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The Nature of the Therapeutic Alliance between Nurses and Consumers with Anorexia Nervosa in the Inpatient Setting: A Mixed Methods Study

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ABSTRACT

Aims and Objectives: To develop a greater understanding of the nature of the inpatient therapeutic alliance between nurses and consumers with Anorexia Nervosa.

Background: Consumers with Anorexia Nervosa (AN) value interpersonal relationships with nurses, finding these relationships meaningful and therapeutic. It is established that the therapeutic alliance enhances outcomes for consumers with AN. However, establishing the therapeutic alliance in the inpatient setting is considered challenging.

Design: This study employed a two-phase mixed method explanatory sequential design. An initial quantitative survey, phase one, was followed by the collection and analysis of qualitative data, phase two.

Methods: Phase one employed validated survey instruments, measuring the perceived degree of therapeutic alliance and elements of ward milieu. Phase two involved semi-structured interviews that focused on therapeutic relationships between nurses and

consumers, with specific exploration of the results from phase one. Data collection commenced May 2014 and concluded February 2015.

Results: The therapeutic alliance involved interpersonal engagement and a balanced application of authority. In a therapeutic alliance, nurses cared for consumers with an interpersonal finesse, whilst maintaining clear distinction between the consumer as an individual and Anorexia Nervosa as an illness. Nurses also developed a therapeutic alliance by occupying their position of power with consistent yet individualised expectations, and by maintaining appropriate professional boundaries.

Conclusions: The therapeutic alliance between nurses and consumers with anorexia nervosa is not developed through negotiation of equal partners. Rather, the therapeutic alliance is dependent on nurses' capacity to maintain their position of power, whilst demonstrating their trustworthiness to the consumer. In trusting the nurse, consumers felt safer in investing in a new concept of wellbeing.

Relevance to Clinical Practice: By understanding the nature of the therapeutic alliance as it is described in this study, nurses have an enhanced capacity to develop effective therapeutic alliances with consumers. A maternalistic style of nursing emerged as a viable approach.

What does this Paper Contribute to the Wider Global Community?

- The quality of the therapeutic alliance between nurses and consumers is dependent on nurses therapeutically occupying their position of power.
- In developing a therapeutic alliance, nurses and consumers with Anorexia Nervosa must engage in a process of separation from the illness.
- A maternal style of care may be a viable conceptual model for developing the therapeutic alliance in this specific area of nursing.

KEYWORDS

Anorexia Nervosa; Consumer Perspectives; Mental Health Nursing; Mixed Methods; Nurse-Patient Relations; Psychiatric Therapeutic Process; Therapeutic Alliance; Therapeutic Relationships.

INTRODUCTION

In mental health nursing, a therapeutic alliance is an interpersonal, mutual and negotiated collaboration necessitated by and focused on the resolution of identified health needs and goals (Zugai *et al.* 2015). Therapeutic relationships are the cornerstone of mental health nursing (Welch 2005), and are also associated with beneficial mental health consumer outcomes (Horvath *et al.* 2011, Priebe & McCabe 2008). In the treatment of Anorexia Nervosa (AN), the therapeutic alliance contributes to enhanced outcomes for consumers (Zaitsoff *et al.* 2015). Although the therapeutic alliance is operative in all therapeutic contexts (Meissner 2007), variations in the therapeutic setting carry implications for the application and nature of the therapeutic alliance. The nature of the therapeutic alliance between nurses and consumers with AN, as it applies to the inpatient setting, is then ambiguous and worthy of focused investigation.

BACKGROUND

The caring collaboration engendered by a therapeutic alliance is considered an effective conduit of care, valued by consumers who have received treatment for AN in the inpatient setting, and by the nurses who specialise in their care (Salzmann-Erikson & Dahlén 2017, Sibeoni *et al.* 2017). However, the nature of AN as a mental illness and its interaction with the nurse's role hinders the development of a therapeutic alliance. The development of a therapeutic alliance between nurses and consumers with AN is strained, in part, because AN

is an ego-syntonic mental disorder; AN becomes incorporated into the consumer's identity. Consumers with AN often deny their illness, are ambivalent about participation in care, and relapse is common (Guarda 2008, Higbed & Fox 2010). These factors disrupt the foundations of therapeutic alliance, such as, mutuality, trust and collaboration.

