Master in Mental Health

RESEARCH DISSERTATION

Mental Health Nurses experiences of developing Therapeutic Relationships with the Families of Service Users experiencing an Eating Disorder

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SUMMARY

Mental Health Nurses experiences of developing Therapeutic Relationships with the Families of Service Users experiencing an Eating Disorder.

The goal of this study is to explore Mental Health Nurses (MHN) experiences of developing Therapeutic Relationships (TR) with the Families of Service Users (SU) experiencing an Eating Disorder (ED).

There is National & International support for collaboration between MHN's and families in Mental Health (MH) and the area of ED. Irish Policy encourages family involvement in Mental Health Services (Department of Health & Children 2006), while Family Involvement is further recommended specifically in the treatment of ED (Treasur *et al.* 2007). For collaboration to exist, a relationship must exist and to benefit all (SU; Family; MHNs), this researcher advocates that the relationship should be therapeutic in nature. It was therefore of interest to the researcher to explore; what are the experiences of MHN's in developing TR's with the Families of service users experiencing an eating disorder.

Using a qualitative descriptive design. Two focus groups of 4 MHN's with experience working with SU's experiencing an ED and their Families were held. At the time of recruitment all MHN's worked in one of two Community Settings of an Irish Mental Health Service. The focus groups were audio recorded and transcribed verbatim using a professional transcription service. The author then analysed the data using Colaizzi's (1978) framework. Data was managed with the aid of NVivo Version8.0 Qualitative Analysis computer software.

Four themes emerged from the data:

- A Consistent Approach to the Common Goal

- An Uneven Collaboration

- The Challenge of Expressed Emotion

- MHN's Awareness

In developing a TR with families the participants aimed to involve and support families, however challenges existed; Expressed Emotion, Inconsistent Approach, Ineffective Collaboration, Severity of the ED and Confidentiality. The MHN's also identified both them and families needed more education and support.

The concept of developing a TR with SU's is a second language to MHN's; Developing TR's with families may be a more alien concept to MHN's. This would give rise to the chicken or the egg question; which comes first- the TR or the collaboration? To improve the overall healthcare experience for Families and encourage Collaborative Care, MHN's should be aware of their relationship with Families.

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ABSTRACT

Mental Health Nurses experiences of developing Therapeutic Relationships with the Families of Service Users experiencing an Eating Disorder.

Aims: The aim of this study is to explore Mental Health Nurses (MHN) experiences of developing Therapeutic Relationships (TR) with the Families of Service Users (SU) experiencing an Eating Disorder (ED).

Background: There is National & International support for collaboration between MHN's and families in Mental Health (MH) and the area of ED. Irish Policy encourages family involvement in Mental Health Services (Department of Health & Children 2006), while Family Involvement is recommended in the treatment of ED (Treasur *et al.* 2007). For collaboration to exist, a relationship must exist and to benefit all (SU; Family; MHNs), this researcher advocates that the relationship should be therapeutic in nature. It is therefore of interest to the researcher to explore; what are the experiences of MHN's in developing TR's with the Families of service users experiencing an eating disorder.

Method: Using a qualitative descriptive design. Two focus groups of 4 MHN's with experience working with SU's experiencing an ED and their Families were held. At time of recruitment all MHN's worked in one of two Community Settings of an Irish Mental Health Service. The groups were audio recorded and transcribed verbatim using a professional transcription service. The author then analysed the data using Colaizzi's (1978) framework and data was managed with the aid of NVivo Version8.0 Qualitative Analysis computer software**.**

Findings: Four themes emerged from the data: A Consistent Approach to the Common Goal; An Uneven Collaboration; The Challenge of Expressed Emotion and MHN's Awareness. In developing a TR with families the participants aimed to involve and support families, however challenges existed; Expressed Emotion, Inconsistent Approach, Ineffective Collaboration, Severity of the ED and Confidentiality. The MHN's also identified both they and families needed more education and support.

Conclusion: The concept of developing a TR with SU's is a second language to MHN's; Developing TR's with families may be a more alien concept to MHN's. This would give rise to the chicken or the egg question; which comes first- the TR or the collaboration? To improve the overall healthcare experience for Families and encourage Collaborative Care, MHN's should be aware of their relationship with Families.

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Explanation of terms:

Service User in the context of this study refers to patient/client/resident/person experiencing a Mental Health Problem using the Mental Health Services; Family is used in an extended sense to include parents/relatives related by blood/significant others/carers; Service User experiencing an eating disorder is used as an alternative to 'sufferer' of an eating disorder, person, loved one, family member, child will all be used interchangeably; Eating Disorder- Anorexia Nervosa/ Bulimia Nervosa/ and associated eating disorders; Mental Health Professional/ Mental Health Nurse/ Nurse/ Doctor/ Allied Health Professional etc.

CHAPTER ONE: INTRODUCTION

1.1 Background

As a Mental Health Nurse (MHN) working on an acute female general Mental Health (MH) admission unit the researcher is witness to Service Users (SU) presenting with Eating Disorders (EDs) on a regular basis- new admissions and repeat admissions. The unit does not have designated beds for SU experiencing an ED nor has any of the staff had specific training in the field. The researcher has firsthand experience of the dynamic, ever changing relationship that can often exist between MHN's (as part of the Multidisciplinary Team MDT), SU's experiencing an ED and their Families. At times within the intertwined relationships, high expressed emotion, failures in communication and conflict (resolved and resident) can exist.

There is a defined Therapeutic Relationship (TR) between the MHN and SU. A relationship does exist between the MHN and Family but the therapeutic element of that same relationship may be subject to scrutiny. There is international support for collaboration between nurses and families in mental health and the area of eating disorders (Treasure *et al.* 2007). For collaboration to exist, a relationship must exist and to benefit all (service user; family; nurses), this researcher advocates that the relationship should be therapeutic in nature. It is therefore of interest to the researcher to explore; what are the experiences of MHN's in developing TR's with the Families of SU's experiencing an ED.

1.2 Significance of the Study

According to Peplau (1952) the TR is seen as a vehicle to achieve health and aims to effectively respond to the problems of living experienced by individuals living with mental illness (Barker *et al.* 1996). It is fair to say families and carers live with mental illness also. Much emphasis is placed on the family in regards to caring for their loved one. In Ireland, there is a move towards recognition for the role families play in caring for their loved one with publications such as 'A Vision for Change' and 'The Journey Together' (Department of Health & Children (DoH&C) 2006, 2008).

There is a paucity of National and International research exploring TR's with Families of SU's experiencing an ED. Recent studies exploring family experience of ED's and interactions with Mental Health Professionals (MHP's) have found; families experience a lack of support, an array of unmet needs; feel isolated, uninvolved and often feel judged by health professionals (McMaster *et al.* 2004, Winn *et al.* 2004, Highet *et al.* 2004, Tierney 2005, Wilkinson & Mc Andrew 2008). Research on nursing perspectives tends to focus on the views, attitudes and behaviours of nurses regarding family presence in mental health and other health care settings and barriers to collaboration in care between health professionals and families (Winefield & Burnett 1996, Kass *et al.* 2003, Rose *et al.* 2004, Sjoblom *et al.* 2005, Treasure *et al.* 2007, Fisher *et al.* 2008).

Family involvement in the treatment of ED's is internationally advocated (NICE

1994, Treasure *et al.* 2007).   However the published research exploring family experience identifies that policy had not translated into practice. It is clear that a relationship does exist between MHN's and the families of SU's experiencing an ED, but are MHN's experiencing the development of TR's with families? This research hopes to gain understanding and insight into the experiences of MHN's in developing TR's with these families and begin to fill the gap that exists within the literature on this topic

1.3 Study Purpose

The purpose of this qualitative study is to gain an understanding of the experiences of MHN's in developing TR's with the families of SU's experiencing an ED. Using focus groups, it is hoped through descriptions of MHN's experiences, we will uncover the factors, both positive and negative, that influence the development of TR's with the families of SU's experiencing an ED. Through recommendations from MHN's it is hoped to ascertain what supports are needed to allow for greater development of TR's with a view to increased collaboration between nurses and families as collaborative care often depends on the quality of these relationships.

1.4 Aims and Objectives of the Proposed Study
Question:

What are the experiences of mental health nurses in developing therapeutic

relationships with the families of service users experiencing an eating disorder?

Aim:

- To explore the experiences of mental health nurses in developing therapeutic relationships with the families of service users experiencing an eating disorder.

Objectives:

- To ascertain factors that contribute (facilitators) to the development of therapeutic relationships with the families of service users experiencing an eating disorder.

- To ascertain potential barriers (challenges) to developing therapeutic relationships with the families of service users experiencing an eating disorder.

- To explore types of supports needed for mental health nurses to develop therapeutic relationships with the families of service users experiencing an eating disorder.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Bell (2005) reflects the purpose of a Literature Review (LR) is to show an understanding of the research topic and that the theories of the subject are applied and developed. Through this literature review the researcher will give a detailed and critical overview of the existing relative research to the topic under exploration.

When the researcher began her search for literature on Mental Health Nurses (MHNs) experiences of developing Therapeutic Relationships (TRs) with the Families of Service Users (SU's) experiencing an Eating Disorder (ED), she found no studies specific to this phenomenon. In using the terms and synonyms of the terms encompassed in the title she then embarked on separate searches of the available databases in the Trinity College Library in the hope of finding related studies and articles.

Literature Search

CINAHL TERMS	EBSCO HOST	PUBMED	GOOGLE SCHOLAR
Eating Disorders Anorexia Therapeutic Relationship; with	Same Terms:	Same Terms:	Same Terms: When articles seemed appropriate, access journal directly through Trinity

families; with clients; patients; service users

Nurse Experience

Parent Experiences

Family Involvement

Caring; families; clients; service users with eating disorders

Nurse attitude

Nurses Views

Collaboration | | | College Databases. |

The majority of the literature found and reviewed was International (i.e. not from an Irish Perspective). A great body of literature exists supporting collaborative care practices between families and Mental Health Professionals (MHP's) in the treatment of ED; while the studies included in this LR are not solely specific to MHN's, they all relate to MHP's. The Family experience of ED and their experiences with MHP's has also been extensively explored. The greater part of the literature reviewed

suggests families experience a lack of support, a lack of understanding and in general report negative interactions with MHP's (inclusive of MHN's).

There were some studies investigating the nurse (General & Mental Health Nurse) experience of developing TR's with SU's experiencing an ED which are included however as previously stipulated there were no studies exploring MHN's experiences of developing TR's with the Families of SU's experiencing an ED. As a result the existing qualitative and quantitative research included in the LR is not exclusive to MHN's or to the families of SU's experiencing an ED. It tends to focus on the views, attitudes and behaviours of nurses regarding family presence and involvement in mental health and other health care settings (Sjoblom *et al.* 2005, Fisher *et al.* 2008) and barriers to collaboration in care between mental health professionals and families (Winefield & Burnett 1996, Kass *et al.* 2003, Rose et al. 2004, Treasure *et al.* 2007).

The literature has been divided into the following sections:

- Introduction to Eating Disorders

- Family Involvement in Treating Eating Disorders

- Family Experience

- Therapeutic Relationships

- Therapeutic Relationships with Service Users experiencing an Eating Disorder

- Therapeutic Relationships with the Families of Service Users experiencing an Eating Disorder.

2.2 Introduction to Eating Disorders (ED)

Eating Disorders (ED) are serious illnesses affecting 1-2% of young women (Robinson 1999) and are associated with significant morbidity, mortality, physical and psychiatric consequences (Zerbe 1996). In Ireland epidemiological data suggests an annual incidence of 10 cases of anorexia nervosa per 100,000 population for females and 0.5 for males (Department of Health & Children (DoH&C) 2006). Bodwhys (2010) suggest there are 200,000 people experiencing an ED throughout Ireland. The DoH&C (2006) estimate a20% mortality associated with eating disorders, it is thought 60% of individuals fully recover and 20% partially recover. Considering the high prevalence and mortality rate, there were three designated beds in the public sector and two eight bedded units in the private sector in 2006 (DoH&C 2006). This indicates the majority of those experiencing ED's are treated in a general Mental Health setting and the designated bed situation was still unchanged in 2009 (Mental Health Commission (MHC) 2009).

Traditionally, treatment interventions for people with ED's have been offered either on an inpatient or outpatient basis (Kong 2005). Inpatient care is advised for persons with more serious forms of ED's such as extreme weight loss, daily bulimia/purging, consequential serious medical complications and impaired psychosocial functioning (Piran & Kaplan 1990). Treatment involves nutritional and medical stabilization, medical supervision accompanied by family, individual and

occupational therapies (Anzai *et al.*2002).   Studies consistently show adults and adolescents responding well to both family therapy and family interventions (Treasure *et al.* 2007).

2.3 Family Involvement in Treating Eating Disorders

Support for family/carer involvement in Mental Health Services is now recognised within Mental Health Policy nationally and internationally (DoH&C 2006, MHC 2007, 2008a, 2008b, Department of Health UK 2000, 2002, NICE 2002, 2004).   NICE guidelines (National Collaborating Centre for Mental Health 2004) promote it is good practice to work jointly with the carers [of SU's experiencing an ED of **all ages**] and provide them with appropriate information about the nature of the illness, its risks and its prognosis.

Treasure *et al.* (2007) suggest effective communication between healthcare professionals and families assist in increased collaboration and partnership in the management of eating disorders.   They developed collaborative care workshops for people who care for someone with an ED.   The aim of these workshops is to interrupt some of the maintaining factors of ED's and equip carers (of adolescents and adults) with the skills to become "expert carers" (pp.26).   The construct of expressed emotion (EE) has been named as a causal maintaining factor in ED's from a small but consistent body of work (Treasure *et al.* 2007).   Although research into these workshops is ongoing, Treasure and co-workers found the pilot studies to be both acceptable and efficacious in terms of carer well being and the burden of care.

Sepulveda *et al.* (2008) assessed 28 carers that had participated in the workshops (6 workshops delivered in 2 hour sessions over three months). Assessments were undertaken at baseline, at the end of the workshops and three months later. Two psychologists administered the General Health Questionnaire (GHQ), the Experience of Caregiving Inventory (ECI) and the Eating Disorder Symptom Impact Scale (EDSIS). They found the level of carer distress (GHQ) fell significantly, the level of carer burden (ECI) also reduced as did the specific difficulties caused by the ED symptoms (EDSIS) and these changes were maintained over 3 months. The transfer of specialist skills within the programme was highly valued by the carers. The authors acknowledge that this was a small exploratory study without a control group; they advise a randomised control trial of the effectiveness of these workshops before the findings can be fully interpreted.

At the Eating Distress Conference (2005) it was suggested that co-operation between family and professionals can be shown to restore normal eating by creating a supportive atmosphere without fears and anxieties. With this in mind, the speakers recommend that family members and professionals need to work together and speak the same language of positive values and hope, both need to model and teach active living, demonstrate a positive outlook on life and as part of that normal eating will be established.

Family involvement strategies for other Mental Health problems such as schizophrenia have been found to improve families perceived burden of care, improve expressed emotion and decrease relapse rates for service users experiencing a mental health problem (Leff *et al.* 1987, Scazufca & Kuipers 1996). However Budd & Hughes

(1997) investigated what families actually found helpful about family interventions and what they perceived therapeutic about the programs. Using semi structured interviews and a methodology developed in psychotherapy process research (Stiles *et al.* 1986) they interviewed 20 family members that had participated in a family intervention program in South Wales, United Kingdom. The data was first coded, when the adequacy of the coding was established the data was reanalysed and a coding system was used to enable the researcher to examine the presence or absence of the impact of the helpful/unhelpful behaviour.

The most common reported impact was that families found that the intervention had increased their level of knowledge about and understanding of the illness. Followed by the support they felt at knowing they had a point of contact in the service and the therapeutic alliance they had developed with the MHP's. Budd & Hughes interpreted from the results that the emotional support and reassurance the families perceived was just as helpful if not more helpful than the other components of the group. They advocate that using this type of methodology is likely to be powerful in isolating the specific impacts of family intervention that are helpful, nonetheless they agree that their observations are highly speculative and more research is needed. Most relevant for the purpose of the authors own study was the families felt the therapeutic alliance they had developed with the MHP's was very helpful, the families valued the "empathy and warmth of the therapists and the genuine concern the therapists had expressed" (pp.343).

Mental Health Professionals need to be aware that components of the therapeutic relationship that are important between service users and clinicians e.g. trust

and commitment (Morse 1991); accurate empathy, unconditional positive regard and genuineness (Rogers 1973); confidentiality, non judgemental attitude, responsiveness and consistency (Murry & Huelskoetter 1991) can be beneficial when nurturing family involvement (Budd & Hughes 1997). It is important for mental health professionals to have an understanding of what the family are experiencing when their family member is given a diagnosis of an ED and the responsibility that accompanies caring for that person.

