Nurses and the ‘therapeutic relationship’: caring for adolescents with anorexia nervosa

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Background. Research studies suggest that hospital programmes for young people diagnosed with anorexia nervosa have high readmission rates and limited effectiveness. Nurses caring for these adolescents face a particular set of problems in seeking to establish therapeutic relationships.

Aim. This paper reports a study with the original aim of providing rich data on the development of therapeutic relationships between adolescents diagnosed with anorexia and paediatric nurses. However, it was discovered that paediatric nurses were struggling to develop therapeutic alliances with these adolescents. The study was then modified to explore the difficulties and obstacles hindering the formation of therapeutic relationships in this context.

Method. The study used naturalistic inquiry. The 10 participants were Registered Nurses from the acute wards of an Australian children’s hospital with at least 2 years’ experience of caring for adolescents with anorexia nervosa. The data were collected using semi-structured interviews that were recorded on audiotape and then thematically analysed both manually and with the aid of the NUD*IST computer package.

Findings. Participants described how they struggled to develop therapeutic relationships in this clinical environment. Three themes emerged: (1) ‘Struggling for understanding’ explores the difficulties nurses experienced in coming to terms with the complexities of a diagnosis of anorexia nervosa and its recovery processes. (2) ‘Struggling for control’ examines the power struggle between nurses and patients and the mutual distrust that often developed between them as a consequence of this struggle. (3) ‘Struggling to develop therapeutic relationships’ describes the difficulties some nurses had in establishing therapeutic alliances with these adolescents.

Conclusion. Recommendations are made for improving the nursing component of hospital treatment programmes for adolescents with anorexia nervosa in the direction of more genuinely therapeutic relationships.

Keywords: anorexia nervosa, nursing, naturalistic inquiry, recovery, therapeutic relationship, hospital setting

Introduction

Nursing literature is rich in articles exploring the theme of the therapeutic relationship. The importance of this relationship in nursing adolescents diagnosed with anorexia is also well established but there is still insufficient research to provide an in-depth understanding of these difficulties and why they develop or of how nurses believe therapeutic relationships
might be improved. This article reports on a study conducted as a contribution to such understandings. Throughout the article, the terms ‘adolescents with anorexia’, ‘people with anorexia’, or ‘patients with anorexia’ refer to adolescents diagnosed with anorexia nervosa.

Previous studies

Garrett (1991) studied nurses working with severely anorexic patients in five eating disorder units of Sydney hospitals. Her interviews examined nurses’ experiences of nursing anorexia nervosa sufferers and their perceptions of their rewards and difficulties in caring for these patients. King and Turner (2000) looked at the emotional ‘roller-coaster’ journey that nurses go through in caring for adolescents with anorexia in Victorian public hospitals. They explored the ‘highs’ and ‘lows’ of the job and focused on nurses’ values and how these were challenged, as frustration and anger set in.

Both studies suggest a strong need for education programmes to support nurses, for new treatment plans and for nurses to have a greater say in the formulation of treatment programmes. My study of adolescents with anorexia in a paediatric setting aimed to extend these two studies. My initial aim was to explore the development of successful therapeutic relationships with this unique group of patients but, like King and Turner (2000), I discovered that nurses were struggling to develop such alliances and I turned instead to recording and explaining the difficulties and obstacles hindering the formation of therapeutic relationships. It was not my intention to replicate King and Turner’s (2000) study but my findings were very similar to theirs. I do not claim to have discovered any concrete solutions for eradicating the obstacles it identifies but the study does support both others in finding that nurses still do not receive adequate education, support and preparation for dealing with this challenging disorder in an acute care setting.

