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POSTDOCTORAL STUDIES**

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Eating Disorders Nursing: Roles, Skills, and the Therapeutic Alliance

Kirsti Pryde

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial
fulfillment of the requirements for the MSc degree in Nursing

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Abstract

A mixed method study was conducted to gain an understanding of the role of the eating disorders (ED) nurse and to explore the nurse-patient therapeutic alliance in this context. Thirty-five nurses from six ED treatment centres in Canada and America participated. The qualitative component involved manifest and latent content analyses of semi-structured interviews. From this, nine nursing roles were identified in addition to the skills, challenges and rewards of ED nursing. Three themes emerged in relation to the therapeutic alliance: creating a therapeutic environment, establishing a connection, and empowering patients. The quantitative component consisted of an established measure of therapeutic alliance in questionnaire form. Results from the survey supported the qualitative findings in identifying differences between Canadian and American nurses.

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Kirsti Pryde, RN, APN, BScN, BA

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Chapter One – Introduction

1.1 Research Problem

The role of the nurse caring for eating disorders (ED) patients has varied over the years, yet limited attempts have been made to clearly define this role. This lack of definition is due in part to the fact that this role has been expanded in recent years, focusing on the psychosocial and therapeutic aspects of care, in addition to meeting the physical needs of this complex patient population. The role of the ED nurse is also affected by the structure and content of various ED treatment programs, their funding, and their staff compliment in terms of what services nurses are expected to provide for this population of patients. Due to the varying components of the ED nurses' role and the limited in-depth identification and analysis of these roles from a multi-site perspective, a unified, comprehensive educational program focusing on ED nursing has not been developed.

It has been suggested that one component of the ED nurses' role is the development of a therapeutic relationship or alliance with the patient (Gallop, Kennedy, & Stern, 1994). The ED nurse is central in the treatment of patients with ED because nurses often have the most continuous patient contact and the greatest opportunity to interact and develop a relationship with the patient (Ryan, Malson, Clarke, Anderson, & Kohn, 2006). The importance of the nurse-patient relationship with ED patients is exemplified in a study by Owen and Fullerton (1995) where the primary nurse caring for the patient was rated by patients and staff as being the most supportive healthcare professional on the team. Through the development of a therapeutic relationship with the patient based on warmth, positive regard, and empathy, an improvement in patients'

outlook, feelings of autonomy, self-esteem, and a decrease in denial can result (George, 1997).

1.2 History of Eating Disorders Nursing

Understanding the history of ED and how the nurses' role has evolved with this population of patients is necessary in order to identify the nurses' unique function in the multidisciplinary team and to provide a context to the nurse-patient alliance. The first eating disorder to be identified was Anorexia Nervosa in the late 1600's by Richard Morton. He described a physical state characterized by emaciated patients who were, "like skeletons only clad with skin" (Morton in Garfinkel & Garner, 1982, p. 14). Further clinical depictions of this disorder were not presented until the 19th century, at which time, Charles Lasegue (France) and William Gull (England) independently described the illness in detailed clinical reports (White, 1991). These descriptions differed in that Gull's focus was on the medical aspects of anorexia and Lasegue's was on the psychological realm.

The role of the ED nurse at this point was described as follows; "a nurse is firm and persuasive, who, under the direction of a doctor, would enforce a dietary regimen within the girl's home. The nurse was a factotum for the doctor: she represented his moral authority within the distressed household" (Jacobs Brumberg, 1988, p. 152).

It was not until the 1930's and 1940's that Waller, Kaufman and Deutsch (1940) ascertained that anorexia nervosa was a physiological disorder, secondary to a psychic disturbance. Patients were hospitalized in psychiatric wards and therapy consisted of psychoanalysis. Nursing care at this stage went beyond the traditional medical approach to include providing, "supportive nursing care, general support in a controlled

environment, beginning with bed rest and gradually increasing activity” (Garfinkel & Garner, 1982, p. 235).

By the 1960’s healthcare professionals realized that a treatment regime that consisted solely of psychoanalysis and general nursing care was not effective for recovery. Specialized treatment programs for patients’ suffering from ED began to emerge in the late 1970’s, both in hospitals and residential treatment facilities in the community. Nursing care began to expand to include; group facilitation/therapy, education, emotional support, as well as the traditional medical monitoring/physical assessment/medication administration. Attributes of ED nurses began to be described as; caring, compassionate, non-judgmental, sensitive, and consistent (Weiner, 1999).

In recent years, voluntary in and out-patient programs were established to treat patients from a multidisciplinary perspective including; psychiatrists, psychologists, nurses, social workers, occupational therapists, and dietitians (Hindmarch, 2000). Anorexia nervosa and bulimia nervosa (and their respective sub-types) are the primary ED for which people seek treatment. Treatment approaches focus on improving patients’ self-concept and self control through medical interventions, nutritional rehabilitation, and individual/group therapy (Gilbert, 2005).

ED treatment research has been approached from various points of view, ranging from medical models (Andersen, 1999; Kaplan & Garfinkel, 1999) to psychosocial models (Gilbert, 2005, Palmer, 1990), from the patient perspective (Malson, Finn, Treasure, Clarke & Anderson, 2004; Patching & Lawler, 2009) to the perspective of the healthcare professional (Burket & Schramm, 1995; Jarman, Smith & Walsh, 1997), using both qualitative (Ryan, et al., 2006) and quantitative methods (Toman, 2002).

1.3 Rationale

As an Advanced Practice Nurse (APN) working with ED patients in a multidisciplinary treatment program, my interest was peaked in the various roles nurses' participate in within this context. ED treatment currently consists of specialized services offered to patients in a variety of treatment settings. These settings include; hospital-based treatment, residential, individual, and out-patient services. Knowing the perspectives of other ED nurses working across treatment facilities in Canada and the United States would be helpful in understanding this complex role.

Furthermore, part of my function as an APN is to develop training programs for nurses coming into this field; thus a comprehensive understanding of the roles and skills required of these nurses is important in informing this work. In addition, a comprehensive description of ED nurses' roles can make clear these functions, thereby informing other ED treatment facilities with program development, training, and ongoing evaluation.

My interest in the therapeutic relationship or alliance with ED patients comes from my experience as a nurse working with ED patients on an in-patient hospital unit over the past 10 years. It was during this time that I began to recognize the importance of this alliance as a function of the ED nurses role both within myself and my colleagues. It was my perception that patients responded in a positive manner to the formation of a therapeutic alliance by virtue of nurses being empathetic, caring, and by the development of trust between patient and nurse. I was interested to see if nurses in other ED treatment centres identified the therapeutic alliance as part of their role.

1.4 Purpose

The purpose of this study is twofold. First, it is intended to improve understanding of the functions of ED nurses by identifying and describing the various roles across different contexts. Currently there is little understanding of the various components of this complex role so the findings will contribute to the nursing literature in this area. Furthermore, comprehensive descriptions of ED nurses' roles and skills will provide a basis for the development of training programs and assist with program development and evaluation. Second, measurement of the therapeutic alliance together with a qualitative exploration of the relationship between ED patients and nurses will make it possible to examine whether a therapeutic alliance is part of this role and how it is developed and utilized in patient care. These insights will be important in educating nurses on the development of a therapeutic alliance with patients.

1.5 Aims of the Study

The aims of the study, therefore, are (1) to identify various aspects of the role of the ED nurse in various settings across Canada and the US, including skill requirements and interaction techniques used by ED nurses, (2) to explore the nurse-patient relationship from the perspective of ED nurses to see whether a therapeutic alliance is part of this role, and (3) to identify the perspectives of Canadian and American nurses regarding a therapeutic alliance through analysis of the Working Alliance Inventory Scale (Horvath, & Greenberg, 1989).

Chapter Two – Literature Review

The following will take the format of describing the search strategies utilized for the literature review, focusing on ED, ED nursing and the therapeutic alliance. Next ED diagnoses and the clinical, psychological, and social aspects of these complex disorders are presented. Subsequent to these descriptions, a review of the concept of therapeutic alliance is discussed and a theoretical framework supporting this concept is offered.

2.1 Search Strategies

Few researchers have focused on the role of the ED nurse, and even fewer in combination with therapeutic alliance. Therefore, a systematic approach was taken to review the literature for this project. For the purposes of the review, the topic was broken down into five main parts. First, a general review of the ED literature was conducted. Second, a search of therapeutic alliance literature including defining the concept of therapeutic alliance, its attributes, and antecedents, Third, identification of research linking ED and therapeutic alliance (non-nursing). Forth, identification of nurse-patient therapeutic relationship/alliance models (non-eating disorder). Finally, a specific search of nursing and therapeutic alliances with ED patients was performed.

Search terms utilized both individually and in combination were; *ED, anorexia nervosa, bulimia nervosa, nurse, role, treatment, therapeutic relationship, therapeutic alliance, medical complications*, and the *history of ED*. Database searches included; Medline (1950-November, 2008), CINAHL (1980 – November, 2008), PsychARTICLES (1980-November, 2008), PsychINFO (1980- January, 2009) and HealthSTAR (1999- November, 2008). Manual searches of the following journals

consisted of International Journal of ED (1998 – Present) and the Journal of Psychosocial Nursing (1997-2007). Searches were limited to English text only.

The literature search also included a review of eating disorder books (medical, psychological, and nursing topics) at the University of Ottawa Libraries, Morisset (MRT) and Health Sciences (RGN). A review of the 2007 Academy of ED conference presentations was completed as well as ED web sites, including; The Academy for ED and the National Eating Disorder Information Centre (NEDIC). The initial literature review was completed at the commencement of this project in the fall of 2007, and updated yearly, with the final update completed in February 2009.

2.2 Eating Disorders Overview

2.2.1 Definitions of eating disorders and prevalence

The two main ED that are treated in treatment facilities are anorexia nervosa (AN) and bulimia nervosa (BN). Anorexia nervosa can be defined as a condition where a patient with an intact appetite, deliberately and willfully restricts food intake and/or over exercises in an effort to achieve thinness as a protection against becoming ‘fat’. Loss of weight and obvious emaciation are denied by the patient.

Bulimia nervosa is a condition in which abnormal craving for food results in bingeing followed by purging. The food is usually of high caloric content and is consumed so fast that the person can hardly chew it properly. The patient reports a feeling of loss of control and an inability to stop the bingeing episode. Immediately following a binge eating episode, the patient is in a state of anguish with feelings of guilt and self-criticism. These unpleasant feelings are partly relieved by inducing vomiting or abusing laxatives (Pryde, 2007).

The estimated prevalence in the female population of Western societies is 0.5 for anorexia nervosa and 2-3 % for bulimia nervosa (Harris & Barraclough, 1998) Exact numbers are difficult to access due to the potential of undiagnosed cases.

2.2.2 Symptoms and clinical picture

The term “symptom” in the field of ED pertains to patients’ behaviours as a function of their eating disorder. Symptoms may range from food restriction to purging, i.e. self-induced vomiting, laxative abuse and/or diuretic use, to over-exercising (Forbush, Heatherton, & Keel, 2007; Wolk, Loeb, & Walsh, 2005). Patients may use one or all of the above symptoms at any one point during the course of their illness. In addition, the symptom(s) utilized by the patient may not remain consistent during the course of their illness, often changing over time depending on how the patient perceives his or her self and to what extent they deem the symptom to be effective (Anderson, 1999).

ED patients have a strong focus (obsession) on their weight, size, shape, and overall appearance (Crisp, Norton, Jurczak, Bowyer, and Duncan, 1985; Bardone-Cone, Maldonado, Crosby, Mitchell, Wonderlich, Joiner, et al., 2008). Subsequently, patients develop a distorted view of their body image, which leads to body dissatisfaction, resulting in negative compensatory behaviours in order to change the way that they look (Paxton, McLean, Gollings, Faulkner, & Wertheim, 2007).

Patients’ underlying beliefs about themselves reflect highly perfectionist ideals (Forbush et al, 2007), low self esteem, and low self confidence (Garfinkel, 1985). These beliefs augmented by the effects of starvation and/or purging, lead to attempts at using food as a means of control or coping (Crisp et al, 1985). Hsu remarks that “fatigue,

insomnia, restlessness, social isolation, and a constant preoccupation with food and exercising result” (1986, p. 573).

2.2.3 Co morbid disorders

Eating disorders are not often seen in isolation. A number of co-morbid or co-existing disorders are frequently associated with ED, including depression (Palmer, 1990; O’Brien & Vincent, 2003), anxiety (Kaplan & Garfinkel, 1999), obsessive compulsive disorders (Weltzin, Cornella-Carlson, Weisensel, Timmel, Hallinan & Bean, 2007), post traumatic disorders (Sansone & Sansone, 2007), substance abuse (Andersen, 1999) and personality disorders, typically borderline personality disorders (Kaplan & Garfinkel, 1999).

2.2.4 Eating disorders assessment

ED patients require a thorough medical and psychological assessment prior to diagnosis and treatment. Medical assessments usually include; a complete medical history since childhood including a family medical history, dieting behaviours including use of purging, diuretics, and/or laxatives, exercise routines, and a complete physical exam including bloodwork and an electrocardiogram.

Psychological assessments include; obtaining information regarding the patient’s desired ideal weight and perception of body appearance, social interactions, depression, anxiety level, stressors, and suicidal ideation (Muscari, 2002, p. 25).

2.2.5 Medical complications

Due to the complex nature of ED there are a myriad of medical complications commonly present. The two most prominent (and often life threatening) medical issues are those of gastrointestinal (GI) and cardiac complications. GI problems encountered with this population of patients include: esophagitis, due to repeated purging; constipation (potential of a bowel obstruction) due to laxative abuse; and bloating, due to digestive irregularities and reduced bowel activity (Turner, Batik, Palmer, Forbes, McDermott, & Brett, 2000; Mitchell & Crow, 2006). Cardiac problems frequently identified are electrolyte imbalances (predominately hypokalemia) due to repeated purging, hypotension, dizziness, fainting, swelling of the feet/ankles, decreased heart rate, cardiac arrest, and sudden death (Mitchell & Crow, 2006; Katzman, 2005; Schulte & Mehler, 1999).

Hormonal disturbances related to ED can result in amenorrhea (decreased leutinizing and follicle-stimulating hormones) and possible infertility (Irwin, Part 1, 1993). Patients striving to maintain a pre-pubescent body are usually pleased with the absence of their menses, but are unaware of the potential long-term effects of this disturbance to their hormonal function. Body density tests performed on anorexic patients indicate moderate to severe osteoporosis, leaving the patient open to pre-mature fractures (Harris & Cumella, 2006; Mitchell & Crow, 2006; Katzman, 2005).

Other medical complications that are prevalent, although not necessarily life threatening with ED are; dental erosion due to contact with stomach acid from repeated purging (Steele & Mehler, 1999), the development of kidney stones related to

dehydration (Schulte & Mehler, 1999), and fine-hair growth lanugo on the body, and hair loss on the head (Mitchell & Crow, 2006).

2.2.6 Cognitive presentation

As well as the numerous medical complications associated with ED, the cognitive presentation of the ED patients is important to note. Some of the more commonly encountered presentations include cognitive impairments such as decreased concentration, difficulty comprehending and speaking, and memory-related problems (Seed, Dahabra, Heffernan, Robertson, Foster, Venn, et al., 2004). These cognitive impairments are usually fully reversible upon maintaining an adequate intake and discontinuing purging behaviours (Mitchell & Crow, 2006).

2.2.7 Social issues

Today's society has a significant impact in the development and sustainment of ED. The focus of the media and subsequently society itself on the 'perfect body' is presented in such formats as 'unrealistic' air-brushed magazine models, fashion runway models, and sports/movie celebrities (Wolf, 1997; Adderholdt & Goldberg, 1999). White writes, "overeating and non-eating are viewed as a protest against the way in which women are regarded in society as objects of adornment and pleasure," (1991, p. 71).

Family, friends, school, and work also greatly influence the recovery process. While their behaviours and involvement is often motivated by a genuine sense of fear as well as caring for the patient, over-involvement or 'policing' of the patient can occur, which can influence and be potentially detrimental to recovery. The term 'policing' refers to the person feeling the need to watch over the patient to "keep them safe".

Although altruistic in essence, this type of support is counterproductive in that patients often increase their ED behaviours in an effort to maintain control of their lives (Costin, 1996).

As societal awareness of ED increases, employers and educational institutions attempt to be flexible in order to offer patients support and time-off for participating in extended treatment. This remains a challenging issue as it forces patients to admit that they have a problem to people other than to themselves, their family, and their close friends.

2.2.8 Treatment overview

Treatment for ED, anorexia nervosa and bulimia nervosa are aimed at medical stabilization of the patient, symptom management, increasing self esteem and self confidence, and addressing body image issues (Sylvester & Forman, 2008). Treatment is achieved through intense medical and psychological interventions focused on cognitive restructuring, nutritional rehabilitation, and group/individual therapy (Irwin, Part 2, 1993; Muscari, 2002; Malson, Finn, Treasure, Clarke, & Anderson, 2004).

2.2.9 Treatment programs

In Canada and the United States, ED treatment is provided in four different formats. In-patient care is usually provided in a general hospital, often located on a mental health unit, providing care 24 hours a day, seven days a week. This form of treatment is reserved for patients with severe forms of ED who are requiring a high level of medical stabilization, in a structured environment, in conjunction with nutritional rehabilitation and psychological therapy (Palmer, 1990). Residential treatment is similar in format to in-patient treatment, except that it is located outside of a hospital in the

community facility and therefore does not deal with patients who are *severely* medically compromised, until they have been stabilized elsewhere (Muscari, 2002).

Day treatment programs are common for patients with moderate to severe forms of ED, providing services Monday to Friday that combine nutritional rehabilitation and intensive psychological treatment (Kong, 2005; Zipfel, Reas, Thornton, Olmstead, Williamson, Gerlinghoff, et al., 2002). As healthcare dollars are often over-stretched in current economic times, out-patient services are rapidly growing in both countries. Both group and individual treatment services offer support, education, and medical monitoring for mild to moderate cases of ED (Mitchell & Crow, 2006).