Nurses then experience difficulty in establishing therapeutic relationships due to: experiences of deceit and manipulation, a misunderstanding of AN, a struggle for control, an inability to be non-judgmental, and the emotional challenge, frustration and exhaustion from the demands of nursing consumers with AN (King & Turner 2000, Ramjan 2004).

Without a clear understanding of the therapeutic alliance as it applies to the inpatient setting, nurses will continue to struggle with caring for consumers with AN, and consumers will not benefit from interpersonally well-informed nursing care. The aim of this study was to establish a greater understanding of the nature of therapeutic alliance between nurses and consumers with AN in the inpatient setting, by considering consumer and nursing perspectives.

METHODS

In achieving the aim of this study, a sequential mixed methods approach was employed, with an initial quantitative phase and a subsequent qualitative phase. Findings from the initial phase (phase one) were subject to further exploration in the subsequent phase (phase two). Recruitment and data collection commenced 16 May 2014 and concluded 12 February 2015.

Participants

This study recruited consumers and nurses from six wards with a specialised program for the treatment of AN, in five hospitals in New South Wales Australia. Three wards were

dedicated mental health inpatient units and three were combined medical/mental health wards. Non-probability convenience sampling was utilised, justified by the need to sample from a specific population from specific locations (Schofield 2004). Neither the nursing or consumer sample was stratified, as reasonable inferences could not be developed from the limited sample size.

Consumer Participants

The participating consumers were required to be over 12 years old, of either sex, have experienced at least one week of inpatient care for the treatment of AN in the participating ward, and medically stable.

Nurse Participants

Participating nurses were required to be working in a unit specialised AN unit. ~~recruited from the six wards.~~ There were no restrictions regarding designation and experience, as the diverse skill mix is inherently an element of ward context.

Data Collection - Phase One

During the initial phase, data were collected via surveys that incorporated five instruments to obtain both consumer and nursing perspectives. Consumers' perception of the strength of the therapeutic alliance was measured with the Inpatient-Treatment Alliance Scale (I-TAS) (Blais 2004); their satisfaction with care with the Client Assessment of Treatment scale (CAT) (Priebe *et al.* 2009); and their eating disorder psychopathology with a youth version of the Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn & Beglin 1994). The quality of ward climate was measured with the Essen Climate Evaluation Schema (EssenCES) (Schalast *et al.* 2008), administered to both consumers and nursing staff. Nurses' attitudes towards mental health consumers were measured with the Attitudes Towards Acute Mental Health Scale 33 (ATAMHS-33) (Baker *et al.* 2005).

A relatively small sample size was predicted for this study, due to the limited size of the available consumer and nurse populations under study. Therefore, the results from these data provided descriptive picture of each unit rather than analysed for inferential purposes. In addition, the results of phase one provided insight into areas needing further exploration in phase two.

Data Collection - Phase Two

Phase two involved semi-structured interviews with nurses and consumers that were audio recorded and transcribed. Semi-structured interviews allowed participants to express and introduce topics, and allowed the interviewer the capacity to explore ideas introduced by the participants (Minichiello *et al.* 2004). Interviews were held in a private office or similarly discrete location. Consumer participants were permitted to have a parent or other significant person accompany them in the interview. The interview schedules were developed specifically for this project and are included as appendices. In addition to standard questions, noteworthy findings from phase one were used to augment the ~~semi-structured interview~~ schedules for each individual site, for example, *'From the surveys I handed out on the ward, I noticed that patients here rated their satisfaction with treatment quite poorly. What do you make of this? Please comment on this finding so that I might understand more about what it means'*. Phase two was ceased at the point of data saturation.

Data Analysis

Phase One Data Analysis

Quantitative data were entered directly into statistical software (SPSS v22; IBM 2013) for analysis. Descriptive statistics were used to describe the measure of each concept under study. With the means generated, comparisons were also made with previous studies that used the same instruments.