Background

The therapeutic relationship

A therapeutic relationship is a dynamic, two-way, reciprocal relationship between a caregiver and a patient and at times the patient’s family (McKlindon & Barnsteiner 1999). The relationship is ‘caring, clear, boundaryed, positive and professional’ (McKlindon & Barnsteiner 1999, p. 238). Nurses in acute care settings are well suited to establish therapeutic alliances with patients, as they care for them 24 hours a day, 7 days a week, and so provide for a substantial amount of their physical, psychological and emotional care (Nichols 1993). But anorexia nervosa is a chronic condition and this is one of several reasons why nurses find it hard to develop therapeutic relationships with these patients in acute care wards. Peplau (1952) and later researchers have identified elements which are essential if a relationship is to be therapeutic. These are: trust and commitment (Morse 1991), accurate empathy, unconditional positive regard and genuineness (Rogers 1973), honesty and support (Halek 1997a), confidentiality, a non-judgemental attitude, responsiveness and consistency (Murray & Huelskoetter 1991, Dexter & Wash 1995).

A successful therapeutic relationship requires the nurse not only to have high-quality communication and interpersonal skills but also to be able to build rapport and trust with the patient (McQueen 2000). Trust is the most important of these elements (Morse 1991, Irwin 1993, Johns 1996) but ‘trust, like respect cannot be demanded; it has to be earned’ (Martin 1987, p. 12). The establishment of a therapeutic relationship is a pivotal factor in the treatment and recovery of patients with anorexia nervosa (Deering 1987). Without a trusting, therapeutic nurse–patient relationship, the treatment and recovery of people with anorexia can be unnecessarily impeded and prolonged (George 1997, Halek 1997a).

Anorexia nervosa, recovery and treatment

Anorexia nervosa is a complex eating disorder with a multifaceted aetiology and to date no reputable treatment approach (Finelli 2001). The sufferer ‘wilfully’ self-induces starvation due to a fear of gaining weight (Vandereycken & van Deth 1994) but the fear may come from a variety of sources including grief, loss and abuse. sufferers are obsessed with three forms of control: over their eating, body weight and food [National Mental Health Strategy (NMHS) 1998, 2000]. To understand the complexities of anorexia, it must be seen from the perspectives of history, society and culture, biology and psychology but a discussion of each of these perspectives (Garrett 1998) is outside the scope of this article.

A ‘cure’ or a complete reinstatement of health is rare with anorexia nervosa (Halek 1997b). It is therefore more realistic for nurses to aim for ‘recovery’ or as Beresin et al. (1989, p. 120) call it, a ‘psychological rebirth’. This happens when the sufferer forms a ‘new healthy identity’, although some maladaptive behaviour may continue. Therapeutic relationships (although not necessarily with health professionals) are crucial in the process (Beresin et al. 1989). More effective nursing will require nurses to explore in greater depth the many reasons for self-starvation and the meaning of anorexia
for the sufferer. It will also require nurses to understand the meaning of recovery (Garrett 1998).

Confused beliefs about the aetiology of anorexia have affected methods of treatment. These most commonly include hospitalization, weight restoration, medication, psychotherapy, behaviour therapy, behaviour modification therapy and family therapy (Thompson 1993, President and Fellows of Harvard College 1997). Each treatment makes its own unique contribution, but all have limitations. No one treatment has been found to be superior to another (Moorey 1991). In fact many people with anorexia have recovered without therapy (Garrett 1998, Ben-Tovim et al. 2001, Swan et al. 2001). None of the treatment approaches to date have been shown to increase recovery rates. Only 50% of anorexia nervosa sufferers ‘fully’ recover (Anderson 1997). Most anorexia nervosa sufferers relapse at some time in their life (Herzog et al. 1999).

The hospital where this research was undertaken currently uses a ‘Level System’ based on ‘behaviour modification’ for patients with anorexia nervosa. Patients start on level 1 or 2. As they gain weight, fulfill program requirements and exhibit changes in their psychological functioning, they move up the levels until they reach level 5. Medically unstable patients are placed on level 1: strict bed rest with bedpans. Medically unstable patients are usually fed high-calorie liquid supplements via a nasogastric tube while on bed rest. For the other levels, the patient has toilet privileges and program requirements include eating meals in the kitchen, 30 minutes bed rest following main meals, one shower per day of 10 minutes duration, two phone calls in and two out, visitors for 2 hours each day during the week and for 3 hours on weekends and attendance at school, group, physiotherapy or therapy sessions. Progress is evaluated at the twice weekly meetings and decisions are made regarding the patients’ ‘level’ status and what privileges, such as ‘gate passes’ or ‘off bed rest’, they will be allowed (Simonds et al. 2000).

