Caring for adolescents with acute and complex mental health needs in hospital settings: conceptualising and enabling nursing identity, task and intervention.

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Thank you to all the co-authors and collaborators I have been lucky enough to work with. I would like to express particular thanks to Dr Kirsty Smedley, for over 20 years of passionate and inspiring professional collaboration, combined with a rare and precious friendship.

Finally, thank you to my brilliant and tender-hearted partner Lisa, whose values and integrity in her own work as a mental health nurse always inspire to me to do better. Without her love and support this would not have been possible

This thesis is dedicated to my Mum and my sister, who in their own unique ways have taught me nearly all I know about courage, grace and tenacity; and to Sue Foulkes, from whom I learned by experience about the importance of adults who are prepared to lend you their thinking hearts, when your own is in pain.

Declaration

This thesis includes a portfolio of publications that have been published in peer-reviewed journals. The thesis includes reference to additional published works, and a research report, which provide supplementary evidence. The portfolio of published works submitted as part of the thesis is in Appendix 1. The author's original contribution to each paper is listed in Section two, which is verified by the collaborating authors in Appendix 2.

Table of abbreviations

BO	Burnout
CAMHS	Child and adolescent mental health services
CF	Compassion fatigue
CQC	Care Quality Commission
CS	Compassion satisfaction
CYP	Children and young people
DE	Department of Education
DH	Department of Health and Social Care
HCA	Health care assistant
IF	Impact Factor
MDT	Multi-disciplinary team
MHA (1983)	Mental Health Act (1983)
NAPICU	National Association of Psychiatric Intensive Care and Low Secure Units
NHS	National Health Service
NMC	Nursing and Midwifery Council
NDG	Nursing Development Group
RMN	Registered mental health nurse
PICU	Psychiatric intensive care unit
ProQOL	Professional quality of life
ProQOL V	Professional Quality of Life Scale, Version 5 (Stamm, 2010)
PWDG	Psychoanalytic work discussion group
STS	Secondary traumatic stress
SJR	Scientific Journal Ranking
WHO	World Health Organisation

Abstract

Background: Adolescent psychiatric intensive care units (PICU) play a significant role in child and adolescent mental health care pathways, not just in the UK but across Europe. Prior to the papers included in this thesis, there was no primary research in the field of adolescent PICU nursing. This thesis presents a series of five papers that directly address this gap and make a unique contribution to knowledge and understanding in the field of adolescent inpatient mental health nursing.

Research Objectives

1. Investigate the role of psychodynamic theory in understanding the interplay between mentally distressed adolescents, nursing staff, and the inpatient care context.
2. Investigate the nature of adolescent mental health nursing and nursing intervention, in a previously unexamined area of child and adolescent nursing practice; adolescent PICU.
3. Conceptualise a model of mental health nursing within adolescent PICU settings.
4. Use this new conceptual understanding to develop and test a novel intervention, to support and enable adolescent mental health nurses to articulate, enhance and sustain the therapeutic tasks of their work.
5. Evaluate the impact of this intervention on staff experience of their work and care provision.

Method: The research is situated within a transdisciplinary psycho-social research framework. Psychodynamic praxis is integrated into systematic qualitative and quantitative research methods, to develop an original methodology to achieve the research objectives through a process of co-production with participants. Developmental object-relations and attachment theory are used as a lens, through which the detail of adolescent mental health nursing work can be seen.

Outcomes: A new model of adolescent PICU nursing is proposed. The process by which the mutually constitutive relationship between the young people's developmental and mental health needs, the PICU care context, and the nursing task, manifests as a series of interlocking and unresolvable tensions, is

elaborated. It is proposed that these tensions are the space in which unique nursing interventions are produced.

Adolescent PICU nursing is conceptualised as an intersubjective process analogous to the good-enough carer-infant relationship, in which a rigorous and technical form of love, is elaborated as the key method of intervention. Key to the implementation of ‘love as method’ are the concepts of the container-contained relationship, projective identification and reverie, alongside a willingness to continuously occupy unresolvable tensions as demanding but productive spaces.

The emotional and psychological impact of continuously residing in a state of tension and of maintaining close physical and relational proximity to highly disturbed young people, means that the factors that enhance and impede the therapeutic task of nursing in adolescent PICU are two sides of the same coin, mediated by the process of projective identification.

Conclusions: An evidence-based case is made for detailed, faithful and receptive observation of mental health nursing approaches that parallel, acknowledge and re-centre the place of a specific and disciplined form of love, as the method for creating the interpersonal conditions for recovery from acute and complex mental distress, especially when these manifest in young people.

A critical appraisal of the methodology used in the thesis demonstrates the suitability and validity of psychoanalytically informed research methods, for investigating invisible or hidden relational elements of adolescent mental health inpatient practice. However, care must be taken to limit replication of power dynamics that have historically left mental health nurses in epistemically disadvantaged positions.

Implications: The implications for adolescent mental health nursing praxis, education, management and policy are highlighted, and recommendations for further research are made.

Preface

The following letter was written to the nursing team who participated in the research in this portfolio of published works, through their participation in weekly psychoanalytic work discussion. My intention was to provide them something of the Reverie (Bion, 1962a) that the research in this thesis highlights is central to their practice as adolescent PICU mental health nurses.

Dear Nursing Team,
Today is my last day working with you. So much of the work we have done together in the Nursing Development Group has been about how you help young people learn to be appreciative, to express their thanks, and to notice what they will take with them from their time with you that will help them on the next bit of their journey. So, it is time for me to take a moment to do the same.

Thank you. Having the chance work with you all, to be welcomed into your team and to be given the privilege to witness the work you do every day has been a great honour; opening my eyes to the all the subtle details and everyday-heroic elements of your work; and helping me fall back in love with my own profession of mental health nursing.

In my favourite childhood book, a very smart fox once said
"It is only with the heart that one can see rightly. What is essential is invisible to the eye".[1]

This is never truer than when thinking about when young people (and me!) leave the ward – what they take with them and what they leave behind in you. So, I would like to remind you all of something of what we have learnt together in the group, about the important but invisible parts of your work:

Things never go well by accident. When the ward, the team and the care of the young people are all working well it is not by luck! Remember to ask yourselves: what is that we are doing that is working and helping young people to stay safe and recover?

Emotion is information – learning about young people through the ways in which they can stir up strong feelings in you is key to coming know and understand them and

[1] *This quote is from 'The Little Prince' by Antoine de Exupéry (1943). It is a seminal piece of children's literature that provides a post-war critical narrative on the state-sanctioned violence that can ensue from privileging generalisation and abstraction over recognition of individual humanity. It is a parable for the transformative power of love and of how the chasm between the states of childhood and adulthood can be bridged: with patient, tender attention to specifics and intimate connection with each other. Quotes and elements of the text are used throughout the thesis to illustrate key points and assertions.*

how to help. It is ok to be stirred up: just remember to give each other time and space to talk and think about the ways they make you feel, and why? before you act.

The hardest work can often look like doing nothing. Being receptive and attendant to all the ways that young people communicate with you, taking it in, finding ways to make sense of it and respond to it helpfully whilst keeping you own feelings under control - this is work. It takes emotional and psychological effort. It has a name – *Reverie*. Receiving this in childhood is understood to be the foundation of the mental resilience and wellbeing that we carry into the rest of our life.

Small details count. Whilst the occasional quick-win that comes from seeing someone respond well to medicine is important; longer term transformation and recovery comes from repetition of the tiny details of moment-to-moment care. The developmental processes of furnishing children's hearts and minds with skills that will help them heal their own wounds, through relationships that install something of a good-enough carer inside them, fans the embers of hope and belief in their own value. It is these experiences that young people will continue to hold in mind, just as something of them remains with you and contributes to your learning and development, after they have gone.

Whilst there is much sadness for me in leaving, I also know that this sadness comes from appreciation of what a precious gift having had the chance to learn about your work really is. It will be a gift that stays with me long after I leave. To know that there is a place where there are people who step forwards - to lend themselves to our wounded youngsters in their darkest moments - when the natural instinct is to step back, and that they do so with such generous, tenacious, brave and thinking hearts, is to be reminded of something of the very best of our humanity.

Thank you.

Wishing you all the very best,

Celeste

Articles included in the portfolio of published work

To distinguish papers in the portfolio from other citations, throughout the thesis, papers included in the submission are cited in bold (e.g. **Foster, 2009**), Full texts of these papers are located chronologically in Appendix 1, reflecting the progression of the research study on which they report and my training as a researcher.

Paper 1:

Foster, C. (2009). Adolescents in acute mental distress on in-patient paediatric settings: Some reflections from a paediatric liaison practitioner. *Journal of Child & Adolescent Psychiatric Nursing,* 22(1), 16-22. https://doi.org/10.1111/j.1744-6171.2008.00165.x.

Paper 2:

Foster, C., (2018). Investigating professional quality of life in nursing staff working in adolescent psychiatric intensive care units (PICUs). *The Journal of Mental Health Training, Education and Practice,*14(1), 59-71. https://doi.org/10.1108/JMHTEP-04-2018-0023

Paper 3:

Foster, C. & Smedley, K., (2019a). Understanding the nature of mental health nursing within CAMHs PICU. Part 1: identifying nursing interventions that contribute to the recovery journey of young people. *Journal of Psychiatric Intensive Care,*15(2), 87-102. https://doi.org/10.20299/jpi.2019.012

Paper 4:

Foster, C. & Smedley, K. (2019b). Understanding the nature of mental health nursing within CAMHS PICU. Part 2: Staff experience and support needs. *Journal of Psychiatric intensive care,* 15(2),103-115. https://doi.org/10.20299/jpi.2019.013

Paper 5:

Foster, C. (2020). Investigating the impact of a psychoanalytic nursing development group within adolescent psychiatric intensive care. *Archives of Psychiatric Nursing*. https://doi.org/10.1016/j.apnu.2020.08.008

Supportive evidence

In addition to the portfolio of papers, the author has published several other publications relevant to the thesis. These provide additional information or illustrate further application of some elements of the papers included in the portfolio. These papers are listed as supportive evidence and are cited throughout the thesis in bold italics (e.g. ***Fisher & Foster, 2016***).

Foster, C., Birch, L., Allen, S., Rayner, G., (2015). Enabling community practitioners to work with young people who self-harm. *Journal Mental Health Education, Training and Practice*, 10 (4), 268-280. http://dx.doi.org/10.1108/JMHTEP-05-2014-0011

Foster, C., & Smedley, K. (2016). Investigating the nature of mental health nursing within an adolescent psychiatric intensive care unit: identifying nursing interventions that contribute to the recovery journey of Young People. Full Research Report, University of Salford. http://usir.salford.ac.uk/id/eprint/41231

Fisher, G., & Foster, C. (2016). Examining the needs of paediatric nurses caring for children and young people presenting with self-harm/suicidal behaviour on general paediatric wards: Findings from a small-scale study. *Child Care in Practice*, 1-14. https://doi.org/10.1080/13575279.2015.1118013

Foster, C. (2020). Child and adolescent mental health: long term conditions – the nursing response. In*: Glasper et al. (Eds) A textbook of Children and Young People's Nursing, 3rd Edition.* Sussex: Wiley Blackwell. (In Press). http://usir.salford.ac.uk/id/eprint/57291

Introduction and overview

This portfolio of published work examines mental health nursing care of adolescents who are hospitalised due to acute and complex mental health needs. These published works conceptualise a new model of nursing care through the application of psychoanalytic theory. These published works investigate: 1) the role of psychodynamic theory and practice in understanding the interplay between mentally distressed adolescents, nursing staff, and their care contexts; 2) the nature of mental health nursing identity and primary task in adolescent psychiatric intensive care units (PICU); 3) the contribution that nursing and nurse-initiated interventions make to the recovery journey of young people in these settings; 4) the specific staff support needs that must be met in order for them to effectively sustain the therapeutic tasks identified; 5) how these needs can be met.

Section one presents a discursive summary of the extant literature and research in which the thesis is situated. This is drawn from a systematic scoping review that has been updated and refreshed over the period of the research. Gaps in the literature are identified and the rationale for the thesis is outlined.

Section two addresses the aims and objectives of this thesis and portfolio of published works and lists the articles under examination and how they contribute to the research objectives.

Section three elaborates the research philosophy, methodology and design utilised across the portfolio of papers, and the ethical considerations.

Section four presents a synthesised summary of the key findings from across the portfolio of papers.

Section five presents a critical commentary on the contribution of the papers to the advancement of knowledge in adolescent mental health nursing, and in particular, the previously unexamined area of mental health nursing in adolescent PICU settings. A critical appraisal of the methodology is undertaken, to ensure that claims of new knowledge and contributions are appropriately situated.

Section six summarises the key thesis findings, implications, and recommendations for future research and practice.

In accordance with the underpinning psycho-social research philosophy adopted, critical reflection on personal and professional learning from the research journey is integrated throughout the thesis.

Section 1: Background

1.1 Introduction

In the UK, it is estimated that 1 in 5 children and young people experience emotional health or behavioural problems at any one time (Deighton et al., 2018). In the last 25 years, the prevalence of longstanding mental health conditions in children and young people (aged 4-24 years) has consistently increased (Pitchforth et al., 2018). The case for intervening effectively to prevent mental ill health, maintain emotional wellbeing and provide evidence-based treatment for mental illness, in children and young people, cannot be overstated.

During adolescence, a young person acquires the physical, cognitive, emotional, social, and economic resources, or vulnerabilities, that are foundational for later life health and wellbeing or longer-term risk of illness. At an individual, family and population level, the relative health capital that this balance of risk and resilience creates influences the health and wellbeing of the next generation (Patton et al., 2016). It is estimated that up to 75% of adult mental health conditions have their onset before the age of 24 years (Kessler et al., 2005). Mental ill-health in youth and beyond is associated with a wide range of additional negative health and social outcomes (Das et. al., 2016).

Mental health and illness in children and teenagers are intimately linked to child development. The heightened prevalence of mental distress and illness in adolescence can be best understood through a developmental lens. A full elaboration of the social, emotional and development determinants of mental ill-health in young people can be found in ***Foster (2020)***. In summary:

The primary job of a child is to grow and develop towards adolescence, acquiring the skills, resources and resilience needed to successfully manage the stresses and strains of transition to adult life. In good enough circumstances, children are supported and enabled through each stage of development by positive attachment relationships in which they feel a sense of safety and belonging, and in which their physical, emotional and psychological needs are understood and met (Bowlby, 1988). In time, these relationships help the child develop their own coping skills, sense of esteem and ability to understand and regulate their emotions, gradually

moving towards independence. Good-enough attachment relationships serve to buffer the impact of stressful life events.

Adolescence is a time of preoccupation with one's body and identity in the context of puberty and the tasks of individuation and separation. The stress related to uncertainty regarding one's physical and psychological identity – its distinctiveness and acceptability in relation to the other – can create a level of mental distress (Williams, 2002; Briggs, 2009). In addition, the psychological, social, emotional and physical demands of puberty test the strengths and vulnerabilities that early life has furnished the young person with. Many young people experiencing severe and complex mental health difficulties do so in the context of carrying wounds from traumatic experiences and disrupted care relationships in early life.