2.2.10 Psychological aspects of treatment

A variety of different therapies have emerged in the treatment of ED. To delve into these therapies in great detail would be beyond the scope of this project. However, for discussion purposes, some current ED therapies include; cognitive behavioural therapy (Wilson, Fairburn, Agras, Walsh, Kraemer, 2002; Constantino, Arnow, Blasey, Agras, 2005), inter-personal therapy (Loeb, Pratt, Walsh, Fairburn, Wilson, & Labouvie, et al., 2005), dialectical behaviour therapy (Safer, Telch & Agras, 2001), emotion focused therapy (Greenberg, 2008), hypnosis (Mantle, 2003), and family therapy (Wilson, Grilo, Vitousek, 2007). Some treatment providers' focus on using only one type of therapy, but many integrate a combination of therapies in programs.

2.2.11 Provider issues

Due to the complexity of ED and the integral nature of the healthcare provider to the treatment, repeated issues are faced by ED staff of all disciplines (Burket & Schramm, 1995). One such issue is that of maintaining professional boundaries. As

patients are in treatment for long periods of time, have high re-admission rates, and are frequently seeking acceptance and recognition from those around them, professional boundaries can become blurred and staff over-involvement can often occur (Warren, Crowley, Olivardia, Schoen, 2009).

Second, by virtue of the disorder itself, patients may be manipulative and defensive, leading to transference and counter transference issues (Burket & Schramm, 1995; Kaplan & Garfinkel, 1999). Multidisciplinary treatment is focused at providing a consistent team approach that incorporates a firm, but caring manner to help alleviate staffs' negative feelings and responses to patient behaviour. Safety of the patient, both with respect to emotional vulnerability as well as physical safety (including protection from cutting, self induced vomiting, and substance abuse) should always be a priority.

Third, this challenging population of patients often leads to healthcare provider frustration and 'burnout' due to patients' feelings of helplessness and hopelessness, resulting in non-compliance with treatment (Manley & Leichner, 2003; Geller, 2002). Frequent discussions amongst the healthcare team, including the provision of feedback to other team members, as well as offering empathy and support is helpful to maintain team members' own confidence, interest, and objectivity (King & de Sales Turner, 2000).

A final consideration is that of the healthcare provider's own beliefs' about ED's, their awareness of themselves and their bodies, and their personal level of self esteem. Being in the 'business' of addressing these issues with patients on a daily basis can increase one's sensitivity to body image and related issues (Warren, et al, 2009).

2.2.12 Nursing and eating disorders

Nurses working with ED patients are in a unique position as a member of the treatment team, as they often provide the most continuous, day to day care for this population of patients. They have the opportunity to make ongoing assessments of patients' condition and progress (or lack thereof) during their time spent providing physical care, facilitating groups, and supervising meals. As a result, they have the best chance to provide education and support to both patients and families alike (Irwin, Part 2 1993).

Few studies have addressed ED nursing. One such study by Ryan, Malson, Clarke, Anderson, and Kohn (2006) used a qualitative approach, a discourse analysis of interviews, to describe the nursing experiences of 15 ED nurses in Australia. From an analysis of the interviews three themes were identified: loving support, surveillance and disciplining of patients, and constant, ever-present care. ED nursing as 'loving' support described the empathetic relationship that develops between ED patients and their nurses. ED nursing as discipline and surveillance identified the ED nurses' role of monitoring patients' behaviours and symptoms. Finally, ED nursing as constant, ever-present care captured the concept of ED nurses providing continual, round the clock care to their patients.

Other descriptions of ED nursing have pointed to the fact that nurses' assessments of patients incorporate the whole person rather than just one aspect of their illness, unlike other disciplines (Newell, 2004). Newell further illustrated that ED nurses; develop empathetic relationships with their patients, involve the patient in their own care to promote taking responsibility, sit with patients while they eat, coordinate the multidisciplinary treatment team, and assist to develop a comprehensive treatment plan.

2.3 Therapeutic Alliance

2.3.1 Theoretical background

Three interrelated theories shall be briefly identified as a foundation for this research project based on perspectives from psychology, namely Carl Rogers and nursing, Hildegard Peplau and Jean Watson. All three of these theories focus on the relationship developed with the patient during the provision of care.

In the 1950's, psychologist Carl Rogers (1951) became a proponent of what has been called 'client-centred therapy'. This type of therapy placed the relationship that was formed between the therapist and the client as a central component of effective treatment. He proposed that the relationship itself was in fact healing and therapeutic.

Roger's theory focused on the idea that we all have "an innate tendency to develop our constructive, healthy capacities (actualization) and require warmth, respect, and acceptance from other people (need positive regard)" (Ewen, 1993, p. 377). Based on this assumption, Roger's identified the need to develop a therapeutic relationship with the client that revolved around the concepts of empathy, trust, and genuineness, resulting in an increase in the patient's self respect and positive regard (Rogers, 1951).

The first proponent of interpersonal therapeutic relationships between the nurse and the patient was Hildegard Peplau. Peplau studied the work of Rogers and stressed the need to develop a nurse-patient relationship. In her development of the Psychodynamic Nursing Model, Peplau described the nurse-patient relationship as, "a partnership where the nurse moves from expert care provider to being a partner with the client in order to improve the client's capability" (Marriner Tomay, & Raile Alligood,

2002, p. 383). Peplau (cited in Marriner et al., 2002) further explained that this relationship consists of four phases:

1. Orientation: the need for help is determined.
2. Identification: the patient identifies the nurse as a helper.
3. Exploitation: power shifts from the nurse to the patient to accomplish goals.
4. Resolution: the patient frees self from the nurse and achieves established goals.

The third theorist of interest to this project is Jean Watson. Like Rogers, Watson emphasizes the importance of developing a 'helping-trust relationship' with the patient, based on the principles of caring, empathy, and warmth. Her philosophy and subsequent theory (theory of caring) promoted a more passive role for the nurse and encouraged patient empowerment and self-responsibility (Watson, 1988).

Watson made some general suggestions for implementing her theory into practice (1994, p. 42):

1. Mobilizing client's own resources for solving problems.
2. Clinician in the background allowing the client to be the subject of the experience.
3. Goal is to suspend control and participate in the process.
4. Authority is derived from the client's experience and the inter-subjective knowledge that is co-created by the relationship.

2.4 Therapeutic Alliance Concept Analysis

The concept of 'therapeutic alliance' is present in the literature as a theoretical and practical means for healthcare professionals to interact with patients and families

(Hummelvoll, 1996). The dictionary defines the term therapeutic as, “providing or assisting in a cure” and alliance as, “an association to further the common interest of the members” (Merriam-Webster, 2007). Terms (and/or concepts) that are similar and in some instances used interchangeable with therapeutic alliance are: “working alliance” (Horvath & Greenberg, 1989) and “helping alliance” (Luborsky, 1994) from psychology, and “nurse-client relationship” (Gallant, Beaulieu, & Carnevale, 2002), “helping-trust relationship” (Watson, 1994), “therapeutic partnership” (Hamilton-Wilson & Hobbs, 1995) and “therapeutic relationship” (Virani, Tait, McConnell, Scott, & Geroglas, 2002) from nursing.

Although the term ‘therapeutic relationship’ is common in the literature and everyday practice “connecting or binding participants in a kinship or friendship,” (Merriam-Webster, 2007), it leads one to think of the interaction as a form of friendship rather than an interaction that respects professional boundaries. Therefore, the term ‘therapeutic alliance’ is selected for use in the following research. Kim, Boren, and Solem (2001) describe therapeutic alliance as, “a dynamic interactional process in which patient and provider collaborate to carry out mutually negotiated goals in a shared partnership” (p. 314-315).

Prior to utilizing the concept of therapeutic alliance in this project, a concept analysis was carried out (Pryde, 2005) using Walker and Avant’s method for analysis (Rodger & Knafl, 2000). This method for analysis was selected because it provides one with a systematic, structural approach to concept analysis and aids in clarifying ambiguous concepts. This concept analysis had numerous purposes. The first was to identify the attributes of therapeutic alliance within the realm of nursing. The second

was to promote a clearer understanding of how this concept relates to nursing and what the nursing roles are in building a therapeutic alliance. The third was to enhance and advance nursing knowledge development and education. The fourth was to develop a working definition of ‘therapeutic alliance’ to illustrate that this concept is continually evolving and lastly to demonstrate its practical applications and place in research.

Both attributes and antecedents of therapeutic alliance were identified.

Attributes are words or “characteristics of the concept that constitute a real definition as opposed to a nominal or dictionary definition” (Rodger & Knafl, 2000, p. 256).

Attributes of therapeutic alliance identified through a review of the literature are illustrated in Figure 1 (Madden, 1990; Bordin, 1979; Horvath, 2000; Horvath & Greenberg, 1989; Bischko, 1998; George, 1997; Ramjan, 2004; Pryde, 2005).

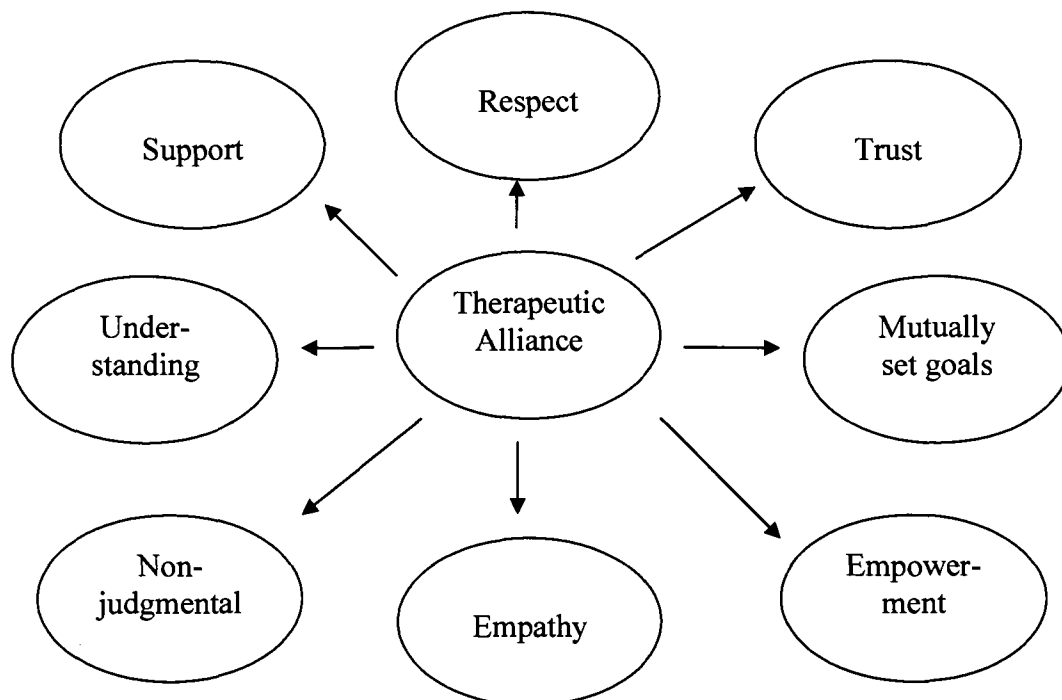


Figure 1: Attributes of the concept of therapeutic alliance.

An antecedent is a, “situation preceding an instance of the concept” (Rodger & Knafl, 2000, p. 111). Seven antecedents for the concept of therapeutic alliance were identified. First, there must be a willingness or desire by both parties involved to participate in communication. Second, there must be adequate interest in helping, understanding of therapeutic alliance concepts, and knowledge of basic therapeutic communication techniques. Third, adequate motivation on the part of the patient to concentrate on treatment and recovery is required. Fourth, the provision of a supportive, non-restrictive environment is important. Fifth, includes actual or perceived support by the patient/family/friends must be present. Sixth, there must be an awareness of the consequences of dependence and/or transference. Seventh and finally, the stage of disease/patient condition must be taken into account (Pryde, 2005).

2.5 Therapeutic Alliance Literature Review

2.5.1 Therapeutic alliance

The basis of therapeutic alliance is the development of a relationship between the patient and therapist, based on the core components of trust, empathy, and developing common goals (Horvath, 2000). Proponents of the concept suggest that by developing a relationship or an ‘alliance’ with the patient, the healthcare professional will establish a bond that facilitates communication and encourages the development of a mutually derived treatment plan, positively affecting treatment outcomes (Gallop, Kennedy, & Stern, 1994).

The concept of therapeutic alliance primarily finds its roots in psychology. Early therapists such as Sullivan, believed that one’s personality is based on a relationship with others. “Personality is the relatively enduring pattern of recurrent interpersonal

situations which characterize a human life – personality can never be isolated from the complex of interpersonal relationships in which the person lives” (Sullivan 1947, cited in Ewen, 1993, p. 209).

Bordin (1979) further developed the idea of the need for an interpersonal relationship between the patient and therapist, calling it the ‘working alliance’. He proposed that this relationship or alliance was made up of three components: “*bonds*, referring to interpersonal attachments, liking, trusting; *tasks*, agreements or consensus between therapist and client with respect to ‘what is to be done’ in therapy; and *goals*, consensus on the short and long-term outcome expectations between therapist and client,” (Horvath, 2000, p. 167). Bordin expounded that it was the alliance itself along with the development of mutually derived goals that effected change.

Present day Cognitive Behavioural Therapy (CBT) supports the idea that it is a combination of forming an alliance and the content of the therapy that will improve patient outcomes. The alliance itself is not enough. CBT theorists stress the importance of the quality of the alliance as part of the therapy process. “The alliance creates an environment of safety and trust, conditions that are necessary to learn, implement, and practice the techniques that are ultimately responsible for therapeutic change,” (Horvath, 2000, p. 165).

Psychological research has focused on various aspects of therapeutic alliance including its impact, clinical implications, and measurement. A meta-analysis of 24 studies, conducted by Horvath and Symonds (1991) found that there is no significant relationship between the type of therapy and outcome. Others support these findings and further demonstrate that the strength of the alliance is the best predictor of outcome

(Hatcher & Barends, 1996). Clinical implications regarding the development of an alliance indicate that it is independent of the type of therapy delivered, placing more emphasis on the *quick formation* and *strength* of the alliance (Cecero, Fenton, Nich, Frankforter, & Carroll, 2001).

2.5.2 Therapeutic Alliance and Eating Disorders

The concept of therapeutic alliance with respect to patients with ED can further be explored. In a study of 51 anorexic female patients using structured and unstructured interviews to identify factors influencing their recovery, Tozzi, Sullivan, Fear, McKenzie, and Bulik (2003) found that developing a supportive relationship was the number one factor aiding treatment. Participants indicated that, “a supportive relationship was the driving force that assisted them in recovery” (p. 150-151).

Working with treatment-resistant eating disorder patients, Vitousek, Watson, and Wilson (1998) acknowledge that patients’ frequently do not comply with treatment and are reluctant to develop therapeutic relationships. As a result of their descriptive work, they proposed that, “clinicians are encouraged to acquire a frame of reference that can help them understand the private experience of the individuals with ED, empathize with their distress at the prospect of weight gain, and acknowledge the difficulty of change” (Vitousek, et al., 1998, p. 391).

Similarly, Thornton, Beumont, and Touyz (2002), describe the development and implementation of a day treatment program in Australia based on different day treatment programs at five international ED treatment centres. The authors’ deduce that the type of treatment offered needs to match the stage of change of the patient, i.e. readiness for change. The development of a therapeutic alliance was seen as “central to the process of

change” (Thornton et al, 2002, p. 7), particularly for patients who are ‘chronic’ in nature or reluctant to change. They further to explain that by establishing a therapeutic alliance with the patient based on empathy and respect, the healthcare provider can best provide treatment for this challenging population of patients.

2.5.3 Therapeutic alliance and nursing

Challenges to a medical view of nursing are key to the inclusion of alliance/relationship models into the nurses’ role. Research works such as Schroeder and Maeve (1992) and Hummelvoll (1996) highlight the significance of the nurse forming an active partnership with patients. Both of these place an emphasis on empowering the patient, mutually determining treatment goals, and supporting the patient via effective communication and cooperation. Both provide suggestions for clinical applications in the form of patient assessment and treatment planning, but do not actively integrate these as part of the nurses’ day to day role in terms of providing detailed explanations as to how to do so.

Bischko (1998) defines the client-nurse relationship as a “therapeutic tool” in and of itself, highlighting the need and benefit of creating a supportive, interactive, trusting, and nonjudgmental environment. Emphasis is placed on the ease to which this kind of intervention, the client-nurse relationship, can be applied, as well as its benefit to patient outcomes.

The Canadian Nurses Association Best Practice Guideline (BPG) for “Establishing Therapeutic Relationships” indicates that, the therapeutic relationship is an interactive process between the nurse and the client. It describes this relationship as a “purposeful, goal directed relationship that is directed at advancing the best interest and

outcome of the client,” (Virani, 2006, p.13). The BPG offers guidance, direction, and general recommendations, but is not directly prescriptive as to how to implement this.

2.5.4 Therapeutic alliance and nursing eating disorders patients

The importance of the nurse-patient relationship with ED patients is detailed in a University of Michigan Medical Center study, which compared 29 ED inpatients’ perceptions of the helpfulness of support systems, such as ED nurses, co-patients, nutritionists, social workers, and psychiatrists. Results from the patient and staff feedback forms indicated that the primary nurse who was caring for the patient was rated by patients and staff as being the most supportive member of the treatment team. Nurses, “were highly rated for being non-judgmental, patient, and open, characteristics that foster trust in a patient population that traditionally has strong trust issues” (Owen & Fullerton, 1995, p.40).

George (1997), focused on the importance of the nurse forming a therapeutic relationship with the ED patient. She proposed that through the development of a therapeutic relationship based on warmth, positive regard, and empathy, a decrease in symptoms (increased feelings of autonomy, higher self-esteem, and decrease in denial) would result.