The study

Aim

The purpose of the study was to explore the difficulties and obstacles hindering the formation of therapeutic relationships for nurses caring for adolescents with anorexia in a paediatric setting.

Methodology

The methodology of this study was based on the ‘naturalistic’ or ‘constructed’ research paradigm (Erlandson et al. 1993). The naturalistic approach allowed the participants to express their experiences in their own words and in the ‘natural setting’ where they work. It helped to reveal how the context – the hospital ward, treatment method and position of nurses – influences nurses’ creation of meaning (for anorexia, recovery and therapeutic relationships) (Lincoln & Guba 1985).

Participants

Ten Registered Nurses took part in the interviews. Six were recruited from the adolescent ward and four from the general medical ward of a children’s hospital. Three were male and seven female. The clinical educators and nursing unit managers of both wards assisted in recruitment by publicising the study and identifying staff who met the inclusion criteria (at least 2 years’ experience in caring for adolescents with anorexia nervosa, excluding pool and agency nurses whose experience may not have been continuous). Participants’ ages ranged from 26 to 48 years. They had from 5 to 26 years experience as nurses and from 2 to 6 years experience working with adolescents with anorexia. None had had any formal mental health training.

Data collection

The data were collected using tape recorded semi-structured interviews. Written questions guided the study and kept participants on track, but I was open to investigate unplanned issues (Roberts & Taylor 1998). Interviews explored participants’ difficulties in caring for adolescents with anorexia, and the obstacles to and importance of therapeutic relationships. They (1–2 hours each) were conducted in private interview rooms at the hospital at a time convenient for each participant. Each interview began with the request ‘Would you like to tell me about what it is like to care for adolescents with anorexia nervosa on this ward?’. I was a member of the group under study and used a journal to verbalize my own values prior to during and following the research on issues relating to the care of adolescents with anorexia. There are advantages and disadvantages to interviewing colleagues. One advantage was that I had built rapport and trust with some nurses and this may have made the interview process less threatening for them. However, a disadvantage was that they may not have given information that they thought would be obvious to me because I currently worked or had worked on their ward. In both interviews and analysis, it was essential to lay aside preconceived biases or judgements.
Ethical considerations

Approval was obtained from the children's hospital where the study took place and from the University of Western Sydney. The study aims were fully explained verbally, and participants were then given an information sheet. Participants signed a consent form. Participation was voluntary, and interviewees were able to refuse to participate at any time. They were not required to answer questions if these caused distress. To my knowledge, no participant experienced any distress. Codes and pseudonyms were used for all transcripts and interview data.

Data analysis

Data collection and analysis occur simultaneously in naturalistic inquiry (Appleton & King 1997). The audiotapes were transcribed, read and re-read, and then subjected to thematic analysis, manually as well as with the use of the Non-Numerical Unstructured Data Indexing, Searching, and Theorising (NUD*IST) computer package. This was used to keep track of the analysis decisions and to retrieve the emerging themes. Themes were coded through a line-by-line analysis. The themes and interpretations were checked for accuracy with participants as well as their colleagues and supervisors.

Findings

Three major themes emerged from the analysis: ‘struggling for understanding’, ‘struggling for control’ and ‘struggling to develop therapeutic relationships’. These themes are illustrated below, with special attention to the last two.

Struggling for understanding

With little education in mental health or knowledge about how recovery from anorexia takes place, participants struggled to understand such a complex disorder. Many participants believed that their patients had caused their own harm and needed to ‘fix it themselves’, and they were angered about this when there were ‘really unwell “kids” on the ward’ who (by implication) were more deserving of care:

Frustrating...there’s nothing pinpointing why they’re that way. It’s all in their heads. There’s no set guidelines as to ok this is what you’ve got to do to fix it...they have to fix it themselves. Basically...when there’s...really unwell kids on the ward...you think how can you be doing this... (Skye)

