statistical software (SPSS Version 22.0 (IBM 2013)) for analysis. Descriptive statistics: mean, median or number and percentage (dependent on the nature of the data) were used to explore each concept under study. The mean scores from each instrument were first compared to those from previous studies that utilised the same instrumentation (Appendix H). Following determination of a satisfactory distribution of data from the shared EssenCES scale, comparisons of consumer and nurse responses were undertaken using the independent samples *t*-test, with statistical significance set at $p \leq 0.05$. Similar statistical comparisons between wards were desirable but not performed due to limitations of per-ward sample size. Descriptions of these per-ward, and other, data were used to guide phase two.

Phase Two Data Analysis

The semi-structured interviews that followed the quantitative phase were transcribed through a transcription service. The electronic audio-files were de-identified of all personal or site related information prior to transmission to the service. Upon review of the transcripts, coding formats were developed in order to ease interpretation of themes. The data were interpreted both deductively and inductively through a thematic analysis, which identified themes that were recurring and or emphasised by the consumer and nurse participants (Browne 2004).

In interpreting the consumer transcripts, the coding format from a prior qualitative project (Zugai, Stein-Parbury & Roche 2013) was utilised for deductive analysis. This coding format consisted of the themes that were developed from that study. However, data from the current study carried a range of new themes that were not suitably gleaned or organised by the deductive approach. Over the lengthy course of data analysis, many new themes occurred to the principal researcher that warranted reporting. Therefore, an inductive analysis gleaned additional themes not revealed by the former coding format alone. With completion of both the deductive and inductive approach, all data were synthesised into a final set of themes that most effectively reported the findings. The data was revisited many times over to ensure that the reported themes were well substantiated and justified.

In presenting the data, the themes and ideas expressed by participants were established by using their own words (Axford et al. 2004); direct quotes from the interviews were used to substantiate findings. Quotes were attributed a pseudonym, ie., *'Daisy' aged 12*. Ultimately, the qualitative analysis integrated the quantitative and qualitative data, as the qualitative analysis established in-depth, person centred meaning to the quantitative findings. It is in this way that the quantitative and qualitative data were meaningfully interpreted.

Ethical Considerations

Integrity, respect for persons, beneficence and justice were the overarching guiding principles for conduct in this project. Ethical considerations in this study were guided by the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council 2007). Ethical considerations for this project were of particular importance, given the vulnerability of consumers with AN. Ethical approval was attained from a Sydney based lead Human Research Ethics Committee (HREC) (Appendix I) and Site Specific Approval was gained from the participating hospitals' governance committees. The UTS HREC ratified the ethical approval for this study (Appendix J). The principal researcher covered all costs associated with the study (travel, equipment and stationary, transcription fees, etc). No conflicts of interest threatened the ethical integrity of this project.

Consent

Participation in this project was voluntary and fully informed consent was sought from all participants, as well as parental consent for interviews with adolescent consumers under the age of 18. The nursing participants in this study were considered to be capable of independently providing full consent for both the quantitative and qualitative phase. Consent for the data collected in the quantitative phase was implied, as completion of the survey indicated willingness to participate. Activities associated with the surveys posed non-significant risk to the safety of participants, thereby validating such a form of consent. Written consent for interviews was obtained (Appendices K & L), and information packages were provided to consumers (Appendix M), nurses (Appendix N), and parents/guardians (Appendix O) as appropriate. The

process of gaining consent from the consumer participants accounted for the implications of AN as a mental disorder.

The consumer participants in this study varied in the degree to which they were cognitively affected, which was dependent upon their degree of starvation and stage of recovery. Fortunately, AN as an illness itself would not impair the capacity of the consumer participants to make decisions regarding participation in this study, or understand what participation involved. AN is associated with an inability to make appropriate decisions involving food and exercise, and is associated with misperceptions regarding body image. AN as an illness therefore did not impair the consumer's capacity to comprehend the requirements of participation. Initial contact for participation was made by a member of the treatment team, rather than the principal researcher. This initial contact made by a member of the care team (doctor or nurse) ensured that the consumer was approached by a person with whom they were more likely to be familiar and comfortable with, and therefore feel less pressured to participate. Furthermore, the treating team verified that the consumer was cognitively and medically stable to the degree that their consent and participation was viable.

Participants in this project were in dependent relationships with the facilities in which they worked or were cared for. Participants were assured that their consent and participation or refusal to participate would have no effect on any current or future treatment at, or relationship with, the hospital, with their specific contributions kept confidential. No payment or reimbursement was offered to participants, no incentives impacted the decision to participate, and there was no cost to the participant, other than time devoted to participation.

Risk, Benefits and Management

Consumers, nurses and the contributing facilities were at risk from the conduct of this study. The risk posed from this study was justified in light of the management strategies that mitigated risk, and the potential benefits and outcomes from this research project. The conduct and progress of this research was supervised by experienced academics at all stages to safeguard ethical integrity. The quantitative phase posed minimal risk. The instruments required for the quantitative phase were

not burdensome or overly intrusive in content, required no more than 10-15 minutes to complete, and were anonymous. Although these surveys may have posed an inconvenience, consumers were only recruited at times that did not interfere with care, and nurses were given the option of taking the survey home, which minimised disruption to ward activity. Great care was taken to ensure that hospital staff and consumers were not unnecessarily burdened.

The qualitative phase of the research posed greater risk to participants. For consumer participants, there was a possibility that the content of the interviews would be distressing, due to the potential for re-experiencing or remembering intrusive or negative experiences from the inpatient setting. Although these recollections could have been undesirably revisited, the benefit from being able to understand consumer perspectives may offer directions to enhance care and inpatient experiences. The confidentiality of participants was only to be compromised in the event that a participant voiced intention to harm themselves or someone else. The principal investigator, as a registered nurse, had a legal and ethical duty as a mandatory reporter in such an instance. It was also possible that consumers could have experienced retribution from nursing staff for their participation in the research. It is worth noting that many of the consumer participants from the qualitative phase were outpatients at the time of data collection, thus their participation was outside the knowledge of nursing staff. For inpatients, their responses were kept confidential, thereby leaving nurses without any awareness of any individual consumer perspectives of their care.

For nurses, there was a possibility that the content of the interviews would be discomfiting. It was also possible that nurses would be highly conscious of responses and give information that was socially desirable. As a consequence, a nurse would potentially feel embarrassed or judged. Privacy in interviews, confidentiality and the non-judgemental nature of the interviewer mitigated this potential experience for nurse participants. If a consumer or nursing participant became distressed or unable/unwilling to continue the interview, the interview was to be ceased. The principal researcher was a registered nurse, capable of exercising interpersonal supportive skills, and was prepared to organise referral to the treatment team at the facility of data collection for support and counselling. Fortunately, no such instance occurred.

In contributing to this research, no certain benefits were offered or expected for participants. However, the opportunity to have expressed thoughts and feelings about experiences may have been a therapeutic or gratifying activity. To have potentially contributed to the wellness of others may have been rewarding to the participants. The participating facilities were at risk from this study, due to the potential disclosure of identifiable data. In mitigating this risk, the specific results generated from each site of data collection were kept confidential in publication and not shared with other facilities. However the specific findings from each ward were reported to the respective facilities. This reporting may have led to enhanced services and practice.

The consumers involved in this study were particularly vulnerable, in that they were a population with a mental illness, many of whom were unable to provide independent consent due to their age. Furthermore, developing safe procedures to protect participants and the researcher was vital, in light of the vulnerability of a largely female consumer population, and in light of the principal researcher being a male. To mitigate risk, the principal researcher was accompanied during his visits to facilities and during interactions with consumers. However, for private interviews, both confidentiality and transparency was required to ensure ethical integrity. Procedures were developed for each individual site, subject to available space and resources. Interviews were usually conducted in an office with a window. This assured that no information could be overheard, but permitted visual contact by staff.

Data Management

Strict measures for data management were necessary, as the privacy and confidentiality of participants was vital for the ethical integrity of this project. The true identities of participants were not reported, and all contributions from participants were non-identifiable. Data were coded with pseudonyms assigned to participants. The publication of the study in a PhD dissertation and journal articles did not allude to any individual identities. The means of data collection were designed to simultaneously protect the confidentiality of participants. The survey forms did not indicate consumer or nursing identity, although the last page in the survey package requested the name of the participant for qualitative data collection. This page was separated from the survey forms, and could not be re-identified with the survey form.

These forms were disposed of at completion of data collection, when they were no longer required.

During the qualitative phase, the name of the participant was not part of the data gathered or as part of recorded data. The consent forms were the only records with participant names and there was no link to their assigned pseudonym used for reporting. All paper materials which had information from or pertaining to participants (consent forms, questionnaires, transcripts, etc) were stored in a locked filing cabinet, within a private and secure premises. All electronic files were stored securely on a password protected laptop, and a backup USB was stored within the filing cabinet. Data will be stored for 7 years after publication. Data will then be destroyed through means of incineration. This time frame is in accordance with UTS institutional guidelines.

Summary

This study employed a mixed methods approach, in which a quantitative phase preceded a qualitative phase. In utilising a sequenced approach, the initial quantitative findings enhanced the subsequent qualitative phase; outstanding or extraordinary findings were subject to qualitative follow-up. Non-probability, convenience sampling was used to collect data from two very specific populations; consumers who had experienced hospitalisation for AN, and the nurses that cared for them. Data collection occurred in six wards from five hospitals in the Sydney metro region. The sample size was anticipated to be small in light of the small population size. The quantitative phase involved the use of five surveys for consumer and nursing participants. These surveys measured the quality of the alliance, ward milieu, consumer satisfaction, eating disorder psychopathology and the quality of nursing attitudes towards mental health. The qualitative interviews focused on the nature of the inpatient therapeutic alliance, and the implications of the ward context. These data were analysed with a thematic analysis approach. Due to the vulnerability of participants, the ethical integrity of this study was conscientiously protected. Fully informed consent was sought from all participants. Procedures to protect participants and facilities were implemented.

Chapter Five: Results

Introduction

This chapter details results of both phases of this study. The sequence of results reflects the chronological order of data collection involved in the explanatory sequential design: follow-up explanations model. That is, the presentation of quantitative data precedes the reporting of qualitative data.

The Sites of Data Collection

For this study, data were gathered from six different wards within five different hospitals. Wards and hospitals were deidentified through the use of codenames: A1, B1, C1, C2, D1, E1. Sites A1, B1, C1 and C2 were wards within large, public metropolitan tertiary referral centres, whereas sites D1 and E1 were wards within smaller private hospitals. Sites A1, C1 and C2 were wards within paediatric hospitals.

Site A1 was a general adolescent ward, with a combination of inpatient consumers with AN as well other adolescent medical patients. Site B1 was a general medical ward, with a sub-section for adolescents being treated for AN. Sites C1 and C2 were paediatric wards within the same hospital. Site C1 was a medical ward, in which consumers with AN were medically stabilised. With medical stabilisation, consumers then graduated to being cared for in site C2, which was an acute psychiatric ward. Sites D1 and E1 were very similar, in that they were both wards that specialised in the management of eating disorders, and they primarily cared for adult consumers with AN. Sites D1 and E1 catered exclusively for consumers who were medically stable, and these sites did not practice nasogastric feeding.

Phase One

As described in method, phase one results first provides an overall view of the sample in relation to previous studies, followed by a comparison of ward climate as perceived by consumers and nurses using the EssenCES subscales, and a description of units across all scales. A total of 128 participants completed surveys (65 nurses, 63 consumers). Of the 63 consumer participants, only one was male. Given the maximum

sample of size of 180 (90 nurses and 90 consumers), the response rate was 72% and 70% for nurses and consumers respectively. In accordance with the aims of the study, the phase one results provided useful findings to guide and complement phase two results.

Consumer Data

I-TAS: Inpatient-Treatment Alliance Score

The overall I-TAS mean across the consumer sample was 3.70 (SD: 1.30) with a wide range (0.7-5.8). This mean is relatively low compared to other studies that have utilised the I-TAS instrument, such as in Blais (2004), Kerfoot, Bamford & Jones (2012) and Rise et al. (2012), in which a mean score ranging from 4.5-5.0 is more typical.

EssenCES: Essen Climate Evaluation Schema

The EssenCES subscale means across the consumer sample are provided in Table 2. Consumers surveyed for this study scored the Patient Cohesion and Experienced Safety subscales relatively highly compared to previous studies (Howells et al. 2009; Kerfoot, Bamford & Jones 2012; Milsom et al. 2014; Quinn, Thomas & Chester 2012; Schalast et al. 2008). It is necessary to consider the context of these studies, as the EssenCES was primarily developed for use in the forensic/secure setting. In contrast, the mean consumer Therapeutic Hold subscale score is more akin to that published in other studies, and more closely corresponded with scores from medium security settings (Milsom et al. 2014; Quinn, Thomas & Chester 2012). All subscales showed a wide range of responses.

Table 2 EssenCES Subscale Scores (Consumers)

	Mean	SD	Min	Max
Patient Cohesion	14.4	3.70	5.0	20.0
Experienced Safety	15.7	3.35	6.0	20.0
Therapeutic Hold	11.1	4.02	2.0	20.0

CAT: Consumer Assessment of Treatment

The CAT score (mean 5.5, SD: 2.33) across the consumer sample is relatively low compared to other studies conducted internationally, where means typically ranged between 6-8 (Priebe et al. 2011; Priebe et al. 2006). However, the CAT mean in this

study closely corresponded with a mean of 5.52 from an involuntary population, as found by Priebe et al. (2009). This indicates the surveyed consumers perceived a lesser degree of satisfaction with care compared with those in other studies.

EDE-Q: Eating Disorder Examination- Questionnaire

Compared to population norms for females aged between 12-42 (Carter, Stewart & Fairburn 2001; Mond et al. 2006), the consumers surveyed for this study reported severe eating disorder psychopathology across all subscales (Table 3). Indicative of the severe eating disorder psychopathology within the surveyed sample, community norms for Global EDE-Q scores range between 1.5-1.6.

Table 3 EDE-Q Subscales Scores

	Mean	SD	Min	Max
Restraint	3.5	2.00	0	6.0
Eating Concerns	3.3	1.55	0	6.0
Weight Concern	4.3	1.69	0.5	6.0
Shape Concern	4.8	1.51	0.5	6.0
EDE-Q Global	4.0	1.49	0.5	5.8

Nursing Data

EssenCES: Essen Climate Evaluation Schema

Compared with previous studies reporting staff scores, the subscale scores across the nursing sample (Table 4) reported a slightly higher Patient Cohesion subscale mean, a much higher Experienced Safety subscale mean, however Therapeutic Hold was of a similar magnitude (Howells et al. 2009; Milsom et al. 2014; Schalast et al. 2008).

Table 4: EssenCES Subscales (Nurses)

	Mean	SD	Min	Max
Patient Cohesion	12.0	3.23	6.0	19.0
Experienced Safety	14.0	2.91	7.0	20.0
Therapeutic Hold	15.8	2.42	10.0	20.0

ATAMHS-33: Attitudes Towards Acute Mental Health 33

As described in method, the ATAMHS-33 provides an overall score that indicates nurses' attitudes towards consumers, with higher scores indicative of a greater quality of attitudes. Nurses in this study indicated relatively high quality attitudes towards consumers with acute mental health needs (Table 5), relative to the findings from

Baker, Richards & Campbell (2005) and (Foster et al. 2008). Compared to previous studies all subscales were higher scoring, except the positive attitude subscale, where respondents scored slightly lower.

Table 5: ATAMHS-33 Subscales and Overall Score

	Mean	SD	Min	Max
Care or Control	64.0	9.49	34.0	81.0
Therapeutic Perspective	36.1	5.03	25.0	42.0
Hard to Help	17.2	4.20	7.0	28.0
Positive Attitude	21.4	3.58	10.5	30.0
Semantic Differential	43.3	10.02	8.3	62.3
Overall Sum	185.6	21.97	124.2	228.1

Comparison of Nurse and Consumer EssenCES

Analysis of the EssenCES scores was of particular interest, as this was the only instrument common to both nurses and consumers. Statistically significant differences were found between the groups across all subscales (Table 6). Consumers scored substantially higher in regard to Patient Cohesion and Experienced Safety, while the opposite was true for Therapeutic Hold.

Table 6: Comparison of EssenCES Subscales

EssenCES	Consumer (n=63)		Nurse (n=65)		t (df)	p	Overall (n=128)	
	Mean	SD	Mean	SD			Mean	SD
Patient Cohesion	14.4	3.70	12.0	3.23	3.979 (126)	<0.01	13.2	3.66
Experienced Safety	15.7	3.35	14.0	2.91	2.989 (124)	<0.01	14.9	3.23
Therapeutic Hold	11.1	4.02	15.8	2.42	-8.058 (101.08)	<0.01	13.5	4.07

Ward Differences

Although statistical tests were not viable for ward comparison due to sample size, individual ward results were examined in order to better inform the structure of the qualitative interview schedule. Distinct differences are apparent between wards on a number of the instruments and subscales (Table 7 and Table 8). Wards A1 and B1 represent the extreme mean scores for the EssenCES subscales, with both consumers and nurses on ward B1 reporting the highest Patient Cohesion sub-scale scores. The differences were quite large: consumers on B1 scored 6.5 higher than consumers on A1, and nurses on ward B1 scored 5.8 higher than nurses on ward A1. However, in

contrast, and demonstrating the disparity between consumers and nurses in regard to Therapeutic Hold, consumers on ward B1 had the lowest score of all the wards, while nurses on the same ward scored highly.

In regard to the ATAMHS, although less distinct than the EssenCES scores, ward B1 was again the highest, with nurses on A1 again the lowest. A different pattern was seen with consumers' assessment of treatment (CAT), with wards C2, D1 and E1 all scoring much higher than the other 3 wards. Despite the potential value of findings, quantitative findings were not compared to the type of ward (paediatric or adult, public or private, etc) as this may serve to compromise the de-identified nature of the data.

Table 7: Consumer Survey Scales, by Unit

	A1		B1		C1		C2		D1		E1	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
EssenCES												
Patient Cohesion	10.6	3.23	17.1	3.20	13.5	3.54	15.4	1.51	13.2	1.40	16.4	3.10
Experienced Safety	14.3	3.93	16.8	3.14	18.0	2.83	16.1	2.91	15.4	3.70	15.8	2.77
Therapeutic Hold	10.2	4.51	9.5	4.77	11.5	2.12	11.6	4.31	12.8	2.93	12.0	3.14
EDE-Q												
Restraint	3.0	2.09	2.8	2.34	3.9	.14	3.3	2.35	3.1	1.56	5.0	1.12
Eating Concerns	2.7	1.67	3.2	2.00	4.4	1.77	2.7	1.33	3.5	.83	4.1	1.23
Weight Concern	3.7	1.94	4.2	2.16	5.6	.57	3.8	2.35	5.1	.54	4.6	.89
Shape Concern	4.3	1.63	4.7	1.88	5.8	.22	4.2	2.30	5.6	.40	5.1	.81
EDE-Q Global	3.4	1.66	3.7	1.89	4.9	.67	3.5	1.93	4.3	.65	4.7	.84
ITAS												
Goals	.3	1.39	3.3	1.60	2.9	1.59	4.1	1.46	4.0	.88	4.0	1.15
Collaboration	3.3	1.69	3.3	1.71	2.5	2.59	3.8	1.52	3.8	.69	3.9	.62
Bond	3.6	1.59	3.3	1.73	4.2	1.65	4.1	1.60	4.5	.82	4.3	1.18
ITAS Mean	3.4	1.45	3.2	1.63	3.2	1.91	4.0	1.44	4.1	.72	4.1	.91
CAT												
	4.6	2.41	4.2	2.56	3.7	3.06	6.2	2.09	6.7	1.40	6.8	1.51

Note: Statistical tests were not performed due to small sample size per unit

Table 8: Nurse Survey Scales, by Unit

	A1		B1		C1		C2		D1		E1	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
EssenCES												
Patient Cohesion	9.7	3.00	15.5	2.38	10.3	2.00	12.9	2.12	11.3	3.08	14.0	1.51
Experienced Safety	13.3	2.68	15.4	2.42	13.0	2.63	11.6	2.64	16.6	2.61	13.5	2.00
Therapeutic Hold	14.6	2.36	16.8	2.93	15.4	1.57	16.6	1.72	17.0	2.11	15.3	2.82
ATAMHS-33												
Care or Control	58.8	8.17	66.9	14.48	69.1	3.04	67.3	4.92	65.3	8.07	59.3	8.97
Therapeutic Perspective	33.5	4.35	37.9	5.41	38.9	2.15	37.9	4.56	37.0	5.44	32.3	4.83
Hard to Help	16.1	3.04	17.5	5.13	19.3	3.64	16.9	4.14	17.6	5.33	15.8	3.54
Positive Attitude	21.0	3.80	21.1	2.91	20.1	2.36	19.9	5.42	23.8	3.22	21.9	3.17
Semantic Differential	38.0	10.95	50.1	9.24	40.2	8.51	48.1	10.57	47.2	6.44	36.8	5.35
Overall Sum	176.6	7.87	199.7	24.45	190.4	13.45	186.5	18.34	192.9	28.27	166.0	23.78

Note: Statistical tests were not performed due to small sample size per unit

Summary of Phase One Findings

The EDE-Q scores indicated that consumers in this study were severely ill with eating disorder psychopathology. The low scores on the I-TAS instrument suggested that consumers had a relatively low perceived alliance with nurses in the inpatient setting compared to other populations of consumers. This corresponds with the Therapeutic Hold sub-scale on the EssenCES, where consumers scored lower than nurses. Also in regard to the EssenCES, consumers reported a high degree of cohesion with fellow inpatients, and both consumers and nurses felt safe within the inpatient setting. Nurses reported an alliance with consumers consistent with that experienced by nurses within the forensic/secure setting, and scores on the ATAMHS-33 indicated that nurses had overall positive attitudes towards consumers. Consumers reported on the CAT that they were relatively unsatisfied with care. Significant differences were found between consumers and nurses on all of the EssenCES sub-scales, and differences were also apparent between units on all instruments, although these were not tested statistically.

In further understanding and expanding on the quantitative data, qualitative interviews explored these findings. In accordance with the method, the generic qualitative interview format was adjusted using phase one findings, to develop site specific versions for consumers and nurses in each ward (Appendices F & G). The low consumer alliance scores and the difference of alliance scores between nurses and consumers were explored. Other factors of context identified in phase one, such as the severity of eating disorder psychopathology, low consumer satisfaction with care, and the effect of positive nursing attitudes towards consumers, were also explored.

Phase Two

Qualitative data were collected through semi-structured interviews with 34 consumer participants and 20 nursing participants. Of the consumer participants, only one participant was male. Interviews with nurses lasted between 16 and 101 minutes with an average duration of 40 minutes, for a total time of 13 hours and 30 minutes. Interviews with consumers lasted between 11 and 48 minutes with an average duration of 25 minutes, for a total time of 14 hours and 21 minutes (Appendix P). Interviews were not conducted at sites C1 and C2, due to the discontinuation of the eating disorder program at that location.

The interviews focussed on the nature of relationships between nurses and consumers, and the implications of ward context on these relationships. A generalised thematic scheme was developed from analysis of the data, representing responses from both participant groups. Several prominent themes were identified: the nature of nursing relationships, the implications of AN, the rules, and influential contextual factors. Each theme has respective subthemes.

Demographic Data

Consumer Participants

Demographic data of the consumer participants are tabulated in Table 9.