It is important for the nurse to initiate a trusting relationship with the patient. Treasure, Todd, and Szmukler (1995) suggest that the “therapeutic relationship should be collaborative, with a kind, firm, and consistent approach used to tackle the disordered eating behavior” (1995, p. 279). ED nurses are required to use this therapeutic relationship as a means of assisting patients with challenging cognitive distortions and changing behaviours. During the course of treatment, controlling symptoms (purging

and restricting) gradually becomes the responsibility of the patient themselves, thus promoting autonomy and self-control.

A number of obstacles to the development of a therapeutic relationship between nurses and ED patients have been identified. Ramjan (2004) in a (specific naturalistic study design) of ten Australian nurses working with adolescents with anorexia nervosa located in an children's hospital identified three themes. The emergent themes were:

- (1) 'Struggling for understanding' which explored the difficulties nurses experienced in coming to terms with the complexities of a diagnosis of anorexia nervosa and its recovery process.
- (2) 'Struggling for control' which examined the power struggle between nurses and patients and the mutual distrust that often developed between them as a consequence of this struggle.
- (3) 'Struggle to develop a therapeutic relationship' which described the difficulties some nurses had in establishing therapeutic alliances with adolescents (Ramjan, 2004, p. 495).

It has been suggested that patients with ED are often in denial of the severity of their disorder and report feeling a loss of control as a result of commencing treatment, leading to a power struggle between the nurse and the patient (Wolfe & Gimby, 2003; Muscari, 2002; Warren, et al, 2009). Wolfe and Gimby believe that the development of a therapeutic relationship/alliance between the patient and the ED nurse based on empathy, trust, and genuineness is beneficial to patients' recovery because it decreases the opportunity for a power struggle to commence.

Gallop, Kennedy, and Stern (1993) in a quasi-experimental study compared the strength of the therapeutic alliance between ED patients who completed treatment ($n = 21$) and those who left the program prematurely ($n = 10$). The results indicated that patients who completed the program, perceived the therapeutic alliance as significantly stronger than those who did not. This alliance was noted to be strongest between patients and nurses compared to other disciplines. The authors' propose that the higher strength of the alliance between patients and nurses is reflective of the frequent contact that nurses have with ED patients, leading to the development of a stronger alliance between the two. However, the study was somewhat limited in that the sample size was small and included only eight nurses out of the 18 staff participants.

2.6 Working Definition of Therapeutic Alliance

Based on the literature review, the following working definition of therapeutic alliance will be used: A complex bi-directional interaction that is formed between nurse and patient or nurse and family, that maintain appropriate boundaries and is based on the principles of trust, empathy, caring, and support to work towards a common, mutually derived goal(s) (Pryde, 2005).

2.7 Summary of Literature Review and Evidence Limitations

In summary, the role of the nurse with ED patients has started to become more prominent in the ED and nursing literature and the importance of this role is being identified as a highly specialized area of nursing. Research has shown that this role is indeed multifaceted, including aspects from both medical and mental health nursing (George, 1997; Newell, 2004). This review of the literature indicates that there is a significant lack of exploratory work in this area. What has been conducted has been

limited to studies that address the perspectives of nurses with respect to ED nursing rather than detailing their roles and skills (Ryan, et al, 2006; Ramjan, 2004)).

Research regarding the concept of therapeutic alliance focuses on describing the attributes and antecedents of therapeutic alliance, its quality, as well as its measurement and evaluation. Although the literature expresses the importance of developing a therapeutic alliance with patients in regard to treatment outcomes, it does not extend to make a strong connection between these factors and the actual role of the nurse from a practical perspective. That is in terms of how it is developed or how it is utilized in the planning of patient care.

The following research addresses the aforementioned issues by furthering the inquiry into the role of the ED nurse by examining ED nurses' perspectives across several settings of care in North America. In addition, it aims to explore the use of a therapeutic alliance by the ED nurse and relates nurses' perspectives on the importance of this component in their role.

Chapter 3 - Methods

3.1 Research Design

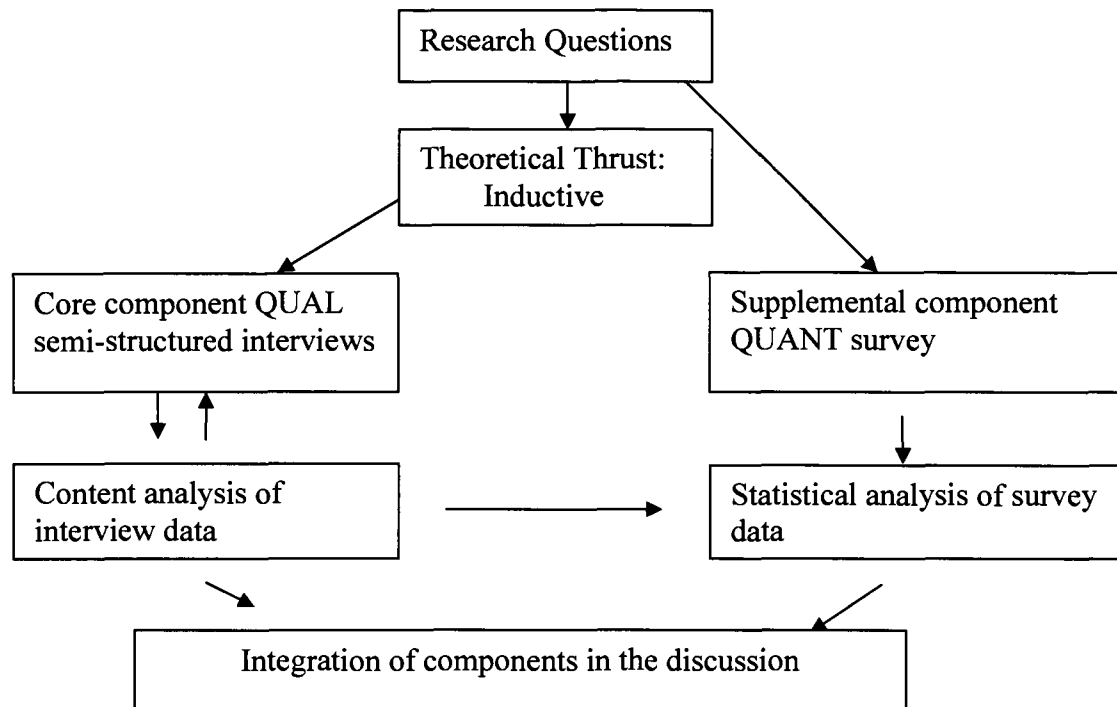
An exploratory mixed method design was chosen as the most appropriate approach to use for identifying the role of the ED nurse and its various components and for exploring the nurse-patient relationship in terms of the therapeutic alliance. The choice to use a combination of both qualitative and quantitative designs brings strength to this study by addressing this complex topic from two different approaches. The qualitative component strengthens the ability to describe the phenomena in question using enhanced description and validity, and by being appropriate for the inquiry stage of this topic. The quantitative approach acts to support and reinforce the qualitative findings and allows for statistical comparisons to be noted between groups. Although a mixed method approach is more time consuming for both the participant and the researcher, the quantity and quality of information obtained support the value of this design.

In this study, the qualitative component, the semi-structured interview (see Appendix E), provides opportunity for a comprehensive description of the role of the ED nurse and the nurses' views on the development of a therapeutic alliance with the patient. The quantitative section, the Working Alliance Inventory, Therapist Version, Short Form (WAI-T-S, Horvath & Greenberg, 1989, see Appendix A for WAI-T-S), provides a measure of therapeutic alliance, from which comparisons between Canadian and American nurses can be made. Thus, having a combination of the two approaches serves to strengthen the consistency of the results obtained (Polit & Beck, 2004).

The core component of the data is qualitative using manifest and latent content analyses of data obtained from semi-structured interviews with ED nurses. Content analysis “is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action” (Elo & Kyngas, 2007, p.). Manifest content analysis is a form of content analysis that focuses on “the elements that are physically present and countable” (Gray & Densten, 1998, p. 23 cited in Neuendorf, 2002). This form of descriptive analysis is appropriate for identifying and describing the roles, skills, and various components of ED nursing. Latent content analysis was chosen for the analysis of questions regarding the nurse-patient relationship to explore the therapeutic alliance. This form of analysis is more interpretive and aims to gain a deeper understanding of the themes that emerge from the words/phrases coded in the text (Neuendorf, 2002).

The supplementary component is a cross-sectional survey of participant characteristics (e.g. level of experience, years ED nursing) and completion of a measure of therapeutic alliance, the WAI-T-S. Participants were asked to fill out the survey upon completion of the qualitative interview QUAL > quantitative (Munhall, 2007). Figure 1 provides an illustration of the research design. The interview was chosen to be completed prior to the completion of the WAI-T-S so as to avoid influencing the participants’ views regarding the concept of therapeutic alliance during their interviews.

Figure 2. Mixed method research design.



3.2 Sampling and sample size

Sampling was purposeful. A sample of 35 participants was selected for this exploratory study. This large sample size was deemed necessary to provide a diverse sample in terms of nursing roles and experiences given the types of treatment, age/experience ranges of participants, and location of facility, i.e. Canada and the United States and to examine whether there were any differences between roles across settings. As a result of such a large sample size, saturation, the point at which no new information is being gleaned, was readily achieved in the qualitative component of this research (Polit & Beck, 2004).

3.2.1 Eligibility criteria

The inclusion criteria stipulated that nurses participating must have some clinical

contact with patients as part of their role and that at least part of their time was with adult patients 18 years or older. Participation was open to male and female registered nurses, licensed practical nurses, nurse practitioners, and clinical nurse specialists working in Canada or the United States. Nurses currently working for The Regional Centre for the Treatment of ED at The Ottawa Hospital (four nurses total) were excluded from the study as they were involved in pilot testing of the questionnaires.

3.2.2 Sample

The total sample consisted of 35 nurses comprising of registered nurses ($n = 33$), licensed practical nurses ($n = 1$), and nurse practitioners ($n = 1$) working full-time ($n = 24$), part-time ($n = 10$), and casual ($n = 1$) with ED patients. Participants worked with in-patient ($n = 2$), out-patient ($n = 3$), both in and out-patients ($n = 9$), and residential patients ($n = 21$) in a total of six treatment centers in both Canada ($n = 14$) and the United States ($n = 21$). Participants included 33 females and 2 males, ranging in age from 25 to 77 years ($M = 49.82$, $SD = 13.54$). The educational backgrounds of the nurses involved were; BScN ($n = 12$), Diploma ($n = 15$), MScN ($n = 1$), Associates Degree ($n = 6$), and MA ($n = 1$). The years of experience working as a nurse ranged from 2 to 54 years ($M = 23.91$, $SD = 14.13$) and the years of experience working as a nurse with ED patients ranged from 1 to 24 years ($M = 7.96$, $SD = 5.16$) years. Of the 35 participants, 20 provided individual treatment only (Can. = 2, U.S. = 18) and 15 provided both individual and group treatment (Can. = 12, U.S. = 3). All 35 participants worked as part of a multidisciplinary team that included; psychiatrists, medical physicians, psychologists, psychometrists, therapists, counselors, dietitians, nutritionists, registered nurses, nurse practitioners, licensed practical nurses, social workers, spiritual

teams, occupational therapists, art therapists, equine staff, psychiatric technicians, research assistants, program evaluators, and administrative support staff.

3.2.3 Setting

Treatment facilities comprised of Canadian in-patient (3) and out-patient (1), and American residential centres (2). They ranged in size from 6- 90 patients at full capacity. Two of the three Canadian in-patient programs, as well as the out-patient program were located on the mental health units of general hospitals, while another in-patient unit was located in a separate building at a mental health hospital. The two American residential centres were free-standing facilities, independent of general or mental health hospitals.

Minimum and maximum weight restrictions for admissions varied from site to site with patient Body Mass Indexes (BMI's) ranging from 10 to 25 depending on diagnosis and type of facility, i.e. in-patient, out-patient, or residential treatment. The 'normal' BMI as per Health Canada guidelines ranges from 18.5 – 25 (Health Canada Website, 2009).

3.2.4 Ethics and recruitment

Lists of ED treatment facilities were obtained through each respective country's ED information centers, the International Academy of ED nursing members listing, and the Ontario Community Outreach Program for ED. Managers, Program Directors, and Coordinators of various treatment centers in Canada and the United States were contacted by the student either by phone and/or e-mail to discuss possible recruitment at their site. Eight treatment centers were contacted; four in the United States and four in Canada. Six agreed to participate. Two other facilities expressed an interest, but were unable to participate due to excessive workload at the time.

Ethical approval was obtained prior to the commencement of this project (see Appendix B for ethics approvals). As per treatment facility requirements, on-site Principle Investigators were identified as requested at two sites and appropriate data sharing agreement (see Appendix C for data sharing agreement) were developed and followed. All procedural and ethical formats outlined were followed during each of the 35 interviews. This study was conducted at six ED treatment centres; two in the United States and the other four in Canada. Ethical approval was initially granted by the University of Ottawa and The Ottawa Hospital Research Institute where the pilot component of the study took place. Approval was then obtained from the six centres who were interested in participating, on the understanding that all of the semi-structured interviews would be carried out by the student researcher either on site or by telephone, depending on participants' preferences.

Following ethical approval and procedures to access staff at each facility, the nursing managers identified nurses working at their respective facilities who were interested in finding out more information about the study. Interested nurses were sent a copy of the research information sheet and the consent forms (see Appendix D for the information sheets and consent forms used at various sites). Upon return of the signed consent form, the student arranged an interview with each participant at their convenience (within one to two weeks).

3.2.5 Confidentiality and anonymity

An independent study number (unique identifier) was assigned to each participant upon agreement to participate and was attached to the WAI-T-S questionnaire and interview transcripts. Lists of names and study numbers were locked

in separate filing cabinets in the thesis advisor's office. All written data was kept in Kirsti Pryde's office, room 4401, The Ottawa Hospital, General Campus during the data collection and analysis periods. Electronic data was stored on Kirsti Pryde's desktop computer in her office, room 4401, The Ottawa Hospital, General Site. The computer is password protected and in a locked private office. Telephone interview tapes were destroyed (wiped clean) after transcription and verification. Transcribed notes and completed questionnaires were kept in a locked filing cabinet in the principal investigator's thesis advisor's office at the University of Ottawa after the data analysis was complete. All written documentation will be kept for 15 years after which time it will all be shredded.

3.3 Procedures and Measures

Twenty-eight face-to-face interviews were conducted in private rooms pre-determined by coordination staff at each treatment facility. Interviews were audio-tape recorded on an iTALK recorder to allow verbatim transcription. Telephone interviews (seven) were taped on the same machine linked into the phone system in the student's office, at, Ottawa Hospital, General Campus. Interviews took between 15-30 minutes.

Semi-structured interview questions were developed for the interview. Nine of the open-ended questions focused on identifying the components of the role of the ED nurse, including its challenges, satisfying aspects, and differences from other forms of nursing (see Appendix E for interview questions, French and English). Two open-ended questions developed to elicit responses regarding the nurse-patient relationship and to explore the therapeutic alliance, asked "describe some of the personal attributes or characteristics that you possess which are important in you work as an ED nurse" and

“how would you characterize your relationship with patients: What would you say the relationship that you form with ED patients is based on?”.

Prior to the interviews the questions were examined by two in-patient nurses and one day hospital nurse at the Regional Centre for the Treatment of ED at the Ottawa Hospital for ease of comprehension of the questions and to ensure that questions had relevance to the topic of ED nursing. Four changes were made to the interview questions based on the feedback from the pilot studies. These changes included clarifying the meaning of a question, i.e. rewriting it with alternative words, combining two questions into one because they were essentially asking the same thing, and changing the phrasing of two questions to include more detail.

Following the interview, participants were asked to complete the WAI-T-S questionnaire. The interview was conducted first so as to not influence the survey responses. This interview included 11 questions pertaining to characteristics of the sample such as years working in ED and demographics. In addition to this participants completed the Working Alliance Inventory, Therapist Version, Short Form (WAI-T-S, Horvath & Greenberg, 1989). The WAI-T-S is a 12 item, self report Likert-type scale, with responses to statements ranging from 1 = never to 7 = always. It includes three subscales (four items each) measuring therapeutic bonds (interpersonal attachments), agreement on tasks (what to do in treatment), and agreement about goals (consensus on outcome expectations) (Horvath, 2000, p. 167). Reliability (Cronbach’s alpha, Cronbach, 1951) of this scale was found to range between .84 and .93 (Cecero, Fenton, Nich, Frankforter, & Carroll, 2001). Convergent, concurrent, and predictive validity of this scale in comparison with similar scales, such as the Revised Helping Alliance

Questionnaire (HAQ-II; Luborsky, Jacques, Barber, Siqueland, Johnson, Najavits, Frank, & Daley, 1996) and the California Therapeutic Alliance Rating System (CALPAS; Marmar, & Gaston, Gallagher, & Thompson, 1989) measuring therapeutic alliance is supported, but is limited for differentiating between subscales (Horvath & Greenberg, 1989). Instructions were given to participants to select a former patient and to respond to the 12 questions on the WAI-T-S with that patient in mind. The name or description of the patient was to remain anonymous. Upon completion of the WAI-T-S, participants were sent the WAI-T-S and asked to complete it and return it to the student in person or in a prepaid, pre-addressed envelope.

3.4 Qualitative Analysis

Upon completion of each interview, the student transcribed the audiotapes from the telephone interviews. Accuracy of the transcription of 10% of the tapes (randomly selected) was verified by an independent reviewer, before destruction of the tapes.

Content analysis, using an inductive approach was utilized to analyze the data obtained from interview questions. In keeping with content analysis methodology, the collection and analysis of the data were conducted concurrently, throughout the course of the interviews. Original tapes of interviews and transcripts notes were reviewed and analyzed after each interview by the student researcher.

The unit of analysis for the manifest content analysis was words or phrases from participants' responses. These words or phrases were highlighted and upon further review, broken down into categories. The frequency of these codes and categories was noted. Prior to reviewing the coding and grouping with independent reviewers, the

categories were each identified by mutual agreement amongst the student and her advisors.