Phase Two Data Analysis

Qualitative data were interpreted through a thematic analysis, which identified themes that were recurring and or emphasised by the consumer and nurse participants (Browne 2004).

The thematic analysis involved both deductive and inductive approaches, as described by (Elo & Kyngäs 2007). Data were initially coded by the first author using a template from the results

of a prior study (Zugai et al 2013 ~~redacted for review~~). Additional themes that were not revealed by the coding format alone were then added, based on inductive analysis. All data were then synthesised into a final set of themes that most effectively captured the findings.

Reliability was established by confirmation of themes as reported in previous studies. 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 are used to substantiate findings.

Ethics

The conduct of this study was guided by the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council 2007), and by the Declaration of Helsinki (World Medical Association 2013). Ethical considerations for this project were of particular importance, given the vulnerability of consumers with AN.

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. Prior to gaining consent from consumers, the treating team verified that the consumer was cognitively and medically stable to the degree that consent and participation was viable. The PI was a PhD student experienced in qualitative research, and was overseen by experienced supervisors. Confidentiality was maintained by removing identifiable information in the interview transcripts and through the use of pseudonyms in reporting the

results. Ethical approval was attained from the participating hospitals and the relevant university.

RESULTS

Sixty-three consumers and sixty-five nurses (n=128) completed surveys in phase one. Thirty-four consumers and twenty nurses (n=54) were interviewed in phase two. The demographic data of the participants from phase two is presented in Table 1.

The average duration of interviews was 40 minutes for nurses, 25 minutes for consumers. From phase one, it was established that consumers perceived a relatively poor therapeutic alliance with nurses (mean I-TAS 3.70, SD 1.30) (Blais 2004, Rise *et al.* 2012), a low satisfaction with care (mean CAT 5.5, SD 2.33) (Priebe *et al.* 2011, Priebe *et al.* 2006), and a high degree of eating disorder pathology (mean global EDE-Q 4.0, SD 1.49) (Carter *et al.* 2001, Mond *et al.* 2006). Nurses reported a positive attitude towards mental health consumers (mean ATAMHS-33 sum of 185.6, SD 21.97) (Baker *et al.* 2005, Foster *et al.* 2008). These findings were integrated during the phase two interviews, the results of which are the focus of this report.

Three major themes were developed from analysis of phase two data. The first is termed 'love and limits', a direct quote from one of the nurse participants, indicating that nurses maintained a delicate balance between the interpersonal warmth of caring whilst enforcing ward rules. The second, therapeutic separation, signified the therapeutic imperative to detach the consumer from the illness. The final theme relates to how nurses maintained their authority and professional boundaries.

'Love and Limits'

The therapeutic alliance between nurses and consumers involved an interpersonal connectedness in tandem with thoughtfully applied authority; firm behavioural management was accompanied by interactions that reassured consumers of their inherent worth. The findings are categorised according to their contribution to either category: the 'love' aspect involved the interpersonal component of the therapeutic alliance, the 'limits' aspect involved the way that nurses applied the rules of the program and managed their position of authority.

Love

Genuine Caring

Consumers wanted to feel genuinely cared for, and nurses understood this. Despite consumers indicating a relatively poorly perceived alliance in phase one data, consumers and nurses emphasised the imperative of therapeutic interpersonal dynamics throughout hospitalisation. Ultimately, the positive 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. The positive attitudes that nurses held towards consumers (phase one) enhanced the capacity for nurses to develop and sustain genuinely caring relationships.

Unconditional Positive Regard

Consumers wanted to be treated with respect, and perceived by nurses as legitimate patients, worthy of dignity, compassion and trust. Nurses then interacted with consumers in a way that conveyed positive, unconditional regard for their worth. Nurses' professional responsibility in ensuring weight gain was at times in conflict with maintaining a non-judgemental approach. Nurses then fulfilled their professional role carefully and tactfully.

“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’ve got to 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).