The dynamic brain development in adolescence is a period of opportunity, not just vulnerability. The only other period in the life course when our brains are subject to such rapid and significant neurological change is infancy (Patton et al., 2016). The brain's interaction with social environments shape the capabilities an individual takes forward into adult life. Good quality interpersonal relationships with reliable and helpful adults, combined with psychological approaches that promote the young person's sense of coherence and mastery, can be life changing interventions.

In the UK, child and adolescent mental health services (CAMHS) are currently being re-organised around the THRIVE model (Wolpert et al., 2014, see Figure 1.), which seeks to configure services in a needs-led, rather than organisation-led, way.

Figure 1: The THRIVE Model: the place that young people are in and the input and help they need (Wolpert et al, 2014)

The care pathway begins with community and school-based access to information, signposting and advice; moving to access to evidence-based programmes for specific difficulties, delivered by school-based and/or specialist community CAMHS; and ending with inpatient care for those whose symptoms and associated risks cannot be managed at home, even with intensive treatment and monitoring. It is the work of nurses providing care for young people in the last two quadrants of the THRIVE model (extensive treatment, risk management and crisis response), that this thesis is concerned with.

The landscape of adolescent mental health inpatient settings in the UK has altered during the period between publication of the first paper in this portfolio and the last. In 2009, the Department of Health (DH) tried to re-establish the number of inpatient beds available, following a cut in numbers in the early part of the decade that was meant to signal a move towards community-delivered services. This cut was too deep, and clinical need regularly outstripped supply (**Foster, 2009**). The number of inpatient beds in the UK has significantly increased since 2009. However, the ongoing increase in mental health difficulties in young people, combined with 'austerity' cuts in community CAMHS provision, still means that demand periodically outstrips supply.

There is national consensus that admitting children to hospital comes with significant developmental risks (Hannigan et al., 2015). Treatment should be provided in the community, wherever possible, whilst understanding that hospital treatment will always be required by some young people (Department of Health/ Department for Education [DH/DE], 2017). This is particularly so in the UK due to a lack of crisis intervention services for young people, that are aimed at avoiding hospital admission (Hannigan, Goold & Maxwell, 2019).

Internationally, inpatient units remain the most widely used element of acute mental health service pathways for young people (Hayes, Simmons, Simons & Hopwood, 2017). Both internationally and in the UK, mental health nurses are the biggest component of the workforce in adolescent inpatient care settings, carrying the burden of responsibility for maintaining safety across the 24-hour cycle of care (**Foster, 2018,** McAllister & McCrae, 2017).

There are broadly four types of hospital setting that a young person may find themselves in:

- Locally commissioned paediatric medical wards (0-18 years); whilst waiting for a mental health assessment, following acute presentation to A&E.
- General adolescent inpatient units (12-18 years); regionally commissioned open care-settings that provide multi-disciplinary (MDT) care for young people who have consented to admission, and those who are detained under the Mental Health Act (MHA, 1983).
- PICUs and high dependency units (12-18 years); nationally commissioned in relatively small number, providing short-term intensive MDT treatment in locked or restrictive settings for young people detained under the MHA (1983) due to acute and complex mental health difficulties associated with high risk behaviours.
- Medium and low secure units (12-18 years); nationally commissioned restrictive environments for longer term management and treatment of young people with mental health needs associated with persistent risks to self or other, including offending behaviour.

Each of the three types of mental health unit described have a service specification for admission criteria, purpose, environment, workforce and

treatment-access requirements (E.g. NHS England, 2018). However, there is no model or philosophy of nursing care specified within these. This is a gap that this thesis addresses, by proposing a new model of nursing care for adolescent PICU.

Although essential, adolescent inpatient units are also problematic as their set up is almost 'anti-development' for young people. Historically, their focus and operating procedures have been extrapolated from adult acute psychiatry models, with little space included for thinking about the different biological, social and emotional needs of adolescents (Milavic, 2009). The strategy of replacing local beds through regional and national commissioning arrangements means that young people are often geographically separated from their family and friends at a life stage when peer and family connection is essential (Hannigan et al., 2015). The safety and control-focus in the hospital environment directly challenges young people's need for individuality, freedom of expression and independence (Le Francois, 2013). This often triggers psychological defences, over and above the reason for admission, meaning that young people can leave hospital with a range of additional risky coping responses (Hannigan et al., 2019). Adolescent ways of coping and communicating intrude upon the defences of healthcare institutions (routines, tasks, control). This impacts upon nursing staff and can negatively affect their responses to, and ways of coping with, the young people in their care (**Foster, 2009; *Fisher & Foster, 2016***). This is particularly so, because inpatient units tend to have a higher proportion of nurses at the beginning of their career. Mental health nursing training remains largely adult-focused and knowledge of adolescent-friendly approaches is acquired over time through on-the-job experience.

Optimising the contribution and minimising the risks of inpatient mental health care to young people's recovery requires a detailed and dynamic understanding of:

- the iterative impact of adolescents in mental distress, nursing staff and the contexts in which they receive care, upon each other;
- the nature of mental health nursing care provision within inpatient settings; and
- the factors that can corrode the helpful elements of nursing care and the support needed to sustain them.

The portfolio of papers within this thesis make a unique contribution to understanding each of these domains.

1.2 Literature review

1.2.1 Literature search strategy

Prior to commencing the multi-methods research study from which papers two to five are derived (**Foster, 2018, 2020; Foster & Smedley, 2019a, 2019b**), a systematic scoping review was undertaken to establish the current state of the evidence and the policy context in the field of adolescent PICU nursing.
The search strategy was designed to cover the 3 key domains of the research study:

- Adolescent psychiatric intensive care (PICU) nursing
- Professional quality of Life in nurses working in adolescent PICU
- Implementation of psychoanalytic work discussion/reflective practice groups in adolescent PICU

The full systematic scoping review method applied is provided in Appendix 3.

Findings from the search informed the research questions, design and background for papers two-five (**Foster, 2018, 2020; Foster & Smedley, 2019a, 2019b**). To ensure that any new emerging evidence was included in this thesis, the search process was repeated throughout the research study implementation and dissemination/ publication period (2016, 2018, 2019 and 2020).

It was identified early in the search process that there was no published research specifically related to adolescent PICU nursing. Therefore, searches were organised by constituent component, collated and then refined using pre-defined inclusion/exclusion criteria (see Appendix 3, Figure A1).
The constituent components were:

- Psychiatric intensive care
- Adolescence
- Inpatient mental health nursing
- Professional quality of life
- Psychoanalytic work discussion/ reflective practice groups

The literature review highlights the literature gaps and builds a rigorous case for the research that was undertaken as part of this thesis. Findings from the review were synthesized using thematic analysis (Kastner et al., 2012). They are presented under theme headings:

- The state of research in adolescent PICU
- Mental health nursing approaches and models of care in PICU settings
- Adolescent mental health inpatient settings
- The impact of acute and intensive care inpatient work on mental health nurses
- Work discussion and reflective practice for nursing teams

1.2.2 State of research in adolescent PICU

PICUs play a significant role in child and adolescent mental health care pathways in the UK and across Europe. The number of dedicated adolescent PICU units are small. In the UK there are an estimated 96 adolescent PICU beds. However, PICUs play an important part in the recovery journey for a significant cohort of children in any twelve-month period due to high patient turnover, as a result of the model of care being based on time-limited admission. Adolescent PICU services are usually mixed gender, "secure" inpatient environments for the short-term containment and treatment of young people detained under the Mental Health Act (MHA,1983). A full account of the key characteristics of adolescent PICU is provided in **Foster (2018).** The relative success of a PICU admission is pivotal in deciding whether a young person's trajectory is toward a return to community care or longer-term restrictive or secure mental health care (**Foster, 2018**). Adolescent PICU environments provide for a population with more diverse and complex presentations than either their adult counterparts or general adolescent mental health inpatient units (**Foster & Smedley, 2019a**; NHS England. 2016). Prior to the papers included in this thesis, there was no primary research in the field of adolescent PICU. There have been three descriptive accounts of service provision published (Jasti, Khan & Jacob, 2011; Kahila, Kikku & Kaltiala-Heino, 2004; Smith & Hartman, 2003); a UK national minimum standards document (NAPICU, 2015) and a UK NHS service specification (NHS England, 2016). This limited evidence highlights that the reason for such complex and heterogenous patient groups in

adolescent PICUs is due to the patchy nature of community and crisis services for young people and the paucity of appropriate therapeutic placements for young people with multiple diagnoses. Four of the papers in this portfolio are drawn from an original multi-methods research study that was designed specifically to address the absence of research in the field of adolescent PICU (**Foster, 2018, 2020; Foster & Smedley 2019a, 2019b**). Using qualitative and quantitative methods they investigate:

- What is the nature of mental health nursing in adolescent PICU?
- What is its primary task?
- What is nursing intervention in adolescent PICU?
- What is the effect of adolescent PICU on mental health nursing professional identity?
- How can mental health nurses be supported to sustain the primary task of their work?

1.2.3 Mental health nursing approaches and models of care in PICU settings

The lack of research in adolescent PICU means that any knowledge regarding PICU nursing approaches can only be drawn from adult PICU literature, which is better established (Gwinner & Ward, 2013).

As reported in **Foster (2018)** and **Foster and Smedley (2019a);** Adult PICU environments are largely organised around short-term care within a highly contained environment for those experiencing acute psychiatric distress, who are usually a risk to themselves or others (Bowers 2012; NHS England 2016). The environment and high levels of violence and aggression are managed through relatively high staffing levels. The dominant workforce is unqualified nursing assistants, working alongside registered mental health nurses. They carry the responsibility for creating a secure environment where multidisciplinary care and treatment can be delivered safely (McAllister & McCrae 2017). However, several studies have concluded that there remains no evidence regarding the efficacy of treatment approaches in PICU environments and there is an absence of clearly articulated principles and practices of nursing care in these environments (Bowers 2012; Gwinner & Ward 2013; McAllister & McCrae 2017).

There is little evidence that quality of patient care is compromised by the lack of clear nursing approach, when compared to other inpatient settings (Lemmey, Glover & Chaplin, 2013). There is a limited but notable amount of evidence that treatment outcomes are positive for patients who are in acute psychiatric distress (Gwinner & Ward 2013). What is missing is an understanding of the mechanisms that bring change. These are gaps in research that **Foster and Smedley (2019a, 2019b)** address.

Five studies analyse the core characteristics of nursing within adult PICU (Bjorkdahl, Palmstiema & Hansebo, 2010; Gwinner & Ward, 2015; McAllister & McCrae, 2017; Salzmann-Eriksson, Lutzen, Ivarsson & Eriksson, 2011; Salzmann-Krikson, Lutzen, Ivarsson & Eriksson, 2008; Ward & Gwinner, 2015). A key theme emerging across these studies is managing the tension between regulating the environment to ensure safety, and interpersonal interventions which support and promote recovery for clients. Core nursing interventions have been identified: engagement with patients to help them narrate their subjective experience, communication, information-giving, risk management and surveillance (Bjorkdahl et al., 2010; Gwinner and Ward, 2015; Salzmann-Eriksson et al., 2011; Salzmann-Krikson et al, 2008). Time and workload pressures limit the amount of psychosocial or interpersonal nursing interventions delivered within PICU settings (McAllister & McCrae, 2017; Gwinner & Ward, 2015).

In the absence of elaborated paradigms or defined principles of practice, the nursing task and approach is significantly influenced by organisational and environmental drivers (Gwinner & Ward, 2013). These drivers privilege actions that ensure safety and order, over more individualised interpersonal approaches that can bring uncertainty. This can reduce the primary function of the PICU to the suppression of aggressive and violent behaviour (Dix, 2016). This observation has led to a call for the development of PICU nursing practice standards, that recognise both the person-centred care and control-based elements of the role (Ruszczynski, 2012; Ward & Gwinner, 2015). The new model of adolescent PICU nursing set out in this thesis, elaborates an evidence-based set of principles that advances knowledge in this way (**Foster, 2020; Foster & Smedley, 2019a; 2019b**).

1.2.4 General adolescent mental health inpatient settings

Globally, general adolescent inpatient mental health units are the most used component of acute adolescent mental health services. Their purpose is to contain risk, acute distress responses and stabilize symptoms (Hayes et al., 2019). The level of restriction and surveillance in general adolescent mental health inpatient units is lower than in adolescent PICU, reflecting lower levels of clinical acuity and associated risk, but not necessarily a lower level of complexity or need.

Available evidence asserts that such inpatient units are largely effective at stabilizing symptoms of acute mental distress, but that there is little understanding of why or how this occurs (Hayes et al., 2017). Delaney (2019) highlighted that the process by which nurses contribute to the quality of child inpatient treatment is largely absent in research, asserting that this leads to an assumption that anyone could do it, thereby devaluing nursing expertise.

Rasmussen, Henderson and Muir-Cochrane (2012), argued that because much of adolescent mental health nursing is tacit and of limited visibility to those looking at it from the outside, mental health nurses need to be enabled to articulate their own identity, within the particular context in which they operate. The process requires detailed qualitative design to understand models of care and interventions and must include nurses as key stakeholders (Delaney, 2018; Hayes et al., 2019). The papers in this thesis address these issues.

Published studies identify adolescent mental health nursing as a specialty with unique challenges and a source of moral distress for staff (Mathews & Williamson, 2016; Musto & Schreiber 2012; Rasmussen et al., 2012). The challenge for staff is related to the two-fold task of adolescent care: to treat and manage the young person's presenting mental health disorder, at the same time as supporting normal adolescent development (Kahila et al., 2004). The patient group is much more heterogenous than in equivalent adult services (Mathews & Williamson, 2016). The 12-18 years age range means that there is wide diversity of developmental stage and functional abilities (Delaney & Hardy, 2008). This means the needs of young people can quickly outstrip the available staff resource (Mathews & Williamson, 2016). Adolescents have more physical and immature strategies for self-regulation, meaning that impulsivity and decision-making mistakes are to be

expected as part of their developmental stage. Thus, there is a dilemma for nurses working with adolescents, in relation to providing space and freedom to move around versus the need for close supervision (Delaney & Hardy, 2008). **Foster (2009)** highlighted how a valency between adolescent and nurses' experience of their external context, their position within it, and the defense mechanisms activated to manage these experiences, can result in the admission of adolescents to hospital settings being traumatic for both young person and nurse. Matthews and Williamson (2016) found that 'detached and 'cool' responses to behavioural challenge and emotional distress that are required within the setting, are counterintuitive for staff. Participants reported that required responses conflicted with personal moral codes and instinctive approaches to childcare. Usual professional coping strategies are rendered useless in the face of adolescent distress (**Foster, 2009**), triggering staff to turn away from or avoid engagement with the adolescent's psychological needs *(**Fisher & Foster, 2016**)*.