The coding and categories were then reviewed independently by an ED nurse and the Program Evaluator at the Regional Centre for the Treatment of ED at the Ottawa Hospital. Cohen's Kappa, a measure of chance corrected agreement, used assessed reliability for the manifest content analysis coding. The reliability of the coding was 0.65 between the student researcher and the Program Evaluator and 0.66 between the student researcher and an ED nurse, with a 95% confidence interval (Chuang, 2009). Both of these values represent a level of "substantial agreement" as per Landis & Koch's criteria (Landis & Koch, 1977). Any discrepancies were discussed between the coders and resolved.

A latent content analysis was used to analyze responses to questions regarding the nurse-patient relationship. Similar to manifest content analysis the transcribed interviews were read and re-read by the student. The level of analysis utilized was set at assessing for like sets of words or phrases (meaning units). These meaning units were given a code and interpreted by the researcher in the context of the questions and the interview as a whole.

Like meaning units were identified and grouped together to form categories. The "purpose of creating categories is to provide a means of describing the phenomenon, to increase understanding and to generate knowledge," (Elo & Kyngas, 2007, p. 111). These newly formed categories were then reviewed by the research student and discussed with the thesis advisors to identify emerging themes. Themes

identified were representative of the content and meaning of the interview responses following in depth analysis and review.

3.4.1 Rigor of qualitative component

Rigor of documentation, procedural rigor, and ethical rigor were respectively upheld by clearly outlining the study elements (context, research questions, and philosophy), accurately recording the data, and adhering to the ethical standards appropriate for a study of this nature and across multiple sites (Burns & Grove, 2001).

Credibility is the, “confidence in the truth of the data and interpretations of them” (Polit & Beck, 2004, p. 430). Data was reviewed and discussed with independent reviewers with knowledge of the methods and content area enhancing the credibility and conformability (data being objective) of the analysis. During the analysis, categories that emerged out of the interview transcripts were differentiated by concrete definitions agreed on by all reviewing the responses. Direct quotations were included in the findings to illustrate the meaning of the interview contents (Graneheim & Lundman, 2003).

Transferability is established when the findings make sense when applied to persons in similar situations outside of the immediate context of the study (Lincoln & Guba, 1985). Transferability was addressed by including a variety of participants, i.e. various ages, work experience, and location/type of ED treatment facilities. By including demographic information and detailed accounts using examples of the responses provided by the participants, increases the transferability of the findings to similar sites and situations.

The dependability (data remaining stable over time) was dealt with by frequently discussing the responses to the interview questions and subsequent data analysis with the thesis committee over the period of data collection (Polit & Beck, 2004). In addition, the analysis process and findings are clearly described to the reader.

Coding of the latent content analysis questions was reviewed independently by a second ED nurse and a Psychologist at the Regional Centre for the Treatment of ED at the Ottawa Hospital. These two staff was asked to identify words or phrases that they believed were indicative of a therapeutic alliance with the patient. Their findings were compared with the student and any discrepancies discussed and resolved.

3.5 Quantitative Analysis

3.5.1 Plan of quantitative analysis

The plan was to complete analysis of the qualitative component prior to data analysis of the quantitative component. The reason for this is because the quantitative data analysis is directed toward clarifying some of the key findings that emerged from the qualitative analysis. However, it also includes statistics (mean and standard deviations) to describe the sample in terms of demographic information (country, age, setting, gender) and characteristics (employment status, educational background, number of years in nursing, and number of years working as an ED nurse) and scores on the WAI-T-S and its subscales. Associations between demographics/characteristics and the WAI-T-S are examined using Pearson r correlation coefficients. Any differences between groups are examined using t -tests, two-tailed, alpha 0.05.

Chapter 4 - Findings

4.1 Findings

The interviews and surveys conducted with the ED nurses included a variety of responses pertaining to: (1) ED nurses' roles, skills, and characteristics, (2) the nurse/patient relationship, and (3) the WAI-T-S. Therefore, the findings will be presented in three sections. The first section will describe the roles, skills, and characteristics the nurses' viewed as important for ED nurses to possess that were identified from a manifest content analysis of participants' responses. Also identified in this section are some of the challenges, satisfying elements, and unique differences encountered by nurses working with people with ED. The second section presents findings from a latent content analysis of nurses' responses to questions regarding their relationship with patients to explore whether the concept of therapeutic alliance is part of this. Finally, the third section contains the quantitative results from nurses' responses to the WAI-T-S.

4.2 Roles, skills and characteristics

4.2.1 Eating disorders nurses' roles

From an explanation of their roles nine components were identified from the content analysis and verbatim from participants (see Figure 1), these included *Administrator, Mental Health Nurse, Team member, Researcher, Clinical Role, Educator/Self Learner, Patient Advocate, Safety Provider, and Group Facilitator.*

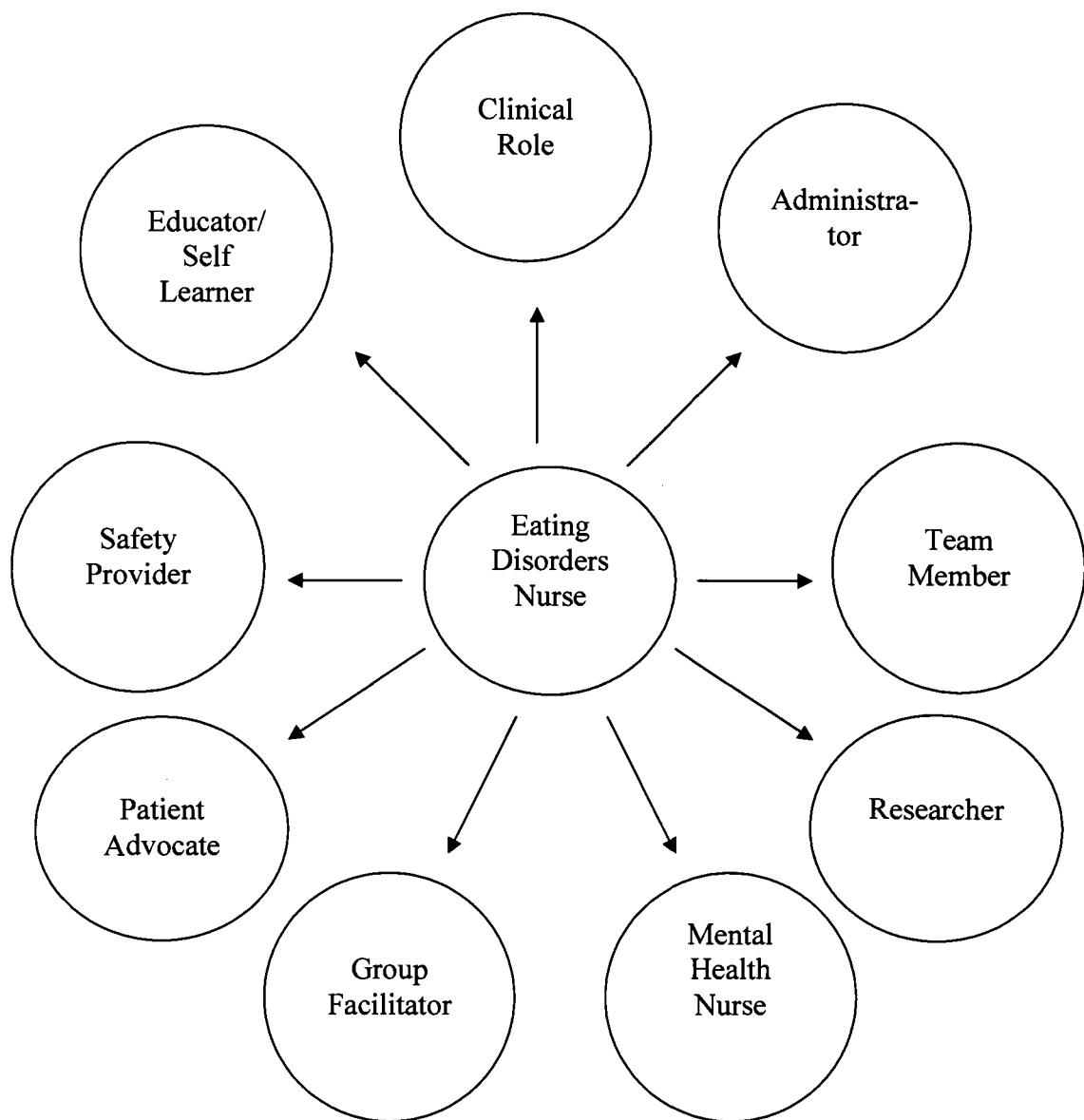


Figure 3. Roles of the eating disorders nurse as identified in the semi-structured interview with participants.

Administrator - The Administrative component of their role included tasks such as; performing clerical work, management duties, insurance and case management, documenting, ordering, and coordination activities. Thirty of the 35 Canadian and American nurses' identified administrative work as a component of their role. Clerical work included such things as "*making first contact with the patient with respect to their referral*" (ID 101), making assessment appointments, and completing staffing workload reports.

Management duties identified were; payroll, staffing the units, developing fair patient assignments, and "*making sure that the care of the patients was being done in a timely manner*" (ID 116). With respect to insurance and case management, one nurse described her role as, "*obtaining and summarizing accurate information for outside reviews and reviewing case management to authorize benefits*" (ID 108). Another nurse stated, "*a lot of our work revolves around how much the insurance company will pay to let patients stay*" (ID 119). American nurses made frequent reference to the time limitations that they experience in treating their patients due to limited insurance coverage, whereas this was not an issue for Canadian nurses, except as it applied to patients' length of stay when space was limited.

Documentation was a frequently mentioned administrative task. This included daily charting on progress notes, completing intake evaluations, transcribing doctors' orders, and counting of the narcotics every shift. Ordering of unit supplies, laboratory work, and medications was also identified as being part of administrative duties, as was coordinating unit activities. This ranged from arranging patient transport for transfers to

and from the hospital, and developing the program schedule, to coordinating meetings with patients and within the team.

Mental Health Nurse- Four main aspects to the role of the mental health nurse were identified. The first was that of performing mental status assessments on a daily and ‘as needed’ basis to monitor for cognitive changes throughout patients’ treatment. A second aspect was that of providing one-to-one time together with the patient. *“We are seen as semi-therapists as we are always available to talk if they are going through a hard time”* (ID 104). One nurse furthered to illustrate this, *“patients come to us rather than going to anyone else”* (ID 110).

Providing family support was another aspect in which nurses meet with both patients and their families to provide support and education. A fourth aspect was crisis management, which was depicted as dealing with patients having “flashbacks”, suicidal ideation, and self harm (cutting), *“if a patient is hysterically crying, I intervene. I talk to the patient one on one”* (ID 115). Interestingly, only 9/21 of American nurses reported mental health nursing as part of their role, whereas *all* Canadian nurses who participated identified this as being part of their role.

Team member- Being a team member was identified as being a part of the nurses’ role by 11/14 (79%) Canadian nurses and 9/21 (43%) of American nurses. This component comprised of treatment planning as a team, team communication, and multitasking, i.e. covering each others roles as needed. Treatment planning included both program planning and individual treatment planning.

Team communication was described by one nurse as, *“I am the person who keeps the communication going”* (ID 114) and by another nurse as, *“I communicate with*

the treatment team every morning in report. I give a report off to all the disciplines and just give a highlight from the last 24 hours on each patient. I am always communicating with those disciplines if issues come up” (ID 116). Part of being a team member meant being able to multi-task. As one nurse pointed out that, *“we see what the need is and take care of it”* (ID 110). Others described it as being available to cover sick calls, assisting non-registered staff with more complex patients, and being the one, *“who is basically responsible for everything that is needed”* (ID 111).

Researcher- Only three Canadian nurses of the 35 nurses interviewed made mention of research. These nurses had both developed and participated in research activities pertaining to ED disorders patients. One nurse identified a current project, *“I am involved in a research project with other staff...where patients chart on their own chart”* (ID 121).

Clinical Role - Clinical “hands-on” nursing activities, such as medication administration, wound care, monitoring test results, dealing with medical complications and crisis, on-going physical assessments, and nutrition (both food intake and care of feeding tubes) were frequently reported by participants. Care and monitoring of feeding tubes, medication administration, and dealing with medical complications were noted as making up the largest part of the ED nurses’ clinical role. The clinical role was described by one nurse as, *“I give meds, draw blood, take vital signs, palpate abdomens, access cardiac status, measure height and weight, start IV’s, and deal with medical complications. I take a patient assignment and see both in-patients and out-patients”* (ID 120).

Educator and Self Learner – The role of educator encompassed a range of activities from answering questions and providing information to patients, families, and staff to teaching medical students to draw blood. Only one Canadian nurse (7%) compared to 11 American nurses (52%) identified this as an aspect of their role. Nurses also mentioned their own continuing education. Many referred to ‘in-house’ education programs provided by the treatment centre staff as well as external educational opportunities, i.e. taking Dialectic Behaviour Therapy and Emotion Focused Therapy, either in their own time or sponsored by their employers.

Patient advocate- The importance of being an advocate for the patient was mentioned in relation to communicating the patients’ needs to the rest of the treatment team. For American nurses this also meant working on behalf of the patient with insurance firms.

Safety provider- Providing safety for patients with ED incorporated various aspects of the patients’ care, such as luggage searches and removal of all sharps in cases of self harm. Bathroom monitoring was required to prevent potential symptoms, i.e. purging behaviour and safety issues related to drug and alcohol withdrawal due to the increased risk for cross addiction.

Group facilitator- Mealtime supervision was identified by many of the Canadian nurses 12/14 and a smaller number of American nurses 7/21. Mealtimes were viewed as challenging, “*At mealtime, I monitor a table and watch for food rituals and I address them as I can or if it is better to do, I do 1:1 afterwards*” (ID 107). Tasks include assisting patients with meal preparation and following the meal with an ‘after-meal’ discussion about how they were feeling. Facilitating (or co-facilitating) also incorporated group therapy by Canadian but not American nurses. Group programs

included those of; relaxation, relationship, self image, body image, mindfulness, as well as grocery shopping with patients.

Nurses noted that their role varied somewhat depending on staff availability and assignment for the shift, i.e. charge nurse, medication nurse, or general staff nurse. The overlapping of roles was frequently reported by participants depending on the needs of the patients on any given day. Nurses stated that, “*you have to be quite flexible to fill in any job*” (ID 122).

The results of the number of responses from the interview question number 12 are outlined in Table 1.

Table 1

Number of Responses by country to Question 12 Identifying the Role of the Eating Disorders Nurse

Role	Total responses	Canadian nurses (%) N = 14	American nurses (%) N = 21
Administrator	30	12 (86%)	18 (86%)
Mental health nurse	23	14 (100%)	9 (43%)
Team member	20	11 (79%)	9 (43%)
Researcher	2	2 (14%)	0 (0%)
Clinical role	30	12 (86%)	18 (86%)
Educator/Self Learner	12	1 (7%)	11 (52%)
Patient advocate	2	0 (0%)	2 (10%)
Safety provider	13	4 (29%)	9 (43%)
Group facilitator	8	8 (57%)	0 (0%)

4.2.2 Skills required of an eating disorders nurse

Participants also described the skills that they felt were important to nurses working with patients with ED (Table 2). These linked with the various roles of the ED nurse and expanded on this information by highlighting the skills required to fulfill these roles. Mental health skills included; therapeutic communication skills such as, counseling/therapy skills, psychiatric knowledge and assessment skills, and psychiatric experience with trauma, post traumatic stress disorders, and dealing with physical and sexual abuse. The uniqueness of the context and caring for patients with ED was illustrated in the following response,

“Being able to take in the big picture and realize that some of them may be cognitively challenged and give you one word answers. The eye contact won’t be good, energy level is not there and they may not understand your questions. Until patients are fully nourished we need to keep communication open. Takes a while for someone to be nourished and that’s why we have a structured environment. Know how to assess and respond to different diagnosis” (ID 108).

Furthermore, the ability to recognize their own ‘self awareness’ was seen as valuable. One nurse stated, *“nurses coming here often feel that they have to do everything for patients...you have to see how you effect others, especially in difficult situations” (ID 133).* Patience and tolerance of patients who do not respond right away to treatment was mentioned as being a vital skill as well. The ability to multi-task and to vary ones role from day to day was noted as an extremely useful expertise to acquire.

“Most of the time I am the medication nurse...I count the narcotics and give the morning meds. I also monitor a table and watch for food rituals at mealtime.

Sometimes I help with flushing NG tubes. If the Mental Health Technician's are busy and someone needs the use the bathroom, I monitor the patient in the bathroom. I answer the phones. If you are the charge nurse, you have to communicate with the doctor. Sometimes I just help...I mean there is always something to do" (ID 107).

Table 2

Number of Responses by country to Question 13 Identifying the Skills of the Eating Disorders Nurse

Skill	Total responses	Canadian nurses (%) N = 14	American nurses (%) N = 21
Administrative	4	3 (21%)	1 (1%)
Mental health skills	21	12 (86%)	9 (43%)
Interpersonal skills	4	2 (14%)	2 (10%)
Researcher	2	2 (14%)	0 (0%)
Clinical skills	26	8 (57%)	18 (86%)
Teaching skills	3	1 (7%)	2 (10%)
Multi-tasking skills	2	0 (0%)	2 (10%)
Organizational skills	1	1 (7%)	0 (0%)
Self awareness	2	2 (14%)	0 (0%)

4.2.3 Approaches utilized by eating disorders nurses

Many nurses in both Canada and the United States identified “building a therapeutic relationship with the patient” as an effective approach with ED patients. As

one nurse noted, *“I think it is really important that the role of the nurse include, when you first contact be a warm caring person because they are so anxious about the referral that I think you should establish a therapeutic relationship right from the word go”* (ID 101). Key terms such as trust, empathy, support, caring, understanding, being non-judgmental, and setting boundaries were listed to describe the techniques utilized by nurses to develop these relationships. The identification of these terms links directly with the major components of the concept of therapeutic alliance.