Empathy, Understanding and Sensitivity

To engage consumers with sensitivity and empathy, nurses needed to understand the nature of AN, and how inpatient treatment would be inherently distressing for consumers. In understanding AN, they were able to sensitively provide care and assist consumers with the challenging expectations and activities of hospitalisation.

“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” (Margaret, Nurse).

Motherly/Sisterly Nursing

Nurses and consumers described effective nursing as involving a ‘motherly’ or ‘sisterly’ role adoption. The ‘motherly/sisterly’ approach engendered many of the effective dynamics of interpersonal relationships. 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. 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. The nurses whom consumers perceived as motherly or sisterly left lasting impressions, and consumers reflected on them with great appreciation.

“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 want to 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).

Limits

Safety and Predictability

Consumers in this study valued consistent expectations, finding comfort in predictable routines of care. However, nurses delivered care with varying expectations about the way that consumers should adhere to the rules of the eating disorder program. Inconsistencies in nursing care were regarded negatively by both nurses and consumers, with some consumers attributing the low degree of satisfaction with care (phase one) to be partially due to perceived inconsistencies. The uncertainty of expectations led consumers to experience confusion and anxiety. Consumers’ sense of ambivalence was initiated when confronted with inconsistencies.

“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 got to 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).

Furthermore, when nurses made exceptions or alterations to the rules, this equipped 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).

Conversely, consistent, clear and predictable nursing 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 relieved consumers from the anxiety of making decisions involving food and exercise.

Fairness and Rationalisation: Non-Punitive Intent

Rules were better experienced by consumers when they were well substantiated, explained clearly and applied fairly. Consumers were then likely to acknowledge the nurse’s professional responsibility, and experienced the application of rules as therapeutically intended.

“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 going to destroy the relationship” (Evelyn, Nurse).

Conversely, inequities in the application of rules frustrated consumers and were demoralising. Consumers felt that inconsistent expectations were unfair, implied undue preferential treatment, and were experienced as de-motivating. Consumers’ confidence in the therapeutic merit of the eating disorder program was undermined.

“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).

Flexibility: Individualised Care

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. These changes were not made at the expense of weight gain, but rather with the intent of enhancing care and progress. Nurses exercised leniency in order to relieve consumers from expectations that were 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).

Therapeutic Separation

In a therapeutic alliance, nurses and consumers maintained clear distinctions between the consumer and AN as an illness, a therapeutic separation. Nurses made a conscious effort to view the consumer as a person in need of care and understood that AN was a compelling mental disorder. Correspondingly, when consumers recognised AN as pathology separate to who they were as a person, they more readily engaged in care. In light of consumers'

severity of eating disorder psychopathology (phase one), the process of separation was a therapeutic imperative.

Distinguishing the Consumer from the Illness

Nurses were cognisant of the need 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.

“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).

Consumers were often enmeshed within the pathology of AN, yet recognised that it was important to externalise it as a peripheral element of themselves.

“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).

The way nurses delivered care was influential over the consumer’s preparedness and amenability for therapeutic separation, especially when they assisted consumers in developing 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

Consumers perceived a negative personal inference when they experienced corrective measures as punitive or disciplinary; they felt akin to a perpetrator. This perception sabotaged the therapeutic alliance. Nurses mitigated this negative impression by clearly defining AN as a pathology requiring intervention, and the consumer as a worthy recipient of care. In minimising punitive interpretations of care, nurses reminded consumers ‘you’re ill’, rather than ‘you’re bad’. Consumers were then more liable to interpret nursing interactions as genuinely caring, thus trusting the nurses’ therapeutic motive.

“We can have a laugh with them and then they still turn their heads and go, ‘Okay. You’ve got to 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).

Therapeutic Maintenance of Authority and Professional Boundaries

In this study, nurses occupied a position of power and authority. The way that nurses utilised and maintained their position of power carried implications for the quality of the

therapeutic alliance; the way that nurses wielded their authority had implications for their relationships with consumers.

Collaboration and Authority

Nurses believed that the best approach was not dependent on the use of an authoritative or coercive style of interaction. Rather, the best approach was reliant on collaboration, supportiveness and patience. By relying on the power of interpersonal connection, consumers felt a willingness to engage in care. In contrast, nurses who did not adopt an interpersonal style, and relied on their inherent authority were described as distant, forceful, 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).