Their frustration made them sceptical and pessimistic about ‘full’ recovery and therefore disillusioned with their patients and this type of work, regarding it as ‘easy’ and ‘a waste of time’ compared with other forms of nursing, which they saw as having higher status in the hospital. Many participants believed that they themselves were ‘failures’ because they did not feel in control of the recovery process (Crowe 1997, King & Turner 2000). Although they characterized work with anorexic patients as ‘easy’, most found it stressful for long stretches of time because of their frustrated attempts to understand anorexia and recovery. Much of this stress also came from the ongoing struggle for control about which they were eloquent. Jodie explains: ‘...it’s all a question of...an emotional and psychological battle with them and that constant battle can be...quite...distressing for some staff’.

As a member of the group under study, the researcher was aware of the lack of education and training in mental health issues for nurses in this particular acute care setting. Currently, this hospital provides no formal education focusing on the care of adolescents with anorexia. A few participants mentioned previously attending a course, which dealt with understanding anorexia nervosa and other mental health issues, but this course no longer exists. Nurses with training in mental health are more likely to have acquired knowledge and skills to assist them in caring for people with this challenging condition. Education for these ‘specialist’ nurses needs to include an understanding of the elements, stages and turning points in recovery from anorexia nervosa and not only of its symptoms and aetiology. As a consequence of this study, an education package has now been compiled for nurses caring for adolescents with anorexia in this hospital.

In Australia, there are specific training courses for nurses in ‘Child and Adolescent Mental Health’, run by organizations such as the Royal College of Nursing and through universities. Generally these courses come at a cost to the consumer, both personally and financially. However, it is vitally important that nurses caring for adolescents with anorexia receive this training in mental health issues, and the health care system needs to take some responsibility in ensuring that its nursing staff are appropriately prepared to care for these particularly vulnerable adolescents.

Struggling for control

In the absence of real understanding about anorexia or the recovery process, participants saw their work in terms of the behaviour modification programme that they were required to enforce. The extremely controlling nature of the programme led to rebellion from patients, who were then
perceived as ‘manipulative’, and to struggles from participants to reassert the control the programme demanded. Participants followed the programme even when they were not convinced of its value. As a result, power was in play between participants and patients, and both groups felt that they were continually ‘struggling for control’. Instead of the trust required for a therapeutic relationship, both groups mistrusted each other.

**Struggling for power**

The main arena for this struggle was food. One way in which participants asserted their power (and took away their charges’ control) was by ‘choosing their foods’. Participants wanted to help to get the patients better, but felt that they were being hindered by the adolescents’ refusal to relinquish control or, as they put it, to ‘co-operate’. As Sarah pointed out, ‘…these girls are 15, 16, and they’re acting like adults and they can…talk…and fight back normally, not like a 3-year old. And that can be hard’. Participants reported that the adolescents saw nasogastric feeding as ‘punitive’ and they would do anything to ‘sabotage’ it. They would fight the nurses ‘tooth and nail’ to regain ‘control’ over their predicament. Nurses were thus unconsciously acting like jailers; participants understandably found this constant ‘battle for control’ an impediment to therapeutic alliances. It caused them great anguish, and they saw clearly those patients’ ‘manipulation’ and ‘cheating’ were direct results of this condition. Nurses were thus unconsciously acting like jailers; participants understandably found this constant ‘battle for control’ an impediment to therapeutic alliances. It caused them great anguish, and they saw clearly those patients’ ‘manipulation’ and ‘cheating’ were direct results of this situation with regard to food. They also thought that the struggle would continue whatever the means of re-feeding employed:

…they see [the feeds] as punitive. They know that it’s designed to increase their calories, which they dearly don’t want…there’s power as we said, we’re pumping it in against their will…so by manipulating, by cheating…they are doing several things. They are getting a bit of control out of their life, they cut down their calories…they stop us from being in charge, they achieve what they want…If you could magically come along and plug something into their head which gave them calories, they’d want to unplug it. I don’t think it…would be any different. (Mike)

The ‘power struggle’ clouded participants’ perceptions, and they did not see any ‘immediate’ improvements and this was frustrating. They were tired of the ‘whinging and crying’ and ‘going over and over the same old ground’.