Three different interaction approaches were identified by staff. A direct, firm approach was chosen by 2/14 (36%) of Canadian nurses and 6/21 (29%) of American nurses. When describing how they interacted with patients they reported such phrases as, *“you have to be firm and let them know what the consequences are”* (ID 103). Other nurses described their nurse-patient interactions as, *“let’s just say they don’t get away with as many things with me as they do with the others, which lends to building up trust”* (ID 105), and *“I can be firm...I am pretty direct...I am up front with them”* (ID 121).

A gentle, loving approach was used by 5/14 (36%) of Canadian nurses and 9/21 (43%) American nurses. Here nurses talked about *“being loving and caring”* (ID 112) and *“I am very motherly. So I can give advice that comes out as motherly advice and it might be accepted a little bit easier from the girls. I think I have a really good rapport going with them”* (ID 111).

And finally a combination of firm and caring was the approach for 7/14 (50%) of Canadian nurses and 6/21 (29%) American nurses. Nurses described knowing when to take a firm stance and when to take a softer approach. This was illustrated in the

following statement *“meal times are the hardest for patients and redirecting the patients in a firm yet loving manner and letting them know they’re not being punished...so, trying to be loving and compassionate when redirecting”* (ID 109).

4.3 Challenges of Eating Disorders Nursing

Four main challenges of ED nursing were identified by participants during the interviews: (1) working as a team; (2) dealing with their own reactions; (3) dealing with patients; and (4) environmental challenges. Ways in which staff dealt with these challenges are also noted.

Working as a team – Participants identified keeping communication up to date amongst team members in order to maintain consistency in the treatment. This was a challenge due to the large number of staff and shift work. Nurses also reported that dealing with personality and attitude differences amongst team members was difficult at times.

“I spend more time with staff sometimes than patients and that’s because not having enough opportunity to get into their own lives and they come onto the unit and they get stuck with the issues they hear about the patients it just raises their whole energy levels and then they get into conflict with each other” (ID 108).

Dealing with their own reactions – Different challenges were noted with the staffs’ own reactions; being aware of ones own feelings; understanding ED issues; awareness of counter-transference; keeping strict boundaries; and acknowledging that treatment is not always successful.

“Mainly when a patient is not accepting their eating disorder. It’s easy for me to say and expect them to just get over it. But that is not how we have this

therapeutic relationship. We have our own expectations, we can't make that become part of the patient's expectations. We have to stay on that therapeutic level" (ID 110).

Dealing with patients - Working with ED patients on a continual basis was reported as frustrating at times. One nurse explained that,

"A lot of patients struggle, sometimes it's three steps backwards and three steps forward, and some days it's just three steps back and that's part of recovery. So just reinforcing even though, some days are harder than others we can help them get through those days and that's how we build the foundation. If they don't want to be here for themselves they won't put all their effort into recovery and that is very challenging" (ID 109).

Other aspects of dealing with patients that were reported as challenging were: working with personality disorders; helping patients to separate the physical aspects of the disorder from the emotional; and trying to understand the patient's viewpoint.

Environmental challenges – Nurses reported that dealing with society and the physical environment of the treatment facility added a challenge to their work.

"I think our biggest challenge is society. Feminine society talking about diets, etc. We can control this in a normal environment, yet ED patients do not see this the same way, they have a distorted image of this. It is challenging for me not to talk about things that we talk about in society all the time. The biggest challenge is to stay away from the touchy subjects. No food talk and we just bring it back to a more positive topic" (ID 104).

Dealing with Challenges – Participants responded to dealing with challenges from two points of view. One in dealing with staff challenges and two, dealing with patient challenges. First, with staff challenges, nurses reported that supporting each other, increasing communication amongst all staff, self reflection, and debriefing with co-workers were helpful ways in which they dealt with issues. As one nurse described “*I share with colleagues. Sometimes the behaviour component is hard to digest sometimes. That is why we have rehash after the group to talk about what went through our minds*” (ID 124).

4.4 Job Satisfaction for the ED Nurse

Participants identified four areas that made them feel professionally satisfied in their jobs: (1) seeing improvement; (2) feeling appreciated; (3) making a difference; and (4) self improvement.

Seeing improvement – Nurses’ frequently identified that seeing an improvement in patients was satisfying to them. Noticing a change in patients’ behaviour and attitude by implementing what had been taught, trusting in others, and making changes for themselves were positive aspects. As one nurse described, “*Seeing the person being able to manage what they couldn’t before. Seeing them trust people*” (ID 110).

Sustaining this transformation following discharge was also important.

“My biggest satisfaction to see a totally very sick person coming here probably almost dying on a medical floor and working here for six months really hard and see them going into recovery more and discharge from in-patient. Their will for life change. Saying thank-you. This is what I live for” (ID 123).

Feeling appreciated – For the nurses feeling appreciated meant more than people saying

thank-you. It was being respected and valued by patients, families, and staff.

“Appreciating my smile. I know I did a good job. When people can identify that. You were my favorite nurse. It is pleasant to hear that I have been an advocate for them. Knowing that you have been on their side” (ID 104).

Making a difference – Nurses mentioned that making a contribution by being able to provide education, tools, and support to facilitate patients’ recovery was gratifying. *“I guess when I realize that I notice that I actually helped someone and they succeeded or challenged themselves. That is rewarding to actually help people”* (ID 127).

Self improvement – Learning a new set of skills and being able to learn and grow as a person and a nurse were identified as fulfilling. As one nurse stated, *“I enjoy working with ED because it is a specialty and the training and the knowledge that go with it, is a lot”* (ID 115).

4.5 Differences Between ED Nursing and other Types of Nursing

Participants contrasted their current role in ED nursing from previous experiences working in other areas of nursing. One of the main differences was that it is an expanded and more complex nursing role that includes a variety of nursing skills and abilities in order to address the needs of this patient population.

Eating disorders nursing was also reported as being different in terms of increased autonomy. Comparing her current role with her previous work in psychiatry one nurse acknowledged that, *“here (ED treatment facility), I have a lot more autonomy because the doctors trust us to run groups and deal with individual crisis. I didn’t have that before”* (ID 135). Nurses also described their interactions with patients as more intense and personal in this context.

Given the diversity and complexity of ED nursing, participants gave a number of suggestions for new staff entering the field. Education in ED focusing on body image, desire for thinness, dealing with anger and manipulation, cognitive distortions, as well as co-morbidity were identified as being key areas of focus.

“There cannot be enough education to understand what ED is about. I don’t think it is well understood. Some nurses may have a lot of experience, but not with ED. That is critical, otherwise you are just going through the motions and it is hard to identify how it is helping. Knowing the definitions of anorexia and bulimia for a start. The education piece is so important” (ID 119).

The importance of the physical aspects of ED, including a knowledge of the potential medical complications of ED, strong assessment skills, clinical nursing skills, and a basic understanding of nutrition were identified. The psychological aspects of ED nursing were frequently referred to by participants. Encouraging new staff to learn how to facilitate a group, work with families, and utilize effective therapeutic communication skills were suggested. As the following quote illustrates,

“To be able to be comfortable with talking to the patients about their psychological struggles. I know that nurses are more used to doing things in a very structured type of way. They talk about ‘therapizing the patient’. They need to learn to learn how to deal with patients emotions. Also, learning how to run a group, i.e. being a group leader” (ID 128).

4.6 Therapeutic Alliance and the ED Nurse

Through latent content analysis of participants’ responses to questions regarding their personal attributes/characteristics as well as their relationships with patients, three

themes emerged: (1) *creating a therapeutic environment*; (2) *establishing a connection*; and (3) *empowering patients*. These three themes build upon one another to describe the process of developing a therapeutic alliance between the nurse and ED patient throughout a patient's treatment and recovery.

4.6.1 *Creating a therapeutic environment*

Nurses stressed the importance of creating an environment that promoted a feeling of comfort, safety, and security to best allow patients to be at ease for treatment. Certain traits such as being positive, easy to approach, and calm were attributes identified by participants as being key for the creation of this kind of atmosphere. As one nurse described, *"patience, being kind and understanding is really important. Not being over reactive. It doesn't do any good"* (ID 114). Another nurse furthered to explain, *"I'm easy to talk to, easy to approach. A lot of individuals who are not very open are able to be with them and that has always been the case in nursing for me I have found"* (ID 101).

One nurse explained that she uses herself as a role model to engage with patients; *"I am the bubbly morning person. I just make sure, no matter what, I am smiling. I want them to know that they can start their day positively. They can start their day on a good foot"* (ID 114). Alternatively, other characteristics of the nurses developed with experience in working with ED patients over time. Nurses expressed this as, *"empathy, I think that over the years, I have learned to be very empathic, patient, and open-minded to clients' struggles and to reserve judgment because the illness is so complicated"* (ID 120) and *"understanding...I think you have to be understanding and*

non-judgmental, particularly with this population. Being non-judgmental, so that they will open up to you and you can treat them accordingly” (ID 128).

4.6.2 Establishing a Connection

Establishing a connection was seen as vital to the treatment and subsequent recovery of patients. In this theme, nurses’ described a number of ways in which this was achieved. As ED patients are often reluctant to engage in relationships with anyone due to lack of trust and/or self confidence, development of trust was crucial to forming relationships with patients. Trust was gained through providing opportunities to connect, spending time together, and being there for the patient.

“There is the issue of trust particularly with new clients. Patience and understanding. Trying to develop an alliance with them. Trust, showing them that you are human and a lot of the things that they think/experience people who are well experience too. Being reliable and caring” (ID 120).

“I think it’s pretty much about introducing myself and knowing who I am and that

I want to know who they are and make them sit down out of the chaos and get some of this out... to get to know you right now so we can help you where you are physically, medically, nutritionally and what is hurting” 108).

Providing patients with the opportunity to connect with staff in a non-verbal way also emerged. As one nurse described,

“I take the patients for a walk to talk. I teach them how to get in touch with what is going on, on the outside. Connecting with nature. Looking out of their window at night at the moon – is it a quarter, half, crescent, or full moon.

Smelling the air and the changes in the air” (ID 132).

The use of effective communication techniques was repeatedly noted by nurses as another means of connecting with patients. Nurses' reported that their use of various communication techniques was based on individual need, as well as the patient's cognitive ability and stage of treatment. Verbal communication techniques that were mentioned were; repetition, the appropriate use of humour, explanations, open-ended conversations, and moving the focus from the general to the specific. The following three quotations illustrate these communication techniques:

"They often have the answers, but are struggling. Encourage them. Giving them information so that they know you are a safe person. Stay true and follow through with what you have said to them. Let them know that you are human. Being honest is very important. The challenge for staff is knowing when enough is enough to tell them that" (ID 119).

"You want to open up the doors to communication. If you always treat everything like it's theirs...I don't know how to describe it... I try to make them feel comfortable and talk about anything...to project the idea that nothing is off the table to talk about," (ID 121).

"Technique that I use when I'm meeting with the girls one on one is I start general then move to the specific and see on a general note if they will open up to talk about what's going on with them. But if they're not responding to a general approach then I might move more specific and ask them more specific things" (ID 116).

Picking up on subtle non-verbal cues was also reported as being important.

“Something I have developed since I have been here, my ability to talk about what is going on in the room, i.e. I am noticing some resistance her, i.e. what’s happening and bring this to their awareness” (ID 128).

Finally, establishing mutual goals with the patient was reported as significant in connecting with ED patients. As one nurse stated, *“If you are not on the same page and share the same goals, it is difficult” (ID 122).*

4.6.3 Empowering Patients

Empowering incorporated a desired outcome for ED treatment in helping patients to identify issues that contributed to their illness, to eliminate unhealthy symptoms, and to develop new, healthy coping skills and strategies. When deciding where to work one nurse stated that, *“I wanted to empower women... and body acceptance. Our clientele is all women, so that spoke to me” (ID 126).* Another nurse explained that, *“I try to get them to understand that we are a team and they are part of that team. I am not here to fix them. They have to participate to fix themselves. To help them recognize that they have as much power as I have” (ID 121).*

Nurses described four ways that they felt that their role helped to empower patients. One approach to achieve self empowerment was by treating each patient as an individual and adjusting their care to meet the unique needs of each patient. One nurse stated that, *“A patient said to me that I made her feel like a human being and not a number... and that’s why I am here” (ID 118).*

Motivating patients to take responsibility was apparent throughout the treatment process, starting as early as the initial assessment phase (encouraging treatment) right through to the transition/follow-up stage of treatment and long lasting recovery. A nurse

reflecting on her experience explained, *“I kind of get where patients are coming from. I am good at motivating others with team building and talking with each other”* (ID 129).

Thirdly, validating patients’ thoughts and feelings was reported as being helpful in empowering patients and assisting them through the recovery process. Patients often develop misperceptions about themselves and the world around them. Thus, permitting them to express their thoughts and feelings openly gave rise to being able to promote self confidence and increase self esteem and self worth. *“I encourage them to speak up if they don’t agree. I validate what they say”* (ID 127).

Providing support encouraged patients to move forward in their treatment was seen as another way of empowering patients. Through analysis of the responses it was evident that providing patients with the knowledge that support was available, give them the confidence and security to empower themselves.

I think for myself probably all other nurses like to try and help patients and they want to be there in a positive way to support them through difficult times and I am always happy to see a patient improve and they can go about their daily activities without an eating disorder” (ID 110).

4.7 Quantitative Results

All the quantitative data were entered into SPSS V15 for analysis. Prior to completing any analysis, the data were screened, and assumptions of normality and homogeneity of variance were checked (Field, 2005). Descriptive analyses were outlined in the methods section.

The reliability of the WAI-T-S was explored using Cronbach’s measure of internal consistency (Cronbach, 1951). This analysis produced an alpha statistic of .81.

This result is slightly lower than previous research on the WAI-T-S that produced alpha's in the range of .84-.93 (Cecero, et al., 2001), but the level does indicate that the measure is internally consistent.

Scores for the WAI-T-S and its subscales are shown in Table 3. A score of 4 is equal to a response of "sometimes" and a score of 5 is equal to "often" with respect to how the participant might rate his/her interactions with a patient. Table 3, reflects the average scores of both Canadian and American nurses on the WAI-T-S overall and its subscales (maximum score for each subscale and total = 7).

Table 3: WAI-T-S total scale and subscales scores.

Component of WAI-T-S	Mean Scores total sample N = 35 (standard deviation)	Mean Scores Canadian N= 14 (standard deviation)	Mean scores American N = 21 (standard deviation)
Task	4.80 (0.86)	5.36 (0.59)	4.43 (0.82)
Bond	5.66 (0.74)	5.98 (0.47)	5.44 (0.82)
Goal	4.86 (0.69)	5.18 (0.62)	4.65 (0.66)
WAI-T-S total	5.10 (0.11)	5.51 (0.44)	4.84 (0.67)

Canadian nurses' scores on the WAI-T-S (total) were noted to be higher than U.S. nurses' scores. Nurses over the age of 50, had higher scores than those younger than 50. No difference in scores was noted on the WAI-T-S with respect to the number of years working as a nurse or working as an ED nurse. Pearson's r correlation was conducted between age, years working with ED patients, years working as a nurse, and the WAI-T-S total score. Although no statistically significant ($p < 0.05$) results were

obtained, a correlation between age and WAI-T-S scores was trending towards significance ($r = -.316, p = 0.05$).

Based on the findings from the qualitative analysis, role/skill differences between sites, the mean differences between nurses in Canada and the US were analyzed using a t-test to determine if any significant differences were present between countries with respect to therapeutic alliance. Canadian ED nurses ($M = 5.51; SD = 0.44$) scored significantly higher on the WAI-T-S than American ED nurses ($M = 4.84; SD = 0.67$), $t(33) = 3.29, p < .002$. The American nurse participants were older ($M = 53.75; SD = 14.56$) than the Canadian nurse participants ($M = 43.77; SD = 9.37$), $t(31) = -2.19, p < .04$). Given the trending association between age and the WAI-T-S it was important to remove possible effects of age. Thus an analysis of covariance (ANCOVA) was conducted to determine whether location (Canada or the United States) of the participants affected their WAI-T-S results, if age was portioned out. Indeed, the covariate age was statistically significant $F(1, 30) = .82, p < .03$. In turn, the age-corrected model yielded a statistically significant effect, $F(2, 30) = 5.74, p < .008$. Examination of the mean WAI-T-S scores indicated that Canadian nurses had higher WAI-T-S scores ($M = 5.52; SD = 0.45$) than their US counterparts ($M = 4.82; SD = 0.67$) when age was controlled for. A large effect size was also noted to be present, $r = .51$ (Becker, 1999; Fields, 2005). The differences in means on the WAI-T-S between diploma prepared nurses ($M = 5.20; SD = 0.71$) and degree nurses ($M = 4.96; SD = 0.58$) was not significant $t(33) = -1.04, p = 0.31$.

Chapter 5 - Discussion

This study focused on identifying the various roles of the ED nurse, including the skills and approaches used in ED treatment. In addition, it also looked at whether the development of a therapeutic alliance with the ED patient was considered by nurses as part of their role. Other aspects of ED nursing that shall be discussed in the following are; challenges of ED nursing, rewards of ED nursing, the therapeutic alliance and ED nursing, training and education, as well as the implications for nursing, and finally suggestions for future research and the limitations of this study.

5.1 Eating Disorders Nursing and Nurses Roles

Although previous studies (Ryan, et al, 2006; Muscari, 2002) have identified various roles of the ED nurse, this current study expanded on these studies to describe ED nurses' roles from a multi-site, multi-country perspective. The nine nurses' roles identified provide a comprehensive description of ED nursing that reflects its complexity. It further illustrates the significant changes to this role that have occurred from the early ED treatment history. ED nurses have gone from being basic bedside caregivers to being independent, multi-functional members of the treatment team.