The Importance of Boundaries

Nurses maintained professional boundaries in order to protect their professional authority as a nurse. In maintaining appropriate boundaries, nurses remarked on the importance of not permitting their own personal needs to influence judgements and interactions.

“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 knowledge of the wards’ rules and protocols, nurses maintained therapeutic boundaries more effectively. Well defined rules gave nurses the confidence and authority to act in the best interest of the consumer.

“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).

Motivated by their pathology, consumers would at times engage in relationships that salved the personal needs of vulnerable nurses, offering praise, validation and acceptance. In doing so, consumers gained leverage over vulnerable nurses, and the nurses’ authority as a therapeutic agent was eroded. This was more likely with nurses close to the consumers’ age.

“And they come across very strongly, and they section you out from others. 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).

DISCUSSION

Nurses established a therapeutic alliance by maintaining a balance between positive interpersonal engagement and the therapeutic employment of their authority: *'love and limits'*. 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.

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 (Boughtwood & Halse 2010, Colton & Pistrang 2004, Gulliksen *et al.* 2012, Oyer *et al.* 2016, Sly *et al.* 2014, 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 *et al.* 2010). Meaningful relationships assisted consumers with the challenges of hospitalisation (Sly *et al.* 2014, Zugai *et al.* 2013). 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).

Separation and externalisation of AN from the consumer is recognised as important to recovery (Dawson *et al.* 2014, Fox & Whittlesea 2016, 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.

Nurses' internal process of separation was dependent on a non-judgemental and understanding orientation. 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 *et al.* 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.

In developing a therapeutic separation, it was important that consumers were acknowledged as unique individuals, as opposed to a 'walking eating disorder' (p. 22, Smith *et al.* 2016). An over-focus on weight gain and emphasis on the illness led consumers to feel punished and invalidated as an individual (Colton & Pistrang 2004, Offord *et al.* 2006).

Conversely, by focusing 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 *et al.* 2006, Reid *et al.* 2008). 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 *et al.* 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.

Nurses were vested with power over consumers because they were responsible for enforcing the rules of the program; 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.

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 invoke non-adherence and resistance (Colton & Pistrang

2004, Offord *et al.* 2006, Sly *et al.* 2014, Zugai *et al.* 2013). An overly rigid approach, or conversely an unduly flexible approach, is liable to compromise consumers' confidence in care (Oyer *et al.* 2016). A therapeutic alliance in this study involved nurses maintaining a consistent set of expectations, whilst also having degree of flexibility for individualising care. Akin to other consumer perspective research, consumers in this study valued clear and unambiguous expectations and predictability in care (Zugai *et al.* 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 *et al.* 2006). By relinquishing control to nurses, consumers were relieved of the stress that was 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 *et al.* 2016, Snell *et al.* 2010).

Despite dissatisfaction experienced during acute inpatient care, consumers often retrospectively view care as justified, recognising that they were unable to safely facilitate their own recovery (Guarda 2008, Offord *et al.* 2006, Zugai *et al.* 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. 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. Consumers were typically engaged in care with a high degree of ambivalence that was amplified when they perceived an opportunity to compromise weight

gain. Therefore, it is not only ineffective to burden the consumer with the responsibility of maintaining adherence, but also an unfair expectation.

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 *et al.* 2006, Zugai *et al.* 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 *et al.* 2016).

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 *et al.* 2016). 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).

Consumers and nurses in this study described positively perceived nursing care, some indicating that effective nurses assumed a 'motherly' or 'sisterly' role. 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 *et al.* (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, their 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.

Equality between a nurse and consumer is impossible, however nurses can instead strive to establish mutuality (Briant & Freshwater 1998). In this study, the motherly or sisterly role was adopted 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; the maternalistic approach exemplified the balance of love and limits. Maternalism also engendered the unconditional positive regard, understanding and non-judgemental tact, all necessary for therapeutic separation.

