'HAVING ATTITUDE': NURSES' PERCEPTIONS OF THE QUALITIES AND SKILLS NEEDED TO SUCCESSFULLY NURSE THE 10-24 YEAR OLD CLIENT.

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Abstract.

This thesis presents a grounded theory study following Glaser's methodological stance. It explores nursing of the 10-24 year old client through interviews with thirteen registered nurses. The participants worked in a variety of clinical settings including community, hospital and specific adolescent services. From the analysis of the data emerged the complexity of the nurses' work with the chosen age group. The study identifies that the quality of the nurse/client encounter may enable the young person to feel accepted and to be empowered to make their own health choices.

This thesis identifies how 'Having Attitude' is seen by the nurse participants as critical in the care of the young person. 'Having Attitude' is about the nurse balancing the dependence/independence needs of the young person with their family and peers, and about being acceptable to the client. This results from the work of the nurse which is characterised by the nurse 'being competent' and 'being supportive' whilst taking into account all of the socio-political factors that effect the nurse's working situation. The socio-political context impacts upon the young person's life in terms of the types of health issues they have, and the availability and affordability of appropriate health services. It also impacts on the environment in which the nurse works, in terms of the complexity of the concerns with which young people present, current health reforms and funding issues. The nurse needs to have a broad knowledge base and ability to work within a complex situation. Nurses believe they can make a difference to the young person's health experience when they are supportive, competent and 'have attitude'.

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Chapter One.

Introduction.

Background and methodological choice.

This research is about how nurses care for young people. Young people are broadly defined as those people who are at the stage of development between puberty and adulthood (World Health Organisation (WHO), 1993). For this research young person is the term used to describe those aged between 10 and 24 years. This is to avoid the differences used in the literature to define adolescents / youth / young people.

Little is written in the literature internationally or nationally about nursing of the young person. Most research pertaining to the young person is about suicide, sexuality and other health issues, rather than how the nurse cares for the young person. I became interested in the topic through my teaching of adolescent health to students in a comprehensive nursing programme. My background in nursing and sociology gave me insight into the disadvantages, in terms of access to health services, that young people face.

The study aimed to establish the qualities, knowledge, skills and attitudes needed to successfully nurse persons aged from 10-24, and to describe how nursing the young person differs from nursing other age groups. Initially I planned to investigate expert nursing of this age group but quickly realised that in a grounded theory study it was more appropriate to start with a broad area of concern or interest. As "expertness" did not emerge from the data I did not investigate it further. The study is from the perspective of nurses who work with young persons, not from clients of their services. This choice was made as I was interested in the nurses' viewpoint, and the literature from their perspective is limited. When referring to nurses in general the pronoun she will be used, as in New Zealand high proportions of registered nurses are female.

For this research I chose to use Grounded Theory methodology, as there is little literature about nursing the young person. The use of Grounded Theory is appropriate where knowledge of the topic under investigation is limited (Baker, Wuest & Stern, 1992; Chenitz & Swanson, 1986; Stern, 1980). Data were gained by interviewing registered nurses about their work with young people. The methodology will be discussed further in chapter three.

The young person.

The word adolescence is poorly defined in the literature. Difficulties relating to definition are due to different interpretations of when adolescence begins and ends (Taylor & Muller, 1995). Age, physical, psychosocial and legal factors vary in relation to when the adolescent is considered adult. The WHO refers to adolescents as the person aged between 10-19, youth as between 15-24 and young people as inclusive of both age spans (WHO, 1993). The Central Regional Health Authority (CRHA) in its funding of services includes people in the 10-24 age span as young persons (CRHA, 1995). A useful definition is put forward by Baumrind (1987):

> Our culture has no rites of passage to demarcate the change in status from child to adult, but it has instead a long transitional period that we call adolescence. By adolescence I refer to an age span roughly between ages ten and twenty-five that is heralded by the accelerating physical changes accompanying puberty; results in sexual maturity and identity formation; and eventuates in emancipation from childhood dependency and crucial decisions concerning school, love and work. Adolescence is a psychosocial stage in the lifespan and therefore specific to class and culture (p.97).

Many of the issues faced by persons in the 10-24 age group relate to the complexity of modern social life, therefore the developmental, cultural, and socio-economic environments have to be considered when promoting appropriate health care.

The health of young people.

New Zealand statistics indicate that the health of young people could be improved (CRHA, 1995; Maskill, 1991; Ministry of Health, 1997). Potential threats to the young person's wellbeing include behaviours such as smoking, alcohol, solvent and drug use, unemployment, sexual related matters, poor nutrition and relationship problems (Brash, 1989a; Brash, 1989b; CRHA, 1995; Gray, 1994; Maskill, 1991). Maskill identified that New Zealand was behind other countries in providing specific health services for young people, while Brash (1989a) commented that in New Zealand, as well as overseas, educational programmes for professionals on adolescent health are virtually non-existent, despite a growth in the literature identifying the health needs of adolescents.

What do young people want from health providers?

Several studies have identified what young people want from a health service (CRHA, 1995; Gray, 1994; Tarrant & Scanlen, 1995; Taylor, 1988). In 1994 the CRHA, in conjunction with the Porirua City Council, performed a needs analysis of health in the Porirua area (National Research Bureau, 1994). It identified, that, in particular, the youth of the area lacked access to health services. Reasons for this included lack of transport, lack of knowledge of services, language barriers, and inability to pay for services. Those interviewed said that they wanted services staffed by professionals who were aware and supportive of the needs of youth. In another study Gray (1994) found that young people were clear about what they considered to be appropriate services. She states that they "were prepared to use existing health services for general medical or accident and injury related problems, but were less comfortable using these services for personal health matters" (Gray, 1994, p.5).

Research carried out in Australia has similar findings to the New Zealand studies. Wyn (1994) reports on research carried out in 1991 by the Youth Research Centre, Victoria. The project explored the social meaning of heterosexual relationships for young women. The key findings were that young women were relatively ignorant about sexually transmitted diseases (STDs) and safe sex practices, the current health

services dealt inadequately with the needs of young women. The attitudes of health providers and the fear that confidentiality may be breached were the main reasons given for not getting professional advice or treatment. As well the project identified the need for health providers [nurses] to act in ways that enhance the well being of the client.

There is a belief that the provision of specific services for the young person will address their health needs, however O'Sullivan (1993) comments on the success or otherwise of an independent practice for young people. She states that "if one of the providers is not interested in adolescents, the practice does not hold together" (O'Sullivan, 1993, p.139). It is therefore important to establish the qualities, knowledge, skills and attitudes needed to successfully nurse young persons.

Chapter overview.

Chapter two: A review of the literature.

Literature relating to the broader area of the topic being researched is discussed in this chapter. Included in the topics that I searched as part of my research proposal were books and articles on primary health care, youth culture, health related issues for young people and expert nursing.

Chapter three: Methodology.

This chapter describes the research process for this study. The first part of the chapter reviews Grounded Theory as a methodology and then presents how I carried out this study.

Chapter four: The context for the nurse/young person encounter.

The nurse/young person relationship is influenced by the context in which the encounter occurs. This chapter is the start of the data analysis and it examines those factors that give rise to young person seeking health care. As well those factors that affect the work environment of the nurse are discussed.

Chapter five: The work of the nurse.

Chapter five continues the presentation of the data. This chapter reviews the nurse's work with her clients. No matter which age group or in which environment nursing takes place the need to be competent and act in ways that support the client are important aspects of the nurses' care. The next chapter continues to present the data.

Chapter six: 'Having Attitude': Nurses' perceptions of qualities and skills needed to successfully nurse the 10-24 year old client.

This chapter looks at how nurses work differently with young people. The data presented outlines those characteristics and qualities of nurses who successfully work with young people. The model that was developed from the analysis of the data is presented.

Chapter seven: Discussion, limitations and future research.

The chapter includes a discussion of the theoretical model and the findings of this study. The implications of this research for the health of young people, the provision of services and nursing education are also discussed.

Conclusion.

As little is written in the literature about the nursing of the client aged 10-24, this study aims to explain the nurses' perspective of the qualities, knowledge, skills and attitudes needed to successfully provide care to this age group. It aims to describe how practice may differ with this age group.

Chapter Two.

A review of the literature.

The use of literature in Grounded Theory research.

The use of literature in Grounded Theory research varies from other research methods. A pre-study literature search is not done because the literature is a form of data and is used to support the emerging theory that comes from the analysis of the data (Glaser, 1992). The literature the researcher needs to pursue is identified by the categories emerging in the study (Hickey, 1997). The researcher starts with a broad area of interest that narrows as the research progresses. The literature helps with clarifying issues and raising questions when emerging themes arise from the data. This process enables the researcher to pursue the ideas in further data collection (Hickey, 1997).

Stern (1985) states that doing a pre-study literature review poses problems for the research process. These are that "The search may lead to prejudgement and effect premature closure of ideas and research inquiry; (2) the direction may be wrong; and (3) the available data or materials used may be inaccurate" (Stern, 1985, p.153). These pitfalls do exist for the researcher, however if the review is brief and the researcher keeps an open mind the literature can be used to assist justification for the study proposal.

When putting forward my justification for the research, a preliminary search of the literature relating to the young person was carried out. This chapter discusses the literature used as the focus of my research proposal. The following themes were identified: the world of the young person, health issues for young people and the education of health professionals in the care of the young person.

The world of the young person.

One theme identified from the literature is the need to understand young people and, in particular, behaviours that may have an effect on their health status (Roye, 1995; Taylor, 1990; Tressider, 1996). Morrison (1996) reports that the advertising agency Mojo has labelled young people as the ACES (alienated, cynical, experimental and savvy) generation. Reported in *The Dominion* she identified that young people are difficult to pigeonhole, even though they belong to groups they remain individualistic. She had this to say about New Zealand young people and the peer groups they belong to:

> A tribe is typified by race, music, clothing, attitudes toward life and they share common values and a common sense of purpose. In New Zealand they include the homie, grunger, Goth, raver, metaller, tagger, surfie, skater, rap and hip hop, but the groups are constantly changing and teens sometimes identify with more than one. Teens today don't identify with their generation as much as their immediate peer group and are not overly nationalistic, relating more to being from the North Shore rather than Auckland (Morrison, 1996, p.11).

Because young people can be identified as having their own view and way of being in the world, the concept of youth culture is often used to describe the world of young people in Western societies such as New Zealand. In fact there are several youth lifestyles depending on the contexts in which the young live (Hendry, Shucksmith, Love & Glendinning, 1993).

Taylor (1990) contends that youth culture is a key influence in risk taking behaviour and therefore must be understood for health promotion and prevention programmes to be effective. Culture can be defined as a way of living. Novitz (1989) describes culture as:

> [...] collections of behaviour patterns, institutions, values, bodies of knowledge and systems of belief. And it is the nature of these ingredients, as well as the way in which they hang together, which determines the character of any particular culture (p.282).

A characteristic of youth culture is that it is collective by nature. The group gives the young person a chance to develop an individual identity as the group meets the need for belonging and gives the young person independence from the family and a means to make statements about their values and beliefs. Which group to be part of is dependent not only on who the young person sees themselves as, but also what is seen as acceptable to one's peers. 'In' and 'out' groups are part of the culture and it is very important to be part of an 'in' group, and therefore the young person will act in ways to become part of it. For example the young person will dress in a particular way that identifies them as one of the group (Taylor, 1990).

Another characteristic is the belief in the immortality of self. The belief that "nothing will happen to me" leads to risk taking behaviours. Risk taking behaviour is that which relates to engaging in activities that have a high level of danger associated with them. Hendry et al (1993) contend that risk taking is part of being a young person and is in part due to the young person's inability to see the consequences of their actions and in part to the excitement associated with the activity. This could account for the high level of drinking and driving by young males (Plant & Plant, 1992; Taylor, 1990).

In a political sense youth culture is about conforming to the group whilst appearing to rebel. However, Taylor (1990) warns that through conformity to the group's values the young person may be disempowered by not having the right to make decisions for self. Because of their age, marginalisation can occur as adults have the power to determine what is socially acceptable for those under twenty to do. Legal constraints mean that a young person in New Zealand can consent to sex at sixteen, but cannot vote until eighteen, or buy alcohol until twenty (Gilbert, 1996). A dilemma exists for the health professional as individual empowerment of the young person to make healthy lifestyle choices may alienate them from the group. Collective empowerment may be more effective in reducing risk taking behaviours (Taylor, 1990).

In New Zealand young people are influenced by American culture however they adapt this imported culture in order to express a unique local culture as identified by Morrison (1996). Health promotion packages and prevention strategies need to have the support and input of local young people that are to be targeted in any campaigns and services, in order for this information to be relevant (Taylor, 1990).

Health issues for young people.

Health status of young people.

Other key themes in the literature are those health issues that affect the young person's social, physical and mental wellbeing. The WHO (1989, p.2) identifies that the young person's environment i.e. "the home, the community, school, work and leisure" is a factor in their healthy development. According to Maskill (1991) the young person's environment influences their health status. By this, she means that the environment influences directly or indirectly "... by shaping healthcare systems and influencing the personal actions of individuals" (Maskill, 1991, p.31). Disley (1989, p.7) states that "the causes of adolescent mortality are not diseases, but are primarily related to preventable social, environmental and behavioural factors", a view supported by Maskill, who asserts that for young people, social and economic factors have the most effect on their health status. The WHO (1993) maintains that young people are vulnerable to the changes in social conditions that have occurred in recent years. They attribute tobacco use, unwanted pregnancy, STDs and alcohol use to changing social and moral behaviours in society. They contend also that young peoples' desire to experiment with substances, such as alcohol and tobacco, is often exploited for financial gain.

Brash (1989b) points out that adult behaviours such as alcohol use may be available to young people before they are developmentally ready or have the necessary skill to cope with them. Brash contends that for young people, risk taking is a sign that the young person is able to move to adult roles. This view is not supported by other literature (Hendry et al, 1993) that takes the line that risk taking is more related to the young person's inability to see the consequences of their actions. Peer pressure, personality factors, family and community have all been identified as factors that are associated with health risk behaviours such as smoking, and use or non use of condoms (Cotterell, 1996; Hill & Tisdall, 1997; Plant & Plant, 1992). These factors can also be responsible for the young person being cautious about getting involved in risk behaviours (Hill & Tisdall, 1997).

From 1987 to 1992, income levels for young people in New Zealand dropped by 22% (Ministry of Youth Affairs, 1994). Youth rates, part-time work and low paid jobs are some of the causal factors. White (1994) contends that unemployment is a health issue for young people as the stress and poverty associated with not having work has a detrimental effect on an individual's health status. Rising unemployment has been cited as a reason for increased suicide rates (Baume, 1988; Disley, 1994). Suicide was the second most common cause of death by injury for young males in New Zealand after motor vehicle accidents (Public Health Commission, 1994).

Most young people in New Zealand are healthy, however Maskill (1991) identifies some areas of concern. These areas include the high injury rate especially for males, plus the high rates of asthma, hepatitis B, STDs, pregnancy, abortion, and mental health problems related to stress and substance abuse. Of concern are the higher rates of mortality and hospitalisation for Maori (Maskill, 1991; Public Health Commission, 1994).

By the mid-nineties the New Zealand Governments' goals for the health of young people were identified as the following:

- To reduce death rates, injury and disability from road traffic accidents.
- To reduce tobacco use, exposure to environmental tobacco smoke, and their adverse health consequences.
- To promote responsible sexual behaviour to minimise unplanned pregnancy and the incidence of sexually transmitted diseases and HIV/AIDS.
- To improve health by reducing alcohol-related harm.
- To improve health by minimising harm related to substance abuse.
- To promote mental health and reduce death rates from suicide.

(Public Health Commission, 1994, p.207).

In 1997 these goals remained the same with indications to show that in most areas there was movement towards achieving the goals. The exceptions are in the areas of STDs and mental health (Ministry of Health, 1997).

Health services for young people.

There is very little literature about what constitutes appropriate nursing practice for the 10-24 year old client. This could be due to the lack of specific adolescent health services in many countries, including New Zealand. As early as 1986 the Child Health Committee of the New Zealand Board of Health identified that there was a need for services geared to the young person's needs. These included adolescent health centres, school health services, specialist outpatient services, day treatment and in-patient facilities and an increase in the number of health professionals working specifically with young people (Child Health Committee, 1986). In recent years the need for specific health services for young people continues to be recognised (CRHA, 1995; Maskill, 1991; Ministry of Health, 1995; Taylor & Muller, 1995).

In response to the identified need for services, a few young person clinics have been set up, however confusion exists in terms of defining the age span of the client group. In a local health initiative in the Nelson area, nurses set up a clinic for adolescents. Beckingsale (1993) reported that of the client group:

> Females outnumbered males 4:1. The age group most represented was 16, followed by 15, 17 and 13. There were 7 over 18 and up to 24 years - we decided we could not turn away those presenting outside the WHO definition of a teenager i.e. 10-19. The youngest adolescent was 12 (p.5).

Beckingsale does not give a reason for the expanded age range seen but the extension to seeing clients up to age of 24 fits with the New Zealand Ministry of Youth Affairs age span for youth, the CRHA definition of young people and the age span for this research. As each individual's development occurs at a different time, some young people in their early twenties are still experiencing the same health and social concerns of the teenage years e.g. those associated with sexual activity. It can be seen to be a reasonable rationale for extending a health service to those in their early 20s.

Both individual and social factors may stop a young person from accessing the health services. In a study by Gray (1994) young people gave the following reasons for not seeking help:

- Cost of treatment.
- Not wanting to make a fuss.
- Embarrassment.
- Lack of information about how to access a service.
- Fear of parents being contacted.
- Worry about what a doctor might say.
- Dislike of doctors.
- Unable to spare the time.
- No service available.
- Unable to obtain an appointment.
- Lack of transport (p.43).

According to the CRHA report (1995) *Young & Healthy Whiti Te Ra* young people at school like to use school services but some have difficulty accessing free services when they have left school. Reasons given are that cost, transport and the young person's need for their family not to know of the visit are factors that act as barriers to access.

In New Zealand providers of health promotion services include: "health promoters, community health workers, school health nurses, public health nurses, student health services, pharmacists, general practitioners (GPs) and practice nurses, nurse clinics, accident and emergency (A&E) services, Family Planning Association and STD (sexually transmitted disease) Clinics" (CRHA, 1995, p.14). The media and education institutions are other providers of health promotion activities. The need to co-ordinate the delivery of the various activities was identified, as was the need to ensure that the principles of the Ottawa Charter were upheld (CRHA).

Few primary health care or medical and specialist services are delivered specifically to young people and they are not available in all geographic areas. The CRHA identified this as a barrier for young people.

Primary health care and young people.

When looking at how the young person's health needs are to be met, most of the solutions favour a primary health care approach. It has been identified that young people need health services that are available, acceptable and affordable to them (Child Health Committee, 1986; Klein, Slap, Elster & Schonberg, 1992). Another factor is that primary health care assumes that participation be one criterion for providing a service. Gillis (1988) suggests that nurses working with young people include them in the development of health promotion programmes including peer run activities. The primary health care focus is also seen in the WHO's aims for promoting the healthy development of young people. The aims identified include, creating a supportive environment, having good communication skills, use of approaches that take account of the young person's beliefs and behaviours, and focussing on total lifestyle rather than an individual behaviour. Other identified aims are the need to involve young people themselves in planning and implementation of care, and having close links between community programmes (WHO, 1993).

School health services.

The literature on school health services relates mainly to the British and North American education systems and has an emphasis on the role of nurses in providing those services. Farrow (1996) asserts that the invisibility of the health promotion role of school nurses was a factor in the cuts to school nursing services during the health reforms in Britain during the 1980s. Yet at the same time health promotion activities in schools have increased through curriculum changes and mainstreaming. These are areas in which nurses have the skills to contribute, however, Farrow asserts that less qualified personnel are being employed to give health promotion and he implies that this is not beneficial for the young person. Cohen (1994) sees nurses as appropriate professionals to promote and give sex education in schools as they are seen as non-authoritarian. Whether nurses are the appropriate health educators in schools is arguable. Many professionals with education backgrounds may have a better ability to get the information across to the school age person than a nurse with no teaching experience. According to Brash (1989a) New Zealand does not have adequate training for health professionals in relation to adolescent health.