The findings in this study are representative of the types of roles that have grown to meet the physical, psychosocial, and emotional needs of today's ED patient in a variety of treatment facilities in both Canada and the United States. As ED treatment in North America has evolved, the role of the ED nurse has expanded to keep up with the demands of both the patients as well as the limitations placed on treatment by limited government funding and health insurance constraints. The focus on the clinical aspect of the nurses role (and skills) in the United States is perhaps suggestive of the need to

meet the demands of insurance companies who continue to decrease the funding available for ED patients, thus increasing the need to treat patients faster (tube feeding).

Canadian nurses placed a greater emphasis in their interviews on mental health and group facilitator roles compared to their American counterparts. This could be reflective of the separate staffing position of “therapist” in American treatment centres that is not present in the Canadian system. As result of not having ‘therapists’ in the Canadian system, ED nurses often find themselves taking on this component of treatment. The quantitative results that indicated that Canadian nurses scored significantly higher on the WAI-T-S than American nurses are perhaps indicative of the ED nurses’ role in Canada allowing for more time to be spent with the patient in a therapeutic form, i.e. group facilitation, rather than a primarily clinical focus.

Through analysis of the interviews, it became evident that ED nurses in both countries frequently need to be flexible in their role. Although participants were all part of multidisciplinary teams, nurses indicated that they are expected to have the ability to “fill in” for other disciplines as needed, on any given day or shift. The need for ED nurses to be able to multi-task was indicated in responses that illustrated that although the nurse might be assigned to be the ‘medication nurse’ for the shift, that nurse may be required to cover for any member of the treatment team. In doing so, the ED nurse could be called upon to provide education to patients and/or families, monitor bathroom safety, cover the charge nurse’s position, and potentially any other role required during the course of treatment, within his/her scope of practice. Thus reinforcing the fact that comprehensive training is required for ED nurses to feel both comfortable and confident in order to fulfill these demands.

This study not only illustrates the role of the ED nurse, but also the autonomous nature of the nurse in this specialty area. As noted within the available literature (Irwin, Part 2, 1993; Ryan et al., 2006), nurses, due to their continuous presence with patients, are often the only member of the treatment team required to monitor, assess, intervene, evaluate, and report the ongoing condition and progress of the patient. This holistic, independent approach was universal in the responses obtained from participants.

5.2 Skills and Approaches in Eating Disorders Nursing

A second contribution of this research arises from its detailed descriptions of the skills and approaches utilized by ED nurses. Various studies have presented the multidimensional nature of ED, identifying the medical complications, cognitive impairments, interpersonal difficulties, and the multitude of treatment issues (Turner et al., 2000; Paxton et al., 2007; Forbush et al., 2007; Wolfe & Gimby, 2003). This study however, sought to amalgamate and extend the above information from the nurses' own perspectives including a description of the skills and approaches required to perform their roles. The *large* variety of skills and approaches that were identified by participants illustrates the need for a combination of both education and experience to prepare one for this role. A combination of medical, mental health, administrative, and interpersonal skills were most frequently highlighted by ED nurses as those pertinent to ED nursing.

Participants identified the importance of developing a therapeutic relationship/alliance with the patient as an effective approach to treatment which is consistent with previous research with ED patients (Owen & Fullerton, 1995; George (1997). The frequent references to the concepts of the therapeutic alliance, i.e. empathy,

trust, patience, etc., throughout the interview sessions illustrated this point as well as linking to the working definition of therapeutic alliance developed as a result of the literature review. The ED nurses included in this study focused on the need to develop a relationship with the patient early and maintain its strength throughout treatment.

Nurses in this current study furthered the existing research to identify three sub-types of their approaches, including the use of: a direct, firm, approach; a gentle loving approach; and a combination of firm and caring approaches. The use of these approaches appeared to depend on a combination of the individual nurses' personal attributes, previous experiences, and training leading them to develop their own personal 'style' that could vary depending on the needs and nature of each individual patient. A training program focusing on identifying ones' own interpersonal style and its relationship to caring for patients would be useful.

5.3 Challenges in Eating Disorders Nursing

Challenges that were identified by ED nurses during the course of the interviews were indicative of the nature of ED and its treatment in a team format. Findings reported were similar to those found in previous studies (Warren et al, 2009; Manley & Leichner, 2003) with respect to dealing with feelings of frustration and boundary issues, but novel with respect to dealing with the challenge of working as a team. Although a few staff expressed their satisfaction and appreciation of the support and guidance that they receive from other team members, numerous ED nurses stated that they found this one of the most challenging aspects of their job due to differences in personalities and professional status. Suggestions that were offered by participants to help alleviate this issue included: improving communication amongst staff members, acknowledgement of

each team members' skills and capabilities, and including all staff members in having an 'active' voice in treatment planning.

5.4 Rewards in Eating Disorders Nursing

Job satisfaction was reported as important to ED nurses and was identified as often being related to patient progress, feeling appreciated, and self improvement. These results tap into different aspects of job satisfaction than were identified by Warren et al., 2009, whose findings indicated that staff working with ED patients, "enjoy the challenge" and find it "an opportunity to experience a challenging but also deep relationship with clients...to appreciate the complexity of the work" (Warren et al., 2009, p. 41).

5.5 The Therapeutic Alliance in Eating Disorders Nursing

Further to the above mentioned approaches that ED nurses use to develop a therapeutic alliance with the patient, three themes emerged from the latent content analysis of the interviews; *creating a therapeutic environment*, *establishing a connection*, and *empowering patients*. These themes evolved from an integration of the findings that identified the personal attributes of ED nurses as well as the approach used to develop a therapeutic relationship with the patient. Each theme was constructed in order to connect with the previous one, thus building a continuum of care from start to finish. This was exemplified as nurses described their efforts during the treatment process to provide an open, non-judgmental atmosphere for treatment, followed by time spent together with patients to develop trust, working towards the final steps of treatment, patient independence and recovery.

With respect to the concept development of therapeutic alliance identified in the previous literature review (Owen & Fullerton, 1995; George, 1997; Wolfe & Gimby, 2003), participants across countries and settings in this study frequently referred to the same attributes throughout their interviews. These included being non-judgmental, caring, developing trust, respect, empathy, support, and understanding alike. In addition, numerous ED nurses indicated that they possess traits such as being compassionate, patient, kind, and calm, all of which they found extremely helpful in their roles. They expressed that their varied work (medical, surgical, and community nursing) and life experiences (being mothers, wives/husbands, and volunteers) also benefited their abilities to perform their jobs.

Participants reported that they felt that the development of a therapeutic alliance *was* part of their role as an ED nurse and attributed increased success in communicating with and motivating treatment resistant patients by using its concepts, such as being encouraging, being realistic, and persevering, as part of treatment. This was supported by the quantitative analysis, which indicated that both Canadian and American ED nurses identified the development of a therapeutic alliance as part of their role.

The findings further the existing research (Ryan et al, 2006; Ramjan, 2004) by providing evidence that the need to develop a therapeutic alliance with the ED patient is universally indicated to be imperative by ED nurses in multiple treatment settings.

5.6 Implications for Training and Education

Arising out of this study and that of others (Warren, et al., 2009) is the strong need to develop a comprehensive training program for nurses working with ED patients. The findings indicate that ED training should ideally consist of providing nurses with a

review of fundamental clinical nursing skills, mental health nursing skills, group facilitation, nutrition, and teaching skills. Strong emphasis should be placed on the interpersonal component of a training program, stressing the need to develop an alliance with the patient based on trust, empathy, and support. The inclusion of both basic and advanced therapeutic communication skills would also be helpful for staff to learn. The differences in the roles identified between Canadian and U.S. ED nurses should also be considered in the development of training programs, in that the American ED nurses' role has a stronger medical focus than their Canadian counterpart.

5.7 Implications for Nursing Practice

5.7.1 Advanced practice nursing

Advanced Practice Nursing is an umbrella term that represents nurses who have completed a graduate level of education and are working autonomously, creating and implementing new nursing practice (Gardner, Chang, & Duffield, 2007). There are five components to the advanced practice nurse's role; clinical practice, consultation, education, leadership/administration, and research. It is the "effective interaction, blending and simultaneous execution of the identified skills, knowledge, judgment and personal attributes in highly complex practice environments and health care organizations that characterize advanced practice nursing" (Canadian Nurses Association, 2000, p. 6). Each of these APN roles will be discussed in relation to the findings of this study.

5.7.2 Clinical practice and eating disorders nursing

An advanced practice nurse working in ED can do a number of things to affect his/her own clinical practice as well as that of other nurses. First, the APN collaborates

with the multidisciplinary team to assess patients and develop individualized plans of care. Second, the APN co-facilitates groups with other multidisciplinary staff. Working with other team members in this manner, provides a unique opportunity for teaching and supervision of new staff members. Third, medical directives and new protocols can be developed, implemented, and evaluated by the APN. Front-line, clinical ED nurses have direct access to the APN in order to provide valuable input into treatment development as an integral member of the treatment team. Finally, the APN assesses complex practice issues, and develops innovative approaches and programs to address patient needs, based on feedback and input from clinical ED nurses.

5.7.3 Consultation and eating disorders nursing

Advanced practice nurses are in the unique position of being able to provide consultation to nursing staff, management, interdisciplinary team and physicians regarding clinical and professional practice issues. The APN acts as a liaison and consultant to other health care facilities and can participate in the coordination of complex care and discharge planning for patients transitioning from one component of the program to another. This links directly with the clinical nurses' role of administration, i.e. formalizing the transfer, as well as the role of patient advocate, in terms of jointly developing the continuing treatment plan post discharge.

5.7.4 Education and eating disorders nursing

The APN acts as a resource nurse and clinical expert within the specialty of ED. Part of this role is to develop and deliver orientation to new staff joining the treatment team as well as for temporary staff providing coverage during absence. Ongoing educational sessions provided for staff should be based on current best-practice to

promote quality patient care for patients with ED. The content of these sessions should stem directly from information obtained from research undertaken by both clinical nurses and APN's alike. In the context of ED, the APN, clinical nurses, and other members of the treatment team can also provide education to both patients and families via public workshops and presentations along with clinical nurses.

Clinical nurses are also supported in their own professional development and career planning as it pertains to ED and related issues (co morbid disorders). APN's are also provided with the opportunity to expand their knowledge by furthering their education through attendance at courses, workshops, and conferences.

Through involvement in undergraduate and graduate nursing education the APN can raise awareness of ED to nurses working in various other fields, such as medicine and surgery, strengthening the ability of these nurses to work with ED patients not currently in treatment. The APN and clinical ED nurses participate in nursing training through presentations to students during their mental health rotations to spark an early interest in working in this dynamic field. Greater understanding may decrease stigma of "self-inflicted" condition and encourage others to enter the field.

5.7.5 Leadership/Administration and eating disorders nursing

As APN positions quite often include a management role, the APN can utilize the findings of this study to participate in and support nurses in continuous quality improvement initiatives such as evaluation of the effectiveness of interventions and nursing services on patient outcomes. The APN can act as a mentor to nursing colleagues and others to enhance and support nursing practice based on the need of both patients and staff. Through their patient advocate and educator roles, clinical ED nurses

can work jointly with APN's to become leaders in promoting research and education in ED, thus addressing the key societal issues of glorifying thinness and reducing the judgmental attitude towards body shape and weight.

5.7.6 Research and eating disorders nursing

The APN can contribute to the broader context of nursing knowledge through research, knowledge dissemination, presentations and publications. Clinical nurses can also be supported with their own research to advance knowledge in this complex field. As identified in this study, clinical ED nurses have taken on the role of researchers, basing their studies' on issues that arise from current clinical practice. As clinical nurses have a greater understanding of services delivered, research ideas will be relevant, resulting in staff having greater confidence in the implementation of outcomes.

5.8 Implications for Future Research

In this study, the participants indicated a great deal of comfort with the interview method of data collection. They expressed that they were able to explain their viewpoints better in this format rather than in a structured, written questionnaire. As a novice researcher, I found the interview process both rich in the quality and quantity of the information that was obtained for a topic at an exploratory level. Future researchers may wish to build upon the information obtained in this study, such as the need to develop a therapeutic alliance with the patient, to include responses from ED nurses working in different types of treatment programs or other parts of the world.

The benefits of a mixed methods approach were that it provided two ways to collect information about ED nursing and the development of a therapeutic alliance with the patient in this exploratory phase of research. This approach also provided a clear

context from which findings were interpreted and various perspectives could be included. In the analysis component, it also helped to identify a difference in roles between Canadian and American nurses that might not have been apparent with a single approach.

5.9 Limitations

A limitation of this study is that there was an absence of hospital-based treatment programs in the American sample. This potentially could have tapped into a variation in the American ED nurses' role because of a potential difference in the severity of the patients, thus affecting treatment as well as a different staffing compliment in a hospital which may affect the nurses' role. Another limitation was the small number of strictly out-patient nurses that were included in this study. Not having continuous contact with the patients may have affected their responses. It would have been interesting to make further comparisons between in and out-patient nurses as to their views on the development of a therapeutic alliance and to their role.

Although the interview method of data collection produced a vast amount of information and participants stated that they felt comfortable with the process, the use of interviews might have given rise to responses that conform to socially accepted norms rather than their own opinion (Polit & Beck, 2004). In order to reduce the risk of this happening, participants were reminded that their responses would remain anonymous and they were free to express their true feelings.

Another limitation was the WAI-T-S. The WAI has three different versions, the therapist version (which was utilized in this current study), the patient version, and an observer version. It is traditionally used (Horvath & Greenberg, 1989; Gallop,

Kennedy, & Stern, 1994) to compare scores between different participant groups, i.e. between patients and therapists as to their views of the therapeutic alliance arising during therapy. The use of the WAI-T-S in the current study was limited in that only the therapists, or in this case, ED nurses participated, therefore limiting the use of this tool to identifying average scores on the scale and allowing comparisons between nurses to be made.

Further research into the concept of therapeutic alliance could take the direction of developing a new therapeutic alliance questionnaire specifically for nurses and surveying both nurses and ED patients as to their thoughts and feelings pertaining to an alliance and compare these results with treatment outcomes.

Although self-report approaches to research are advantageous in the wealth of information that can be gleaned, they are potentially confounded when discussing ones behaviour(s), as one is not always aware of how our actions are perceived by others. This could be overcome in future studies by interviewing staff about their own behaviours as well as including staff descriptions of their colleagues behaviours for comparison purposes.

Although few of the interviews in this study were conducted over the phone (six), participants may have limited their responses as they were not engaged in a face to face conversation that can encourage discussion from non-verbal cues. Conversely, telephone interview participants may have felt more comfortable with describing their views, due to the anonymity of the format.

The sample itself was representative of Canadian treatment facilities, as it included nurses from both in and out patient programs in four different locations. The

American sample was more limited in that it included only two treatment centres, both residential in format and not hospital-based programs. This limitation might affect the transferability of the findings in that the programs and roles of the ED nurses may differ.

A final limitation that became apparent during the course of the research relates to the mixed-method design. Although this method was rich in terms of the depth and breadth of the data that it provided, it was difficult to compare the two components and to subsequently explain the findings in a succinct manner. This comparison was challenging because although the concepts of therapeutic alliance were readily identified in the interview responses, it was difficult to quantify the development and strength of a therapeutic alliance from this component. Conversely, the level of therapeutic alliance was indeed measurable from the WAI-T-S scores, but the details of the alliance were not defined.

5.10 Concluding Statement

As a result of using a mixed-method approach, a vast array of information was gleaned from participants in two formats (interview and survey). From the qualitative interviews it was possible to identify and describe facets of ED nurses' roles and skills, in addition to rewarding aspects of ED nursing and challenges faced by nurses in their work. In relation to the therapeutic alliance, the two components added strength to the findings. The qualitative component enabled nurses to elaborate on the nurse-patient relationship and illustrate how a therapeutic alliance/relationship is developed within the clinical setting. Whereas, identification of a therapeutic alliance through the quantitative component, added support to this finding and facilitated meaningful comparisons based on the qualitative findings. In conclusion, this study is original in its approach and scope

to understanding the role of the ED nurse; from their own perspectives and in a variety of treatment settings across Canada and America. Furthermore, the findings add to a growing body of literature on the therapeutic alliance/ relationship in nursing by identifying it as part of ED nursing.

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Working Alliance Inventory

Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____ in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it *never* applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL ; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

© A. O. Horvath, 1981, 1984.

1.	_____ and I agree about the steps to be taken to improve his/her situation.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
2.	My client and I both feel confident about the usefulness of our current activity in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
3.	I believe _____ likes me.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
4.	I have doubts about what we are trying to accomplish in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
5.	I am confident in my ability to help _____.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
6.	We are working towards mutually agreed upon goals.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
7.	I appreciate _____ as a person.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
8.	We agree on what is important for _____ to work on.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
9.	_____ and I have built a mutual trust.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
10.	_____ and I have different ideas on what his/her real problems are.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
11.	We have established a good understanding between us of the kind of changes that would be good for _____.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
12.	_____ believes the way we are working with her/his problem is correct.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always

Appendix B

Notification of REB Initial Approval**Date:** July 14th, 2008**To:** Dr. D Woodside

Rm. 210, 8th Floor, North Wing, Eaton, Toronto General Hospital, 200 Elizabeth St.

Toronto

Ontario, Canada

M5G 2C4

Re: 08-0528-BE

Description of the Components of the Role of the Nurse with Eating Disorder Patients and Whether the Development of a Therapeutic Alliance with the Patient is Part of that Role

REB Review Type: Expedited**REB Initial Approval Date:** July 8th, 2008**REB Approval Date:** July 8th, 2008**REB Expiry Date:** July 8th, 2009**Documents Approved:**

Study Protocol

Received on: April 9th, 2008

Documents Acknowledged:

Project Information Sheet

Received on: July 8th, 2008

Informed Consent Form

Received on: April 9th, 2008

The above named study has been reviewed and approved by the University Health Network Research Ethics Board.

If, during the course of the research, there are any serious adverse events, confidentiality concerns, changes in the approved project, or any new information that must be considered with respect to the project, these should be brought to the immediate attention of the REB. In the event of a privacy breach, you are responsible for reporting the breach to the UHN REB and the UHN Corporate Privacy Office (in accordance with Ontario health privacy legislation - Personal Health Information Protection Act, 2004). Additionally, the UHN REB requires reports of inappropriate/unauthorized use of the information.