Four studies have specifically investigated nursing provision within general adolescent mental health inpatient units and identified key elements of nursing care: 1) providing an environment that confers emotional and physical safety; 2) structure and goal setting; 3) theoretically informed approaches to interpersonal engagement and communication; 4) supporting self-management through skill development and psychoeducation; 5) enabling access and engagement with evidence-based interventions and therapies (Delaney 2017; Hayes et al., 2019; Rasmussen et al., 2012; Reavey et al., 2017).

1.2.5 Impact of acute and intensive care inpatient work on mental health nurses

The impact of workplace stress on nursing staff wellbeing, professional identity and job satisfaction must be addressed to ensure high quality and compassionate care delivery. The cumulative work-related stress experienced by healthcare providers impacts negatively upon the delivery of healthcare services (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski & Smith-MacDonald, 2017). Compassion fatigue and burnout, the two most common outcomes of workplace stress, are associated with reduction in reflective capacity, indifferent and hard responses towards patients and a reduction in staff mental wellbeing (Coetzee &

Klopper, 2010). A sense of job or compassion satisfaction protects against burnout (Ray, Wong, White & Heaslip 2013).

There were no published studies specifically investigating the impact of work in adolescent PICU settings, prior to **Foster (2020)** , but data can be drawn from studies that include adult PICU nurses, mental health nurses in psychiatric settings that share some similar characteristics (e.g. acute and secure units), and general adolescent mental health inpatient units.

In a survey of morale amongst adult mental health workers in England, PICU staff were identified as at especially high risk of emotional strain and burnout because of an interaction between high job demand, low perception of autonomy and poor support (Johnson et al., 2012). Studies in adult PICU settings note a lack of respect and inadequate resources provided to nurses working in PICU settings that adversely affect staff satisfaction (Gwinner & Ward, 2013). The care of service users who present with high levels of violence, as is the case in PICU, provokes difficult feelings and contributes to negative work experience (Sondenaa, Lauvrud, Sandvik, Nonstad & Whittington, 2013). High levels of close patient observation, a cornerstone of how the safe environment is maintained in adolescent units of all kinds, has been shown to negatively impact staff wellbeing (O'Brien & Cole, 2004). Whilst mental health nurses have responsibility for maintaining a safe environment (McAllister & McCrae, 2017), nurses in adolescent inpatient units have been found to be excluded from admission and skill-mix decisions, undermining their capacity to meet this responsibility (Delaney and Hardy, 2008; **Foster, 2009**). Matthews and Williamson (2016) reported that the process of having to normalize an abnormal environment, combined with an imbalance between the level of occupational demand and support provided, was a significant source of workplace stress and moral distress in an adolescent inpatient unit.

The literature in mental health nursing identifies an iterative relationship between the impact of work and professional identity, brokered by emotional labour. Emotional labour is the effort consumed by suppressing one's own emotions to care for others effectively, while also caring for oneself (Edward, Hercelinskyj & Giandinoto, 2017). Emotional labour demand is high in all areas of nursing (Sinclair et al., 2017) but it has been described as the heart of mental health

nursing, due to its pivotal role in forging therapeutic relationships with individuals experiencing acute and severe mental distress (Delgado, Upton, Ranse, Furness & Foster, 2017; Edward et al., 2017). A strong sense of professional identity protects against the effects of workplace adversity (Edward et al., 2017). Gwinner and Ward (2013) assert that well elaborated paradigms for nursing approach to recovery may be instrumental in helping staff surmount the highly demanding nature of the PICU environment. Whereas, a poorly defined sense of professional identity, value and task is itself a source of workplace adversity (Sercu, Ayala & Bracke, 2015).

Edward et al. (2017) found that investment of emotional labour in mental health nursing is two-faced. It is required for the growth and satisfaction for both client and staff, but also contributes to staff burnout and compassion fatigue. The mitigating factor between these two positions is emotional intelligence, i.e. self-awareness, empathy and the capacity to reflect on and regulate strong emotions in action (Goleman, 1996). Staff require support that permits expression of concerns in a supportive environment, opportunities for learning and for developing psychological capacities to manage the specific demands of their work (Edward et al., 2017; Winship, Shaw & Haigh, 2019).

Foster (2018, 2020), Foster and Smedley (2019b) provide detailed applications of the concepts of professional quality of life, burnout, and emotional labour to mental health nursing in adolescent PICU and contribute a unique understanding of the mutually constitutive relationship between adolescent, nurse and the specifics of the care environment, and how this shapes mental health nursing intervention, identity and wellbeing.

1.2.6. The relatedness of psychoanalytic and mental health nursing praxis

Mental health nursing and support work can be described as fundamentally psychodynamic in nature, in that it is within the quality of the therapeutic nurse-patient relationships that change occurs (Flynn, 1998; Lopes and Cutliffe, 2018; Winship, 1995). The nursing care of adolescents specifically entails being receptive to unconscious somatic communications, or projective identifications (Midgely et al., 2013). This means that nursing teams develop a uniquely detailed

sense of young people, based on what it ‘feels like’ to be in their company, in a range of different contexts across the 24-hour cycle of care. However, this knowledge is often tacit or embodied rather than articulated through language. Psychological nursing intervention is often hidden in affective processing and non-verbal responsiveness or embodied in ‘the doing’ of practical but symbolically representative tasks. This makes it hard to observe (**Foster & Smedley, 2019a**; Rasmussen et al., 2012).

Psychoanalysis investigates states of mind that are hidden from subjects and yet shape their thoughts and behaviours (Rustin, 2007*)*. Psychoanalysis elaborates how states of mind come to bear on the intersubjective space within relationships. Psychoanalysis has a specific lexicon for describing processes to name and make use of the unique tacit experiencing of their patients that nurses develop (Ruszczynski, 2012; Winship et al., 2019).

The psychoanalytic nature of nursing is not a new idea, but rather one that has been forgotten or slid out of view (Haraway, 1988). Peplau’s (1952) seminal interpersonal theory of nursing, in fact has the full title of ‘*Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing’.* Peplau was trained in psychoanalysis and her work was influenced by the analyst Henry Stack-Sullivan (Winship, Bray, Repper & Hinshelwood, 2009). Peplau’s work was radical in demonstrating the potential for independent scholarship in nursing; articulating nursing as a psychodynamic interpersonal process; and stressing that this process should function cooperatively, to create power shifts in which patients and nurses become active players, rather than passive recipients of doctor’s instruction. In the context of neoliberal marketisation of health, which maintains the power and wealth of those already at the top, it is perhaps not surprising that a woman-authored idea, of the relational and social as a tool for transforming suffering and challenging established power hierarchies in medicine, has become a historical relic. A relic that has been retired in favour of more ‘rationale’, economically lean approaches such as CBT, which locate the problem and solution within individual responsibility, whilst simultaneously maintaining the essential position of the specialist (Viens, 2019). Peplau does still feature in nurse education curricula, but often diluted or reduced to a fragment - the least

revolutionary component of her psychodynamic nursing model, the four stages of the relationship (Winship et al., 2009).

1.2.7. Psychoanalytic work discussion groups and reflective practice for nursing teams

Work Discussion is a psychoanalytic model for delivering a specific form of reflective practice group. Work Discussion originated as a means of providing psychoanalytic perspectives for professionals for whom psychoanalysis is not their primary training (Rustin, 2008a). Psychoanalytic Work Discussion groups (PWDG) span the boundary of staff support and staff development, focusing upon the emotional dynamics of the experience of work to promote understanding of the emotional processes of self and other (Datler, Datler & Wininger, 2018). A detailed account of the method of PWDG is provided within **Foster (2020)**.

PWDGs are a helpful forum for education and social care staff working with distressed adolescents in non-hospital settings (Briggs, 2009; Ellis & Wolfe, 2019; ***Foster et al., 2015***; Jackson, 2008; O'Sullivan, 2019; Warman & Jackson, 2007); for workers in a paediatric medical inpatient setting (Trelles-Fishman, 2019); and in custodial/secure services for adults with complex needs and challenging behaviour (Ruszczynski, 2012; Winship et. al., 2019).

There is no research that focuses on psychoanalytic Work Discussion or other forms of reflective practice group within adolescent PICU or other adolescent mental health inpatient settings. There is little research that focuses on the experience of Work Discussion or reflective practice group participants (Thomas & Isobel, 2019). It has been argued that descriptive single case studies, usually used to report on the potential benefits of PWDG, need developing to provide a more rigorous mechanism for evaluation (Datler et al., 2018).

Foster (2020) outlines the particularities of caring for young people in restrictive settings that indicate the potential usefulness of PWDGs for enabling nursing staff in adolescent PICU. The literature suggests that psychoanalytic ways of thinking and understanding are useful for nurses working in adolescent PICU environments. PWDGs have potential to provide staff support that serves to promote greater agreement between workers regarding the nursing approach,

alongside a means of understanding the interaction between the mental disturbance of those they care for and the impact of the environment within which they operate (Winship et al., 2019). **Foster (2020)** tests and evaluates this hypothesis through implementation and evaluation of a bespoke PWDG, specifically adapted to meet the needs of nurses within adolescent PICUs. A rigorous evaluation method is used to elaborate the benefits and mechanisms by which they occur, from the participant's standpoint, to address the identified gap in the literature.

1.3 Literature review summary and thesis rationale

There is increased global awareness of the significance of adolescence as the peak age of onset of mental health conditions that persist into adulthood, and importance of effective and timely approaches to prevention, treatment and recovery for this age-group (Patton et al., 2016). In the UK and other western countries, adolescent care is increasingly understood as a distinct speciality (World Health Organisation [WHO], 2015). Internationally, inpatient units are the most widely used element of acute adolescent mental health services (Hayes et al., 2017) of which nursing is the largest component of the workforce. Yet there is dearth of research investigating the role of nursing in adolescent mental health inpatient units and its impact on patient care (Delaney, 2019). There is no research focusing on the specialty of adolescent PICU. This is a knowledge gap that the portfolio of published works in this thesis addresses.

The lack of research into nursing philosophies and models of care in adolescent mental health settings means that mechanisms for achieving positive outcomes and the contribution of nurses is poorly defined and understood by nurses themselves, and by the wider multi-disciplinary team (Delaney, 2018; Hayes et al., 2019; Rasmussen et al., 2012; Musto & Schreiber, 2012).

This is important because an iterative relationship exists between mental health nursing identity, the emotional impact of the work and the working context that shapes nursing identity, and service users' consequent experience of care (Edward et al., 2017; Sinclair et al., 2017). Workplace stress and low job satisfaction are associated with reduced warmth and compassion towards service

users (Coetzee & Klopper, 2010). Within adult PICU literature, evidence suggests that clearly articulated nursing paradigms helps mental health nurses manage the intense demands of the work. It is work that can be characterised as the forging of therapeutic interpersonal relationships for the explicit benefit of the service-user, within the constraints of the particular care setting in which they are located, and for which nurses are responsible for maintaining (Delaney, 2017).

Focus on the therapeutic relationship as the agent for change within the mental health nursing discipline has led to a call for recognition of the fundamentally psychodynamic nature of mental health nursing (Delaney et al., 2017; Gallop & O'Brien, 2003; Lopes & Cutcliffe, 2018). This builds on Peplau's (1952) seminal work which first characterised the core of mental health nursing as a transformative psychodynamic interpersonal process. However, contemporary commentators on mental health nursing knowledge and theory argue that there has been a progressive dislocation from the seminal work of Peplau and other psychodynamically informed mental health nursing theorists (Winship et al., 2009). This is a result of speciality-based drivers of healthcare and an increased reductionist focus upon biomedically informed diagnosis, treatment and tasks (D'Antonio et al., 2014). This process has led to a lack of availability of clear language within nursing disciplinary knowledge with which mental health nurses can articulate their work, particularly, relating to the relationship process (Delaney & Ferguson, 2014). So, although mental health nursing scholarship highlights the value placed on engagement and relationships, this has not driven a programme of research to identify and support the critical relational elements of inpatient nursing care (Delaney, 2018). Instead, neoliberal policy drivers produce a narrow focus on risk assessment, surveillance and absence of disease markers (Viens, 2019).

In adolescent inpatient settings, the psychodynamic relational focus of mental health nursing is significantly amplified. This is due to the additional need to foster healthy attachment relationships and tend to the development-promoting dimension of caring for young people, to mitigate the disruption of usual developmental processes caused by hospitalisation (***Foster & Smedley, 2016***). Yet the state of mental health nursing research and theory in relation to care of adolescents is even more limited, overshadowed or subsumed into adult focused

approaches, with adultist assumptions that deny the uniqueness of adolescent mental health nursing (Delaney, 2019).

To be without language or a framework to name the fundamental processes of one's occupation is to be reduced to a series of functions and to be blinded to one's own processes (Gopnik, 2014). The implications for patient care are grave. If there are no words available to name, characterise and think about it, how is it possible to visualise, critically reflect upon, enhance or improve the performance of one's work? Or, to understand and advocate against the distorting forces to which it may be subject from other disciplinary groups or organisational pressures? (Dix, 2016; Gwinner & Ward, 2013).

To see requires an "*instrument of vision"* (Haraway, 1988, p.586) – one that seeks to mediate the relatively subjugated standpoint of adolescent PICU mental health nurses. By virtue of nurses' position within disciplinary hierarchies and their proximity to and association with mentally distressed children, it is a standpoint located at the intersection of masculinist biomedical science, white capitalist patriarchy, sanism and adultism (Le Francois, 2013). Research tools are required that enable specific and embodied vision (Haraway, 1988), that enable adolescent mental health nurses to see and define themselves, rather than subject them to further deleterious external definition (Lorde, 1976). This thesis proposes that the use of psychoanalytic theory and practice, applied through inductive, co-productive data collection and analysis methods, can operate as such an 'instrument of vision'. Furthermore, that in doing so, it can (re)place the psychodynamic and development-promoting heart of adolescent mental health nursing.

Within adult PICU and general adolescent mental health inpatient nursing literature, there is a limited but notable amount of evidence to suggest that treatment outcomes are positive for patients who are in acute psychiatric distress (Gwinner & Ward, 2013), but an absence of understanding of the mechanisms that bring about change (Hayes et al., 2017). This situation warrants a critical examination of what is it that nursing teams are doing to achieve these outcomes? How can it be amplified, generalised and maintained? What are the specific,

potentially unique, demands of caring for adolescents in PICU contexts? And, how can we support nurses to meet these demands?

The portfolio of papers in this thesis utilise psychodynamic praxis to generate new co-produced research data in the field of adolescent mental health inpatient nursing to answer these questions. Developmental object-relations theory is used as a lens of analysis, to make the specific nature and contribution of nursing within adolescent mental health inpatient settings explicit. Theory developed in the first paper in the programme of work (**Foster, 2009**) is extended and tested within the specific context of adolescent PICU, where there is no prior research, through a multi-method research study (**Foster, 2018, 2020; Foster & Smedley, 2019a, 2019b**).