All higher education campuses in New Zealand provide some health services for young people. The limited hours the services on tertiary campuses are open were a factor identified as a possible barrier to the young person using the service (Le Blanc, 1995). She reports on a workshop that identified as essential to the provision of effective student health services, that the nurse be multi-skilled, and that the service be open for extended hours. She points out that often only one nurse is employed on a campus and this posed difficulties for meeting expectations of staff and students in relation to the type of service provided.

In the USA the Society for Adolescent Medicine identified the following criteria to improve services for young people: availability, visibility, quality, confidentiality, affordability, flexibility and coordination (Klein et al, 1992). In other words to improve the health status of young people, they need services that are user friendly, in their vicinity, and at a cost they can afford.

The young person in hospital.

The literature supports the belief that being in hospital is a stressful event for the young person. In a study by Stevens (1986) sixty-three young people aged 12-17 years were interviewed about stressful events during their hospitalisation for elective surgery. The participants felt stressed about the surgery and its risks, pain and the separation from family and friends. Developmental level, self esteem or prior experience did not make a difference to the stress experienced by the young person.

Denholm (1988) interviewed young people about their hospital experience and found both negative and positive reactions to the care given. Anxiety, pain, lack of activities, the food, specific procedures such as insertion of a naso gastric tube, missing peers, and being away from home were all identified as negative aspects of the experience. Other negative factors related to the care given by nurses. Gender differences were identified with female participants more concerned about their interactions with the nurse and male participants being more concerned about the nurses' skills and the promotion of autonomy. Positive experiences related to the friendliness of the nurse and the way in which the patient was prepared for procedures and treatments. Personal

growth from the experience, family and friend support, and having appropriate age related activities were all cited as positive experiences.

Several authors have noted that young people are mainly cared for in adult or children's wards and conclude that the environment is not always conducive to the young person's needs (Burr, 1993; Farrelly, 1994; Gillies, 1992; Kuykendall, 1989; Taylor & Muller, 1995). In contrast a study in France concluded that a paediatric ward was more appropriate for suicide attempters than an adult ward because the children's ward was more likely to be nurturing and have a family centred focus to care (Gasquet & Choquet, 1994).

The need for nurses to take account of the developmental tasks of young people as well as the health issue is identified (Mackenzie, 1988; Muller, Harris, Wattley & Taylor, 1992). According to Gillies (1992) the young person needs privacy, peer company and acknowledgement of their independence needs. Several authors have acknowledged that creating space which is user friendly is beneficial to the young person (Burr, 1993; Roye, 1995; Taylor & Muller, 1995). To meet the developmental needs Roye (1995, p.23) states that "grouping adolescents together whenever possible can be helpful, particularly for leisure activities geared to this age group".

Being friendly and having good communication skills have been identified as important qualities of the nurse caring for the young person (Kuykendall, 1989; Roye, 1995). It is recognised that young people may react in an aggressive way due to their vulnerability related to the unnatural setting of a hospital. Kuykendall contends that the nurse needs to see the situation from the young person's perspective in order to communicate well and allay anxieties and fears for the client.

Educating health professionals.

The issue of specific education about young people and their needs is another identified theme in the literature. A survey of North American nurses indicated that there was a need for more skills and knowledge of adolescent health, growth and development (Bearinger, Wildey, Gephart & Blum, 1992). In a New Zealand study

looking at preregistration curricula for nurses, occupational therapists and physiotherapists, Julian (ND) found that the time given to adolescent health varied and was mainly incorporated into different modules, often within a lifespan approach. When looking at medical training in adolescent health Newman (1992) found that specific training in the area was lacking. As well he found that a " survey of four medical school libraries showed that only one had one of the two major journals in adolescent health" (p.8).

Those who care for adolescents require "a great deal of skill and understanding" (Taylor & Muller, 1995, p.82). This raises the question as to what skills are needed and how the nurse develops the ability to successfully work with the 10-24 year old client. WHO (1996) recommends that nurses have the necessary skills and competence to promote health and prevent ill health, as well as being able to care for people during illness and rehabilitation.

Conclusion.

This chapter has provided an overview of the literature relating to health care, youth culture, and the health issues of young people that had formed my ideas prior to commencing this study. This review has identified the issues related to the access of services by young people, and the lack of specific education in adolescent health for health professionals. The literature that relates to the study's findings is reported in the data analysis chapters. Chapter three will discuss the research methodology for this study.

Chapter Three.

Methodology.

Introduction.

The methodology used in this research is Grounded Theory. Grounded Theory is the process of discovering the basic social, psychological processes operating within an area of inquiry, and from the data theoretical constructs are built (Baker, Wuest & Stern, 1992). This chapter sets out to explain the Grounded Theory approach to research and the process used in my study.

Why Grounded Theory for this research?

Liehr and Marcus (1994, pp.264-265) state that Grounded Theory is used to "construct theory where no theory exists or in situations when existing theory fails to explain a set of circumstances". The literature on adolescent health is generally written for a variety of health professionals; doctors, psychologists and community workers. The literature on young people often has a body of information that gives an outline of the developmental stage and a focus on the care of the health problem e.g. suicide, substance use, Human Immunodeficiency Virus (HIV), heart disorders, teenage pregnancy (CRHA, 1995; Drummond, 1996; Klein et al, 1992; Maskill, 1991). This trend is also true in the literature that relates to nursing the young person (Taylor & Muller, 1995; Zeigler, 1995). Limited focus is given to how the nurse works with young people compared to how she should address a particular health issue. This research will add to the limited body of knowledge related to nursing the young person.

As well as being useful where little is known of the topic, Grounded Theory is also suitable for exploring what is happening in a work situation such as nursing. This is because it makes visible the social and psychological processes of the nurses' work (Benoliel, 1996). This study can add to the body of nursing knowledge, especially for

those working with young people. The relevance of Grounded Theory to nursing will be discussed later in this chapter.

Grounded Theory Methodology.

Grounded Theory is a methodology developed in the 1960s by two sociologists, Glaser and Strauss. These two addressed the criticism that qualitative research lacked rigor by using both qualitative and quantitative procedures to look at the phenomenon of dying (Benoliel, 1996). It was from this research that the Grounded Theory approach grew. Glaser and Strauss (1967, p.2) state that Grounded Theory is "...the discovery of theory from data systematically obtained from social research". Therefore the main aim of the Grounded Theory approach is to develop theory that is derived from gathered data. This means that the methodology is about process.

> Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research (Glaser & Strauss, 1967, p.6).

The process is directed towards determining what is going on in a particular situation and it involves constant comparison of all data. Constant comparative analysis will be discussed further later in this chapter.

Glaser and Strauss (1967) contend that the theory must have 'fit' and 'work'. This means that the theory is clearly linked to the data.

> ... a Grounded Theory that is faithful to the everyday realities of a substantive area is one that has been carefully *induced* from diverse data (Glaser & Strauss, 1967, p.239).

The theory needs also to be meaningful and able to "explain the behavior under study" (Glaser & Strauss, 1967, p.3). This means that the generated theory must be readily recognised as explaining to those in the area of study the everyday realities and this is achieved by ensuring it is bedded in the data. Everyday realities of the situation are the

things that give an understanding of the problems and how those in the situation manage change over time.

The philosophical roots of Grounded Theory are founded from Symbolic Interactionism. In terms of the Grounded Theory approach to research the data will reflect the meaning of the situation for those involved. Hutchinson (1986a, p.127) states that the researcher can be confident that the theory derived from the research is relevant when those in the situation recognise "... the researcher's constructs ("Wow, that's it")".

Symbolic Interactionism.

George Herbert Mead was a founder of the symbolic interaction school of thought in sociology (Annells, 1996). The main characteristic of Mead's perspective is that the self is defined through social interaction with others. Individuals create reality by attaching meanings to situations. Mead (1934) asserts that symbolic interaction involves:

> ...the relation of the gesture of one organism to the adjustive response made to it by another organism, in its indicative capacity as pointing to the completion or resultant of the act it initiates (the meaning of the gesture being thus the response of the second organism to it as such, or as a gesture). What, as it were, takes the gesture out of the social act and isolates it as such – what makes it something more than just an early phase of an individual act – is the response of another organism, or of other organisms, to it. Such a response is its meaning, or gives it its meaning (p.145).

Mead (1934) contends that meanings are expressed through the use of symbols such as language, dress and gestures. How a person interprets these symbols is seen as a basis for how they will act. Meanings are shared by groups of people, and are learnt through the process of socialisation. Members of a group analyse and interpret the behaviour of others and act in response to their interpretation. The actions of members are therefore contextually based. Interaction of people in all kinds of situations lead to redefinition and new meanings for the players.

Blumer developed further the ideas of Mead, integrating them into a methodology for qualitative research (Cheek, Shoebridge, Willis & Zadoroznyj, 1996). He was a student of Mead's and is credited with coining the name 'Symbolic Interactionism'. Blumer was concerned with interpretation and understanding by those in given situations. This approach contrasted with the sociological perspective of structural functionalism dominant in America in the 1950s and the ideas of stimulus response mechanisms as explanations for human behaviour (Cheek, Shoebridge, Willis & Zadoroznyj, 1996).

Three premises underlie Blumer's perspective of Symbolic Interactionism. The first is that "human beings act toward things on the basis of the meanings that the things have for them" (Blumer, 1969, p.2). The things he referred to may be physical objects, other people, ideas, social institutions and situations. By the statement he meant that people have an interpretation of things such as a chair and act towards that object from their understanding of it. According to Blumer (1969) the meaning things have for people can be overlooked by psychological and sociological explanations that see behaviour as either being due to factors such as status or as cause-effect phenomena. He sees the meaning as central in the development of human behaviour. The second premise is that "the meaning of things is derived from, or arises out of, the social interaction that one has with one's fellows" (p.2). As people interact with each other they define the situation. The meaning comes from the gestures, language and actions that occur when two or more people communicate. The third premise is that "meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2). Things have meaning for the individual based on how the person communicates with the self about them. In each situation the person interprets the meaning of an idea, object or event and acts on the basis this meaning has for them.

The essential point of Blumer's perspective is that people do not respond directly to the world, they place a meaning on it and respond to the meaning. When people engage in interaction with others they take account of the meaning of the situation for themselves and others.

> Human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions (Blumer, 1969, p.79).

Social life involves a constant process of interpreting the meanings of one's own acts and those of others. This philosophical way of understanding society leads to the possibility for the study of people's interpretations of situations and their interactions with others.

Symbolic Interactionism as a methodological stance.

What is significant about Blumer's contribution to the Symbolic Interactionist perspective is that he saw its value as an approach for social science research. "Its methodological stance, accordingly, is that of direct examination of the empirical social world" (Blumer, 1969, p.47). According to Blumer (1969) studies need to have the power to explain and interpret the everyday realities for those involved in the situation. He contends that:

> "Reality" for empirical science exists only in the empirical world, can be sought only there, and can be verified only there (Blumer, 1969, p.22).

Blumer (1969) identified two aspects of social science inquiry for studying an area of interest. These he termed "exploration" and "inspection" (p.40). Exploration is when the researcher moves from one way of looking at an area of interest to another way of viewing the same situation. It also involves the researcher following up a particular lead. As the inquiry proceeds the researcher "changes his recognition of what are relevant data as he acquires more information and better understanding" (Blumer, 1969, p.40). Several research techniques may be used in this mode of inquiry, as the aim is to build a picture of the situation.

Inspection involves analysis of the social world. Blumer (1969) identifies that inspection has two components, the first being the key elements of the investigation. These elements may be "processes, organization, and happenings" (Blumer, 1969,

p.44). The other component is to see the relationships between the elements. The aim of inspection is to understand it in the context of the empirical world. Naturalistic inquiry is possible because of 'inspection' and 'exploration' of the social world. Denzin (1989) states that naturalistic inquiry attempts to "reproduce as fully as possible the actual experiences, thoughts, and actions of those they study" (p.79). It is from Blumer's perspective of viewing scientific inquiry that Glaser and Strauss were able to develop Grounded Theory as a methodology.

The relevance of Grounded Theory to nursing.

A factor that has influenced the use of Grounded Theory by nurses has been the association of Glaser and Strauss with the nursing department at the University of California. Nurses who had been students of theirs picked up on the method and subsequently applied it to research in nursing (Baker, Wuest & Stern, 1992). Benoliel (1967), a student of Glaser and Strauss, was the first nurse to use Grounded Theory for nursing research (Hutchinson, 1986a).

Holloway and Wheeler (1996, p.99) contend that the "orderly and systematic way in which the data are collected and analysed" is a reason for Grounded Theory's popularity with nurse researchers as this way of working is reflected in nursing practice. Nursing practice involves the nurse in assessing, identifying problems and potential problems, planning care, carrying out actions that help meet the client's needs and evaluating the care given. The skills involved in these activities require the nurse to determine what is happening in the situation and this is the same question that is asked when collecting and analysing data in Grounded Theory.

Grounded Theory studies by nurses have the potential to aid the development of a body of knowledge in nursing. Glaser (1992, p.18) states that, "since Grounded Theory is general its methods work quite well for analyzing data within the perspective of any discipline". Wuest (1995, p.125) contends that Grounded Theory research is useful to nursing because it is able to identify underlying social experiences which can "become a basis for nursing action". If the nurse has an understanding of what is happening in a particular situation, she can then act in ways to influence the

circumstances of the situation. Research using Grounded Theory can make nursing and its practice visible, as it has the potential to not only describe the characteristics of the phenomenon under study, but also, to explain the contexts that influence client and nurse interactions. Because of its approach, Benoliel (1996) asserts that this type of research can move the knowledge of nursing practice beyond nurse/client relationships to include the wider perspectives of what informs those relationships.

> Findings from carefully done GT research by nurses have provided images of the powerful influence of social and contextual forces on the life experiences of vulnerable people in crisis and change. How to assist nurses in practice to define their work in these context-dependent terms is a challenge for the future (Benoliel, 1996, p.318).

Lawler (1991) used Grounded Theory as part of her research methodology as it:

> ...provided the scope to theorise areas of social life which have not so far been well studied, and where I had little to lead me, other than literature which told me the topics I wanted to explore were dealt with largely by silence and invisibility (p.9).

Having outlined the basis for choosing Grounded Theory, its background and relevance to nursing, I will set out the approach as described by Glaser (1978).

Debate about the methodology.

Since the development of Grounded Theory in the 1960s its use as a methodology has spread widely. Currently there is debate in the literature about how Grounded Theory is undertaken. According to Melia (1996) refinement of the method has led to differences of process with this type of research, and consequently a clash between the cofounders.

In his book, *Emergence vs Forcing Basics of Grounded Theory Analysis,* Glaser (1992) accuses Strauss of not adhering to the method of research that they developed.

The book is a dialogue of what Grounded Theory is according to Glaser and how Strauss has developed another method. The key area of difference is that Glaser sees Strauss as forcing the data and calls his approach "full conceptual description" (Glaser,1992, p.2). This difference arises from the more detailed method of coding and categorising adopted by Strauss and Corbin (1990).

Annells (1997) sees the differences arising from an evolutionary development of social science research from 1970-1986 in response to debates about the nature of interpretive research, the objectivity of the researcher, challenges of rigor. Stern (1994) states that there were always differences between the approaches of Glaser and Strauss.

> Apparently they thought they were using it the same way. Students of Glaser and Strauss in the 1960s and 1970s knew the two had quite different *modus operandi,* but Glaser only found out when Strauss and Corbin's *Basics of Qualitative Research* came out in 1990 (Stern, 1994, p.212).

Benoliel (1996) and May (1996) maintain that over the years different researchers have used Grounded Theory without always fully understanding how to go about it. May (1996) attributes the differences in research studies to a lack of mentorship in the method. It could also be attributed to the differences between the cofounders. According to Annells (1997) the differences in the approaches have a philosophical basis as well as process distinctions. Benoliel (1996, p.413) identifies that many of those undertaking Grounded Theory research are not "grounded in the epistemological underpinnings of the interactionist research tradition".

Annells (1996) asserts that:

> The research question is somewhat dependent on the "worldview" of the researcher. Although the research focus may emerge from a variety of sources, the actual formulation of the question arises from the researcher's notions about the nature of reality, the relationship between the knower and what can be known, and how best to discover reality. Thus the selection of method can be

> viewed as also arising from the basic philosophical beliefs about inquiry as held by the researcher (p.379).

Annells (1997) and Stern (1994) assert that when doing Grounded Theory research the researcher follows the traditional approach, Glaser and Strauss (1967), or that developed by Strauss and Corbin in 1990. This study has followed that of Glaser and Strauss developed in the 1960s, as it was important for me as a beginning researcher to focus on one approach to minimise confusion.

The process of Grounded Theory.

This section looks at how one goes about undertaking Grounded Theory research. The process used is not linear as the researcher is gathering data, analysing data and reading all the time (Stern, Allen & Moxley, 1984). The methodology also has elements of inductive and deductive logic. It is primarily an inductive logic that guides the study as the theory emerges after data collection starts. The deductive component is when the researcher is guided to sample further data from comparative groups or a subgroup so that the emerging theory can be checked out (Glaser, 1978). Grounded Theory includes the processes of sampling, data collection, data analysis and the use of literature. Throughout the process the researcher has to maintain what Glaser and Strauss (1967) call theoretical sensitivity.

Theoretical sensitivity.

According to Glaser and Strauss (1967, p.46) theoretical sensitivity assists the researcher to "conceptualize and formulate a theory as it emerges from the data". Glaser (1978) contends that theoretical sensitivity is gained by the lack of fore-ordained ideas when entering the field, by being open to what is happening in the situation and having an awareness of the significance and meaning of the data.

> Theoretical sensitivity refers to the researcher's knowledge, understanding, and skill, which foster his generation of categories and properties and increase his ability to relate them into hypotheses, and to further integrate the hypotheses,

> according to emergent theoretical codes. Accomplishing this result in relevance, fit and work are the criteria of Grounded Theory (Glaser, 1992, p.27).

The researcher starts with a general perspective or problem rather than a hypothesis to be tested. The research process is guided by what is found in the data.

Sampling.

A Grounded Theory study is searching for the underlying social psychological process in the situation rather than a descriptive unit (Glaser, 1978). A descriptive unit describes the properties of the phenomena being studied whereas a basic social process is "something that occurs over time and involves change over time" (Glaser, 1978, p.97). The aim of qualitative research is to explain the perspective of an individual or group so the sample group is obtained because of their knowledge and experience in the area of study.

Sampling in a Grounded Theory study involves two aspects. The first is that participants are sought where the phenomenon to be researched exists. Later theoretical sampling is used as the data guide the researcher to develop categories and to check how they relate to each other (Chenitz & Swanson, 1986). Theoretical sampling involves checking out the emergent conceptual categories so the researcher goes to sample groups experiencing the phenomenon and the literature that relates to the new information. According to Glaser and Strauss (1967) what is important is that groups are chosen so that theory can be generated. The authors recount how they went to different settings to observe patients dying in order to get data for the developing concepts derived from the data.

Data collection.

Grounded Theory data can be collected from various sources including participant observation, interviews and reviewing documents (Stern et al, 1984). The use of interview as a method of data collection allows the researcher to obtain the perceptions of the participants about the topic being studied. The interview process is interactive

in nature enabling the researcher to clarify the meaning of a word or concept during the interview by asking for further explanation of the topic. For the registered nurses in the study, similar experiences and insights gave them an understanding of what is involved in their practice with the young person. Because this study was looking at the nurses' view of their work situations, data could be gained through the interview process.

When inquiry into the area of interest starts the researcher uses broad sources of data, later narrowing the search as concepts emerge. This is known as theoretical sampling and it is described by Glaser and Strauss (1967) as:

> ... the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (p.45).