Please be aware that it is UHN policy that research-related activities involving an external party require a research agreement. An 'external party' refers to a corporation other than UHN or an individual who is not UHN personnel. Should a research agreement be required in this case, the study may not begin at UHN until the agreement has been signed by all parties. Should the negotiation process raise concerns, the REB reserves the right to reconsider its approval.

If the study is expected to continue beyond the expiry date, you are responsible for ensuring the study receives re-approval. The REB must be notified of the completion or termination of this study and a final report provided.

Appendix C

DATA SHARING AGREEMENT

This Agreement, effective as of the date of signature of the last party to sign below, is made between University Health Network, Toronto, Ontario (hereinafter "UHN" or the "Disclosing Party"), and the University of Ottawa (hereinafter "uOttawa" or the "Receiving Party"), with respect to data that employees of UHN will provide to uOttawa for a questionnaire/interview study entitled "Description of the Components of the Role of the Nurse with Eating Disorder Patients and Whether the Development of a Therapeutic Alliance with the Patient is Part of that Role" (the "Study"). Dr. Blake Woodside is the medical staff member responsible for the Study at UHN. The UHN Research Ethics Board ("REB") number is 08-0528-BE. The Study has also been reviewed by the Ottawa Hospital REB (# 2007796-01H) and The University of Ottawa REB (# H 01-08-08). Dr. Christine McPherson is the faculty member responsible for the Study at uOttawa. Ms. Kirsti Pryde, an Advanced Practice Nurse at Ottawa Hospital and an MScN student at uOttawa, is conducting the Study for her Master's thesis. In consideration of the Disclosing Party's making such Data (as defined below) available to the Receiving Party, the Parties hereby agree as follows:

1. As used in this Agreement, the term "Data" means medical data or information that certain nurses employed at UHN will supply by mail, face-to-face interviews and/or telephone questionnaires to Ms. Pryde. Ms. Pryde and the Receiving Party shall not use any information that identifies an individual participant in the Study for any other purpose than the Study, or disclose it to any third parties. UHN employees shall not be contacted until the Study has been approved by the three REBs mentioned above.

2. The Receiving Party agrees that it shall, and shall require its directors, officers, employees, medical staff, research fellows, students, consultants, and advisors to:

(a) maintain all Data in confidence, except as permitted by this Agreement (including publication permitted by section 7). The Receiving Party may disclose or permit the disclosure of any Data to its directors, officers, employees, medical staff, research fellows, students, consultants, and advisors who need to know such Data for the purposes of the Study, and who are obligated to maintain the confidential nature of such Data;

(b) use all Data solely for the purposes of the Study;

(c) allow its directors, officers, employees, consultants, medical staff, research fellows, students and advisors to reproduce the Data only to the extent necessary for the purposes of the Study or this Agreement, with all such reproductions being considered confidential; and

(d) not transfer the Data disclosed under this Agreement to any third parties without prior written consent from the Disclosing Party and without obligating such third parties to comply with the terms and conditions hereof.

3. The obligations of the Receiving Party under Section 2 above shall not apply to the extent that the Receiving Party can demonstrate that certain Data is required to be disclosed to comply with applicable laws or regulations, or with a court or administrative order, provided that the Disclosing Party receives prior written notice of such intended disclosure and that the Receiving Party takes all reasonable and lawful actions to obtain confidential treatment for such disclosure and, if possible, to minimize the extent of such disclosure.

4. The Receiving Party acknowledges that the Disclosing Party (or any third party entrusting its own confidential information to the Disclosing Party) retains ownership of the Data disclosed by the Disclosing Party.

5. Disclosures shall take place under this Agreement within one (1) year of the effective date. This

Appendix D



uOttawa

Université d'Ottawa
Faculté des sciences
de la santé

École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Project Information Sheet

Title of the study: Identification of the Components of the Role of an Eating Disorder Nurse

Principal investigator:

Kirsti Pryde
Advanced Practice Nurse
Regional Center for the
Treatment of Eating
Disorders
The Ottawa Hospital
Ottawa, Ontario
613-737-8899 ext. 79304

Supervisor(s):

Dr. Christine McPherson
Assistant Professor
School of Nursing
University of Ottawa
Ottawa, Ontario
613-562-5800 ext. 8693

Dr. Dianne Groll
Assistant Professor
Department of Psychiatry
Queen's University
Kingston, Ontario
Adjunct Assistant Professor
School of Nursing
Ottawa, Ontario
613-548-5567 Ext. 2135

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: From this research we wish to learn more about the role of an eating disorder nurse with the aim of describing this role for the purposes of developing a training program for this specialty area.

Participation: Participation will involve a telephone interview lasting 30-45 minutes. During this interview you will be asked questions about your position as an eating disorder nurse. This interview will be audio taped. In addition, you will be mailed a 12-item questionnaire that asks about ways that you might think about your patients. If you wish to participate in this study, please complete the consent form and return it in the pre-addressed, postage paid envelope.

(valid until January 6, 2009)

☎ 613-562-5473

📠 613-562-5443

451 Smyth (3051)
Ottawa ON K1H 8M5 Canada

www.uOttawa.ca

Procedure: Once your consent form is received, you will be contacted by Kirsti Pryde to set up a day and time that is convenient for you to participate in the telephone interview. Upon completion of this interview, you will receive the questionnaire by mail to complete and return in another stamped, pre-addressed envelope that will be provided for you. We would appreciate receiving it before November 30, 2008. If we do not receive it by said date, we will send you a notice of reminder.

Confidentiality: The information that you will share will remain confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Your answers to the open-ended question will be published in polled (aggregate) format. However, we may use verbatim quotes from the interviews in presentations and publications but neither you (nor your organization) will be identified. The Ottawa Hospital Research Ethics Board and the University of Ottawa Research Ethics Board may audit study records.

Anonymity: Anonymity is guaranteed since you are not being asked to provide your name or any personal information. A unique numerical identifier will be used instead.

Conservation of data: The questionnaires and audio taped transcriptions will be kept in a locked filing cabinet in the office of the researcher at The Ottawa Hospital during the data collection and analysis period. Following that, the transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed. The audiotapes will be destroyed following their transcription to paper.

Voluntary Participation: You are under no obligation to participate and if you choose to do so, you may choose not to answer questions that you do not want to answer or to withdraw from the study at any time without giving any reason. If you choose to withdraw, you can decide whether you would like the data gathered until the time of withdrawal to be included in the study or not.

Information about the Study Results: Once the study is completed, you may obtain a copy of the results from Kirsti Pryde, 501 Smyth Rd., Room 4401, Ottawa, Ontario, K1H 8L6.

If you have any questions or require more information about the study itself, you may contact the researcher or her supervisor at the numbers mentioned hereinabove.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613-562-5841, ethics@uottawa.ca.

Please keep this form for you records.

Thank-you for your time and consideration.

(Adapted from the sample "Letter of Information", University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)

(valid until January 6, 2009)



HÔPITAL RÉGIONAL DE
SUDBURY
REGIONAL HOSPITAL

Project Information Sheet

Title of the study: **Identification of the Components of the Role of an Eating Disorder Nurse**

Principal investigator: Kirsti Pryde
Advanced Practice Nurse
Regional Center for the Treatment of Eating Disorders
The Ottawa Hospital
Ottawa, Ontario
613-737-8899 ext. 79304

Supervisor(s): Dr. Christine McPherson
Assistant Professor
School of Nursing
University of Ottawa
Ottawa, Ontario
613-562-5800 ext. 8693

Dr. Dianne Groll
Assistant Professor
Department of Psychiatry
Queen's University
Kingston, Ontario
Adjunct Assistant Professor
School of Nursing
Ottawa, Ontario
613-548-5567 Ext. 2135

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: From this research we wish to learn more about the role of an eating disorder nurse with the aim of describing this role for the purposes of developing a training program for this specialty area.

Participation: Participation will involve a telephone interview lasting 30-45 minutes. During this interview you will be asked questions about your position as an eating disorder nurse. This interview will be audio taped. In addition, you will be mailed a 12-item questionnaire that asks about ways that you might think about your patients. If you wish to participate in this study, please complete the consent form and return it in the pre-addressed, postage paid envelope.

Procedure: Once your consent form is received, you will be contacted by Kirsti Pryde to set up a day and time that is convenient for you to participate in the telephone interview. Upon completion of this interview, you will receive the questionnaire by mail to complete and return in another stamped, pre-addressed envelope that will be provided for you. We would appreciate receiving it before July 15, 2008. If we do not receive it by said date, we will send you a notice of reminder.

Confidentiality: The information that you will share will remain confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Your answers to the open-ended question will be published in polled (aggregate) format. However, we may use verbatim quotes from the interviews in presentations and publications but neither you (nor your organization) will be identified. The Ottawa Hospital Research Ethics Board and the University of Ottawa Research Ethics Board may audit study records.

Anonymity: Anonymity is guaranteed since you are not being asked to provide your name or any personal information. A unique numerical identifier will be used instead.

Conservation of data: The questionnaires and audio taped transcriptions will be kept in a locked filing cabinet in the office of the researcher at The Ottawa Hospital during the data collection and analysis period. Following that, the transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed. The audiotapes will be destroyed following their transcription to paper.

Voluntary Participation: You are under no obligation to participate and if you choose to do so, you may choose not to answer questions that you do not want to answer or to withdraw from the study at any time without giving any reason. If you choose to withdraw, you can decide whether you would like the data gathered until the time of withdrawal to be included in the study or not.

Information about the Study Results: Once the study is completed, you may obtain a copy of the results from Kirsti Pryde, 501 Smyth Rd., Room 4401, Ottawa, Ontario, K1H 8L6.

If you have any questions or require more information about the study itself, you may contact the researcher or her supervisor at the numbers mentioned hereinabove.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613-562-5841, ethics@uottawa.ca.

Please keep this form for you records.

Thank-you for your time and consideration.

(Adapted from the sample “Letter of Information”, University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)



Project Information Sheet

Title of the study: Identification of the Components of the Role of an Eating Disorder Nurse

Principal investigator:	Jenny Hague Clinical Nurse Specialist Douglas Mental Health University Institute DSI Perry, E- 3200 Verdun, Montreal, Quebec 514-761-6131, ext. 2473
Research Student	Kirsti Pryde Advanced Practice Nurse Regional Center for the Treatment of Eating Disorders The Ottawa Hospital Ottawa, Ontario 613-737-8899 ext. 79304
Supervisor(s):	Dr. Christine McPherson Assistant Professor School of Nursing University of Ottawa Ottawa, Ontario 613-562-5800 ext. 8693 Dr. Dianne Groll Assistant Professor Department of Psychiatry Queen's University Kingston, Ontario Adjunct Assistant Professor School of Nursing Ottawa, Ontario 613-548-5567 Ext. 2135

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Jenny Hague, Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: From this research we wish to learn more about the role of an eating disorder nurse with the aim of describing this role for the purposes of developing a training program for this specialty area.

Participation: Participation will involve a telephone interview lasting 30-45 minutes. During this interview you will be asked questions about your position as an eating disorder nurse. This interview will be audio taped. In addition, you will be mailed a 12-item questionnaire that asks about ways that you might think about your patients. If you wish to participate in this study, please complete the consent form and return it in the pre-addressed, postage paid envelope.

Procedure: Once your consent form is received, you will be contacted by Kirsti Pryde to set up a day and time that is convenient for you to participate in the telephone interview. Upon completion of this interview, you will receive the questionnaire by mail to complete and return in another stamped, pre-addressed envelope that will be provided for you. We would appreciate receiving it before September 1, 2008. If we do not receive it by said date, we will send you a notice of reminder.

Confidentiality: The information that you will share will remain confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Jenny Hague, Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Your answers to the open-ended question will be published in polled (aggregate) format. However, we may use verbatim quotes from the interviews in presentations and publications but neither you (nor your organization) will be identified. The Ottawa Hospital Research Ethics Board and the University of Ottawa Research Ethics Board may audit study records.

Anonymity: Anonymity is guaranteed since you are not being asked to provide your name or any personal information. A unique numerical identifier will be used instead.

Conservation of data: The questionnaires and audio taped transcriptions will be kept in a locked filing cabinet in the office of the researcher at The Ottawa Hospital during the data collection and analysis period. Following that, the transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed. The audiotapes will be destroyed following their transcription to paper.

Voluntary Participation: You are under no obligation to participate and if you choose to do so, you may choose not to answer questions that you do not want to answer or to withdraw from the study at any time without giving any reason. If you choose to withdraw, you can decide whether you would like the data gathered until the time of withdrawal to be included in the study or not.

Information about the Study Results: Once the study is completed, you may obtain a copy of the results from Kirsti Pryde, 501 Smyth Rd., Room 4401, Ottawa, Ontario, K1H 8L6.

If you have any questions or require more information about the study itself, you may contact the principal investigator, the student researcher, or her supervisors at the numbers mentioned hereinabove.

If you have any questions with regards to the ethical conduct of this study, you may contact the Ombudsman of the Douglas Mental Health University Institute, 6875 Lasalle blvd., Montreal (Quebec) H4H 1R3, telephone : (514) 761-6131 local 3287, e-mail : Ombudsman@douglas.mcgill.ca or the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613-562-5841, ethics@uottawa.ca .

Please keep this form for you records.

Thank-you for your time and consideration.

(Adapted from the sample “Letter of Information”, University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)

Feuille d'information sur le projet

Titre de l'étude : Détermination des composantes du rôle d'une infirmière spécialisée dans les troubles de l'alimentation

Chercheuse principale : Jenny Hague
Infirmière clinicienne en soins spécialisés
Institut universitaire en santé mentale Douglas
DSI Perry, E- 3200
Verdun, Montreal, Quebec
514-761- 6131, 2473

Etudiant Kirsti Pryde
Infirmière de pratique avancée
Centre régional de traitement des troubles de l'alimentation
L'Hôpital d'Ottawa
Ottawa (Ontario)
613-737-8899, poste 79304

Superviseuses : D^{re} Christine McPherson
Professeure adjointe
École des sciences infirmières
Université d'Ottawa
Ottawa (Ontario)
613-562-5800, poste 8693

D^{re} Dianne Groll
Professeure adjointe
Département de psychiatrie
Université Queen's
Kingston (Ontario)
Professeure agrégée adjointe
École des sciences infirmières
Ottawa (Ontario)
613-548-5567, poste 2135

Invitation à participer : Vous êtes invité à participer à l'étude mentionnée ci-dessus dirigée par Kirsti Pryde (étudiante à la maîtrise en sciences infirmières) et supervisée par Jenny Hague et les D^{res} Christine McPherson et Dianne Groll.

But de l'étude : Pendant la recherche, nous désirons en apprendre davantage au sujet du rôle d'une infirmière spécialisée dans les troubles de l'alimentation pour bien décrire ce rôle en vue d'élaborer un programme de formation dans ce domaine.

Participation : Si vous participez à l'étude, vous devrez répondre à une entrevue qui dure de 30 à 45 minutes. Pendant cette entrevue, on vous posera des questions au sujet de votre poste en tant qu'infirmière spécialisée dans les troubles de l'alimentation. Cette entrevue sera enregistrée. De plus, on vous postera un questionnaire comportant 12 questions au sujet de votre façon de voir vos patients. Si vous désirez participer à l'étude, veuillez remplir le formulaire de consentement et le retourner dans l'enveloppe affranchie et préadressée.

Procédure : Dès que nous aurons reçu votre formulaire de consentement, Kirsti Pryde communiquera avec vous pour fixer la date et l'heure de votre entrevue au moment qui vous convient le mieux. Après l'entrevue, vous recevrez par la poste le questionnaire que vous devez remplir et retourner dans l'autre enveloppe affranchie et préadressée qui vous sera fournie. Nous aimerions le recevoir au plus tard le premier Septembre 2008. Si nous ne le recevons pas d'ici cette date, nous vous enverrons un rappel.

Information au sujet des résultats de l'étude : Après l'étude, vous pouvez obtenir un exemplaire des résultats auprès de Kirsti Pryde, 501, chemin Smyth, bureau 4401, Ottawa (Ontario) K1H 8L6.

Si vous avez des questions ou désirez obtenir des renseignements supplémentaires au sujet de l'étude à proprement parler, vous pouvez communiquer avec la chercheuse ou sa superviseure au numéro mentionné ci-dessus.

Si vous avez des questions concernant des aspects éthiques de l'étude, vous pouvez communiquer avec L'ombudsman de Douglas institute universitaire en sante mentale, 6875 Lasalle blvd., Montreal (Quebec) H4H 1R3, telephone : (514) 761-6131 local 3287, e-mail : Ombudsman@douglas.mcgill.ca ou le responsable de la déontologie en recherche de l'Université d'Ottawa, au pavillon Tabaret, 550, rue Cumberland, bureau 159, Ottawa (Ontario) K1N 6N5, tél. : 613-562-5841 ou ethics@uottawa.ca

Veuillez conserver le formulaire dans vos dossiers.

Merci du temps et des efforts que vous avez consacrés à l'étude.

(Adapté du « Formulaire de consentement » présenté par Catherine Paquet du Bureau d'éthique et recherche de l'Université d'Ottawa, 4 avril 2007)

Informed Consent Form



uOttawa

Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

Title of the study: Identification of the Components of the Role of an Eating Disorder Nurse

Principal investigator:

Kirsti Pryde
Advanced Practice Nurse
Regional Center for the
Treatment of Eating
Disorders
The Ottawa Hospital
Ottawa, Ontario
613-737-8899 ext. 79304

Supervisor(s):

Dr. Christine McPherson
Assistant Professor
School of Nursing
University of Ottawa
Ottawa, Ontario
613-562-5800 ext. 8693

Dr. Dianne Groll
Assistant Professor
Department of Psychiatry
Queen's University
Kingston, Ontario
Adjunct Assistant Professor
School of Nursing
Ottawa, Ontario
613-548-5567 Ext. 2135

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: The purpose of the study is to determine and describe the role of a nurse caring for eating disorder patients.