Table 9: Consumer Demographic Data

Consumer*	Age	Age of Onset	Age of Treatment
Abigail	16	16	16
Amber	17	Unable to recall	17
Brittany	Not stated	Unable to recall	Unable to recall
Chloe	17	14	15
Christine	19	13	14
Dominique	17	Unable to recall	Unable to recall
Emily	24	23	24
Gemma	17	13	15
Georgina	15	12	14
Helen	16	15	15
Jane	13	13	13
Jennifer	22	17	20
Kathryn	63	Unable to recall	Unable to recall
Kaye	17	13	16
Linda	18	12	12
Lionel	23	20	22
Lisa	18	15	16
Lynette	27	15	19
Madeline	27	26	27
Marjorie	29	15	28
Mary	20	19	19
Matilda	20	12	17
Melanie	17	Unable to recall	Unable to recall
Melinda	16	15	15
Michelle	19	14	19
Nellie	19	16	17
Phoebe	27	16	16
Rebecca	18	16	18
Roweena	17	15	16
Shirley	18	13	17
Stacey	16	15	16
Tracey	15	14	14
Wendy	18	17	18
Whitney	20	15	18
Mean	20	15.5	17.5

* Pseudonyms (see Method)

Nursing Participants

70% of the nursing participants were Registered Nurses, 20% were Endorsed Enrolled Nurses (able to administer medications), and 10% were Assistants in Nursing. The average length of nursing experience was 12.5 years (range 0.5-30 years), and the average length of clinical experience specific to eating disorders was 7 years (range 0.5-17 years). The majority of nurses (85%) had no formal training related to caring for consumers with AN, except for in-service training sessions; with the remaining having education related to eating disorders professional conferences. One participant had formal education in family therapy and general counselling. Detailed information is provided in Appendix Q.

Themes

In addition to aiding the interpretation of quantitative data, the primary aim of the interviews was to develop an understanding of the nature of therapeutic alliance between nurses and consumers with AN, and the way that contextual factors in the inpatient setting influenced these relationships. In analysing the data, themes and respective sub-themes were developed and are outlined in Table 10. For each sub-theme, a quote from participants is used to establish the participants' voice in the results.

From the results, the overall attributes of the therapeutic alliance are not unlike those described in the literature review chapters of this thesis. Close interpersonal relationships were valued by consumers and nurses, and these relationships had therapeutic implications. However, AN as an illness and the implications of AN, emerged as a highly detrimental factor in relationships between nurses and consumers, particularly in light of the professional responsibilities that nurses carried. Therefore, in developing a therapeutic alliance, nurses maintained a balanced approach; nurses simultaneously ensured that consumers felt cared for, whilst tactfully enforcing the rules. Finally, the nature of the ward itself carried implications for the relationships between nurses and consumers.

Table 10: Qualitative Themes

Primary Themes	Sub-Themes
<p><i>The Nature of Relationships</i> This theme details the nature of the therapeutic alliance between nurses and consumers.</p>	<p><i>Genuine Caring: ‘I always feel like they genuinely care’</i> The attributes and importance of positive interpersonal dynamics between nurses and consumers with AN.</p>
	<p><i>Creating a Caring Milieu: ‘feeling more at home’</i> The implications of nursing interactions on the perceived quality of the ward milieu and hospital experience for consumers.</p>
<p><i>Interpersonal Dynamics of Anorexia Nervosa</i> This theme explains the complex interactions between AN and the therapeutic alliance.</p>	<p><i>Pathological Sabotage: ‘we see nurses as the baddies’</i> The interpersonally destructive implications of AN.</p>
	<p><i>Therapeutic Separation: ‘developing insight’</i> The importance of developing a separation and eschewal of AN.</p>
<p><i>The Rules and the Nurse’s Authority</i> The implications of the nurse’s use of authority and application of rules for relationships between nurses and consumers.</p>	<p><i>Therapeutic Maintenance of Authority and Professional Boundaries: ‘love and limits’</i> The way that nurses needed to achieve a balance between interpersonal investment, whilst not compromising professional responsibilities or boundaries.</p>
	<p><i>Consistency of Nursing Expectations: ‘it is easier when the rules are consistently applied’</i> The importance of consistency in the application of rules.</p>
<p><i>Contextual Factors</i> This theme details the factors that influence relationships between consumers and nurses, unique to the inpatient setting.</p>	<p><i>Hospitalisation and the Nursing Role</i> The implications of the nature of hospitalisation and the nursing role itself.</p>
	<p><i>The Implications of Internal Group Dynamics</i> The implications of the relationships and interactions between consumers. The implications of the relationships and interactions between nurses.</p>
	<p><i>Time in Hospital</i> The implications of the length of admission time.</p>

The Nature of Relationships

The nature of relationships between nurses and consumers was a prominent theme in interviews. Nurses and consumers spoke about the nature of relationships in great detail, and remarked on the varying effects these relationships had. Consumers highlighted the way that relationships with nurses resulted in an enhanced inpatient environment and experience.

Genuine Caring: *'I always feel like they genuinely care'*

Consumers and nurses emphasised the imperative of therapeutic interpersonal dynamics throughout hospitalisation. Nurses most effectively delivered care through a genuinely caring and nurturing relationship. Genuinely caring nurses were reassuring and comforted consumers during their challenging hospitalisation. Consumers felt safer when they felt they were genuinely cared for. Ultimately, the interpersonal dynamics of effective nurse-consumer relationships led to consumers feeling secure in trusting the therapeutic intent of nurses, who were trying to facilitate weight gain. Despite common themes, nurses and consumers made distinctive contributions, owing to their varying roles in the nurse-consumer relationship. The following quotes demonstrate the value of nurses expressing authentic interest, commitment and concern for the wellbeing of consumers.

"A nurse will call me aside and have a talk to me and see how I'm going. So I found that helpful... It definitely makes me feel - I guess, my feelings are validated and heard and respected. But also, it enables me to feel safe with my thoughts if they know what's going on..." (Shirley, Consumer).

"I think it's really important to have a good relationship with the patients so that then if there are things going on for them- they're sensitive topics or they're sensitive things for them to talk about- then you have that good rapport, or that good relationship with them so that they will sort of open up to you" (Lucinda, Nurse).

In feeling genuinely cared for, consumers navigated the course of hospitalisation with a sense of safety from companionship with nurses. The absence of a sense of genuine caring from nurses led to demoralisation, and consumers potentially questioned the value of hospitalisation.

"I've had times where I've been really, really distressed. Particularly last admission, I asked a nurse and I just really need to speak to someone and she was like, 'I've already spoken to you. I don't have time'. I was quite upset and quite seriously considering whether I was going to leave. I was filling out discharge papers and I was really upset... I was finding it really hard. I knew I

wanted to leave because I didn't want to eat. I wasn't sure if I had the strength to actually take actions to ensure I was eating outside or perhaps the right action was to stay. I was just feeling depressed and the fact that the nurse didn't really care and that I wasn't worth her time, I was just – it made me feel, well, what's the point in staying? What's the point?... she doesn't even care, why would I stay?" (Matilda, Consumer).

Findings from Phase One of this study suggested that nurses had positive attitudes towards consumers with acute mental health needs. These positive attitudes enhanced the capacity for nurses to develop and sustain genuinely caring and productive relationships.

"I think that it is highly demanding and if you do care, then obviously, that's gonna show in the relationship that you have with the patients and they generally would be more cooperative and hopefully get better outcomes and leave hospital earlier in a better state" (Lucinda, Nurse).

Non-judgemental, positive regard

Consumers valued feeling that nurses held them in non-judgemental, positive regard. Consumers wanted to be treated with respect, and perceived by nurses as legitimate patients, worthy of dignity, compassion and trust.

"Some nurses also treat you like just a normal patient, like if you like have a scratch on your leg or something or you have to get like a stitch. Some nurses treated you just like a normal patient... I felt more comfortable when people just treat me as another patient in the hospital" (Roweena, Consumer).

Conversely, consumers negatively appraised nurses who made them feel as though they were judged as deceptive or dishonest. Such interactions were particularly demeaning when judgements were made in reference to baseline generalisations about people with AN. That is, consumers were offended by nurses who made stereotyped assumptions about people with AN (such as the assumption that all people with AN lie and manipulate to sabotage care). Such a prejudicial approach to interaction affronted consumers' sense of dignity and individuality.

“There was one, actually, and she was universally hated and she was just so crazy about everything and she was always right. I remember this one time at meal time, I dropped this apple totally accidentally ‘cause why would you get rid of the apple? It’s fruit. And she’s like, ‘I saw you!’ and she was like, ‘You did that on purpose!’ and I was like, ‘No, I dropped it at the start of the meal’ and even my friends saw me drop it, and she went straight to the doctor and she’s like, ‘We should move her up a meal plan. She’s being bad. She’s not eating’” (Gemma, Consumer).

Whilst nurses understood the importance of a non-judgemental approach, they acknowledged that their responsibility in ensuring weight gain brought complexities. Some nurses found that their professional responsibilities conflicted with a non-judgemental approach.

“So if they are hiding stuff in the room or whatever it is, we have to go in and search their belongings. And it still can be difficult because I do think it does affect the relationship, their trust, and you gotta be working with them, trying to catch up with them as often as you can and have a really good staff-patient relationship with them and then you have to run a room search. And it can be difficult” (Elaine, Nurse).

In order to care for consumers in a non-judgemental manner, nurses fulfilled their professional role carefully and tactfully.

Empathy, understanding and sensitivity

In caring for consumers with AN, nurses possessed an emotional and professional competence to engage with sensitivity and empathy. By having a thorough understanding of AN, nurses were able to sensitively provide care and assist consumers with the distressing expectations and activities of hospitalisation.

“Yeah, they’re really good, like they’re trained to know what we’re going through. So it is not just sort of like they don’t have the whole, ‘Oh, just hurry up and eat it’, sort of response, they understand it is distressing” (Whitney, Consumer).

"I think nursing management does incorporate the therapeutic alliance with the patients and against the disorder. That's enhanced by having a sound knowledge of the illness and then having the ability to connect with the patient and understand their individual concerns. And then provide constant positive regard and reassurance and instilling a sense of hope for their recovery, I think, simply by being present and being empathetic particularly towards distress felt by a patient" (Margaret, Nurse).

Despite the Phase One findings regarding positive nursing attitudes, nurses in this study remarked that those who did not work with mental health consumers on a regular basis were more likely to have negative attitudes and a poor understanding of consumers with acute mental health needs. By failing to understand AN, nurses may not take a sensitive approach towards consumers experiencing the distress of weight gain, and mishandle consumers' complex stressors.

"I've seen agency nurses come in and they'd just be here for the work... They don't know what eating disorders are. I guess they don't have an insight about it. So I don't blame them for not knowing, because they just get sent here anyway. But the main difference is their patients would say, 'This nurse just asked me why do I eat six times a day?' and stuff like that. That would be very triggering for them. It's very important for the nurses that work here to know something about eating disorders, because it's a very sensitive issue for them to talk about food or exercise or things like that. That would trigger them to be emotional or break down all of a sudden, to be aggressive and stuff like that" (Samuel, Nurse).

Negative attitudes towards consumers stemmed from a lack of understanding and acknowledgement of mental illness, and a lack of compassion for assisting those struggling with AN. It is also evident that consumers with AN were perceived by nurses to be 'challenging'. For nurses who did not regularly care for consumers with AN, these patients were challenging in ways that evoked feelings of frustration and dissatisfaction.

Motherly/sisterly nursing

Nurses and consumers, particularly in the child and adolescent setting, described effective nursing as requiring a 'motherly' or 'sisterly' role adoption. The 'motherly/sisterly' approach engendered many of the effective dynamics of interpersonal relationships. These nurses were genuinely caring, non-judgemental, empathic and sensitive, and were effective in utilising their interpersonal skills in order to encourage and support consumers towards weight gain. In response, consumers felt a willingness to engage in the eating disorder program as a means of reciprocation in the relationship; consumers wanted to please these nurses by collaborating in care. These nurses left lasting impressions, and consumers reflected on them with great appreciation. The terms 'mother' and 'sister' were assigned based on the age of the nurse.

"She was the mum and she was so proud... you become like family and then there's some that become like your sisters. You actually feel like you belong. And then there's some that you can tell that are just there because it's work and they just wanna do their job and go... But there's a few others who actually treat you like family and they actually make you feel welcomed and loved, and it makes the experience a lot easier..." (Lisa, Consumer).

"For new patients they need a bit more nurturing and more like a motherly role. Because that's another thing, they're also taken away from their parents. And a lot of the patients haven't spent a prolonged time away from their parents or particularly away from home, sleeping away from home every single night for two to six weeks. So I always try with new patients to take a softer approach, I suppose, and be a little less strict in those first couple of days" (Isla, Nurse).

Creating a Caring Milieu: 'feeling more at home'

Hospitalisation and the firm expectation of weight gain was anxiety provoking and distressing for consumers. However, interpersonal relationships with nurses created a milieu that consumers and nurses described as feeling 'more at home' or 'normalised'.

Normalisation and comfort

A hospital admission was often unexpected, abrupt, and not necessarily facilitated in tandem with the consumer's own will or determination. Furthermore, the hospital environment and routine were highly unfamiliar and foreign. For several weeks and months, consumers lived away from their families and friends, and the comforts of home to which they were accustomed. Activities in school, university, or places of employment were suspended. Despite affronts to familiarity, nurses were able to restore a sense of normality and comfort to the consumer's experience.

"They just made me feel very comfortable in the environment and made me feel not so much alone... It kind of makes me feel a bit normal because when you first go in there, you feel very out of place" (Georgina, Consumer).

"Instead of the nurses going off and doing their own thing, actually interacting and spending time with them, playing games, watching TV, or even just being with them and giving them things to distract them makes a massive difference to their day 'cause their days are quite drawn out being in a hospital. So it makes a massive difference... Instead of it being a hostile hospital type of environment" (Monique, Nurse).

Safety and security

In addition to normalising the environment, nurses assisted consumers in feeling emotionally safe and secure in hospital. Through sensitive interactions, nurses mitigated the anxieties inherent with weight gain. Consumers were then better equipped to trust nurses and their therapeutic intent, and therefore participate in the eating disorder program with a lesser degree of apprehension. In this way, nurses assisted consumers to participate in the ward program, thus weight gain.

"If they're seeing that you're struggling at the table, maybe rubbing your arm a bit, or giving you a quick hug afterwards, or coming in making sure you're okay, asking if you need anything. Just that sort of stuff, and checking in, making sure you're coping okay... they're making that effort to make you feel safe and make you feel secure" (Whitney, Consumer).

“Often times when we first touch base with them, particularly those that are distressed, that’s where we can build our first sort of trust relationships, by actually just settling them down, calming them down, introducing them, and getting to know their surroundings because - particularly in eating disorders- that distress is often based around fear and the fear from what’s going on in their headspace...” (Angela, Nurse).

Interpersonal Dynamics of Anorexia Nervosa

The relationships between nurses and consumers are compromised due to the implications of AN as a pervasive illness. In overcoming the pathological influence of AN, nurses and consumers must work towards maintaining clear distinctions between the consumer and AN as an illness.

Pathological Sabotage: ‘we see nurses as the baddies’

Nurses and consumers described the way that the psychological and behavioural implications of AN as an illness interfered with and compromised the development of a strong relationship. Consumers with AN were ambivalent about recovery; weight gain is incompatible with the psychopathological orientation of AN. In fulfilling their professional role, nurses are largely focussed on weight gain. The implications of such diametric opposition sabotaged the mutuality of goals required for an alliance; consumers and nurses did not necessarily share a harmony in beliefs and efforts.

Disunity of goals and perceived coercion

Due to the nursing role in behavioural management, and the aversion consumers commonly had towards weight gain, consumers were less likely to perceive nursing care as helpful or therapeutic. To the contrary, consumers were more likely to experience nursing care as distressing and frustrating, resulting in resentment directed towards nurses. This perception of nurses compromised the consumer’s capacity to develop a bond and trust with nurses.

“There can tend to be quite a bit of arguments. And nurses I guess, making the patients break down and cry because they just can’t do something or they can’t - yeah. And it’s the eating disorder talking. I guess some patient’s eating disorders can be extremely rude to the nurses sometimes... You get sometimes

really angry at the nurses and frustrated and you can't stand them. But it's not - it's very difficult to explain... At the same time, you have nothing against them because you know that they're trying to help you and it's your eating disorder that's getting angry at them. 'Cause they're trying to get you to do the right thing" (Shirley, Consumer).

At an extreme, nurses were perceived by consumers as a coercive or oppressive authority. The therapeutically intended actions taken by nurses were interpreted as disciplinary or punitive. Such an interpretation of nursing care meant that nurses were not credited with being caring or compassionate.

"Most of them [nurses] were just these big bad people that were forcing food down our throats so we didn't like a lot of them. We didn't even give a second thought, like they weren't really a person, they were just some monster.... We see them as these big bad people but some of them just sort of treat and see us like a disease that they have to control" (Melanie, Consumer).

"Well, they feel really anxious around food and eating. And when you've got specific nurses telling you to eat and forcing you to, you're naturally not gonna like them" (Kaye, Consumer).

Consumers attributed the low degree of alliance with nurses to the lack of shared goals and motivations between them and nurses.

"There are just people who aren't motivated and therefore aren't enthusiastic about being here and about changing, so that definitely impacts the relationship they might have with the staff members, I think... if someone's not really motivated to be here they are just gonna be apathetic towards the program in general, which I think would impact their relationship with staff and they would just become more frustrated or look for things to become frustrated by, whether that be by staff members or the program itself" (Jennifer, Consumer).

"Yeah. It's pretty true. But you can't blame them [consumers]. I mean, their [nurses] purpose is to do something that they [consumers] hate. And the kids

are there for something that they don't wanna be through at all. So, they're kinda working against each other in a way" (Melinda, Consumer).

Frustration and emotional fatigue

Nurses described feeling drained and exhausted from caring for consumers with AN, and attributed these feelings to a range of factors associated with the nature of AN. The complex and challenging nature of AN often led to repeated and lengthy admissions for some consumers. The failure to observe progress in consumers, despite considerable investment of effort, was demoralising for nurses. Furthermore, consumers sometimes behaved in a deceptive or manipulative manner in order to compromise weight gain and therapeutic goals. Such instances frustrated nurses as their professional efforts were sabotaged. Nurses then struggled to trust in consumers, and questioned the efficacy of their own practice and felt ineffectual. Nurses were exhausted from uncertainty regarding the therapeutic merit of their efforts, which at times seemed futile. At times the ongoing exhaustion and frustration led to withdrawal of interpersonal investment.

"I think if someone's been in here numerous times, and for whatever reason there's been conflict or it hasn't worked, I think sometimes it can be counterproductive. It can be counterproductive for the relationship. You think, 'Oh, God!' And I mean you try not to – well, let's face it– We're human beings and, if somebody's been in here ten times and for whatever reason it hasn't worked: they've pushed the boundaries, they've done the wrong thing, they've gone off and got drunk, come back, abused things, hidden things – you start to get... your mind shuts down a bit" (Evelyn, Nurse).

"Looking after an ED is not very rewarding either. So you give, give, give, give but you don't actually get anything, you don't get that.... 'Is that working? Is that working?' I think it's very tiring" (Tanya, Nurse).

Therapeutic Separation: 'developing insight'

In a therapeutic alliance, both nurses and consumers maintained a mental partition drawing a distinction between AN as pathology and the consumer as a person in need of care. Nurses made a conscious effort to view the consumer as an individual, without

making inferences about the consumer based on their mental disorder. When consumers recognised AN as pathology they were able to more readily engage in care collaboratively, recognising the caring intent of nurses. Such therapeutic separation enabled the alliance to develop.

Distinguishing the consumer from the illness

Nurses were highly cognisant of their own perception of the consumer in order to separate the healthy individual and the pathological eating disorder. By understanding the nature of AN, and how AN influenced consumer behaviour, nurses managed their own internal conflicts and frustrations, thereby curtailing the risk of frustration and burnout. The capacity to separate AN from the consumer was considered an essential internal process.

“If you don’t separate the eating disorder from the person, you’re lost, and that really has to be the first port of call when you’re first establishing a relationship with a patient, and this is where your non-judgemental response comes. This person has an illness and the illness may be affecting how they’re behaving right now. So what can I do to help them to behave in a way that’s going to be more helpful to them? And that’s really when we’re talking about it from a point of view of an eating disorder at the table. How can I help them to deal with that behaviour?” (Pamela, Nurse).

Nurses devoted conscious effort to supporting the individual towards recovery, whilst fighting the eating disorder. Consumers appreciated nurses maintaining a distinction between the individual person, and AN as a separate pathology.

“You might think that you’re nasty to nurses or you’re just a pain and frustrating and rigid and argumentative and you might attribute that to you as a person rather than your illness. Whereas, the nurse might be able to see past that and, I suppose, more easily distinguish between the person and the illness, and perhaps their connection with the person might be easier” (Matilda, Consumer).

Recognising and externalising pathology

Consumers were often highly enmeshed within the pathology of AN. They recognised that it was important to acknowledge AN as pathology and to externalise it as a peripheral element of themselves; recovery involved an ongoing process of separation of AN from their personality.

“There’s me and then there’s the eating disorder. The eating disorder hates it here. The eating disorder doesn’t want to stay here. Until I can consciously make decisions without the eating disorder, like getting its hands in there, I have to stay here until... I’m without the eating disorder” (Michelle, Consumer).

“Your illness is who you are. But I think as part of the re-feed, you can think more rationally, you sort of can start to separate those thoughts a bit. But when you are in the thick of it, you can’t. It’s just like there’s no other way other than those disorder thoughts. And that can make you act and say things that I think it will kind of change who you are. For the worst usually” (Wendy, Consumer).

The way nurses delivered care was influential over the consumer’s preparedness and amenability for therapeutic separation. Nurses assisted consumers with the development of insight.

“When someone’s struggling with say, eating a meal, or something like that, and they’re fighting against it, often you can say something like, ‘Look, we’re fighting against this together. I’m helping you’, and if you refer to this disease – to anorexia as something other than them... So, it’s externalising the disease and it makes them feel a lot... I think it makes a difference in terms of separating them from the illness” (Lucinda, Nurse).

Recognising caring intent

In maintaining a therapeutic separation, nurses avoided modes of interaction that were liable to be interpreted by consumers as judgemental, critical, coercive or punitive. Nurses sought to enact the rules of the eating disorder program, without leading consumers to feel personally blamed or culpable. When nursing facilitated corrective measures were experienced as punitive or disciplinary, consumers perceived

a negative personal inference; they felt akin to a perpetrator. This impression was negatively experienced and sabotaged the alliance. Nurses mitigated this negative impression by assisting consumers to understand the pathological role played by AN, and the respective nursing responsibility of countering the pathology of AN. Nurses did so by clearly defining AN as a pathology requiring intervention, and the consumer as a worthy recipient of care. In understanding the therapeutic motive of the nurse, consumers were then more liable to interpret nursing interactions as genuinely caring and trustworthy. Effective nursing interactions involving behavioural management emphasised to the consumer *'you're ill'*, rather than *'you're bad'*.

"We can have a laugh with them and then they still turn their heads and go, 'Okay. You've gotta hurry up. You've got five minutes before the meal', and you don't go, 'You're a mean person for saying that', or 'You're trying to be rude'. You kind of see it as 'oh – thanks for the reminder'. Because you do see them as a normal human, but then you know they have this role that they're getting paid and marked or they have guidelines they need to follow" (Phoebe, Consumer).