Section 2: Aims, objectives, and published works

2.1 Aims

To investigate the role of nurses who care for adolescents with acute and complex mental health needs in hospital settings.

To utilise a developmental, object-relations approach to understand, articulate and enable adolescent mental health inpatient nursing care.

2.2 Primary research objectives

1. Investigate the role of psychodynamic theory in understanding the interplay between mentally distressed adolescents, nursing staff, and the inpatient care context.
2. Investigate the nature* of adolescent mental health nursing and nursing intervention, in a previously unexamined area of child and adolescent nursing practice; adolescent PICU.
3. Conceptualise a model of mental health nursing within adolescent PICU settings.
4. Use this new conceptual understanding to develop and test a novel intervention to support and enable adolescent mental health nurses to articulate, enhance and sustain the therapeutic tasks of their work.
5. Evaluate the impact of this intervention on staff experience of their work and care provision.

* Within the portfolio of papers and this thesis ‘Nature’ has been operationally defined as pertaining to tasks and actions, role, knowledge, skills, theory and practice, professional values and beliefs and philosophical position.

2.3 Secondary research objective

A secondary objective addressed in the thesis is:

6. To critically evaluate the papers within the portfolio, to evaluate the suitability and validity of applying psychoanalytically informed data collection and analysis tools for researching the field of adolescent mental health nursing.

Table 1. provides an overview of how the portfolio of papers meets the research objectives. The contribution of the paper, the methods utilised, the place and impact of the publication and the independent contribution of myself as author are summarised. Detailed methodological information for each paper is provided in Section 3. A synthesised summary of findings for the portfolio of papers is presented in Section 4. Signed statements of collaboration to confirm author contribution are provided in Appendix 2. A full elaboration of the unique contribution of the papers is provided in section 5.

Table 1: Summary of contribution of published works to the objectives

	Authors	Title	Date	Research method	Research objective	Journal	Journal impact measures	Contribution to thesis	Author contribution to the work	Citation	Institution repository download	Research Gate reads
1	Foster, C	'Adolescents in acute mental distress on inpatient paediatric settings: some reflections from a paediatric liaison practitioner'	2009	Descriptive case study Theoretical discussion paper	1, 4	Journal of Child and Adolescent Psychiatric Nursing.	Citescore: 1.1 SJR 0.43	Theory and hypothesis development regarding the impact acutely unwell adolescents on nursing staff within hospital settings, and the type of staff support needed.	Wholly independent work	6	Not available full text	83
2	Foster, C	'Investigating professional quality of life (ProQOL) in nursing staff working in adolescent psychiatric intensive care units (PICUs)'	2018	Research study Quantitative	1, 2	The Journal of Mental Health Training, Education and Practice.	Citescore: 1.1 SJR 0.36	Empirical insights into ProQOL within the mental health nursing population working in a previously unexamined context of APICU using validated tool.	Wholly independent work	2	296	190
3	Foster C. Smedley K.	Understanding the nature of mental health nursing within CAMHS PICU.	2019	Research study Qualitative:	1, 2, 3, 6	Journal of Psychiatric Intensive Care	SJR: 0.42	Systematic analysis of nature of APICU nursing, identification/	Principal Investigator: All components of the study except clinical	1	649	/

		Part 1: identifying nursing interventions that contribute to the recovery journey of Young People		Theoretically informed inductive content analysis				elaboration of nursing interventions in APICU setting	project site governance monitoring and internal verification of results. Attachment theory-focused components of discussion jointly contributed to by C. Foster & K. Smedley. See statement of collaboration and contribution Appendix 2			
4	Foster C. Smedley K.	Understanding the nature of mental health nursing within CAMHS PICU. Part 2: Staff experience and support needs	2019	Research study Qualitative: Theoretically informed inductive content analysis	2, 3, 4, 6	Journal of Psychiatric Intensive Care	SJR: 0.42	Articulation of impact of work upon staff and support needs. Articulation of conceptual model of APICU nursing	As above	1	76	/
5	Foster C.	Investigating the impact of a psychoanalytic nursing development group within Adolescent	2020	Research study Qualitative: Semi-structured interviews. Hybrid Inductive-	4, 5, 6	Archives of psychiatric and mental health nursing	IF: 1.266 Citescore: 2.4 SJR :0.5	Design, implementation & evaluation of staff support method to address needs identified within papers 3 & 4	Principal investigator: all components of the study except data collection and internal verification of	/	/	/

		Psychiatric Intensive Care		deductive thematic data analysis					results. See statement of collaboration and contribution Appendix 2			

Section 3: Research paradigm and methodology

Psychoanalysis and mental health nursing share a common challenge in relation to locating them within specific research philosophies and epistemologies. The ontological assumptions of both locate them on the border of two classical epistemologies - positivism and interpretivism - troubling the positions that they border (Bender and Holmes, 2019; Clemens, 2007; Wallerstein, 2009).

Some components of psychoanalytic method have led to it being located within positivistic empirical natural sciences, in which systematic observation is identified as the primary method of knowledge generation. Whilst the presumption of the reality of the unconscious – an unobservable and untestable element of mental life - has located it within hermeneutic enquiry (Rustin 2007; Clemens 2007). Similarly, it is often proposed that nursing, especially mental health nursing, is both an art and a science and that these different domains cannot be reconciled, only negotiated in practice. The result of this attempt to locate nursing within classical research philosophies has been the bifurcation of ontology in nursing, splitting material and subjective elements of existence (Bender & Holmes, 2019). Whilst this is not distinct to nursing or psychoanalysis, it is problematic for research in both fields, as both are greater than just theory or disciplinary knowledge. They are clinical praxis; ones that are specifically interested in subjectivity and have a relatedness to the empirical natural sciences that inform contemporary understanding of health and illness (D'Antonio et al., 2014; Rustin, 2007). As stated by Clemens (2007), both psychoanalysis and mental health nursing clearly have something to do with science and are not clearly sciences.

This leads to questions of how to undertake empirical research on subjectivity? And, how to underpin it with a coherent research philosophy, such that it can be situated and critiqued in a broader body of evidence within the field? This is particularly problematic as both positivistic and interpretivist epistemologies have been charged with reducing reality to the limits of human knowledge (Fletcher, 2017) - either through making knowledge the lens through which reality is constructed, or by limiting reality to only that which can be empirically known and measured. The accusation is amplified in the case of research on subjectivity because the state of

human knowledge in the field of subjectivity is particularly piecemeal and contested (Redman, 2016). The challenge is to strive towards research methods that enable simultaneous appreciation of the concrete 'real' and the meanings and representations that are symbolised within it (Haraway, 1988).

To address the above questions, the method adopted in this thesis is that suggested by Hollway (2008): to start from first principles, stating the underlying assumptions of psychoanalytic and mental health nursing ontology that inform the researcher's world view; explicitly accounting for how these assumptions inform epistemological position, research design and the choice of methods within the design; and finally, critically evaluating the claims that can be made about the nature of the knowledge that is generated.

3.1 Underpinning ontological assumption: Love as method

The ontological assumption underlying the published work in this thesis is that the nature of existence, being, and the origin of the self is a relational process, at the heart of which is love. This ontological position is implicitly, rather than explicitly, threaded through the portfolio of papers. However, undertaking a retrospective analysis and synthesis of the papers for the final thesis has produced for me a much clearer understanding of my position, which is explicitly articulated here. It has given me an opportunity to further develop my thinking about the role of love as a primary method within adolescent mental health nursing practice. This will be explored in detail in Sections 4 and 5.

Though there are many different forms of love, all share common roots in childhood experience (Perlman,1999). The need for love has been described as an essential character of the human design (Bergman, 1980), and as the essential driver for development (Ferenczi, 1949; Fromm, 1957).

Beyond Freud's theories on love as a re-finding of the oedipal parent and/or reunification with idealized aspects of the self, is his understanding of the presence of a loving "attitude of the ego" in the conditions of abiding love (Freud, 1915). In which, a mature ego integrates multiple and conflicting feelings and impulses in order to meet the needs of the other (Bergman, 1980). This notion of love is

developed within Kleinian and post-Kleinian object-relations theory. In this frame, the psychodynamics of human existence, and psychoanalysis as a practice, are a developmentally informed, dynamic, relational process (Yakeley, 2014). Within this relational process the origin of the self is social. Development of mental functioning, a sense of one's identity and subjectivity, develop through intimate relationships with carer's (Rustin, 1989). Here, love and/or its absence are equally significant in their shaping of the self (Klein, 1959).

Similarly, at the core of mental health nursing theory is a privileged belief that as relationships are essential to human development, so relationships and interpersonal processes must be essential to health and healing (Delaney and Ferguson, 2014; Peplau, 1952; Stickley & Freshwater, 2002).

"What exists for the nursing discipline are not already-demarcated metaparadigm domains, but rather interdependent, dynamic relations that constitute people, including nurses, in their health/environment circumstance. The nursing discipline aims to skilfully access this dynamic relationality as the basis for action and reflection to produce both positive health trajectories and knowledge that facilitates future action and reflection" (Bender, 2018, p.1)

This is akin to Bergman's idea of a healing love (1987), in which the healing object, provides helpful emotional experiences with the potential to heal injuries and deprivations acquired in earlier life. Whether in nursing or psychoanalysis, healing love of this kind invokes an asymmetric relationship, requiring the helper to be mindful of and able to integrate complex and conflicting desires of the other. Within the overlapping world views of nursing and psychoanalysis, internal and external reality are understood to be mutually constituted: mediated by relational experience of our self in the context of the other, the other in the context of self, and the attendant affective experiences. The nature of the transformative components of relational experience are therefore often invisible and non-verbal (Delaney et al., 2017), or within a psychoanalytic paradigm, unconsciously communicated:

"It is only with the heart that one can see rightly; that which is essential is invisible to the eye"

(de Saint-Exupéry,1943, p.72)

Implicit in the famous quote, from de Saint-Exupéry‘s ‘The Little Prince’, is that within the nature of human being is both the capacity to see with one’s heart (a lens), and a preparedness to commit one’s heart to the endeavour for the benefit of someone else (a tool for production).

This is central to Klein’s world view: the fundamental human struggle is between care and concern for others and their destruction, that love and hate are not opposites and that love is the constraining force that modifies our innate aggressive and destructive impulses that result from profound existential anxiety (Alford, 1998). The raw capacity from early life to express an unselfish regard or caritas for the welfare of others, is, in object-relations theory, born out of an innate human capacity to identify with the suffering of others. However, it arises (or not; or in problematic ways) as a response to the specific quality of love and care received from one’s primary carers (Klein, 1946). Love is therefore both innate and produced, generative and resultant, content and method.

Within nursing theory, it has also been postulated that this specific form of love/caritas – the will to extend oneself for the purpose of nurturing the growth of an other - is an essential component of the nurse-patient relationship (Delaney et al., 2017; Winship, 1995). However, due to the physically intimate nature of our work, we are resistant to name it as such for fear of conflation with erotic, sexual or romantic forms of love (Stickley & Freshwater, 2002; Menzies-Lyth, 1988). The innately sexualised nature of the physical and emotional tasks of adolescence as a developmental stage can only intensify such fears, potentially foreclosing explicit articulation of the role of practices founded on love within mental health nursing of young people.

In both psychoanalytic and mental health nursing practice, the centrality of love extends beyond being the driver or disrupter of growth – it is a form of treatment or method. The emotions at the heart of mental distress and internal conflict (isolation, fear and despair) can only be alleviated by intimate engagement and love (Delaney & Ferguson, 2014; Gopnik, 2014; Stickley and Freshwater, 2002).

Transference, the primary vehicle for exploration and working through in psychanalytic treatment, is by any other name the problem of love. Detailed tracking of the ways in which the transference relationship is played out between analyst and

patient, is utilised as an observable proxy for the unconscious. The unconscious, or gap in the individual's conscious awareness of their own processes, is always constituted of the Other (Clemens, 2007). That is, the object-relations installed from the relational experiences of our primary carers, shadows of our first experiences of love, good and bad, that we then impose upon our perception of the external world in the here and now (Alford, 1998).

In adolescence, there is additional complexity to this process. The experience of the pubescent body as a site of loss (Polmear, 2004), and an oscillating source of turmoil and power (Lombardi & Pola, 2010), combines with the requirement to rework infantile drives and dependency experiences. Intense ambivalence towards attachment figures and carers is produced, alongside difficulties keeping an integrated appreciation of one's own mind and body (Shapiro, 2003: Waddell, 2018). Mental health work with adolescents, requires the capacity to be able to bear being both a loved and hated object, and to remain receptive to young people's projections and aggressive impulses (Midgley, Cregeen, Hughes & Rustin, 2013; Waddell, 2018), experienced as embodied countertransference (Stone, 2006). Love as method in this context, is in part the capacity to receive everything, but to filter it so that only that which the other can manage is offered back, or, as coined by Ferenczi (1949), tenderness.

Whether by providing relational proximity to ameliorate mental distress, or the use of self for the working through and articulation of the transference-countertransference, it is a central assertion within this thesis, that both mental health nursing and psychoanalytic therapy with adolescents demand a specific form of love. Love that is a form of practice in the service of the growth of the other. One that requires discipline, dedication, attention to detail, patience and rigour (Ferenczi,1949; Stickley & Freshwater, 2002). This thesis elaborates, and thereby makes a unique contribution to knowledge, the principles and application of 'love as method' in adolescent mental health nursing.

3.2 Epistemology

The intersubjective, relational process focus of my underpinning ontological assumptions mean that a broadly interpretivist research epistemology is required, to understand subjective experience and the meanings ascribed by participants to their experience (Clarke, Hahn & Hoggett, 2008). However, this is not sufficient in itself. There is a requirement to acknowledge and capture the external context that comes to bear on intersubjective and intrapsychic process, as material realities that have profound impact upon young people and their professional carers, e.g. violence, trauma, death and discrimination (Haraway, 1988).

A psycho-social research position (Frosh, 2003, 2015; Hollway, 2004) has been adopted. As within this epistemological frame, external realities are recognised at the same time as it is recognised that realities of this kind are socially and psychically mediated (Redman, 2016). Within a psycho-social framework, understanding of all psychic/psychological and social domains that make up the focus of investigation are sought and "thought together" (Frosh, 2003, p.1547) – from the individual through to system and structure, and the connections between them. This includes that which is not measurable or the 'extra-rationale', in terms of emotional dynamics and the unconscious (Taylor, 2017).

Within psycho-social research, the hyphen is most important, as it denotes the need to avoid dualism – things are not intrapsychic or social, each is always multiple, mediated by the other (Hollway, 2008). The social is symbolised within and productive of internal states, but these internal states are also understood to have their own autonomy and cannot be reduced to purely social meaning (Frosh, 2015; Redman, 2016). The hyphen becomes a third space, different to the sum of the two domains that it connects/distinguishes (Hogget, 2008). This parallels the intersubjective space created within an interpersonal encounter or relationship, in which the subject and object cannot and should not be split (Haraway, 1988).