Participation: Your participation will consist essentially of completing a 30-45 minute telephone interview, which will be audio taped, and completing a 12 item questionnaire either during your workday or on your own time, whichever is more convenient for you. You will be contacted to set up a convenient time for the telephone interview.

(valid until January 6, 2009)

☎ 613-562-5473
📠 613-562-5443

451 Smyth
Ottawa ON K1H 8M5 Canada
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Risks: Your participation in this study will entail that you will volunteer information pertaining to the daily activities of your job. Every effort will be made to minimize these risks and you are aware that you have the option not to discuss components of your job that you may find upsetting or do not wish to discuss.

Benefits: Your participation in this study will help to advance nursing knowledge in this specialty area.

Confidentiality and anonymity: The information you will share will remain confidential. The contents will be used solely for the purposes of this research. The only people who will have access to the research data are Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Answers to the open-ended question may be used verbatim in presentations and publications but neither you (nor your organization) will be identified. Results will be published in polled (aggregate) format. Anonymity is guaranteed since you are not being asked to provide your name nor any personal information. A unique numerical identifier will be used instead. The Ottawa Hospital Research Ethics Board may review your relevant study records for audit purposes.

Conservation of data: The questionnaires and audiotapes transcriptions will be kept in a locked filing cabinet in the office of the researcher at The Ottawa Hospital during the data collection and analysis period. Following that, the audiotape transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed (shredded). The audiotapes will be destroyed (wiped clean) following their transcription to paper.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or choose not to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Consent:

Acceptance: I, _____ agree to participate in the above research study conducted by Kirsti Pryde of the School of Nursing, University of Ottawa, under the supervision of Dr. Christine McPherson and Dr. Dianne Groll.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613- 562-5841, ethics@uottawa.ca.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Researcher's name (print): _____

(Adapted from the sample "Informed Consent", University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)



HÔPITAL RÉGIONAL DE
SUDBURY
REGIONAL HOSPITAL

Informed Consent Form

Title of the study: Identification of the Components of the Role of an Eating Disorder Nurse

Principal investigator: Kirsti Pryde
Advanced Practice Nurse
Regional Center for the Treatment of Eating Disorders
The Ottawa Hospital
Ottawa, Ontario
613-737-8899 ext. 79304

Supervisor(s): Dr. Christine McPherson
Assistant Professor
School of Nursing
University of Ottawa
Ottawa, Ontario
613-562-5800 ext. 8693

Dr. Dianne Groll
Assistant Professor
Department of Psychiatry
Queen's University
Kingston, Ontario
Adjunct Assistant Professor
School of Nursing
Ottawa, Ontario
613-548-5567 Ext. 2135

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: The purpose of the study is to determine and describe the role of a nurse caring for eating disorder patients.

Participation: Your participation will consist essentially of completing a 30-45 minute telephone interview, which will be audio taped, and completing a 12 item questionnaire either during your workday or on your own time, whichever is more convenient for you. You will be contacted to set up a convenient time for the telephone interview.

Risks: Your participation in this study will entail that you will volunteer information pertaining to the daily activities of your job. Every effort will be made to minimize these risks and you are aware that you have the option not to discuss components of your job that you may find upsetting or do not wish to discuss.

Benefits: Your participation in this study will help to advance nursing knowledge in this specialty area.

Confidentiality and anonymity: The information you will share will remain confidential. The contents will be used solely for the purposes of this research. The only people who will have access to the research data are Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Answers to the open-ended question may be used verbatim in presentations and publications but neither you (nor your organization) will be identified. Results will be published in polled (aggregate) format. Anonymity is guaranteed since you are not being asked to provide your name nor any personal information. A unique numerical identifier will be used instead. The Ottawa Hospital Research Ethics Board may review your relevant study records for audit purposes.

Conservation of data: The questionnaires and audiotapes transcriptions will be kept in a locked filing cabinet in the office of the researcher at The Ottawa Hospital during the data collection and analysis period. Following that, the audiotape transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed (shredded). The audiotapes will be destroyed (wiped clean) following their transcription to paper.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or choose not to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Consent:

Acceptance: I, _____ agree to participate in the above research study conducted by Kirsti Pryde of the School of Nursing, University of Ottawa, under the supervision of Dr. Christine McPherson and Dr. Dianne Groll.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613- 562-5841, ethics@uottawa.ca.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Researcher's name (print): _____

(Adapted from the sample "Informed Consent", University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)



Informed Consent Form

Title of the study: Identification of the Components of the Role of an Eating Disorder Nurse

Principal investigator: Jenny Hague
 Clinical Nurse Specialist
 Douglas Mental Health University Institute
 DSI Perry, E- 3200
 Verdun, Montreal, Quebec
 514-761-6131, ext. 2473

Student Kirsti Pryde
 Advanced Practice Nurse
 Regional Center for the Treatment of Eating Disorders
 The Ottawa Hospital
 Ottawa, Ontario
 613-737-8899 ext. 79304

Supervisor(s): Dr. Christine McPherson
 Assistant Professor
 School of Nursing
 University of Ottawa
 Ottawa, Ontario
 613-562-5800 ext. 8693

Dr. Dianne Groll
 Assistant Professor
 Department of Psychiatry
 Queen's University
 Kingston, Ontario
 Adjunct Assistant Professor
 School of Nursing
 Ottawa, Ontario
 613-548-5567 Ext. 2135

(valid until January 6, 2009)

Invitation to participate: You are invited to participate in the abovementioned research study conducted by Kirsti Pryde, (MScN student) supervised by Jenny Hague, Dr. Christine McPherson and Dr. Dianne Groll.

Purpose of the Study: The purpose of the study is to determine and describe the role of a nurse caring for eating disorder patients.

Participation: Your participation will consist essentially of completing a 20 - 30 minute interview in person, which will be audio taped, and completing a 12 item questionnaire either during your workday or on your own time, whichever is more convenient for you. You will be contacted to set up a convenient time and location for the interview.

Procedure: Once your consent form is received, you will be contacted by Kirsti Pryde to set up a day and time that is convenient for you to participate in the interview. Upon completion of this interview, you will receive the questionnaire by mail to complete and return in another stamped, pre-addressed envelope that will be provided for you. We would appreciate receiving it before December 15, 2008. If we do not receive it by said date, we will send you a notice of reminder.

Risks: Your participation in this study will entail that you will volunteer information pertaining to the daily activities of your job. Every effort will be made to minimize these risks and you are aware that you have the option not to discuss components of your job that you may find upsetting or do not wish to discuss.

Benefits: Your participation in this study will help to advance nursing knowledge in this specialty area.

Confidentiality and anonymity: The information you will share will remain confidential, unless required by law. The contents will be used solely for the purposes of this research. The only people who will have access to the research data are Jenny Hague, Kirsti Pryde, Dr. Christine McPherson, and Dr. Dianne Groll. Answers to the open-ended question may be used verbatim in presentations and publications but neither you (nor your organization) will be identified. Results will be published in polled (aggregate) format. Anonymity is guaranteed since you are not being asked to provide your name nor any personal information. A unique numerical identifier will be used instead. The Ottawa Hospital Research Ethics Board may review your relevant study records for audit purposes.

Conservation of data: The questionnaires and audiotapes transcriptions will be kept in a locked filing cabinet in the office of the research student at The Ottawa Hospital during the data collection and analysis period. Following that, the audiotape transcriptions will be kept in a locked filing cabinet in the thesis advisor's office for a period of 15 years at which time they will be destroyed (shredded). The audiotapes will be destroyed (wiped clean) following their transcription to paper.

(valid until January 6, 2009)

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or choose not to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Consent:

Acceptance: I, _____ agree to participate in the above research study conducted by Kirsti Pryde of the School of Nursing, University of Ottawa, under the supervision of Jenny Hague, Dr. Christine McPherson and Dr. Dianne Groll.

Information about the Study Results: Once the study is completed, you may obtain a copy of the results from Kirsti Pryde, 501 Smyth Rd., Room 4401, Ottawa, Ontario, K1H 8L6.

If I have any questions about the study, I may contact the principal investigator, the student researcher, or her supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the Ombudsman of the Douglas Mental Health University Institute, 6875 Lasalle blvd., Montreal (Quebec) H4H 1R3, telephone : (514) 761-6131 local 3287, e-mail : Ombudsman@douglas.mcgill.ca or the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel. 613- 562-5841, ethics@uottawa.ca or Dr. Marion Olmsted, tel. 416-340-4800, ext. 4923.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Researcher's name (print): _____

(Adapted from the sample "Informed Consent", University of Ottawa Research Grants and Ethics Services Presentation, Catherine Paquet, April 4, 2007)



Formulaire de consentement éclairé

Titre de l'étude : Détermination des composantes du rôle d'une infirmière spécialisée dans les troubles de l'alimentation

Chercheuse principale :	Jenny Hague Infirmière clinicienne en soins spécialisés Institut universitaire en santé mentale Douglas DSI Perry, E-3200 Verdun, Montreal, Quebec 513-761-6131, ext. 2473
Etudiant	Kirsti Pryde Infirmière de pratique avancée Centre régional de traitement des troubles de l'alimentation L'Hôpital d'Ottawa Ottawa (Ontario) 613-737-8899, poste 79304
Superviseuses :	D^{re} Christine McPherson Professeure adjointe École des sciences infirmières Université d'Ottawa Ottawa (Ontario) 613-562-5800, poste 8693 D^{re} Dianne Groll Professeure adjointe Département de psychiatrie Université Queen's Kingston (Ontario) Professeure agrégée adjointe École des sciences infirmières Ottawa (Ontario) 613-548-5567, poste 2135

Invitation à participer : Vous êtes invité à participer à l'étude mentionnée ci-dessus dirigée par Kirsti Pryde (étudiante à la maîtrise en sciences infirmières) et supervisée par Jenny Hague et les D^{res} Christine McPherson et Dianne Groll.

But de l'étude : L'étude vise à définir et à décrire le rôle d'une infirmière qui s'occupe de patients ayant un trouble de l'alimentation.

Participation : Votre participation à l'étude consistera essentiellement à participer à une entrevue de 20 à 30 minutes, qui sera enregistrée et qui comportera 12 questions. Vous pourrez le faire pendant vos heures de travail ou pendant vos temps libres, selon ce qui vous convient le mieux. On communiquera avec vous pour fixer la date de l'entrevue téléphonique.

Procédure : Dès que nous aurons reçu votre formulaire de consentement, Kirsti Pryde communiquera avec vous pour fixer la date et l'heure de votre entrevue au moment qui vous convient le mieux. Après l'entrevue, vous recevrez par la poste le questionnaire que vous devez remplir et retourner dans l'autre enveloppe affranchie et préadressée qui vous sera fournie. Nous aimerions le recevoir au plus tard le quinze décembre 2008. Si nous ne le recevons pas d'ici cette date, nous vous enverrons un rappel.

Risques : Si vous participez à l'étude, vous devrez fournir des renseignements concernant vos tâches quotidiennes à votre travail. Nous ferons tout ce que nous pourrons pour réduire ces risques le plus possible. Vous pourrez toujours choisir de ne pas discuter d'éléments de votre travail que vous jugez dérangeants ou que vous ne voulez pas aborder.

Avantages : Votre participation à l'étude aidera à faire progresser les connaissances dans le domaine des soins infirmiers dans cette spécialité.

Confidentialité et anonymat : Les renseignements dont vous nous ferez part demeureront confidentiels, sauf dans les situations où il est exigé autrement par la loi. Ils ne serviront que pour la recherche. Les seules personnes qui auront accès aux données de la recherche sont Jenny Hague, Kirsti Pryde et les D^{res} Christine McPherson et Dianne Groll. Votre réponse à la question ouverte pourrait être citée dans des exposés et des publications, mais ni vous ni votre organisation ne seront identifiées. Les résultats seront publiés globalement. L'anonymat est garanti puisque nous ne vous demanderons pas de donner votre nom ou d'autres renseignements personnels. On utilisera à la place de votre nom un numéro d'identification unique. Le Conseil d'éthique en recherches de L'Hôpital d'Ottawa peut vérifier des éléments pertinents de votre dossier de l'étude pour vérification.

Conservation des données : Les questionnaires et les transcriptions des bandes sonores seront conservés dans un classeur verrouillé dans le bureau de la chercheuse à L'Hôpital d'Ottawa pendant la collecte et l'analyse des données. Par la suite, les transcriptions des bandes sonores seront conservées dans un classeur verrouillé dans le bureau du directeur de thèse pendant 15 ans. Les documents seront ensuite détruits (déchiquetés). Les bandes sonores seront effacées après leur transcription sur papier.

Participation volontaire : Vous n'êtes aucunement obligé de participer à l'étude. Si vous choisissez d'y participer, vous pouvez vous retirer de l'étude en tout temps ou choisir de ne pas répondre à certaines questions. Vous ne subirez aucune conséquence négative. Si vous choisissez de vous retirer, toutes les données déjà recueillies seront détruites.

Consentement :

Acceptation : Je, _____, accepte de participer à l'étude mentionnée ci-dessus dirigée par Jenny Hague, Institut universitaire en sante mentale Douglas et Kirsti Pryde de l'École des sciences infirmières de l'Université d'Ottawa, sous la supervision des D^{res} Christine McPherson et Dianne Groll.

Information au sujet des résultats de l'étude : Après l'étude, vous pouvez obtenir un exemplaire des résultats auprès de Kirsti Pryde, 501, chemin Smyth, bureau 4401, Ottawa (Ontario) K1H 8L6.

Si j'ai des questions au sujet de l'étude, je peux communiquer avec la chercheuse principale ou sa superviseure.

Si j'ai des questions concernant des aspects éthiques de l'étude, je peux communiquer avec Ombudsman de Institut universitaire en sante mentale Douglas, 6875 Lasalle blvd., Montreal (Quebec) H4H 1R3, telephone : (514) 761-6131 local 3287, e-mail : Ombudsman@douglas.mcgill.ca ou le responsable de la déontologie en recherche de l'Université d'Ottawa, au pavillon Tabaret, 550, rue Cumberland, bureau 159, Ottawa (Ontario) K1N 6N5, tél. : 613-562-5841 ou ethics@uottawa.ca

Le formulaire de consentement est imprimé en deux exemplaires, dont un pour mes dossiers.

Signature du participant : _____ Date : _____

Signature de la chercheuse : _____ Date : _____

Nom de la chercheuse (en lettres moulées) :

(Adapté du « Formulaire de consentement » présenté par Catherine Paquet du Bureau d'éthique et recherche de l'Université d'Ottawa, 4 avril 2007)

Appendix E

Interview Questions

1. Age?
2. Gender?
3. Do you work in Canada or the United States (circle one)
4. Do you work in a private or public treatment center?
5. In-patient or out-patient (circle one)?
6. Part-time or full-time (circle one)?
7. Number of years working in eating disorders?
8. Number of years working in as a nurse?
9. Education level (highest level completed)?
10. Are you part of a multidisciplinary team and if so what are the other disciplines?
11. Do you provide group or individual treatment?
12. What are the different aspects of your role as an eating disorders nurse? Your day-to-day activities?
13. Can you tell me about the types of skills you have when working with clients with ED? Can you describe situations where these skills are used?
14. Can you describe some of the personal attributes or characteristics you possess which are important in your work as an ED nurse? Ex?
15. How would you characterize your relationship with patients?
What would you say the relationship that you form with ED patients is based on?

16. What techniques/approaches do you use when caring for patients with ED?

Can you describe some of these approaches and techniques?

17. What is your biggest challenge in interacting with ED patients? How do you deal with this?

18. When do you feel professionally satisfied in your job?

19. Is ED nursing different from other nursing jobs you have done in the past? In what ways does it differ?

20. What do you feel would be helpful to new staff entering the area of ED?

21. Do you use a particular type of therapy or treatment model and if so what is it?

Questions d'entrevue

4. Quel est votre âge?
5. Quel est votre sexe?
6. Travaillez-vous au Canada ou aux États-Unis? (encerclez une réponse)
4. Travaillez-vous dans un centre de traitement privé ou public?
5. Travaillez-vous auprès de patients hospitalisés ou en clinique externe? (encerclez une réponse)
6. Travaillez-vous à temps partiel ou à temps plein? (encerclez une réponse)
7. Nombre d'années de travail dans le domaine des troubles de l'alimentation?
8. Nombre d'années de travail comme infirmière?
9. Scolarité? (niveau de scolarité le plus élevé atteint)
10. Faites-vous partie d'une équipe multidisciplinaire et, si c'est le cas, quels sont les autres domaines représentés?
11. Offrez-vous des traitements de groupe ou individuels?
12. Quels sont les différents aspects de votre rôle comme infirmière spécialisée dans les troubles de l'alimentation?
13. Quelles sont les compétences que doit, selon vous, posséder une infirmière spécialisée dans les troubles de l'alimentation pour faire son travail?
14. Selon vous, quelles sont les qualités que doit posséder une infirmière spécialisée dans les troubles de l'alimentation pour faire son travail?
15. À votre avis, sur quoi est fondée la relation qui se crée entre vous et les patients présentant un trouble de l'alimentation?

16. Quelles techniques/méthodes utilisez-vous pour interagir avec les patients?
17. Quel est votre plus grand défi dans votre interaction avec les patients présentant un trouble de l'alimentation?
18. Qu'est-ce que vous estimez satisfaisant sur le plan professionnel dans votre travail?
19. Pensez-vous que le travail de l'infirmière spécialisée dans les troubles de l'alimentation soit différent du travail que vous avez fait dans le passé comme infirmière non spécialisée? Pouvez-vous donner quelques exemples?
20. Quelle information devrait-on fournir aux nouveaux membres du personnel pour les aider à travailler dans ce domaine?
21. Comme infirmière spécialisée dans les troubles de l'alimentation, utilisez-vous une thérapie particulière ou un modèle de traitement particulier ? Si oui, lequel?