Data are collected until no new patterns occur. Patterns are the key elements that form categories that explain the relationships between similar and different events. The interviewing process ends when the data is 'saturated'; i.e. no new data are found or all aspects of the phenomenon are described in full (Glaser, 1978; Morse, 1995; Stern, 1980).

Theoretical sampling helps the researcher to get saturation of the data (Morse, 1995). Morse points out that it is not the amount of data but the 'richness' that counts. "Richness of data is derived from detailed description, not the number of times something is stated" (Morse, 1995, p.148). She states that data collection ceases when a comprehensive theory can be built. If saturation is not reached developing the theory is impeded.

Another aspect of data collection is the use of field notes. Field notes are made when observing a specific situation or after an interview. The field notes are a written record of what the researcher recalls about the situation and what things stood out for them. Hutchinson (1986b, p.192) stated that her field notes for a study of a neonatal unit comprised of "experiences, observations, personal thoughts, and ideas about theory and method". Later these notes form part of the data for analysis.

Data analysis.

As the data are collected analysis begins. The analysis of data is continuous and ongoing by constant comparison of all the material collected and involves comparing each piece of new data with that already collected and coded (Glaser, 1978).

Coding.

Coding is the process of analysing the data line by line to identify words that describe what is happening in the situation. Glaser (1992) calls this phase 'open coding'. He describes the process in this way:

> ...the data are broken down into incidents, to be closely examined and compared for similarities and differences, while constantly asking of the data the neutral question "What category or property of a category does this incident indicate?" (p.39).

The process of comparing similar incidents develops categories ie. clusters of codes form according to how well they fit together. Categories are formed from the coded data that fit together. While doing this the researcher memos his or her ideas, while asking what is the relationship of one code to another.

Theoretical coding is done when the main concepts emerge. Additional data are collected and analysed for the specific purpose of developing hypotheses and identifying properties of the main categories (Stern et al, 1984). To help the researcher clarify the nature of the category, its context and potential consequences, Glaser (1978, p.74) describes eighteen coding families including one called the "six C's: Causes, Contexts, Contingencies, Consequences, Covariances and Conditions". Several theoretical codes may fit the data however Glaser advises the researcher to focus on only one integrative pattern.

Memoing.

> Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding (Glaser, 1978, p.83).

In order for the researcher to develop theory it is necessary for memos to be written. For the researcher the writing of memos, whilst doing the analysis of the data, enables the development of the theory. Hutchinson (1986b) explains that the analyst conceptualises when coding and then assesses how the concepts relate to each other. According to Glaser (1978) memoing is a continual process throughout the timeframe of the research and it is an essential step of doing Grounded Theory. Memos are sorted and clustered and from these abstract ideas the theory emerges.

Generating theory.

Theory is generated by the use of comparative analysis. As the data are analysed the researcher identifies the emerging relationships between the elements. As conceptual frameworks are discovered the researcher uses the literature, additional interviews and observations to further explore the concept; this is known as theoretical sampling. The use of memos supports the development of the ideas about the processes found in the data.

As the analysis progresses a core integrating category emerges to explain the data. The core category is representative of the main problem or concern for the people in the setting e.g. the nurses in this study. The core category is central to the study, reoccurs frequently in the data, and takes time to saturate. "The core category can be *any kind of theoretical code:* a process, a condition, two dimensions, a consequence and so forth" (Glaser, 1978, p.96). At this point the theory can be tested with the participants (Christensen, 1988). According to Glaser all Grounded Theory studies have a core category with some research also having what is called a basic social process i.e. there are two or more stages.

The theory emerges from the data and it can be either a substantive or formal theory. Substantive theories are those that apply to one context such as the nurse-client relationship or to a particular setting. Formal theories have a more conceptual basis and are derived from the basic social processes being found in different situations (Glaser & Strauss, 1967). A theory that clearly identifies the links of the data to the categories and has explanatary power is considered good. A good theory also shows process rather than static situations (Holloway & Wheeler, 1996).

Use of literature in Grounded Theory.

According to Glaser (1992) there are three types of literature used when doing Grounded Theory research. He identifies these as follows:

> ... (1) non-professional, popular, and pure ethnographic descriptions, (2) professional literature related to the substantive area under research, and (3) professional literature that is unrelated to the substantive area (p.31).

Each of these plays a part in supporting the research process. The first group of literature is considered part of the data and needs to relate to the substantive area of study. This literature is read by the researcher at any stage of the study (Glaser, 1992). The researcher first reads the professional material that is unrelated to the substantive area being studied. The purpose of this is to increase theoretical sensitivity. The reader looks at style and formats which assists later writing and a sociological thinking process. Berger (1963) identifies the sociological perspective as the ability to debunk i.e. to look beyond the presented explanation of how things are in society.

> To ask sociological questions, then presupposes that one is interested in looking some distance beyond the commonly accepted or officially defined goals of human actions. It presupposes a certain awareness that human events have different levels of meaning, some of which are hidden from the consciousness of everyday life (Berger, 1963, p.41).

Reading of the literature from professional material related to the area of study only commences when the analysis has developed the emerging theory and this literature then integrated into the theory.

> ... during sorting and then writing, the researcher-analyst by constant comparison reconciles differences, shows similarities in concepts and patterns, and imbues his work with the data and concepts in the literature (Glaser, 1992, p.33).

The use of the literature is to aid the generation of the emerging theory rather than for the purpose of verification (Glaser, 1992).

Credibility of Grounded Theory.

Debate exists in the literature about the rigor of qualitative research methods (Emden, 1997; Glaser & Strauss, 1967; Sandelowski, 1986). The rigor or trustworthiness of a qualitative research project is shown in the writer's ability to demonstrate how the findings and interpretations were arrived at. Koch (1994, p.976) states that if the reader can "audit the events, influences and actions of the researcher" the study is deemed to be trustworthy. When writing of the Grounded Theory method and its rigor Glaser and Strauss (1967) suggest:

> ...that criteria of judgment be based instead on the detailed elements of the actual strategies used for collecting, coding, analyzing, and presenting data when generating theory, and on the way in which people read the theory (p.224).

Credibility in Grounded Theory studies is achieved by what is called the fit i.e. "the theory must closely fit the substantive area in which it will be used" (Glaser & Strauss, 1967, p.237). This means that the participants and those working in the area should recognise and understand the theory that has been derived from the data. With Grounded Theory, the data are derived from the area of study and the codes fall into place naturally, not being forced by the researcher.

In my own research I endeavoured to follow the process outlined above. The next section details what I did to explore my topic of interest as well as the ethical considerations for this particular study.

How I went about this study.

In this study I aimed to establish the qualities, knowledge, skills and attitudes needed to successfully nurse this age group and to identify if practice was different from other age groups. It has been a large part of my life for the past two years. Whilst carrying out this research project I identified with the point made by Glaser (1978) i.e. that all aspects of the researcher's life have an effect on the processes involved in the

Grounded Theory method. This exercise seemed to be a stop start affair, at times a heavy load and at other times totally absorbing me.

> Generating theory is done by a human being who is at times intimately involved with and other times quite distant from the data - and who is surely plagued by other conditions in his life (Glaser, 1978, p.2).

I chose my particular topic for research because of my interest in the health of young people. I sought ethical approval, which was granted, and I began my research. This section sets out the process following the granting of ethical approval. The steps involved the selection of participants, the collection of data, the analysis of the data gathered and the writing process. Each of these will be discussed.

Research participants.

Participants were sought by advertising in two New Zealand nursing journals; *'Kai Tiaki', New Zealand Nursing Journal* and *Nursing Praxis in New Zealand.* Other nurses were contacted through notices sent to specific services for the 10-24 year old and through word of mouth. The advertisements asked those nurses interested in the study to contact me by phone, fax or email (appendix one). When interested nurses responded to the advertisement I sent them an information sheet (appendix two) and a consent form (appendix three) to sign and return to me. When I received the consent form I phoned the participant to set up a suitable interview time.

The criteria used to select participants were that they had:

- Registered nurse status.
- Experience of working with the 10-24 year old.
- Signed a consent form.

Following the recruitment of nurses I ended up with 13 participants for this study. The nurses came from a wide range of practice areas in both hospitals and the community. For some, the 10-24 year old was their main focus of practice, whereas for others the practice environment catered for a wider age span. The hospital areas of practice included paediatric wards, adult oncology, medical, and surgical wards in Crown

Health Enterprises (CHEs). The nurses in the community worked in public health, mental health services, sexual health clinics, and "one-stop shops". One stop shops are specific health services designed to provide a wide range of health care for young people. The emphasis of these services is on information and preventative health care. Participants had varying lengths of nursing service and geographically the nurses came from all over New Zealand, so small regional areas as well as large metropolitan areas were represented. To maintain privacy for the nurses and their employers the specific work areas have not been identified in this study.

I commenced the data collection whilst still recruiting participants. This practice fits with the Grounded Theory method as new sources of data are sought in response to the emerging theory (Glaser, 1978). There was a four-week interval between the publishing of the recruitment advertisements in the two journals. As different participants responded to each advertisement, it took a two to three month period for them to contact me and interviews could be spaced out. This time gap allowed for most interviews to be transcribed and analysed before the next participant was interviewed.

Data collection.

The interview was the method of data collection used in this study because it enabled me to get an understanding of how nurses working with young people perceived the skills and qualities of their nursing practice. The data could be gained through the interview process, as the registered nurses were able to talk about their experiences and insights of what practice meant when caring for the 10-24 year old client. The focus was on their work with the young person so the sample group all had experience in the area of study. Participant observation and interviewing of young people was not done. I chose to limit the study to be the nurses' perception of the topic to manage doing a masters degree and working full time.

The interview was either face to face or by telephone. Because of geographical location four interviews were conducted by phone. These participants were contacted and a time agreed when it would be suitable for me to phone for the interview. The phone call was audiotaped and field notes made on the completion of the call. The

face to face interviews were at a place and time convenient to the participant. Each participant took part in 1-2 interviews of approximately one hour's duration, and were at my home, or the participant's home or work place. These interviews were also audiotaped. Prior to starting the interview each participant was reminded about his or her right to withdraw from the study at any time. The focus of the interviews was on how the nurse worked with young people.

The interview often had a conversational style. Denzin (1989, p.109) contends that the interview "should be approached as a conversation". It involves two or more individuals talking about the questions and it ends when the researcher feels the questions have been answered (Denzin, 1989). The format of each interview involved the use of semi structured interviews in order for the participants to give as full a description of their work as possible. Barriball and While (1994) contend that using semi structured interviews enables the interviewer to gain more in-depth information than a structured interview or survey could reveal. They see this type of interview as being:

> ... well suited for the exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers (p.330).

After each taped interview a typist transcribed the tape. Names of people and organisations were not included in the transcript to ensure confidentiality. In order to assist the analysis each transcript was numbered by line and page number, with a wide margin on the right for coding. When the typist returned each tape and transcript to me I listened to the tape to see that the transcripts were accurate and made changes as required. Most changes were to do with the spelling of medical terminology. When listening I also noted questions that needed clarification or further explanation. A copy of the transcribed interview was then given to the participant for feedback. Returning the transcripts to the interviewees was to ensure that they had included all they wanted to say. It was also an opportunity for them to have anything removed that they felt would have broken confidentiality or did not express what they wanted to say. Only two of the returned transcripts had changes made.

As well as the taped interviews I wrote field notes after each interview noting my impression of the interview and identifying what seemed to stand out as important in the data. These field notes were looked at during the analysis phase in order for me to track my thoughts and ideas.

> I felt the interview went quite well, as [name] appeared relaxed and was willing to answer all my questions. I wonder if I am talking too much. At times it seemed more like a conversation than an interview. Must find that article about using conversation as interview technique. [...] I get the impression that good adolescent nurses relate to their patients as people in an 'accepting' way. Also something about keeping updated with knowledge. Life experience?? plays a role in developing expertise. (Field notes, 20/4/97).

As each interview was transcribed the data analysis was continued.

Data analysis.

This stage involved several steps i.e. coding, memoing, theoretical sampling. During the process of data analysis the researcher has to maintain theoretical sensitivity.

Data analysis and interviewing were occurring simultaneously as new participants became involved in the study. After each interview and when the transcripts were being analysed I kept memos. Memoing during this stage helped me later with the identification of the core category.

First I coded each transcript line by line. This meant reading the transcript, asking the question "what is happening here?" identifying the key event in each line or sentence and giving it a code. I labelled as "going the extra mile" the following examples: "taking your kid's tapes in for them [the patient] to hear, taking video tapes in that your kids have got" (Amy. 1:25). The key events were underlined and the code written in a right hand column on the transcript. The scripts were then cut up and the corresponding codes from each interview were put together in a plastic sleeve. Each was then reviewed to identify similarities or differences. A large number of codes emerged and on closer examination some codes were renamed or collapsed into others,

as they were similar e.g. thinking like they think, accepting, respecting where at, all became a non-judgmental nursing approach. As the codes were compared with each other patterns emerged in terms of what codes linked together.

My next step was the identification of categories and their relationship to each other. I was also following up the literature that related to the emerging categories. Several transcripts had been analysed before broader categories emerged from looking at the data and seeing how the codes fitted together. Large sheets of paper were used to draw the links. I met at regular intervals with my supervisor to discuss my data. Also, two other masters' students and myself would meet to discuss our work. Work colleagues also helped me get clear about the ideas that were emerging about my descriptive model.

Christensen (1988) identified that the development of the theoretical framework of her research on people's experience in hospital took longer than she had anticipated. This was also my experience as it was not until late in the analysis that the core category emerged.

When I had a working model I contacted five of the participants to discuss it with them and to get feedback from them on its relevance. The discussions confirmed that the model explained the key characteristics of nurses working with young people, as well as the relationship that they perceived made a difference to the young person's experience.

The writing process.

At the start of the study my supervisor asked me to write a draft introduction and methodology chapter to help me focus on the research task. This was helpful for me to understand the process I needed to follow. I did not return to the writing phase until the completion of the analysis of the data.

The descriptive model became clearer during the writing of each of the data chapters. The inclusion of relevant literature into the work helped to identify the links and the ideas I had about what it is to nurse the young person.

Whilst going through the process of the research I kept in mind those aspects that ensured no harm would come to the participants or myself. These considerations are set out in the next section.

Ethical considerations.

According to Ramos (1989) the increasing complexity of nursing research means that the researcher has a greater moral responsibility to act in ways that protect the participants and at the same time safeguard the integrity of the research inquiry. The researcher has a responsibility to inform the participants of their rights and how the information gathered will be used.

With this in mind I took care to ensure that I upheld my ethical responsibilities to my participants. In this study I did this by gaining ethical approval from the appropriate bodies, getting informed consent from the participants, maintaining confidentiality, ensuring credibility in the data analysis phase and ensuring anonymity when writing up the thesis. Each of these points will be discussed further in this section.

Approval process.

As this study was to involve nurses from a variety of areas in New Zealand ethical approval was required from several bodies, including Massey University Human Ethics Committee, Whitireia Community Polytechnic Research Committee and a multi site approval from the CRHA Wellington Ethics Committee. This process took seven months because of the need for several committees to examine the proposal. As well, different formats of the proposal were required for each committee. When I gained approval I then started to recruit participants.

Consent.

As the researcher it was important to me that the participants were fully aware of their rights as participants and had given me their informed consent. As well as the written consent at the start of each interview the participants were reminded of their right to

withdraw from the study at any time and also their right to refuse to answer any questions. With their consent granted I set out to gather the data.

Confidentiality.

Confidentiality was maintained throughout the research project. I, as the researcher, carried out each of the interviews. Each interview was audiotaped and notes taken from time to time by myself. The interviews were transcribed and the typists used to transcribe each interview signed a confidentiality agreement (appendix four). Data was stored in a locked cupboard.

Anonymity.

To ensure the anonymity of the participants while analysis of the data was being done a code number for each transcript was used so that individuals or the agencies they worked for could not be identified. Pseudonyms were used in this thesis, as well all references to specific locations or services have been excluded from the document. Participants will be given their own interview tapes back after the thesis has been completed and marked.

Credibility of this study.

According to Hutchinson (1986a, p.128) "pitfalls may confront a budding grounded theorist, all of which strongly influence the quality of the proposed theory". The pitfalls she refers to relate to premature closure, no core variable emerging from the data and the decisions of the researcher.

Premature closure is a factor as this is a Masters thesis that had a definite timeframe for completion. A model describing how nurses' work with young people has been developed however it has not developed to a formal theory that can be generalised to other settings or groups of health professionals.

The model was discussed with five of the participants who all expressed that it fitted how they saw the characteristics of the nurse and their work with the young person.

As well the model was discussed with two non-participants I had contact with through my work. One was a Family Planning nurse and one a nurse that had previously worked in a 'one stop shop'. All expressed that that was how they saw nursing the young person.

I endeavoured to maintain theoretical sensitivity throughout the process of researching. When looking at my own practice area the roles and characteristics of the nurse are familiar so I was not ignorant of the topic to be researched. Lawler (1991) states that she is sceptical that any researcher starts with no preconceived ideas, and according to Christensen (1988):

> The tabula rasa ideal cannot be applied to researchers examining their own arena of professional practice (p.59).

Holloway and Wheeler (1996, p.103) say that professional experience, documents and studies can "create awareness in the nurse of relevant and significant elements in the data" which helps the researcher maintain theoretical sensitivity.

Often at the beginning of the research process the experience of the researcher and the ideas the researcher has of the topic gives the impetus to get started, and may influence the opening stages of the data collection process. However the researcher can be open to the data taking them down a different path, which is what Glaser, and Strauss (1967) saw as essential to the process. As a nurse researcher I took care to stay connected to the data in the research project. The nurses I interviewed were unknown to me and came from areas I did not practise in. Throughout the analysis of the data and the emergence of the descriptive model discussions with my supervisor kept me grounded in the data.

Conclusion.

To summarise Grounded Theory was the chosen methodology for this study as it is considered appropriate where little is known of the topic. Grounded Theory has its roots in the Symbolic Interactionist perspective as defined by Mead and later Blumer.

Glaser and Strauss developed this form of research in the 1960s. Because of their involvement with the nursing department at the University of California many nurses have adopted this methodology for nursing research.

Grounded Theory involves collecting data, using the constant comparative method for analysis, coding, memoing, theoretical sampling and further coding occurs until a core category emerges from the data. How I went about these processes were discussed, including the management of ethical considerations. The following chapters will detail the data analysis beginning with the context that informs the nurse/young person relationship.

Key to abbreviations in data chapters.

[...]	Section of quote missed out.
[Adolescent unit]	Words added by researcher for clarity of quote.
(Name. 1:1)	Refers to participant's pseudonym, first or second interview and page number of quote.
[Pause]	Represents a hesitation break in flow of participant's speech.
Indent	Participant quotes.
Italics in quotes	Researchers comments/questions.

Chapter Four.

The context for the nurse/young person encounter.

Introduction.

Nursing of the young person occurs in a variety of settings, including community agencies or hospitals, and for many different reasons. The interaction between the nurse and young person may be short or long-term depending on the health issue.

This is the first of three chapters that present the findings and analysis of the study, including the integration of further data from the literature to assist with development of the emerging theory (Hickey, 1997). Categories derived from the data explain from the perspective of the participants what is happening when nursing the young person.

Nursing always occurs within a context and therefore any research into nursing must be contextualised so that meanings and relationships can be understood. Macdonald (1982) defines the term context as "the parts of a discourse or treatise which precede and follow a special passage and may fix its true meaning: associated surroundings, setting" (p.280). In this study the 'context' for the nurse/young person encounter refers to the conditions, situation, and environment that impact on the encounter. The context includes all of the factors that influence the here and now moment of the encounter between the nurse and the young person seeking help. Both the environment of the young person and the environment of the nurse impact on what each brings to the situation. Macdonald defines environment as " surrounding conditions influencing development or growth" (p.437).

The WHO (1989, p.12) stated that "healthy development presupposes the availability and accessibility of health care at primary, secondary, and tertiary level". They also contend that young people view their health in "holistic rather than fragmented terms" (p.46). The participants in this study worked at each level of care and in flexible ways

to allow for the young person's needs being met. The work of the nurse will be discussed in chapter five.