Stenner and Taylor (2008) identify a specific characteristic of psycho-social research as transdisciplinary, i.e., the application of one set of disciplinary knowledge and tools to help articulate "*that which escapes the disciplinary knowledge*" (p.431) associated with the phenomena under study. In this case, psychoanalytic tools and

theory are applied as qualitative research methods (Redman, 2016) to further the study of adolescent inpatient mental health nursing.

3.3 Influence of epistemology on research design and methods:

3.3.1. Rationale for the selection of applied psychoanalytic research methods and theory as the overarching design

As outlined in the background, mental health nursing and support work is fundamentally psychodynamic in nature, because it is within the quality of the therapeutic nurse-patient relationships that change occurs (Lopes and Cutliffe, 2018; Flynn, 1998; Peplau, 1952). A methodology is required that can make this process and constitutive elements visible. Menzies-Lyth (1988) seminal study of institutional defences against anxiety demonstrated the power of close observation combined with psychoanalytic analysis, to reveal important intrapersonal and organisational dynamics within nursing practice.

Developmental object-relations and attachment theory are used throughout the thesis as a theoretical lens to illuminate and identify issues. A psychoanalytic theoretical lens provides a very high level of magnification of detail, as it seeks to track and understand moment-to-moment changes in states of mind, using the detailed tracking and sensing of ‘good-enough’ parenting as its prototype (Winnicott 1971; Bion, 1962). Not dissimilar to ‘good enough’ parenting, nursing is highly concerned with the detail of people’s everyday lives and experiences (Brush and Vasupuram, 2006). Under an ordinary level of magnification this can look ordinary and domestic, but under detailed scrutiny it is revealed as highly complex (Deacon and Cleary, 2012). Developmental object-relations and attachment theory explicitly attend to the specificity of caring for adolescents: the ‘to and fro’ between infantile and teenage states of mind, as they wend their way towards adulthood, and the ways in which this manifests in carer-adolescent relationships (Waddell, 2018).

3.3.2 Alignment of research methods to the epistemological framework:

The generation of situated, narrative data is at the heart of psychoanalytic and psycho-social research methods (Briggs, 2005, Taylor, 2017). However, it is argued that the generation of both nomothetic and idiographic data, through quantitative and qualitative methods, should be sought and used in parallel, to maximise and enhance understanding of complex phenomena, and to capture as closely as possible the way in which it is experienced (Briggs, 2005; Wallerstein, 2009). In line with this, mixed methods were adopted within the different arms of the research in the papers included this thesis.

A summary of methods used within each paper can be found in Table 2. Methods were aligned to the primary purpose of each study, utilising the nomenclature outlined by Wallerstein (2009), for identifying the most appropriate type of research approach (conceptual/empirical/evaluative) for psychoanalytic studies, according to the purpose (descriptive/discovery/ justification). Methods were selected to best address the research objective and questions being answered by each arm, and to enable a coherent programme of research through a process of progressive inquiry.

In paper one (**Foster, 2009**), a single case study method is employed. Systematic clinical observation of nurse-patient encounters within a paediatric medical inpatient unit is used to generate qualitative case-study data (Yin, 2003). Adolescent development and psychoanalytic object-relations theory is utilised to analyse this data and theorise the phenomenon of nursing adolescents in acute mental distress in hospital settings.

In paper two (**Foster, 2019**), a quantitative data collection and analysis method is employed, using a validated measure to quantify professional quality of life within a cohort of adolescent PICU nurses. The study uses a longitudinal, non-experimental design with a purposive sample. Quantitative data was collected from a sample of the entire staffing complement, qualified nurses (RMN) and health care assistants (HCAs), working in an adolescent PICU in the North of England. Repeated measures were administered at three consecutive intervals, three months apart, using a validated self-report measure, the Professional Quality of Life Scale V (ProQOL V, Stamm, 2010). Data was analysed via inferential statistical analysis. The ProQOL V benchmark data and findings from research investigating professional quality of life

in the closest working environment to adolescent PICU that could be found, were used for comparison. Individual item level analysis was undertaken to assess sensitivity of the ProQOL V measure for the adolescent PICU workforce. As it was collected in a clinical setting in which no research had been previously undertaken, the quantitative data provides both a descriptive baseline account of an unexamined area of practice (Rustin, 2008b) and a framework within which emerging phenomena and questions can be explored through qualitative methods (Briggs, 2005).

Table 2: Paper by paper summary of research methods

Paper	(1) Adolescents in acute mental distress on inpatient paediatric settings: some reflections from a paediatric liaison practitioner	(2) Investigating professional quality of life (ProQOL) in nursing staff working in adolescent psychiatric intensive care units (PICUs)	(3) Understanding the nature of mental health nursing within CAMHS PICU. Part 1: Identifying nursing interventions that contribute to the recovery journey of young people	(4) Understanding the nature of mental health nursing within CAMHS PICU. Part 2: Staff experience and support needs	(5) Evaluating the impact of a psychoanalytic nursing development group within adolescent psychiatric intensive care unit
Purpose	Conceptual	Empirical	Conceptual	Conceptual	Evaluative
Research approach	Descriptive	Discovery	Discovery	Discovery	Justification
Overarching method	Qualitative Case study	Quantitative Longitudinal, non-experimental	Qualitative Conceptual text analysis	Qualitative Conceptual text analysis	Qualitative Interviews
Data collection tool	Clinical observation	Validated psychometric measure	Psychoanalytic Work Discussion group	Psychoanalytic Work Discussion group	Semi structured Interviews
Coding analysis and abstraction	Theoretical, grounded in specific instances	Empirical Statistical - descriptive & inferential	Inductive Content analysis	Inductive Content analysis	Hybrid inductive/ deductive Thematic analysis

In papers three and four (**Foster & Smedley, 2019a, 2019b**), a qualitative design is employed. A bespoke weekly PWDG was designed and implemented as a tool for generating rich narrative data on a subject for which an existing data set is not readily available for systematic analysis, i.e. the nature of mental health nursing, intervention and identity within adolescent PICU (professional subjectivity).

The embodied and relational nature of the work means that psycho-social and psychoanalytic research needs to use methods where participants have some influence over the construction of the interpretation of results (Hollway, 2004). A bespoke adaptation of the PWDG method was applied as a tool for coproducing new data and for interpretation of the meaning of this data, through creation of interpersonal spaces where participants can articulate and ascribe meaning to the relational aspect of their work (***Foster & Smedley, 2016***). The unit of analysis was defined as the set of notes from one PWDG, each checked and agreed by the nursing team. The sample was 26 units of analysis spanning a six-month period. The value of Work Discussion as a research method is that the first level of data analysis is undertaken within the PWDG itself, allowing for multiple different interpretations (Briggs, 2005). However, to reach the required standards for a research method for new knowledge generation, Work Discussion needs to be located within procedures for recording detailed descriptive reports, and for second level data analysis and abstraction that are systematic, observable, replicable and subject to testing through independent participants (Wallerstein, 2009; Rustin 2008b). In **Foster & Smedley (2019a, 2019b)** a rigorous, theoretically informed, inductive content analysis method has been used to archive, organise, code and analyse data (Elo and Kyngas, 2007).

Paper 5 (**Foster 2020**), is a qualitative evaluative study. A cross-sectional, non-experimental design was employed with a purposive sample. Descriptive data outlining the bespoke adaptations of the PWDG is provided. Data collection was undertaken through participant interviews for the purpose of understanding the experience and impact of participating in the Work Discussion groups. Data was coded and analysed through a hybrid inductive/deductive thematic analysis method (Fereday and Muir-Cochrane, 2006), using cross-case analysis.

3.4 Ethical considerations

The multi-methods research study that makes up a significant part of the portfolio of papers submitted for this thesis was screened using the Health Research Authority Ethics Decision Tool (http://www.hra-decisiontools.org.uk/ethics/). It was confirmed as requiring local university research ethics committee approval, rather than NHS IRAS ethical approval. This was because no patients or patient information were involved in the intervention.

The study was approved through the University of Salford, School of Health and Society Research Ethics and Governance Committee (Reference: HSCR14/19, see Appendix 4) and via the Operational Research and Development Policy of the independent organisation, in which the research was conducted. This included completion of the organisation's research passport, to ensure minimum governance standards were met. Local service approval was given by the Young People's Service Governance Committee. After approval from the University of Salford research ethics committee, final organisational approval was given by the hospital provider's Executive Director for Research & Development and the project was logged with the hospital provider's Research and Development Office.

Project participants gave written informed consent to participate. All research data was managed in accordance with the Data Protection Act (1998 & 2018) and the General Data Protection Regulation (GDPR, 2018), and the University of Salford research information governance policy (https://beta.salford.ac.uk/sites/default/files/2020-05/ResearchDataManagementPolicy2016.pdf).

There is no identifying patient material included in the study. Material regarding clinical issues discussed in the PWDG (**Foster & Smedley, 2019a, 2019b**) was recorded as part of the group process in aggregated themes, with staff and patient identifiers removed. This was made available for all unit staff members, stored on the unit's private drive within the hospital's secure server (in accordance with the organisation's standards for data protection). The principle researcher had access to this information as part of their employment, when on the hospital site. All data collection and analysis of the material was undertaken on the Hospital site.

All components of the research study were conducted in accordance with the Nursing and Midwifery Council Code of Conduct (NMC, 2018); the British Association of Counselling and Psychotherapy (2018): Ethical Guidelines for Researching Counselling and Psychotherapy; the Royal College Nursing (2009) Research Ethics: A Guide for Nurses and the University of Salford ethical principles and procedures for undertaking research (https://testlivesalfordac.sharepoint.com/sites/EthicsandResearchGovernance/Shared%20Documents/AcademicEthicsPolicy.pdf?cid=21d5c234-6849-47e4-916c-fd7ff3865109).

3.5 Reflexivity and establishing rigor in the research process

Within the epistemic frame of psycho-social research studies, one's own subjectivity must be located and considered in relation to the effects upon the knowledge produced (positional reflexivity). And yet, within the psycho-social research frame, 'self' is multiple and cannot be known completely (Pillow, 2003), making complete and transparent reflexivity impossible (Haraway, 1988). Similarly, within the field of psychoanalytic practice, in which personal analysis and supervision to bring previously unknown and unconscious elements of one's self to the fore, are the bedrock of the treatment frame; it is accepted that this is a lifetime's work that can never be fully achieved.

Instead, what has to be accepted is the situated nature of knowledge (Haraway, 1988), alongside the reality that the knowledge we generate as researchers is 'limited, specific and partial', shaped by the focus of our own interests and the specific circumstances within which research is conducted (Corlett and Mavin, 2018). Recognizing the situated and partial nature of research knowledge generation can enable what Haraway (1988) has described as a feminist objectivity; creating the ability to find and contribute to a larger visual field by joining with others, patching our specific and partial views together in order "to see together without claiming to be another" (p.586).

One mechanism utilized in this thesis, to optimize transparency of the standpoint from which knowledge is generated, is of being explicit regarding one's own ontological assumptions (Section 3.1) and position as a researcher (Section 3.5.1). However, this is not sufficient by itself. Cousin (2010) highlights that without critical interrogation 'positional reflexivity' creates a situation in which the researcher's privileged position just functions as a 'special pair of glasses' through which participant's experience and subsequent data are viewed, rather than enhancing rigor. To address this, Day's (2012) framework for ensuring rigor throughout the process has been applied. This requires questioning three aspects of research practice - Thinking, Doing and Evaluating - to ensure both positional and methodological reflexivity.

Thinking, requiring interrogation of one's understanding of reality and the nature of knowledge, is undertaken in this methodology section of the thesis (Section 3), and applied within the critical analysis of the papers and their unique contribution (Section 5).

Doing, requires interrogation of one's relationship with the research context, participants and data. This begins with an account of my rationale for research methods selected (Section 3.4.2) and my position as a researcher and its implications (Section 3.5.1). It continues through detailed exposition and application of data collection, analysis and abstraction methods provided within each research paper included in the portfolio. Finally, the specific environmental, cultural and disciplinary context in which the studies are situated (adolescent, PICU and nursing) is retained within the synthesis of findings from across the body of work (Section 4) and the implications are analysed with Section 5.

Evaluation, requiring consideration of the question 'what is valid and valuable research?' is undertaken within the Critical Analysis (Section 5.3). This builds on the critical evaluation of findings and methods provided within each individual paper. A micro and macro-level analysis is presented of the impact of researcher position, theoretical perspective and methodological claims of new knowledge and contribution.

3.5.1 Researcher position

In considering why I chose this subject of study and my relationship to it, I was mindful of the observation that research subject and setting can reflect an inner dynamic of the researcher (Clarke et al., 2008). The subject of my research is adolescent mental health nursing. So, by definition it is also mental health nurses, the adolescents that mental health nurses provide care for, the settings in which this occurs (hospital settings, specifically PICU hospital settings), and the wider health care context within which all this sits. It cannot be ignored that the research study in adolescent PICU, upon which much of the thesis is based, came about in a period of my own transition, moving from full-time clinician and part-time academic to the other way around. This period represents an adolescent space in my career pathway, characterised by a process of mourning one element of my identity to develop and move forward with another (Polmear, 2004).

I started my career, first as a healthcare assistant in a secure adolescent inpatient unit and then as a staff nurse within a general adolescent mental health inpatient unit. Here I would also take up my first managerial post. These formative professional experiences have driven a career-long passion for making the specific experiences and requirements of mentally distressed adolescents and the relationship between childhood trauma and mental distress, visible within the innately biomedical and adultist world of acute psychiatry, in which mechanisms that create distress are often disguised (Nayak, 2020).

Here, there is an important intersection with my personal biography. I am the daughter of a naval nurse who was forced from her chosen career by her pregnancy with me. I am the granddaughter of a nurse whose career was decided by the realities of the Second World War. In my identities as a woman, daughter, sister, partner and friend, I have lived and seen the intergenerational impact of institutional and patriarchal heteronormative aggression on the health and choices afforded to women and children. In this context, I have also experienced the transformative effects of ‘love as method’ - being held in the loving gaze and thoughtful mind of others, who are prepared to commit themselves for your betterment and development. I have benefitted from the privilege and resource afforded by this kind of loving care, whether through moment-to-moment care or enablement of education and social mobility.