The Rules and the Nurse's Authority

At all sites, a program and set of rules dictated the expectations regarding consumer participation in care. Nurses held a position of authority within the ward, and were ultimately responsible for ensuring that consumers were supported in adhering to the rules. Nurses were also responsible to manage events involving non-adherence. The application of rules and maintenance of nursing authority had implications for the relationships between nurses and consumers, as well as the overall inpatient experience.

Therapeutic Maintenance of Authority and Professional Boundaries: *'love and limits'*

Nurses remarked on the importance of maintaining a balanced approach in applying the rules of the eating disorder program. A well tempered balance between interpersonal investment and firm behavioural management was considered necessary, and was described as a balance of *'love and limits'*.

“It’s love and limits. It always has been. You praise when you need to, and give them the encouragement and motivation to do these things. And then you need to give them boundaries as well. Because we’re also trying to manage an eating disorder as well as being respectful with set boundaries and do all that type of stuff. So sometimes you gotta be a bit cruel to be kind. And so, I have a little saying. It’s called, love and limits” (Tanya, Nurse).

Collaboration and authority

The manner in which nurses wielded their authority had implications for the relationships between nurses and consumers. Nurses believed that the best approach was one not dependent on the use of an authoritative or coercive style of interaction. Rather, the best approach was dependent on collaboration, supportiveness and patience. Such an approach itself minimised the need for potentially coercive measures.

“Authority doesn't work with a lot of these kids ‘cause they'll fight against – especially the age as well. They'll fight against any sort of form of authority” (Lucinda, Nurse).

“So you just have a general discussion and pick them up on their behaviour rather than just sit there, not say anything and be like, ‘A pea fell off your plate’. ‘You've got butter on your fingers’, those types of things. So you just have a general discussion and make a joke out of it and be like, ‘Show me your fingers’, and ‘What is it, butterfinger day?’ or say something funny. And then I'm like, ‘You better get that off’, and then they'll just do it straight away. If you notice that they're doing it all the time, you can give them sort of a pre-warning. I'll be like, ‘That's your last warning, next time you know it's a bolus’, or make a joke out of giving them the bolus, which is a supplement drink” (Isla, Nurse).

Similar to the views expressed by nurses, consumers had a preference for nurses who relied on engagement and interaction. These nurses were perceived as encouraging and supportive. Consumers felt a willingness to engage in care and trusted the therapeutic intent of nurses who relied on the power of interaction rather than the power of their authority. In contrast, nurses who did not adopt an interpersonal style,

and relied on their inherent authority were described as distant, coercive, forceful, cold, insensitive or apathetic.

“We have some up there that just stare at you while you eat. They won’t talk. If we talk around the table, they’ll be like, ‘No girls, you have to eat. Don’t talk, eat. You’ve got a time limit’, and everything. With some other nurses, if you go over the time limit, they’re nice... They’re not just pushing at you all the time. Let’s say, the main nurse has kept pushing on me, I get really angry and I just fight back and I’m like, ‘No, I’m not doing it’. But if the nice nurses just sit down and talk to me if I’m upset, or if I have to drink Ensures they’ll get me to do it. If they won’t treat me with respect, I won’t treat them with respect” (Helen, Consumer).

Compromised boundaries: alterations in the orientation of authority

Nurses remarked on the importance of maintaining the boundaries of their professional role. Failing to maintain professional boundaries risked compromising their professional role as well as the consumer’s recovery journey. Nurses perceived that their professional role was compromised when the power orientation in the relationship approached equality, akin to the equal power orientation in friendship in which interaction brings mutual gratification and influence. In the context of an equally powered relationship, nurses were less able to depend on their authority as a nurse to make well-informed and therapeutic decisions. Nurses needed to be in a position of authority in order to effectively assist consumers towards recovery.

“The more intimate the relationship, the more boundaries you’re likely to cross because they’ve been there so long that it changes from more of an acute patient-nurse relationship to one of friendship and casual conversation. And then, it starts to cross the boundaries... I feel like that’s no longer therapeutic, and it’s going more into crossing borders, crossing boundaries. And in a sense, it is therapeutic still, but it’s more – it’s going more towards friendships than being beneficial” (Audrey, Nurse).

The closeness of the ‘friendship’ form of interaction was a source of discomfort for nurses, as they felt their professional integrity was threatened and their authority was

compromised. In such instances nurses felt uncomfortably obligated to act in a reciprocal manner towards the consumer.

“And they come across very strongly, and they section you out from others so – because I’m very close in age to them, they say like, ‘Oh, I want you’, ‘I prefer you’, ‘I don’t like them’, ‘You do this, you do that with me instead’. So it’s quite difficult and then, of course, because you get closer to them, it does influence their care because then you feel bad, like providing discipline and that to them, because then they’ve befriended you so then you feel like you’re betraying their friendship and their trust if you do that” (Audrey, Nurse).

Audrey’s friendship style of engagement with consumers eroded her professional role, and rendered her unable to exert the authority required to effectively care for consumers with AN.

“That is one of my probably key problems at the moment; I want to be liked” (Audrey, Nurse).

In maintaining appropriate boundaries, nurses remarked on the importance of not permitting their own personal needs to influence judgements and interactions. While Audrey permitted her own needs to compromise her professional role, other nurses managed boundary challenges more effectively.

“I tend to try my best to understand that they are here for a reason. I think sometimes it’s confusing because you have a conversation with them and honestly you’d be talking to a friend. And then you see another breakdown and I kinda gotta remind myself that when they do say bad stuff to you and they yell at you and stuff, it’s ‘well, I’m meant to be the worker, they’re meant to be the sick one’” (Martin, Nurse).

“You always have to just remind yourself to remain professional and question that what you say to the patient and what you do with them is specifically for their benefit” (Isla, Nurse).

By having a clear unambiguous set of rules and protocols, nurses maintained therapeutic boundaries more effectively. The rules gave nurses the confidence and authority to act in the best interest of the consumer.

“I think it makes it hard to have a balance between being good cop, bad cop I suppose. So you wanna make sure that they do follow the rules and stick to the program because the whole focus of the program is to get them well. And those rules are in place for a reason and to protect them from their own behaviours” (Isla, Nurse).

“They [the rules] can be really helpful, so they can be like your backfall if someone's saying like, ‘No. I refuse to eat this’, and they all say, ‘No. I refuse to eat it’. Then that’s okay. You have a rule to fall back on and you know if they don't eat it, they'll have to have the bolus or whatever else” (Lucinda, Nurse).

The age and physical appearance of nurses influenced the integrity of boundaries. Adolescent consumers readily sought to place nurses in a friendship role, particularly nurses who were of a closer age. Conversely, nurses of an advanced age were less likely to be perceived as a viable friendship figure.

“So a lot of the girls are mid to late teens, like 15, 14, 16. And I’m 22 so we can kind of relate more than, say, the nurses that are in their 40s or 50s. And it’s easier to make friends with people your own age. You’re like, ‘Oh, yeah, I was just in school’, ‘Oh, yeah, I’ve done this, I’ve done that’. going through the same experiences pretty much. And then, of course, all the nurses that are older also have the more experience and able to create those boundaries. I think it’s more of shared experiences with age” (Audrey, Nurse).

“It’s difficult for a nurse who’s got less experience, or even for those who are closer in age to the patients to feel comfortable setting limits and enforcing consequences for unacceptable behaviours... because we’re an adolescent unit. If the nurses are a new grad or there’s someone who’s closer in age to the patients, they don’t have the life experience. They find it much more difficult to set limits and follow through with consequences. So it’s really important that

we target new grads or new people coming to work in the ward and mentor them and give them the skills to be able to put those limits into place”

(Margaret, Nurse).

Consistency of Nursing Expectations: *‘it is easier when the rules are consistently applied’*

In implementing the behavioural program, nurses exercised discretion in the application and interpretation of rules. Consequently, nurses delivered care with varying expectations about the way that consumers should adhere to the ward’s eating disorder program. Variations in nursing expectations were potentially experienced positively or negatively. In most accounts, inconsistencies in nursing care were regarded negatively by both nurses and consumers. Some consumers attributed the low degree of satisfaction with care to be partially due to perceived inconsistencies.

Safety and predictability

Consistent and predictable expectations gave consumers a sense of security. Firm and well defined rules established boundaries, within which consumers were able to progress towards wellbeing. By maintaining a firm set of rules, nurses disabused consumers of the anxiety of making decisions involving food and exercise.

“Because the fact that the rules are there means that they don’t have to make a decision about it. They are here, they are here for a program, they don’t have to decide that that is the rule, that’s what I do. Whereas, otherwise, if they don’t have that and they can just do whatever they like all over the place then they are not going to learn to set those rules and those boundaries... Where the distress comes is if the staff don’t follow the rules. So if they let patients get away with stuff and that’s often a problem” (Angela, Nurse).

Conversely, inconsistencies undermined the benefits of a well defined system of rules and presented as an opportunity for non-adherence. When confronted with inconsistencies, the consumer’s sense of ambivalence was initiated.

“You sort of start to question, ‘I could be getting away with that’, and then it just messes with your head a bit. But then you’ve just gotta remind yourself that

actually, I'm here for myself. I've just got to do the right thing. But it is easier when the rules are consistently applied" (Wendy, Consumer).

When nurses made exceptions or alterations to the rules, this served to equip the eating disorder with leverage to pathologically negotiate the program.

"It sets precedents for exceptions and that just causes havoc not just on the day but the week. 'Oh, last week we were allowed to do this' or 'This person did that so I should be allowed to do it'. When you're unwell, you're going to find every reason why you shouldn't do it and it just facilitates that" (Matilda, Consumer).

Rationalisation and non-punitive intent

By maintaining a consistently applied set of expectations, consumers were less likely to experience rules as punitive or personally critical. By applying rules to all inpatients equally, consumers were less likely to feel individually targeted or criticised. Instead, consumers were more likely to acknowledge the nurse's professional responsibility, and experience the application of rules as therapeutically intended. Consumers were also less likely to perceive rules and expectations as punitive if nurses justified and substantiated care with explanation and rationalisations.

"So we try and be very sensitive with the rules. If there's something they don't understand, we try and explain it. So I guess the big thing is, if the rule is breached, then it's how you approach explaining to them and why. So if you can come up with a rationale, I think it's not gonna destroy the relationship" (Evelyn, Nurse).

"But she was really good with like explaining everything and like giving you warnings about things. Like I remember one time, when I was hooked up to my night feeds and she put it on 55 instead of 50. And I was freaking out because I was scared of the five extra millilitres an hour. But then she just like, she like got the folder out and checked, and explained why she put it on 55 and everything and it just made you feel better. And if you were upset she'd come over and help and talk to you" (Dominique, Consumer).

Fairness

Inequities in the application of rules frustrated consumers and were demoralising. Consumers felt that inconsistent expectations were unfair, and implied undue preferential treatment. Furthermore, in the presence of conflicting expectations, consumers were liable to develop preferences for less stringent nurses, thereby compromising their relationships with nurses who were more observant of the ward program.

“It’s frustrating when you see other people doing the wrong things and you’re doing the right thing and they don’t get pulled up for it... Just seeing some people get away with things that you know if a different nurse was on that it wouldn’t happen. So, I guess, some are a lot more lenient than others and it is just annoying, especially if you are someone that just complies and does the right thing. It’s like, ‘why am I bothering to comply when I can get away with doing that?’ So yeah, that is frustrating” (Madeline, Consumer).

“Rules need to be set for everyone... I think the rules have to be kinda set in stone with minimal leeway because you have to avoid the ‘friendly staff-mean staff’... If you’re letting them kind of get away with stuff that they shouldn’t, someone else who is doing their job well, following the rules will appear mean. And I also think it will reflect badly on that person who is doing a good job. Because you’ll find that people won’t like him as much because they’re seen as mean, because they’re being firm” (Martin, Nurse).

Confusion and ambiguity

The stress of being cared for in the inpatient setting was exacerbated if the rules of the eating disorder program were ambiguous or inconsistently applied. The uncertainty of expectations led consumers to experience confusion and anxiety. Consumers were more comfortable in having a clear understanding of nursing expectations.

“A lot of nurses have different rules for things. You might ask one nurse if you can do something one day and they’ll say yes and then the next day, the nurse will say no. That’s confusing” (Lynette, Consumer).

Helpful modifications

Despite the overall disapproval of inconsistencies, in certain circumstances thoughtful modifications to the ward protocols, to better enact the spirit of the law rather than the letter of the law, were considered appropriate and productive by nurses and consumers. Importantly, these changes were not made at the expense of weight gain, but rather with the intent of enhancing care and progress. In this way, the nurse reinforced and praised recovery behaviour. Nurses were more likely to exercise leniency in order to relieve consumers from expectations that were likely to be experienced as punitive, demoralising, unnecessarily restrictive or degrading.

“Some of the food requirements were a bit harsh. If you ate an orange, you had to lick the juice off the plate. There was one nurse that was really, really lovely and she said, ‘That’s not a normal eating habit’ and she actually didn’t make us do that and I found that a lot of the other patients really loved her” (Georgina, Consumer).

“And they’ve been extremely supportive and given me quite a bit of I guess, leeway in following some of the rules I guess. As in, they’ve allowed me to go to my room instead of sitting in the bed rest when I’m feeling really crappy which has been really helpful... It’s not leniency as in doing the wrong thing. Leniency in, I guess, giving me a bit of a break” (Shirley, Consumer).

“I think it’s sometimes better to pick your fights. If a person generally is struggling and you think forcing them is going to escalate the situation, perhaps it is better to be lenient and move on and then come back to it later on” (Martin, Nurse).

Contextual Factors

Both consumers and nurses highlighted how the contextual factors in the inpatient setting influenced the nature of interactions and relationships between them. The contextual factors described had the potential to be both therapeutically productive and counter-productive facets.

Hospitalisation and the Nursing Role

The safety and structure necessary for caring for consumers with severe AN is attainable in the inpatient setting. The ward itself, and the way that nurses worked on the ward, had implications for the way that consumers experienced hospitalisation. The nature of hospitalisation and the nursing role were interdependent as factors influencing the relationships between nurses and consumers.

Comfort, privacy and dignity

Nutritional rehabilitation in the form of weight gain was experienced by consumers as distressing and challenging. Consumers typically attributed the low degree of satisfaction with care to the uncomfortable and undignified nature of hospitalisation and the forced nature of treatment.

“It’s not a lovely experience. It’s quite gross. I hated the early mornings and having pee in the pan and wear the disgusting blue gowns and I hated that. And that’s why – and you hate being – you’re like – you gotta eat this, especially for the first few days when you just get admitted, you don’t get to choose what you eat and that’s just horrible” (Lisa, Consumer).

The overall distress of hospitalisation and weight gain was made particularly egregious when exacerbated by a perceived undignified or degrading treatment setting. Some consumers described hospitalisation as an uncomfortable and or humiliating experience. The lack of privacy, primitive amenities and loss of freedoms and sources of accustomed home comforts were experienced with displeasure.

“Especially in that room, they always try and put eating disorder patients in that four-bedded room, which is regarded as the fishbowl because everybody just looks in, no matter who they are, how many times they’ve walked past, you just get their eyes. It’s just very publicised. Kind of like a zoo animal, really” (Gemma, Consumer).

“A couple of times, without going to too much detail, I’d be getting changed or something and one of the nurses would come and open the curtain because she’s like, “You can’t have the curtain closed’. This is at night or something. And it’s like, ‘What?’ It was really frustrating. But most of time, it was okay.

And especially when I got my own room, it was much better” (Rebecca, Consumer).

Lack of privacy compounded the consumer’s sense of exposure and vulnerability, exacerbating the distress from weight gain itself. Furthermore, sensitive or personal self-disclosures were less likely to be shared with nursing staff.

“So the nurses changeover they’d go to the ward and they’d say ‘Bed 31, her weight has gone up this much or down this much’, and everyone would hear your weight and it was the most triggering thing. And then you knew that everyone knew your weight and it just made you feel horrible. And then if you heard someone’s weight and it was less than yours, you’d be like, ‘Oh no, I’m really big’, and you’d stress out and it would be really triggering and it would just make it a whole lot harder when everyone knew your weight” (Dominique, Consumer).

“When the doctors came, and you just had like the little curtain and they kind of just put it around. And everyone could hear what they were talking about. And I remember they’d ask - you got questions like are you constipated and all these questions and you couldn’t really answer because you knew like none of the girls were purposely listening. But you knew that everyone could hear so you felt like you couldn’t really tell them personal things. It was the same with the nurses if they were talking to you about like how you’re feeling, you couldn’t really feel that you could really tell them everything because you knew like all the girls could sort of hear everything” (Dominique, Consumer).

In contrast, consumers who experienced adequate privacy were more satisfied with their care experience, had closer relationships with nurses, and were more comfortable with making sensitive disclosures.

“They don’t just barge in, they knock before they come in, which is good. And if they’re locking bathrooms or whatever, they’ll always check with you first if it’s okay to do that. So there’s not really an issue with privacy... Yeah, my space is respected. It’s a fairly relaxed and casual environment for the most part. Our

privacy is respected. Yeah, little things like that make a huge difference”
(Marjorie, Consumer).

Nurses understood the importance of a dignified and discreet setting. Nurses voiced that ensuring adequate privacy was essential for the development of strong interpersonal connections with consumers. Consumers needed to feel confident that sensitive disclosures were handled with dignity and sensitivity.

“We always make sure that we have privacy if we are talking to someone about something. Most of the patients have their own private rooms, they don’t all, but if we are having a one to one personal conversation, we don’t have it in a dormitory. If we are just sitting down there chatting or playing cards or something like that then yes, we would because it’s not something that you’re having that sort of an intimate conversation with. But confidentiality and privacy is a major process and we take that very seriously” (Angela, Nurse).

Workload factors

Aspects of the nursing role and inpatient setting hindered therapeutic interaction. During busy periods in the ward, nurses were limited in their capacity to interact with consumers when tasks and or administrative matters demanded their attention. Poor staffing, in relation to both numbers and skill mix, also negatively impacted on nurses’ capacity to interact with consumers to good effect. Insufficient numbers of nurses led to reduced intimacy of interactions, and a greater task focus. A poor skill mix potentially left less experienced nurses with unmanageable and poorly fulfilled responsibilities.

“Sometimes when it’s a bit chaotic, it’s easy to slip under the radar a bit particularly for someone like me because I’m terrible at communicating. I’m very bad at just being like ‘okay, I’m not okay’. So when it’s a bit more chaotic, it’s easier just to be unnoticed by staff... It’s just a lot more personal when there’s less people on the ward... I think it’s just in those busy times when sometimes it will be helpful to have another person there” (Nellie, Consumer).

“Definitely being short staffed really affects everything. Because you’d have to do your nursing work plus your one-on-ones with patients. So if you have more

nursing work, you'd have less one-on-ones. So I guess it really does affect and that could domino into something more difficult, I guess. So if you haven't say, talked to a patient, it could carry on to the next shift that they'd still feel in this low mood. So staffing does really affect as well" (Samuel, Nurse).

In addition to not being overwhelmed by tasks, the nursing role in care needed to be holistically considerate of the consumer's needs, both physical and emotional. To this end, a nursing focus on weight gain and behavioural management as the salient element of care was considered unhelpful by consumers. Consumers remarked that the poor degree of satisfaction with care was in part attributable to the perceived absence of affection or individualised care, and the focus on weight gain rather than psychological wellbeing.

"Well, no one really ever asked how I was. No one said, "How are you today?" It was always focusing on our weights and how much we're eating and even if we really struggled through a meal... It was a bit frustrating when I was in there because I thought even if we're eating, it doesn't mean we're okay mentally" (Kaye, Consumer).

"Yeah I think that's probably because all they focus on is weight gain and we feel like that's kind of not the problem. Obviously they need to make you medically stable and everything but it's like, I feel like I'm just leaving - all you feel like they're doing at hospital is they make you fat and then they leave you worse than when you came like mentally because you just feel like bigger than ever. So it's just like they're not really focusing on easing you into it, and like helping you and supporting you or giving you strategies, like it would be nice if they give you a few strategies. They don't really talk about your problems" (Dominique, Consumer).

The nursing role was potentially less focussed on interaction and interpersonal engagement in wards with co-mingling medical patients (such as on A1 and B1), compared to wards that specifically cared for consumers with eating disorders (such as on D1 and E1). Simultaneously nursing both medical patients and consumers with AN reduced time for the development of interpersonal relationships with consumers. In a

mixed ward, nurses felt inclined to assist their colleagues with medical patients, and were conscious of their accountability in ensuring that task orientated aspects of nursing were fulfilled. Nurses felt that tending to acute medical needs and tasks for which they were accountable (such as medications, fluid orders and fluid balances) took precedence over interpersonal engagement, for which they were held less accountable. Nurses therefore prioritised work accordingly.

“If the other patients on the ward are quite needy in terms of their medical stability, you end up helping your colleagues. And because they [consumers with AN] are a bit more stable in terms of vital signs and medicinally, they're sort of left to their own devices and you don't have time to communicate with them as much...” (Isla, Nurse).

“Sometimes you won't just have eating disorders. You might have medical patients as well, so then it becomes quite difficult to give attention to the other girls and they can tend to get brushed off to the side because they're not as medically ill as some other people” (Monique, Nurse).

Not only did nurses experience a challenge in simultaneously caring for medical patients and consumers with AN, consumers were liable to feel neglected or less validated if medical patients were seen to be treated with precedence or greater concern.

“It seemed like they had other priorities apart from you, which in some sense is bad, because it makes you feel like you're not cared for” (Tracey, Consumer).

“They treat you as if you weren't sick enough to have their full attention. You were a chore compared to people in there with cancer or cystic fibrosis... I think it would have been a bit different if you would have been the only priority. You wouldn't have to be in there and look at all these people with all these serious illnesses and then feel bad because you're taking up the nurses' time and they feel like you're taking up their time on a sickness that is insignificant to them” (Gemma, Consumer).

Opportunity for interpersonal engagement

The nursing role within the inpatient setting positioned nurses for therapeutic intimacy and engagement because nurses were ever-present on the ward and delivered the majority of face-to-face care. No other healthcare provider was as firmly embedded within the ward context and delivery of care. Nurses then occupied an observational platform that led to an intimate insight into consumers' personalities, strengths and struggles. The proximity to consumers that nurses worked within enhanced the opportunities for nurses and consumers to interact meaningfully as people. The position and intimate role of nurses in the inpatient setting led consumers to perceive nurses as a safe and viable person to rely on for interpersonal and emotional support.

"I think it's part of building a trusting relationship. I think there's an awareness of your family, you're individual situation, they obviously have insight into how you go about eating, they're aware of the whole scope of the treatment plan and they are kind of the ones that are on the ground and stuff like that... I suppose it makes them in quite, I suppose a powerful position, not as like an abuse of power but more as like a resource... It's the connection between what happens in the dining room and the doctors and also kind of as a communicator" (Matilda, Consumer).

"I think that the nurses' key role in treating patients with anorexia nervosa is to be a sign, a symbol of support and encouragement... Nurses are the front line and they give the one-on-one support, 24/7. Whenever a patient needs anything and stuff like that. And I guess - yeah, their key role is just to be there for patient's needs 24/7 and just encourage them basically every day" (Samuel, Nurse).