Table 1 identifies the categories and codes that form the context. Each category will be presented as separate entities, although in reality they are inseparable.

Table 1. The context for the nurse/young person encounter.

Recognising the needs of the young person. Being aware of health issues of young people. Being aware of social issues facing young people. Recognising growing independence. Awareness of client knowing/not knowing. Being aware of the stressful situation for the young person.
Being aware of socio-economic realities Knowing about young peoples accessing services. Adapting to Health Reforms.
Coming together: The health setting environment. Age confusion in organisations. Ideal set-up.

Recognising the needs of the young person.

Taylor and Muller (1995) maintain that nurses need to know about the developmental tasks of adolescence so that they can assist the young person to achieve them. When working with a young person the nurse needs to take account of what is happening to the young person. The following codes form the category named recognising the needs of the young person: *being aware of the health issues of young people, being aware of social issues facing young people, recognising growing independence, awareness of client knowing/not knowing, and being aware of the stressful situation for the young person.*

Being aware of the health issues of young people.

The WHO (1993) noted that changes in society can make the young person vulnerable and this in turn can impact on their health. The participants in this study identified a wide range of reasons for the young person seeking or requiring care, including sexual matters, having a medical or surgical problem, cancer and mental health concerns.

> There's a whole lot of issues that are specific to adolescence that I think would need to be addressed. Things like risk taking behaviour in general but there's always the alcohol and the drugs, and the sort of sexual things that are going on with young adolescents, and the emotional things. [...] Most psychiatric patients have their first admission in adolescence or in this age group (Jane. 1:7).

Tressider (1996, p.230) identifies that "depression and other mental health problems may first show up at adolescence and young people's reluctance to tell anyone may have disastrous consequences for themselves, their families and friends".

The young person's need for health services sometimes relates to risk taking behaviour. Coggan, Disley, Patterson and Norton (1997) identified that young people in New Zealand are engaging in high levels of risk taking behaviour. One participant identified that risk taking behaviours are related to pressures young people face. According to her they:

> Try to black out, forget the bad, forget they're not doing well at school, keep getting nagged by mum and dad and then engage in alcohol and then have unprotected sex. [...] The young men in that, [...], age group are under pressure to perform, like to be good at sport, to be a macho man, to be in control of your feelings or not having feelings and that's a real issue for them (Gill. 1:14).

Being aware of social issues facing young people.

Young people face many social issues that can have an effect on them. Some of the issues identified by this study relate to poverty, family relationships, and alcohol use.

> Some of them have no self-esteem, don't have good family relationships, not good mothers and fathers, some have been kicked out, some are on the streets (Jan. 1:23).

> Quite a lot come from pretty poor and not very well educated backgrounds, so that makes a difference in language, expectations and knowledge and things (Sandy. 1: 37).

Leaving school with no qualifications puts young people at risk of having poor health status (National Health Committee, 1998). This is a very real issue for Maori and Pacific Nations people. "In 1996, 39% of Maori and 27% of Pacific Nations students left school with no qualifications, compared with 14% of students from all other ethnic groups" (p.30).

On leaving school young people may become employed, seek housing independently from the family, and form their own families (Hill & Tisdall, 1997). In New Zealand in the 1990s young people feature disproportionately in the unemployment figures. "People aged 15 to 24 comprised 14.8% of the population in 1996 yet they made up 40% of people unemployed and actively seeking work" (National Health Committee, 1998, p.27).

Alcohol use and pregnancy are other social issues faced by young persons. A New Zealand study looking at a cohort of 16-year-olds found that alcohol misuse was associated with early onset of sexual intercourse and higher incidences of unprotected sex (Fergusson & Lynskey, 1996). Marilyn who works in a STD clinic often sees the impact of alcohol increasing the likelihood of the young person having unprotected sex.

> Or it may be that they have been to a party and drunk too much and they weren't too sure what had happened and wanted to make sure that everything is all right, we get that reasonably often (Marilyn. 1:14).

The National Health Committee (1998, p.77) identifies that "teenage pregnancy is associated with an increased risk of poor social, economic and health outcomes for both mother and child and leads frequently to intergenerational poverty". Perceiving teenage pregnancy as a problem associated with economic status came after the 1960s sexual revolution (Dixon & Baragwanath, 1998). Prior to this period teenage pregnancy was viewed as a moral issue related to premarital sex and illegitimacy. These authors identify that little research has been done in New Zealand on how adolescent mothers and their children fare.

The participants also recognised that some young people have many social issues and may "fall through the cracks" if too many agencies are dealing with the person's social problems.

> We did have an interesting fourteen year old in a few months ago who came in with a broken hand, broken bones in his hand. How he'd broken his hand was punching a [gang] member and missed him and got the wall, smashed his hand. He was intoxicated at the time so there's another issue, and he was expecting a second child. So there is a whole lot of social issues. [...] Apart from the fact we work very tightly in a multidisciplinary team within the hospital this boy was well known to CYPS (Children and Young Persons Service), so I guess one of the first things we do is get our social worker involved and then she investigates other agencies the young person's already plugged into. One of

> the problems can be when we try and actually get too many people involved. [...] Breakdowns in communication occur (Barbara. 1:7).

Recognising growing independence.

A major developmental task for young people is the development of their own identity (Heaven, 1994; Muuss, 1988). One manifestation of the young person's search for their identity is the issue of dependence versus independence. The degree of independence the young person achieves is dependent upon their own abilities and motivation and the parent's ability to let go (Taylor & Muller, 1995). The participants in this study identified that young people have changing needs in terms of family and friends being present during a visit or stay in a health care service. One participant who works in a hospital paediatric ward explained greater independence as being able to do more for themselves:

> They can do for themselves. They're sort of now independent, they just are, in meeting their daily living needs, say feeding, hygiene, basic activities of daily living. A ten year old up to a sixteen year old can feed, dress and keep themselves clean whereas younger than that, particularly the two, three, four year olds need much more guidance. And they also have very different peer relationships and different needs from their families as well (Sandy. 1:7).

When asked by the researcher to explain those different needs she responded with the following statement.

> [...] By the time they have reached the age of about ten or so they are much more able to verbalise for themselves what's important to them. And they are more independent in the world and they don't need a parent. [...] You'll get some children who are very self-possessed and quite independent and confident at ten and then you'll get others fifteen or sixteen who are not. And I think one of the things that is particularly important is the adolescent sense of self. I mean they are still, depending on their age of course, the younger end or the older end. Their family plays an integral part in their lives and they are an integral part of their family. But at a certain age the boundaries start to be

> pushed and adolescents can be quite stroppy and non-compliant. [...] I talk more to them as patients than to the parents whereas when they are younger I would talk at least as much to the parents (Sandy. 1:8-9).

Another participant identified the need for:

> Realising that adolescence is a time of, you know partly wanting parenting and partly pulling away from parenting (Gill. 1:5).

When nursing the young person the way in which the individual at times depends more on friends than family and vice versa needs to be acknowledged by the nurse. When faced with an illness the young person may have a harder time achieving independence from their family (Zeigler, 1995).

Awareness of client knowing/not knowing.

Participants described the level of knowledge about health issues by young people as limited and at times inaccurate. *Awareness of client knowing/not knowing* is about the nurse identifying the young person's lack of knowledge of body parts and functioning, not knowing how to protect themselves, or what a nursing procedure is for. As well, the source of information enhances or inhibits their level of knowing.

> And they don't know their body part names, a lot of them do not know the names for their body parts. [...] Who's going to tell them, I don't know where it comes from? Some of them don't go to school so they don't get it from school, some parents don't know themselves (Jan. 1:3).

Another participant put it this way.

> Generally a 15-year-old's knowledge base isn't that high and sometimes where they've got that knowledge from, the things they've learnt are a little bit inaccurate. So it's trying to work out what they've learnt and what they need to be taught or talked about. [...] It depends where they've got the information from. It may be things that they have read in a magazine or heard from friends.

> It's just a matter of working with what they do know and clarifying the right information and giving them more information if they need it (Marilyn. 1:3-4).

Awareness of client knowing/not knowing is also about the nurse finding out what the young person actually knows and to inform them if they do not know. This is in order to give them appropriate knowledge, particularly about normal body functions and what is happening to them in the context of their health issue. One participant in a hospital setting, nursing a young man with a broken leg, had this to say:

> Well I was explaining to a boy the other day why we do colour, warmth and movement, sensation observation of his foot and nobody had ever told him. He's been there about two weeks by that stage and so I said to him "do you know why we are doing this?" And he said "no". So I explained about, you know, the fracture and the fact that his nerve or blood supply could be damaged and that was why we had to do them quite frequently just when he had a new plaster on. Just in case there was pressure (Sandy. 1:23).

Being aware of the stressful situation for the young person.

Young people faced with health problems find life traumatic whether they are cared for in a hospital or community setting (Taylor & Muller, 1995). In this study the participants perceived a *stressful situation* for the young person as one that related to facing an event that negatively impacted on them:

> When you do a pregnancy test and it comes back positive. They are devastated, they are 14 or 15 years old (Jan. 1:24).

Another participant stated that young people did not like being in institutions.

> No young person likes being in an institution full stop. They are isolated, unfamiliar with their surroundings, threatening. Nothing but adults running around, it's scary (Alexis. 1:18).

For the young person the illness that brings them into a health service and thus the care of the nurse can be a frightening experience.

> Yeah, I'm just thinking – for the acute ones it's fear of the unknown and a lack of control and that sort of thing. For the longer term ones it's fear of the known which is quite different, but also they're in an institution, they're removed from society, normal society as we know it, and they have [pause] they may do quite a bit of their growing and developing in, within the hospital or at least [...], within the health services environment. [...] for them their issues are more, you have to think about their actual normal development and, them starting to make choices for themselves, then thinking about ongoing life issues as far as what they're going to do with their lives [...], relationships with family and friends and activities, physical activities and all those things, as far as we can, can keep them going while they're within the institution and support them while they're out there in the community in between times as well (Laura. 1:10).

In a study by Brydolf and Segesten (1996a, p.41) symptoms associated with the disease of ulcerative colitis "led to fear and were experienced as threatening". In another study of 13 to 17 year olds with diabetes, being insulin dependent posed a threat to their physical, psychological and social wellbeing. The study also found that there was a perceived threat to the young person's career and family choices (Kyngas & Barlow, 1995). Participants also reported the fear and threat to the young person's wellbeing when confronted with the experience of ill health. One role of the nurse is to help the client cope with this experience. One participant identified that hospitalisation could be more traumatic for the young person, due to lack of knowing about the illness and how to be, rather than the risky behaviour that they engaged in.

> I think the key role of the nurse is to be able to form a friendship with this person. Because I think their biggest problem when they come into hospital is fear, fear of everything, fear of having been taken away from the stability of alcohol oddly enough [what they know]. And then coming into a strange place where they don't really want to be because its better to be where you are than somewhere else unknown (Sue 1:10).

Another aspect of recognising the young person's needs is what participants identified as changing behaviour. When the young person is confronted with a serious health issue that puts them in a stressful situation, they may display behaviours that impede their progress. This relates to the illness and treatment interfering with normal patterns of growth and development.

> A lot of their needs are psychosocial needs. Like they're away from their peers, if they are hospitalised for say six months, like two months, a month and then again another month with small breaks at home. In between times they are missing their peers. [...] And although they catch up with their peers on the weekend that they have leave, the peers are really scared off by the enormity of the illness that their friend has. So there's a sense of isolation. That's a big issue, because from that isolation comes depression, comes non-compliance, comes anger, a huge amount of fear. They feel different, they feel not as accepted as they did before their illness. [...] It kind of manifests non-compliance and anger. They don't want their chemotherapy or they don't want their oral medication that they may have to take. One of the big issues is that they don't do their mouth care that's what I've found. It's because it is something that's not, it's not the norm. [...] They're supposed to do them up to four or five times a day. They come back with ulceration, they can't eat, they can't drink, you know, and that's part of their being in control. Everything is taken from them at an age when they are moving towards independence and that is, that lack of independence manifests itself in anger, and um, the deliberate non-compliance. I don't mean deliberate in the sense that [pause] I mean it's the only thing in a sense that they've got to hold onto, the control over their body (Amy. 2: 1-3).

Staff working with young people with cancer need to understand how to mange them because of the multiple issues that arise (Evans, 1993). Long (1985) contends that nurses' knowing about adolescent development and having awareness of their own values and beliefs is helpful for a therapeutic relationship between the nurse and the young person.

Being aware of socio-economic realities.

The participants were very aware of the impact of socio-economic factors on the young person's ability to have their health needs met. Being aware of socio-economic realities forms the category that came from the codes named, *knowing about young people accessing services and adapting to health reforms.*

Knowing about young people accessing services.

Availability of services is one determinant of access to health care for young people. In a review of health services for young people the CRHA (1995, p.5) identified that services for "drug and alcohol problems, mental health, sexual and reproductive health" are the top priority. They concluded that there were not enough services for young people in these identified areas.

According to the CRHA, 10-24 year olds are most likely to see their GP to have their health needs met, with 20-24 year olds being the highest users. They attributed the visits to short term illness, injury and need for contraception. Young people also visited chemists, dental services, and to a lesser degree, nurses.

The costs associated with paying for the service and travel to a distant location were barriers that the participants identified in the young person's ability to access a health service. Community based services were seen as increasing the access for the young person.

> The whole profile changes being out of the hospital. [...] Our place [adolescent unit] is really informal. They just come in. So that's non-threatening for them. We, I work for the CHE so we are contracted to the RHA [Regional Health Authority] so the services we provide are free to them [young people] (Tom. 1:4).

A participant who worked in a STD clinic explained that even if the service was free other barriers existed:

> And another big issue I find with this age group is the financial issue, and fortunately we provide a free service but accessing that service could sometimes be a problem for travelling. The school age children, it's being able to get out of school to access that service and for people who are in the work force generally their age group is new in a job and sometimes it would be difficult to take the time off (Marilyn. 1:2).

If money was perceived as an issue for the young person the participant often took this into account and included care for a health issue that was not specific to the speciality area.

> Sometimes it might be pregnancy and that's not sort of our speciality but if the money is a problem we have a talk to them (Marilyn. 1:14).

When the financial circumstances were seen to be a barrier for the young person the clinics had changed their policies so that nurses could ensure that treatments were given to the client.

> One of the biggest issues is non-compliance, that is not taking treatment. We have got around that by giving them treatment here. If we gave them prescriptions they would not always go, query lack of money to pay for them, and get the prescription filled. They don't have the money, they don't have the time and they don't have the transport. So non-compliance I suppose, that's probably one of the bigger issues, but we've got most of that covered now. We have the drugs in the cupboard, and we give it to them (Jan. 1:1-2).

A wide range of government policies and resourcing, as well as socio-economic factors, influence access to services and the availability of services for the young person. In recent years New Zealand has seen major changes to its health care system as a result of ongoing health reforms.

Adapting to health reforms.

Cuts to government spending were identified by the participants in this research as having an impact on the environment that they worked in. As well, they saw that cuts to services acted as a barrier to persons in the 10-24 year age group seeking health care. Since 1990 New Zealand has seen major reforms to the health care system with a move from a predominantly free public service to one of user pays. A key aspect of the move has been for a funding split between provider and purchaser (Bowie & Shirley, 1994). Health agencies are required to contract for their services from the Health Funding Authority which has come to mean a climate of reduced funding and one to three yearly service contracts. This effects the nurses' work in various ways.

> We have a three-year contract and it's just coming up to the end of the first year and we have been told to cut back because we are seeing too many patients. Because up until this year we saw 10,000 patients a year and they have told us we only have funding for 8,000. [...] Well they are meant to go to their GP's they have been told to go to their GP's. They are told they can go to Family Planning, they can go anywhere as long as we are not paying for it. *With the 10-24 year old would that act as a barrier?* Yes. Of course if patients just front up, we would see them. The nurses have been rapped over the knuckles because we have seen 28% more than we should have. It's bizarre, really bizarre (Jan. 1:19-20).

Another nurse spoke of sexual health services being reduced because of the decreased funding.

> We used to run a clinic up in [country town] but that got axed. *So where do they go now?* I think a few go to their GP for general conditions but if they need a specialist consultation then they have to make the trip (Marilyn. 1:12).

This may be an issue for high school students who may not wish to see the family doctor, or their family to know of their clinic visit. It can be difficult for the young person to get time off school or travel to a health professional without their parents knowing. The ability for the young person to visit a clinic in school time helps them to keep the visit private.

The health reforms have impacted on all sectors in New Zealand with some of the rural regions being particularly vulnerable to decreased specialist services. Health professionals, families and others in the Taranaki area are currently fighting to keep the Child and Adolescent Community Centre open. The closure has been attributed to financial constraints (Humphreys, 1998).

One participant in a second interview spoke about the changing age span for the work of the paediatrician in a smaller hospital.

> Since the first interview Jane spoke of how young people were now being treated in the paediatric area until they were much older. She stated that she thought this was due to a declining population in the geographical area. The idea that the medical profession was staking a claim in having their services maintained was given as another possibility (Field notes, 15/7/98).

Williams (1996) asserts that the restructuring has had a significant impact on the working environment of the nurse. Williams also claims that the loss of services, bed shortages, lack of suitably qualified staff and increased workloads have led to wide spread frustration with the reforms on the part of nurses.

Coming together: The health setting environment.

Coming together forms the basis for the health encounter between the nurse and the young person. The length of time involved, the setting, and the health concern(s) of the young person influence this health encounter. Community settings that the participants worked in included sexual health clinics, mental health services and one specific adolescent service. Hospital settings that participants worked in were medical, surgical, oncology adult wards or paediatric services. The codes for this category are *age confusion in organisations* and *ideal set-up.*

Age confusion in organisations.

The code *age confusion in organisations* refers to how health services designed to cater for adults or children lack a clearly defined rationale for a young person to move from one service to another. Many of the health settings in New Zealand fail to provide specific young person facilities. Only one specific young person's service run by nurses is accounted for in this study. The specific service for young people had a clearly defined age span.

> We are contracted to work from 11 to 25 years. We work within that age group. Within the schools we pick up some intermediate age, starting with like puberty (Tom. 1: 1).

Mostly the young person finds themselves either in adult care or paediatric care. In one community setting the participant identified the age range of her clients as:

> Our youngest is probably, well thirteen but it goes up to eighty-five (Jan. 1:1).

This means that the nurse needed to provide services and relate to a wide age group. When it came to distinguishing the age span for moving from a children's ward to an adult ward local practice seemed to be more the deciding factor.

> This is a paediatric ward going through from five to fifteen year olds, so once they reach their fifteenth birthday, they, they generally go to an adult ward (Barbara. 1:1).

> We've just started taking 10 to 16s. [...] We've done 16-24s and we get a huge number in that age group with their tonsillitis's and quinsies and so on. They are a fascinating group really interesting to nurse. But because of difficulty accessing paediatric beds we are now taking 10 and above. We've only started that in the last few weeks (Mary. 1:1).

> I worked in adult oncology, which included adolescents from fifteen up. But there were some adolescents in the ward who were younger than fifteen. If

> they needed a bone marrow transplant they were transferred to ward [number] (Amy. 1:1).

Assigning of the young person to a paediatric or adult ward may depend on several factors such as the treatment required, availability of beds and the doctor's preference. In a study by Burr (1993) some of the nurses and adolescents interviewed thought that the admission clerk made the decision based on the young person's size.

The participants in this study recognised the difficulties that arose when the service they worked for catered for mixed age groups. This is particularly true when age is used as a criterion in hospitals to decide if a young person is placed in the paediatric ward or an adult ward.