Resigning psychological defences and the empty safety of AN, consumers permitted maternalistic nurses to challenge what were typically held as immutable perceptions and beliefs.

Consumers in this study trusted maternalistic nurses. Trust is a fundamental aspect of the alliance (Meissner 2007, Zugai *et al.* 2015). Trust was the sense of confidence and security a consumer had, despite being vulnerable to the nurse in the context of a power differential.

In trusting the nurse, the consumer faithfully invested in the therapeutic intent of the nurse, and embraced a new concept of wellbeing.

Limitations

The sample of nurses and consumers was heterogeneous in regard to age, acuity of illness, setting and context of care, and nurses varied greatly in professional dynamics. 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. Of both the consumer and nursing sample, males were highly under-represented, which is expected given the largely female inclination of both groups. Whilst the quantitative sample size of both consumers and nurses is insufficient to make powerful inferences, the analysis was focused on developing descriptive statistics. Time constraints also were not permissive of a larger sample size. Although multiple factors of context were examined, many other contextual factors would be worthy of investigation, for example the fidelity of the eating disorder program. The first author and person who collected the data being a male, interviewing a mostly female population, may have carried implications for the nature of participants' responses.

CONCLUSION

Without negotiation as a viable means of developing mutuality, nurses developed a therapeutic alliance through a balance of interpersonal finesse with considered use of power. This conceptualisation 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.

Further to this study, a rigorous investigation of the association between the therapeutic alliance between nurses and consumers and consumer outcomes would be informative.

Outcomes of interest include weight gain, retention in care and eating disorder psychopathology. In doing so, it would be useful to measure the strength of the therapeutic alliance at different points of the therapeutic experience, such as that performed by Brown *et al.* (2013). The concept of maternalism in AN 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. Furthermore, whether a maternalistic style of nursing is applicable or appropriate for male nurses is unclear.

RELEVANCE TO CLINICAL PRACTICE

By understanding the nature of the therapeutic alliance as described in this study, nurses will have enhanced capacity to care for consumers with AN. Nurses must recognise and harness the therapeutic potential of their position of intimacy and power in the inpatient setting. A maternalistic approach may be an effective nursing approach, however a maternalistic role adoption seems outside the purview of a professional nurse, and an antecedent to boundary transgressions. The integration of the therapeutic alliance concept in practice is dependent on the availability of appropriate resources, training and structured supervision for nurses. The organisation and culture of the ward must be conducive to the

alliance, with nurses given sufficient time and opportunities to engage with consumers.

Formalised educational support that aids the application of the findings of this study would assist nurses with developing effective therapeutic relationships with consumers.

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Table 1: Demographic Data

Consumer Sample Demographics (n=34)	
Gender	97% Female (n=33), 3% Male (n=1)
Mean age in at time of interview	20 years
Mean age of onset of illness	15.5 years
Mean age of first treatment	17.5 years
Nursing Sample Demographics (n=20)	
Gender	80% Female (n=16) 20% Male (n=4)
Designation	70% Registered Nurses (n=14) 20% Enrolled Nurses (n=4) 10% Assistants-in-nursing (n=2)

Appendix 1: Consumer Interview Schedule

- 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?
- Hospitals are often busy and chaotic places. 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?
- Did it seem like there were enough nurses to take care of you, or did it seem that there were too many?
- Did it seem like the nurses had enough time to take care of you?
- How did having different nurses caring for you affect the relationships you had with nurses?
- How did spending time with other patients affect the relationships you had with nurses?
- 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 that we haven't already discussed?

Appendix 2: Nurse Interview Schedule

- How many years of nursing experience do you have?
- How long have you been nursing people with eating disorders, in particular, anorexia nervosa?
- What specialist training have you undertaken in relation to caring for people with AN? What was the nature of that training?
- How do you find the relationships you form with patients to affect their wellbeing?
- What role do nurses play in anorexia treatment and consumer wellbeing? What do they do and say that helps patients?
- What else, if anything, do nurses do to help patients recover from anorexia nervosa?
- 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?
- How do your multiple 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?
- 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 that we haven't already discussed?