Consumers experienced intense anxiety and apprehension about gaining weight, and subsequently expressed frustration and hostility towards nurses. Rather than an interpersonal hindrance, events of consumer distress were an opportunity for nurses to better understand and engage with consumers. As the consumer struggled with anxiety over eating and weight gain, the nurse was able to observe and assist the consumer with pathological obstacles. If well handled, acute events of distress

enhanced the quality of the relationship, as the nurse demonstrated empathy and sensitivity for the consumer's complex needs.

“Almost every day we see a patient get upset, especially after every meals, but then through that interaction with them, you get to understand what they are going through, although it's the same problem, same dilemmas for all other patients which is quite typical of each other. So it's like we know how to deal with them, we know now how to interact with them, how to support them. So in a way – but personal experience-wise, that's how I actually understand that eating disorder. When patients do come in and say ‘Okay, I think I've eaten so much. I'm fat, this and this, that and that’. I think it's really one way of them to actually tell that ‘I'm actually struggling here, I needed help here’” (Shane, Nurse).

Nursing education and proficiency

Nurses in this study had very little formal education and training for the treatment of AN. Most had not received education beyond brief in-services and knowledge transmitted by senior nurses.

“Quite often, they do come to us with their problems, which is also difficult 'cause we don't really have that training in order to bring out their feelings and let them reveal them themselves rather than imposing our ideas and our interpretations of the situation on them. So, though that does happen, it's not supposed to, but there a couple of patients that are like, ‘I don't wanna talk to the psychologist. I wanna talk to you’. And you're not really sure what to do. I think our main one is about monitoring their physical health and trying to ensure that they do physically get better by eating the appropriate amount, stopping them from exercising...what else? What do I do?” (Audrey, Nurse).

“There isn't specific training. The only thing that really is available is the online training that The Centre for Eating & Dieting Disorders have put up. There isn't any specific training. There're certainly no courses that can be run... The amount of education for people in eating disorders is very, very limited...” (Pamela, Nurse).

As a highly experienced nurse, Pamela suggested that learning to effectively care for consumers with AN could only effectively develop with on the job experience and reflection.

“It’s the nurse’s skill to be able to appeal to that recovery side of them and find it and work on it. That really is what works. And that just comes with the years of working with the area. There is no education program that would give you that” (Pamela, Nurse).

The Implications of Internal Group Dynamics

This theme describes the implications of the internal interactions within the consumer group itself. This theme also describes the implications of the internal interactions within the nursing team. The relationships between consumers and the relationships between nurses carried implications for the quality of the therapeutic alliance.

Interactions within the consumer group

Consumers and nurses indicated that the group of inpatients within the ward were either a source of recovery focused support, or a pathological influence. The therapeutic quality of the inpatient group varied considerably, and was highly dependent on the individuals within the inpatient group. Consumers spoke primarily about the therapeutic benefit of their fellow inpatients, whereas nurses spoke primarily about how interactions between inpatients were potentially counter-productive.

Peer support, understanding and positive motivation

Consumers found a useful recovery resource within their fellow peers being treated for AN. With a common experience, consumers considered fellow inpatients an important source of non-judgemental and empathic support, ultimately helpful in sustaining recovery behaviours and motivation. With these strong bonds, consumers found hospital better experienced, and were better supported in managing the distress and apprehension associated with the ward program.

“It was helpful. You didn’t think that you were the only one with a problem. So you will talk about your issue to them and then they’ll talk about it back to you. So, everyone understood each other, and everyone was friendly... It is a good

thing because if one patient was struggling through a meal, everyone would sort of support them, and help them get through it as well” (Stacey, Consumer).

“You’ve also got people who want to get better and I think that’s a really important thing to be around - people who are pro-recovery. And that makes a huge difference to how your admission is and what you do when you get out” (Wendy, Consumer).

With a greater recovery resolve derived from the support of their peers, consumers more effectively engaged with the eating disorders program, which enhanced the quality of their therapeutic alliance with nurses.

Peer pathological influence

Despite potential benefits, fellow consumers were also described as a source of pathological influence. The perceived anxieties of a fellow struggling inpatient were vicariously and empathically experienced, which subsequently led to an acknowledgement of the threat to thinness, and a reciprocal fear of eating and weight gain.

“Because they look at each other a lot. If one person struggles with their meal, you’ll generally find that the whole mood at the table will change. The mood of the girls will change if there’s one person mucking up. I generally find it changes kind of everything because they look at each other a lot” (Martin, Nurse).

“Sometimes it can be a bad thing. For example, after you’ve been there a while you get to choose your meals, they give you a menu, and say if you’re doing at the same time, you’re kind of talking about it, the conversation sort of turns to like more anorexia. If you choose white bread someone would be like, ‘Why are you choosing white bread?’ It’s not even like them trying to be like, ‘That’s so unhealthy’, It’s just like it’s a fear for them. If it’s a fear for them it’s kind of like a fear for you” (Dominique, Consumer).

Furthermore, consumers observed fellow inpatients engaging in surreptitious pathological habits and counter weight gain strategies. If consumers wished to evade weight gain, these behaviours were potentially learnt and subsequently practiced.

“You put a bunch of people that are like that in one room and they're all gonna influence and trade tricks and tips of the trade and stuff” (Gemma, Consumer).

“I think that the longer that they stay, the more that they can pick up habits from the other girls as well. And they get in to that culture of hospital and eating disorder habits. And they can learn tricks from each other or they compare each other” (Isla, Nurse).

With pathological influence from peers, consumers engaged in the care program with less recovery focus, and were subsequently less likely to maintain an effective therapeutic alliance with nurses.

Competition for attention

Some consumers complained about fellow inpatients who sought to gain disproportionate attention and care from nurses. Consumers experienced jealousy, and were frustrated that detrimental or dishonest behaviours seemed to elicit a greater proportion of the nurse’s focus and attention. This led to resentment within the inpatient group, and also made consumers feel less cared for relative to other consumers. Feeling relatively neglected was detrimental for the quality of their therapeutic alliance with nurses.

“I do feel like when you’re more compliant and obedient and well behaved you are, you kind of fly under the radar a lot more... I guess what I’m just trying to say is it sometimes seems that the more you go by the rules and are just pleasant and respectful, the less attention you get in some ways. Sometimes it’s just annoying because you sometimes just feel like you are being ignored and you’ve done nothing wrong so... it seems like there are some people that just like to get attention” (Madeline, Consumer).

“And also I think they tend to get jealous among each other as well. The others will discuss it if they see you pull a patient away to give them a bit more

individual care. Even though, I guess they would all appreciate it if they were struggling. I assume that they get a bit jealous... They'll question 'why did she get to have time with you in the conference room away from the group?'" (Isla, Nurse).

Reinforcement of attitudes

In collective fashion, the inpatient group validated and intensified feelings of approval or disapproval towards nurses. The opinions that consumers shared amongst themselves influenced the consumer's overall perception and evaluation of nurses. These shared impressions impacted on the relationships between nurses and consumers.

"If there's a nurse on who seems incompetent, I think they find out about it and it can be that people kind of gather their less unfavourable opinions together and decide that they don't like that nurse, and give that particular nurse a hard time. So I suppose that kind of bitchiness could come through in that way... It tends to be that everyone either likes a nurse or doesn't. And I think that relationships between patients affect that hugely..." (Lynette, Consumer).

"If one of the nurses did something one of the girls didn't like, we'd all watch out for her and we'd get really angry" (Jane, Consumer).

Interactions within the nursing team

In order to develop a therapeutic alliance, nurses devoted considerable emotional and intellectual effort in their interactions with consumers. Working in a team environment, harmonious collegial relationships were an important resource for nurses to sustain their efforts.

Nursing support and solidarity

Nursing consumers with AN was considered a demanding and exhausting role. Nurses needed to be emotionally resourced and supported to maintain the therapeutic separation between the consumer as an individual, and AN as a pathology. Nurses depended on their colleagues as a source of encouragement, support and supervision. With the support of their colleagues, nurses felt confident in their caring role and the therapeutic merit of their conduct.

“It makes a really big difference, I think, if we didn't have such a good group of nurses. It would have made looking after those sorts of patients really, really difficult, just because it is a tiresome job, ensuring that all rules and all things are done, and that kind of thing. And also, I think you've got to have staff that you know and trust because you've got to have backups... So, I think it is really important. I think you have tough days, when you don't have a good supportive person working with you, 'cause generally it's team nursing, and I think team nursing works well for them because you need to kind of have someone to bounce back off” (Lucinda, Nurse).

“It is a good work environment and there's a good team; everybody's communicating well and, especially in this field, you can't – like I said, clients can get quite negative. It can be a bit challenging at times, so it's hard for staff as well and just two staff and maybe 14, 13 patients at times. So I think getting on with your staff members and having a good work relationship is paramount... They're just very supportive” (Elaine, Nurse).

Time in Hospital

Inpatient admissions for the treatment of AN are often lengthy, lasting weeks or months. The sustained periods of interaction enhanced the development of relationships between nurses and consumers. Consumers and nurses indicated varying amounts of time in the development of an interpersonally meaningful relationship. Some indicated that the foundation of an effective relationship could be established in the first few days, others indicated that a firm relationship required some months. It was generally agreed however that relationships grew stronger and more intimate over time. In addition to the passage of time, an improving nutritional state enhanced the consumer's capacity to engage with nurses.

“So there were people who had been there for several months and they seemed to have a closer bond with nurses. But then people who were just new, they're still trying to get to know the nurses and the nurses are trying to get to know them. It took me about three weeks. So I'd say maybe, up to a month to build a really strong relationship” (Tracey, Consumer).

“I think early on in the stages of treatment, it starts to be difficult for them to connect with staff. But once they actually get a bit more settled in the unit and they get used to the unit and they get used to the staff, they tend to come out and tell us a little bit more and then kind of more things start coming off them and they kind of talk a little bit more about different issues that they have”
(Elaine, Nurse).

Summary of Results

The Phase One findings indicated that consumers perceived a poor alliance with nurses, poor satisfaction with care, and a high degree of eating disorder psychopathology. Nurses reported good attitudes towards consumers with acute mental health needs. A discrepancy between the alliance perceived by nurses and consumers was apparent in relation to the Therapeutic Hold subscale in the EssenCES instrument, with nurses indicating a higher perceived alliance. Together, results in both phases indicated that AN as a disorder was a highly influential factor in the dynamics of nurse-consumer relationships.

Data from interviews indicated the importance of interpersonal nurse-consumer relationships, and the way that these relationships enhanced the consumer’s inpatient experience. AN as an illness ultimately compromised the quality of relationships between nurses and consumers; consumers and nurses then needed to devote effort to separating AN as an illness from the consumer. The way that nurses utilised their authority and applied the rules of the eating disorder program needed to be well-tempered to maintain both rapport and professional boundaries. Ultimately, the rules of the eating disorder program were best applied in a consistent fashion. Contextual factors such as the nature of hospitalisation and nursing role, the inpatient group, and the duration of an admission influenced the quality of relationships between nurses and consumers. These results are explored and expanded in the next chapter.

Chapter Six: Discussion and Conclusion

Introduction

This chapter discusses the results of this study in relation to current literature, developing meaningful insights into the nature of the therapeutic alliance between nurses and consumers in the context of the inpatient setting for the treatment of anorexia nervosa. A range of literature is utilised, with a strong focus on research related to consumer and nursing perspectives. Limitations of the study are established. Final conclusions and applications for practice are outlined, as well as future directions for research.

The aim of this study was to investigate the nature of the therapeutic alliance between nurses and consumers being treated for AN, in the context of the inpatient setting.

The objectives in meeting this aim were to:

1. Establish a greater understanding of the nature of therapeutic alliance within the context of the inpatient setting between nurses and consumers with AN.
2. Measure the strength of therapeutic alliance between nurses and consumers with AN in the inpatient setting.
3. Understand the consumer perspective of therapeutic alliance with nurses in the context of the inpatient setting.
4. Understand the nursing perspective of therapeutic alliance with consumers in the context of the inpatient setting.

Therapeutic alliance has been variously defined throughout its use and development. For this chapter, therapeutic alliance is defined as it was in Chapter Two, on page 18: 'an interpersonal, mutual and negotiated collaboration necessitated by, and focussed on the resolution of, identified health goals'. This definition frames the discussion.

In this study, the nature of the therapeutic alliance was influenced by the implications of AN as an illness, nurses' role in care, and other contextual factors specific to the inpatient setting. Owing to the nature of AN, the therapeutic alliance was distinguished by the presence of a striking difference in power between nurses and consumers. The orientation of power in relation to the development of mutuality was the key focus of consumers and nurses. The therapeutic alliance between nurses and consumers with AN was dependent on nurses maintaining a careful balance between interpersonal engagement and the therapeutic use of power: a balance of 'love and limits'. This balance was crucial for developing a therapeutic separation. Therapeutic separation was the state in which the consumer and nurse mutually recognised the pathological nature of AN, the caring role and intent of nurses, and the consumer as a worthy individual in need of care. A therapeutic separation preceded the development of a concordance of therapeutic efforts, mutuality. A mutual confidence in the understanding that the orientation of power was employed to credit and protect the consumer is the principle upon which successful separation and mutuality was dependent. A maternalistic approach emerged as a valued style of nursing care.

Context and the Therapeutic Alliance

This study revealed that the inpatient context carried substantial implications for the nature of the therapeutic alliance. AN as an illness was highly influential over the nature of relationships. The inpatient setting and nursing role, nursing workloads and length of stay in hospital also influenced the nature and development of relationships.

Anorexia Nervosa as an Illness

This study is primarily distinguished by the finding that AN as an illness itself was the primary contextual factor influencing the nature of the therapeutic alliance. The participants of this study indicated that the severity of AN and overall eating disorder psychopathology contributed to the low degree of alliance, as established by phase one findings. It is established that for consumers, the essential and structured focus on weight gain is the most highly criticised and poorly experienced element of AN care (Swain-Campbell, Surgenor & Snell 2001). The nursing role in behavioural management was inherently uncomfortable for consumers, as nurses were responsible for consumer

participation in meals and the minimisation of exercise. In recognising the nurse's clinical role, consumers were liable to deliberately avoid or sabotage a relationship due to the threat to their thinness; overall, the nature of AN hindered therapeutic interaction (Snell, Crowe & Jordan 2010).

Particularly for those ill to a degree requiring hospitalisation, consumers with AN are typically in a state of ambivalence about recovery as the illness becomes part of the consumer's identity (Colton & Pistrang 2004; Dawson, Rhodes & Touyz 2014; Espindola & Blay 2009; Reid et al. 2008; Tan et al. 2003; Westwood & Kendal 2012). The diametric opposition between the nurse's professional role and the consumer's mental pathology jeopardised the quality of the relationship (Ramjan & Gill 2012). The questionable volition of engagement in care and ambivalence of consumers carried implications for the quality of relationships (Wright 2010). Interpersonal connections and mutuality were then strained by divided resolve. In addition to the nature of AN, other factors of context were influential over the nature of the alliance.

The Inpatient Setting and Nursing Role

The inpatient setting and the structure of care delivery was influential over the quality of relationships between nurses and consumers. The inpatient setting and routine is designed to enhance nurses' capacity for close observation. The transparency of the inpatient setting had an ambivalent potential. Positively, with the ubiquitous presence and role of nurses, nurses and consumers were well situated to understand and know each other in great depth and intimacy. Nurses were then better enabled to assist consumers with overcoming the anxieties of weight gain and hospitalisation (Bakker et al. 2011; Ryan et al. 2006). However, while the inpatient setting was advantageous for the development of intimacy and an alliance, the suspension of privacy and the nurses role in observation were potentially experienced as an unwelcome invasion (Ramjan & Gill 2012).

To this end, nurses acknowledged the importance of privacy and confidentiality for the treatment of AN (King & Turner 2000). Adequate privacy helped consumers to feel dignified and secure in making personal disclosures that would otherwise risk embarrassment, discrimination and or stigma. In this way, reasonable privacy and

confidentiality enhanced the intimacy of knowledge nurses had about consumers (Appelbaum 2002), and enhanced consumers' ability to trust nursing staff (McCann & Micevski 2005). Reaching a productive degree of privacy was challenging, as consumers with AN required a degree of close observation that did not permit the compromise of weight gain.

Ward Milieu

The concept of ward atmosphere involves social structures and interactions, as well as the physical environment (Nicholls et al. 2015). The consumer participants of this study remarked on the way that positive relationships with nurses enhanced their environmental experience; the therapeutic alliances that nurses developed led to an enhanced ward atmosphere and milieu. This was evidenced by the themes in which consumers described how interactions with nurses led to a more 'at home' or 'normalised' environment, in which consumers felt emotionally secure. The relationships that developed between nurses and consumer brought a humanistic quality to the ward setting: an enhanced milieu.

Milieu is an important consideration for care in the inpatient setting, with implications for outcomes and experiences of consumers, such as consumer satisfaction and motivation (Eklund & Hansson 2001), and absconding (Muir-Cochrane et al. 2013). It is noteworthy that consumers only remarked on the way that their relationships with nurses enhanced the milieu. This suggests that for the treatment of AN, the nature of relationships between nurses and consumers is the most influential factor in relation to milieu. The physical layout of the ward was not a noteworthy contextual factor, as it is suggested in other research of consumer and healthcare professional perspectives (Curtis et al. 2007; Nicholls et al. 2015). The absence of a focus on the 'geography' of the ward is likely due to the fact that the wards from this study did not conform to the typical locked mental health ward. The wards that the consumers were cared for on were medical wards, which had an eating disorders program. Such wards did not have locked doors, Perspex windows dividing consumers and nurses, and these wards did not have seclusion rooms. It is likely due to these absences that geography was not a remarkable theme.

Nursing Workload

Nursing workload was also a contextual factor with influence over relationships. Arduous workloads compromised the capacity for nurses and consumers to develop a therapeutic alliance. When overburdened, nurses prioritised tasks and protocols, diminishing the interpersonal elements of their care (Ramjan & Gill 2012). Heavy workloads were particularly egregious in the context of a ward with co-mingling medical patients (McCann & Micevski 2005). Co-mingling medical patients were potentially considered as more deserving of care, compared to consumers with AN who had a 'self-inflicted' illness (Ramjan 2004; Tierney 2008). For consumers, co-mingling with medical inpatients not subject to the rules of the eating disorder program served to highlight limitations and restrictions in freedoms by comparison (Ramjan & Gill 2012).

Time in Hospital

The length of stay in hospital was also an influential aspect of context. According to most participants in this study, relationships grew in intimacy and closeness over time, which is similar to the findings of McCann & Micevski (2005). The therapeutic alliance is an effective approach in a healthcare environment with adequate time, where the achievement of tasks and goals may be complex or elusive (Madden 1990; Zugai, Stein-Parbury & Roche 2015). Though sufficient time for a relationship to develop is important, a good first impression is liable to enhance the overall development of the relationship (Sly et al. 2014).

In the context of care investigated in this study, nurses delivered care and assisted consumers with recovery by maintaining a position of power in the relationship. The way that nurses occupied and utilised their position of power determined the quality of the therapeutic alliance. Nurses were then considerate in their use of power.

Love and Limits

Nurses established a therapeutic alliance by maintaining a balance between positive interpersonal engagement and the therapeutic use of power: 'love and limits'. The term '*Love and Limits*' was derived from an interview, in which the nursing participant described the challenge of being a caring, interpersonally adept nurse, whilst also

fulfilling professional duties. The 'love' aspect pertains to the interpersonal dynamics of nursing care, and respective implications. The 'limits' aspect refers to the way that nurses maintained a conspicuous intent of countering AN, with care efforts clearly intended to do so. By maintaining a solid foundation of positive interpersonal dynamics, consumers felt confident about the therapeutic intent of the nurse, and experienced treatment as an act of caring. As consumers recognised nurses' caring role and intent, they developed a sense of confidence in the fidelity of the position of power that nurses held. With an approach of 'love and limits' nurses validated the worth and value of individual consumers, whilst impressing the unacceptability of AN. This balance ultimately assisted the consumer in identifying the pathological nature of AN.

'Love': Positive Interpersonal Dynamics

Although the overall strength of the alliance measured in phase one of this study was relatively weak, trust, empathy, warmth and rapport were considered foundational for therapeutically experienced interactions and relationships. Corresponding with other consumer perspective literature, consumers valued attentive, empathic, hopeful, understanding and non-judgemental, genuinely caring, available nurses, with whom authentic and honest relationships could be developed (Abbate-Daga et al. 2013; Boughtwood & Halse 2010; Colton & Pistrang 2004; Espindola & Blay 2009; Gulliksen et al. 2012; Oyer, O'Halloran & Christoe-Frazier 2016; Roots, Rowlands & Gowers 2009; Sly et al. 2014; van Ommen et al. 2009; Wright & Hacking 2012).

Although acknowledging challenges, nurses recognised the value of non-judgemental, hopeful and genuinely caring attitudes. Nurses demonstrated these attitudes by maintaining sensitivity, supportiveness and availability for the consumer (King & Turner 2000; McCann & Micevski 2005; Ryan et al. 2006; Snell, Crowe & Jordan 2010). Availability involved both physical presence and readiness for emotional engagement, which was dependent on a context of care that enabled nurses to engage with consumers to this effect.

Meaningful relationships assisted consumers with the challenges of hospitalisation (Bakker et al. 2011; Sly et al. 2014; Swain-Campbell, Surgenor & Snell 2001). With the

establishment of positive interpersonal dynamics, consumers felt a sense of safety and comfort in knowing that nurses genuinely cared for them and were available during the anxious tempest of hospitalisation (Wright & Hacking 2012). Consumers felt secure and validated when cared for with kindness and understanding (Gulliksen et al. 2012). By acknowledging and validating the distress associated with weight gain and the anxiety provoking expectations of nutritional rehabilitation, nurses enhanced the perceived dignity of care (Gustafsson, Wigerblad & Lindwall 2014). Through the power of interaction, the anxiety and distress of weight gain was diminished, and a 'home-like' sense of normality and comfort was restored in an otherwise foreign hospital setting (Wright & Hacking 2012; Zugai, Stein-Parbury & Roche 2013).

The importance of environmental modification was particularly evident in light of consumer accounts that described the inpatient context as uncomfortable, a waste of time, or an isolative suspension from activities, relationships or interests that are personally fulfilling (Offord, Turner & Cooper 2006; Ramjan & Gill 2012). The absence of interpersonal tenets or perceived callousness led to attempts by consumers to sabotage care, rebelling against a perceived coercive authority (Boughtwood & Halse 2010; Espindola & Blay 2009). Without the development of positive interpersonal dynamics, consumers lost faith in the merit of the power differential, and rebelled against nursing staff. In this way, positive interpersonal dynamics enhanced nurses' capacity to effectively occupy their position of power.

'Limits': Therapeutic Power

AN is a serious mental disorder, and hospitalised consumers are typically at a point of life-threatening acuity. When admitted to the inpatient setting, consumers' activities of daily living were limited and controlled to conform with a rigid behavioural program. Nurses were responsible for ensuring that consumers were supported in maintaining recovery behaviours, and were consequently vested with power over consumers; consumers were deliberately deprived of autonomy and decision-making power in relation to weight gain. The inpatient care of AN was then characterised by a marked power differential.

This power dynamic conflicts with Meissner's (2007) description of the alliance, wherein autonomy, initiative and freedom of participation are fundamental to the alliance. According to Bordin (1979) the alliance involves mutually agreed upon goals, mutually agreed upon tasks for achieving those goals, and an interpersonal bond. However, negotiation over goals and tasks involving eating and exercise behaviour in the treatment of AN was minimal or not attempted in the context of this study. The consumer's degree of pathology was such that negotiation was not a viable activity; the consumer's power and capacity for autonomy was held in abeyance. The overall implication of this unique power orientation is that nurses must establish mutuality through a means other than equally powered negotiation. Nurses then relied on the ability to convince the consumer that care was delivered sincerely on behalf of their interest, demonstrating that the power differential was forthright and trustworthy. Nurses did so by relying on interaction as a medium of influence, and by applying the rules of the ward program consistently, but also with careful consideration.