**Mutual mistrust: the issue of manipulation**

Most participants felt ‘manipulated’ by adolescents with anorexia. Their definitions of ‘manipulation’ varied, some feeling that it was ‘playing one nurse off against another’ or that it was ‘lying’ or ‘twisting words around’ to gain ‘control’. Others believed that ‘manipulation’ was ‘upsetting the boat’ and ‘causing infighting’, so that patients could ‘get away with blue murder’. Still others defined manipulation as ‘non-compliance’ with the treatment programme ‘because they don’t agree with it and it’s not what they want to do’ (Lilly). Participants’ lack of knowledge about this complex condition led them to ‘expect manipulation’, dread it and be unwilling to give their charges ‘a clean slate again’ when it happened. Unsurprisingly, the adolescents saw the participants as ‘authority figures’. It was extremely difficult to gain the adolescents’ trust, when participants had the roles of ‘baddy’, ‘enemy’, ‘policeman’, ‘parent figure’, ‘manipulator’, ‘army officer’, ‘spy’, ‘dibber dobber’ (someone who reported their behaviour to senior staff), or ‘big brother’. Participants felt that forming a trusting relationship was difficult for them because these adolescents saw them as ‘taking control away’, as inflictors of ‘punishment’, and as ‘invaders of privacy’ when they followed and enforced the treatment programme. Overall, they felt that ‘manipulation’ was a way that these adolescents could gain ‘control’, while causing them great frustration and grief. Mike was the only participant to see manipulation in a positive light, as a ‘survival instinct’.

Although Morse (1991) believes that primary nursing is advantageous for establishing therapeutic relationships, as did those participants who had tried it in Garrett’s (1991) study, my participants did not think it would be ‘a good thing’. Their negative experiences in the acute setting led them to believe that primary nursing, while it would provide the consistency that their own programme lacked, would also mean that nurses would be ‘getting caught up in their (anorexic) negative cycle and their way of thinking’. Perhaps with greater education in mental health issues, participants would value the benefits of primary nursing and its advantages for establishing therapeutic relationships. The primary nursing model could help reduce the ‘mutual distrust’ issues described, such as ‘playing one nurse off another’, thereby strengthening the formation of trusting relationships.

Participants found it difficult to trust adolescents with anorexia and if they did give them their trust, they felt that ‘they just go back on that’, so they chose not to trust them at all. The formation of a therapeutic relationship was limited by participants’ suspicion (Morse 1991). They were stressed and burnt-out from dealing with manipulation, and unfortunately stress leads to the ‘unequal distribution of care and attention to other patients on the ward’ (May 1991, p. 555). Lilly explained: ‘I’m not as keen as I might have been to look after them…I’m more likely now to request not to…’. The preconceived idea that adolescents with anorexia were
‘manipulative’ created major obstacles for the development of therapeutic alliances:

...they can make us trust them less...not that we trust them a great deal to begin with anyway...But they can...keep us on our toes...Some of them can be very sneaky in what they do...they'll go to extremes, exercising in the bathroom, throw up, hide laxatives and...they are so ill that they just...don't want to put on the weight and so some of them will get syringes and aspirate their NG tube feeds back...We have seen it before and that’s why we are not so trustworthy (sic) of them. (Brooke)

‘Manipulation’ by patients left some participants feeling ‘cheated’, betrayed or ‘failures’. They believed their role was to get the adolescent better and when the adolescent prevented recovery from happening, participants felt as although they had ‘failed’ in some way (May & Kelly 1982, Gallop & Wynn 1987, King & Turner 2000). The distancing and evasion of responsibility that resulted from this sense of failure was detrimental to therapeutic relationships (Martin 1987, King & Turner 2000).