Studies support and recognise the need for families and health professionals to work together (Jubb & Shanley 2002; McMaster *et al*. 2004) and advocate a partnership in care approach (Jubb & Shanley 2002; Wilkinson & Mc Andrew 2008). Feeley and Gottlieb (2002) and Jubb & Shanley (2002) stipulate nurses should develop a strengths focused approach for working with families, promoting the idea of partnership and collaboration in dealing with the problem at hand and therefore providing a better quality of life for the service user than it is possible to provide separately. Jubb and Shanley (2002) attribute the use of the traditional medical model's focus on the individual service user as damaging to family involvement. They also stipulate professionals often fail to identify the potential therapeutic benefits that families can offer resulting in families and carers finding it difficult to build alliances with health care professionals, particularly nurses (Wilkinson & Mc Andrew 2008). Jubb and Shanley (2002) attribute the use of the traditional medical model as a factor that can inhibit families contributing to helping their family member find the road to recovery; the focus of care is on the service user resulting in the service user's family and their social environment being ignored.

Families should be acknowledged for their expertise in caring for their family member (Kass *et al.* 2003) after all, families are expected to take over the caring of their family member when they leave hospital (Wilkinson & Mc Andrew 2008). The willingness of families to be involved should be embraced at an early stage.

2.4 Family Experience

There has been stealth of international research exploring the family experience of ED and services for ED. All studies have reported similar findings; a general lack of support for the needs of families (Mc Master *et al.* 2004,Winn *et al.* 2004, Highet *et al.* 2004, Tierney 2005, Kartolova-O'Doherty *et al.* 2006, Wilkinson & Mc Andrew 2008). A major issue in the published literature on family experience of ED is that parents feel their concerns are not taken seriously or validated by the healthcare professionals who have responded dismissively in the first instance (Ball & Ball 1995). Parents in the main viewed healthcare professionals (defined as nurses, physicians, psychologists, clinical social workers, therapists and teachers) as "not helpful" and indeed felt that healthcare professionals "blamed and shamed" them for their childs' illness (Sharkey-Oregano 1999, p.135).

However this lack of support is not exclusive to the families of SU's experiencing an ED. Kartolova-O'Doherty *et al.* (2006) family support study acknowledged that caring for a family member with a mental health problem can have a substantial, negative effect on the health and psychosocial well being of the whole family and its individual members. In this Irish qualitative study using semi-structured interviews nearly half of the 38 participants reported that their initial encounter with

mental illness had been the hardest period, worsened by the lack of understanding, practical advice, or appropriate response at the time of their first contact for help. Voluntary support services such as Schizophrenia Ireland were cited as participants as the best and sometimes the only form of support services.

Similarly, Mc Master and co-workers (2004) Australian qualitative descriptive study of the parent experiences of eating disorders found that the 22 parents interviewed endured a long, hard journey to find the appropriate help for their child. They often felt excluded, reported feelings of distress, powerlessness, alienation and a continuing resentment about health professionals. They often found staff attitudes to be stereotypical and reported mostly negative experiences of interactions with health professionals. The authors acknowledge the themes cannot be generalised due to the small number of participants, but they recommend addressing the needs of this group is of primary importance. Resembling Feeley & Gottlieb (2002) in acknowledging the strengths families can bring to the table, they suggest that MHP's recognize the family are integral to the recovery process and develop a partnership approach with families. Mc Master *et al.* (2004) advise this would mean allowing families to be "agents of change" (pp. 72) rather than MHP's controlling the situation and keeping the power to themselves.

Again, feelings of powerlessness and isolation amongst carers were also identified in Wilkinson & McAndrew's (2008) phenomenological enquiry into 4 carers' experiences of exclusion from an acute psychiatric ward in the UK. Using Van Manens' technique for analysis of the interviews, a total of four themes emerged, as well as powerlessness and isolation, a need to be valued and recognised as well as a desire for

partnership was reported. The carers felt that MHP's, particularly MHN's used confidentiality as a means of avoiding engaging with carers. A limitation of this study besides the small sample is that some of the carers were reporting experiences that may have happened two years previously so the findings may have been affected by recall bias.

Winn *et al.* (2004) interviewed 20 carers of individuals with Bulimia Nervosa (BN) recruited from in the United Kingdom over the phone using a semi structured interview guide in order to assess their needs. The interviews were analysed using a content analysis approach. The carers identified they needed information on the early signs of ED and treatment, practical advice and guidance on how to manage abnormal eating behaviours and somebody to talk to about their experiences. Several of the participants reported they had met a lack of expertise within the service provision and several of the participants had been excluded from their family members care on the grounds of confidentiality. Similar studies exploring carer/family experience of living with a person with and ED all made reference to a general lack of support for the needs of families, exclusion from services and a lack of acknowledgement, feel uninformed regarding progress and treatment process of their family member and have difficulty accessing services and a professional they could rely on (Highet *et al.* 2004; Tierney 2005). Professionals often fail to identify the potential therapeutic benefits that families can offer (Jubb & Shanley 2002) and families and carers have reported finding it difficult to build alliances with health care professionals, particularly nurses (Wilkinson & Mc Andrew 2008). Despite the lack of empirical evidence for such theories, covert blame has often led to therapeutic misalliance with the clinician

(Terkelsen 1983). Families often feel that health professionals blame them for their family member's illness and often previous experiences have left families with feelings of resentment towards health professionals (Barnheim & Switalski 1988; Mc Master *et al.* 2004). This resentment can lead to rejection of the therapist, creating an atmosphere of adversity and mistrust with poorer outcomes for the service user (Canavan 2000).

Abraham & Shanley (1992) recommend that nurses should regard visitors and relatives alike as constituting an enormous therapeutic potential. Jubb & Shanley (2002) delineate that nursing staff should be given support and education in the form of workshops around family-centred care with a view to improving the experiences of families and interactions between families and healthcare professionals.

2.5 Therapeutic Relationships (TR)

The focus of developing therapeutic relationships has primarily been between the mental health nurse and the service user. The importance of therapeutic relationships as vehicles for achieving health was first highlighted by nurse theorist Hildegard Peplau (1952) and has since been defined as a dynamic, two-way, reciprocal relationship between a service user and care giver (Mc Klindon & Barnsteiner 1999). Components of therapeutic relationships have been identified as trust and commitment (Morse 1991); accurate empathy, unconditional positive regard and genuineness (Rogers 1973); confidentiality, non judgemental attitude, responsiveness and consistency (Murry & Huelskoetter 1991). The quality and effectiveness of therapeutic relationships have been linked to the service user returning to good health and adherence to treatment

(Muscari 1988; Cameron 1996; George 1997). Therapists displaying the components mentioned above were found to be more successful than those that didn't (Barrett-Leonard 1985).

2.6 Therapeutic Relationships with Service Users experiencing an Eating Disorder

Developing and maintaining a therapeutic relationship with a service user experiencing an eating disorder is particularly challenging and difficult for nursing staff (Mc Namara 1982, Kenny 1991, Muscari 1991). Studies have found nurses can often have negative impressions of the eating disordered person. Negative attitudes, stereotyping and staff labels can exist, service users are seen as difficult, with self induced illness, deceptive behaviours and often labelled as manipulative (Story 1976, George 1997, King & Turner 2000).

In a qualitative phenomenological Australian study using Husserl philosophy King & Turner (2000) explored 5 registered general nurse's experiences of caring for adolescents with anorexia nervosa. Initially the participants embraced values to guide their practice; equality of care being non judgemental, assuring patients' rights and forming relationships based on trust. However participants disclosed that overtime their core values were eroded away causing them to become suspicious, untrusting, judgemental and uncaring and lose faith in themselves as nurses.

Ramjan's (2004) naturalistic inquiry into 10 registered nurses experiences, found that mistrust, manipulation and a struggle for control were the main difficulties and obstacles encountered by nurses caring for anorexic adolescents in forming TR's.

The same difficulties and obstacles have also been experienced by nurses caring for an adult population experiencing ED's (George 1997).

Adequate support (Muscari 1991), adequate education and supervision (George 1997) prior to working with people experiencing ED's is recommended. King & Turner's (2000) and Ramjan's (2004) studies indicated the need for extensive registered preparation, on- going support and development of education programmes to enable registered nurses to care for this client group with greater understanding. A need for new care regimes and development of protocols which incorporate a new way of thinking and a desire to have greater involvement in the planned care of their patients was also identified by participants (King & Turner 2000).

2.7 Therapeutic Relationships with the Families of Service Users experiencing an Eating Disorder

As previously stated the author was unable to find any study specific to MHN's experiences of developing TR's with the families of SU's experiencing an ED. In their paper on the hospital's role in treating EDs, Stern *et al.* (1981) suggested strong TRs and effective collaboration between families and healthcare professionals was necessary due to the complexity of coping with and treating eating disorders. They stipulate conflict can arise and splitting can occur among families and healthcare professionals that cause strain on existing therapeutic relationships. They detail a conceptual family developmental model of anorexia nervosa integrating psychodynamic and family

therapy for a hospital programs' therapeutic involvement with SU's experiencing an ED.

A major hypothesis of the model is that the SU and their family are developmentally arrested in the area of separation-individuation and the entire treatment team function as parents creating a protective empathic environment similar to what the "good enough" mother creates for her infant, allowing the infant to separate while remaining emphatically available.   A criticism would be the wording of the model which may be deemed politically incorrect nowadays using terms such as the "anorexic family" (pp.397). It may also be argued that the family may be viewed as the problem or with deficits, contradicting Jubb and Shanley's (2002) strengths focuses approach to the family. Despite this the model encourages a consistent approach among all team members and proposes solutions to predictable crises that arise in the complex treatment of the illness. It also urges the team to provide with "a combination of structure, reliability, emphatic availability, and support of initiative" (pp.397).

Developing TR's with families will depend on the views and perceptions MHN's and MHP's have of the family and family involvement. In a Swedish single site study, focus groups were used to examine nurses' views of the family in psychiatric care (Sjoblom *et al.* 2005). The four groups of four to six participants generated four themes within the findings: 'compassion for and understanding of family members', 'the carer as a recipient of negative feelings', 'preconceptions of mental illness in the family and society' and 'difficulties and dilemmas in the meeting with family members'.

Supporting Winefield and Burnett (1996), results indicated that nurses were

faced with a conflict of loyalties; a 'double- bind' situation existed, often torn between advocating for the patient over the family (Sjoblom *et al*. 2005:566). Nurses found that families had mistrust for care staff and struggled to hand over care. They found that families often expressed feelings that the nurses found difficult to handle, although they acknowledged they had adequate resources such as clinical supervision to support them. The nurses understood this expressed emotion evolved from the families' sense of powerlessness in relation to the illness and in everyday situations or contact with the care; they had experienced the families being slightly 'muted' when their family member was admitted because of having to wait to get help. They discussed how communication between themselves and the families was often affected due to issues of confidentiality, where their loyalty guided by policy lay with the service user.

The nurses welcomed visits from family members at designated times but wanted to get on with the care themselves as family members could also be a burden 'by butting in and getting in the way' (Sjoblom *et al*. 2005, p. 565). This is contradictory to collaborative care practices that view the family as a focal point, recognising the families wish and need to be involved in care (Rutledge *et al*. 2000).

In recognising the strengths of families as advocated by Feeley & Gottlieb (2002), nurses viewed families as an important source of information, as the information they provide can be very beneficial to improving patient care and value the support and reassurance they can provide to their family member (Sjoblom *et al*. 2005). The authors concluded that although nurses had an understanding and expressed compassion and sympathy for the families' situation; a lack of cooperation with families arises from a lack of resources where priority is given to the patient in regards to service

provision or in an ethical dilemma of confidentiality.

As stipulated above this was a single site study. All participants came from the one ward with a total of 23 staff, although the authors stated participation was voluntary 20 of the staff participated. The reason given for the non participation of the three staff was staff training. The unit manager divided the group into four smaller groups depending on staff rotation. With this in mind one must question how voluntary participation in the study was and urge cautiousness in interpreting the findings as participants may have felt pressured to report desirable views. The authors themselves draw on this in their criticism of the focus group method in that it can censor the things that differ from the group norm. However they suggest these findings can be deemed trustworthy as the participants talked about the positive and negative aspects of the topic and did not try to put themselves in a complimentary light.

In concordance with Sjoblom *et al.* (2005), Fisher *et al.* (2008) recognise the support and reassurance the family can give to the service user especially during nursing interventions. They stipulate that nurses interact with family members of patients on a daily basis. In order to examine the attitudes and practices of nurses towards family presence during routine nursing care they undertook a quantitative descriptive study using a convenience sample of 89 nurses. All nurses worked within the same rural community hospital in the United States of America.

A 22 item questionnaire developed by the authors was sent to all of the 488 patient care employees. It consisted of 9 items exploring family presence during routine nursing care measured on a 4 point Likert scale (4 = strongly agree; 1 = strongly disagree; 0 = no opinion); 9 items that assessed behaviours related to family presence on

a 5 point Likert scale (5 = always; 1 = never; 0 = not applicable); 2 open ended questions (job performance hampered by family presence; preferences for handling family presence within the department) and 2 demographic items (job title; years of patient care). The authors state that interrater reliability for the 18 attitude and behaviour items was acceptable (Cronbach's alpha = 0.859).

Despite the incentive of a $5 video rental card on return of the questionnaire, the response rate was low 22% ($n = 107$). The majority of these respondents were nursing staff ($n = 89$). The authors chose only to report the findings of this group because they believe that this group provide the majority of patient care. The group that returned the questionnaire represented 30% of the nursing staff that were sent the questionnaire.

Respondents acknowledged the support and reassurance the family can give to the service user during nursing interventions and believe that families can take part in giving care to their family member if they (and their family member) wish to. Communication, teaching, involvement of family and psychosocial support were common reported behaviours.

Although this study did not involve MHN's nor was it in a mental health setting its findings could be deemed applicable for such a setting. It is also an expectation within the role of an MHN to communicate and involve families. The study found nursing staff who believe family presence to be important were more likely to communicate, teach, involve and support families in daily care. Similarly to the participants in Sjoblom *et al.* (2005) who preferred designated visiting times, there was low support among the respondents for family members being allowed to visit whenever the patient wishes.

There was agreement among the respondents with most of the family presence attitude items, although a degree of ambivalence among nursing staff towards enacting family presence existed. Nurses who believed that family members should be able to participate in simple hands on care did not regularly engage in any of the family presence care behaviours, including support for patient wishes for family members to be present during routine care.

The authors acknowledge the small sample, the use of a single site, the low response rate and the potential for participants to report desirable behaviours. They suggest cautious interpretation of the findings, but in general results support the principles of family centred. They view the results of respondents and the 'silence' of non respondents as helpful and can be used in designing educational tools and strategies to promote family involvement and to support review and revision of policies regarding family presence. The role of the healthcare organisation in providing support and education to nurses regarding family centred care and involving families is recognised but nurses must also examine their own attitudes and behaviours towards family presence.

Nurses and other Mental Health Professionals (MHP's) own attitudes and behaviours have been found to be barriers to collaboration with families. Kass *et al.* (2003) undertook a descriptive retrospective 23-item survey to identify barriers to collaboration between mental health professionals and families of persons with severe mental illness. The researchers with the assistance of the Minnesota Centre for Survey Research (United States of America) developed the questionnaire based on a review of the literature and from the response of three focus groups consisting of participants that

had taken part in one of three National Alliance for the Mentally Ill Professional Provider Education Courses (PP FEC).

The survey questionnaires were mailed to 76 course participants consisting of course coordinators, case managers, nurses, physicians, psychologists, social workers and other members of the Multidisciplinary Team (MDT). No names were requested, only demographic details. A likert-type scale was used to respond to researcher generated list of barriers to collaboration between MHP's and families. 31 participants returned the questionnaires.

Since completing the aforementioned course a change in attitude was noticed by 77.4% of respondents including an increased awareness of the challenges faced by family members, being more sensitive to the needs of families, and increased empathy and compassion towards family members. While 64% of the professionals noted a change in their practice, they were now more likely to involve family in discussions with clients and in treatment and care planning. They were also communicating directly with families by acting as a resource and providing information and support.

The main barriers to collaboration with families were cited as lack of time, feelings of conflict about treating the client versus treating the family, the belief that involving the family may be harmful to the client and the lack of measurable evidence that involving the family may be beneficial to the client.

Loss of hope and giving up, the stigma of mental illness, families' feelings of guilt and shame, the client not wanting the family to be involved and the families difficulty communicating with the client were identified as barriers by MHP's that prevented the family from getting involved. Interestingly the MHP's viewed the family

barriers as a result of emotional burnout on the part of the family members rather than communication problems on their part. Kaas *et al.* (2003) state that one of the objectives of the course was to promote a sense of partnership among families and MHP's, to discourage the "us versus them" attitude that tend to favour the MHP's judgement over the family's experience (pp. 751). However after the course the authors found that MHP's were still undecided as to whether the family or the client should be the focus of their efforts, leading the authors to believe that "changing attitudes and practice behaviours will take more than a ten week course" (pp. 751). While the authors acknowledge the small sample size may limit generalisability of the findings, they do not question why the response rate was so low. The silence of the non respondents may reflect the impact the course left on them.