The consumers and nurses in this study indicated that authoritative and coercive styles of care were a misuse of power. A collaborative approach dependent on interaction and interpersonal finesse was preferred by consumers and more likely to lead a harmonised effort, whereas rigid control and a dictatorial approach was likely to inspire non-adherence and resistance (Colton & Pistrang 2004; Espindola & Blay 2009; Offord, Turner & Cooper 2006; Sly et al. 2014; Zugai, Stein-Parbury & Roche 2013). By maintaining an interpersonal approach, consumers were more likely to experience care collaboratively, rather than feel threatened or forced by an approach dependent on power (Gulliksen et al. 2012). Nurses maintained both the rules of the eating disorder program and the quality of the relationship by relying on interpersonal engagement as a persuasive influence. They cared for consumers with clear guidance and direction, in tandem with a supportive and understanding presence (Beukers et al. 2015). By maintaining a caring approach dependent on the power of interaction, consumers were liable to trust the nurse's caring intent and feel secure.

An overly rigid approach, or conversely an unduly flexible approach, is liable to compromise consumers' confidence in care (Oyer, O'Halloran & Christoe-Frazier 2016).

A therapeutic alliance in this study involved nurses maintaining a consistent set of expectations, whilst also having degree of flexibility for individualising care.

Consistency in Care: Curtailing Ambivalence

Akin to other consumer perspective research, consumers in this study valued clear and unambiguous expectations and predictability in care (Bakker et al. 2011; Long et al. 2011; Zugai, Stein-Parbury & Roche 2013). The firm rules of the ward program suspended the consumer's control over eating and exercise; consumers were unable to engage in the behaviours that resulted in their hospitalisation (Offord, Turner & Cooper 2006). By relinquishing control to nurses, consumers feel disabused of the stress that is provoked by the rigid routines that characterise AN (Smith et al. 2016)

Well-defined rules and protocols gave consumers and nurses confidence in fulfilling their respective roles. The confidence and certainty that a nurse has in their role reassures consumers and mitigates anxieties (Gulliksen et al. 2012; Oyer, O'Halloran & Christoe-Frazier 2016; Snell, Crowe & Jordan 2010). In a predictable environment, consumers felt secure and able to trust the therapeutic intent and credibility of nurses. Consistently applied rules and expectations reified the representation of AN as pathology, and reinforced prescribed care as forthright, thereby aiding a therapeutic separation. However, in the presence of varying nursing expectations, consumers were liable to question the credibility of the care program.

Understanding the nature of AN is essential for appreciating how inconsistencies undermined the consumer's recovery resolve. Consumers meticulously obsessed over the minutia of their food intake and energy expenditure. They experienced an ostensibly minor inconsistency as a significant aberration of the prescribed care. When confronted by such variations, the consumers lost faith in the credibility of the care program and the competence of nurses. This led them to question the aptitude of the healthcare professionals with seemingly capricious standards. This uncertainty compromised nurses' claim to be therapeutically forthright, and is an opportunity for ambivalence to interfere with recovery motivation.

In addition to maintaining a consistent set of expectations, nurses ensured that opportunities for undermining the therapeutic program were minimised, and did so by

minimising opportunities for consumers to compromise weight gain. Consumers were typically engaged in care with a high degree of ambivalence that was amplified when they perceived an opportunity to compromise weight gain. When opportunities were not removed, the consumer was likely to succumb to the compulsion to compromise weight gain.

The phase one findings of this study demonstrated that consumers being treated on an inpatient basis experienced a low satisfaction with care. Despite dissatisfaction experienced during acute inpatient care, consumers are often retrospectively appreciative of strongly compelled or non-negotiable care, recognising that they were unable to safely facilitate their own recovery (Bakker et al. 2011; Colton & Pistrang 2004; Neiderman et al. 2001; Offord, Turner & Cooper 2006; Tierney 2008; Westwood & Kendal 2012; Zugai, Stein-Parbury & Roche 2013). Consumers with AN are hospitalised due to their inability to safely self-regulate eating and exercise outside of the containment and supervision offered by the inpatient setting. Therefore, it is not only ineffective to burden the consumer with the responsibility of maintaining adherence, but also an unfair expectation. Ultimately, nurses assisted consumers by relieving the burden of demoralising ambivalence through consistency and the maintenance of an environment that minimised opportunities for compromising weight gain. Consistent expectations also reduced the potential for consumers to perceive nursing favouritism; if consumers felt that rules were applied consistently, they were less likely to perceive favouritism in nursing care. Favouritism was recognised as a potentially counter-productive nursing activity, leading to ineffective management (Ramjan 2004).

Flexibility: Individualised Care

Despite the emphasis placed on consistency, an inflexible and rigid application of protocols hampered relationships between nurses and consumers (McCann & Micevski 2005), with unjustifiably restrictive care being interpreted punitively (Offord, Turner & Cooper 2006; Zugai, Stein-Parbury & Roche 2013). Consumers described an appreciation of nurses who applied rules with careful discretion and flexibility. Without compromising the consumer's weight gain, nurses modified care to better meet the individual needs of consumers. In doing so, the relationships between nurses and

consumers were enhanced. These modifications improved the experience of weight gain by enhancing the sense of collaboration and dignity in care (Colton & Pistrang 2004). Individualised care involves making decisions in consideration of the consumers stage of recovery, and other personal and individual factors (Oyer, O'Halloran & Christoe-Frazier 2016).

With a balance of 'Love and Limits', consumers developed confidence in the therapeutic power differential, and subsequently identified the pathological nature of AN. By assisting consumers to recognise AN as pathology, nurses facilitated a therapeutic separation.

Therapeutic Separation

AN is an ego-syntonic disorder, as pathological attitudes, beliefs and thought processes are pervasively ingrained into the consumer's identity. Consequently, separation and externalisation of AN from the consumer is recognised as important to recovery (Dawson, Rhodes & Touyz 2014; Espindola & Blay 2009; Lamoureux & Bottorff 2005; Smith et al. 2016). In developing a therapeutic alliance, the individual consumer and AN as an illness were distinctly contrasted, a therapeutic separation.

Prior to facilitating and assisting the consumer's separation from AN, nurses established their own internal separation process; the individual consumer could not be colluded and intermingled with AN as a definitive personal characteristic (Boughtwood & Halse 2010). Nurses recognised consumers' uniqueness then viewed individual consumers and the pathology of AN as separate entities. Nurses' internal process of separation was dependent on a non-judgemental and understanding orientation, because in being so, they were less likely to attribute experienced frustrations towards individual consumers. By understanding and accepting the nature of AN, nurses were better able to resolve inner turmoil that would otherwise hinder interpersonal development (King & Turner 2000; Snell, Crowe & Jordan 2010).

As nurses maintained a non-judgemental and understanding orientation, consumers experienced care accordingly. Without apprehension of judgement, consumers felt comfortable in developing close relationships with nurses. In feeling interpersonally

secure with nurses, consumers were receptive to the distinction that nurses made between them as an individual and AN as an illness. Their relationships with nurses enabled consumers to identify the pathological nature of AN, thus developing an internalised separation process. With attitudes supportive of separation, nurses cared for consumers in a way that acknowledged their unique individuality.

Recognition of Consumer Uniqueness

In developing a therapeutic separation, it was important that consumers were acknowledged as unique individuals, rather than just a 'walking eating disorder' (Smith et al. 2016). To this end, it was then important that nurses demonstrated that weight gain was not the only salient goal or interest of treatment (Espindola & Blay 2009; Offord, Turner & Cooper 2006). During the course of interviews, consumers were critical of nurses that were focussed on weight gain at the exclusion of all other consumer needs. An over-focus on weight gain and emphasis on the illness leads consumers to feel punished and invalidated as an individual (Colton & Pistrang 2004; Offord, Turner & Cooper 2006).

By focussing on holistic goals not necessarily related to physically observable progress, nurses affirmed to consumers that their eating disorder was not a personally defining characteristic, and affirmed that the consumer was a unique person with diverse needs (Offord, Turner & Cooper 2006; Reid et al. 2008), thus contributing to a therapeutic separation. Caring for consumers with respect to their non-pathological identity enhanced the experience of care and recovery resolve (Bezance & Holliday 2013; Gulliksen et al. 2012; McCann & Micevski 2005; Offord, Turner & Cooper 2006). By respecting consumers as individuals, consumers engaged in and experienced care as a participatory effort (Gulliksen et al. 2012), which was superior to an approach dependent on reluctant submission. Such participation led to mutuality and trust in the relationship.

Mutuality: Trust

The combination of 'Love and Limits' and a therapeutic separation developed a concordance of efforts and interpersonal harmony that are characteristic of a therapeutic alliance. By maintaining an unambiguous and confident focus on care with

an affectionate, understanding and kind nature, nurses created a relationship in which consumers felt secure, validated and cared for (Gulliksen et al. 2012). The development of trust was the hallmark of a well-established therapeutic alliance. Trust was the sense of confidence and security a consumer had, despite being vulnerable to the nurse. Trust was the state in which the consumer felt safe, despite the sheer difference in power.

In trusting the nurse, the consumer faithfully invested in the therapeutic intent of the nurse, and embraced a new concept of wellbeing. Through resigning psychological defences and the empty safety of AN, consumers permitted nurses to challenge what were typically held as immutable perceptions and beliefs. Trust was the interpersonal state in which mutuality was experienced. Throughout the course of interviews, a maternalistic approach emerged as a valued aspect of care.

Maternalism

Consumers and nurses in this study described positively perceived nursing care, some indicating that effective nurses assumed a ‘motherly’ or ‘sisterly’ role. These nurses were interpersonally adept and effectively maintained strong relationships throughout the varying stages of hospitalisation. The motherly/sisterly nurses warmly and tactfully assisted consumers with challenging aspects of hospitalisation, and made a memorable and meaningful contribution to the wellbeing of consumers. The term ‘motherly’ was typically used in reference to nurses who were much older than the consumer; while ‘sisterly’ nurses were those older yet closer in age. Despite the differentiation in terms, both motherly and sisterly nurses were distinguished by a maternalistic approach, described by Wright & Hacking (2012) as:

“The maternalistic approach is personal and individual, used to describe a person who cares about the patient as well as for them. Maternalism here also better reflects the protective, feeding and nurturing role that is adopted by the staff” (p. 112-113).

Maternal role assumption in eating disorders nursing has been previously identified and explored (Ryan et al. 2006; Wright 2015). Ryan et al. (2006) indicated that the nursing assumption of a maternal role accompanies meaningful caring, empathic and

supportive interpersonal interaction, and a maternalistic nursing style was identified by a consumer in the study by Zugai, Stein-Parbury & Roche (2013). Wright (2015) asserts that nurses deliberately assume a motherly role and mode of interaction, subsequently enhancing care for consumers by harnessing the therapeutic value of maternalistic care and presence. The physical proximity of nurses, and their employment of sensitivity, empathy and therapeutic touch, are of a maternalistic quality (Wright 2015). From the previous and current research, nurses adopt a maternalistic approach for its therapeutic expediency. That is, the maternalistic approach was adopted as it is considered an effective means of caring for consumers.

In this study, the motherly or sisterly role was adopted as a natural response to the consumer's needs for intimacy, and as a means of therapeutically managing consumers' vulnerability in the presence of a power differential. Maternalistic nurses were effective in interpersonally engaging with consumers, whilst concurrently maintaining a tactful focus on therapeutic expectations in relation to eating and exercise behaviour; the maternalistic approach was a balance of love and limits. In the inpatient setting, particularly in the involuntary inpatient setting, nurses occupy a position of power over consumers. Equality between a nurse and consumer is impossible, however nurses can instead strive to establish mutuality (Briant & Freshwater 1998). A maternalistic style of nursing was then adopted in order to develop a therapeutic alliance in a context that involved a power differential. Maternalism also engendered the unconditional positive regard, understanding and non-judgemental tact upon which a therapeutic separation was dependent.

Compared to participants from the adult setting, maternalism and parental role assignment was a stronger theme in interviews with participants from paediatric setting, which is akin to the observations of Ryan et al. (2006). The adolescent age group may be more accustomed or inclined to seek parental figures in nurses, and adolescents may be less observant of professional boundaries that would otherwise be considered by more mature consumer groups. A maternalistic style of nursing was however also described in the adult setting by Wright & Hacking (2012), therefore suggesting that the maternalistic style is viable with a range of ages. In maintaining the therapeutic quality of the maternalistic approach, clinical relationships must be

recognised for their transient nature, leading to the eventual independence and empowerment of the consumer (Wright 2015).

Challenges in Developing the Therapeutic Alliance

Whilst this study was focussed on the development of positive interpersonal relationships, participants also reflected on obstacles that hindered the therapeutic alliance. In response to the challenges and stressors of caring for consumers with AN, some nurses withdrew emotional engagement as a measure of self-preservation. This led to a punitive dynamic in relationships between nurses and consumers. Poorly maintained professional boundaries also threatened the therapeutic merit of the power differential. By placing personal needs ahead of consumers' wellbeing, nurses were liable to empower consumers in a way that subverted therapeutic progress.

Emotional withdrawal

It is surprising that the phase one results regarding nursing attitudes were suggestive of positive attitudes, as many of the interviewed nurses found caring for consumers with AN to be emotionally exhausting. It is well established that clinicians caring for consumers with eating disorders suffer from burnout (Woodrow, Fox & Hare 2012). Within the firm behavioural expectations of the inpatient setting, consumers with AN often surreptitiously deceived and wilfully undermined nursing care in a calculated manner. Consumer behaviours that intentionally sabotaged care served as an affront to the nurse's sense of motivation, confidence and hope. The professional satisfaction that a nurse could experience from the mutual pursuit of health goals was unlikely. The absence of mutuality demoralised and discouraged nurses, with negative implications for the therapeutic alliance.

Ongoing dissatisfaction and frustration left nurses vulnerable to attitudes and styles of interaction that impaired the process of therapeutic separation. With an impression that consumers caused their illness, nurses were liable to interact with consumers in a judgemental manner, seeing consumers with AN as less deserving of care (Ramjan 2004). Applying care with prejudiced attitudes resulted in a failure to acknowledge the unique identity of consumers, leaving them feeling like a 'diagnosis' (Gulliksen et al. 2012; Offord, Turner & Cooper 2006; Tierney 2008), which is in precise opposition to

the aim of the separation process. Without a sense of confidence in the non-judgemental nature of nurses, relationships were liable to be superficial or characterised by insincerity (Sly et al. 2014). With ongoing resistance, poor clinical progress and the development of judgmental negative attitudes, nurses questioned their professional aptitude and felt ineffectual, leading to a state of demoralisation (King & Turner 2000; Snell, Crowe & Jordan 2010).

With poor returns on invested emotional effort, nurses were liable to adopt a nursing style less dependent on emotional engagement, opting to fulfil their role in an emotionally sterile, robotic manner. Nurses withdraw emotional involvement as a self-protective effort (Stein-Parbury 2014); the disappointment and frustration of demoralisation was negated if an emotional investment was not initially attempted (King & Turner 2000; Ramjan 2004; Ramjan & Gill 2012). By holding consumers culpable for their disorder, and with the withdrawal of care and compassion, consumers are liable to feel ashamed and belittled (Gulliksen et al. 2012). This was antecedent to the assumption of punitive roles.

Punitive Role Assumptions

Without confidence in nurses' caring intent and in the absence of a therapeutic separation, consumers experienced care punitively, which leads to resistance (Dawson, Rhodes & Touyz 2014). An approach wherein consumers were assumed or pre-determined to be untrustworthy was liable to initiate a relationship of authority and control (Gustafsson, Wigerblad & Lindwall 2014; Ramjan 2004). A 'gaoler/perpetrator' role assumption was liable to develop, with nurses occupying their position of power as gaolers, consumers occupying the role of an inmate. The description of nurses as gaolers, army officers, and other coercive forms of authority is a recurring theme in eating disorder literature (King & Turner 2000; Ramjan 2004; Ramjan & Gill 2012). A 'quasi-penal' or punitive experience of care is common for consumers (Ryan et al. 2006), particularly if care is delivered in a non-consensual manner (Tan et al. 2003). An approach of authority and control was not only exhausting for nurses, but was also considered professionally unfulfilling (Snell, Crowe & Jordan 2010).

Professional Boundaries and the Power Differential

The integrity of the power differential that enabled nurses to assist consumers in their recovery was dependent on the maintenance of firm professional boundaries.

Consumers acknowledge that the maintenance of professional boundaries is necessary for the therapeutic integrity of relationships (Oyer, O'Halloran & Christoe-Frazier 2016). During the course of interviews, it was apparent that the nursing participants often engaged in their occupation seeking a sense of professional satisfaction through encounters and relationships with consumers. Despite the potential for fulfilling relationships, the therapeutic merit of the power differential was dependent on nurses placing the consumer's needs at the forefront of their attention and concern, without personal needs interfering with approach or actions (Stein-Parbury 2014). Nurses were then cautious in interactions with consumers to ensure that relationships were strictly geared for the benefit of consumers. Conversely, permitting personal needs to dictate the course of interactions was liable to compromise the therapeutic merit of relationships.

The psychological nature of AN sometimes led consumers to deliberately undermine the nurse's therapeutic role and intent, by re-orientating the therapeutic power-differential. Throughout the course of care, nurses may exhibit needs and vulnerabilities: needs for approval, friendship, or other personal needs. Upon identification of a nurse's vulnerabilities, a consumer could then begin to meet these needs. By meeting the nurse's personal needs, the consumer established an interpersonal position to exert pressure on the nurse. With this capacity, the consumer could lever the nurse to compromise expectations involving weight gain. In this way, well-maintained professional boundaries safeguarded the therapeutic alliance. Vulnerable or ill experienced nurses were more likely to engage with the consumer and unwittingly become complicit in the transaction, accepting the consumer's interpersonal offer. Younger and less experienced nurses in this study were at a greater risk of such a boundary transgression.

Nursing Age and Boundary Implications

Due to their appearance and manner, younger nurses were more readily placed into a 'friend-like' role, which weakened their capacity to exercise authority to therapeutic

effect. Conversely, nurses of an advanced age were more readily placed into a role that had an inherent degree of authority. These role assignments carried implications for the integrity of boundaries, with younger nurses being at greater risk of boundary violation.

The nursing adoption of a 'friend-like' role was more likely to alter the therapeutic power orientation. These roles carried a power orientation closer to a state of equality, with both parties sharing power more equally. Such a power orientation was inappropriate, giving the consumer power that they were unable to safely manage. The boundary compromise occurred in a fashion akin to a transference and counter-transference transaction. The consumer observed the younger appearance of the nurse, and applied expectations toward the nurse accordingly; the nurse was a viable candidate for friend-like interactions, rather than a professional nurse with authority. The younger nurse, being less professionally experienced and more accustomed to a younger role in interactions, was more likely to respond and engage in the relationship in a manner acquiescent with the consumer's expectations. If left uncorrected, this pattern of interaction neutralized the nurse's capacity to fulfil their professional role. That is, the consumer developed a degree of pathological leverage.

Recovery

It is important that the findings of this study are considered in relation to the recovery movement. Recovery is typically conceptualised as a long term or ongoing journey, where consumers navigate the course of their wellbeing with a self driven determination to achieve goals that are personally meaningful (Till 2007). Conversely, the treatment for AN in the inpatient setting typically involves seizing the consumer's control over eating and exercise, with little to no negotiation in the process. Care is typically delivered in this manner, as the life threatening acuity of starvation warrants such a suspension. In light of this conflict, nurses are faced with the challenging task of both maintaining a philosophically sound approach, whilst also ensuring the physical safety of consumers. Maintaining a recovery approach in the context of inpatient AN care is a balance of love and limits.

Recovery is conceptualised as a longterm, non-linear process of change involving self-determination and self agency, empowerment, meaning and purpose, social connectedness (Leamy et al. 2011; Onken et al. 2007). Whilst these principles cannot be realised in the confines of the inpatient setting, the therapeutic alliance that nurses develop with consumers in the inpatient setting is geared to prepare consumers for a tier of independence compatible with recovery. Nurses deliver recovery oriented care by moving beyond diagnostic labels through separation and develop recovery supportive relationships with a therapeutic alliance (Chester et al. 2016).

As part of an approach focussed on recovery, diagnostic labels must be eschewed (Chester et al. 2016), and the process of separation is conducive to this. It is necessary to consider that the DSM-5 establishes a fixed polarity between mental illness and wellbeing. Such categorisations are not considerate of the needs of individuals, and promote an approach dependent on generalisations. Therefore, mental health texts such as the DSM-5 must be recognised as limited in this regard, and care efforts must be individually tailored.

Implications

In consideration of the unique context and nature of the therapeutic alliance in this study, implications that are specific to this context are developed. Implications are developed for nursing application, as nurses are ultimately responsible for the development of the therapeutic alliance. Implications address the ways that nurses are supported to develop the therapeutic alliance in inpatient setting, and the way that nursing care is coordinated and delivered therein. Implications also address the ways that nurses maintain a therapeutic power differential. Nurses' capacity to develop a therapeutic alliance is enhanced by a cohesive team based approach, as well as ongoing education and supervision.

The implications developed in this section include specific recommendations for nursing practice. To implement these recommendations, nursing policy and protocols would need to suitably emphasise the importance of meeting nurses' physical and emotional needs to effectively sustain therapeutic practice. In order to develop therapeutic alliances as a routine aspect of care, nurses will need to be supported with

adequate physical resources, opportunities for continuing professional development, training, supervision and debriefing. It is also important to consider that the successful recommendations would be dependent on a committed team of healthcare professionals, dedicated to implementing evidence based practice. The implications of this study can only be realised with a systemic adoption, which is supportive of individuals.

The Inpatient Setting

As earlier established, consumers felt safer developing intimate relationships with nurses in the context of a discrete and dignified care setting. The establishment of privacy and dignity for consumers receiving mental healthcare is then an important consideration, as dignity is particularly susceptible to compromise in an involuntary context (Gustafsson, Wigerblad & Lindwall 2014), and consumers with AN are frequently cared for on such a basis (Douzenis & Michopoulos 2015; Kendall 2014). The vulnerability and exposure of consumers in the inpatient setting must be tactfully managed (Wright & Hacking 2012). Individual bedrooms and bathrooms, and access to non-clinical areas (such as a common room or activity room) may establish a sense of dignity, privacy and clemency that would otherwise be enjoyed in a home environment. The inpatient setting is optimised if consumers are able to individualise their surroundings (Ramjan & Gill 2012), establishing a more home-like environment. Four-bedded rooms are an inappropriate area for sensitive disclosures and are not suitable for discussions regarding care. Such interactions should then be conducted discretely, in a private room or office.

Staffing, Workload and Routine

Nurses cannot be overburdened with tasks to the degree that consumer's interpersonal needs are compromised. Workloads must be appropriately managed to ensure that nurses are able to devote adequate resources to the development of a therapeutic alliance. Medical or administrative duties should not remove nurses from their unique observational platform or capacity for interaction. In wards with co-mingling medical patients, it is appropriate that nurses are firmly assigned either one or the other. Ideally, consumers with AN are cared for in an exclusive setting, with nurses specialised in delivering the care needed by such consumers.