What has been produced in the intersection of my personal and professional biography is a deeply held commitment to the principles of humility, service, and compassion for the life of others as the basis of meaning in one's own life (De Beauvoir, 1972). This is combined with a deep interest and respect for the emotional and relational components of domestic and care work. It is work that is often seen as 'women's work', constituted of components that are hard to quantify, and that are devalued and rendered invisible within healthcare institutions and the wider apparatus of society and state (Brush and Vasapuram, 2006; De Frino, 2009; Schuengel, Kef & Worm, 2010). It is a phenomenon that has valency with my (nursing) profession's disciplinary tendency to do the work and hope it speaks for itself, behind which is a commitment to levelling power imbalances and enabling others. Though Peplau devoted her scholarship to the careful naming and valuing of psychiatric nursing, when asked how she would like to be remembered she responded, *"As a responsible citizen and as a nurse, and leave the rest to history."* (Church, 2000, p23). This tendency within the profession of mental health nursing is available for use by forces that have a vested interest in keeping the 'domestic' work of nursing in its (subjugated) place. It has also provided a screen behind which I have been able to hide the wounds of my early experiences, which taught me to hide aspects of myself out of view and to avoid expressing agency or ownership over my abilities, as a means of avoiding denigration or replication of the power plays that created those wounds in the first place.

Why is this self-disclosure relevant to my thesis? Because, the focus of my work has been to enable adolescent mental health nurses to name and define their craft and contribution, whilst in a parallel process, I have struggled to engage with the process of articulating the unique contribution to knowledge that I have made; a requirement for the award of PhD. With the support of my supervisors, this is a tension that I have had to occupy, feeling my way through in order to find a mechanism for speaking in spite of my fear (Lorde, 1977), in a way that does not betray my values.

As my career progressed, I worked as a paediatric liaison practitioner providing consultation, advice and support for staff working in paediatric medical inpatient services, whilst concurrently completing my adolescent psychotherapy training. A training I embarked upon specifically to help me address the sense of grasping wordlessly at intense staff-patient dynamics that I could see, but not always name or

make sufficiently available for working through. It was at this point that I wrote the first paper in the series (**Foster, 2009**).

My final NHS post, was as an older-adolescent community mental health service manager and clinician, spending all my energy and efforts to keep young people out of hospital, knowing the deleterious impact it can have on them. The positive risk-taking needed to achieve this outcome was only made possible by the safety net provided by those very same inpatient services. Services that are largely staffed by the lowest paid strata of the nursing workforce (health care assistants and newly qualified staff nurses) and subject to some of the highest levels of violence and workplace adversity (Baeza et al., 2013).

The move from NHS to university employment brought the opportunity to utilise the experience and skills gained as a senior mental health nurse and adolescent psychotherapist back where I started, in a (different) locked adolescent inpatient unit. However, this time to use my acquired privilege and power to support and, through research, shine a light on the work undertaken within it. Working as an honorary psychotherapist, tasked to provide support and staff consultation in this adolescent PICU, led to the design and implementation of the multi-methods research study reported on in papers two-five (**Foster, 2018, 2020; Foster & Smedley, 2019a, 2019b**).

3.5.2 Implications for my approach to the research process and to writing.

Sharing characteristics and experiences with subject and participants has some benefits. I have both a participant and observer's appreciation of the level of tenacity and persistence needed by young people, staff and family, to endure the hardships of adolescent inpatient settings. I have first-hand experience of how those hardships can at times shut down thinking and tenderness towards self and others, in favour of instinctive survival mechanisms. I have a detailed understanding of the procedural and operational work of nurses in hospital settings, alongside an appreciation of the structural inequalities that exist within multidisciplinary inpatient mental health teams, in terms of nurse's place, voice and contribution. All of which mean I have a contextual understanding and sensitivity in relation to my subject that can help achieve a deep level of understanding and interpretation of the data (Day, 2012).

At the same time, I am not an inside researcher. My dual identity as a mental health nurse and psychotherapist, combined with working in the participating organisation on an honorary basis, afforded me a freedom of movement, which means I am positioned differently to my research participants. The effect of my simultaneous and sometimes contradictory positionalities of nurse/psychotherapist and insider/outsider are explored further in **Foster (2020),** using Briggs (2008) concept of 'temporary outsidership'.

My position also means that there are risks that I grappled with through the research process. As an adolescent mental health nurse, I am to some extent researching my own identity. No longer in clinical practice as a nurse, there is a danger of being nostalgic, and of longing for it to have meant something. This comes with potential for romanticising and rarefying what is seen within the data. In my wish to foreground the relational elements of nursing practice and that which makes a positive difference, there is a risk of 'turning a blind eye' (Steiner, 1985) to the knowledge that adolescent inpatient mental health units are institutions that are products of and re-produce intersectional power dynamics (Crenshaw, 1989). Institutions in which young people are subjected to legally sanctioned restrictions on their freedom, structural racism, sexism homophobia and narrow social constructions of 'normal', based on adultism and sanism (Le Francois, 2013). To try to counter the tendency toward 'romanticising knowledge at the margins' the knowledge produced from my series of papers is critiqued in Section 5, in light of the systemic context in which is situated (Haraway,1988).

In addition, my own positive experience of psychoanalytic training helping me to name and navigate a way through something that my mental health nursing language could not, poses a risk of reification of psychoanalytic theory; mistaking concepts as concrete occurrences, rather than a conceptual, symbolic language to be applied to help illuminate and communicate the observed phenomena.

Several approaches have been applied to mitigate these risks. One has been to seek multiple perspectives upon realities that can help to (partially) recognise the distortions and blind spots in our own understanding of the world (Hollway, 2008). The portfolio of works presented in this thesis uses both empirical and experiential knowledge as legitimate epistemological methods of enquiry, applying quantitative

and qualitative research methods to view the subject through different lens (Bender and Holmes, 2019). Data collection has been undertaken by independent colleagues where appropriate. Data analysis methods have been systematically applied and rigorously adhered to, as a means of being accountable for how particular readings of the data was reached (Frosh & Eminson, 2005). In addition, across the body of work, process notes, facilitator and researcher reflective field notes have been kept and systematically archived. These have been used alongside independent internal verification and peer review processes, to enhance the process of reflexivity throughout.

The risk of concretely identifying with the nursing staff participants comes with the potential to deny the power, privilege and relative freedom that come with my additional roles of psychotherapist, researcher and academic. Denial of the asymmetric relationship between researcher and participant in qualitative research, in which participant lived experience is turned into data that often benefits the most privileged (i.e. researcher becomes Dr), can lead to reproduction of structures of oppression, even when the intention is to use research to do the opposite (Huisman, 2008; Langellier, 1994). Central to the process of trying to mitigate this risk has been the use of a data collection method (PWDG) that facilitates co-production and first level analysis of the data with participants, and that also provides a concurrent staff support intervention (**Foster, 2020**). This is an application of the underpinning ontological assumptions of my work, and of my values as a feminist and nurse. Situated knowledge requires the object of knowledge to be agents in the generation of knowledge rather than passive resources that are used to reinforce the power of the researcher (Haraway, 1988). Furthermore, the purpose of research should bring benefit to participants. The duty of the researcher is to work in the service of the participants, and to treat the experiences that they are generously offering with caritas/love. Methods of abstraction have been used that retain the details and contextualise any generalised principles within the specifics of the subject. This is intended to protect against the risk of dehumanization that can come with the stripping of complex biography down to a statistic or generic model (Gopnik, 2014). Despite this, asymmetrical power relationships with participants cannot be completely equalized and are critically analysed in Section 5.

A challenge of writing the final thesis of a PhD by published works is that one is retrospectively constructing a coherent account of the research process reflected in the published papers. In this case, papers that were developed over a ten-year period. At the beginning of which, my knowledge of research philosophy, method and understanding of power dynamics within the research process was different to now. The temptation to present an overly neat and theorised narrative of the decisions made is ever present (Haraway,1988). In fact, many of the decisions in practice were made on an instinctive and pragmatic basis in response to tacit understandings of the tensions present. Therefore, the relative success of the measures taken are interrogated as part of the critical analysis process in this thesis.

The synthesis of findings from across the portfolio of papers reflects a psycho-social positionality. In particular, giving due attention to the iterative relationship, and potential integration, between knowledge that pertains to the intense study of specific subject and objects within the micro-context being researched, and more generalized abstractions that can be transferred to understanding of wider structural issues (Briggs, 2005; Huisman, 2008; Wallerstein, 2009). Therefore, synthesis and critical analysis of findings from across the portfolio of papers as a whole body of work are mapped against explicit research objectives, to retain the specificity of the research context, and presented thematically to capture emergent data-driven findings that can be transferred to a wider context.

Section 4: Findings

The key findings from the papers submitted in this portfolio of published works are synthesised here under the themes of:

- Impact of adolescents on nurses and on the care setting
- Understand adolescent PICU nursing – developing a model
- Nursing intervention in adolescent PICU and its impact upon professional wellbeing and identity
- The role of gaze and observation
- Professional quality of life
- PWDG as a method of staff support

4.1 Impact of adolescents on nurses and the care setting

Against a historical backdrop of marginalization and dismissal of the specific needs of adolescents in mental distress and of the unique challenges for service provision, that prevail in acute psychiatry; **Foster (2009)** theorizes the challenge of providing mental health care for adolescents in hospital settings, and identifies general principles for enabling nursing staff who work in these settings.

By applying psychoanalytic theories of adolescent development, trauma and organizational dynamics to systematic clinical observations, **Foster (2009)** articulated the impact of adolescents in acute mental distress who are admitted into hospital settings on the staff caring for them, and the young people's consequent experience of that care.

The primary findings were:

- An understanding of the mutually constitutive relationship between the adolescent, the nurses and the care context.
- A profound resonance between adolescent and nursing staff states of mind and the defence mechanisms they both used to manage pain and trauma.

Foster (2009) demonstrated how valency between elements of the developmental tasks of adolescence, the disciplinary culture of nursing and the organisational structure, meant that nurses and the adolescents admitted to the ward often shared a common internal object, leading to dominant feelings sweeping across the group

via the process of projective identification. The paper provides an explanatory model of how this occurs.

Projective identification is the innate and unconscious ability to stir up feelings in our carers through non-verbal processes, that enables us to communicate and get rid of unbearable states of being, and have our needs met (Riesenberg-Malcolm, 2001). Essential to our survival in early life, although it is increasingly replaced by language as we get older, it is never completely replaced and is often returned to during times stress (Bion, 1962a). In adulthood a reliance of projective identification for communication and defence is often understood as problematic and indicative of earlier disruptions in psychological development (Winship et al., 2019). Whilst this is also true for young people, it is important to recognise that adolescence is a period in which there is a more developmentally ordinary return to reliance on this communication mechanism, due to the mismatch between the intensity of the emotions young people experience and their incomplete language development (Briggs, 2009).

Adolescent defence mechanisms serve to expel rather than contain pain, tilt towards acting out rather than thinking through, and towards the use of the body to manage/regulate and communicate (Waddell, 2018). Hospital settings are also organised in way that promotes excessive work rates/action to cut out space for thinking (Waddell, 2005). There is an external systemic pressure to ‘do something’ where thinking is perceived as ‘doing nothing’, mirrored by internalised pressures that nurses carry from their disciplinary culture (Menzies-Lyth,1988; Winship, 1995). This is coupled with a reliance on the ‘body’ of the hospital ward and its routines and procedures to manage and regulate distress. There are additional pressures for nurses working with children, due to the higher social expectation to keep children alive and well, compared to the acceptance of the presence of ill-health in adults.

Using Garland’s (2002a) definition of trauma - that which pierces our resilience and confirms something of our worst fears - **Foster (2009)** showed how admission of the adolescent has the potential to be traumatic for both young person and nursing staff. For adolescents, the primary difficulties they are experiencing that lead to admission trigger reversion to a more ‘paranoid-schizoid position’ (Klein, 1946) as vulnerability triggers anxieties about annihilation and persecution, activating the defence of

splitting. The hospital environment is a direct challenge to their need for individuality and independence, further activating psychic defences and the need to fight, to surmount the authoritative and paternalistic structures that constrain the adolescent.

For staff, the circumstances and organisational processes that govern unplanned admission, along with the nurse's place within the hierarchy, mean they rarely have control or autonomy in relation to the decision making. This combines and resonates with the impact of the distressed adolescent themselves. Adolescent ways of coping at times of acute distress intrude upon usual institutional defences against anxiety associated with "everyday work" – i.e. the performance of tasks and routine (Menzies-Lyth, 1988). The ways in which young people communicate their needs with an intense emotionality can quickly render the nurse's sense of competence and confidence useless, whilst simultaneously putting staff back in touch with their own adolescence (**Foster, 2009**). This finding was replicated in the study by **Foster and Smedley (2019a)**, in which the challenges most often brought by staff for support were not related to symptoms of the young person's mental health condition *per se*, but to the emotional and behavioural disturbance that is a function of adolescence itself.

Adolescent fears and states of mind - mental and physical powerlessness - become mirrored in the staff, leaving them feeling overwhelmed. This experience is amplified across the nursing team, due to young people outnumbering the nurses, causing nurses to gang together and rely on their own primitive unconscious defences for managing the existential threat that they are facing. What can result is a cycle of escalating indirect communication of need by young people and nurses, via projective identification (i.e. giving each other and those around them a taste of what it feels like to be them), followed by defence against the experience of being projected into in this way (splitting, denial and acting out), with no soothing of distress (**Foster, 2009**). Furthermore, in a later study by ***Fisher and Foster (2016),*** collective team memories of these episodes of escalating distress, actively discouraged nursing staff from engaging with future young people in mental distress who were admitted into their care.

Foster (2009) begins to track in detail and articulate the relationship between nursing staff wellbeing/distress in the workplace and their capacity to provide

effective thoughtful care for young people in mental distress, and the way in which projective identificatory processes mediate this relationship. At its heart is the knowledge that the success of unconscious communication via projective identification, whether as babies, teenagers or adults, is dependent upon the availability of adults who are receptive to receiving and thinking about what they are being invited to feel, i.e. acting as an emotional container (Bion,1962b). Thus, for nursing staff to be able to provide this kind of attendant and attuned care for teenagers, it must also be provided for them.

To support nursing staff who are looking after adolescents in acute distress, to maintain their capacity to think under fire, **Foster (2009)** hypothesised that strategies are needed which:

- are based on a detailed understanding of the nature of the primary task of adolescent mental health nursing within a given setting;
- provide emotional containment for both staff and young people;
- nurture hopeful objects outside of times of crisis;
- model a healthy respect of nurses' defence and coping mechanisms as a means of helping them respect the adolescent's coping strategies, rather than try to crush or extinguish them (This is a prerequisite for getting staff to invest in the internal world of the young people who are causing them so much distress);
- translate psychoanalytic and interpersonal constructs that help make sense of what they are being subject to, in such a way that they can be given in bite sized chunks that can be easily applied;
- understand the context/ system/ organisation as an active player and accommodate understanding of real external pressures and constraints in the way in which support is organised;
- integrate the thoughtful/symbolic with the practical/concrete.

The findings of **Foster (2009)** informed the design and implementation of a multi-methods research study investigating the specific setting of adolescent PICU, a context in which no previous research had been undertaken.