The mistrust between participants and adolescents with anorexia was mutual. Interviewees explained that these adolescents were initially unwilling to trust anyone because they ‘fear opening up’. They came to mistrust participants in particular because, as a result of the behaviourist treatment plan, they saw them as bad people ‘trying to make them fat’. Participants felt that this mistrust could escalate if health care professionals did the wrong thing. Lilly explained: ‘...they’ll tattletale on nurses who haven’t flushed my tube or didn’t know how to prime the machine...That patient is not going to feel comfortable being looked after by that person’. Mistakes by health care professionals are deterrents to therapeutic relationships (Muscari 1998, Bulik & Kendler 2000). A therapeutic relationship requires health care professionals to be able to admit errors and realise the boundaries to their understanding of the disorder, as trust without competence is pernicious to the therapeutic relationship (Bulik & Kendler 2000). Participants’ lack of knowledge and powerlessness to modify the ‘programme’ was at the root of this mutual lack of trust.

**Struggling to develop therapeutic relationships**

Manipulation, mistrust and the struggle for control were the major obstacles to developing therapeutic relationships in these wards but participants also talked about an additional set of obstacles. Blaming the victim, labelling and stigmatising adolescents as ‘anorexic’, and appearing to have favourites among patients all made the establishment of therapeutic relationships arduous.

**Blaming the victim**

Some participants felt that these adolescents were ‘causing their own harm’. Without an understanding of the chronic nature of anorexia nervosa, they found it hard to be sympathetic, and Ian clearly demonstrated this lack of understanding: ‘They had the choice. They didn’t have to sort of go along with the...so-called norms of society and trying to fit into a specific clique. They had the choice, but they chose to go the way that they did’. ‘Blaming the victim’ was especially pronounced when participants contrasted anorexic patients with other ‘chronically sick kids’ on the ward, such as ‘adolescents with cystic fibrosis’, Skye put it like this: ‘...it’s very hard to, sort of, have complete understanding and compassion when you feel they may be able to contribute to getting themselves better’. Participants saw adolescents with anorexia as using services that other sick ‘kids’ – deemed more worthy of a therapeutic alliance – required (Breeze & Repper 1998). This attitude seemed to be exacerbated by being short-staffed and pressure from the hospital system for a quick recovery (Breeze & Repper 1998).

Paradoxically, participants wanted both to have the ‘control’ and for patients to take ‘control’. This confusion and ambivalence was a result of a poor understanding of anorexia, compounded by the ongoing futile ‘struggle for control’. Education is the key to less ambivalence and frustration. Research shows that many health professionals share these negative attitudes, do not enjoy caring for mental health patients and provide them with less care because they believe these patients are ‘causing their illness’ or have a ‘self-induced illness’ (Olsen 1997, Bulik & Kendler 2000). It has also been found that negative attitudes change with greater understanding (Fleming & Szmukler 1992).

**Labelling**

Labelling is the process of attaching negative tags to certain behaviours to show that they are considered deviant, and hence morally inferior. For most participants, ‘anorexic’ was such a label. It effectively placed these patients outside the range of ‘normal’ illness behaviour and led participants to treat sufferers as ‘bad patients’ (Goffman 1961) or even as criminals. An overwhelming sense of frustration at not getting the patient better, lack of understanding and lack of skills and support to handle and care for these patients led some participants to describe them using prison terminology. They cast patients metaphorically as ‘criminals’ who ‘do their time’ and ‘eat to get out’ of the ‘prison’ or who are ‘repeat offenders’ and keep returning to the ‘prison’ with ‘suspended sentences’. This language reveals another truth about the participants’ situation: they were, effectively,
What is already known about this topic

- Anorexia nervosa is a complex eating disorder predominantly affecting females in which sufferers are obsessed with controlling eating, body weight and food.
- Establishment of a therapeutic relationship is a pivotal factor in the treatment and recovery of patients with anorexia nervosa.
- Developing and successfully maintaining a therapeutic relationship is particularly challenging and arduous when caring for people diagnosed with anorexia and nurses can experience frustration with these patients in acute care wards.

What this paper adds

- Insight into the specific difficulties and obstacles experienced by paediatric nurses attempting to establish therapeutic relationships with adolescents diagnosed with anorexia nervosa.
- Confirmation of previous findings that nurses still do not receive adequate education, training, support and preparation for dealing with this chronic illness in an acute care setting.