A Team Based Approach

It is important that the nursing team is harmonious and characterised by solidarity. Nursing consumers with AN was described as a demanding role, leading to feelings of exhaustion and depletion. However in the counsel of their peers, nurses in this study derived comfort and reassurance, similar to the way described by McCann & Micevski (2005) and Snell, Crowe & Jordan (2010). Without concern for feeling judged by colleagues, nurses are able to seek candid counsel with peers and receive emotional support when required. By sharing experiences and advice through honest and open dialogue in the safety of supportive peers, nurses as a team sustained and developed their emotional capacity to engage with consumers effectively. Nurses felt validated and comforted by confiding with trusted colleagues, restoring their motivation and resolve to therapeutically engage with consumers. Furthermore, a harmonious and well communicating team enhanced the capacity for nurses to deliver care in a consistent manner (Snell, Crowe & Jordan 2010; Zugai, Stein-Parbury & Roche 2015).

Education and Professional Development

As part of equipping nurses to care for consumers effectively, appropriate education, support and supervision should be provided. A professional understanding of eating disorders enhances nurse's capacity to establish interpersonal relationships consumers with AN, and support recovery through therapeutic separation (Bezance & Holliday 2013; Cockell, Zaitsoff & Geller 2004; Reid et al. 2008). Factual information and advice regarding AN encourages and eases adherence, and develops therapeutic attitudes (Beukers et al. 2015; van Ommen et al. 2009). Consumers also feel safer being cared for by knowledgeable and experienced staff, and education may assist nurses to overcome negative attitudes that may serve to hinder the process of separation (Westwood & Kendal 2012). Similar to the findings from this study, there is recognition that education for nurses caring for consumers with AN is both necessary and limited (King & Turner 2000; McCann & Micevski 2005; Ramjan 2004). For these reasons, nurses that are currently working in inpatient units with consumers with AN need education and clinical supervision. Such support should be delivered and maintained by experienced and amply qualified Clinical Nurse Educators.

Maintaining the Therapeutic Merit of the Power Differential

The therapeutic alliance in the context of this study was dependent on nurses utilising their position of power with scrupulous focus on assisting consumers towards recovery. Implications are then developed in relation to separation, the mitigation of punitive roles, and for nurses' professional satisfaction. The transient nature of hospitalisation also carries implications for the power differential, as nurses must prepare consumers to therapeutically manage autonomy.

Recommendations for Therapeutic Separation

Nurses are individually responsible for maintaining the attitudes and mindset required for interacting in a manner supportive of separation and the therapeutic alliance. A constant self-vigilance ensures that nurses provide care and exercise their power therapeutically (Snell, Crowe & Jordan 2010). In effecting separation, clinicians' use of language should reify the division of the person and the disorder into separate entities (Wright & Hacking 2012). Interactions should ultimately assure the consumer that therapeutic efforts are directed against the ED, rather than against the consumer, with whom the nurse is seeking an alliance (Bakker et al. 2011; Beukers et al. 2015; Offord, Turner & Cooper 2006). Whilst the mental partition of separation is productive, the consumer must be held accountable for their responsibility in maintaining recovery focused behaviour, rather than simply attributing pathological behaviour to an ethereal, detached pathological force that is AN (Wright & Hacking 2012).

Avoiding Punitive Role Assumptions

As part of developing a therapeutic separation, the assumption of punitive roles must be mitigated. This is particularly necessary in light of the rigid regimen that characterises the nature of AN care. By substantiating the purpose of rules, consumers were less likely to perceive a punitive intent (Offord, Turner & Cooper 2006; Zugai, Stein-Parbury & Roche 2013). By explaining and substantiating care through sound rationalisations, nurses enhanced the experienced dignity of hospitalisation, enhanced insight and decreased the consumer's degree of resistance (Bakker et al. 2011; Gustafsson, Wigerblad & Lindwall 2014; McCann & Micevski 2005; Snell, Crowe & Jordan 2010). The nurse's confidence in their role, conveyed through well substantiated explanations, also mitigated the consumer's anxiety (Snell, Crowe &

Jordan 2010). Physical interventions, such as the insertion of a naso-gastric tube (a commonly non-consensual procedure eliciting consumer resistance (Neiderman et al. 2001)), are best performed in a manner minimising perceived coercive use of nursing power (Gustafsson, Wigerblad & Lindwall 2014).

Consumers appreciate a balanced style of care in which they are supported to gain weight without a total loss of autonomy (Offord, Turner & Cooper 2006; Reid et al. 2008). As part of mitigating punitive experiences, consumers should then be offered choices in care where appropriate. By giving consumers choices in care, care programs are less restrictive in nature. Less restrictive environments are more conducive to an alliance (Donnelly et al. 2011).

In a paediatric setting, the mitigation of coercion is particularly pertinent, due to younger patients increased likelihood of experiencing coercion, compared to adult patients (Hillen et al. 2015). Despite the emphasis placed on minimising coercion, the evidence regarding the merits of involuntary treatment and the impact of perceived coercion is inconclusive, with established advantages and disadvantages (Douzenis & Michopoulos 2015; Schreyer et al. 2016).

Professional Satisfaction

Nurses are individually responsible for the safety of their professional satisfaction and the management of professional exhaustion. Nurses cannot engage with inpatient consumers with the expectation that their investment of professional efforts will necessarily mature a professionally gratifying return. AN is an illness that manifests a discordance of efforts and lack of mutuality, resulting in nurses' demoralisation and withdrawal of intimacy (King & Turner 2000). Due to the nature of AN, nurses should aim to be professionally gratified by factors not determined by the consumer's engagement in care. For example, nurses who seek to be gratified through control and accomplishment may be frustrated and instead project resentment towards consumers, the perceived cause of frustrations (Ramjan 2004).

Nurses were professionally satisfied by ensuring that consumers were progressing towards weight gain and recovery, in spite of consumer opposition or resistance. By deferring to ward protocols and objective rules for wellbeing, nurses mitigated

frustration, demoralisation, and the subsequent withdrawal of intimacy that compromised alliance potential. Nurses are responsible for ensuring that their use of power is effective and ethical, and that professional boundaries are strictly maintained for the benefit of the consumer. To establish effective boundaries, nurses need to understand their own vulnerabilities and how these effect the relationship (Briant & Freshwater 1998).

Returning Consumer Autonomy

A therapeutic alliance is developed in order to empower consumers to strive for recovery (Zugai, Stein-Parbury & Roche 2015). Although it is necessary and productive to suspend the consumer's autonomy in the initial stages of treatment (Offord, Turner & Cooper 2006; Sly et al. 2014; van Ommen et al. 2009), it is essential that consumers develop a self-sustained motivation to strive for long-term wellbeing. As such, the power differential that characterised the therapeutic alliance in this study must be recognised as a transient feature of care. With the ongoing progress of the consumer, nurses graduate from a supervisory role to that of a safety net, offering consumers support where necessary (Bakker et al. 2011).

Consumers' safe discharge is dependent on their preparedness for transition and ability to independently maintain a recovery focused autonomy (Bezance & Holliday 2013; Smith et al. 2016), and consumers recognise that their own individual motivation to recover is essential (Colton & Pistrang 2004; Dawson, Rhodes & Touyz 2014; Espindola & Blay 2009; Federici & Kaplan 2008; Tierney 2008; Westwood & Kendal 2012). Encouraging consumers to be responsible and accountable provides opportunity for the development of motivation and recovery resolve (Bakker et al. 2011), crucial for sustaining wellbeing after discharge (Offord, Turner & Cooper 2006). Giving patients responsibility and choices in care develops the alliance, in that consumers develop into engaged agents of their own wellbeing (Long et al. 2011; McCann & Micevski 2005; Offord, Turner & Cooper 2006; Reid et al. 2008; Sly et al. 2014; Tan et al. 2003). As part of a therapeutic alliance, nurses empower consumers by ensuring that adequate resources are organised and mobilised (Zugai, Stein-Parbury & Roche 2015), which may involve preparing family and loved ones to support the consumer upon discharge.

Limitations

The findings of this study must be considered in relation to inherent limitations. The sample of nurses and consumers was heterogeneous in regards to age, acuity of illness, setting and context of care, and nurses varied greatly in professional dynamics. The consumer sample consisted of both adolescents and adults. At the time of data qualitative data collection, some consumers were being cared for as inpatients while others were being cared for on an outpatient basis, in both public and private hospitals. Participating nurses represented a range of designations, experience levels and were varied in educational background. This variation in the sample diminishes the applicability of findings to a specific setting or consumer group. However, the variation within the sample developed a set of findings that are arguably more transferrable to other consumers and nurses.

A selection bias may have influenced findings. Participants who filled out surveys and engaged interviews may have been motivated to participate by either a highly positive experience of relationships, or a highly negative experience of relationships, thereby leading to an over-representation of extremes. Furthermore, the gender of the principal researcher (male) may have disinclined participation from the largely female consumer population, for whom males were possibly a source of unwelcome attention, distress or anxiety. Possibly limiting the depth of disclosures, the largely female consumer sample may have been more comfortable making disclosures with a female investigator, rather than a male. Of both the consumer and nursing sample, males were highly under-represented, which is un-extraordinary given the largely female inclination of both groups.

The quantitative investigation is limited in numerous ways. The quantitative sample size of both consumers and nurses is insufficient to make powerful inferences. With the exception of the EDE-Q, none of the instruments (I-TAS, EssenCES, CAT and ATAMHS-33) have been used exclusively for populations with AN, or within populations of nurses that care for consumers with AN. Without a point of reference, the interpretation of quantitative findings is challenging. This study has then potentially established a precedent and baseline for further studies of populations

with AN, employing respective instrumentation. Although multiple factors of context were examined, many other contextual factors would be worthy of investigation.

Reflexivity

It is important to consider the degree to which reflexivity influenced the interpretation of data and findings (Creswell 2009). The principal researcher, being a nurse himself, may have biased the interpretation of data in a number of ways. For example, the interpretation of data may have unduly idealised nurses, or not have fully acknowledged nursing limitations. Furthermore, the principal researcher, having previously conducted research that found that the therapeutic alliance was important, may have been inclined to validate the previous study. To mitigate the implications of reflexivity, the principal researcher adhered to sound methodological procedures, and worked closely with experienced academics, ensuring the fidelity of procedures and the interpretation of data.

Future Directions for Research

In contemporary practice, concerns over professional boundaries may lead nurses to an emotionally conservative, detached or aloof approach (Stein-Parbury 2014; Wright 2015). Although promising, the concept of maternalism in nursing presents complexity for the maintenance of professional boundaries. A nursing approach with an ostensibly parental style of interaction is ethically questionable. The assumption of a 'motherly' style of nursing suggests an over-reach of the nursing role, pushing the limits of professionalism. Such an approach may seem to be outside the purview of a professional healthcare provider. A maternalistic role assumption suggests that nurses may be susceptible to emotional 'over-involvement' or potentially lead to a misappropriation or abuse of power.

The concept of maternalism in eating disorders care requires further investigation for its application in practice. For the adoption of a maternalistic nursing style, clear guidance must be provided to ensure that nurses can confidently and safely approach nursing with the heightened degree of intimacy necessary for developing a therapeutic alliance with consumers. Whether a maternalistic style of nursing is applicable or appropriate for male nurses is unclear. For example, therapeutic touch delivered by

female nurses in a maternalistic manner is obviously more ethically defensible than that which could be delivered by a male nurse.

In addition to developing an enhanced understanding of the therapeutic alliance, this study has revealed avenues of further research. A rigorous investigation of the association between the therapeutic alliance between nurses and consumers in the inpatient setting and consumer outcomes would be informative. Outcomes of interest would pertain to weight gain, retention in care and psychopathology. There are multiple studies that investigate the association between therapeutic alliance in the treatment of AN and outcomes in a range of different contexts, such as in Family Based Therapy, Cognitive Behavioural Therapy, inpatient care, as well as other therapies. These studies employ highly varying methods and produce highly varying results, which challenges the generalisability of these studies. Because the implications of the therapeutic alliance vary considerably dependent on therapy type, it is necessary to understand how the alliance effects outcomes in the relationships specific to those between consumers and nurses in the inpatient setting. It would then be useful to establish the strength of the alliance with a range of instruments, at different stages of therapy and recovery, in relation to outcomes.

By measuring the alliance at a range of times in hospitalisation, it will be possible to develop an understanding of the most effective developmental pathway of the alliance. For example, Brown, Mountford & Waller (2013) suggest that the alliance developed later in therapy was more associated with positive outcomes compared to the early perception of the alliance. Although the strength of the alliance measured in this study was relatively low, this may be appropriate and therapeutic in a context where consumers are inherently opposed to treatment. It may be that the sense of alliance with nurses at the end of hospitalisation is a greater determinant of outcomes.

This study examined the therapeutic alliance in relation to a limited range of contextual factors. Other unexplored contextual factors may be examined to better understand the context in which the inpatient alliance is developed. It would be useful to explore contextual factors such as treatment fidelity, overall physical privacy, and the perceived quality of meals. It would also be useful to measure these contextual

factors on an ongoing basis over the course of care, rather than a single measurement as performed in the current study. Furthermore, investigating the implications of consumer's voluntary status in relation to the alliance would be informative. Determining the relationship between the age of consumers, the alliance and outcomes is another avenue for investigation. In a review of consumer outcome studies, alliance ratings were not related to outcomes in adults, however investigations of adolescents with AN indicate positive alliance-outcome associations, particularly in the context of Family Based Therapy (Brauhardt, de Zwaan & Hilbert 2014).

It may be useful to explore the implications of AN subtypes (restricting and binge/purge) on the alliance. In this study, no preference to restricting type and binge/purge type was indicated, despite previous findings (Woodrow, Fox & Hare 2012) where restrictive types were considered more likeable, and binge/purge types were more challenging. This thesis has very firmly advocated a nursing approach that separates the consumer as an individual and AN as an illness. It is worth considering other theoretical orientations that may or may not depend on the hypothesis of therapeutic separation. There may yet be more useful ways of conceptualising the disorder.

Conclusion

Recovery from AN is a personal journey in which consumers increasingly recognise and develop distance from the disorder (Lamoureux & Bottorff 2005). It is a process that requires a desire for a renewed sense of control (Dawson, Rhodes & Touyz 2014). Consumer perspectives indicate that recovery involves a re-orientation of life, values and meaning: the development of a new identity without AN, from which gratification and satisfaction is derived. Recovery is a process of developing self-knowledge and new paradigms. Recovery may involve purposeful engagement with occupational, social, political, community or spiritual facets (Espindola & Blay 2009; Matussek & Knudson 2009). That is, complete recovery from AN and self-reclamation is the ongoing personal responsibility of the consumer (Federici & Kaplan 2008; Lamoureux & Bottorff 2005). Nurses are in a position to establish a foundation for this long recovery passage through the development of a therapeutic alliance.

Over the course of a century, therapeutic alliance as a concept has developed considerably; from Freud's development of the transference concept, therapeutic alliance is now conceptually advanced and integrated into theory and practice. As a way of delivering ethical and evidenced based care, nursing has adopted the therapeutic alliance concept from the dyadic disciplines. Nurses are then responsible for the effective integration of the concept into various specialties and settings. By sourcing consumer and nursing perspectives, this study has developed an understanding of the therapeutic alliance that is developed in the inpatient setting for the treatment of AN.

Therapeutic alliance in the context of inpatient AN care is particularly unique due to the necessary difference in power between nurses and consumers. Without negotiation as a viable means of developing mutuality, nurses must develop mutuality through separation. This understanding of the alliance is applicable in nursing contexts where consumer autonomy is temporarily suspended for their long term benefit, such as in involuntary care. Of all the health disciplines working in the inpatient setting, no other health professionals occupy the ongoing familiarity and closeness that nurses occupy with consumers. For the benefit of consumers, this intimacy must be recognised for its therapeutic potential and respectively exploited. The integration of the therapeutic alliance concept in practice is dependent on structured supervision and support for nurses.

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*: The attached appendix is a generic version. Site specific versions vary according to the requirements of each individual site.

Journal Article

Appendix A

The following article was written during the course of PhD candidature, authored by Joel Zugai, Jane Stein-Parbury and Michael Roche, published 2015 in the journal *Issues in Mental Health Nursing*, Volume 36, Issue 4:

Therapeutic Alliance in Mental Health Nursing: an Evolutionary Concept Analysis

Nursing Survey Package

Dear Participating Nurse,

Thank you for taking the time to contribute to this research project. Your responses will be used to better understand the nature of relationships between nurses and patients with anorexia nervosa, and the inpatient setting. All contributions you make are confidential, and you will not be personally identifiable from the information you provide.

This survey package consists of two surveys. The first survey is the 'Essen Climate Evaluation Schema' or the 'EssenCES'. This instrument measures the overall quality of the inpatient environment. The second instrument is the 'Attitudes Towards Acute Mental Health Scale' or the 'ATAMHS-33. This instrument measures the nature of attitudes nurses have towards patients being treated in the acute mental health setting. Please take your time and answer the survey questions as truthfully as possible.

At the end of the surveys, you are given the opportunity to express interest in further participation in an interview at a later date, or you may decline to do so.

Upon completion of the survey, please return the survey package to Joel Zugai, the principal researcher. Joel Zugai will be available to answer any questions and will address any concerns you may have.

We sincerely appreciate your contributions to this project, and apologise for any inconvenience arising from participation in these surveys.

-Joel Zugai, RN.
Principal Researcher
University of Technology Sydney

Essen Climate Evaluation Schema

We want to understand more about the ward you are in. Please indicate how much you agree with the below statements.

		Not at all	Little	Somewhat	Quite a lot	Very much
1	This ward has a homely atmosphere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	The patients care for each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Really threatening situations can occur here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	On this ward, patients can openly talk to nursing staff about all their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Even the weakest patient finds support from his/her fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	There are some really aggressive patients on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Nursing staff take a personal interest in the progress of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Patients care about their fellow patients' problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Some patients are afraid of other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Nursing staff members take a lot of time to deal with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	When a patient has a genuine concern, he/she finds support from his/her fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	At times, members of the nursing staff are afraid of some of the patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Often, nursing staff seem not to care if patients succeed or fail in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	There is good peer support among patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Some patients are so excitable that one deals very cautiously with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Nursing staff know patients and their personal histories very well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Both patients and nursing staff are comfortable on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attitudes Towards Acute Mental Health (33)

The aim of this measure is to develop an understanding of the attitudes and knowledge of staff towards patients with mental health problems.

This should take approximately 15-20 minutes.

The questionnaire has been through a period of validation to ensure it is a reliable and valid method of developing an understanding of attitudes.

For questions 1-25 please tick the appropriate box to your point of view.

For questions 26-33 please mark on the line between the two words where, in your opinion, the average patient you care for lies.

The data will be combined for analysis and no attempt will be made to identify you personally. No personal information enabling you to be identified will be passed to your managers or your peers.

Confidential: All information collected in this questionnaire remains confidential.

Question	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
1. Alcohol abusers have no self control							
2. Patients with chronic schizophrenia are incapable of looking after themselves							
3. Members of society are at risk from the mentally ill							
4. Mentally ill patients have no control over their emotions							
5. Staff should not talk to patients about their delusions							
6. Deliberate self harm more often happens when other people are around							
7. Depression occurs in people with a weak personality							
8. The cause of many psychological problems is bad nerves							
9. Patients with mental illnesses are more likely to harm someone else than themselves							
10. Acute wards are little more than prisons							
11. Mental illness is the result of adverse social circumstances							
12. Many normal people would become mentally ill if they had to live in a very stressful situation							
13. Those with a psychiatric history should never be given a job with responsibility							

Confidential: All information collected in this questionnaire remains confidential.

Question	Strongly agree	Agree	Slightly agree	Neutral	Slightly disagree	Disagree	Strongly disagree
14. Those who attempt suicide leaving them with serious liver damage should not be given treatment							
15. Violence mostly results from mental illness							
16. Psychiatric patients are generally difficult to like							
17. Patients who abuse substances should not be admitted to acute wards							
18. Psychiatric treatments cause patients to worry too much about their symptoms							
19. It is difficult to negotiate care plans with patients in acute environments							
20. It is hard to help patients who are emotionally disturbed							
21. Psychiatric drugs are used to control disruptive behavior							
22. Mental illnesses are genetic in origin							
23. Psychiatric illness deserves as much attention as physical illness							
24. The manner in which you talk to patients affects their mental state							
25. People are born vulnerable to mental illness							

Confidential: All information collected in this questionnaire remains confidential.

For questions 26-33 please mark on the line between the two words where, in your opinion, the average patient you care for lies, for example.

26. Safe	_____	Dangerous
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This indicates that you feel patients are slightly more dangerous than safe.

26. Safe	_____	Dangerous
27. Adult	_____	Child
28. Mature	_____	Immature
29. Optimistic	_____	Pessimistic
30. Cold-hearted	_____	Caring
31. Polite	_____	Rude
32. Harmful	_____	Beneficial
33. Clean	_____	Dirty

Thank-you for your help in completing this questionnaire.

Further Participation

Thank you for completing the surveys! Your contributions to this project are highly appreciated. All responses are kept confidential.

If you would be interested in furthering your participation in this project by participating in an interview, please leave your name and contact details (such as your mobile phone number or email address) in the space below. If you do not wish to participate in an interview, leave the page blank. **This page will be separated from the survey package to maintain your anonymity.**

Name: _____

Contact Details: _____

Again, thank you very much. Your contributions are highly valued. Have a lovely day.

Very sincerely,

-Joel Zugai, RN.

Principal Researcher



Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

Mr J Zugai, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email: [REDACTED]

Prof J Stein-Parbury, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email: jane.stein-parbury@uts.edu.au

Dr M Roche, Faculty of Health, University of Technology Sydney. Ph: 9514 4811, email: michael.roche@uts.edu.au

Dear Nurse,

We would like you to consider participating in a research study that will be conducted in your hospital. We are conducting a research study which looks at the relationships between nurses and patients with anorexia nervosa, and the inpatient environment. Joel Zugai is a PhD candidate at the University of Technology Sydney, and is supervised by Professor Jane Stein-Parbury and Dr. Michael Roche.

The relationships between nurses and patients are known to be influential over health outcomes. Because of this understanding, we are very interested in the relationships you have with patients who are being treated for anorexia nervosa. We are also very interested in the way that the inpatient environment influences these relationships. It is our intention to establish evidence based recommendations at the completion of this project.

Participating in this project will involve filling out a few short surveys, not requiring more than ten minutes of your time. You will also be offered the opportunity to participate in an interview, as a follow-up on the survey results. The interview will be conducted at a later date at a time of your convenience.

Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time this will not otherwise affect your employment or current and future relationship with XXXXX. All contributions you make are confidential, and you will not be identifiable from the data you provide. This letter is for you to keep.

If you have any concerns about the conduct of this study please do not hesitate to discuss them with Joel Zugai or with the Research Ethics Manager (XXXX XXXX) or Secretary of the Ethics Committee that has approved this project. The reference number for this project is HREC/13/SCHN/399.

Your contribution to this research is very much appreciated.

Kindest regards,
Joel Zugai



Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

Mr J Zugai, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email: [REDACTED]

Prof J Stein-Parbury, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email: jane.stein-parbury@uts.edu.au

Dr M Roche, Faculty of Health, University of Technology Sydney. Ph: 9514 4811, email: michael.roche@uts.edu.au

Dear Adolescent,

We would like you to consider participating in a research study that will be conducted in your hospital. We are conducting a research study which looks at the relationships between nurses and patients with anorexia nervosa, and the inpatient environment. Joel Zugai is a PhD candidate at the University of Technology Sydney, and is supervised by Professor Jane Stein-Parbury and Dr. Michael Roche.