4.2 Understanding adolescent inpatient nursing from the ground up – developing a model of adolescent PICU nursing

Foster and Smedley (2019a, 2019b) set out an inductive investigation into the nature of mental health nursing in adolescent PICU. Content analysis of the data identified seven interrelated themes: (1) Presenting difficulties; (2) Complexity within the clinical environment; (3) Tensions; (4) Nursing Interventions; (5) Frustrations; (6) Staff experience; (7) Learning and development (Figures 2a, b, c).

Figure 2a: Young people's presenting difficulties, complexity and tensions (reproduced from **Foster & Smedley, 2019a**)

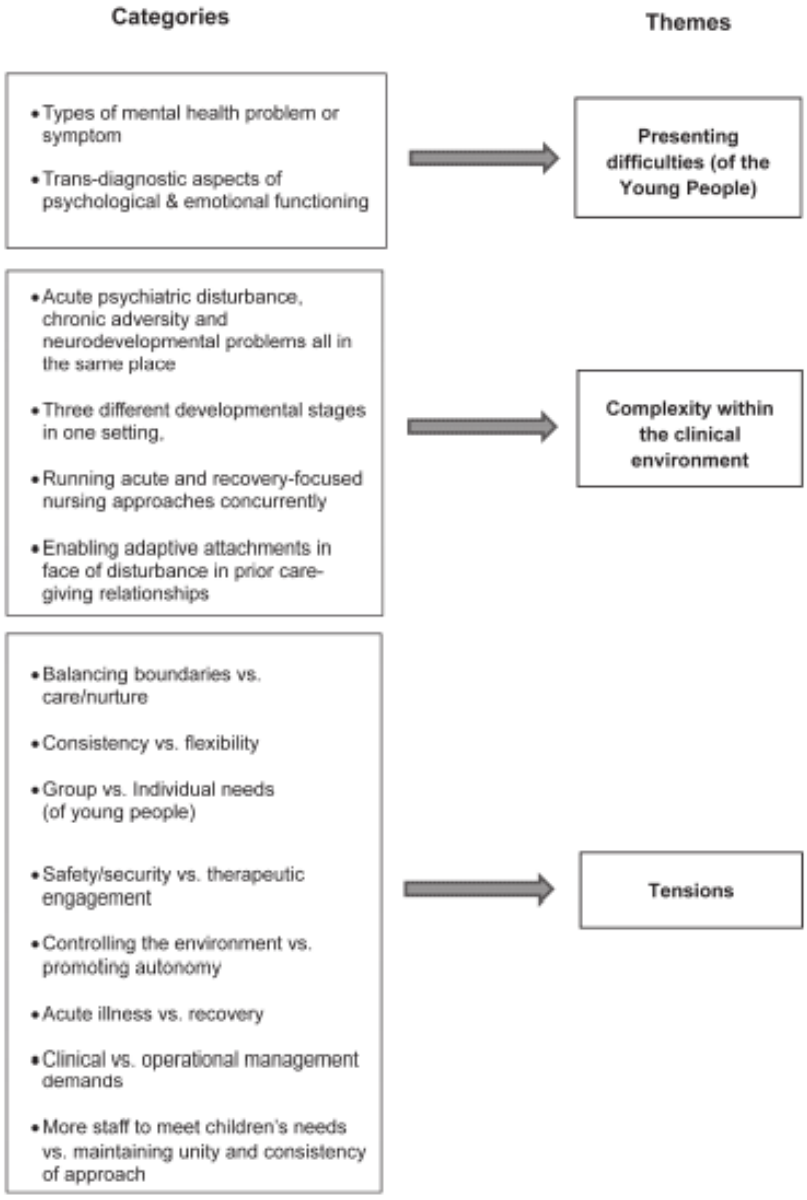


Figure 2b: Nursing interventions (reproduced from **Foster & Smedley, 2019a**)

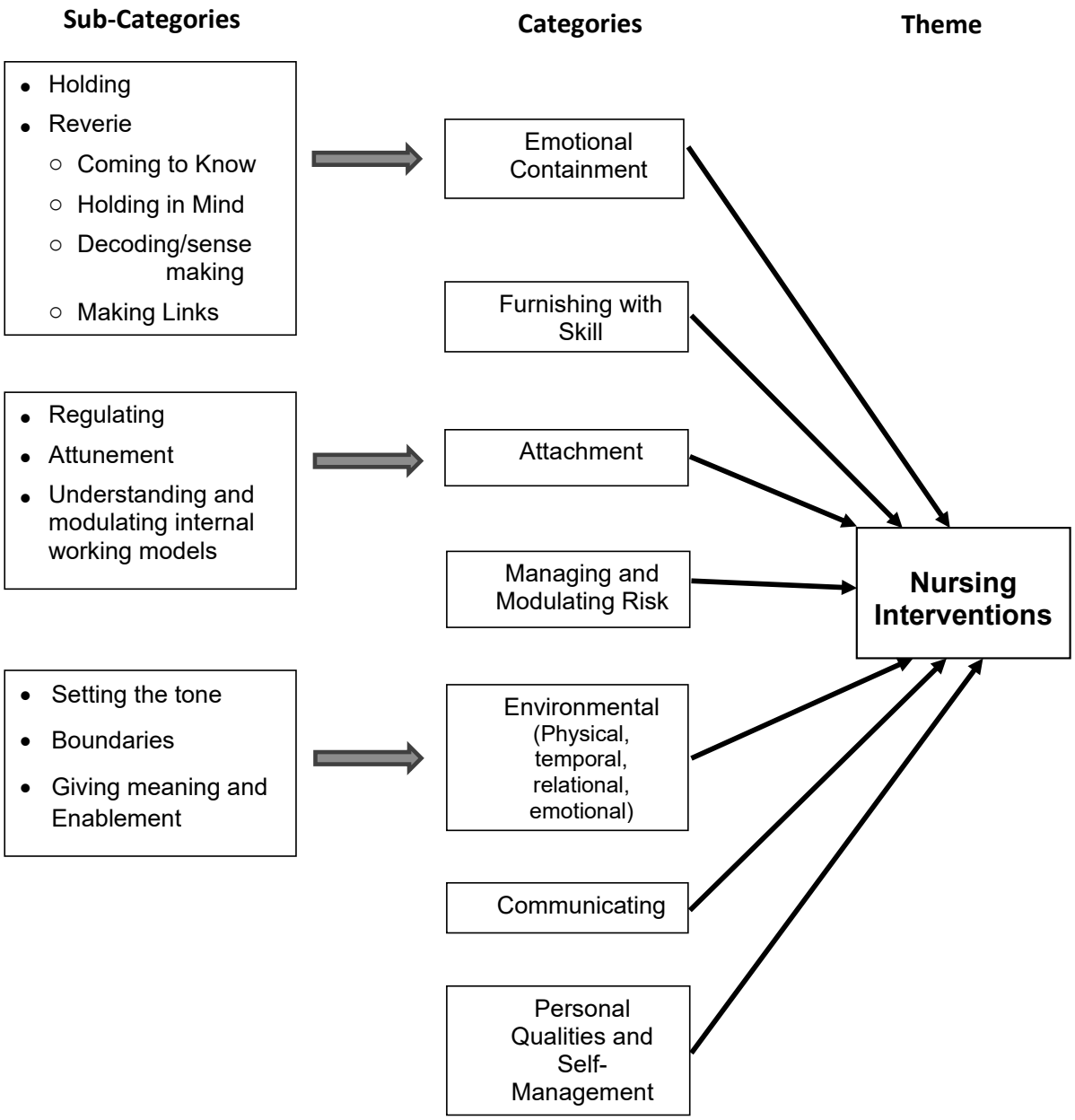
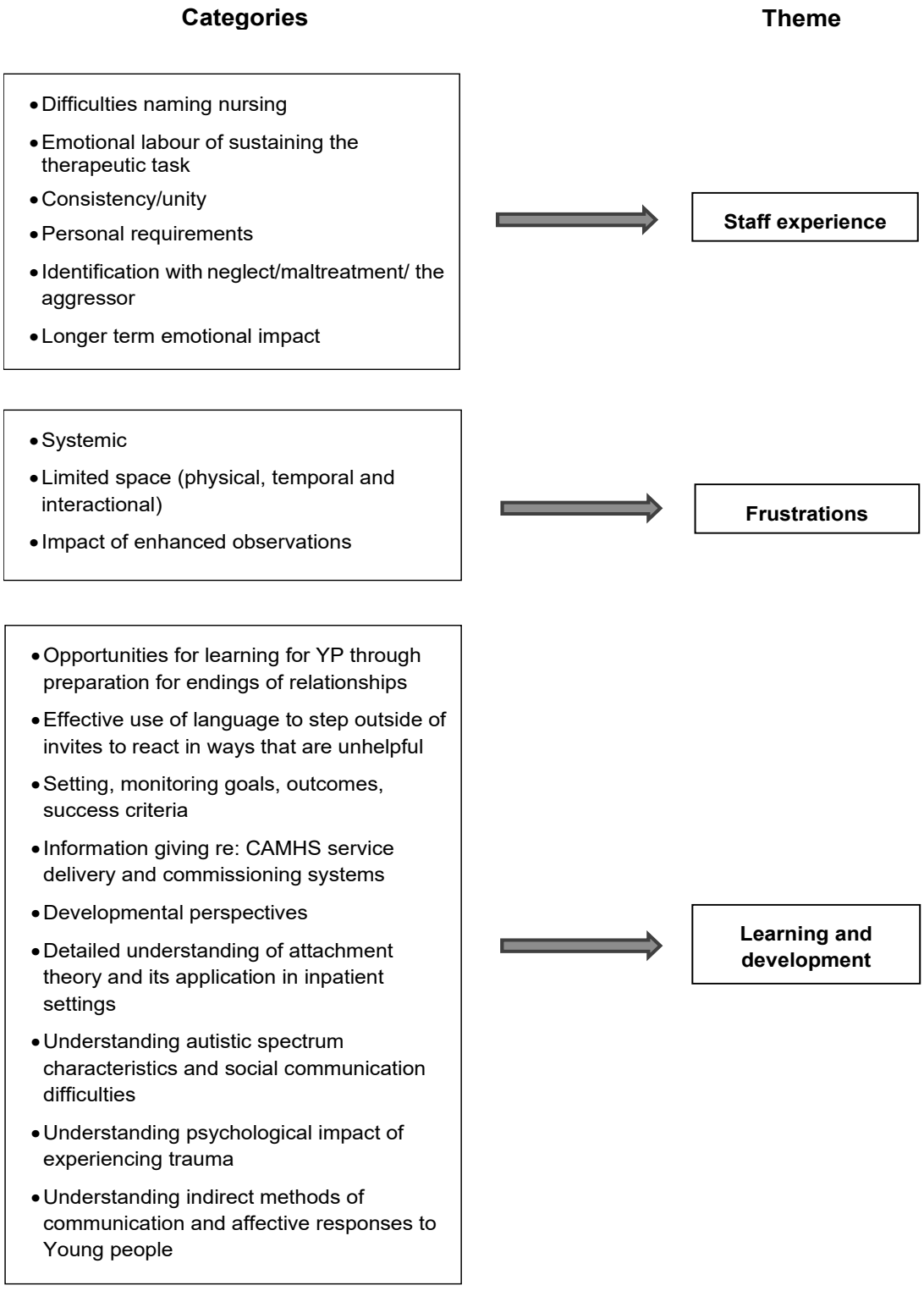


Figure 2c: Staff experience, frustrations and sources of learning (reproduced from **Foster & Smedley, 2019b**)



Analysis of the dynamic relationship between each element created a new conceptual model of mental health nursing in adolescent PICU, showing an intersectionality of environmental, systemic and developmental contexts that shape the primary task; the unique interventions that emerge to achieve this task; the staff experience of undertaking the work; and the facilitating and inhibiting factors that affect performance of their task and their professional identity. The model is presented in Figure 3.

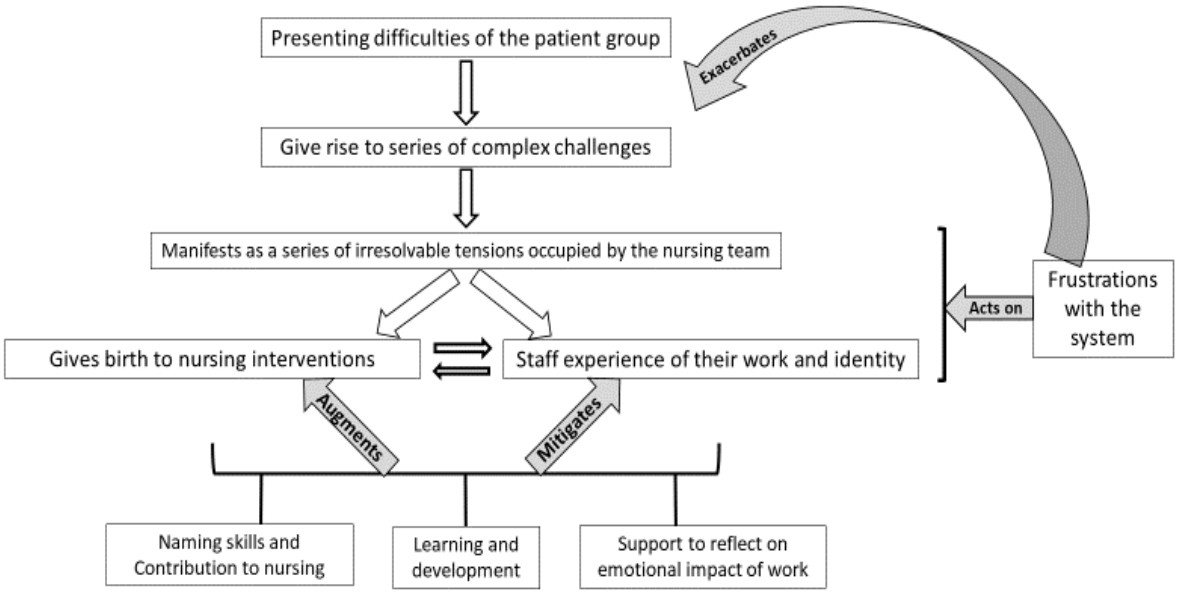


Figure 3. Model of Adolescent PICU Mental Health Nursing (reproduced from **Foster & Smedley, 2019a**)

Young people admitted to the unit experienced the full range of mental health disorders that would usually be expected within an acute psychiatric setting (**Foster & Smedley, 2019a**). However, it was not the psychiatric diagnosis that was most important in shaping the nursing response, but a range of trans-diagnostic aspects of psychological and emotional disturbance that are a function of the adolescent process (Briggs, 2009). These included adolescent emotionality and defences against such emotionality and peer, sexuality and identity disturbances that were

driven by the adversity or trauma that had precipitated their mental health crisis, or exacerbated by the mental health condition itself (**Foster & Smedley, 2019a**).