> All the young people have a lot of their friends, they can be coming in all day and if you're in a very mixed general ward it creates a lot of problems with the elderly people. Elderly people that you think were deaf suddenly can't stand the noise. I mean I'm nursing one boy at the moment who's sixteen and he's got a terrible skin condition. And so he's got all his friends in, he's playing his video games, he, he's driving the other patients mad. [...] All of a sudden Mrs So and So who you thought was terribly deaf, seems to hear his video games. *How do you manage this?* Well, it's very difficult, with great difficulty actually because, you know, you're sort of trying to meet their needs and you're trying to let Mr So and So or Mrs So and So, who's in another cubicle, sort of, you know, having their needs met. Its not easy because really there's no, there's no special place set aside for teenagers basically. *Right.* And I, I feel that they're a, they're a forgotten group in our hospital (Jane. 1:4-5).

In a hospital setting appealing to the young person's ability to reason was used to get them and their friends to be quieter and considerate of other patients needs.

> Well, if there are lots of them and they are really noisy we just have to go in and say "look please just consider the other people here and just keep the noise down". Or see if they would perhaps go and take over the playroom if there was nobody else in there (Sandy. 1:20).

> I say to them "your friends are ringing up all the time [using main ward phone], why don't you ring them?" Sometimes they will then use the card phone and ring them [friends] (Jane. 1:6).

Another factor when the young person is nursed in a service designed for another age group, is the inability to meet the young person's needs. A participant from an oncology ward saw that neither a children's or adult setting met the young person's needs.

> It's not appropriate in a children's ward, and its not actually appropriate in the adults ward, and I think, for nurses, we discussed it several times, that it was inappropriate. Like the whole arranging of cancer treatment for adolescents in hospitals isn't appropriate. [...] Adolescents keep strange hours and we know that, you know they kind of sleep in all day and they're up at night (Amy. 1:3).

Even when participants recognised the need for the young person to have their own space other factors prevented it happening.

> Unfortunately because the ward's so busy, I can't actually put one room aside for that. But I do believe that adolescents do have unique and individual needs and a general paediatric ward isn't ideal (Barbara. 1:12).

The wish of nurses to provide specific environments for young people was often outside their sphere of control as it usually meant changes in policy and had funding implications. Commenting on the British Health Service Burr (1993, p.13) concluded that "despite policies produced by governmental, professional and voluntary bodies, there was a marked lack of suitable provision for adolescents in hospital". Nurses in this study also identified the New Zealand scene as similar to that in Britain.

Ideal set-up.

Whether the nursing of the young person occurred in the community or in a hospital setting the participants identified a need to provide a suitable young person friendly

space. Those participants who worked in hospitals strongly distinguished the need for young people to have space that was specifically for them.

> Ideally either a place of their own or a room with [other patients of] their own age (Rachel. 1:3).

> They need their own space. They need a room. They virtually need a whole area for themselves where they can have all their video games and their noise and their friends. And just feel a bit more like a home because basically it is their home while they're in hospital. And some of our patients come in quite often, especially our cystic fibrosis [patients] (Jane. 1:5).

> I have always wanted to [make changes] here and never actually been able to pull it off. Have a room set up for adolescents where the environment is changed so that it's more user friendly. Just as far as posters go, maybe having music, a couple of armchairs, access to things that are age appropriate, stage appropriate (Barbara. 1:12).

One of the reasons for needing separate space was for the facilitation of friends visiting.

> If they had a door that led to the outside their friends could come in. That they didn't have to go through the ward. [...] It had a sitting area and it had a little bit of a kitchen as well. So that they could eat when they liked, because that was really important and socially eating with their friends is important. And eating Kentucky Fried and fast foods, like those sort of things because that's something that they really missed (Amy. 1:3).

According to Muller et al (1992) nurses in hospitals have a responsibility to make a suitable environment for the young person. Nurses should try to create an appropriate environment to allow adolescent development to progress. "This should offer privacy, somewhere for peer interaction, appropriate materials such as radios, mirrors, cosmetics, magazines, and games for groups (e.g. a pool table). A kitchen and opportunities to make drinks and snacks are recommended" (Muller et al, p.149). This

is further supported by a study in Britain that identified the need for hospitals to have specific units to meet the needs of the young person (Burr, 1993). In New Zealand it could be possible for specific units to be set up in larger hospitals, however funding cuts and lack of suitably qualified health professionals would be barriers to this occurring in the near future.

Conclusion.

This chapter has set out the factors that influence the nurse/young person encounter. The context has been identified in terms of those health issues that affect the young person, their life circumstances, and the provision of health services. The categories that came from the data included the nurses' recognising the needs of the young person, the nurse being aware of socio-economic realities and the coming together in the health setting.

The next chapter explains the work of the nurse from the perspective of the participants in this study.

Chapter Five.

The work of the nurse.

Introduction.

The Nursing Council of New Zealand (1995) states that nursing practice:

> Can occur in a variety of settings with individuals or groups. It refers to a nurse helping people to meet their health needs through a purposeful relationship and use of professional knowledge and skills in accordance with her/his qualifications as a registered or enrolled nurse (p.10).

In any setting or with a particular group the nurse adapts her way of working to meet the individual person's needs. Christensen (1988, p.95) states that "the work of the nurse is shaped by the nature of nursing's specialised assistance and the ability of the individual nurse to select appropriate nursing strategies to ease the path of the patient through the experience". The participants identified the work they did in their endeavours to meet the young person's health needs. The codes and categories that relate to the work of the nurse are identified in Table 2.

Table 2. The work of the nurse.

Being competent. Having knowledge of growth and development. Being able to assess. Knowing the situation. Having people skills. Knowing your job.
Being supportive. Acknowledging the client's rights. Involving the client in care. Going the extra mile. Recognising an advocate role. Teaching the client. Multidisciplinary approach.

Being competent.

The WHO (1996, p.4) states that a nurse "requires competence to develop and perform functions that promote and maintain health as well as prevent ill-health". As identified in this study 'being competent' implies that the nurse has a level of knowledge and skill that enables her to meet the needs of the client. Benner (1984) identified the following five levels of competence for nurses.

1. Clinical practice for the novice depends on rules which guide practice as nurses have no experience with the situations in which they are required to perform.

2. The advanced beginner does have some experience of situations but needs guidance with prioritising as they cannot reliably identify what is most important in a given situation.
3. The competent practitioner usually has two to three years' experience and is able to cope with and manage many aspects of clinical nursing. However the competent nurse is not able to work as speedily or as flexibly as may be required in the situation.
4. The proficient nurse is able to see a situation holistically and is therefore able to hone in on the client's problem more easily.
5. Benner identifies the expert as someone who is not reliant on rules or guidelines to correctly identify the situation and act appropriately. The expert nurse has an intuitive grasp of situations and quickly identifies and responds to the situation.
With experience the nurse gains competence in her nursing practise (Macleod, 1996).

In relation to the work of the nurse with the 10-24 year old client, codes identified in the study included: *having knowledge of the stage of growth and development, being able to assess, knowing the situation, having people skills, knowing your job.* These codes form the category I call 'being competent'.

Having knowledge of growth and development.

In order for nurses to give competent care it is necessary for them to have an understanding of normal growth and development patterns for the stage of development of the client. This understanding enable the client's needs to be met appropriately (Benner & Wrubel, 1989; Frederick & Reining, 1995). Similarly Bourgeois (1989) and Drake (1996), writing about the needs of pregnant adolescents, assert that nurses need to determine the stage of growth and development of the young person before planning interventions. This is to ensure the success of those interventions.

Having *knowledge of growth and development* was identified by the participants in this study as a fundamental aspect of working with clients, in particular when working with young people.

> I think that, having a knowledge of the developmental tasks of adolescents is crucial, to give them good care (Barbara. 1:1).

Knowing normal growth and development patterns enables nurses to better understand how illness or risk behaviours of young people impact on the normal processes of maintaining health.

> Your nursing skills hinge on your understanding of the adolescent, where they are at at the time, like around puberty for example. [...] A young male going through puberty and who's hospitalised or has cancer for example. It's a critical time for them because they're coming to terms, not only with their own, physical growth and their changes in hormones and their change in body which is their physical growth, and their mentality is changing and the emphasis is going from their parents to the peer group, and then, [...], there's a bit in the middle where they've got to have chemotherapy or they've got to have some sort of cancer treatment and it means it's all interrupted, all their, their processes all interrupted for them, and it sends like their hormones into (pause) chaos and then, [...] and delays some of the growth, you know, the physical. *Right.* And that for, for a lot of adolescents that's a really big trauma (Amy. 2:3).

Knowledge of growth and development enables the nurse to help the young person to adjust to the experience of hospitalisation.

> A child is adjusting to who it is and what it is and what it's doing here. They don't know themselves where the separation from you and themselves is, so this is really the paediatric nurse's job, is to help them through this transition of becoming adults, if you like, and guiding them because they are often misunderstood for themselves. [...] but a child can waver into who am I, what am I doing here, how did this happen and why etc, etc and we, as paediatric nurses, needed to guide them through them being able to tell us what their problem was both psychologically, physically, mentally and how they were going to fit back in home after all that had happened (Sue. 1:5).

Participants spoke of the illness experience sometimes leading to the young person regressing to an earlier stage of growth and development at a time when they are becoming more responsible for themselves.

> In their everyday lives they're just starting to take more responsibility and I think accepting the consequences of the decisions they make is a huge thing for adolescents. And we see that really well illustrated with their reaction to health care. Often they're managing quite nicely in their lives and then something goes wrong and they just give up, it's that regression thing really (Mary. 1:6).

Knowledge of growth and development enables the nurse to provide appropriate care. This can mean recognising that the person's health behaviours will not change if the nurse does not take into account the cognitive and emotional level of the client. Elkind (1984) contends that by understanding how the young person thinks nurses are able to be more effective educators and counsellors. The following story is an example from a participant working in a STD clinic who reflected on missing this point with one young girl.

> I give you an example if you like about a wee girl who I had who was 13. She came in here because she thought she might have something [STD]. I took care of her and we talked about what she should do to keep herself safe cause she might get pregnant. That was fine, so yes she was going to do all this and she went away and came back with the same thing, she didn't have anything, but she thought she might because she had unprotected sex. So I went over the condoms again and gave her the condoms and said "Make sure you use these condoms, make sure your partner uses these condoms because you might get pregnant, you're not on anything". And you know, is this what you want to do, the whole bit. Her choice, she could say no. So she went away, and she came back again and I said to her "Now you remember what I told you about using condoms", and she said "Yes". "Well did your partner use the condoms", she said, "I don't know", and I said "what do you mean you don't know". "Well it's in the dark. I don't see what he does. It's in the back seat of a car". So there's no relationship at all it's, was just bonking. [...] In the back of the car without any love, respect, care. Because I said to her you could help him put it

> on if you wanted, it could make it better and she just got all shy when I said that to her, it wasn't even a relationship. She was 13. Just 13, and we were expecting too much from her (Jan. 1:25).

Being able to assess.

Assessment is a vital aspect of the nurses' work and it is essential for the nurse to develop assessment skills in order to surface the underlying health concern and understand the young person's circumstances. The participants in this study reported that history taking, observation and spending time were all methods used to gain information on the client's state of wellbeing.

History taking means gathering as much information as possible from the client in order to determine the problem and plan appropriate interventions. A nurse working in a sexual health clinic identified the range of data needed.

> When they come in to see us, we take a general history. First of all we just ask what they've come in for and then we go through a general history, a medical history, a history of sexually transmitted diseases, a gynaecological history, past partners, condom use. We also go through smoking, drinking to assess whether they drank and whether or not they had safe sex practices or use of drugs, blood transfusions, any tattoos, any history of abuse (Marilyn. 1:3).

Nurses also need to ask the young person who will give them support to deal with the current health concern. From the findings of a study looking at social support and coping in adolescents with cancer, Nichols (1995, p.239) recommends that "There is a need to assess those persons in the adolescent's social network who may be available to provide specific support for the adolescents".

As one nurse put it assessing the client was not only about history taking but also about observation.

> Paediatric nurses have to observe and this observing is not necessarily talking, it's using your eyes, hearing [...]. The adult will tell you what's wrong with

> them whereas a child often won't tell you but it will tell its mate or something like that. So there's more observation, more in-depth observation (Sue. 1:4).

Since nursing was first recognised as a profession by Florence Nightingale, observation has been recognised as important skill for the nurse.

> In dwelling upon the vital importance of *sound* observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort (Nightingale, 1969, p.125).

The ability to assess provides the means so that the nurse "adjusts her nursing to the moment-by-moment circumstances of the patient in a way that an unqualified person cannot do" (Christensen, 1988, p.227).

Knowing the situation.

Knowing the situation means taking into account all the factors that affect the client's health and wellbeing. Participants in this study recognised that young people are often reticent about giving others personal information for a variety of reasons and the nurse needed to be aware of this. One participant identified the need for the nurse to get to know the client so that she could know what was happening:

> And you have to be able to read them well too, you know, like you read the signs and symptoms because they don't often volunteer information. *So your observation?* Yeah, and you know things before they actually happen, you know, but, and I think that it's for the nurse to get to know the patient really well, really well, because there will be things that they won't say. Because sometimes like, with this lad, he was bleeding and he wouldn't say he was bleeding because he felt that if he was bleeding he wasn't going to be able to go home and yet he knew that he'd be scared to go home because he was bleeding. So he was caught in a dilemma (Amy. 1:21).

Knowing the situation may be jeopardised when staff is unfamiliar with the area of work and the clients. One participant identified that when nurses are new to an area they may act without taking the client's situation into account.

> Somebody new on the ward had given him his blood results. Now that's not uncommon, *right,* but if that person, the nurse who had given them had known more about the situation in the case, or had conferred with others, she'd never have given out those blood results, because he was coming in the next day anyway (Amy. 1:13).

Knowing the situation entails a deeper level of assessment by the nurse to uncover what is going on for the young person. Anticipating the needs of the person is part of knowing the situation, as is acting on that knowledge. One study identified that knowing the patient involved two aspects; knowing the person and knowing the patients' typical pattern of response (Tanner, Benner, Chesla & Gordon, 1993). The participants of this study support knowing the person. In order to know the young person the nurse needs to spend time with them.

> Spending more time with them, not just playing but finding out what's going on. And what they need and things like that because they are all so individual (Laura. 1:5).

Having people skills.

This involves the nurse having skills and life experience that enables her to work in ways that take into account the whole situation of the client's health experience. This is described well by Mary in the following story.

> I had a very sad case, only just last week, of a young man who tried to hang himself and the rope broke. He had to spend a couple of days in ICU and then came to us. One of my nurses looking after him, who is quite a mature young lady with a bit of life experience and who's not 12 months out yet from graduation. She looked after him and she was, we were trying to pull together who was going to look after him now. He had nowhere to live, that was one of

> the things that had precipitated the suicide attempt. The relationship had broken up, he had no family, no friends here. So there were all the issues of was he still a risk and he'd been assessed by the 'psych' team as 'no he wasn't' and he could go home now. ENT wise we were finished with him and he was past the worst of that so off you go. But where do you go and who is going to look after him, who's going to give him the support, who's going to teach him the skills to get through this. And we'd had various different agencies involved that had been arranged through the psych team while he was in ICU. None of which appeared to be particularly useful to him really, and this young staff nurse did some thinking and got on the phone and got our social worker over and between the two of them they sussed out somewhere for him to live. And she said, "he really doesn't need an ENT follow up, but we're going to lose track of him if he doesn't have one. Can we make up some reason for him to come back". She was thinking outside the box, she was thinking this guy is going and yes we found somewhere for him to live but he's going to be alone and isolated in that place, all the factors that precipitated the attempt are still present. No one out there is going to pick him up because he is 'low risk'. [break in tape] How could she arrange it so that there was somewhere, some link, he still felt connected. He'd obviously been quite comfortable with the care she had given him on the ward and over the few days he was with us he'd come out of himself quite a lot and was responding quite well. And so we negotiated with the ENT registrar that there would be just a physical check up on him so that we could keep tabs and see where he was at. When he'd gone I just had a chat with this nurse and said you know "well what was it that made you start heading along those lines?" And it was just her little extra bit of life experience that had enabled her to kick in where he was at (Mary. 1:26-27).

Research by Radwin (1995) identified that the nurse who took account of the client's life issues as well as understanding the meaning of the illness for the client was able to develop broader strategies for meeting the person's needs.

Knowing your job.

Knowing your job involves gaining experience and maintaining competence through continuing your own education. For the participants knowing your job relates to the learning that takes place in the practice setting.

> Most of those things are taught on the job. There's no sexual health training with the nurses in New Zealand at the moment so when the nurses begin at sexual health they attend a cervical screening course through Family Planning. And the rest of the training is on the job by a charge nurse and by doctors as well. It's sort of an ongoing training so we do an intense three weeks orientation at the beginning and every second Friday morning the whole clinical staff get together for in-service training. We continually have that on different subjects to up our skills (Marilyn. 1:6).

Knowledge of the job related to gaining experience. Macdonald (1982) defines experience as:

> Practical acquaintance with any matter gained by trial: long and varied observation, personal or general: wisdom derived from the changes and trials of life: the passing through any event or course of events by which one is affected: an event so passed through: anything received by the mind as sensation, perception, or knowledge. – *v.t.* to have practical acquaintance with: to prove or know by use: to have experience of: to suffer, undergo. *Adj.* **experienced**, taught by experience: having much experience: skilful: wise (p.460).

Experience gives nurses increased knowledge and competence specific to their areas of work. Maintaining competence meant that the nurses in this study took the opportunities to keep updated in their area of practice. As well many were involved in tertiary study.

> It has just occurred to me that there appears to be a common factor about ongoing education. As I set up or interview the participants something is usually said about their involvement in further education. They all talk of

> either doing University study or keeping up-skilled through inservice, conferences or specialist courses (Field notes, 16/5/97).

Keeping abreast of the knowledge in the practice setting consisted of inservice education and attending conferences.

> We have inservice twice a month, and we have a clinic meeting monthly, that's the four Thursdays of the month. We have all the STD, sexual health disease magazines, articles sent from the library. We attend conferences, we have a special interest group for sexual health nurses at New Zealand Nurses Organisation (Jan. 1: 12-13).

University study was a path for nurses to gain further qualifications. Four of the participants in this study had a Masters degree or were working towards one.

> I'm doing an MA in Nursing (Amy. 1:1)

> I'm in the Masters programme (Sandy. 1.1).

Most of the participant's ongoing education related to nursing theory and clinical related topics rather than specific focus on working with the 10-24 year old client.

According to the Ministerial Taskforce on Nursing (1998, p.57) "there are 500 nurses enrolled in master's degrees and about 20 enrolled at PhD level" in New Zealand at present. Many other registered nurses are either graduating with a bachelors degree or are in the process of completing one through a polytechnic or university. The changes within the health sector have been a factor in the changing nursing roles and creating a need for higher qualifications (Ministerial Taskforce on Nursing, 1998).

Many of the participants had both clinical practice experience and post graduate education, and this may be a factor related to their interest in participating in this research. Higher education was perceived by some participants to have a benefit beyond their immediate work situation.

> I think it's wonderful. I mean if I hadn't gone to [University], it was expensive, but I just found that it gave me so many fishhooks into other areas of nursing. You know I got into quite a few different things, it's given me a different slant on life and it's what I need (Jane. 1:8).

It is not known if this perception of higher education being beneficial translates to improved care of the young person. One study reported that one third of the respondents did not see the need for postbasic education despite limited inclusion of adolescent health in their initial programmes (Hinks et al, 1988). In contrast a more recent study by Hogston (1995) found that nurses perceived ongoing professional education as beneficial in improving the care they gave to clients. A review of the literature by Wood (1998, p.130) found that it "is difficult to prove that CPE [continuing professional education] programmes have a direct bearing on the quality of care delivered to patients".

Being supportive.

Macdonald (1982) defines support as:

> To bear the weight of: to hold up: to endure: to sustain: to make good: to uphold: to back up: to second: to contend for: to represent in acting: to supply with means of living: to nourish: to strengthen. – *n.* act or fact of supporting or upholding: that which, or one who, supports, sustains or maintains (p.1357).