The relationships between nurses and patients are known to be influential over health outcomes. Because of this understanding, we are very interested in the relationships you have with nurses who are taking care of you whilst you're in hospital. We are also very interested in the way that the ward environment influences these relationships. It is our intention to establish evidence based recommendations at the completion of this project.

Participating in this project will involve filling out a few short surveys, not requiring more than 10 or 15 minutes of your time. You will also be offered the opportunity to participate in an interview, as a follow-up on the survey results. The interview will be conducted at a later date at a time of your convenience.

Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time this will not otherwise affect your care at the Hospital. All contributions you make are confidential, and you will not be identifiable from the data you provide. This letter is for you to keep.

If you have any concerns about the conduct of this study please do not hesitate to discuss them with Joel Zugai or with the Research Ethics Manager (XXXX XXXX) or Secretary of the Ethics Committee that has approved this project. The reference number for this project is HREC/13/SCHN/399.

Your contribution to this research is very much appreciated.

Kindest regards,
Joel Zugai



Adolescent Survey Package

Dear Participant,

Thank you for taking the time to contribute to this research project. Your responses will be used to better understand the nature of relationships between nurses and patients, and the inpatient setting. All contributions you make are confidential, and you will not be personally identifiable from the information you provide.

This survey package consists of four surveys. The first survey is the 'I-TAS' or the 'Inpatient Treatment Alliance Scale'. This instrument measures the quality of relationships you have with nurses. The second instrument is the 'Essen Climate Evaluation Schema' or the 'EssenCES'. This instrument measures the overall quality of the inpatient environment. The third instrument is the 'CAT' or the 'Client Assessment of Treatment scale'. This instrument measures how satisfied you are with care. The fourth instrument is the 'EDE Q' or the 'Eating Disorder Examination Questionnaire'. This instrument measures the severity of your eating disorder over the last 28 days. Please take your time and answer the survey questions as truthfully as possible.

At the end of the surveys, you are given the opportunity to express interest in further participation in an interview at a later date, or you may decline to do so.

Upon completion of the survey, please return the survey package to Joel Zugai, the principal researcher. Joel Zugai will be available to answer any questions and will address any concerns you may have.

We sincerely appreciate your contributions to this project, and apologise for any inconvenience arising from participation in these surveys.

-Joel Zugai, RN.
Principal Researcher
University of Technology Sydney

The Inpatient-Treatment Alliance Scale

We are interested in hearing about how you feel your hospital treatment is going so far. We are particularly interested in knowing how well you feel you are working with your nursing team. What we mean by nursing team is all the nurses who work regularly with you during your stay here.

Please read the statements below and circle the number that best fits how you feel about your nursing team right now.

	False						Completely True
1. <u>I feel I'm working well with my nursing team</u>	0	1	2	3	4	5	6
2. <u>I feel that my nursing team has a good understanding of my problems.</u>	0	1	2	3	4	5	6
3. <u>I feel that my nursing team listens to my concerns.</u>	0	1	2	3	4	5	6
4. <u>I feel that someone from my nursing team will be available if I need them.</u>	0	1	2	3	4	5	6
5. <u>I feel that my nursing team wants me to participate fully in my treatment.</u>	0	1	2	3	4	5	6
6. <u>I feel that my nursing team wants to help me.</u>	0	1	2	3	4	5	6
7. <u>I feel like an active member of my nursing team.</u>	0	1	2	3	4	5	6
8. <u>I feel respected by my nursing team.</u>	0	1	2	3	4	5	6
9. <u>My nursing team and I agree about what needs to change so I can leave the hospital.</u>	0	1	2	3	4	5	6
10. <u>I feel that my hospital treatment will be successful.</u>	0	1	2	3	4	5	6

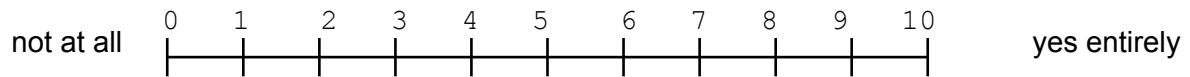
Essen Climate Evaluation Schema

We want to understand more about the ward you are in. Please indicate how much you agree with the below statements.

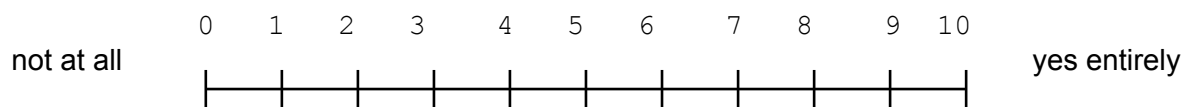
		Not at all	Little	Somewhat	Quite a lot	Very much
1	This ward has a homely atmosphere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	The patients care for each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Really threatening situations can occur here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	On this ward, patients can openly talk to nursing staff about all their problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Even the weakest patient finds support from his/her fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	There are some really aggressive patients on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Nursing staff take a personal interest in the progress of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Patients care about their fellow patients' problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Some patients are afraid of other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Nursing staff members take a lot of time to deal with patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	When a patient has a genuine concern, he/she finds support from his/her fellow patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	At times, members of the nursing staff are afraid of some of the patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Often, nursing staff seem not to care if patients succeed or fail in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	There is good peer support among patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Some patients are so excitable that one deals very cautiously with them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Nursing staff know patients and their personal histories very well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Both patients and nursing staff are comfortable on this ward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clients' Scale for Assessment of Treatment (CAT)

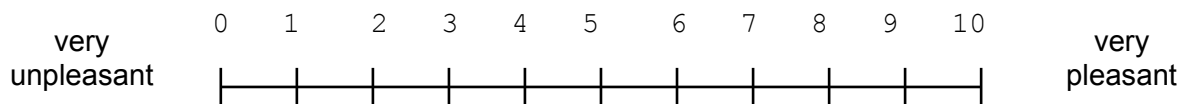
1. Do you believe you are receiving the right treatment/care for you here?



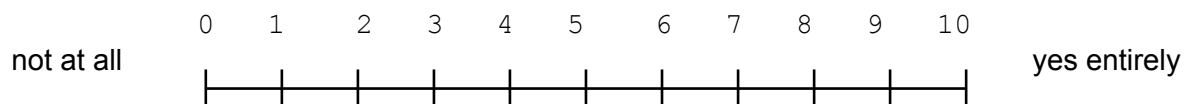
2. Does your psychiatrist understand you and is he/she engaged in your treatment/care?



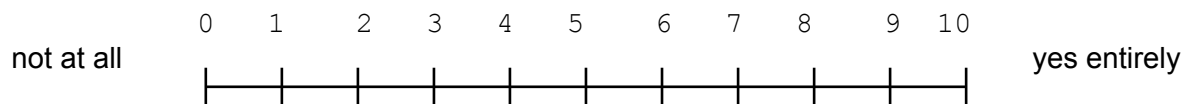
3. Are relations with other staff members here pleasant or unpleasant for you?



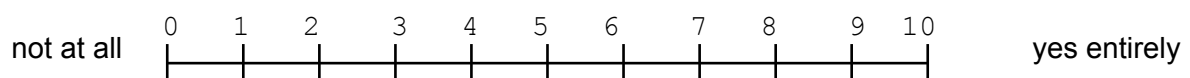
4. Do you believe the other elements of treatment/ care here are right for you?



5. Do you feel respected and regarded well here?



6. Has treatment/care here been helpful for you?



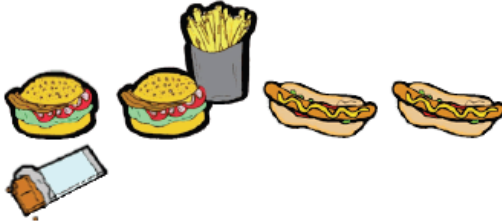
Eating Disorder Examination Questionnaire

PART I: PLEASE READ THIS BEFORE ANSWERING THE QUESTIONS

Some of these questions will ask about any binges that you might have had during the past four weeks (28 days). A binge has two parts: 1) eating a really big amount of food given the situation and 2) feeling out of control.

What is a “really big amount of food?”

A really big amount of food is much more than most people would eat in the same situation. Some examples might be: 1) eating two full meals (such as two plates of salad/first course, two main dishes, two desserts, etc.); 2) eating three main courses (such as 3 plates of pasta); or 3) eating a really big amount of one food (such as 4 brownies) or a few different kinds of foods (such as a big bowl of ice cream, 8 cookies, a donut, and a handful of candy). Below are some pictures of a really big amount of food to help you.



REALLY BIG



NOT REALLY BIG

1. What is “feeling out of control?”

Feeling out of control while eating might mean different things for different people. It may mean that you're: 1) feeling DRIVEN to eat; 2) feeling like you JUST can not stop eating; 3) feeling like you're not able to stop yourself from starting to eat in the first place; or 4) feeling like you shouldn't even try to control your eating because you know that, no matter what, you're going to eat too much. Some kids describe feeling out of control like a ball rolling down a hill, that it just keeps going and going.

Examples of a binge:

1. **REALLY BIG AND OUT OF CONTROL.** After school one evening, Jenny ate 2 pieces of chicken, a large package of frozen vegetables, 3 cups of rice, 1/2 of a coffee cake and a piece of fruit. This is a really big amount of food. While she ate, Jenny felt like she JUST could not stop eating, ate more quickly than usual, and ate until she felt really, really full. Afterwards Jenny was very upset about how much she'd eaten, and said she felt sad, guilty, and mad at herself.

Examples that are not binges either because they are too small or the person does not feel out of control while eating:

1. **REALLY BIG BUT NOT OUT OF CONTROL.** A few times a week, Katie ate lunch at McDonald's with 2 friends. Her usual order was a Big Mac, a fish fillet sandwich, 2 large orders of fries, and a large chocolate shake. This is a really big amount of food. Although she ate more than her friends did and knew she was eating a lot of high-fat food, she didn't feel like she JUST could not stop eating, and she did not feel upset afterwards about how much she'd eaten.

2. **OUT OF CONTROL BUT NOT REALLY BIG.** For lunch one day, Joey had a ham and cheese sandwich with mayonnaise on a roll, a small bag of potato chips, a candy bar, and a Diet Coke. Joey felt out of control because he'd planned to have turkey on whole wheat with lettuce and tomato plus a piece of fruit for dessert, but couldn't stop himself from changing his order. Although this was a big meal, it was not really big, so we wouldn't consider it a binge.

3. **OUT OF CONTROL BUT NOT REALLY BIG.** Lizzie ate 2 donuts someone brought to homeroom one morning. She had started a diet that day and planned to skip breakfast. At first, Lizzie said no to the donuts, but after everyone else had gone to their other classes she snuck back into homeroom and very quickly ate the donuts so no one would see her eating. She felt very guilty and embarrassed after and hated feeling so out of control of her eating, promising to start dieting again the next day. Although Lizzie felt bad about eating the donuts, this was not a really big amount of food, so it would not be considered a binge.

Part II Instructions: These questions are about the **PAST FOUR WEEKS ONLY (28 days)**. In order to help you remember your eating patterns over the past 28 days, try to think of any events that might have changed the way you normally eat, such as holidays, parties, vacations, or stressful events (such as a school project being due, or getting in a fight with your parents). Please read each question carefully. Please answer all of the questions. Thank you very much!

Questions 1 to 16: Please circle the number that is most like your behavior. Remember that the questions are only about the past four weeks (28 days).

ON HOW MANY OF THE PAST 28 DAYS:

1. On how many of the past 28 days have you on purpose been trying to cut down on what you eat to change your shape or weight? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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2. On how many of the past 28 days have you gone for most of the day (8 hours or more) without eating anything in order to change your shape or weight? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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3. On how many of the past 28 days have you tried not to eat any foods that you like in order to change your shape or weight? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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4. On how many of the past 28 days have you tried to stick to strict rules about your eating in order to change your shape or weight; for example, only letting yourself eat a certain type or amount of food, or certain number of calories? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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5. On how many of the past 28 days has thinking about food or calories made it hard for you to pay attention to things you are interested in (for example, watching TV, reading, or playing on the computer)? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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6. On how many of the past 28 days have you been afraid of losing control over eating (afraid that you won't be able to stop eating)? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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7. On how many of the past 28 days have you felt like you did lose control over your eating? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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8. On how many of the past 28 days have you binged (eaten a really big amount of food and felt that you had lost control over your eating)? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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9. Over the past 28 days, how many days have you eaten in secret? Do not count binges. (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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10. On how many of the past 28 days have you wanted a completely flat stomach (as flat as a board)? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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11. On how many of the past 28 days have you wanted your stomach to be empty – to not have any food in it at all? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
------------------	------------------------------	-------------------------------------	----------------------------	--------------------------------------	-------------------------------	-----------

12. On how many of the past 28 days has thinking about your shape or weight made it hard for you to pay attention to things you are interested in (for example, watching TV, reading, or playing on the computer)? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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13. On how many of the past 28 days have you been scared that you might gain weight? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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14. On how many of the past 28 days have you felt fat? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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15. On how many of the past 28 days have you had a very strong wish to lose weight? (circle one)

None of the days	A few of the days (1-5 days)	Less than half the days (6-12 days)	Half the days (13-15 days)	More than half the days (16-22 days)	Most of the days (23-27 days)	Every day
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16. Over the past 28 days, on how many of the times that you have eaten have you felt guilty (that you've done something wrong) because of how it might change your shape or weight? Do not count binges (circle one)

None of the times	A few of the times	Less than half the times	Half the times	More than half the times	Most of the time	Every time
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Questions 17-29: Please look at the first page for help answering these questions. Please circle the number that is most like your behavior. Remember that the questions only refer to the past four weeks (28 days).

OVER THE PAST 28 DAYS:

17. Over the past 28 days have there been times when you have eaten a really big amount of food, compared to what other kids your age would eat in the same situation? (Please circle)

No Yes

18. How many times has this happened over the past 28 days? _____

19. On how many of these times did feel like you had lost control while eating? _____

20. Over the past 28 days have you had times where you felt that you had lost control over your eating, but have not eaten a really big amount of food? (Please circle)

No Yes

21. How many times has this happened over the past 28 days? _____

22. Over the past 28 days have you made yourself throw up? (Please circle)

No Yes

23. How many times has this happened over the past 28 days? _____

24. Over the past 28 days have you taken any medicines that make you go to the bathroom (have a bowel movement)? (Please circle)

No Yes

25. How many times has this happened over the past 28 days? _____

26. Over the past 28 days have you taken water pills (pills that make you urinate or pee)? (Please circle)

No Yes

27. How many times has this happened over the past 28 days? _____

28. Over the past 28 days have you exercised very hard in order to change your shape or weight (and not just for fun)? (Please circle)

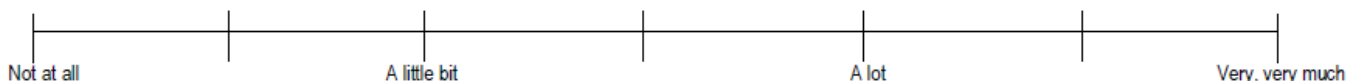
No Yes

29. How many times has this happened over the past 28 days? _____

Questions 30 to 38: Please mark the spot on the line that best describes how you feel. Remember that the questions only refer to the past four weeks (28 days). For these questions, when we say "weight," we mean the number on the scale, and when we say "shape," we mean what you see in the mirror.

OVER THE PAST 28 DAYS:

30. Over the past 28 days, has your weight (the number on the scale) made a difference in how you think about (judge) yourself as a person? (mark off on the line)



Further Participation

Thank you for completing the surveys! Your contributions to this project are highly appreciated. All responses are kept confidential.

If you would be interested in furthering your participation in this project by participating in an interview, please leave your name in the space below. If you do not wish to participate in an interview, leave the page blank. **This page will be separated from the survey package to maintain your anonymity.**

Name: _____

Again, thank you very much. Your contributions are highly valued. Have a lovely day.

Very sincerely,

-Joel Zugai, RN.

Principal Researcher

Interview Schedule- Consumer Version

Appendix F

I am interested in how nurses care for people with anorexia nervosa in hospital. In particular, I want to know more about the relationships you had with nurses and how your experience on the ward influenced these relationships.

I am going to start by asking you a few questions about you.

How old are you?

What age were you when you started having eating problems?

What age were you when you were first treated for eating problems?

I've read a lot about the importance of good quality relationships between patients and nurses. Tell me about the treatment for anorexia nervosa. What role did nurses play in your treatment and wellbeing?

How did you find the relationships you developed with nurses while in hospital?

What did they do and say or do that helped you?

What, if anything, did they say or do that did not help you?

I'm very interested in the experience you had whilst in hospital. I want to ask you some questions about your experience on the ward and the relationships you had with nurses.

Hospitals are often busy and chaotic places. How did this affect the relationships you had with nurses?

A ward is a public and open space, where privacy is not easily offered to patients. How did this affect the relationships you had with nurses?

Sometimes in hospital you may have felt very upset or emotional. How did this affect the relationships you had with nurses?

How do the ward rules affect relationships you had with nurses? How strict were the nurses in enforcing the rules? How did the rules affect your relationships with the nurses, for example, did the rules make it hard for you to get along with the nurses?

To what extent were the nurses available to help you when you needed it? How did the number of nurses who were available affect the relationships you had with them? Did it

seem like there were enough nurses to take care of you, or did it seem that there were too many?

Nurses have a lot of responsibilities and duties on the ward. Nurses give medications, write notes and talk with other healthcare providers and families. How do all these varying responsibilities affect the relationships you had with nurses? Did it seem like the nurses had enough time to take care of you?

In the hospital setting, you spend time with other people who are being treated for AN. How did spending time with other patients affect the relationships you had with nurses?

Sometimes different groups of nurses caring for you provide care differently. How did having different nurses caring for you affect the relationships you had with nurses?

Patients in this ward often have little choice over the nurses who are caring for them. How did this affect the relationships you had with nurses?

The amount of time that a patient spends in hospital is different for everyone. How did the amount of time you spent in hospital affect your relationships with nurses?

Do you think having an eating disorder affected the relationships you had with nurses?

Is there anything else at all you wish to add? Were there any important experiences you had that affected relationships between nurses and patients which we haven't already discussed?

Interview Schedule- Nursing Version

Appendix G

I am interested in how nurses care for people with anorexia nervosa in the inpatient setting. In particular, I want to know about the relationships you had with patients and how the context of the ward influenced these relationships.

I am going to start by asking you a few questions about you.

How many years of nursing experience do you have?

How long have you been nursing people with eating disorders, in particular, anorexia nervosa?

What is your nursing designation? RN, EN, or other?

Do you have a particular position, such as CNE, CNS, CNC?

What is your highest academic qualification?

What specialist training have you undertaken in relation to caring for people with AN? What was the nature of that training?

I've read a lot about the importance of quality relationships between patients and nurses. How do you find the relationships you form with patients to affect their wellbeing?

Tell me about the treatment for anorexia nervosa. What role do nurses play in treatment and wellbeing? What do they do and say that helps patients?

What else, if anything, do nurses do to help patients recover from anorexia nervosa?

I'm very interested in ward context. I want to ask you some questions about the way that ward culture influences the relationships you have with patients.

The inpatient setting is often a busy and chaotic place. How does this affect the relationships you have with patients?

A ward is a public and open space, where privacy is not easily offered to patients. How does this affect the relationships you have with patients?

Interactions in the acute mental health setting are sometimes highly intense or unpredictable. How does this affect the relationships you have with patients?

How do the ward protocols and rules affect relationships you have with patients?

How do staffing levels affect the relationships you have with patients?

As a nurse, you have a wealth of responsibilities. You give medications, write notes and deal with other healthcare providers and families. How do all these varying responsibilities affect the relationships you have with patients?

Nurses care for multiple patients at any one time. How does this affect the relationships you have with patients?

How does the group of nurses you work with during a shift affect the relationships you have with patients?

Patients in this ward often have little choice over who their nurses are. How does this affect the relationships you have with patients?

The amount of time that a patient spends in hospital varies considerably. How does the length of time a patient spends in the ward affect the relationship you have with that patient?

How do you think anorexia nervosa, as an illness, affects the relationships you have with patients being treated for anorexia nervosa?

Is there anything else at all you wish to add? Are there any important elements of ward culture that affects relationships between nurses and patients which we haven't spoken about?