Jailers, since these patients were not free to discharge themselves, and the treatment programme converted the hospital to a prison. This situation, in which participants had become ‘jailers who made them eat, administered punishment for not eating, and in other ways disrupted their sense of control’ (Beumont 1992 cited in Irwin 1993, p. 349), could not be therapeutic.

Favourites: the pros and cons

Having favourites among patients can also be a deterrent to successful therapeutic relationships (Holyoake 1999). The more the participants ‘blamed the victims’ and portrayed them in a negative light, the more likely they were to have favourites whom they did not see as being ‘at fault’ for their disorder. Favourite patients were usually those who followed treatment; that is were compliant, ‘good’ patients (Short et al. 1998) and had agreeable parents. On the other hand, two of the more experienced participants (Brooke and Skye) reported that their favourite patients were the adolescents with anorexia as a group. In this instance, ‘favouritism’ was therapeutic, as these participants showed genuine empathy for the adolescents. Brooke explained that her relationship with them gave her more understanding of their condition and insight into how to help them:

I have established with anorexics...a very good rapport...So it is hard not to have a favourite when someone will open up to you more and you feel like you are making more progress with them and they will tell you why they are not eating... (Brooke)

In contrast Jodie, a nurse educator, explained that having favourite patients was ‘unfortunate’. She explained that all patients should be treated the same and nurses should not have favourites. Kim, also a nurse educator, agreed that having favourites and being their ‘friend’ compromised one’s position as a nurse and placed one in the awkward position of not knowing what to say or do. Having favourites sometimes worked against nurses’ goals, by making them oblivious to issues that were detrimental to the adolescents’ health and progress (Ramos 1992, Mcklindon & Barnsteiner 1999).

Having favourites can bring an ‘imbalance’ to the relationship and sometimes it is best for nurses to show ‘neutrality’ (Mcklindon & Barnsteiner 1999, p. 240). Perhaps the answer, as one of the participants in Garrett’s (1991) study put it, is for all patients to be ‘favourites’ in the sense that all have something unique for nurses to like, in spite of their frailties.

Recommendations

Some nurses suggested that the ideal form of treatment (when patients were out of immediate danger) would be a ‘day programme’, ‘day care facility’ or ‘safe-house’, with appropriately trained staff, rather than the acute setting. Ganellos (1999, p. 139) has commented on the lack of mental health education for nurses and the displacement of emotionally disturbed adolescents into services that are not age appropriate and whose staff are inadequately prepared to work with them. The institutionalization of adolescents with anorexia is one of the problems inherent in a hospital system. Goffman (1961) described a ‘total institution’, as a ‘controlled environment’ where people are forced to comply with rules and regulations, otherwise penalties are applied. Adolescents with anorexia, in this hospital, were similarly expected to comply with the eating disorder programme, which relied on ‘rewards’ and ‘punishment’, to modify their behaviour. However, if treatment continues to occur in hospitals, the hospital system as a whole needs to be more responsive to issues of mental health, and in particular to the need for time to develop therapeutic relationships and not to ‘move people on quickly’ (Breeze & Repper 1998, p. 1303), since this leads inevitably to their readmission.

There continues to be a tremendous need for education and support for nurses caring for adolescents with anorexia in acute care settings. There is also a need for adequate
staffing levels on these particular wards to ensure consistency among staff. For any nursing care plan to be effective, nurses and patients must be intimately involved in its development and evaluation. Nurses who do enjoy and show aptitude for working with adolescents suffering from anorexia are more likely to form therapeutic alliances with their patients and are well suited to continue to see ex-patients as regular outpatients, to consolidate recovery.

Conclusion

Treating adolescents with anorexia in acute wards with behaviour modification programmes clearly creates difficulties for nurses and is not conducive to the establishment of therapeutic relationships. With the implementation of the recommendations above, a more therapeutically conducive treatment programme could be formulated and put into practice. However, changes would be required in the way the hospital, as an institution, currently runs.

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References

Issues and innovations in nursing practice

Caring for adolescents with anorexia nervosa


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