In summation families should be acknowledged for their expertise in caring for their family member (Kass *et al.* 2003) although studies have acknowledged the relief families often feel when they have found help for their family member (McMaster *et al.* 2004; Sjoblom *et al.* 2005). Sjoblom and co-workers' study using focus groups, implied that nurses do have an understanding of the family's situation but blame was attributed to time constraints, lack of resources, the legal and ethical consideration of confidentiality and the emphasis and priority on patient care as reason for lack of cooperation with families.

Time constraints and the lack of evidence that collaborating with families will actually benefit the service user were cited by mental health professionals in Kass *et al*. (2003) study as barriers to collaboration with families. The role of the healthcare organisation in providing support and education to nurses regarding family centred care

and involving families is recognised all studies (Kass *et al.* 2003; Sjoblom *et al.* 2005; Fisher *et al.* 2008). There is a need for a more open dialogue with families (Sjoblom *et al.* 2005), nurses must examine their personal attitudes and behaviours about family presence in the healthcare setting (Fisher *et al.* 2008) but changing attitudes and practice behaviours will take time (Kass *et al.* 2003).

2.8 Conclusion

As a result of the lack of published literature on the development of nurse- family TR with the families of SU's experiencing an ED reflects; it is understandable and comprehendible that research exists highlighting the difficulties families encounter when it comes to interactions with health professionals and nurses alike (Jubb & Shanley 2002; McMaster *et al.* 2004). The literature suggests families often feel frustrated at the difficulty and complexity of accessing care for their loved one (Mc Master *et al.* 2004; Winn *et al.* 2004; Highet *et al.* 2004; Tierney 2005) while health professionals often feel ill equipped to treat effectively service users with an eating disorder (George 1997; King & Turner 2000; Eating Distress Conference 2005) and respond to the needs of families (Sjoblom *et al.* 2005; Treasure *et al.* 2007; Fisher *et al.* 2008). What we do know from the literature on family experience of eating disorders is that families are not experiencing on a regular basis the components that are said to be intrinsic to the development of strong TRs when interacting with professionals.

Mental health nurses interact with family members on a daily basis (Fisher *et al.* 2008). A gap in the literature exists concerning the therapeutic nature of these

interactions and relationships. Literature pertaining to developing therapeutic relationships with service users experiencing an eating disorder continuously highlights challenges faced by nurses (King & Turner 2000; Ramjan 2004).

Studies suggest, an understanding is there for the families' situation but nurses maintain a general degree of ambiguity regarding family involvement. While nurses viewed families as good sources of information, support and reassurance for the SU; they preferred limited involvement and cited reasons of time constraints, confidentiality, conflict of loyalties and institutional processes as reason for not collaborating with families (Kass *et al.* 2003; Sjoblom *et al.* 2005; Fisher *et al.* 2008).Studies from the families of SU's experiencing mental ill health and the families of SU's experiencing an ED perspective are unanimous in their claim of unmet needs, lack of support, information; feel uninformed, excluded and isolated. Families feel under scrutiny by health professionals and past experience has left feelings of resentment (Jubb & Shanley 2002; McMaster *et al.* 2004; Winn *et al.* 2004; Highet *et al.* 2004; Tierney 2005; Wilkinson & Mc Andrew 2008).

Collaborative care in theory is supported to a certain extent by both groups but utilisation in practice is not experienced by families nor does it seem, practiced by nurses. The themes that arose from the literature reviewed on family experience on interactions with health professionals are not congruent with the families experiencing components of a therapeutic relationship as outlined previously. Due to the dearth of literature the author is unable to present a nursing stand point. As previously stipulated in the study purpose, it is the aim to explore MHN's experiences of developing TR's with the families of SU's experiencing an ED. The focus group discussion guide

(Appendix 3) will assist in finding out what are their experiences and thoughts on this subject in an attempt to fill the gap that currently exists within the literature.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter will present the research question, the research design, research sample and the inclusion/exclusion criteria. The researcher will explain how the sample was accessed and the data collection method and procedure will be introduced and discussed, the rationale for selecting methods will be explained. Rigour within the research will be discussed, as will ethical considerations, management issues and methodological limitations will conclude this chapter.

3.2 Research Question

As highlighted in the literature review a significant gap exists in our knowledge about MHN's experiences of developing TR's with the families of SU's, more specifically the families of SU's experiencing an ED. According to Parahoo (1997, p. 123) "research is about finding answers, in order to do so questions must be posed". To address this gap in the research, the researcher posed the following as the research question: What are the experiences of MHN's in developing TR's with the families of SU's experiencing an ED? The goal of this study was to explore these experiences in an attempt to reduce this gap, enlightening further the existing knowledge about the practice of MHN's.

3.3 Research Design

The ultimate goal of nursing research is to develop, refine, and expand a base of knowledge about issues of importance to nurses (Polit & Beck 2006). Clamp (1994)

describes research in nursing as providing a link between practice, education and theory. Research design refers to the overall research approach that will be used. Decisions regarding the research design precede selection of data collection methods. Lacey (2006, p.20) states, in many ways, the choice of research design is the most important stage of the research process, "for it affects all the others". The design is selected on the grounds that it is the most suitable to answer the research question, then the most suitable data collection method is selected (Cormack 2000).

Quantitative research is a formal, objective, systematic process in which numerical data are used to obtain information about the world (Burns & Grove 2005). The quantitative approach to research involves the use of data collection methods such as questionnaires, structured observations, structured interviews and a number of other measuring tools (Parahoo 2006). The main purpose of quantitative research is to measure concepts or variables objectively and to examine, by numerical and statistical procedures, the relationship between them (Parahoo 2006), allowing for the generalisation of findings (Denzin & Lincoln 2005). Objectivity in quantitative research means that the researcher 'stands outside' the phenomena they study. The ways in which data are collected and analysed are expected to be free from bias on the part of the researcher and the participants in the study (Parahoo 2006). The researcher believes that this approach would not be suitable to the nature of the research being attempted and would not be conducive to capturing the subjective meaning of the experiences of the participants.

Qualitative research is a symptomatic, interactive and subjective approach (Burns & Grove 2003). It is the chosen method for this study as it is used to describe

human experience (LoBiondo-Wood & Haber 2002). Qualitative research relies on methods that can allow researchers into the personal, intimate and private world of participants (Parahoo 2006). Denzin & Lincoln (2005) suggest that qualitative researchers believe that rich descriptions of the social world are valuable. Parahoo (2006, p.44) asserts that qualitative research is a broad umbrella covering a number of approaches which subscribe to the "notion that phenomenon can realistically be understood by studying the meaning that people give to them and the context in which they happen". The essential feature of qualitative research is exploration as a means to understand perceptions and actions of participants (Lacey 2006).

A qualitative descriptive design using focus groups as the data collection method will be used to explore the experiences of MHN's in developing TR's with the families of SU's experiencing an ED. The selection of this method was deemed appropriate by the researcher as it is the method of choice "when straight descriptions of the phenomena are desired" (Sandelowski 2000, p. 339). It entails a comprehensive description of everyday events, in the aim that they will discover the "who, what and where" of experiences (Sandelowski 2000, p. 338), discovering new facts about people, events and situations (Porter & Carter 2000). The objective of qualitative descriptive research is to describe the essence of behaviour, based on meditative thought and with the purpose of promoting human understanding (Morse & Field 1996). The key to implementing a good qualitative research study, results in a researcher ensuring the research question is clear, the method selected to answer the question is appropriate, and the people and data needed are available (Speziale 2003).

3.4 Sampling Method

3.4.1 Population and Sample

A population is all the individuals or objects with common, defining characteristics (Polit & Beck 2006), it also refers to the entire class of cases to which the researcher wishes to generalise her research (Porter & Carter 2000). The population of this study is Mental Health Nurses (MHN's). As it would be unlikely and unnecessary [all MHN's may not have had experience working with or developing TR's with the families of SU's experiencing an ED] to include all MHN's in this study; a sample will be selected. A sample refers to the group of people the researcher selects from the defined population (Atkinson 2000). Individuals are selected to participate in qualitative research based on their first hand experience with a culture, social process, or phenomenon of interest (Speziale & Carpenter 2003). In the context of focus groups, participants are selected because they relate to the topic of the focus group and share certain characteristics (Krueger 1994).

Morse and Field (1996) recommend two principles should guide qualitative sampling; appropriateness and adequacy. Appropriateness is derived from the identification and utilization of the participants who can best inform the research according to the theoretical requirements of the study (Morse & Field 1996). In the case of the proposed study non probability purposive sampling of mental health nurses with experience of working with the families of service users experiencing an eating disorder will be used. It is recognised by the researcher that this type of sampling has a very limited ability to generalise findings because its sample is handpicked (Lo-Biondo Wood & Haber 2002); it is a necessary method to ensure the appropriateness of the

sample. If random sampling was chosen it would have changed the nature of the study. It may be likely that the participants selected may have little or no knowledge or experience in developing TR's with the families of SU's experiencing an ED (Morse & Field 1996). Also time constraints may not allow the use of random sampling to produce an appropriate, adequate sample.

Morse and Field's second principle, adequacy of sample, ensures there is enough data to develop a full and rich description of the topic the researcher wishes to explore. Data saturation is the aim of the qualitative researcher (LoBiondo Wood & Haber 2002), where new data no longer emerges in the data collection process. To insure appropriateness and adequacy of the sample inclusion and exclusion criteria are outlined below.

3.4.2 Sampling Criteria

Inclusion Criteria

- An Bord Altranais Registered Mental Health Nurses
- An Bord Altranais Registered Mental Health Nurses with experience working with service users with an eating disorder and their families.

Exclusion Criteria

- Those that do not fit the inclusion criteria.

Rationale for Inclusion/Exclusion Criteria

- The researcher chose not to impose a minimum level of experience required for participants (MHN's) to be eligible to participate in the study; whether how long qualified or in terms of quantifying the amount of SU's experiencing an ED and their families they have worked with.

- It is the norm for MHN's working in a community setting to have a minimum of three years experience so this was taken as a given.

- The researcher did not feel it was necessary that participants should have worked with a minimum number of SU's experiencing an ED and their families. Due to the complex nature of ED's, SU's are often in contact with MHS's for a sustained period of time, MHN's could therefore have multiple experiences even with an individual SU and their family.

3.4.3 Access to Sample

On receipt of ethical approval, the researcher gained access to a sample that fit inclusion criteria by writing to Mr. XX, Director of Nursing, Hospital XX and the Assistant Directors of Nursing of two of the service's community (outpatient) services; Gatekeeper 1: Mr. XY (XY Community Mental Health Services) and Gatekeeper 2: Mr. XZ (XZ Community Mental Health Services) (**Appendix 7a, b & c**). The researcher had hoped to gain access to two community settings predetermined by the researcher. Understandably, due to tragic circumstances (a SU experiencing an ED had taken their own life) the Director of Nursing approved access to only one of the predetermined sites (the tragic event may have been too raw in the minds of the MHN's that may have

proved too distressing for them to talk about). Thankfully permission was granted to access an alternative site.

A poster (**Appendix 8**) and approx 15 information leaflets (**Appendix 9a-c**) were sent to the gatekeeper at each site. The gatekeeper was asked to display the poster in a prominent position and post the information leaflets in the post boxes (pigeon holes) of MHN's working on the site. The poster advertised the study; in the hope that it would encourage interest and discussion among possible participants as well as inviting the MHN's to review the information leaflet that had posted in their post boxes. The information leaflet provided details about the study; addressed the inclusion and exclusion criteria (**Appendix 9a**), the declaration of confidentiality (**Appendix 9b**), rules of the focus group (**Appendix 9c**) and concluded with an invitation to participate. The participants also received a copy of the informed consent sheet (**Appendix 10**). Nurses interested or who required further information were invited to contact myself (the researcher) directly in order to minimize any further additions to the gatekeeper's own workload.

The researcher had informed participants in the information leaflet that when they got in contact expressing willingness to participate their details would be taken (name and contact numbers/email) and the researcher would assess if they fit the inclusion criteria. The researcher also asked the potential participants; approximately how many SU's experiencing an ED and their families they have worked with and how many years qualified they were. It is noted that the inclusion/exclusion criteria do not specify that MHN's must have a quantifiable level of experience nor be a specific number of years qualified. This information would only used for demographic purposes

and in the event there was an oversubscription of willingness to participate.

Initially there was poor response rate, after one week a reminder letter (**Appendix 9d**) and a copy of the information leaflet was forwarded to the gatekeepers for distribution into the post boxes (pigeon holes) of the MHN's. On receipt of the reminder letter approximately 12 potential participants (approximately six from each community setting) began contacting the researcher by telephone and the process of arranging a convenient, suitable time for the focus groups began.

This process proved very challenging. Trying to arrange a suitable time for everyone proved difficult, with much communication back and forth between the participants and the researcher. Among the first group, a general consensus was reached that Wednesday mornings were the most convenient so a date was arranged for April 21st 2010. Unfortunately the researcher was delayed in Spain due the Icelandic Volcanic Ash Cloud, and had to cancel the focus group. Participants (as was the researcher's supervisor) were very understanding and agreed to reschedule. Rescheduling the focus groups took over three weeks, as when the researcher returned (after being stranded in Spain for an extra week); participants that had agreed to participate had either moved to different sites or were on annual leave (holidays). Eventually the groups were organised for May 2010 with 12 MHN's agreeable to participate.

3.4.4 Sample Size

The researcher aimed to interview 6-12 participants to participate over one to two focus groups. In reality, two focus groups of four participants (five women, three men) were

held. Although focus group size tends to vary, Kreuger (1994) has deemed a range of 4-15 as acceptable. The researcher had expected six participants in each group as pre arranged. However, on the morning of the first group two participants had to attend a Case Conference for a service user and on the second morning two of the original participants were called into a management meeting. Luckily they were replaced by two other MHN's that met the inclusion criteria and were agreeable to participate. Two other participants were unable to attend due to staff shortages. The unexpected drop outs were acceptable to the researcher, MHN's are working in a caring profession in a sometimes unpredictable environment, the SU and any emergencies that may arise take priority.

It is recognised that the sample size of eight is small however, Streubert & Carpenter (1999) reiterate that sample size in qualitative research tends to be small due to the large amount of verbal data to be analysed. Therefore sample size should be determined on the basis of information needs (Polit, Beck & Hungler 2001). Data saturation or redundancy of information can be achieved with a small number of participants if information from the participants is adequate and sufficient for the proposed study's aims and objectives (Holloway & Wheeler 2002). As adequacy and appropriateness of the sample was ensured, the participants all contributed well to answering the research question, two focus groups proved sufficient similar themes arose in each group. These themes will be discussed in chapter four.

3.5 Data Collection

Data collection in descriptive qualitative research involves gathering the narrative data

from the participants through interactive processes (Burns & Grove 1999). A variety of strategies can be used to generate qualitative research data: interviews, observations, narrative, and focus groups (Speziale & Carpenter 2003). As previously stated the proposed data collection method is focus groups.

3.5.1 Data Collection Method

Kitzinger (1994, p.104) defines focus group interviews as ''in dept open ended group discussions, which explore a specific set of issues on a predefined and limited topic''. Focus groups were the chosen data collection method as they normally generate a large amount of data in a relatively short space of time (Krueger 1994). They have also proven effective when investigating how knowledge and ideas develop within a certain context (Kitzinger 1994). The focus group method allowed the participants (MHN's) to explore their own meaning of what is being asked, rather than being directed, the discussion guide aided the participants in opening up about their experiences (Polit & Beck 2006).

The focus group interviews used a semi structured discussion guide **(Appendix 3)**. Within a semi structured discussion guide the researcher had listed topics to cover rather than specific questions to ask (Polit & Beck 2006), general questions to clarify participant responses and meaning of responses were used when necessary. A semi-structured discussion guide was chosen as the dross rate or the amount of material that is generated, that has no particular use for the researcher's study is generally lower than in an unstructured interview (Holloway & Wheeler 2002), for the novice researcher, a high dross rate may unnecessarily complicate the already complex data analysis of

focus groups (Kreuger 1998).

Krueger (1994) suggests it is the role of the moderator is to create an accommodating environment that encourages different perceptions, views and opinions without pressuring participants into reaching a consensus. Moderators are considered part of the data collection tool (Burns & Grove 1999), the moderators function is to encourage participants to talk freely about all topics on the guide, facilitating a discussion that leads to rich generation of data (Rabiee 2004).

The researcher was the moderator of the groups, a co-moderator was not used for two reasons; to keep outside interference at a minimum and because there was none available to the researcher at that time. Acknowledging the inexperience of the researcher, in preparation for the role of focus group moderator the researcher attended a practical skills class in data collection and liaised with her supervisor closely. The researcher also drew on her own experience of moderating therapeutic groups within a mental health care setting. The experience of moderating the pilot study also proved invaluable to this novice researcher and will be discussed below.

3.5.2 Pilot Study

Initially the researcher had taken the decision not to do a pilot study as pilot studies are not always used in qualitative research as the research is developmental (Holloway & Wheeler 2002) and potential participants for the proposed study were limited due to staff constraints and inclusion criteria. That said an initial draft of the focus group discussion guide had been tried out during a data collection methods workshop. It was noted that initial discussion focused on developing a T.R. with service users rather than families despite the focus being on developing therapeutic relationships with families.