I-TAS

Author	Setting	Sample (n)	Mean/Sum
(Blais 2004).	Locked medical psychiatric unit.	140	4.55 (0-6) (Mean) (SD:1.35)
(Kerfoot, Bamford & Jones 2012).	3 acute inpatient psychiatric wards.	Measurement occurred Monthly over 19 Months. (262 completed I-TAS measures.)	Scores of all 3 wards averaged, reported as a sum. Highest mean sum reported: 54 . Lowest mean sum reported: 34 .
(Rise et al. 2012).	Outpatient therapy, mental health hospital.	Total Sample: 75 Intervention Group: 37 Control Group: 38	Intention to treat analyses- INT: 4.63 (SD: 1.1) CTRL: 4.55 (SD: 1.1) Per protocol analyses- INT: 5.01 (SD: 0.8) CTRL: 4.69 (SD: 0.8) (Means)

EssenCES—Consumer Sample

Author	Setting	Sample (n)	Mean/Sum
(Kerfoot, Bamford & Jones 2012).	3 acute inpatient psychiatric wards.	Measurement occurred at 2 different times. (Initial sample n=34) (Subsequent sample n=91)	Initial Results Therapeutic Hold: 13 Experienced Safety: 11 Patient Cohesion: 10.5 Subsequent Results Therapeutic Hold: 14 Experienced Safety: 12 Patient Cohesion: 11.5 (Rounded to nearest .5)
(Howells et al. 2009)	3 high secure hospital services, 15 wards.	n=80	Therapeutic Hold: 9.81 (SD: 3.97) Experienced Safety: 8.89 (SD: 4.20) Patient Cohesion: 9.32 (SD: 4.84)
(Schalast et al. 2008)	17 Hospitals, 46 wards. Forensic psychiatric wards.	n=327	Therapeutic Hold: 12.10 (SD: 2.90) Experienced Safety: 13.10 (SD: 2.40) Patient Cohesion: 10.40 (SD: 2.60)
(Milsom et al. 2014)	Medium-security mental health service. 12 wards.	n= 89	Therapeutic Hold: 11.96 (SD: 4.60) Experienced Safety: 11.69 (SD: 4.16) Patient Cohesion: 9.90 (SD: 5.05)
(Quinn, Thomas & Chester 2012)	Secure services for people with intellectual disabilities. Five Low-security wards, two medium-security wards.	n=29 (Low-Secure) n=22 (Medium-Secure)	Low-Security Therapeutic Hold: 14.87 (SD: 0.67) Experienced Safety: 11.08 (SD: 1.08) Patient Cohesion: 9.96 (SD: 1.11) Medium Security Therapeutic Hold: 11.31 (SD: 1.40) Experienced Safety: 7.48 (SD: 1.06) Patient Cohesion: 10.05 (SD: 1.30)

EssenCES- Staff Sample

Author	Setting	Sample (n)	Mean/Sum
(Howells et al. 2009)	3 high secure hospital services, 15 wards.	n=244 Primarily nursing and psychology staff, but multi-disciplinary input.	Therapeutic Hold: 14.17 (SD: 3.29) Experienced Safety: 8.53 (SD: 3.10) Patient Cohesion: 8.05 (SD: 3.85)
(Schalast et al. 2008)	17 Hospitals, 46 wards. Forensic psychiatric wards.	n=333	Therapeutic Hold: 15.30 (SD: 1.50) Experienced Safety: 11.20 (SD: 2.50) Patient Cohesion: 9.80 (SD: 1.90)
(Milsom et al. 2014)	Medium-security mental health service. 12 wards.	n=112	Therapeutic Hold: 14.85 (SD: 3.23) Experienced Safety: 9.95 (SD: 3.92) Patient Cohesion: 9.72 (SD: 3.48)

CAT

Author	Setting	Sample (n)	Mean/Sum
(Priebe et al. 2006)	Voluntary patients within the inpatient and day-hospital setting.	N=206	<p><i>At discharge</i> Day Hospital Group (n=70) Mean: 8.10 (SD: 1.99)</p> <p>In-patient group (n=34) Mean: 6.77 (SD: 2.26)</p> <p><i>3 Months post D/C</i> Day Hospital Group (n=79) Mean: 7.31 (SD: 1.93)</p> <p>In-patient group (n=41) Mean: 6.15 (SD: 2.48)</p>
(Priebe et al. 2009)	Involuntary consumers, 22 hospitals.	n=675, Baseline n=347, 12months	<p>Baseline Mean: 5.52 (SD 2.90)</p> <p>12 Months Follow-up Mean: 5.43 (SD 2.95)</p>
(Priebe et al. 2011)	Consumers admitted for acute care in both day hospitals and conventional inpatient wards across five European countries.	n=765	CAT score on day 3 of admission Mean: 7.6 (SD: 1.9)

ATAMHS-33

Author	Setting	Sample (n)	Mean/Sum
(Baker, Richards & Campbell 2005)	Seven acute mental healthcare units.	<p>Qualified nurses (n=92) and unqualified nurses (n=48) working within acute mental health units.</p> <p>n=140</p>	<p><i>Care or Control</i> Observed Min.: 12 Observed Max.: 70 Mean: 36.2 (SD: 10.0)</p> <p><i>Semantic Differentials</i> Observed Min.: 0 Observed Max.: 60 Mean: 36.6 (SD: 9.0)</p> <p><i>Therapeutic Perspective</i> Observed Min.: 6 Observed Max.: 37 Mean: 15.4 (SD: 5.2)</p> <p><i>Hard to Help</i> Observed Min.: 4 Observed Max.: 25 Mean: 16.6 (SD: 4.2)</p> <p><i>Positive Attitudes</i> Observed Min.: 11.8 Observed Max.: 31 Mean: 25.5 (SD: 3.6)</p> <p><i>ATAMHS-33</i> Observed Min.: 105.3 Observed Max.: 200 Mean: 163.5 (SD: 15.8)</p>

(Foster et al. 2008)	Inpatient mental healthcare.	n=71 Registered nurses and medical orderlies. 23 nurses 48 orderlies	<p><i>Care or Control</i> Observed Min.: 32 Observed Max.: 66 Mean: 47.8 (SD: 7.64)</p> <p><i>Semantic Differentials</i> Observed Min.: 13 Observed Max.: 61 Mean: 32.7 (SD: 9.8)</p> <p><i>Therapeutic Perspective</i> Observed Min.: 9 Observed Max.: 39 Mean: 28.3 (SD: 6.3)</p> <p><i>Hard to Help</i> Observed Min.: 5 Observed Max.: 23 Mean: 12.3 (SD: 4.1)</p> <p><i>Positive Attitudes</i> Observed Min.: 7.4 Observed Max.: 29 Mean: 23.6 (SD: 4.3)</p> <p><i>ATAMHS-33</i> Observed Min.: 104.3 Observed Max.: 201.4 Mean: 114.6 (SD: 18.1)</p>
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EDE-Q

Author	Setting	Sample	Mean/Sum
(Fairburn & Beglin 1994)	Community based sample of young women, 16-35 years old.	n=241	Global EDE 1.554 (SD: 1.213) Restraint Subscale 1.251 (SD: 1.323) Eating Concern Subscale 0.624 (SD: 0.859) Shape Concern Subscale 2.149 (SD: 1.602) Weight Concern Subscale 1.587 (SD: 1.369)
(Mond et al. 2006)	Women aged 18-42 Australian Capital Territory	n=5255	Global EDE 1.52 (SD: 1.25) Restraint Subscale 1.30 (SD: 1.40) Eating Concern Subscale 0.76 (SD: 1.06) Shape Concern Subscale 2.23 (SD: 1.65) Weight Concern Subscale 1.79 (SD: 1.51)

(Carter, Stewart & Fairburn 2001)	Adolescent girls aged between 12-14 years from three single-sex schools (one private and two state schools).	n=808	Global EDE 1.6 (SD: 1.4) Restraint Subscale 1.4 (SD: 1.5) Eating Concern Subscale 1.0 (SD: 1.0) Shape Concern Subscale 2.2 (SD: 1.7) Weight Concern Subscale 1.8 (SD: 1.7)
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Contact for this correspondence:
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 Ethics & Governance Administration Assistant
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 Facsimile: (02) 9845 1317
 Email: ethics.schn@health.nsw.gov.au

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9 April 2014

Mr Joel Zugai
 Faculty of Health
 University of Technology Sydney

Dear Mr Zugai,

HREC Reference: HREC/13/SCHN/399

Project title: Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: A Mixed Methods Study

Reviewed for: The Children's Hospital at Westmead

Thank you for submitting the above project for single ethical and scientific review. This project was first considered by the Sydney Children's Hospitals Network Human Research Ethics Committee (SCHN HREC) at its meeting held on 21 February 2014. The SCHN HREC is accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

This SCHN HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and *CPMP/ICH Note for Guidance on Good Clinical Practice*.

I am pleased to advise that after receiving further information required on 14 March 2014, the SCHN HREC has granted ethical approval of this research project.

Your approval is valid from the date of this letter.

The documents reviewed and approved include:

<i>Document</i>	<i>Version</i>	<i>Date</i>
NEAF, Submission Code AU/1/3A06117		
Protocol	2	31 March 2014
NEAF Amendments		Undated
Covering Letter – Response to 6 March 2014 Review		Undated
Information Package for Interviews – Adolescent	3	31 March 2014
Information Package for Interviews – Nurse	3	31 March 2014
Information Package for Interviews – Parent	3	31 March 2014

J:\PROJECT FILES - Ethics & Governance\Ethics\NEAF\2013\13SCHN399\Correspondence & emails\HREC.13.SCHN.399 - Ethics Approval - 9 April 2014.docx

<i>Document</i>	<i>Version</i>	<i>Date</i>
Adolescent and Parent Consent Form – Master	1	8 November 2013
Nurse Consent Form – Master	1	8 November 2013
Initial Contact Letter – Adolescent, Master	1	8 November 2013
Initial Contact Letter – Nurse, Master	2	6 December 2013
Adolescent Survey Package – Master	1	8 November 2013
Nurse Survey Package – Master	1	8 November 2013
Consumer Interview	2	31 March 2014

Please note the following conditions of approval:

1. The co-ordinating investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
 - Unforeseen events that might affect continued ethical acceptability of the project.
2. Proposed changes to the research protocol, conduct of the research, or length of HREC approval, will be provided to the HREC for review in the specified format.
3. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
4. The co-ordinating investigator will provide an annual report to the HREC and at completion of the study. The annual report form is available on the Hospital's intranet and internet or from the Secretary.
5. Your approval is valid for 5 years from the date of the final approval letter. If your project extends beyond five years then at the 5 year anniversary you are required to resubmit your protocol, according to the latest guidelines, seeking the renewal of your previous approval. In the event of a project **not having commenced** within 12 months of its approval, the approval will lapse and reapplication to the HREC will be required.

Should you have any queries about the HREC's consideration of your project please contact the Ethics and Governance Administration Assistant on 9845 1253.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained. A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Yours faithfully

**Ms Jillian Shute
Executive Officer
Sydney Children's Hospitals Network Human Research Ethics Committee**

NB: All clinical trials must now be registered on a publicly accessible registry such as the Australian New Zealand Clinical Trials Registry. For further information please go to www.anzctr.org.au. Please provide this office with a copy of your registration number for our records if you have not already done so.

Dear Applicant

Appendix J

[External Ratification: The Sydney Children's Hospitals Network Human Research Ethics Committee.
HREC/13/SCHN/399, 09/04/2014 to 09/04/2019]

The UTS Human Research Ethics Expedited Review Committee reviewed your application titled, "Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: A Mixed Methods Study", and agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified.

Your approval number is UTS HREC REF NO. 2014000242

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:

* if accessing within the UTS network: <http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx>

* if accessing outside of UTS network: <https://remote.uts.edu.au> , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: <http://surveys.uts.edu.au/surveys/onlineethics/index.cfm>

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9645
F: (02) 9514 1244

E: Research.Ethics@uts.edu.au

I: <http://www.research.uts.edu.au/policies/restricted/ethics.html>

P: PO Box 123, BROADWAY NSW 2007

[Level 14, Building 1, Broadway Campus]

CB01.14.08.04

E:13



STANDARD CONSENT FORM- Adolescent and Parent

Appendix K

Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

Mr J Zugai, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
[REDACTED]

Prof J Stein-Parbury, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
jane.stein-parbury@uts.edu.au

Dr M Roche, Faculty of Health, University of Technology Sydney. Ph: 9514 4811, email:
michael.roche@uts.edu.au

Joel Zugai is a PhD candidate at the University of Technology Sydney. Joel Zugai is supervised by Professor Jane Stein-Parbury and Dr. Michael Roche.

I have read and understand the information provided, and give my consent for my child to participate in this research study, which has been explained to me by Joel Zugai.

I understand that I am free to withdraw from the study at any time and this decision will not otherwise affect my child's treatment at the Hospital.

NAME OF ADOLESCENT: _____ (Please print)

SIGNATURE OF ADOLESCENT: _____ Date: _____

NAME OF PARENT OR GUARDIAN: _____ (Please print)

SIGNATURE OF PARENT OR GUARDIAN: _____ Date: _____

NAME OF WITNESS: _____ (Please print)

SIGNATURE OF WITNESS: _____ Date: _____



STANDARD CONSENT FORM- Nurse Participant

Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

Mr J Zugai, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
[REDACTED]

Prof J Stein-Parbury, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
jane.stein-parbury@uts.edu.au

Dr M Roche, Faculty of Health, University of Technology Sydney. Ph: 9514 4811, email:
michael.roche@uts.edu.au

Joel Zugai is a PhD candidate at the University of Technology Sydney. Joel Zugai is supervised by Professor Jane Stein-Parbury and Dr. Michael Roche.

I have read and understand the information provided, and give my consent for my participation in this research study, which has been explained to me by Joel Zugai.

I understand that I am free to withdraw from the study at any time and this decision will not otherwise affect my employment or working relationships at the Hospital.

NAME OF NURSE: _____ (Please print)

SIGNATURE OF NURSE: _____ Date: _____

NAME OF WITNESS: _____ (Please print)

SIGNATURE OF WITNESS: _____ Date: _____



ADOLESCENT INFORMATION PACKAGE

Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

Mr J Zugai, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
[REDACTED]

Prof J Stein-Parbury, Faculty of Health, University of Technology Sydney. Ph: [REDACTED], email:
jane.stein-parbury@uts.edu.au

Dr M Roche, Faculty of Health, University of Technology Sydney. Ph: 9514 4811, email:
michael.roche@uts.edu.au

Dear Adolescent,

We would like you to consider participating in a research study that will be at your hospital. This booklet that has been put together to help you decide if you would like to take part in an interview for our research project, which looks at the relationships you have with nurses who are caring for you, and the hospital setting.

Who is doing the study?

This research is being done through the Faculty of Health at the University of Technology Sydney. The research team of this project are particularly interested in mental healthcare. Joel Zugai is a PhD candidate, and is supervised by Professor Jane Stein-Parbury and Dr Michael Roche. This project is personally funded by Mr. Joel Zugai.

What is the study about and its benefits?

We are trying to understand more about relationships between nurses and patients in hospital. By interviewing patients who have been treated for anorexia nervosa, we will be able to gain a clear understanding of their thoughts and views. These perspectives are important for understanding the way that hospital influences the relationships between nurses and patients. Even though you won't personally or financially benefit from this research, your perspectives are very important because it helps us improve the care that patients receive.

What will I have to do if I take part?

Mr Joel Zugai will interview you in a face to face meeting. The interview will be at your hospital where your treating team will be available if needed, and will be recorded on a voice recorder. The interview will examine the relationships you had with nurses and the way that the ward influenced

these relationships. The interview will be conducted in a private office. If it would make you more comfortable, you may invite your parent(s) to sit in the interview room with you.

Do I have to take part in the research?

No you don't. If you say no, that is ok. It is up to you. Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time this will not otherwise affect your current or future care at the Hospital.

Will anyone know that I am taking part or hear about what I tell you?

No, no-one will know what information you gave to the researchers. You can tell them whatever you want and no-one will know that it came from you.

The only time the researchers would have to tell someone is if anyone hurt you or upset you in any way. The researchers would also have to tell someone if you said you might hurt yourself or someone else. If any of those things happen they would have to tell the treatment team in charge of your care.

This study will give you the chance to give feedback and to raise specific concerns about your care at hospital. If you make a complaint about your care, this will be referred to the appropriate head of department.

Is there anything that might make me upset if I take part in the research?

Talking about your experiences with anorexia nervosa and being in hospital might make you feel upset. If anything you talk about during the research does make you upset you can stop the research. Your parents/carers will be told and you will be given the names of people you can talk to about what is making you upset, if that is what you want to do. Counselling from your team at hospital will be made available to you. The researcher can help you arrange that.

What will happen to the information I tell you?

The information you tell us will only be used by researchers to help us understand the relationships between nurses and patients, and the ward. No-one else will be allowed to use this information. The findings generated from this study may be published in a research journal, however you will not be personally identifiable in any publications arising from this project.

The information gathered from this research will be kept by Mr. Joel Zugai. Any personal electronic files will be stored on a password protected computer, and all personal materials in a locked filing cabinet. All personal files and materials associated with this project will be deleted/destroyed 7 years after this project.

If you have any concerns about the conduct of this study please do not hesitate to discuss them with Joel Zugai or with the Research Ethics Manager (XXXX XXXX) or Secretary of the Ethics Committee that has approved this project. The reference number for this project is HREC/13/SCHN/399.

This booklet is for you to keep.

Thank you very much.



NURSE INFORMATION PACKAGE

Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

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Michael.roche@uts.edu.au

Dear Nurse,

We would like you to consider participating in a research study that will be conducted at your hospital. This is a booklet that has been put together to help you decide if you would like to take part in an interview for our research project, which looks at the relationships you have with patients who are being treated for anorexia nervosa, and the way that the inpatient environment influences these relationships.

Who is doing the study?

This research is being conducted through the Faculty of Health at the University of Technology Sydney. The research team of this project are particularly interested in mental healthcare. Joel Zugai is a PhD candidate, and is supervised by Professor Jane Stein-Parbury and Dr Michael Roche. This project is personally funded by Mr. Joel Zugai.

What is the study about and its benefits?

We are trying to understand the nature of relationships between nurses and patients, and the way that the inpatient environment influences these relationships. By interviewing nurses who care for patients with anorexia nervosa, we will be able to gain a clear understanding of your thoughts and views. Your perspectives are important for understanding the way that the inpatient environment influences the relationships between nurses and patients. Although you will not benefit from this project (personally or financially), you will make a contribution to understanding how nursing care can be enhanced.

What will I have to do if I take part?

Mr Joel Zugai will interview you at a time and place of your convenience. The interview will be recorded on a voice recorder. The beginning of the interview will establish some professional details

about you, such as designation, years of experience, etc. The interview will then go on to examine the relationships you had with patients and the way that the inpatient environment influenced these relationships.

Do I have to take part in the research?

No you don't. If you say no, that is ok. Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time this will not otherwise affect your employment or current and future relationship with the Network.

Will anyone know that I am taking part or hear about what I tell you?

No, no one will know what information you give to the researchers. You can tell them whatever you want and no one will know that it came from you.

What will happen to the information I tell you?

The information you tell us will only be used by researchers to help us understand the relationships between nurses and patients, and the inpatient environment. No-one else will be allowed to use this information. The findings generated from this study may be published in a research journal, however you will not be personally identifiable in any publications arising from this project. The information gathered from this research will be retained by Mr. Joel Zugai. Any personal electronic files will be stored on a password protected computer, and all personal materials in a locked filing cabinet. All personal files and materials associated with this project will be deleted/destroyed 7 years after completion of the project.

If you have any concerns about the conduct of this study please do not hesitate to discuss them with Joel Zugai or with the Research Ethics Manager (XXXX XXXX) or Secretary of the Ethics Committee that has approved this project. The reference number for this project is HREC/13/SCHN/399.

This booklet is for you to keep.

Thank you very much.



PARENTAL INFORMATION PACKAGE

Understanding the Therapeutic Alliance Between Nurses and Adolescent Consumers with Anorexia Nervosa in the Context of the Inpatient Setting: a Mixed Methods Study

Investigators:

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Dear Parent,

We would like you to consider allowing your child to participate in a study conducted in their hospital. This booklet has been put together to help you decide if you will allow your child to take part in an interview for our research project, which looks at the relationships they had with nurses who cared for them. We are also interested in the way that the inpatient environment influences these relationships.

Who is doing the study?

This research is being conducted through the Faculty of Health at the University of Technology Sydney. The research team of this project are particularly interested in mental healthcare. Joel Zugai is a PhD candidate, and is supervised by Professor Jane Stein-Parbury and Dr Michael Roche. This project is personally funded by Mr. Joel Zugai.

What is the study about and its benefits?

We are trying to understand the nature of relationships between nurses and patients, and the way that the inpatient environment influences these relationships. By interviewing patients who have been hospitalised for treatment of anorexia nervosa, we will be able to gain a clear understanding of their thoughts and views. These perspectives are important for understanding the way that the inpatient environment influences the relationships between nurses and patients. Although your child will not benefit from this project (personally or financially), your child will make a contribution to the ongoing wellness of others who need hospital care.

Who can participate in the study?

To participate in this study, your child must be in the 12 to 16 year age range, and have been treated in hospital for anorexia nervosa. Participants must be fluent in English. Their treating doctors in hospital must also be satisfied that your child is fit to participate.

Does my child have to take part in the research?

No they don't. Your child's participation is completely voluntary. Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time this will not otherwise affect your child's current or future care at the Hospital.

What will the study involve?

Your child will be asked to attend one interview conducted by Mr Joel Zugai at the hospital location, with the treating team available if needed. The interview will examine the relationships they had with nurses and the way that the inpatient environment influenced these relationships. The interview will be conducted in a private office. You may also attend the interview if your child would be more comfortable with your presence.

Are there any benefits for my child participating in the study?

There are no known benefits for your child in participating in this study. We hope that the results from this study will help us understand more about the relationships between nurses and patients, and the inpatient environment. It is hoped that this will benefit future patients with anorexia nervosa.

Are there any side-effects and risk associated with this study?

It is possible that talking about experiences of their illness or hospitalisation could be upsetting. If there are any signs of distress during the interview, the interviewer will stop the interview and address any immediate concerns. If your child's concerns do not easily resolve, your child will be referred to the treating team at the hospital for counselling. This study will give your child the chance to give feedback and to raise specific concerns about care at hospital. If your child makes a complaint about their care, this will be referred to the appropriate head of department.

Other information

Any information that is obtained in connection with this study and that can be identified with you or your child will remain confidential. Information in any future publication will be presented in such a way that you or your child will not be able to be identified. The information gathered from this research will be retained by Mr. Joel Zugai. Any personal electronic files will be stored on a password protected computer, and all personal materials in a locked filing cabinet. All personal files and materials associated with this project will be deleted/destroyed 7 years after completion of the project.

If you have any concerns about the conduct of this study please do not hesitate to discuss them with Joel Zugai or with the Research Ethics Manager (XXXX XXXX) or Secretary of the Ethics Committee that has approved this project. The reference number for this project is HREC/13/SCHN/399.

This booklet is for you to keep. Thank you very much.

Summary of Qualitative Sample

Appendix P

Consumer	Duration	Nurse	Duration
1A	19min	1A	1hr,41min
2A	12min	2A	56min
3A	18min	3A	39min
4A	20min	4A	35min
5A	19min	5A	28min
6A	13min	6B	22min
7A	14min	7B	52min
8A	17min	8B	44min
9B	18min	9B	27min
10B	20min	10B	40min
11B	22min	11C	1hr,8min
12B	20min	12C	31min
13B	11min	13C	27min
14B	32min	14C	16min
15B	22min	15D	28min
16B	15min	16D	43min
17B	24min	17D	43min
18B	15min	18D	26min
19B	43min	19D	46min
20C	38min	20D	38min
21C	26min	Total:	13hrs, 30min
22C	42min	Mean Length:	40min
23C	20min		
24C	48min		
25C	20min		
26C	34min		
27D	38min		
28D	25min		
29D	45min		
30D	26min		
31D	24min		
32D	36min		
33D	36min		
34D	29min		
Total:	14hrs, 21min		
Mean Length:	25min		

*:Number denotes participant identifier, Letter denotes facility of origin

Demographic Data- Nursing Sample

Appendix Q

Nurse	Nursing Experience (Years)	Eating Disorder Nursing Experience	Qualification and Education (RN) (EN) (AIN)	ED Training	Fulltime (FT), Part-Time (PT), Casual (CAS)
Audrey	0.5	0.5	RN, Bachelor of Nursing.	No Formal Training.	FT
Isla	5	5	RN, Bachelor of Health Science, Master of Nursing, Grad. Cert. Clinical Nursing.	No Formal Training.	FT
Nina	32	11	EEN, Cert. Mental Health Nursing.	No Formal Training.	PT
Hannah	2	0.5	RN.	No Formal Training.	FT
Lucinda	0.5	0.5	RN, Bachelor of Science, Master of Nursing.	No Formal Training.	FT
Monique	1	1	EEN.	No Formal Training.	FT
Tanya	24	13	RN, NUM, Grad. Cert. Health Management.	No Formal Training.	FT
Margaret	35	28	RN, CNC, Master of Nursing.	Eating disorder conferences, family therapy training. Counselling course.	FT
Phyllis	13	12	RN, CNE, Masters in Chemistry, Bachelor of Nursing.	No Formal Training.	FT
Dorothy	7	7	EEN.	No Formal Training.	FT
Pamela	30	17	RN, Director of Nursing, Masters in Nursing.	Eating disorder conferences.	FT
Evelyn	41	2	RN, Associate Dip. Mental Health Management.	No Formal Training.	CAS
Elaine	8	2	RN.	No Formal Training.	PT
Alexandria	9	5	RN, Bachelor of Nursing, Master of Nutrition.	No Formal Training.	PT
Samuel	2	0.5	AIN.	No Formal Training.	CAS
Shane	5	3	RN, CNS.	Eating disorder conferences.	FT
Angela	30	25	RN, NUM.	No Formal Training.	FT
Joshua	6	5	EEN.	No Formal Training.	PT
Sabrina	2	2	RN.	No Formal Training.	FT
Martin	1	1	AIN.	No Formal Training.	CAS
Mean:	12.5	7	RN: 70%, EEN: 20%, AIN: 10%.	85% of participants had no formal training.	FT: 65%, PT:20%, CAS: 15%.

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