For this study, being supportive encompasses those things the nurse does to meet the young person's health needs. Included are those acts that give social support, and emotional and physical support. Being supportive means that the nurse acts in ways that enhance the clients' wellbeing. Participants in this study described ways of working with young people that involved *acknowledging the clients' rights, involving the client in care, going the extra mile, recognising an advocate role, teaching the client* and involvement in a *multidisciplinary approach.* These codes form the category named 'being supportive' and each code will be discussed in the next section.

Acknowledging the clients' rights.

Johnstone (1994, p.211) states that client rights are a sub category of human rights, and declarations of rights for clients are "merely statements about particular moral interests that a person might have in health care contexts and that require special protection when a person assumes the role of a patient or client". Client's rights include the right to health care, the right to be fully informed, the right to have involvement in decisions about their treatment and care, the right to refuse treatment and the right to confidentiality. Middleton (1997) contends that many nurses find the concept of children's rights confusing. He attributes this to beliefs about children and governments failing to recognise child rights.

The participants acknowledged that young people have rights when it comes to making decisions and consenting to care and linked the acknowledging of the clients' rights to seeing them as individuals.

> They are people in their own right, they have a right to make decisions and consent in certain matters (Sandy. 1:12).

> The ability to recognise them as individuals and let them take control. [...] they are fully aware of what's going on and what is happening to their body. They're actually in some ways able to make choices, um, but haven't got the legal right to do that and they can feel out of control (Laura. 1: 2-3).

In order to work safely with young people the nurse needs to be aware of the legal status of clients. Under New Zealand law a "person is a minor or child at law until the age of 20, or earlier marriage" (Perry, O'Donnell, Clyne & Johnson 1995, p.110). When it comes to consenting to or refusing treatment 16 years is taken as the age when young people have the legal ability to make their own choice about having medical or surgical procedures. In New Zealand the Guardianship Act 1968 gives the parents or guardian the authority to consent for the minor except for abortion when a girl under 16 can give her own consent (Bouchier, 1997).

Involving the client in care.

The participants believed that involving the client in their own care helped the young person to have some control over what was happening to them. This meant that nurses intervened in ways that gave responsibility back to the client. One participant described it as:

> The older ones who come in with their tonsillitis and don't want an injection but don't want PR [per rectum] pain relief either, and they can't swallow it so they'll just lie there and be miserable until we [the nurses] point out that that's not part of the deal, and they've actually come to be treated and this is what it involves. And just sort of putting the responsibility back on them. So "OK here's your Diflam gargle and you've got a watch and every two hours you need to do this for yourself if you want to get out of here and get well", and they do it (Mary. 1:5).

The participants used a variety of techniques to help the young person manage their fears of the unknown and the health problem.

> I would do things like massage, very gentle massage, and I would do things like teaching them meditation and visualisations, so they could actually see themselves getting better and a lot of them did. Occasionally we had one who died, you know, but a lot of them didn't. But that was giving them control over their own bodies again and, like, using different visualisations like, for some guys, for example they were really into war and really into the lets shoot those bastards down, you know, that's how they used to express it, and used to imagine, you know, that they had an army inside them and every time they visualised them, the cancer cell, they'd shoot it down, you know, but for the women, the young women, for example, they used to use light or butterflies (Amy. 1: 18).

Treating the young person as an adult and giving them a sense of control and responsibility was a strategy used by the participants when working with the young person.

Going the extra mile.

Nurses sometimes go out of their way to give something, or to do a little extra for the young person, so that a difference is made to the client's experience.

> This fifteen-year-old lad just loved Guns and Roses, and bringing it, [pause] like, you go the extra mile, you see something and you know that they are going to like it. A Guns and Roses poster or something they can put up in their room (Amy. 1:25).

When nurses recognised that the person they were caring for had no or limited social support the nurse would often extend their care to supporting the young person to attend another agency.

> The other day we had a young woman who wanted to terminate [the pregnancy]. I don't know what the entire issue was, she ended having to go up to the hospital for D & C and you know one of our nurses, because she didn't have anyone, went up [...] And that meant a lot to that young person, she wasn't alone, that she had someone up there who she knew who she trusted to be with her (Tom. 1:16).

Recognising an advocate role.

Robertson Green (1993) identified one role of nurses as that of advocate. Macdonald (1982, p.18) defines advocate as "an intercessor or defender: one who pleads the cause of another". In a review of the literature Mallik (1997, p.130) identified themes relating to nurses as advocates, these included the view that "nurses are in the best position in the health care team" to advocate and "nurses have the knowledge to advocate".

This study supports the notion of the nurse having a voice that can be expressed to gain improvements in the health of young people.

> Nurses never want to lose sight of that advocacy role because adolescents can't speak themselves. And there's whole papers coming out on youth suicide,

> masses of it. And I don't believe they are actually addressing the issues, yeah, the whole sexuality is a whole issue that's not being addressed. [...] We need to have input into those papers don't we, and act as advocates because the young people can't do it themselves. They don't get given the papers to look at and even then they are written in a language, are they really interested. The language would turn you off (Gill. 1:21).

Poindexter (1992, p.76) claims that "Individuals cannot contribute to society if they do not receive support to develop healthy minds and bodies". According to her nurses in community settings have had to develop knowledge and skills in "advocacy and coalition-building" (p.72). This means having knowledge of the issues and working strategically to bring about changes.

Participants identified working closely with others for the benefit of the young people as important. However networking tended to be informally instigated by particular individuals.

> We sort of pride ourselves on having a good network of what's happening in our town, and referring them onto someone who is going to be user friendly for them [the young person]. *How do you keep up with the network?* We tap I think because we are out in the community, we get around quite a bit and have our own informal networks. [...] There is a group in the community that is [name] youth collective, so they're a mixture of government agencies and community based agencies that work with young people. We are a member of that so we tend to tap into that. They send us updates but I would like to see a more formal setting of the youth base with the CHE (Tom. 1: 16).

Teaching the client.

Teaching is an accepted part of nurses' clinical role but some nurses may have education as their key role. No participants in this study were educators although all undertook teaching as part of their client care.

> I'm not officially an educator. That's not my title by any means but we do it in conjunction with the clinical aspect (Jan. 1:4).

In chapter four the need for the nurse to be aware of the young persons *knowing/not knowing* about their health issue, body function or what was to happen to them when in terms of tests and procedures was identified. To address the young person's knowledge deficit or to increase their awareness of health issues, the nurse takes on the role of teacher. The participants in this study identified as important the need to take every opportunity to teach the young person and/or their friends about health issues. The nurse was seen as needing to be open to address their concerns. Young people may be shy about seeking health information or talking about their health issue despite wanting the information. Armstrong (1995) states that:

> Teens are curious about a large number of personal health concerns and have many questions. They talk a lot among themselves and are very interested in receiving health information. However, they are often very sensitive about asking professionals questions about health issues (p.562).

Teaching the client entails giving them explanations about their health problems and the necessary procedures and treatments that the person will have. As well, informing clients helps to put them at ease and enable them to make informed choices. The participants in this study recognised the need to put their clients at ease so that they could inform and treat them. One way this was achieved was by giving them facts about the health issue.

> One of the things we do with them is if they have things like warts we always tell them the statistics, like that 1 in 4 New Zealanders have warts. They go like (sigh) and say really? Really 1 in 4? [...], or if they have got herpes it's 1 in 5. It's important that they don't feel isolated (Jan. 1:12).

Another way of putting the client at ease is to explain procedures and treatments to the person so they understand what is or may happen to them.

> [Explaining] the effects of the drugs. Telling them this will make you sick. We will endeavour to minimise that, but it will make you sick (Amy. 1:14).

Nurses use a variety of methods to get the information across. Explaining what the nurse is going to do, pamphlets, visual aids and playing with the equipment are some modes that are useful for teaching the young person.

> Often drawings and diagrams, visual aids can help adolescents understand what's happening with them (Barbara. 1:4).

> We have these wonderful Barbie dolls. We open them up, show them where, what's coming out and what's going in. Letting them [the young person] put in drips and drains on the doll. All sots of things like that, they are able to do (Laura. 1:13).

Another participant adapted the setting to be more user friendly. In the classroom the participant reported:

> We straightaway do not use desks and tables. We try not to do any writing and stuff so that they don't switch off. We try and get them to switch onto us as much as possible. We try and get them doing interactive work, pens and paper like drawing groups, in small groups. Getting them working using icebreakers. Basically getting them to do the work, just facilitating (Tom. 1:9).

Teaching the client is about giving information and supporting the young person so that they can make informed health choices. Taylor and Muller (1995) assert that nurses need to understand the psychosocial influences that affect the young person in order to be an effective health promoter.

Multidisciplinary approach.

Participants working in hospital settings recognised that they were part of a team working together for the benefit of the client.

> The occupational therapist, the physiotherapist, the nurses, the social workers, it's a team. This is not an individual person, this is teamwork. Like I said when I did psychiatry in [psychiatric unit] we used to have weekly team talks about specific patients (Sue. 1:11).

Nurses work with other health professionals, community agencies and schools in order for their clients' needs to be met. The nurses see networking and referring to other organisations as an important part of their supportive role. Likewise the nurse's unique contribution may be recognised by others who refer young people to them.

> We run clinics out in [region] and in the [rural town] and we also try and liase as closely as possible with the nurses in schools. Generally most of our referrals will come from guidance counsellors and it's good if we can get our clients to build up a good relationship with their guidance counsellors. Often that will be an area of referrals, someone we can refer back to (Marilyn. 1:3).

Conclusion

This chapter has set out the components of the nurses' work involved in assisting clients through a health experience. The work of the nurse was identified by two categories. Nurses developed their competence through their knowledge of growth and development, ability to assess their people skills and knowing their job. Support was given to clients through the nurses' acknowledgement of the clients' rights, involving the client in their own care, the teaching role, giving care and working with other health professionals. 'Being competent' and 'being supportive', although essential to the practice of nursing, in themselves do not ensure that appropriate care is given to the young person. Further data is presented in the next chapter to explain the elements that determine how the nurse enhances the wellbeing of the young person when working with them.

Chapter Six.

'Having Attitude': Nurses' perceptions of the qualities and skills needed to successfully nurse the 10-24 year old client.

Introduction.

The previous two chapters have described the background factors and ways that nurses' work with their clients. This chapter discusses the nurses' perceptions of how they make a difference when caring for the young person. In order for the young person to have their health needs met in a way that empowers them to stay engaged in the relationship or return for subsequent care the nurse has to demonstrate more than competent or supportive care. From the data the core category that I have called '*having attitude*' emerged. Macdonald (1982, p.82) defines attitude, as a "posture or position: [...] any condition of things or relation of persons viewed as expressing some thought, feeling, etc". For this study attitude means that the nurse works in ways that enable her to *be acceptable to* the young person and be able to negotiate the *balancing of the dependence/independence needs* of the client. It is the essence of the successful young person/nurse encounter according to this study. Table 3 identifies the codes and categories that relate to '*having attitude*'.

Table 3. 'Having Attitude'.

Balancing the dependence/independence needs of the young person. With family. Involving the family in the young person's care. Enabling the young person to see they have choices. With Peers. Acknowledging the peer as supporter. Educating the peers.
Being acceptable. Developing rapport. A non-judgmental nursing approach.

The participants in this study distinguish how the relationship is hindered or enhanced by the nurses' interactions with the young person. 'Having attitude' permits a therapeutic relationship and increases the likelihood of the young person being accepted as themselves and being empowered to make their own health choices. A therapeutic relationship has been described as being:

> [...] characterized by empathy and trust and facilitates the achievement of clearly and mutually identified patient-oriented outcome goals. Empowerment of both the patient and the professional is possible within a truly therapeutic relationship. Professional boundaries are maintained (McAliley, Lambert, Ashenberg, & Dull, 1996, p.199).

This chapter sets out to explain what '*having attitude*' involves and the importance of this for meeting the young person's health needs.

Balancing the dependence/independence needs of the young person with family.

This study has identified that *balancing the dependence/independence needs* of the young person is an essential aspect of '*having attitude*'. Balancing involves the act of weighing up the options in order to have equilibrium. For the nurse working with the young person, this means recognising their need for independence whilst acknowledging the family and peer relationship to the client. This element will be discussed in terms of how nurses help the young person negotiate family relationships and relationships with their peers.

Several studies have identified the influence of, and importance of, family to the young person (Frydenberg, 1997; Gray, 1988; Heaven, 1994). In a study by Youniss and Smoller (1985) the authors found that the parent–child bond was important to the young person even though they were pushing for greater independence.

> The exploration and testing of individuality, however, occurs in the context of a continuing relationship with parents and family. The process seems credible in light of the broader sociological context that includes these elements: adolescents live at home and are dependent on parents; and parents do not see society as benign, but think they have to help their sons and daughters combat society's traps and find a course toward a successful future (Youniss & Smoller, 1985, p.141).

The participants identified the importance of family in terms of the issue of dependence versus independence for the young person. Young people are moving from childhood to adulthood and according to Russell, Reinhold and Maltby (1996) for parents this transition means the relinquishing of responsibility to their child. When working with a young person the nurse has a role to play in assisting them to manage changes in family relationships.

Nurses help the young person to negotiate family relationships by taking into account the *dependence versus independence* issues of their client within the context of the stage of growth and development and societal expectations for young people. In this study it comprises firstly the nurse *involving the family in the young person's care* and secondly the nurse enabling *the young person to see they have choices.*

Involving the family in the young person's care.

The participants in this study identified the greater independence of the young person than a child e.g. not needing parents to be around for all the time a young person is in hospital or attending clinic appointments. One nurse put it this way:

> Well, we really encourage the parents of younger kids to stay because they are more settled and they do better. And their parents know them better than we do and know their daily routine and the things that are special to them, whereas by the time they have reached the age of about 10 or so they are much more able to verbalise for themselves what's important to them. And they are more independent in the world and they don't need a parent. Occasionally we will have a child who for some reason a parent wants to stay and that's fine or the child wants the parent to stay but that's often associated with pain and acute trauma (Sandy. 1:7-8).

Family support has been identified as being needed in an ongoing way by the young person experiencing a chronic illness or terminal illness. A study by Brydolf and Segesten (1996a, 1996b) identified the need for nurses to meet with family members as an important factor in assisting the young person. These meetings enable family members to cope with the illness experience of one family member. Russell et al (1996), when looking at cystic fibrosis patients moving to adult health services, suggested that it was beneficial to involve the parents in the care of the young person.

Involving the family in the client's care means the nurse needs to balance the issues of dependence versus independence of the young person. Each family situation is unique and the nurse cannot assume the family will be supportive of the young person. With this in mind it is therefore necessary for nurses to check out with the young person if

they want family involved or not. When working with young people nurses make judgements about how much the family is involved in the care of their client.

> I think they also like to get a choice about who gets told what, and it gets a bit tricky when you've got a demanding assertive stroppy mother who wants to know the nth detail of everything. Particularly if the child, young person's over sixteen, and I think, yes if my sixteen year old was in hospital I would feel I need that knowledge if they were still living under my roof, but then it becomes a bit debatable. Whose information is it and who has the right to it and I guess that's where the skill comes in again, pointing out to them that in order to sort of help them recover mum probably should have this information. [...] try and counsel them into realising how important it is and let them give the information. And refer the parent back to the child. "So you want to know what this surgery was for well how about you ask him" and "he'll tell you what he wants you to know. And he may not be ready to tell you at all yet, but give him a bit of space and he might". That sort of approach, so it comes back to nursing the parents or the support people as well (Mary. 1:12).

In response to my question "Tell me a bit about how you manage family relationships?" one participant put it as follows:

> Because you are not only nursing the adolescent, you're nursing the brother and the sister and the mother and the father, you know all the rest. That takes time, and we were lucky in ward [...] that there were built in times for sitting with people. [pause] I would talk to the families, sometimes it was the mother on her own, sometimes the father because they had issues about the other children at home, you know about them not getting enough quality time, about them feeling left out, that the one in hospital got everything, you know from Kentucky Fried to whatever it was in the moment really, and sometimes it was quite expensive stuff. Into giving them time, validating them that was a really important thing and that, um, assisting them through, because they're so deeply involved in it they can't pull themselves back out. You know, like helping them to see that the behaviour that was being displayed at a given time was just a manifestation of anger (Amy. 2:10).

Enabling the young person to see they have choices.

In the context of this study enabling the young person to see they have choices means *acknowledging the young person's rights, maintaining confidentiality* and *allowing independence.*

Hanson and Boyd (1996) describe a case study that shows that the nurse acts as advocate to enable the young person to make informed choices. This involves giving the individual the necessary information, both positive and negative realities of the situation, assessing and enabling family support. Nurses in a study by Robertson Green (1993) "recounted how they frequently acted as an advocate or mediator for the child with the parents" (p.93). This mediation role is supported by the participants in this study who reported withholding information from the parent, especially in the area of sexual health, in order to maintain the young person's right to privacy and right to make their own decisions about health care.

> We pretty much have a general rule that we don't devolve any information whatsoever to anyone except our clients and that goes for anyone across the board but generally there's more of a problem in that area and it is hard for the parents to get used to the idea that we're not going to give them any information about whether they've been there or what they were in for, what their results are (Marilyn. 1:2).

Parents will respond to this practice in different ways, as one of the participants described:

> Parents do get nasty. Some are, some are really good and understand but others say "well you know, she should have to suffer like I did, if she gets pregnant at 14 well too bad". [...] we try, we listen. I generally let them go and listen and then explain that we can't say anything, and I talk about things in very general terms but never ever talk about their child. [...] some parents [...] the adolescents 16,17, they want to know everything and there's others whose child is 14 and they just say 'oh well, that's good'. 'Good on you for doing it' (Gill. 1:8-9).

The need to maintain confidentiality has been recognised as important since the inception of modern nursing.

> And remember every nurse should be one who is to be depended upon, in other words capable of being a "confidential" nurse. She does not know how soon she may find herself placed in such a situation; she must be no gossip, no vain talker; she should never answer questions about her sick except to those who have a right to ask them; (Nightingale, 1969, p.125).

Nurses sometimes intervened to ensure that parents did not "over protect" their child. According to Brydolf and Segesten (1996a) overprotection by parents leads to children not trying and not taking responsibility for themselves.

> Sometimes they need you more to take their side and to sort of be more with them. I'm just thinking about a boy the other week, he simply wanted to go to the toilet on the toilet chair but he really expected me to lug him across the bed and into the chair but I pretended I didn't realise that's what he wanted. He didn't actually say it but he kept saying "I can't do this" and I sort of was really encouraging. And his mother was I could tell by some of her comments "Oh it's too hard in all this" and she was sort of wringing her hands. [...] (After he got himself on chair) I said to his mum quietly "I know it looked a bit mean but I think its been really important for him to get his head round it" and she sort of nodded [...] I remember thinking I think we could have handled it differently but I think we got the best results (Sandy. 1:30).

A key role of the nurse is to assist the young person to see that they have choices. One participant put this aspect into the context of the power relationship that exists between the young person and the nurse and the need to consider this when working with the young person.

> The skills you need are to be able to get alongside the adolescent so you're not, like at loggerheads, and also to try to reduce the power differential. Because you're always going to have that power differential, you're always the nurse and the older person. And bearing in mind that I'm older than a lot of their

> parents, but they don't perhaps see that. So getting alongside them and trying to reduce that power differential, and trying not to tell them what to do. Trying to offer them the choices, "these are the choices, these are some of the choices you've got". So that they actually get to make the decisions themselves. Cause often they don't see they have a choice. So helping them see that there are other ways of doing things (Gill. 1:3).
>
> Saying things to them like "well is it more difficult to tell mum that you are pregnant, or is it more difficult to ask her if you can go on the pill". "What's going to be easier?" Just giving them some alternatives (Gill. 1: 2).

This enabling the young person to see they have choices helps them negotiate the family relationships.

Balancing the dependence/independence needs of the young person with peers.

Peers have a significant influence on the young person's social development (Gray, 1988; Heaven, 1994). It is through the social support of the peer group and close friendships that the young person achieves the developmental tasks related to becoming an adult (Cotterell, 1996). Friends play an important role in the young person's transition to adulthood by supporting their social and cognitive development (Hartup, 1993). One key task of adolescence is seen as the formation of an identity i.e. a sense of who one is and what one is going to do in life (Muuss, 1988). Identity formation is an important precursor to developing intimate adult relationships (Erikson, 1980). Peers help the young person develop a healthy personality by helping them to cope with their changing bodies and changing worlds.