After some thought and discussion with my supervisor it was decided that it was important to acknowledge that developing therapeutic relationships with service users is a primary goal for mental health nurses and it was natural for them to associate T.R.'s with service users rather than families. Hence the first question asks participants to give their thoughts about developing therapeutic relationships with service users, before moving on to families.

As time went on the researcher had become increasingly anxious about moderating the focus groups and decided to review her initial decision not to do a pilot study. A pilot focus group was held at another site alternative to the study sites with two participants that fit the inclusion criteria. The researcher acknowledges that this was a very small number of participants for a focus group, that said, Kreuger (1994) advocates that inexperienced moderators begin with small focus groups in order to increase confidence and facilitate the development of effective moderating skills.

The pilot focus group proved to be a very valuable exercise for the researcher. Firstly, the recording equipment proved suitable and effective. Data was audible and easily transcribed. Secondly, the pilot study relieved some of the moderators own anxiety about moderating the focus groups and provided some hands on practical experience. Thirdly, the participants gave some important feedback on the design of the discussion guide. For the most part they thought the questions were relevant and understandable; however they felt question three which was initially a two part question would be better as two separate questions. They also voiced they had experienced initial anxiety when I (the researcher) had began taking notes at the commencement of the focus group, they later reported that the note taking actually eased their anxiety and

allowed them to speak more freely as they felt less in the "spotlight". Foolishly I had forgotten to mention I would be taking notes at the introduction something I had planned to do. The advice of the participants regarding the discussion guide and moderator etiquette was taken on board and incorporated into the focus group design.

The researcher self transcribed the pilot study. On reflection and from reading the transcript it was clear that a challenge existed to keep the participants focused on discussing their experiences of developing TR's with families rather than service users despite question one, highlighting the researcher needs to be mindful of this when facilitating discussion. The researcher was also conscious of the prompts that were used; the questioning of participants; clarifying participant responses and recapping at the end of the focus group and the influence the above may have on researcher bias. On further review of the transcripts and after discussion with her supervisor the researcher took the decision not to recap at the end of the focus group, to be cautious when clarifying participant responses so not to increase researcher bias. The original prompts were also modified to promote clarity and increased understanding of the discussion guide.

3.5.3 Focus Groups

Both focus groups took place in a room in the participant's place of work. A generic notice was put outside the door asking for 'Quiet Please, Group in Progress' apart from intermittent noise from traffic outside and the window shutters the groups passed off uninterrupted. The researcher and participants were seated in a circle around a small coffee table that held the recording equipment (Sony ICD P620 digital voice recorder) and some refreshments (water and juice); the participants were provided with breakfast

prior to entering the room. Audio recording is the best form of preserving interview data (Holloway & Wheeler 2002), it contained the exact words of the interview, the questions asked and allowed the researcher to concentrate and pay attention to what the participant had to say. The researcher had ensured the rooms were suitable for the recording equipment by testing it before the focus group discussion began.

Prior to data collection, participants were reminded again that the focus groups would be recorded and they had the right to withdraw at any time, before, during or after the recording of data (see ethical considerations). No participant chose to withdraw before or after the study. They were each given two copies (participant copy and researcher copy) of the informed consent sheet, confidentiality agreement and focus group rules to review again and sign. They were reminded that if any form of malpractice or professional misconduct was revealed it was the duty of the researcher to report this to the relevant authorities (see ethical considerations) again this did not happen.

The focus group discussion began with a welcome note, a thank you and a general introduction, they were also informed the researcher may take a few notes throughout the discussion and encouraged not to be put off by this. The discussion went well despite the initial nervousness of the researcher. The researcher ensured to keep the participants discussion focused on their experiences with developing TR's with families and was mindful not to influence the discussion of the participants in a way that would increase researcher bias. At the end of each focus group there was time for the participants to reflect on what was discussed, they were asked if they had anything else to add, an approach advocated by Krueger (1998) to increase validity. In both

focus groups participants reiterated on previous points that they felt strongly about. The participants were again thanked for their time and participation and given a copy of the researchers contact details, if any issues arose they wished to discuss further. Participants have not contacted the researcher since the focus groups.

The focus groups lasted 38 and 30 minutes respectively. The researcher had anticipated the groups would last longer, but towards the end of the discussion the researcher noticed participants becoming a little restless. The researcher learned when the discussion ended that some participants had appointments after the group they were anxious to make. On review of the data, the groups produced a large amount of rich data, despite the relatively short length of the discussion. The analysis of this data will be discussed in detail in the chapter four.

3.5.4 Data Storage

Data will be filed safely, securely and appropriately in accordance with the Data Protection Act (Department of Justice, Equality and Law Reform 2003). The researcher has kept the participant's details, consent forms, field notes in a separate from tapes and discs containing the transcribed information, in locked cabinets within a locked room at her place of work. All computerized data files of the focus groups are firewall antivirus protected and alphanumerically password encrypted (the password is known only to the researcher) and stored in the locked cabinet. All computerized data will be anonymised using codes e.g. FG1B, FG2C. All data will be kept for a maximum of five years post study and then destroyed in accordance with the disposal of confidential waste, hard drives and other computer software will be wiped clean (data erased) using a

professional service to ensure all traces of the data is erased thoroughly and safely. The data was transcribed using a transcription service that is bound to a professional confidentiality agreement with their clients. The researcher's research supervisor was given access to the transcribed interviews after the participant identities had been protected using codes (FG1A, FG2B) and any reference that could identify service users, their families or the location of study site has been removed. Participants have been informed of the intention to publish and share the findings of the research study and that the ethical principle of confidentiality will be adhered to at all times.

3.5.5 Data Analysis

Focus groups were transcribed using a professional transcription service. Data was analysed with the aid of Nvivo 8 (Qualitative Analysis Software) and interpreted using Colaizzi's (1978) framework for data analysis. Data analysis procedures will be explored in detail in Chapter 4.

3.5.6 Rigour

Trustworthiness in qualitative research means methodological soundness and adequacy (Holloway & Wheeler 2002). In qualitative research, rigour is associated with openness, scrupulous adherence to a philosophical perspectives, thoroughness in collecting data, and consideration of all data in the subjective theory developmental phase (Burns & Grove 2003). In demonstrating trustworthiness, Guba and Lincoln (1989) inform us that without the presence of 'credibility', 'transferability' and 'dependability', qualitative research studies will continue to fail under the critical eye of

the evaluator to meet 'rigorous standards' and surrender to the criticisms that it lacks scientific rigour (Koch & Harrington 1998).

To counter specific threats to the validity of qualitative research, the investigator must demonstrate the truth value of multiple perspectives, the dependability of the findings amid variability, the applicability of findings to broader contexts and the freedom from bias in the research process (Guba & Lincoln 1989). It is proposed to demonstrate trustworthiness by adhering to Lincoln and Guba's (1985) framework by developing dependability, credibility, transferability and confirmability.

Promoting Credibility

Measuring credibility involves examining how clearly the data collected and the method of analysis accurately reflect the focus of the study (Polit & Hungler 1999). There are many benefits and limitations of using focus groups as the data collection method that are beyond the discussion of this dissertation. That said, one of the main limitations of using focus group methodology and challenges to the rigour of the design, is the reliance on the skill of the moderator (Twinn 2000). There is a vast array of literature surrounding the role and importance of the moderator within the focus group process (Krueger 1994, Kitzinger 1994, Twinn 2000, Kidd & Parshall 2000, Freeman 2006, Peek & Fothergill, 2009). Krueger (1994) suggests it is the role of the moderator to create an accommodating environment that encourages different perceptions, views and opinions without pressuring participants into reaching a consensus. As many different personalities will be present within the group, moderator skill is needed when facilitating group interaction, managing group dynamics and refocusing the group when

necessary (Kitzinger 1994, Kreuger 1994, Twinn 2000, Peek & Fothergill 2009).

The researcher has acknowledged her inexperience in moderating focus groups. To address this in the hope of enhancing credibility, the researcher 'practiced' moderating focus groups within practical skills classes as part of the taught component of her Master's study. The researcher drew on her clinical experience in facilitating therapeutic and support groups, as well as reading extensively the literature surrounding focus group methods and liaising with her supervisor. Moderating the pilot study gave the researcher further experience and improved her moderating skills which proved invaluable.

Another credibility issue of this method is that focus group moderators are considered an integral part of the data collection tool and the data analysis (Kidd & Parshall 2000, Franklin & Lowry 2001). Davies and Dodd (2002, p.221) state "an essential element of rigour is the assumption that the research process displays a method that is objective". As with all qualitative research, maintaining objectivity is a concern, especially when the method puts the researcher in the role of observer and data analyst (Franklin & Lowry 2001). They advise there is a "thin line" between guiding and influencing focus group discussions as the moderators own perceptions and attitudes may sway the "spoken attitudes" of the group, within the data analysis their concern relates to bias infiltrating the analysis as the "verbal data will only filter through one person's perception" (p.173). Guba and Lincoln (1989) advocate removal of bias from the research process incorporating objectivity on the part of the researcher. While this is not disputed the eradication of subjectivity completely is unattainable and may be viewed as damaging to research and ethical research (Davies & Dodd 2002).

To promote the presence of objectivity, rather than the total elimination of subjectivity the researcher has kept a reflective journal throughout the research process. Koch (1994) insists credibility is strengthened when researchers describe and interpret their experiences demonstrating self awareness and monitor 'what is going on in the research' through keeping a reflective journal (Koch & Harrington 1998). The writer has been using a reflexive approach to her practice stemming from her undergraduate learning. When embarking on a new journey or challenge as is the undertaking of this research, the ongoing self critique and self appraisal of reflexive research as characterised by Koch and Harrington (1998) are found to be particularly useful.

Promoting Transferability

Lincoln and Guba (1985), and Kreuger (1994) collectively support the view transferability is the responsibility of potential users of the research. As previously stipulated, a non- probability purposeful sample of MHN's with experience working with SU's experiencing an ED and their families was chosen from a population of MHN's. This sample came from two community mental health settings within an Irish Mental Health Service. Participants were all familiar to each other. Peek and Fothergill (2009) agree that as with many methodological issues, there is no steadfast rule that should be followed when designing focus groups with pre-existing groups. Krueger (1994) urges caution when using pre existing groups as participants may chose not to report alternative opinions to the group norm. Kitzinger (1994) would suggest that pre existing groups may enable discussion as participants are already comfortable with each other. The latter was the case with this research study, although participants may have

been talking about the same SU's and their families; Kreugers' stance may be disregarded in this instance as participants shared different opinions and were not afraid to disagree with each other.

The readers of the research have been made aware of the derivation of the focus groups. They can make their own judgements whether they relate to the findings and/or transfer them to another setting, either having shared experiences similar to those of the participants or through considering the findings 'plausible' (Koch & Harrington 1998). The reader will decide if the findings are applicable to their setting, before incorporating findings into practice or policy, on the other hand the reader may also choose to dismiss the findings. Thick descriptions and sufficient contextual information (Guba & Lincoln 1989) have been provided in order to allow readers to make informed judgements.

Promoting Dependability

Barbour (2001) insists that whether data analysis is carried out by a lone researcher or research team, it is important to follow a systematic process that should be transparent to the reader in the written research project, clear illustrations of the data analysis procedures have been presented in Chapter Four. Verbatim quotations from the transcripts were included to further demonstrate how themes were derived, as recommended by Sandelowski (1993).   Whittemore *et al.* (2001) suggest reflexive journaling is particularly helpful in signposting the decisions within data analysis, as previously stated a reflexive journal was maintained by the researcher.

Kidd and Parshall (2000 p. 295) highlight "there is still a frustrating vagueness

with respect to specific analytical approaches that can be used to increase confidence in focus group findings". As mentioned above the focus groups were audio recorded and transcribed by a professional transcription service. The NVivo 8.0 qualitative analysis software package was utilized in managing the data and keeping an audit trail of how analysis decisions were made and Colaizzi's (1978) seven step framework was used to analyse the data.

In concordance with step seven of Colaizzi's framework (Chapter Four) a summary of the findings was sent to all eight participants as a final validating step and a way of strengthening dependability of the study. In using the term 'stability' as an alternative to 'dependability', Long and Johnson (2000) suggest that even if the researcher was to present the findings to the group members at the end of the study, stability may not be sufficiently achieved due to the time lapse involved. Therefore focus group participants alone may not be dependable in validating the findings. Nevertheless at time of writing the researcher had received feedback from four of the participants, all four were in agreement with the findings. One participant reported he has been making a conscious effort to have better relationships with families since participating in the focus groups.

Promoting Confirmability

For research to be judged confirmable researchers need to demonstrate the research process in clear and logical manner. While respondent validation is also a method of strengthening confirmability, the researcher will keep an audit trail (Speziale &

Carpenter 2003) using Nvivo that will allow another individual to follow research activities and decisions throughout the research process making the analysis transparent. Whittemore *et al.* (2001) also advocate thick descriptions of data and contextual information should be included in the research report, as previously stipulated the writer plans to include the above allowing the reader of the research to make a more informed judgement.

3.6 Ethical Considerations

The researcher sat before the Ethical Review Board of the Trinity College School of Nursing and Midwifery in December 2009. Recommendations were made by the review board and implemented before submission to the Trinity College Faculty of Health Sciences in January 2010. Ethical approval for the study was granted in February 2010 (**Appendix 5**).

Ethics pertains to doing good and avoiding harm (Orb *et al*. 2000), it is therefore essential that the researcher examines all aspects of the approach to research from an ethical standpoint. Harm can be prevented or reduced through the application of the appropriate ethical principles as outlined by the Royal College of Nursing (1993), for protection of the participants: beneficence; nonmaleficence; fidelity; justice; autonomy; veracity/honesty and informed consent; confidentiality **(Appendix 6)**.

The researcher aimed to adhere to these principles throughout the entire research process.

Prior to the focus groups commencing, participants were again informed of: the purpose of the research; their contribution; how the data will be collected and used; the storage

of the data and the length of time it will be stored for (5 years).

Participants signed an informed consent sheet. Participation in the study was entirely the decision of the participant, no participant should have felt obliged to participate, and participants were also reminded of their right to withdraw at any stage without penalty. This would have been fully respected by the researcher and any data collected form that participant would have been destroyed or returned to the participant at their request. Luckily for the researcher, no one withdrew their participation.

Participants were reminded of their right to confidentiality. Prior to commencement of the focus group(s), participants signed a declaration to adhere to confidentiality regarding the other group members and anything disclosed within the group declaring they would not discuss anything disclosed in the focus group outside the focus group. The researcher has not been informed or heard of any breaches to confidentiality to date.

The participants were informed of the researcher's ethical duty to report any disclosure of malpractice, professional misconduct or criminal activities to the relevant authorities (Director of Nursing; An Bord Altranais; Gardai) and the researcher's requirements by law to report information about child or elder abuse, drug trafficking or crime (Orb *et al*. 2000). Again, this was not an issue.

Throughout the focus groups the researcher (moderator) assessed the well being of the participants before moving on to a new question on the discussion guide. No participant became upset or left the focus group unexpectedly. If this had happened the researcher planned to assess if the focus group needed to be suspended for a comfort break or if a participant had unexpectedly left the focus group the moderator would

have suspended the focus group for a comfort break to assess the well being of the participant. Should participants have needed professional support after the focus groups they were given the number of the Confidential Counselling Service (01 6352393) open to all Health Service Executive employees. At the end of the focus groups participants were provided with a card with this number and also the researchers contact details for their convenience **(Appendix 11)**. The researcher also made a follow up telephone call one week post focus group to assess if any issues arose from the focus group discussion that the participant needed support with, participants reported no issues. The researcher also advised the participant they remained contactable if necessary.

To limit the time away from service users the focus group(s) ran into the participants morning break, breakfast was provided by the researcher to compensate participants for their loss of break and acknowledge their need for food and refreshment.

3.7 Management Issues

The proposed research project was solely funded by the researcher.

Table 1: Resources

Expense	Cost to nearest Euro
Sony ICD P620 Digital Voice Recorder	75
Stationery, Postage, Photocopying and Printing	150
NVivo8 Computer Software License 12 months	90
Telephone Calls	70

Breakfast for 12 people	100
Secretarial Support (Transcription Costs)	140
Printing and Binding of thesis	100
Total Cost	**€725**

Timescale:

STUDY STAGE	MAY 2009	JUN 2009	JUL 2009	AUG 2009	SEP 2009	OCT 2009	NOV 2009	DEC 2009	JAN 2010	FEB 2010	MAR 2010	APR 2010	MAY 2010	JUN 2010	JUL 2010
Develop Research Proposal	■	■	■	■	■	■									
Seek Ethical Approval							■	■	■	■					
Access Sample										■	■	■			
Participant Selection												■	■		

Data Collection											🟩	
Data Analysis											🟩	🟩
Presentation Of findings											🟩	🟩

Illustration 1:

Timescale

3.8 Methodological Limitations

The sampling method (non probability purposeful sample) and sample size are acknowledged as limitations. However, the sampling method was necessary to ensure the researcher would have an adequate and appropriate sample within a short length of time as this study is part there of a Masters (MSc) Mental Health, a different method such as random sampling may have proved too time consuming to find a suitable sample in the available time frame (three months). The researcher is satisfied that a saturation of themes occurred despite the small sample within the two groups. Although Kreuger (1994) would advocate between three and five focus groups the researcher is confident that the groups gave an accurate and valuable description of their

(MHN's) experiences of developing TR's with the families of SU's experiencing an ED. It is not the purpose of qualitative research to be generalisable, however this researcher believes this study presented a 'snapshot' of the participants experiences which may be useful to other MHN's and MHP's in similar settings.

Another limitation is that the researcher is a novice and the choice of data collection method (focus groups) meant the researcher (as moderator) was an integral part of the data collection and analysis processes. The researcher's choice of focus groups as the data collection method proved a good decision. Although organising the focus groups was at times a logistic nightmare they proved fruitful in producing a large amount of rich data in a relatively short space of time. The moderating of the focus groups went smoothly when the initial nervousness of the researcher eased. However, on reflection of the transcripts a more experienced moderator may have explored certain elements of the discussion in more detail. Analysing this data was a daunting task due to the large amount of rich data and the limitations of a word count. The researcher liaised with her supervisor throughout the research journey and data collection and analytic issues were discussed and a solution found. This may go some way in countering the researcher's novice status.

3.9 Conclusion

Thus concludes the methodology chapter. To summarise, this was a qualitative descriptive study to explore the experiences of MHN's of developing TR's with the families of SU's experiencing an ED using focus groups to collect the data. The two

groups of four participants were held in May 2010, the next chapter will describe the data analysis procedure and findings of these groups.

CHAPTER FOUR: DATA ANALYSIS & FINDINGS

4.1. Introduction

This chapter will present the data analysis and findings of two focus groups conducted to explore the experiences of MHN's in developing TR's with the families of SU's experiencing an ED. The groups (four participants in each) were held in May 2010. At the time of recruitment all participants (five women and three men) were working in one of two community settings; two participants were employed as Community Mental Health Nurses (CMHN), one participant was a Clinical Nurse Manager II (CNM11) in a community setting, one participant was a Clinical Nurse Specialist (CNS) of Severe and Enduring Mental Illness and four participants were MHN's working on a Homecare Team (HCT).

Participants had between five and twenty years experience working as MHNs *(mean=12.4yrs)*. As stipulated in the inclusion criteria all participants had worked with SU's experiencing an ED. One participant had worked with ten different SU's experiencing an ED and their families; three participants had worked with three; one participant had worked with five; two participants had worked with one; and one participant had worked with two SU's experiencing an ED and their families.

Table 2: **Participants Grade, Number of Years Qualified and Number of SU's experiencing an ED and Families they had worked with**

GRADE	Years Qualified (m=12.4)	SU's & Families
CNS	17	3
CMHN	10	10
CMHN	11	1
CNMII	11	3
HCT	20	3
HCT	5	5
HCT	10	2
HCT	15	1

The discussion guide (**Appendix 3**) aided the participants in talking about their experiences. The data that derived from the focus groups and how it was analysed will be discussed below and the presentation of the findings will follow.

4.2 Data Analysis

Rabiee (2004) advises that data analysis begins within the focus group by the moderator skilfully facilitating the discussion and generating rich data. Data analysis is part of the process all the way through from the selection of the research problem to the writing up of the final report (Krueger 1998). Morse and Field (1996) recommend simultaneous

collection and analysis of data, this means that interviews are transcribed and analysed as soon as the interview has been completed, this also helps to avoid a data pile-up. Copies were made of the tapes of the focus group recordings and the transcribed files to ensure data will not be lost. The storage of this data has been outlined above.

The researcher used a professional transcription service because of time constraints and as a way of limiting moderator bias by preventing the moderator from filling in gaps of lost data. Data loss is an associated risk of focus groups due to more than one member speaking at a time, utterances and the formation of subgroups (Kidd & Parshall 2000, Peek & Fothergill 2009). There were two occasions where the participants were laughing and talking over each other but this was in agreement with previous points that were audible on the recording. Each participant was given an identification code at commencement of transcription (FG1A, FG2B etc.). The tapes were transcribed within 72hrs and included information on pauses, gaps as well as comments in brackets detailing emotional tones and observational notes (O'Meara-Kearney 1999). On receipt of the transcriptions the researcher read the transcripts while listening to the tapes to ensure the transcription was accurate as recommended by Polit & Beck (2004).

The transcribed interviews were copied into the NVivo 8.0 Qualitative Analysis Software Package (**Appendix 4**). This allowed for the easy retrieval and sorting of large amounts of data. It kept track of the analysis decisions (audit trail) and allowed for the organisation of the emerging themes (Kidd & Parshall 2000).

Colaizzi's (1978) seven step framework for the analysis of interview data was

the chosen method to interpret the information collected from the focus groups (**Table 2**). Colaizzi was selected as the researcher is inexperienced; the framework is deemed suitable for both the experienced and novice researcher (Robinson 2000) and is suitable for the data analysis of qualitative descriptive studies (Polit & Beck 2003).

Table 3: Colaizzi's Seven Step Framework:

Step 1	Read and re-read all transcripts to acquire a feeling for them
Step 2	Review each transcript and extract significant statement
Step 3	Meaning will be established of each significant statement
Step 4	The significant statements will be organised into clusters
Step 5	These clusters will be referred back to the original transcripts to validate them. Discrepancies will be noted among or between the various clusters, avoiding temptation of ignoring data or themes that do not fit in the original cluster.
Step 6	Results will be integrated into an exhaustive description of the phenomenon under study in a clear statement of identification if possible
Step 7	Participants will be then be consulted about the findings as a final validating step

The focus group transcriptions were imported and saved within the 'Internals' section of the NVivo programme. The researcher read and re-read the focus group transcripts over and over again. This allowed the researcher to acquire a feeling for the participant's experiences of developing therapeutic relationships the families of service users experiencing an eating disorder.

The researcher then returned to the transcribed data and extracted significant statements which were the phrases, statements or excerpts that related to the participants

experiences. The significant statements were easily extracted from the complete transcription using the coding function on the NVivo programme.

The researcher then took each significant statement and formulated a meaning that described aspects of the participant's experiences. These formulated meanings were coded together in 'Tree Nodes'. While keeping in mind the aim and objectives of the study, the researcher then organised these formulated meanings into a cluster of themes (Free Nodes). This step revealed common patterns in the data. T

The cluster of themes was then referred back to the transcripts to be certain to account for everything that was significant from the original discussions without introducing ideas that were not represented in the original discussions. An exhaustive description of the participant's experiences that was apparent within each theme was compiled. Member Checking was utilized as a final validating response. The exhaustive description (summary of findings) was returned to the participants to validate the findings. At time of writing the researcher had received feedback from four of the participants; all four were in agreement with the findings. One participant reported he has been making a conscious effort to have better relationships with families since participating in the focus groups.

Table 4: **Analysis of Data- How the themes were derived:**

| Internals	Tree Nodes	Free Nodes
Significant Statements	Formulated Meanings	Themes of Clusters
'I suppose good communication is the foundation stone of developing therapeutic relationships' FG1B	Importance of Consistent Communication in developing therapeutic relationships	A Consistent Approach to the Common Goal

'...the common goal is the same.... everyone singing off the same hymn sheet' FG1A	All stakeholders are working towards the goal (of recovery for the SU), agreeable to the same plan	A Consistent Approach to the Common Goal
'They were left with no control or say in the situation because he was made involuntary and they weren't fully agreeable to the treatment plan anyway' FG2B	Power Imbalance- Acknowledgement that families may be disempowered	An Uneven Collaboration
'Its important to have them on board with whatever the plan is...where families have their own ideas about treatment....they almost have the opposite of what we wanted to do' FG2C	Families need to agree to the set plan and cooperate with it- Compliance with the care plan	An Uneven Collaboration
'....hassle and confrontation and them giving out to me or to us that we weren't doing enough for ...disparaging remarks about the service and what you are not doing....' FG1A	MHN finds it difficult to cope with the families expressed emotions	The Challenge of Expressed Emotion
'I didn't feel confident to engage with the family greatly and I did because I had to but I didn't feel I had enough experience I think to manage a family that were difficult....' FG2B	Acknowledgement of lack of expertise – knowledge and experience	Mental Health Nurses' Awareness

Four themes emerged from the analysis of the information collected from the focus groups:

- A Consistent Approach to the Common Goal
- An Uneven Collaboration
- The Challenge of Expressed Emotion
- Mental Health Nurses' Awareness

Illustration 2:Findings
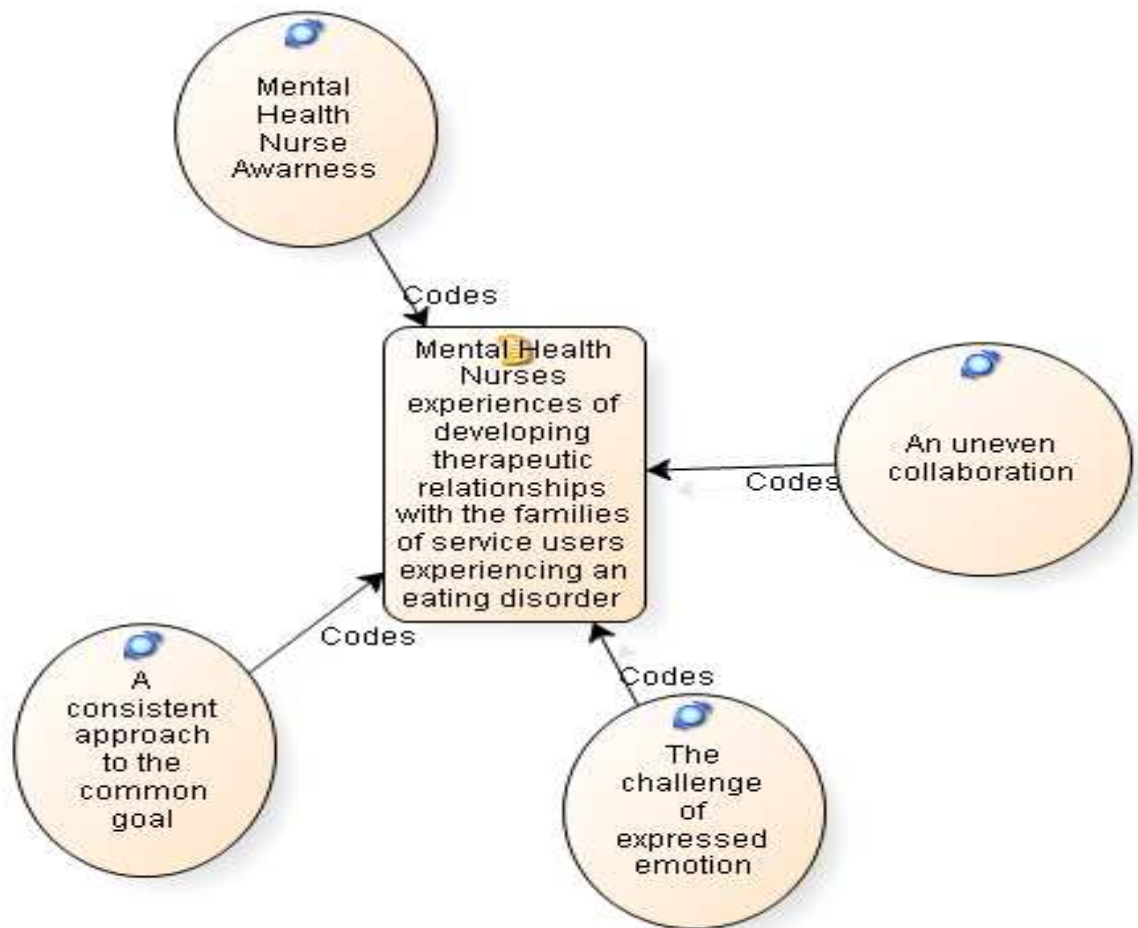
Below, the researcher will illustrate the findings of this research under these headings by using verbatim excerpts from the interviews.

4.3 Presentation of Findings

4.3.1Theme 1: A Consistent Approach to the Common Goal

The 'common goal' of MHN's and families alike is to see the SU in a state of recovery. Although there are many definitions of what delineates recovery? Anthony (1993) argues that the individual can recover even when the illness is not cured.   Whether

families subscribe to this position is unknown and what they interpret as recovery is the subject of further discovery. The reviewed literature suggested that for recovery to be achieved families and Mental Health Professionals (MHP's), inclusive of MHN's need to collaborate and work together.

Involving and working with families of SU's experiencing an ED were objectives of the participants in this study. They stipulated that clear communication and consistency were important factors in developing TR's with families. As echoed in the literature review, issues of control, a lack of consistency and non compliance affected the relationship between participants and families resulting in collaboration being neither straight-forward or easy.

To open the discussion, participants were asked "When you think about developing therapeutic

relationships with service users experiencing an eating disorder, what does this mean to you?"

Followed by "when you think about developing therapeutic relationships with the families of service users experiencing an eating disorder, what does this mean to you?" Both groups elicited different responses. The first group viewed communication, trust and developing a rapport to be the 'foundation stones' of developing therapeutic relationships with SU's experiencing an ED.

FG1B I suppose good communication is the foundation of any relationship be it eating

disorders or any other sort of mental illness...a certain amount of trust and a

certain amount of empathy.

FG1A Yeah I'd agree developing a rapport, trying to gain someone's trust that you are

there to support and help them.   And sort of once you've got that foot in the

door then the rest of it will follow

FG1C I can agree with what they both said there that the therapeutic relationship is

like, the foundation stone you know to actually engaging with the service user.....

Resembling George's (1997) and King & Turner's (2000) studies the second group had

more negative connotations attached to developing relationships with this client group.

FG2A Difficult, anxiety provoking.

FG2B Complicated.

FG2C ... it's not straight forward.

In reference to developing TR's with the families of SU's experiencing an ED both

groups advocated involving families from when they first come in to contact with

services, the therapeutic component of this relationship extended to offering the family support.

FG2A Yeah and involving them kind of from the beginning really. And just offering that level of support and being approachable I think.

FG2C It's important to have them on board whatever the plan is I suppose…

Upon getting the family 'on board', consistency in the relationship with families was important to the participants for two reasons. Firstly, consistency in the sense that all stakeholders (Mental Health Professionals, MHN's, SU's and Families) were on the 'same page' i.e. all agreeable to the set treatment plan. These participants described eloquently that although the MHN's and family member shared the same objective; for the S.U. to 'get well' and 'eat'; effective collaboration was not always a given as sometimes families were not singing off the same 'hymn sheet' as MHN's.

FG1A Just commonality of the common goal basically that you know they were concerned about their child, wanting them to eat, wanting them to get well and you know that's what you are doing as well whether you were coming at it from different angles or whatever it was a common goal.

FG1C I think as well you have to emphasise with the family, the importance of a continuity and consistency that you are all singing off the same hymn sheet

Secondly, there needed to be a consistent approach in the communication between MHN's, family members and SU's alike. Stern *et al*. (1981) highlighted that inconsistencies in approach to the SU experiencing an ED and family may result in splitting, they stipulate "the treatment team will be tested, pitting one member off another" (p.395). Participants had experienced that SU's could recognize a divide among staff and families and use it to 'play one off the other'.

FG1D that you know the program or whatever you've set up with the client that the family aren't jeopardising this or that you know you are all going to the same, it's not like good cop bad cop. That you are all the same set goals and that it's not like the client is going to play one off the other and try and manipulate the situation.

Participants expressed that it took time to develop relationships with families. Communication

within the relationship was affected by a lack of consistency and continuity. All of these nurses were currently working in a community setting, yet they attributed the hospital environment as having a negative impact on developing TR's with families. The high turnover of staff, inconsistent approach, issues of strict regimes, involuntary status and serious threats to physical health all posed a strain on the relationship between the participants and families. Some interventions within a hospital environment such as single or double special observations where a nurse continuously had to be in

the close proximity to the patient often increased families' frustrations, and created a divide in the relationship.

FG2A ... so being an inpatient its usually the last resort and they are usually physically, well there are physical complications and stuff that and then when people are in voluntary like they all kind of get in the way of any kind of you know building of a therapeutic relationship I think.

FG2B ....their child was constantly on a single or double nurse special at all times so they didn't really have that opportunity to spend any time with their child which probably was frustrating for them ..... that pushed the relationship even further apart.

The participants reported that the extent to which they involved families usually depended on the wishes of the SU; their priority was to the SU when it came to issues of confidentiality and at times the families were excluded. Similar to participants in Sjoblom's *et al.* (2005) study, participants found themselves in a 'balancing act' (p.566) between advocating for the SU and trying to maintain a relationship with the family. Participants had experienced families being excluded at the request of the SU and under the guise of confidentiality, communication in the form of information provision had to be limited or censored. They were aware that confidentiality is sometimes manipulated by the SU experiencing an ED as a way of advancing their illness. Stern *et al.* (1981)

recommend that a clear and consistent approach to managing these behaviours is necessary to reduce the effects 'manipulation' and 'splitting' have on the relationship.