> Adolescents help one another temporarily through such discomfort by forming cliques and by stereotyping themselves, their ideals, and their enemies (Erikson, 1980, p.98).

Peer support was identified in this study as being of value for the young person dealing with a chronic illness.

> They develop very, very close friendships and were a support to each other, um, particularly the adolescents with chronic illness that were coming back time and time again. Chronic asthmatics, cystics, um, the oncology adolescent (Barbara. 1:14).

The nurses also recognise that the young person did not have to have a chronic illness for peer support to be seen as important. Peers supported their friends in many ways.

Peers play an important role in the young person's attempts to develop their own identity. Erikson (1980) states that young people over identify with a particular clique as a means for the young people to defend themselves against a sense of identity confusion. Peer groups help the young person decrease their dependency on their families by providing a supportive alternative that enables them to explore their own values and beliefs. The values and norms of the peer group assist the young person to see another perspective while developing their own values and attitudes (Hendry et al, 1993).

Friendships tend to be viewed as committed and having equality (Hartup, 1993). Young people see good friends as those who are companions, are affirming of them, and in whom they can share intimate confidences. These relationships have a give and take nature to them (Cotterell, 1996; Gray, 1988; Heaven, 1994).

Nurses who recognise the importance of friends to the young person enable the young person's transition through the life stage as well as their ability to cope with the health issue. A study by Kyngas, Hentinen and Barlow (1998) identified that young people with an illness were more able to care for themselves when they had the encouragement and understanding of friends. The participants recognised the importance of friends for the young person and acknowledged their significance in very practical ways supporting the ideas of Kyngas et al. The modes of balancing the dependence/independence needs in relation to peers relate to *acknowledging the peer as supporter, advocating contact* and *educating the peers*.

Acknowledging the peer as supporter.

When the young person seeks help without the parent being present the friend acts as a support. As expressed by the participants, friends often play an important part in the young person's coming forward for advice or care. Accepting this practice was important for building a healthy relationship between the nurse and the young person.

> Not many young people come in by themselves, especially the first time, so usually they come in twos, or threes or fours so um, not freaking out when there's a whole group come in and want to have a talk and not just taking one of them. You actually bring the whole group of them (Tom. 1:5).

When trust was established the young person would then come without their friends. As the young person becomes more developmentally mature and is taking more responsibility for themselves, they tend to come without the support of friends.

> *And does that change a bit as they get older?* I think it does and it also changes a bit when they get to know the service so as they feel more familiar with it, their friends may drop off, or their friends are coming individually, but not together (Tom. 1:5).

Hospitalisation or serious illness can impact negatively on the young person's social supports. These experiences can be quite isolating for the young person. This was how one participant described peer support.

> The adolescents that I have seen have really missed their friends, and I think as nurses, we need to encourage the peer visiting because that's what supports them. If they don't get, because very often their friends come and visit them once or twice, they get freaked out by the smell of the place, by old people being there, you know, nurses always being around, and they wouldn't come back again. Like it was too scary for them. Like they had to face their own mortality, you know, and the young person with cancer had to, and their friends had to do that too, and that was something, because we know that adolescents believe in this, this is never going to happen to me. [...] Therefore they were

> left isolated very often and, we used to try and encourage their friends and ring them and ask them to come and visit (Amy. 1:4).

Balancing the needs for peer support in the hospital setting amid the constraints of mixed aged wards often meant the nurse had to act as gatekeeper as well as supporter.

> Sometimes you do just have to become the policeman and say "right, enough of this everybody out". But usually it's explaining that there are other sick people here, that they have some rights as well, and that the prime reason for people being in hospital is to get well and we need to be able to give them the space to do that. Giving them some alternatives you know. "How about a couple of you stay and the others go off and have a coffee and then come back later" (Mary. 1:14-15).

Another aspect of balancing the dependence/independence needs is that a friend may be the young person's only source of support during hospitalisation or a clinic visit. The nurse acknowledges the peer as supporter through having them be with their friend and by involving them in some of the direct care. One participant described involving the friend in the care as follows:

> I had a classic the other day of a youngster come in, she was eighteen actually, but appeared to be functioning at a level of about a fourteen year old. Absolutely petrified of having her tonsils out. Didn't have a parent around. An auntie came at one stage and disappeared again, but her support was um, another teenager a couple of years younger who'd taken the day off college to come and be with this girl. So I talked about that, and then I just got on and involved her. [...] But I got this youngster on board and had her doing thing things like checking the pulse and this sort of thing so I was doing some health education at the same time and she actually came all the way up to theatre with us and then disappeared off and came back later in the evening apparently, [...] I was accepting the friend being there as a support and was happy to involve her and I checked with the patient herself all the way, "do you want your friend to come with us to theatre", that sort of thing, so she was involved (Mary. 1:7-8).

Educating the peers.

The third aspect of involving the peers is that the nurse takes the opportunity to educate the friends as well as the client. This happens by explaining what is going on for the person with the disruption to health as well as answering questions the young person has about health related issues.

> You might go in and see 3 or 4 friends sat around the bed and they might ask you all sorts of stuff. Yeah I haven't got a problem with that sort of thing with them. I might say now you can expect them to be a bit twitchy and hyperactive for a day or so. And you know they will laugh their heads off (Sandy.1:27).

These issues may or may not be connected to the health concern of the client.

> A picture pops into my mind of a delightful group of young men who, can't remember what the chap was in with now, but I remember he had some real macho mates who were going to be there and they were going to be in on everything. And I ended up checking all their blood pressures. And we talked about stress and personalities, and relaxation therapy. A big discussion on hypertension because one of the young men did actually have quite high blood pressure. So we talked about that and I pointed out to him that a one off recording in this sort of environment wasn't accurate but suggested to him that it might be useful for him to go and see his doctor. [...] And we got onto testicular examination, a biggie of mine talking, and whether their mates are there for their tonsils or what they usually end up with brochures of something to take away. It is just seizing the moment (Mary.1:21).

Kiger (1995) contends that health teaching is a key nursing role and it is an integrated aspect of the nurses' work. Whenever nurses are caring for clients teaching is taking place. The nurses in this study identified the need to take any opportunity to educate the client and their friends about any health topic the young person had an interest in.

Being acceptable.

Being acceptable is related to the nurse's ability to work successfully with the young person; to respect them and to act in ways that gives the young person choice. Positive outcomes are perceived by nurses to occur when the nurse is able to get alongside her client. In order to get alongside the young person the nurse embraces an ability for *developing rapport* and a *non-judgemental nursing approach.* These categories form the basis for *being acceptable.*

Developing rapport.

The category named *developing rapport* comes from the codes identified as *being a reliable person, making them feel comfortable, using appropriate language, explaining the process, allowing them to express themselves, using humour, offering a bit of friendship* and *talking about what interests them.*

According to the International Council of Nurses (ICN) (1997, p.73), health services for young people need to "be based on trust, acceptance and genuine understanding of their perceptions, concerns and needs". The need for the young person to trust the nurse was also identified in this study. One participant described it as follows:

> I think that rapport is basically a trust thing and certainly the clients that I see have often had quite a few different people working with them, coming in and out, often people who have let them down so being a reliable person to them. *So what does that mean, being reliable to them?* I guess, those things doing what you say, keeping. I mean if you are working within the realms of confidentiality for that client, keep it confidential and you are not blurting it to their parents and others about this person. And those are the things I would establish working with a young person before we even start sort of going anywhere (Alexis. 1:2).

> They lose their trust, you know, like if you let them down or you divulge a confidence (Amy. 1:28).

> I think there has to be commitment on the part of nurses to make the time. And I think it has to come from an enormous sense of compassion, and by compassion I don't just mean empathy, or suffering with, as the word means suffering with somebody but I think it also means advocacy, and a seeking for justice and I don't know if that has got anything to do with this but that's my perception of what drives me to be with a person. Like they need an advocate. They need to have justice and their behaviours at times manifests itself as anger and it pushes people away but as a nurse I have to see through that and I have to look at things like body language. You know, and look for cues, and look for hesitancies and that sense of helplessness that the adolescent has. And its compassion that enables me to see through it and work with it (Amy. 1: 5).

The nurses' own values and beliefs that are brought to the professional relationship influence how the nurse interacts with the young person. Young people are often reticent about seeking help (Stott, 1983). A negative attitude on the part of a nurse may mean that a young person does not seek further health care (Armstrong, 1995). The nurse therefore needs to be aware of her own attitudes, beliefs and behaviours before attempting health education or developing a therapeutic relationship with young people (Long, 1985).

Non-judgemental nursing approach.

This means *listening, accepting, getting down to their own level, using specific adolescent language, thinking like they think, respecting their space, respecting where they're at, let them initiate stuff, respect as human beings.*

Being non-judgemental means that the nurse has to be seen to accept the young person for who they are, acknowledge them as a person in their own right.

> Able to relate to them really, and not treat them like your children. Not totally treat them as adults but somewhere in between, *right*, being able to sort of listen to them and talk things through with them. [...] I think you probably need communication and being able to put yourself on their level. Non-judgemental. Not like as you're an adult or maybe you're their parent but treat

> them on their own level. [...] Not necessarily the same kind of language but sort of being on their wavelength (Rachel. 1:2).

Another said it was about acknowledging their action in making an appropriate choice to seek health care.

> I think, just treating the young person as an individual, really what they came for if anything is, I always acknowledge them for coming, say its really great that they could come here and talk about it, for anyone it takes a lot of courage to just walk through the door and ask for help. So, you know just saying to the young person, you know its really good that you've come here to talk about this, and try and make them feel comfortable (Tom. 1:4-5).

Being non-judgemental is about the nurse seeing the person not the behaviour, and this is an important element of *being acceptable.* Treating the young person as a person involves identifying negative or at risk behaviour without making judgements or condoning the behaviours.

> I think you have to be careful with the younger people, put them in cotton wool, a little gentle with them a bit more. The older ones know that they've, their words, "been silly", but the younger ones it's part of their life and you have to be gentle with them because you can lose them very quickly and they won't come and if you appear to be in authority or be judgmental, shake your finger at them (figuratively) "You've been a naughty person" they would never come back, they would never come back, they would never go anywhere again. You need to be much more gentle with them and sometimes you just want to take them and say it's okay, especially when you do a pregnancy test and it comes back positive, they are devastated, they are 14 or 15 years old. What would I do if I was 14, I didn't even know about sex then (Jan. 1:24).

> Treating them for who they are, [...] I mean they might be sexually very promiscuous or they might have very bad habits that you know, I or the nurse might perceive as 'come on this is shocking'. If this was my kid I'd give them a good kick up the bum or something like that. But you've got to forget all that

> and just treat them, that young person for where they're at in coming in (Tom. 1:25).

When the nurse does an assessment of a young person they need to ensure that they are not making judgements of the person based on the opinions of other people who have had dealings with the young person.

> You go in and see a young person, you see them as a new face. You need to start your assessment there not judging on what others have, because quite often what others see is quite inappropriate especially if the referral is coming from the parent and quite often the young person will feel that you are coming in to side with the parent and I let the young person know right then and there, which is all part of the trust and building a relationship/rapport that you are in fact there for them not for the parent (Alexis. 1:4).

Participants identified how the presenting emotion or behaviour of the young person was often not the real issue. Therefore the nurse needed the ability to look past the presenting conduct of the client.

> They say that "this food tastes like shit, get it out of my sight", which is chuck it, you know, you just say "well things taste a bit shitty today", and just saying "you're not feeling too well today" or knowing that there's something else behind what they are doing. *Right.* You know that very often it's not, it's not the behaviour that they're presenting, you know, that's the problem, it's something else, and that takes a bit of skill and, you know, kind of understanding for them to entrust, for them to be able to surface that, and if they think that you can take the shit, they'll also trust you (Amy. 1:27).

Negative behaviours may also be part of testing the boundaries, seeing how the nurse will react.

> They'll try you out, they'll push your boundaries and challenge you to the "nth". Just to see how far they can trust you (Amy. 1: 26).

Kuykendall (1981) states that staff may be "met with hostile, aggressive or regressive, withdrawn behaviour" as a result of the young person being in an unnatural, fearful setting. Good communication skills and taking account of the psychosocial needs have been identified as the way for the nurse to get alongside the young person when these behaviours are displayed (Farrelly, 1994; Gillies, 1992; Long, 1985).

According to Long (1985) adolescents are averse to advice giving and negative comments about their friends or behaviours. She states that the nurse helps the young person gain insight into their behaviours by more suggestive comments such as "You mentioned that friend several times. It always seems like you and he get into trouble when you're together" (p.24).

The model: 'Having Attitude': Nurses' perceptions of the qualities and skills needed to successfully nurse the 10-24 year old client.

This section sets out to explain the model (figure 1). The nurse/young person relationship develops when the client seeks health care, and ends when the health need is met or the young person exits from the relationship through death or they become an adult and move to adult status within the health system. This encounter may be for a few minutes or be long term. The study participants believe that when the nurse does not work in a way that enhances the young person's wellbeing, the young person may have difficulty in trusting the nurse, and therefore may opt out of seeking the help required. The model offers a description, from the perspective of the nurse, of the knowledge, qualities and skills needed to successfully nurse the 10-24 year old client.

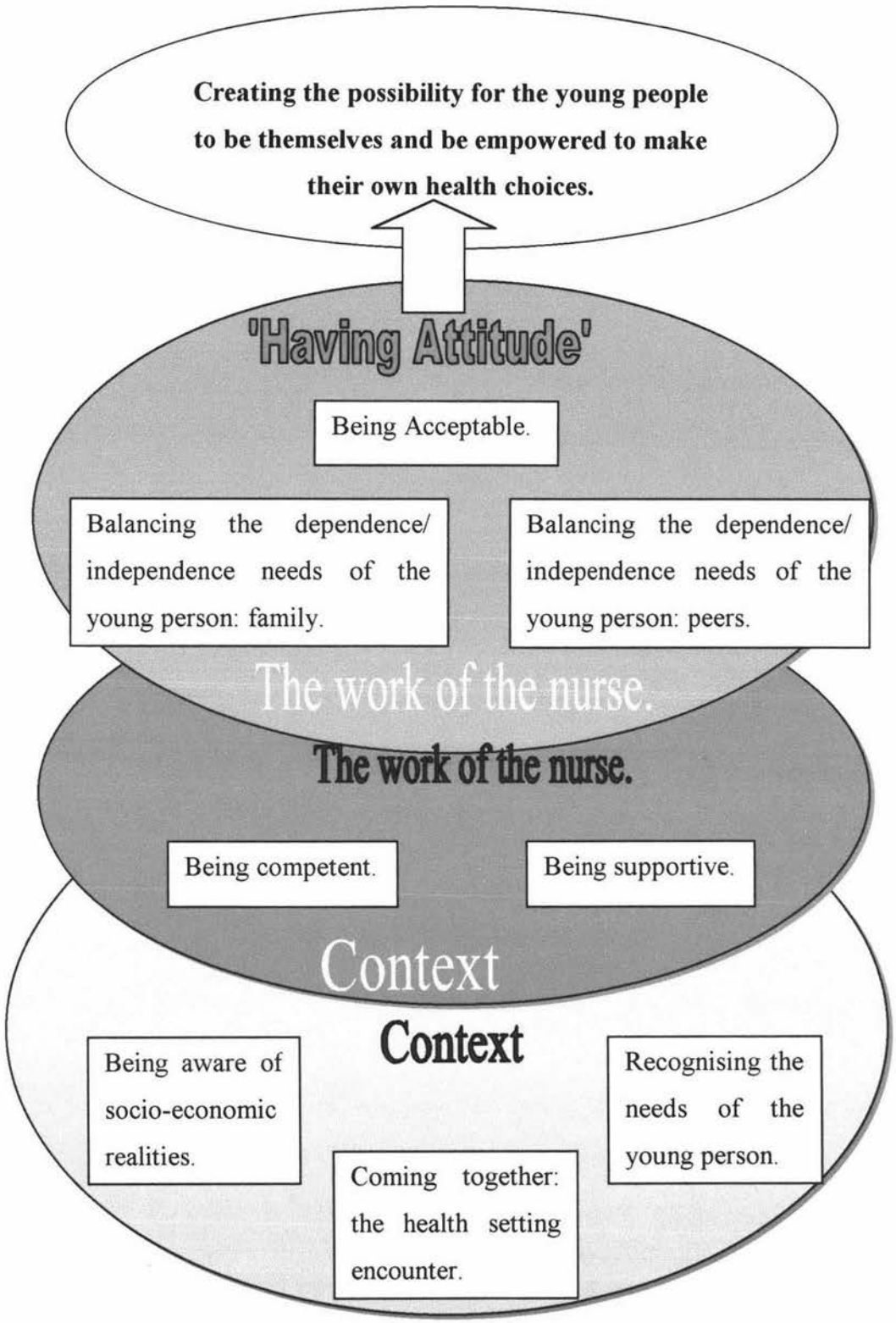

Figure 1. The model. 'Having Attitude': Nurses' perceptions of qualities and skills needed to successfully nurse the 10-24 year old client.

Meaning of the model.

Care of the client takes place within the context of the individual's life situation, the health care system and the political, sociocultural influences of the society. The model consists of three levels that are interrelated. The first level represents the context that influences the nurse/client encounter. The second level is representative of the work of the nurse and the final level explains the core category that represents what makes a successful interaction when nursing the young person.

The context includes all those factors that have an impact on the nurse, the young person and the environment in which they relate with each other. It includes the stage of growth and development of the young person, the health issues young people are confronted with, and the social issues that are part of living in New Zealand in the 1990s. The context affects the work of the nurse by creating the situation in which the day to day practice of the nurse occurs.

Level two relates to the work of the nurse. *Being competent* and *being supportive* are the ways nurses practice in order to meet the health needs of clients. The context influences the work of the nurse through the type of health issues the nurse deals with, the constraints on practice related to organisational factors and shortfalls in funding. It is at this phase of working with the young person that the nurse has the potential to be effective in meeting not only the presenting health issue but also the young person's developmental needs. If the experience is negative for the young person they may exit from the encounter and may not seek help from health services in the future.

The participants' perceptions were that the core category identified in the third level made a difference to the health outcomes of the young person. '*Having attitude*' enables the nurse to be acceptable to the young person. The nurse also works in ways that take account of the young person's needs for dependence and independence. This is done through treating the client as a person, by not judging them and developing a rapport that ensures the young person's confidentiality. When the nurse has attitude she creates the possibility for the young person to feel accepted for who they are, and for them to make their own health choices. It is at this level that a difference can be found from the work of the nurse with other age groups. The nurse often takes action

to involve the client's peers through assisting them to support their friend and taking the opportunities to give them all health education. This is done whether the family is supportive or not.

Conclusion.

The aspect of the nurse's work enabling a successful outcome when working with young people was identified in this chapter by the way the nurse ensured her acceptability to the client and how she balanced the dependence/independence needs of the young person with both family and peers. The core category identified as 'having attitude' is the essence that links the categories together and forms the basis for the model.

Chapter seven discusses the importance of this research for the health of young people, nurses working with young people and nursing education. The limitations of the study and suggestions for further research are also addressed.

Chapter Seven.

Discussion.

Introduction.

This research set out to identify the qualities, knowledge, skills and attitudes needed to successfully nurse persons aged 10-24, and to describe how nursing was different for this age group. This study offers a fresh approach to the nursing of the young person. It looks at nursing in a variety of contexts and finds a common thread that shapes what is essential to the work of the nurse with the young person i.e. 'having attitude'. This chapter discusses the findings that emerged out of the analysis of the data, and includes a discussion of the inferences drawn from the research, importance of the study, limitations of the study and suggestions for future research. The implications and importance of this research will be discussed in relation to the ideas formed from the model.

Being successful.