FG1C   … they don't really want their family members to know you know what's going on, they want to keep the whole thing, the symptoms of their illness you know and they try to cover it up.

FG1B   ….you know because the nature of the illness a lot of the time you know as you said the confidentiality is manipulated in a sense.

Highlighting the importance of effective and consistent communication participants revealed that inconsistent communication resulted in an increase in high expressed emotion or sometimes a breakdown in the TR between MHN's and families.

FG1B   If there is confusion or lack of communication it always sort of manifests in aggression or as you said a lot of hostility.

FG2B   Well it got to the stage that we just weren't involved in the communication at all and it was direct to consultant because of the problems that had been caused.

In the context of this focus group participants did not refer to conflict resolution or discuss experiences where consistency or communication was improved and relationships repaired. However, on reflection the participants recommended regular

meetings between the families and MHP's would have been beneficial in improving communication, continuity and consistency among all stakeholders. According to participants clearer communication would have eased the strain on relationships and improved collaboration.

FG2B Regular meetings would be a good thing, like update meetings. I think that might be something that wasn't done with the person we are thinking of, because of the difficulty with the relationship but if they had a structured weekly meeting that they are updated on everything maybe they would have felt a bit more involved in control with us.

The participants recommended clinical supervision for staff and extra supports for families as a way of ensuring the therapeutic relationship is maintained. However with absence of same participants continued to strive for the 'common goal' with or without the families support for the treatment plan resulting in an uneven collaboration, which will be explored in detail in the next theme.

4.3.2Theme 2: An Uneven Collaboration

Although there was a definite desire amongst participants to involve families, the lack of agreed pathway amongst stakeholders (MHN's, SU's, Families) of how the 'common goal' would be achieved, resulted in collaboration being somewhat uneven and at times ineffective.

There was also a limit to the extent participants wanted families involved, the MHN's had experienced that at times the families could become 'over involved' in the SU's care. Ambiguities existed among the participants regarding family involvement. Firstly, participants as MHP's needed to maintain control in the SU's care, ensuring the care plan was being adhered to. And secondly, due to the high expressed emotion that participants had experienced from families, which will be addressed later, an uncertainty existed that having the family involved would be in the best interests of the SU. Kaas *et al.* (2003) reported that sometimes MHP's choose not to involve families as they do not believe it will benefit the SU. This participant advocated family involvement for other illnesses but was unsure if it was beneficial for SU's experiencing an ED.

FG1A *It might come back to education like there's a lot of evidence out there to say that someone suffering from schizophrenia you know they've a much better positive outcome if they have a supportive family around them. You know so that's something you can tell the family that chances are you that your son or daughter will do better if the family support is there but I don't know if that's the case with anorexia. So I would need to be educated on that.*

The participants revealed that often families were not agreeable to a set treatment plan. This non adherence caused difficulties for the participants and a struggle for control ensued between the MHN's and families. The participants endeavoured to keep SU's treatment plans in place as it was their professional duty, however they maintained an

understanding of the families' sense of disempowerment at having to hand over the care of their family member.

FG2A   I think the control thing is a big thing. They probably had it for so long ....Quite disempowering it must be for parents to have their child admitted to an inpatient psychiatric unit for an eating disorder, it's the last resort as you say.

Disempowerment was exasperated when the SU had been made involuntary.   This struggle added further strain to the TR and participants report that the damage was often difficult to repair.

FG2B   I suppose from our point of view if it was felt that if you didn't stick that strict plan that [the service user] *could very quickly die. And the family felt that, you know, they didn't want* [the service user] *in that strict regime but it had been taken out of their hands because* [the service user] *was an involuntary patient at the time, so it was just a difficult relationship, relationships were difficult and it was very hard to try and smooth that over, given the situation.*

When families did not comply with a treatment plan, they had very little involvement or say in their family members care.

FG2B   I suppose they felt completely, they were left with no control or say in the situation because he was made involuntary and they weren't fully agreeable to the treatment plan anyway.

The participants had experienced that it takes the family time to see the benefits of working together and collaborating on a treatment plan, they felt that families were more inclined to adhere to a treatment plan if they see results.

FG2A   *I think when they start seeing results as well as in you know...*

FG2D   *You know results of the strict plan in place maybe they realise the benefits of it more.*

Nevertheless, if families continuously remained unsupportive and uncooperative or as one participant put it 'interfering' with the treatment plan it was the participants who were responsible for enforcing rules restricting the family visiting. This enhanced the power imbalance further between the nurses and families.

FG2C   *Yeah, and then be kind of covertly bringing him into things like this, its very hard to keep a handle on things.*

FG2B   *But it got to that stage where there was rules that their visiting time or I think they mightn't have been able to visit at all. So it can be difficult you know.*

Stern and co workers (1981) would view this non compliance as the family "testing" the therapeutic team by encouraging the team to "take over", they advocate providing as much structure as the family needs without infringing on their autonomy (pp. 397). It could be suggested the autonomy of the family may not have been fully recognised, but

it is important to point out that care planning is the responsibility of Multidisciplinary Team (MDT) a collective accountability exists as to why the families' autonomy was not respected.

However, intentional or unintentional, the findings suggest collaboration was uneven. While participants wanted families 'on board', they preferred when families were supportive of their (MHN's) plan. The families that did not comply with the plan were perceived as difficult or disruptive, giving the impression that families didn't have an equal say in the treatment of their family member. Participants reported this ineffective collaboration was a challenge to the TR.

FG2C   Its important to have them on board with whatever the plan is I suppose, where families have had their own ideas about treatment, disrupted things sometimes. They almost have the opposite to what we wanted to do..... it is kind of difficult nearly to build a relationship because they have their ideas, we are trying to force our ideas and it just gets... difficult.

4.3.3 Theme 3: The Challenge of Expressed Emotion (EE)

Parallel to ineffective collaboration a high level of EE was evident within the participants' experiences and was a recurrent theme in the focus group discussion. It is unclear if it was a case of the chicken or the egg as to which came first; high EE, inconsistent approach or ineffective collaboration. Participants would suggest both an inconsistent approach and ineffective collaboration extenuated the families expressed emotion.

FG1B ....if there is confusion or lack of communication it always sort of manifests in aggression or as you said a lot of hostility.

FG2C Mine is just coloured by that one main experience so it could be skewed that way. But having the family on the same page as you is I think is important, that was the start of things going wrong. And everything seems to have built from there, suspicion and going against the treatment plan and all that. I think it came from that kind of different perspective.

While the majority of participants reported feeling comfortable developing relationships with families that wanted to be involved high EE was cited as a reason why they didn't 'push' involvement and in some cases contemplated avoiding communicating with families. Choosing not to involve families because of EE can be like fire to a flame. Budd & Hughes (1998) would suggest that involving and working closely with families can actually improve levels of high EE, by reducing anxiety and reassuring family members.

FG1B .... If there's resistance there and you know obviously they don't want to be involved then you know you don't push it or the client doesn't want them involved you have to respect certain things. But I think probably, I've never found it difficult.

FG2B ....the family were difficult in a way, you would nearly think lets avoid it
    [communication] *or whatever but it wasn't avoidable.*

The participants displayed an understanding of where the families expressed emotion
and frustrations evolved from. They appreciated they were parents (like some of the
participants) who simply wanted their child to get well- the common goal of all.
Similar to the "balancing act" that MHN's endeavour (Sjoblom *et al.* 2005, p. 566)
families are also in a difficult predicament, advocating for their family member or
collaborating with the MHP's with whom they sought help from. Participants reported
this dividend of loyalties as well as the stress of the illness caused strain on the
relationship.

FG2B The other thing is if the patient isn't happy and generally they won't be with
    being in hospital the parents as such are strained between do they listen and go
    with their child or do they completely trust us and that will cause problems in
    the relationship with the child so it must be an awful position to be in for them.
    And stressful for them which probably would present in ways that they are like,
    communicating with us.

Participants sympathised with families' sense of powerlessness due to the complexity of
ED's. MHN's as a profession still dependent on the traditional medical model was also
highlighted, with a reference to medication being the prominent force to alleviate
symptoms of Mental Illness.

FG1D ... I suppose the families as well have the feeling of, they are powerless you know it's not like you can take a pill or even someone having schizophrenia where they can, you know, medication can help.

Despite this understanding, participants found it very challenging to develop TRs with families where there were high levels of EE. Participants reported having negative experiences when communicating with families whether in person or on the phone. They sometimes felt the negative EE at a personal level. When the service and service provision was under verbal attack by family members, often they were too, leaving the participants despairing and with feelings of inadequacy.

FG1A ..... hassle and confrontation and them giving out to me or to us that we weren't doing enough for the particular person...disparaging remarks about the service and what you are not doing.... a particular gentleman was quite aggressive you know so we used to go in pairs...... Just picking away at you the whole time kind I would have found that challenging.

FG1C .... you know shouting at you and just having to allow them just to be angry you know... you feel helpless then, you are just saying oh gosh you know. This isn't going anywhere.

FG1B ... on the phone... they feel more at ease with displaying anger and aggression.... its always quite horrible.

Participants themselves developed their own challenging emotions. They described their own frustrations; with the complexity of the illness and with the family's lack of compliance. They also referred to the families' high expectation of what they could achieve.

FG2A   I suppose it's frustrating as well for you if families are going against you really.

FG1D Yeah, because it's a very difficult illness to kind of, there's no right or wrong you know its an individual thing really... they want you to have a magic wand and make it all okay

At times there was transference of this emotion in their communication. The participants mirrored the EE of the family members and confrontation was met with confrontation.

FG1A And eh... so much so that like I've found myself saying to them, to [the family member] at one stage well you know what do you want me to do about it kind of thing. Which wasn't particularly very good I think but actually pulled his horns right in after that and apologised you know.

The ineffective management of anger and other EE attributed to communication breakdowns, ineffective collaboration and the evolvement of 'us and them' attitudes. This 'split' that occurred in some of the participant experiences left them with a sense of regret. They recognized that had there been supports like clinical supervision for themselves or support for the family the participants could have managed EE more effectively.

FG2C   *But with the absence of clinical supervision at the time say if you were in one of those situations where they are angry.... it just makes that 'us and them' thing more I think and that probably leads onto rules coming in. I don't know if there had been other support or other training then it would have been different, it was a difficult family.*

FG2B   *Or if there was a support for them directly you know I know it's difficult to do an inpatient but maybe a support for them in the community where he wasn't involved and we weren't involved in that they could vent their frustrations as well.*

A lot of the participant's experiences, particularly those in the second group were from a retrospective point of view. Therefore the participants had a chance to reflect on and make sense of their experiences. This enabled them to make recommendations about supports needed and acknowledge limitations within their own education in the area of ED's and developing TRs with the families of this client group.

4.3.4 Theme Four: Mental Health Nurses Awareness

The participants had an awareness that they needed to involve families. They stated that a shift towards a more recovery orientated approach (Mental Health Commission 2008) and the configuration of community services (9am -5pm), meant that family involvement and support was now a necessity rather than an aspiration. However as the above themes have described the relationship that accompanied the involvement could be problematic for the MHN's.

The majority of participants in the focus groups recognised a need for more education and support for themselves and for family members. Participants emphasised that their education on developing TR's had been mostly specific to SU's and felt unprepared for dealing with challenges that arose in the relationship with families. They also worried about their lack of knowledge and experience when it came to ED's. There was an awareness that the latter may come across to family members.

FG2B I didn't feel confident to engage with the family greatly and I did because I had to but I didn't feel I had enough experience I think to manage a family that were difficult....

FG2A ... with families I'd feel confident....but with eating disorders you definitely need the added educational component......

Whether due to insecurity about their own knowledge, past experience or inconsistencies in communication, participants felt families' expectations of what they could achieve were unrealistic indicating that families may have different ideas about what delineates recovery

FG1D .... they want us to have a magic wand and make it ok.....

FG1C I think sometimes the families expectations are too high..... they want it all to be fixed while sometimes its a case of just managing things...

While some participants recognised their own education deficits, other participants felt it was the families that needed to be educated more as they had a lack of understanding for their family member's illness. This is similar to Kaas' *et al.* (2003) study where participants felt barriers to collaboration came from the family rather than their own skills.

FG1B I think it helps educating the family because a lot of the time they don't fully understand... so its getting them to understand where there family member is coming from.

In agreement with the participant's point, family support studies such as Kartlova-Doherty (2005) found that families would like more information provision; however

they would also like their MHP to be more understanding and supportive of their needs (Nicholls & Pernice 2009).

All participants felt responsible for their own professional and educational development. Nonetheless, while some participants were keen for group education specific to developing relationships with SU's experiencing an ED and their families with a focus on managing the expressed emotion that encapsulates the relationship, others felt it was unnecessary and a specialist post (Clinical Nurse Specialist CNS) or team would be more suitable. This would indicate there are still uncertainties amongst MHN's regarding their role and responsibility in involving families and developing TR's with the families of SU's experiencing an ED. This said participants had reflected throughout the focus groups; had Clinical Supervision been available to them they would have utilized it, signifying MHN's are willing to improve their relationships with the families of SU's experiencing and ED.

4.4 Conclusion

Through the four themes described above the MHN's spoke of the facilitators and challenges of developing TR's with the families of SU's experiencing an E.D. They also recommended supports that would have improved their own experiences and help in future experiences. These themes and their relevance will be discussed in detail in the next chapter.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

In the previous chapter, Mental Health Nurses (MHN's) descriptions of their experiences of developing Therapeutic Relationships (TR's) with the Families of Service Users (SU) experiencing an Eating Disorder (ED) were presented. The researcher will now endeavor to deliberate on the relevance of these findings. Their place within the contemporary research literature will be considered and discussed with reference to the following three themes.

- An Uneven Collaboration

- The Challenge of Expressed Emotion

- Therapeutic Relationships with Families

5.2 An Uneven Collaboration

In modern health care a person centred focus has been one of the dominant paradigms (Bensing 2000), however with government publications such as "A Vision for Change" (DoH&C 2006) calling for the increased involvement and recognition of carers/family members, a more family/carer inclusive approach is necessary. When asked about their thoughts on developing TR's with the families of SU's experiencing an ED, the participants elicited that they aimed to involve families and offer them a level of support, in essence collaborate with families. They demonstrated an awareness of the importance of having families involved and 'on board', however they cited how

issues of ineffective collaboration such as unclear communication and an inconsistent approach were also a challenge to developing TR's with these families. Nicholls and Pernice (2009) view cultivating good communication and positive collaboration between all carers on a treatment team (families and MHP's) as a positive step to ensuring the SU maintains health. Dixon, Adams and Lucksteds' (2000) extensive review of international studies have reported that family inclusion in the treatment and recovery process has significantly improved the family members treatment adherence, reduced relapse rates, and increased family caregivers well being and coping strategies.

Participants believed that both they and families had a 'common goal' which was to see the SU returning to health and 'eating', in other words in a state of recovery. Participants believed that for this to be attained communication and the approach or pathway to attaining this objective needed to be clear and consistent i.e. 'everyone singing of the same hymn sheet'. A consistent approach to the SU experiencing an ED and their family members has been previously advocated by Stern *et al.* (1981) not only as it reduces the chance of splitting occurring but it also creates a supportive structure for the family.

The participants in this study had experienced the negative impact of a lack of consistency and agreement of the set approach. They voiced that families were at times non compliant or not agreeable to the set care plan, this non compliance caused difficulties within the relationship, effecting communication between participants and families. The participants acknowledged on reflection had there been more consultation with families such as regular family meetings specific to the care planning then the relationship may not have been as strained.

Correspondingly, in van de Bovenkamp and Trappenburg's (2010) study on the relationship between mental health workers and family members, family members reported they did not feel consulted enough when it came to care decisions about their family member. Family members felt that mental health care workers at times misused the patients' right to autonomy and privacy (confidentiality) in order to minimize contacts with family members. During the author's observations on an acute admissions ward in the Netherlands, they witnessed decisions being made without family members being informed. They argue that "it is obvious that the autonomous patient is not always the one mental health workers meet in practice; this makes the argument that family members cannot be informed, consulted to or listened to because of the patient's autonomy a questionable one" (pp. 124).

Stern *et al.* stipulate that the autonomy of the family unit needs to be respected despite the SU and family "testing" the therapeutic team by engaging in activities such as non compliance with care plans, encouraging the team to "take over". However it is evident from the literature that the priority of MHN's remains with the SU and the rights of the SU. The MHP's in Nicholls & Pernices' (2009) study stated that their primary responsibility was the support and treatment of the SU and therefore, any specific family needs were secondary and generally not able to be given equal attention. Van de Bovenkamp & Trappenburg (2010) put forward the idea that mental health care workers and family members frame the role of family members in the care process differently. MHP's frame their own responsibilities and tasks solely towards the (autonomous) SU, the family members of the SU do not play a part in that relationship.

Family members would frame themselves as fellow carers alongside the professionals and feel they should be included in the care process and rightly so.

Barker (2010) would suggest "the great conceit of much psychiatry and psychology was to assume that we- the professional experts could know people better than they know themselves: a foolish and dangerous idea" (pp. 8). While Phil Barker may have been referring to SU's, the same could be said for their carers or families. However it is understandable MHN's and MHP's alike continue to maintain the belief that they are the only experts as they are usually the ones that SU's and families will come to in times of need. This said professionals believing that their expertise is superior to that of the families there is a possibility of a "them and us" attitude as described by Kaas *et al.* (2003). Participants in the present study had experienced the creation of 'us and them' attitudes, they recognised that ineffective collaboration may have contributed to the evolvement of such attitudes. Kaas *et al.* (2004) propose that getting collaboration right between families and MHP's involves a shift in the mind-set and views of MHP's. This involves recognising the expertise and strengths the family has to offer (Jubb & Shanley 2002, Mc Master *et al.* 2004) and nurturing their involvement with clear and consistent communication and regular consultation.

5.3 The Challenge of Expressed Emotion (EE)

In agreement with other studies the participants recognised confidentiality as a barrier in the relationship between MHN's and families (Kaas *et al.* 2003, Sjoblom *et al.* 2005, Nicholls & Pernice 2009 & van de Bovenkamp & Trappenburg 2010). Family care

givers in both Wilkinson & Mc Andrew (2008) and Nicholls & Pernices' (2009) cited the importance placed on confidentiality resulting in a lack of communication between them and the MHP's contributing to feelings of abandonment, powerlessness and exclusion. While participants in this study did not exclude families because of issues of confidentiality they admitted that if it was an issue they didn't 'push' involvement with families or at times had to censor the information they provided to families. This resulted in 'a balancing act' between advocating for the SU and the family, a concept echoed by Sjoblom *et al.*(2004).

However the participants found the EE (particularly frustration, anger and confrontation) they experienced from the family members was the greatest challenge to developing a TR with the families of SU's experiencing an ED. Mc Master *et al.* (2004) found that families experience these emotions because of being excluded from their family members care. Participants in this study admitted they were forced to restrict family visiting time (or sometimes families were not allowed visit at all) when families were continually non compliant with care plans. A question that arises is why were the families continually non compliant with the care plan? Again it reverts back to a lack of a consistent approach from all stakeholders, while it is not the scope of this research to surmise if there was a comprehensive consultation with families regarding the care plan, however the literature detailing family experience of ED's report that families feel excluded from the care planning and treatment process yet are expected to pick up the pieces when their family member is discharged (Mc Master *et al.* 2004, Winn *et al.* 2004, Highet *et al.* 2004, Tierney 2005). Greenberg *et al.* (1997)found families experience lower levels of distress when they are treated as allies and partners

in the treatment process and when they are given practical advice and support about managing behaviours, thus enhancing the caregivers sense of control (Reinhard 1994).

The participants in this study identified that families could feel powerless and experience a lack of control especially when their family member had been made involuntary (Mental Health Act 2001)due to the seriousness of their illness or when they (families) were not agreeable to the care plan. Mc Master *et al.* (2004) found that upon finding help families were excluded from the care of their family member this left them feeling isolated and angry, Mc Master suggest that MHP's should refrain from "controlling the situation" and share the "power" (pp.72) with families by including families in the care planning process.

Nonetheless participants in the focus groups had experienced that at times family members could 'over involved' and had 'high expectations' of what they could achieve, one participant felt the families wanted her to have a 'magic wand'. While a participant in Winn *et al.* 2004 (pp.274) described her joy at meeting a "magic lady" (her daughters therapist), Van de Bovenkamp & Trappenburg puts the perception of over involvement into context; "sometimes family members feel that in order to be heard they need to be assertive, to proactively and repeatedly contact health care professionals in order to be acknowledged and be able to represent the best interests of the patient" (pp. 123).

Sepulveda *et al.* (2008) recommend that nurses should equip families with the requisite skills required for caring for their family member (experiencing an ED) when they are discharged, however transferring of skills to carers and families is a new

intervention and not generally practised by treating professionals. Sepulveda makes a valid point nevertheless it is necessary to have the requisite skills before one can transfer them. The participants in this study did not feel confident in their own skills or experience in working with SU's experiencing an ED or with 'difficult families' at times this lack of confidence meant they contemplated avoiding interactions with families. Some participants felt their lack of expertise was visible to family members, reinforcing the families' lack of faith in service provision. Participants were correct in this thinking. Family members in Winn *et al.* (2004) study believed that a lack of expertise in treating ED's existed in the psychiatric services they encountered.

Tresure *et al.* (2007) advocate expressed emotion should be managed rather than ignored. Some participants requested group education specific to working with SU's experiencing an ED and their families with a focus on managing the expressed emotion they had encountered in their experiences. This sentiment was echoed by MHP's in Nicholls & Pernices' (2009) study where the MHP's professed that they were frustrated at the mental health service in which they worked and policy makers, there was an expectation to involve families, yet MHP's were unsure of how to involve and support families as they had not received any training in the concept of family involvement. Several other studies have cited the role of the healthcare organisation in providing support and education to nurses regarding family centred care and involving families (Winefield & Burnett 1996; Kass *et al.* 2003; Rose *et al.* 2004; Sjoblom *et al.* 2005; Treasure *et al.* 2007; Fisher *et al.* 2008).

This is also a criticism to our own Irish policy makers. "A Vision for Change" (DoH&C 2006) envisions that SU's and carers should be involved at all levels of

Mental Health Services (MHS). That said there are no directives in this policy on how to get and keep families involved, whilst the training implications to enable this cultural shift in health service direction also fail to be addressed. Policy assumes that mental health professionals know how to 'involve and support families/ carers' and have relationships with families and carers. Liaising with families is defined in the varied role and responsibilities of a MHN, and probably included in the job descriptions of other mental health professionals. Despite this there is evidence that this element of our job description is not being adhered to as families continue to receive a lack of information, experience a lack of support and often they feel excluded from their family members care (Kartalova-O'Doherty *et al*. 2006).

5.4 The Therapeutic Relationship

The participants in this study cited many challenges and barriers to developing TR's with the families of SU's experiencing an ED; ineffective collaboration, EE, confidentiality, a lack of consistency and a lack of training. Similar barriers were reported by MHP's in Nicholl & Pernice (2009) study of the perceptions of the relationship between MHP's and family caregivers. Again while the MHP's were aware of the importance of involving families for the benefit of the SU and for the service, this invitation of involvement was not perceived by the families in the study.

The families in Budd & Hughes' (1997) study valued the therapeutic alliance they had developed with the MHP's and felt it was very supportive. They emphasised the empathy and warmth of the therapists and the genuine concern the therapists had expressed had been helpful and comforting. The participants in this study aimed to

support and involve families, however while they specifically named therapeutic components in developing TR's with SU's, this was not the case with families. The participants did feel they had an understanding of the families' situation but whether and how this was conveyed to the family members was not answered in the context of the focus groups. For instance, whether intentional or unintentional, the term "empathy" was only mentioned once in the two focus groups, when mentioned it was in the context of developing TR's with SU's experiencing an ED.

This is an important revelation, although a difficult term to define, Burnard (1992) citing Kalisch states "empathy is the ability to perceive accurately the feelings of another person and to communicate this understanding to them" (pp.43), again while MHN's may think they have an empathic understanding for families, families studied have had different perceptions. The family care givers in Nicholls and Pernices' (2009) study described the professionals' overall lack of insight into the family carers' role and the lack of empathy with their situation and needs. Winn *et al*. (2004), Highet *et al*. (2004) & Tierney (2005) suggest a lack of understanding for the families needs is continually being experienced by families.

The concept of developing a TR with SU's is a second language to MHN's; the majority of care plans this researcher has witnessed begins with 'develop a therapeutic relationship with the client and encourage ventilation of thoughts and feelings'. Now whether the implementation of such a care plan exists is open to debate and may be the subject of further research nevertheless we as MHN's prioritise and associate developing TR's with SU's. Developing TR's with families may be a more alien concept to MHN's.

Forchuk & Dorsay (1995) suggest nurses trying to work with families from a nursing theory base are caught in a dilemma, however they suggest Peplau's (1952) theory of interpersonal relationships is a suitable theory for working with families. While the theory in its entirety is complex, the concept of the overlapping phases- orientation, working (subdivided into identification and exploitation) and resolution developing over time; the emphasis is on the development of problem solving and interpersonal competencies through the evolving relationship, the nurse does not solve the problems for the client but encourages the client to find solutions over time.

The MHN's concept of a TR with a family was to involve and support the family. However due to the many challenges they faced involving and supporting the family, relationships were strained so the relationship between MHN's and families did not proceed the orientation phase. This would give rise to the chicken or the egg question again; which comes first- the TR or the collaboration?

5.5 Conclusion

This researcher set out to explore the experiences of MHN's in developing TR's with the families of SU's experiencing an ED. The objectives were to identify the facilitators, challenges and supports to developing TR's from the MHN's experiences. Enablers were identified as clear communication and consistency of approach on the

part of the MHN's and families i.e. everyone on the 'same page'. The challenges reported included the families' high expressed emotion; severity of the ED and the hospital (inpatient environment) and finally a lack of consistency i.e. families not on the 'same page' as the MHN's and being non compliant with the set care plans.

Supports and recommendations from the MHN's consisted of regular meetings with all stake holders that would improve communication, ensure consistency in approach and/or deal with any discrepancies or disagreement with the approach; clinical supervision so the MHN's would be able to cope with and manage the families' EE; provision of an independent support structure for families was also recommended. More education and training was thought to be necessary for Families and MHN's alike.

As previously stated the therapeutic relationship is dynamic in nature, and its development is a two way reciprocal process. Participants in the present study described the development of a relationship to a certain degree along a therapeutic continuum between themselves and family members. Whether this relationship can be described as a therapeutic relationship should be the subject of future research.

Whether therapeutic or not the relationship MHN's have with the families of SU's experiencing an ED needs to be 'good enough'- so families feel supported and collaboration can be effective with everyone approaching the 'common goal' with a common approach. The researcher suggests this current study will facilitate the development of effective therapeutic relationships between MHN's and the families of SU's as it sheds light and identifies factors which both facilitate and act as a barrier to the development of the TR.

CHAPTER SIX: CONCLUSION

6.1 Outcome, Implications & Recommendations

The aim of this research was to explore the experiences of MHN's in developing TR's with the families of SU's experiencing an ED. The participants identified consistency and clear communication was important in contributing to the development of TR's with the families of SU's. They recognised ineffective communication, Expressed Emotion (EE), confidentiality, a lack of consistency and a lack of expertise as barriers to developing TR's with the families of SU's experiencing an ED. Education and training for themselves and for families, Clinical Supervision, an independent support resource for families and an increase in communication through more family meetings were identifies as supports needed for the development of TR's with the families of SU's experiencing an ED.

The strength of this study is that it gives voice to the experiences of the MHN's. Before this study, we were unaware of their experiences of developing TR's with this family group. Although the results are consistent with other studies exploring the relationships between MHN's and Family Care Givers, this research is specific to the Families of SU's experiencing an ED. While confidentiality was cited in other studies as being a major barrier, in this study the Expressed Emotion the MHN's experienced from families was the greatest challenge to developing TRs with the families of SU's experiencing an ED. The researcher suggests this current study will facilitate the development of effective therapeutic relationships between MHN's and the families of

SU's as it enlightens the reader and identifies factors which both facilitate and act as a barrier to the development of the TR.

Methodological limitations have been discussed in Chapter Three; however one major limitation in this study is the absence of Family voice and Service user voice and their experiences of TRs with MHN's. A study exploring their experiences would complement this study and give a more comprehensive picture by presenting alternative views.

As with previous studies MHN's priority is first and foremost to the SU and then maybe the family depending on their views about family involvement, however particularly with ED's it is important for the families and MHP's to work collaboratively. The introduction of a family intervention/involvement programme would support collaborative work practices between MHN's and families, encouraging a good outcome for the SU and decreased levels of carer distress. Although currently advocated in UK policy (DoHUK 2004), a care plan specific to the needs of families would also be a help to identifying unmet family needs.

A family inclusive approach has also been found to reduce the EE in families. The development of more family inclusive practices like family intervention programs will improve the relationship between the MHN's and families while also improving the outcome for the SU, while also improving the experience of these relationships for MHN's and Families alike.

A clear and transparent pathway of what will and may happen in the treatment of the SU's ED should be explained and presented to the family upon presentation to

the service and this should be updated and reviewed throughout the course of the SU's treatment program. Clear feedback from families either written or verbal should be obtained after family and team meetings indicating the families support or voicing any concerns about the proposed care plan. Issues of confidentiality should be addressed at presentation to the service, and updated regularly.

More research is needed into the therapeutic component of the relationship between MHN's and Families e.g. Do MHN's actually have TR's with families? And Do families experience TR's with MHN's? It was not the purpose of this research to find out if MHN's actually do have or want to have TRs with families of SU's experiencing an ED, the researcher was exploring their experiences. A relationship undeniably exists between families and MHN's, whether this relationship is entirely therapeutic would be the purpose of further research. What the published literature does suggest is that it is necessary for MHP's (inclusive of MHN's) to work together with the families of SU's experiencing an ED for the optimal outcome for the SU. MHN's were asked about their experiences of developing TR's with the families of SU's experiencing an ED and they provided insight into what enabled them and challenged them.

Whether therapeutic or not the relationships MHN's have with the families of SU's experiencing an ED needs to be 'good enough'- so families feel supported and collaboration can be effective so that everyone is approaching the 'common goal' with a common approach. It is fair to say professionals may always experience a 'balancing act' of loyalties while endeavouring to develop TR's with families but it is important that we as professionals endeavour to improve the experiences of families.

6.2 Researchers Note

As a first time researcher, the journey of the research process from research question to appendices has been an enjoyable and challenging experience. The learning process has been incredible and the researchers' ability to cope with stress has developed immensely! While the scars of stress will fade the researchers' interest in further research will not!

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Appendix 1:

Literature Search

CINAHL TERMS	EBSCO HOST	PUBMED	GOOGLE SCHOLAR
Eating Disorders Anorexia Therapeutic Relationship; with families; with clients; patients; service users Nurse Experience Parent Experiences Family Involvement Caring; families; clients; service users with eating disorders Nurse attitude Nurses Views	Same Terms:	Same Terms:	Same Terms: When articles seemed appropriate, access journal directly through Trinity College Databases.

Collaboration			

Appendix 2:

Rationale for Inclusion/ Exclusion Criteria

The researcher chose not to impose a minimum level of experience required for participants to be eligible to participate in the study; whether how long qualified or in terms of quantifying the amount of service users experiencing an eating disorder and their families they have worked with. It is the norm for mental health nurses working in a community setting to have a minimum of three years experience so this was taken as a given. The researcher did not feel it was necessary that participants should have worked with a minimum number of service users experiencing an eating disorder and their families. Due to the complex nature of eating disorders, service users are often in contact with mental health services for a sustained period of time, mental health nurses could therefore have multiple experiences even with an individual service user and their family.

Appendix 3:

Focus Group Discussion Guide

Q1. When you think about therapeutic relationships with service users, what comes to mind?

Prompt:

What does this mean to you?

Is it important to you?

Q2. When you think about therapeutic relationships with the families of service users experiencing an eating disorder, what comes to mind?

Prompt:

What does this mean to you?

Is it important to you?

Now think about a family you have worked with;

Q3. In your experience what enabled you or helped you to establish a therapeutic relationship with the service user's family?

Prompt:

What are the things that make it easy to develop a therapeutic relationship with a family?

Q4 In your experience what challenges did you experience in establishing a therapeutic relationship with the services user's family?

Prompt:

What makes it hard or difficult to develop a therapeutic relationship with a family?

Q5. Tell me about education/training you had for establishing a therapeutic relationship with a service user's family?

Prompt:

Either as a student or since you qualified? It can be formal or informal?

Q6. In your experience did you feel well prepared to develop therapeutic relationships with the services user's family?

Prompt:

What kind of supports do you think are necessary?

What kind of supports do you feel would be beneficial?

Q7. What are your experiences of ending therapeutic relationships with the families of service users experiencing an eating disorder?

Prompt:

How did this come about? Was it on discharge? Did it end well? Did it end badly?

Q8. Is there anything else you would like to add?