The study did identify what nurses' saw as the qualities, skills, knowledge and attitudes needed to successfully nurse the young person. The study identified that nurses required knowledge of growth and development, knowledge of the health and social issues young people face as well as an understanding of the socio-political environment in which they worked. Expert practice with the 10-24 year old client was unable to be determined from the data. In order to get alongside the young person the nurse had to have the ability to develop rapport and to be non-judgemental.

Providing a therapeutic environment.

It is the contention of this research that how the nurse relates to the client makes a difference to the young person's experience. From the perspective of the participants in this study, seeing the young person as an individual who can make choices for

themselves is important. The finding of this study is that, 'having attitude' makes possible the therapeutic environment that enables the young person to make informed choices about their health. In another study, Williams (1998, p.810) found that "therapeutically effective nursing care was found to occur when 'therapeutically conducive relationships' existed between nurses and patients". The question arises whether the nurse can develop 'having attitude', or is it inherent in some nurses?

Both personal and professional experiences have an influence on the nurse's attitudes. In order for the nurse to fully understand what is happening for the young person, she needs to have some life experience as well as knowledge gained through education. The nurses perceived that life experience gave them a broader understanding of the factors impacting on the services they worked for, a deeper understanding of human nature, and an ability to be with the young person despite the behaviour being exhibited by the young person. Part of this life experience is gained from nursing; most of the participants had over five years of practice, and part from experiences faced in one's personal life. 'Having attitude' can be likened to being client focussed. The nurses did focus their care towards the young person's needs, however the concept is broader than client focussed care. It involves the nurse accepting the young person as unique, and facilitating their individual developmental and health needs. It involves making judgements that may at times be seen by others as not in the client's best interest. The compromise between involving or not involving family and peers may create a situation whereby the client or significant others are at odds with the nurse. This can arise when the nurse protects the client by not divulging information to a parent, who may get angry with the nurse. Likewise if the nurse considers it is in the client's best interest to inform a parent about some aspect of care, she runs the risk of losing the young person's trust.

The nurse must want to work with the young person in order to build a therapeutic relationship. The nurse needs to be non-judgemental and have the people skills that enable good communication with clients and others. Can the skills needed for 'having attitude' be taught? Attitudes have three components, beliefs, feelings and behaviours. Wood and Schwass (1993, p.7) contend that "an attitude involving a complex number of beliefs is harder to change. Similarly, it is more difficult to change an attitude which a person holds with intense feeling". Curricula in bachelor of nursing

programmes include communication skills and cultural safety courses. The aim of the courses is to have nurse graduates who work in ways that enhance the wellbeing of others. These courses are designed for the nursing student to develop effective communication skills and to be non-judgmental. Cultural safety courses enable the student to look at their own thoughts, feelings and behaviours in relation to those who are different from them (Joyce, 1996; Ramsden, 1993). Whether the teaching of these programmes is effective has not been fully evaluated. Joyce however identifies that students who demonstrate unsafe attitudes are more likely to be identified and therefore not meet the clinical competencies to pass.

For the registered nurse the opportunity to learn to "have attitude" has no clear pathway. This study did not explore how the participants learnt "to have attitude" and therefore no conclusion can be made about it either being learnt or inherent. Professionally those nurses who reflect on their practice are able to increase their understanding of what is happening for the client, also how what they do impacts the situation and can improve their practice as a result (Emden, 1991). Part of this reflection needs to relate to how the nurse interacted with the client. What judgements did the nurse make about the young person? What actions did the nurse take to ensure the young person's privacy? How did the nurse involve the family and peers? These are all questions the nurse working with the young person needs to reflect on in order to be effective in her practice. Dickinson and Lowe (1996) identify the importance of nurses reflecting on their practice in order to advocate and provide excellent paediatric nursing care. They state that:

> This process (reflective practice) relates to how nurses can begin to transform oppressive situations for both the nurse and the patient into visibly positive situations in a thoughtful, caring and holistic way (p.8).

Provision of services.

According to WHO (1989) health care systems do not provide adequately for the health needs of young people. Services are mainly designed to meet specific child and adult health needs. The question arises as to how best the young person's health needs can be met within a health system undergoing rapid reform and cost cutting. The

participants in this study supported the notion that nurses were appropriate professionals to address the health needs of young people, because they have knowledge of growth and development, the health issues and social pressures young people face. The opportunity nurses have to be creative in their delivery of health care is partly tied to funding issues and the invisibility of nurses' contribution in many health settings can lead to cuts of nursing personnel. Clark (1997) identified that the nursing profession has the knowledge and skill base to address many of the issues facing young people and sees the challenge in terms of skilled nursing.

> And the paradox here is that the more skillful the nurse is in what he/she does, the less likely the observer or even the patient will be to recognize exactly what the nurse has done. We know from our own experience, from what patients tell us and now from rigorously conducted research that good nursing makes a difference to people's health and wellbeing and that in the multidisciplinary activity of health care, skilled nursing has a particular contribution to make but we are not yet very precise about exactly what difference and to what. This makes nursing very vulnerable to the kind of inappropriate substitution that sees nurses as too expensive and easily replaceable by other cheaper health workers (Clark, 1997, p.147).

In New Zealand the lack of specific services for young people highlights the need for those nurses who care for young people in any setting to have the appropriate knowledge, skill and attitude. This is necessary to create the possibility of the young person being accepted for who they are and being empowered to make their own health choices. New Zealand is not the only country that fails to provide specific health services for the young person. Research carried out in England found that hospitals placed the young person, with an acute physical illness, in either a paediatric or adult ward (Burr, 1993). This has been validated in this research project by the nurses who spoke of the difficulties of accommodating the needs of the young person in a setting designed for a different age group.

As young people do not fit neatly into adult or paediatric health services, and it is not always appropriate to have specific young person units, then it is important that their developmental stage is taken into account in the provision of health care. Burr (1993)

makes the comment that nurses in children's wards were more aware of the needs of adolescents than those nurses in adult wards. My research has not shown this difference which could be because the nurses I interviewed were all interested in this age group. The participants spoke of the need to balance the young person's needs with those of others attending the service (see chapter four). Nurses need to create environments that are conducive to meeting the young person's needs such as privacy and peer contact.

Changing family relationships.

Balancing the dependence/independence needs of the young person was identified as an important aspect of the nurses' care and should always be foremost in the nurses' relationship with the young person. The idea that balancing the young person's need for dependence/independence be considered by the nurse, is supported by Klein et al (1992) who contend that adolescents should:

> Be encouraged to involve their families in health decisions whenever possible; however, when such involvement is not in the best interest of the adolescent or when parental involvement may prevent the adolescent from seeking care, confidentiality must be assured (p.168).

This study identified how the nurse working with the young person may play the role of facilitator for the young person to negotiate their family relationships. Nurses working with young people ought to have an understanding of the increasing demands on family relationships. According to Kurtt and Budreau (1997):

> The lives of children and families have become significantly more complicated, busier and riskier. Family life is increasingly challenged by the demands of parents' work, children's extracurricular activities, and the lure of interests and opportunities outside the family (p.254).

The participants' perceptions are that the nurse has the skills to assess the support needs of the young person and that they should be acting to assist the client and family in this. This assessment of support, especially when the nurse will have a continuing

interaction with the client due to the nature of their illness may require assessment of the family functioning. This is supported by Brydolf and Segesten (1996b) whose study identified the importance of the nurse assessing family functioning when the young person has a chronic illness. This enables the nurse to determine the type of support network the client can expect. Lynam (1995, p.124) states that "it is necessary that nurses assess the ways in which families do the work associated with cancer in a young adult member and if necessary become involved in enabling family members to address the issues of concern". Family centred nursing is seen to be the best way to nurse children and young people (Manchester, 1997; Smith, 1995; Whyte, 1994).

The participants identified that often the young people that they cared for did not have supportive families. The nurse working with the young person should not assume that the support will come from the family or that the young person wants family support. Therefore the nurse needs to determine whom else of the client's friends or other adults will be supportive. Brydolf and Segesten (1996a, 1996b) also identified the role of the nurse in facilitating other support when the family support was insufficient.

Importance for the wellbeing of the young person.

Nurses working with young people must be cognisant of the issues that may result in the young person requiring nursing. Young people face many challenges on their way to adulthood. From the findings in this study the factors influencing the health outcomes of young people in New Zealand are similar to those overseas. In the World Health Report 1998 the WHO identified that for young people:

> The transition from childhood to adulthood will be marked for many in the coming years by such deadly "rites of passage" as violence, delinquency, drugs, alcohol, motor accidents and sexual hazards such as HIV and other sexually transmitted diseases. Those growing up in poor urban areas are more likely to be most at risk (WHO, 1998, p.3).

The Ministry of Health (1997) identifies that young males are at high risk of death or injury in motor vehicle accidents and feature highly in the suicide statistics. The

Ministry further identifies that "Maori are over-represented in road crashes by comparison with non-Maori" (Ministry of Health, 1997, p.116). Major health issues facing young people are related to mental and emotional health, having a healthy lifestyle and reducing risk behaviour (McMurray, 1999). It was the perception of the nurses in this study that the broad health issues facing young people were as important as the presenting problem, and had to be considered when the nurse was attending to the client's needs.

The New Zealand Government has identified six goals to improve the health of young people. These relate to reducing substance use, reducing pregnancy and STDs and enhancing road safety behaviours (Ministry of Health, 1997). If the needs of young people in New Zealand are to be met, including the Ministry goals, then special attention and funding have to go into specific services for young people. The health status of young people is tied up with their overall position in society, and their ability to access services. Therefore, nurses working with young people need to be politically active. This means speaking out about the issues they see, becoming involved in policy making, writing submissions in response to discussion papers relating to the health and wellbeing of the young person. Keeping informed and networking assists the nurse to be politically active.

Importance for nursing practice.

Clinical practice.

MacLeod (1994, p.361) states that "the need for a deeper understanding of the nature of everyday nursing practice has never been greater". Her rationale for making this assertion is the drive for more cost effective and efficient nursing services. My research offers the practitioner an insight into the everyday work of the nurse with the young person. If the health needs of young people are to be met nurses working with young people need to understand the every day practice that ensures the young persons health needs and developmental needs are met.

As described by the participants the significance of the peer relationship to the client is important. Nurses working with young people therefore need to acknowledge this and actively encourage the young person to maintain contact with their friends. Having friends be there at the consultation or treatment if the young person wants this. In a hospital setting allowing friends to visit especially in the evenings. Also the nurse needs to support the young person's friends to be with the client, especially when facing a major illness.

Some nursing care of the young person occurs in 'one stop shops' specifically set up to meet the young person's health needs, however most nurses in New Zealand come into contact with the young person in ether an adult or children's service. Therefore it is important that the allocation of clients is carefully handled to ensure the young person has a nurse caring for them that understands their particular needs. This can be said to be true for all age groups, however the participants identified that the young person who feels judged and not trusted will exit from receiving care or seeking future help.

For the successful care of the young person the nurse has the client as the focus of care, reflects on her practice and eases the situation for the client. The role of advocate is important and the balancing of the young person's dependence/independence needs essential.

Health education.

The education role of the nurse is often executed when carrying out other care such as giving medication to a particular client (Kiger, 1995). This is not necessarily true when working with young people. The participants in this research explained how they used every opportunity to not only teach the young person who was their client but also their friends. According to Foster (1988, p.91) "clients demonstrate greater participation in their care when nurses broaden the educational scope and include the client's family and significant others".

From the findings of this study the participants identified that nurses had the necessary knowledge and skill to provide health promotion for young people. Whether other sectors of the community see this may be open to debate. A factor preventing others

from seeing the health promotion role of nursing may relate to the invisibility of the nurse's work.

An assumption is made that health promotion will lead to improved health status for the targeted group, in terms of this study the young person. The nurses in this research recognised the importance of addressing the social factors as well as the health issue. Raeburn and Beaglehole (1989) who recognised the need to address social disadvantage through putting into practice the Ottawa Charter principles of advocacy, healthy public policy and working in partnership support this. Nurses need to include young people in any policy development and health promotion activities.

Importance for nursing education.

In order to meet the New Zealand Government's objectives for the health of young people nursing education needs to ensure that undergraduate curricula include components on the health of young people and the nursing care of those in this age group. The findings of this study raise the importance of nurses not only knowing about specific health issues but also about the need to relate appropriately to the person.

A survey of health care providers in the United States of America identified that the participants considered they had a lack of skills in routine aspects of development and prevention to care for young people. In particular nurses reported a deficiency in their education related to "dealing with sexual orientation concerns, behaviour problems (delinquency and drug use), and depression" (Blum & Bearinger, 1990, p.290). The survey also found that most continuing education for health professionals in regard to the health of young people focused on the more publicised issues such as pregnancy.

Nursing education is in a position to provide advanced education in nursing the 10-24 year old client for those working with or wanting to work with young people. However it is debatable as to how viable these courses would be as few nurses work solely with the 10-24 year old client. It is also unlikely in a climate of reduced funding that employers would fund staff to attend a specific course on nursing the young

person. Distance learning may be a more viable option, as nurses from all over New Zealand could then be targeted as potential students. The participants were all involved in keeping themselves up to date in their fields of practice, although sometimes the conferences attended by the nurses had a focus on the medical treatment of the conditions that the young person had rather than the relationship needs. Currently some adolescent health is included in courses that cover child and family health or health promotion (Julian, ND) but it is given limited hours. In addition to the educator's role in developing suitable programmes, experienced nurses could provide seminars and mentorship for those working with this age group in order to increase the quality of care to the young person.

Limitations of this study.

The limitations of this study relate mainly to the time constraint associated with doing a masters degree and my working full-time. On many occasions I was unable to give the project my full attention due to teaching, marking and course development involved in my job. Secondly, I was prone to procrastination and often got into a rut. Time limits are associated with masters degrees therefore a decision was made to only include nurses as participants in the study.

The findings of this study cannot be generalised to other groups of nurses because of the methodology used. Only nurses who worked with young people were interviewed for this study which limits the findings to the nurses' perceptions of what knowledge, qualities, skills they need to successfully nurse the young person. The number of nurse participants working specifically with 10-24 year olds in New Zealand in this study was limited to one, the remaining participants were equally divided between paediatric and adult services. This may have clouded the findings and left some paths unexplored.

This study provides a description of what happens when nursing the young person. However, it does not reach the level of theory development that would provide a framework for nursing practice and thus is limited in its application.

Suggestions for future research.

The findings of this study provide increased understanding of the knowledge, skills, attitudes needed by nurses working with the 10-24 year old client. Further research that explores the concepts found in this study, especially those related to being acceptable and balancing the dependence/independence needs of the young person would help to confirm the findings of this study by possibly giving conclusive criteria. A study identifying if "having attitude" is learnt or not would have importance for advanced nursing programmes and employment of staff in areas catering for young people.

In order to develop a theory of nursing the young person within the New Zealand context there is a need to build on the findings of this study. This study has only looked at the topic from the perspective of the nurse; future studies with a broader participant base would assist with furthering the development of a theory. These studies would need to involve interviewing young people, their friends and family as well as undertaking observations in the settings where the nurse/young person encounter occurs.

Conclusion.

This research has focussed on the qualities, knowledge, skills and attitudes of nurses working with young people. The use of Grounded Theory as the research approach enabled me to find out nurses' perceptions of what was happening when nursing the young person. The exciting thing was that despite the variety of settings that nursing took place all the nurses identified a way of being with the young person that transcended workplace boundaries.

Nursing of the young person was a field largely unreported in the literature and this study raises as many questions as it answers. The study goes some way to filling the gap in the literature of how nurses work with young people. It offers both a description that explains how nurses in practice work with young people, and a useful starting point for nurses doing research.

Appendices

Appendix one.

ADVERTISEMENT:

I need some help.

Registered nurses needed to take part in research project looking at nursing 10 – 24 year olds.

As part of my masterate studies I would like to talk to registered nurses who have experience nursing those who are aged between 10 – 24 years.

If you are interested in furthering nursing knowledge in this area please call me

Sue MacDonald, Fax: (04) 2373101
or Email: sm@virgo.whitireia.ac.nz
or call collect (04) 4791394 after hours.

Appendix two.

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COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

SCHOOL OF
HEALTH SCIENCES

14/3/97

INFORMATION SHEET.

Title: Expert Nursing of the 10-24 Year Old Client.

Thank you for your interest in the proposed research which aims to describe expert nursing care of the adolescent client / patient. My name is Sue MacDonald and I am doing this research for my Master of Arts in Nursing degree. As well as studying at Massey University I am also a registered general and obstetric nurse and I am currently involved in teaching in the Nursing Degree programme at Whitireia Community Polytechnic. Professor Julie M. Boddy of Massey University is my supervisor.

I am interested to find out more about the characteristics of the experienced nurse when caring for the adolescent client. Very little literature exists on the actual nursing of the adolescent client, and talking to people like yourself is an ideal way of gaining more information. Your contribution will assist the aims of this study, which are to identify and explain the characteristics of the experienced adolescent nurse. The objectives for this research are to:

* further research in the area of adolescent health care in New Zealand.
* describe the qualities of the experienced nurse in caring for the adolescent client.
* describe how the experienced nurse gives care to the adolescent client.

To achieve the aims of this study I am seeking to interview nurses who have experience of working with those aged 10-24. You may work in a variety of settings such as oncology, orthopaedic, paediatric, medical wards in Crown Health Enterprises. As well I also want to interview nurses working for other organisations e.g. schools, family planning, public health, mental health services, sexual health clinics, independent practice and one stop shops.

If you are interested in participating, you will be invited to ask any further questions you may have about your participation in the study. As well, you will be asked to sign a consent form if you want to take part in the study. You will be involved in one or two interviews lasting about one hour each. These interviews will be conducted either by phone or face to face and will be set up and carried out by the researcher. The time and place will be at your convenience. Each interview will be audio taped, with your permission, and the transcript will be given to you to verify that the statements are an accurate reflection of what you wanted to say. Costs of travel and phone calls will be covered by myself.

If you decide to take part you have the right to withdraw from the study at any time during the research. You also have the right to refuse to answer any particular questions. If you have any queries about your rights as a participant in this research, you may wish to contact your professional organisation.

Anonymity will be adhered to in the write up of the thesis and any publications arising from this. You will be allotted a pseudonym that only you and I will have access to. As each transcript will need to be typed up by a third person they also will sign a confidentiality agreement. At the completion of the thesis your tape and transcript will be returned to you.

The information gathered is to be used to further the knowledge of nursing the adolescent client. Firstly it is for my Masterate Thesis. As well, the findings will be used for conference presentations, publications in nursing journals, and in nurse education. A report of the findings will be given to you when the thesis has been written.

Thank you for contacting me about this research. Please do not hesitate to phone me for more information. If you wish to be part of this study the researcher can be contacted at the following address;

Sue MacDonald
Nursing Centre of Learning, Whitireia Community Polytechnic
Private Bag 50910, Porirua City
ph. (04) 237 3103 ext 3732 Email: sm@virgo.whitireia.ac.nz
(04) 479 1394 after hours.

If you wish to contact my supervisor regarding this research;

Professor Julie M. Boddy, Department of Nursing and Midwifery,
Massey University, ph. (06) 350 4326

Appendix three.

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COLLEGE OF
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14/3/97.

CONSENT FORM

Expert Nursing Of The 10-24 Year Old Client.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (*The information will be used only for this research and publications arising from this project).*

I agree / do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

I understand that if I have any concerns about the study, I may contact: The Wellington Ethics Committee, Wellington Hospital 385-5999 ext. 5185.

Signed: _____

Name: _____

Date: _____

Appendix four.

EXPERT NURSING OF THE 10-24 YEAR OLD CLIENT.

Confidentiality Agreement (typist)

I understand that the tapes I am to transcribe contain confidential information.

I agree to maintain confidentiality by not discussing any aspects of the tapes or typed transcripts with any other person, apart from the researcher for the sole purpose of clarifying content.

No other person will have access to the tapes or typed transcripts while they are in my care.

Tapes, transcripts and the computer disc will be returned to the researcher as soon as they are finished with.

Signed:

Date:

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