Appendix 4a:

Free Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
A consistent approach to the co	1	1	19/07/2010 1	JS	19/07/2010 18:	JS
An uneven collaboration	1	1	19/07/2010 1	JS	19/07/2010 18:	JS
Challenges to TR	2	2	18/05/2010 0	RM	19/05/2010 02:	JS
Communication	3	31	14/06/2010 0	JS	15/06/2010 04:	JS
compliance	2	10	14/06/2010 0	JS	15/06/2010 04:	JS
Control	3	17	14/06/2010 0	JS	15/06/2010 04:	JS
Difficult family	3	16	15/06/2010 0	JS	17/06/2010 05:	JS
Education&Training in TR	2	2	18/05/2010 0	RM	19/05/2010 02:	JS
Ending TR	2	2	18/05/2010 0	RM	26/05/2010 20:	JS
Expressed emotion	3	19	15/06/2010 0	JS	17/06/2010 05:	JS
Facilitators to TR	2	2	18/05/2010 0	RM	31/05/2010 15:	JS
Mental Health Nurse Awarness	1	1	19/07/2010 1	JS	19/07/2010 18:	JS
Preparation and Support for TR	2	2	18/05/2010 0	RM	19/05/2010 02:	JS
Sympathy	2	6	15/06/2010 0	JS	18/06/2010 11:	JS
The challenge of expressed em	1	1	19/07/2010 1	JS	19/07/2010 18:	JS
TR with families	2	2	18/05/2010 0	RM	19/05/2010 01:	JS
TR with service users	2	2	18/05/2010 0	RM	19/05/2010 01:	JS
Understanding	3	14	15/06/2010 0	JS	18/06/2010 11:	JS

Appendix 4b:

Tree Nodes

	Name	Sources	References	Created On	Created By	Modified On	Modified By
	An uneven coalition and the three c's	2	33	28/05/2010 16	JS	08/07/2010 00	JS
	Education and Support one size fits all	2	25	28/05/2010 16	JS	31/05/2010 16	JS
	Expressed emotion and 'the difficult family'	2	22	28/05/2010 16	JS	09/06/2010 13	JS
	Where is the empathy	2	16	28/05/2010 16	JS	31/05/2010 16	JS

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Ms Jessica Stewart
~~██████████~~
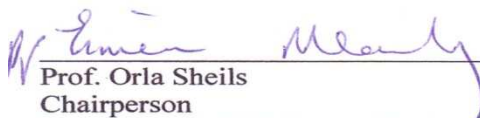~~███████~~
~~████████~~

Thursday, 04 March 2010

Study: Mental health nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in February 2010, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely

Prof. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

Cc
Michael Nash
School of Nursing & Midwifery
24 D'Olier Street
Trinity College
Dublin 2

Schools of the Faculty: Medicine, Dental Science, Nursing and Midwifery, Pharmacy and Pharmaceutical Sciences

Appendix 6:

Royal College of Nursing (1993) ethical principles for the protection of participants.

Beneficence: doing good to people.

Nonmaleficience: not harming people

Fidelity: a relationship based on trust; clients entrust themselves to the care of nurses.

Justice: being fair

Autonomy: respecting people are autonomous persons; not unjustly exploiting relationships that are unequal.

Veracity/honest and Informed Consent: potential subjects decisions to take part of their own free will in research mean that they must be given accurate and clear information.

Confidentiality: the protection of information related to participants that is gleaned in the course of research.

Appendix 7a: Letter to Director of Nursing requesting access to gatekeepers and potential participants

Researcher Details

26th of February 2010

Mr. XX, Hospital XX.

Dear Mr. XX,

I hope this letter finds you well. I am writing this letter to obtain your permission to conduct a research study to **'Mental Health Nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder'** within two community settings within your service. I am currently working as a mental health nurse in X Ward, X Hospital and am undertaking this study as a requirement for a Master in Science in Mental Health at Trinity College Dublin.

The study I plan to undertake aims to gain understanding into the experiences of mental health nurses in developing therapeutic relationships with the families of service users experiencing an eating disorder. It is hoped the study will contribute to delineating what supports are needed to assist mental health nurses in developing relationships with these families in the hope of improving collaborative care practices between nurses and families.

Over the course of two focus groups, I hope to gather data from 6-12 mental health nurses from the XY and XZ Area Community Mental Health Services (participants need only attend one focus group). The focus groups are planned for March/April 2010 and aim to last a max of ninety minutes, the majority of which may run into participants lunch break to minimize time away from service users (lunch will be provided). If this is not a suitable time an alternative time can be arranged, refreshments will also be provided.

With your permission I will ask Mr. XY and Mr. XZ to act as gatekeepers. A poster and 15 information leaflets will be forwarded to Mr. XY and Mr. XZ for distribution to mental health nurses working on the site. Any nurses interested in participating in the study or who require further information will be invited to contact me directly in order to minimize additions to the workload of the gatekeepers. I have included a copy of the contents of the poster and information leaflet for your viewing and have included a copy of the research proposal for further information regarding this study.

Please do not hesitate to contact me if you have any queries. I would be very grateful for your consideration of this request.

Yours sincerely,

_____

Jessica Stewart.

Appendix 7b: Letter to potential gatekeeper

Researcher Details

10th of March 2010

Mr. XY,

XY Community Mental Health Services.

Dear Mr. XY,

I hope this letter finds you well. I am writing this letter to obtain your permission to conduct a research study to explore **'Mental Health Nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder'** within your Community Mental Health Services. I have received permission from Mr. XX, Director of Nursing to contact you to ask if you will act as a gatekeeper to assist me in accessing potential participants. I have also sent this letter to Mr. XZ in the hope that she will act as a gatekeeper also. I am currently working as a mental health nurse in X Ward, X Hospital and am undertaking this study as a requirement for a Master in Science in Mental Health at Trinity College Dublin.

The study I plan to undertake aims to gain understanding into the experiences of mental health nurses in developing therapeutic relationships with the families of service users experiencing an eating disorder. It is hoped the study will contribute to delineating what supports are needed to assist mental health nurses in developing relationships with these families in the hope of improving collaborative care practices between nurses and families.

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With your permission I will forward a poster and 15 information leaflets to you. I would ask that the poster be put up in a site that would be viewed by mental health nurses and the information leaflets be posted into the nurse's post boxes/pigeon holes or if this is not possible given directly. Any nurses interested in participating in the study or who require further information will be invited to contact me directly in order to minimize additions to your own workload. In the event of a slow response rate I will forward a reminder letter for your distribution. I have included a copy of the contents of the poster and information leaflet for your viewing and have included a copy of the research proposal for further information regarding this study.

Please do not hesitate to contact me if you have any queries. I would be very grateful for your consideration of this request.

Yours sincerely,

_____

Jessica Stewart.

Appendix 7c: Letter to potential gatekeeper

<div align="right">

Researcher Details

10th of March 2010

</div>

Mr. XZ,

XZ Community Mental Health Services,

Dear Mr. XZ,

I hope this letter finds you well. I am writing this letter to obtain your permission to conduct a research study to explore '**Mental Health Nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder'** within your Community Mental Health Services. I have received permission from Mr. XX, Director of Nursing to contact you to ask if you will act as a gatekeeper to assist me in accessing potential participants. I have also sent this letter to Mr. XY in the hope that he will act as a gatekeeper also. I am currently working as a mental health nurse in X Ward, X Hospital and am undertaking this study as a requirement for a Master in Science in Mental Health at Trinity College Dublin.

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Over the course of two focus groups, I hope to gather data from 6-12 mental health nurses from the XY and XZ Area Community Mental Health Services (participants need only attend one focus group). The focus groups are planned for March/April 2010 and aim to last a max of ninety minutes the majority of which may run into participants lunch break to minimize time away from service users (lunch will be provided). If this is not a suitable time an alternative time can be arranged, refreshments will also be provided.

With your permission I will forward a poster and 15 information leaflets to you. I would ask that the poster be put up in a site that would be viewed by mental health nurses and the information leaflets be posted into the nurse's post boxes/pigeon holes or if this is not possible given directly. Any nurses interested in participating in the study or who require further information will be invited to contact me directly in order to minimize additions to your own workload. In the event of a slow response rate I will forward a reminder letter for distribution. I have included a copy of the contents of the poster and information leaflet for your viewing and have included a copy of the research proposal for further information regarding this study.

Please do not hesitate to contact me if you have any queries. I would be very grateful for your consideration of this request.

Yours sincerely,

_____

Jessica Stewart.

Appendix 8: Poster

ARE YOU A MENTAL HEALTH NURSE?

DO YOU HAVE EXPERIENCE WORKING WITH SERVICE USERS
EXPERIENCING AN EATING DISORDER AND THEIR FAMILIES?

WOULD YOU LIKE TO SHARE YOUR EXPERIENCES?

If YES.......

I would like to invite you to participate in a focus group to explore your
experiences, focus groups will be held in March/April 2010.

The title of the research study is Mental Health Nurses experiences of developing
therapeutic relationships with the families of services users experiencing an eating
disorder.

More details of this study have been sent to you directly. If you did not receive an
information leaflet or require further information please contact me or your
assistant director of nursing.

Jessica Stewart

jstewar@tcd.ie

Mobile: 0863232914

Appendix 9a: Letter of invite and information leaflet to participants

Researcher Details

17th of March 2010

Dear Fellow Mental Health Nurse,

I would like to invite you to participate in a focus group as part of a study to explore '**Mental Health Nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder'.** I would like to give participants the chance to describe their own experiences in developing and maintaining relationships with the families of service users experiencing an eating disorder. The study aims to gain understanding into these experiences, what a therapeutic relationship means to you, the supports that are needed to develop therapeutic relationships with the said families and what's needed to encourage collaborative care between nurses and families.

The proposed study is in partial fulfilment of the requirement of the Master in Science in Mental Health at Trinity College Dublin and has the ethical approval of Trinity College Dublin and Dublin West/South West Mental Health Services. To gather data I will be conducting audio recorded focus groups planned for March/April 2010, lasting approximately a maximum of 90 minutes. You will only have to attend one focus group.

All data will be filed safely, securely and appropriately in accordance with the Data Protection Act (Department of Justice, Equality and Law Reform, 2003). The data will be kept for a maximum of five years and then destroyed. It is the aim of the researcher to publish the findings of the focus groups. Your identity will remain confidential; your name will not be published and will not be disclosed to anyone outside the group. Prior to commencement of the focus group(s), participants will be asked to sign a declaration to adhere to confidentiality regarding the other group members and anything disclosed within the group. Please find enclosed a copy of this declaration and also a copy of the focus group rules.

There is potential benefit for participants to develop, refine and expand a base of knowledge around developing therapeutic relationships with the families of service users experiencing an eating disorder through exploring their own experiences and listening to the experiences of others. There are no foreseeable adverse outcomes of participating in this study but should a participant become upset or distressed additional support will be available in the form of comfort breaks (during the focus groups) or the HSE Confidential Employee. Counselling Service (numbers will be provided). Participants are informed of the researcher's ethical duty to report any disclosure of malpractice or professional misconduct to the Director of Nursing; An Bord Altranais and the researcher's requirements by law to report information about child or elder abuse, drug trafficking or crime to the relevant authorities (Gardai; Social Services).

I will make a follow up telephone call one week post focus group to assess if any issues arose from the focus group discussion that the participant requires support with. I will be contactable after the focus group also. There is a possibility focus groups may run

into participant lunch breaks to avoid time away from service users but lunch will be provided if this time is not convenient refreshments will also be provided. They will be held in a meeting room within your place of work.

This interview and participation of the study is entirely voluntary and you can withdraw at any time or refrain from answering the questions without stating a reason for doing so. You will be asked to sign an informed consent form stating you agree to partake in the study prior to the focus groups. I am available to meet or can be contacted to discuss the study or answer any questions. You will receive a copy of the focus group transcript and I will need to contact you to confirm the findings, it is hoped these findings will be published.

Mental Health Nurses of all levels of experience are invited to participate in the study when you contact me voicing your interest in participating I will ask the following questions:

- How long have you worked as a Mental Health Nurse?

- Approximately how many service users experiencing an eating disorder and their families have you worked with throughout your career?

This information will only be used in the participant inclusion process if there is an oversubscription of interest to participate in the study.

If you fit the following inclusion criteria and wish to participate in the focus groups please contact me before the 26th of March 2010;

- An Bord Altranais Registered Mental Health Nurses with experience working with service users experiencing an eating disorder and their families.

Thank you for taking the time to consider this request if you require any further information please contact me.

Yours Sincerely,

_____

Jessica Stewart

Appendix 9b: Declaration of Confidentiality

I, _____ agree not to discuss or disclose any information about the content of the focus group discussion or focus group participants outside of the focus group. I will maintain confidentiality at all times regarding the content of the focus group discussion and the identity of its participants.

Signed: _____   Date:_____

Appendix 9c: Focus Group Rules and Outline of Focus Group Proceedings

Focus Group Rules

- **Group members must sign a declaration of confidentiality- What is discussed in the group stays within the group!**

- **Please do not use names of service users and/or their families.**

- **Speak clearly.**

- **One person to speak at a time.**

- **Allow everyone to have their say.**

- **Conversation/ everyone participate.**

- **There are no right/ wrong answers.**

- **Please turn off all mobile phones for the duration of the group as they may interfere with the recording equipment.**

Outline of Focus Group Proceedings

- **Introduction**

- **Warm up and Group rules**

- **Discussion**

- **Wrap- Up Summary**

Appendix 9d: Reminder letter to participants

Researcher Details

26th of March 2010

Dear Fellow Mental Health Nurse,

I would like to remind you of an invitation asking for your participation in a focus group as part of a study to explore **'Mental Health Nurses experiences of developing therapeutic relationships with the families of service users experiencing an eating disorder'** sent to you on the 17th of March 2010. I would like to give participants the chance to describe their own experiences in developing and maintaining relationships with the families of service users experiencing an eating disorder. The study aims to gain understanding into these experiences, what a therapeutic relationship means to you, the supports that are needed to develop therapeutic relationships with the said families and what's needed to encourage collaborative care between nurses and families.

The proposed study is in partial fulfilment of the requirement of the Master in Science in Mental Health at Trinity College Dublin and has the ethical approval of Trinity College Dublin and Dublin West/South West Mental Health Services. To gather data I will be conducting audio recorded focus groups planned for March/April 2010, lasting approximately a maximum of 90 minutes. You will only have to attend one focus group.

All data will be filed safely, securely and appropriately in accordance with the Data Protection Act (Department of Justice, Equality and Law Reform, 2003). It is the aim of the researcher to publish the findings of the focus groups. Your identity will remain confidential; your name will not be published and will not be disclosed to anyone outside the group. Prior to commencement of the focus group(s), participants will be asked to sign a declaration to adhere to confidentiality regarding the other group members and anything disclosed within the group. Please find enclosed a copy of this declaration and also a copy of the focus group rules.

There is potential benefit for participants to develop, refine and expand a base of knowledge around developing therapeutic relationships with the families of service users experiencing an eating disorder through exploring their own experiences and listening to the experiences of others. There are no foreseeable adverse outcomes of participating in this study but should a participant become upset or distressed additional support will be available in the form of comfort breaks (during the focus groups) or the HSE Confidential Employee. Counselling Service (numbers will be provided). Participants are informed of the researcher's ethical duty to report any disclosure of malpractice or professional misconduct to the Director of Nursing; An Bord Altranais and the researcher's requirements by law to report information about child or elder abuse, drug trafficking or crime to the relevant authorities (Gardai; Social Services).

I will make a follow up telephone call one week post focus group to assess if any issues arose from the focus group discussion that the participant requires support with. I will

be contactable after the focus group also. There is a possibility focus groups may run into participant lunch breaks to avoid time away from service users but lunch will be provided if this time is not convenient refreshments will also be provided. They will be held in a meeting room within your place of work.

This interview and participation of the study is entirely voluntary and you can withdraw at any time or refrain from answering the questions without stating a reason for doing so. You will be asked to sign an informed consent form stating you agree to partake in the study prior to the focus groups. I am available to meet or can be contacted to discuss the study or answer any questions. You will receive a copy of the focus group transcript and I will need to contact you to confirm the findings, it is hoped these findings will be published.

Mental Health Nurses of all levels of experience are invited to participate in the study when you contact me voicing your interest in participating I will ask the following questions:

- How long have you worked as a Mental Health Nurse?

- Approximately how many service users experiencing an eating disorder and their families have you worked with throughout your career?

This information will only be used in the participant inclusion process if there is an oversubscription of interest to participate in the study.

If you fit the following inclusion criteria and wish to participate in the focus groups please contact me as soon as possible;

- An Bord Altranais Registered Mental Health Nurses with experience working with service users experiencing an eating disorder and their families.

Thank you for taking the time to consider this request if you require any further information please contact me. My sincere apologies if you have already considered the above invitation and chosen not to participate in the focus groups or do not fit the inclusion criteria.

Yours Sincerely,

_____

Jessica Stewart

Appendix 10: Informed consent

PROJECT TITLE: MENTAL HEALTH NURSES EXPERIENCES OF DEVELOPING THERAPEUTIC RELATIONSHIPS WITH THE FAMILIES OF SERVICE USERS EXPERIENCING AN EATING DISORDER.

PRINCIPLE INVESTIGATOR: Jessica Stewart

BACKGROUND: The study will explore the experiences of mental health nurses in developing therapeutic relationships with the families of service users experiencing an eating disorder. The study will use a semi structured discussion guide using a focus group format. Data will be recorded using audio tape equipment. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

DECLARATION:

I have read, or have read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: …………………………………………

CONTACT DETAILS: …………………………………………

PARTICIPANT'S SIGNATURE: ………………………………………….

Date:………………………..

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:……………………… Date:………………..

Appendix 11: Principal Investigator Contact Details and Support Details

If you have any further queries please contact me

Jessica Stewart

Mobile: xxx xxxxxxx

Email: xxxxxx@tcd.ie

Or if you require further support:

HSE Confidential Counselling Service

01 6352393

Thank You for Participating.