The study found that there was an interaction between these elements of adolescent disturbance, the primary diagnoses of the young people, and systemic challenges within the CAMHS care pathway, which led to four domains of complexity within the care task:

- Managing the differing care needs of young people with acute psychiatric disorders, neurodevelopmental differences and the impact of chronic adversity, in a highly contained space that had been designed with only acute care in mind.
- Delayed discharges, meaning the team had to try and provide less restrictive care plans aimed at promoting longer-term recovery, in the same environment as providing care for acutely disturbed young people with very high-risk behaviours.
- Trying to provide an appropriate care milieu for young people in three different developmental stages (early, mid and late adolescence), whilst managing the concomitant safeguarding challenges.
- Forging adaptive attachment-like relationships - required by all young people, not yet self-sufficient, to meet their basic care needs - in the face of frequent disturbance in primary attachment relationships, compounded by significant geographical separation. (**Foster & Smedley, 2019a**).

In keeping with the assertion made by **Foster (2009),** the physical and procedural environment was identified as an active player in the care dynamic. The tendency of the environment to replicate elements of young people's primary trauma, intensify their disturbance and re-double reliance on their adolescent defences, had to be managed and mitigated by staff. Frustrations linked to these environmental pressures exacerbated the complex challenges and added to the burden of emotional labour for staff (**Foster & Smedley, 2019b**).

Foster and Smedley, (2019a, 2019b), concluded that the primary task in adolescent PICU is: enabling developmental growth and reparation for young people who are experiencing acute psychiatric disturbance during a critical phase of their maturation, often against a back drop of neurodevelopmental challenge and/or chronic adversity

and complex trauma, within a restricted physical environment that cannot avoid carrying echoes and shadows of prior traumas endured by the young people**.** The study found that this manifests as a series of eight irresolvable tensions (Figure 2a):

(1) Boundaries versus care/nurturing; (2) Consistency versus flexibility; (3) Whole group versus individual needs; (4) Safety/security versus therapeutic engagement; (5) Controlling the environment versus promoting young people's autonomy; (6) Acute illness versus recovery; (7) Numbers of staff on shift: increased resource to meet needs versus maintaining unity and consistency of approach; (8) Clinical versus operational management demands (**Foster & Smedley, 2019a**).

The mutually constitutive elements of these tensions, and the requirement to occupy all of them, all of the time, is the crucible in which adolescent PICU nursing interventions are forged. These tensions can never be resolved. The proximal relationship between the two elements of each tension can only be understood and an optimal position, in which the two elements must be held in relation to each other, continuously strived towards. As the primary nursing task is fundamentally relational and developmental in nature, it requires explicit engagement with young people's attachment, dependency needs, and the dialectic nature of adolescent development. It has to be carried out in the face of personal, interpersonal, group, clinical, organisational and environmental pressures, pushing the nursing team towards one direction or the other.

Foster and Smedley (2019b) assert that in adolescent PICU nursing, team identity is shaped by the experience of two forms of emotional labour: acting as a collective container and sense-maker for the indirectly transmitted emotional components of young people's communication, via projective identification, and doing so whilst continuously residing within a state of tension along multiple planes. The result of this is that the factors that enhance or impede recovery are often two sides of the same coin. The emotional toll of the unrelenting nature of the nursing interventions required, actively serves to corrode or undermine staff capacity to keep going with these interventions.

Supporting nursing staff with the process of naming their work and their contribution to care - through opportunities for learning about underpinning theory and evidence to help make sense of theirs and the young people's experiences, in a supported,

reflective thinking space - was shown to augment nursing interventions and partially mitigate the emotional depletion, feelings of loss, helplessness and moral distress associated with them (**Foster, 2018; Foster & Smedley, 2019b**).

4.3 Nursing intervention in adolescent PICU and its impact upon professional wellbeing and identity: Two sides of the same coin

4.3.1. Interventions

Foster and Smedley (2019a) identified 75 distinct nursing interventions, organised into categories of emotional containment, attachment, furnishing with skill, managing and modulating risk, environmental management, communicating and personal qualities (Figure 2b). Detailed examples, of how each of the interventions identified in the study were enacted by the nursing team, are outlined in **Foster and Smedley (2019a).**

The categories of communicating, furnishing with skill, managing the environment and risk management were found to share some commonality with elements of nursing intervention identified in the existing literature re: adult PICU and general adolescent mental health inpatient units, but with some nuanced differences (For specific examples see discussion of advocacy and child-led care in **Foster and Smedley, (2019a)**.

Interventions described within the categories of emotional containment, attachment and personal qualities are distinct from any interventions reported in the adult PICU or general adolescent inpatient unit literature and made up over half of the interventions identified. The inter-relationship between the nursing intervention categories are illustrated in Figure 4. All the interventions identified centre around two elements of work identified by the nursing staff: *"learning about young people through the way they make you feel"* and *"seeing, receiving and reflecting"*. The latter included allowing one's mind to preoccupied the young people on the ward, also expressed by the nursing staff as *"knowing young people's whereabouts"*. This openness to receiving, and preoccupation with making sense of, all of the child's indirect communications of feelings, via the process of projective identification, was coined by Bion as 'Reverie' (1962a), and described by Winnicott (1960) as the process of feeling oneself into the place of the child. It is the sensory-affective-

cognitive processing of all elements of the child/young person's communications, good and bad, and a fundamental component of good enough-care giving. Bion noted that reverie is the psychological source of supply for the child's need for love, essential to development. In psychological helpers this love, as the method for assuaging psychological distress, is expressed in part by a state of "receptive observation" (Bion, 1962b, p.95).

Foster and Smedley (2019a) found that the process of emotional containment within in the adolescent PICU setting was constituted of: providing a physical and psychological holding environment (Winnicott, 1960) that could contain young people at their most frightened and most dangerous moments; utilising reverie as a mechanism for providing a realistic and accepting mirror that sought to reflect all parts of the young person in a coherent way; using experiential knowledge of the young person and their internal working models to try and understand and respond to the underlying meaning of their behaviour and emotional expression; and supporting young people's emotion regulation development. In the early stages of care this was done for young people through providing close physical and relational proximity to staff, to regulate the young person's arousal relaxation cycle (Schore & Schore, 2010). As something of the containment provided began to be installed inside the young person, it was followed by moving to a position of leading young people through a guided process of self-regulation.

Even in the areas of intervention typically associated with mental health nursing, e.g. communication, risk management and teaching skills, **Foster and Smedley (2019a)**, found that they were equally reliant on application of the relational and affective-cognitive processing skills outlined above. Staff described how effective boundary implementation needed them to proactively apply knowledge of individual young people's internal working models, to predict their responses and adapt enforcement of the boundary accordingly. This exemplifies a characteristic of love as a method of intervention: the need to set abstract or general principles against specifics of the individual. As the fox teaches the Little Prince, one cannot love or care for a generalised conception, only an individual rose, fox or young person, that you have come to know through your mutual relational endeavours.

"You are not at all like my rose….as yet you are nothing. No one has tamed you, and you have tamed no one. You are like my fox when I first knew him. He was only a fox like a hundred thousand other foxes…and now he is unique in all the world." (de Saint-Exupéry, 1943, p.71).

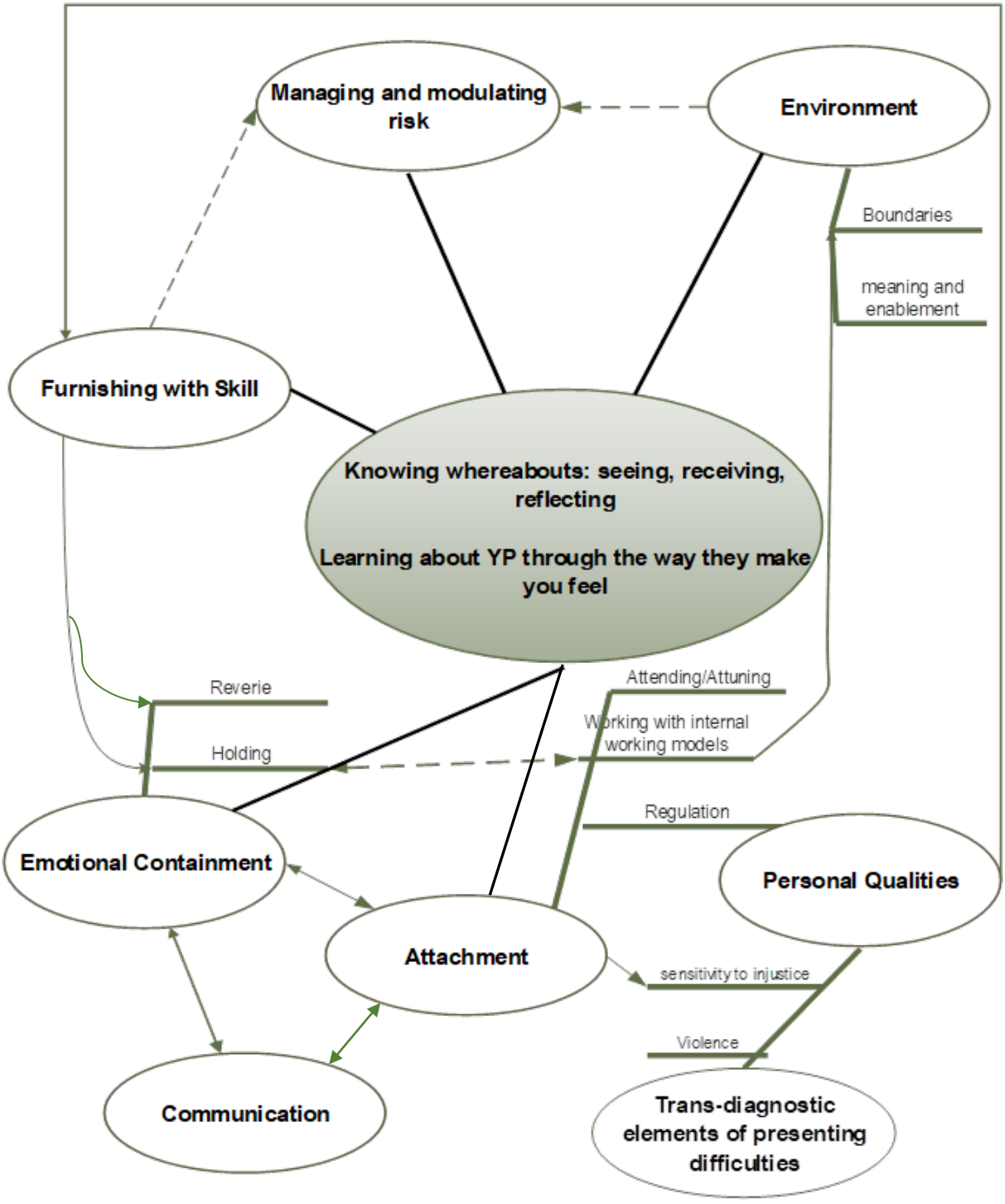
Moving from the general principles to the specific in this way is a mechanism for resisting dehumanisation and for enhancing choice, agency and power (Gopnik, 2014; Nayak, 2020). A point most clearly illustrated in the findings relating to risk management interventions. Detailed knowledge of individual young people was identified by nursing staff as their primary tool for effective risk management. One which enabled them to replace standardised procedural measures, used to maintain safety when young people were first admitted, with less restrictive individualised and collaborative approaches to balance safety with enablement (**Foster & Smedley, 2019a**).

Developing the assertions made by **Foster (2009)**, **Smedley and Foster (2019a)** articulate the specific aspects of the adolescent PICU environment that have to be actively tended to, or mitigated, as part of the suite of nursing interventions. Notably, staff described their sense of obligation to recognise the potential implications of admission to PICU for young people, referring to it as a "last-chance saloon". They described the need to create an environment in which multiple chances could be given to repair mistakes and in which young people were repeatedly helped to come back from the brink of disturbed or violent behaviour. This is in direct contrast to responses to disturbed behaviour in a general adolescent inpatient unit reported by Rasmussen et al. (2012), in which nurses would seek to move disturbed young people on to what they felt was a more suitable environment.

All modes of intervention identified in the study were found to draw heavily on the application of personal qualities (e.g. persistence and commitment to fairness) and required conscious management of one's own affect and instinctive ego needs, in order to act to meet the needs of the young people. This is analogous to the loving attitude of the parental ego (Bergman, 1987; Freud, 1915), in which the carer must use their own internal resources to cope with the intensity of the child's needs without becoming overwhelmed, and with sufficient tenderness to filter out the

elements of one's own experience that would be harmful or overwhelming for the child (Ferenczi, 1949).

Figure 4: Conceptual relationship between content analysis categories of Nursing Intervention (Reproduced from **Foster & Smedley, 2019a**)



4.3.2. Impact upon staff

In the usual process of the container-contained relationship (Bion, 1962), the process of making children's unconscious communications understandable and giving them back in a form that can be tolerated depends not just on the carer, but also on developing capacities of the child to introject that which is offered (Waddell, 2002). The quality of environment in which the carer is providing care – the availability of support, safety and predictability - contributes significantly to whether the process goes well and to the level of emotional labour that a carer has to invest in order to mitigate the environment.

In the PICU environment, young people's earlier adverse experiences and the presence of acute psychiatric disturbance considerably limited their introjective capacities (**Foster & Smedley, 2019a**, Kenrick, 2000). As a result, the staff were required to work much harder to try and make reciprocal connections and meaningful intersubjective communications with young people. The need to avoid repeating or competing with elements of primary attachment relationships, and the inhospitality symbolised by the restrictive environment, added to this complexity. In the short term this could leave staff feeling depleted and overwhelmed, with little opportunity for recovery. Staff reported longer-term impacts of being vulnerable to feelings of powerlessness, therapeutic impotence and despair. Difficulties naming and attributing value to their own work were exacerbated by attempts to manage the loss that accompanied saying goodbye to young people through denial.

"I remembered the fox, one runs the risk of crying a little bit, if one allows oneself to be tamed"

(de Saint-Exupéry, 1943, p.84)

Collectively employing the defence of 'attacks on linking' (Bion,1959), temporarily abated feelings of grief and worry, but also made it difficult for staff to reflect upon their contributions (**Foster & Smedley, 2019b**). Addressing this phenomenon within the PWDG required the facilitator to engage staff directly with their feelings of guilt and with a process of mourning (**Foster, 2020**).

By far the most significant impact of the work upon staff and their consequent provision of care, was the consequence of being in sustained close proximity to the young people and of being open to the process of '*coming to know them through the*

way they make you feel', whilst also sharing an experience of being trapped and restricted within the environment. This made the nursing team vulnerable to concrete identification with elements of the adolescent's projected disturbance. **Foster and Smedley (2019b),** articulate how this can result in identification with maltreatment and neglect, or with the aggressor, leading to persecutory and anxious appraisals of young people and colleagues, and employment of some of the same unconscious defence mechanisms used by the young people, i.e. splitting, projection, attacks on linking, attempts to control the environment.

These findings reiterate the importance of recognising love as method. The feelings, identifications and defences highlighted are the corollary of committing oneself the task of providing loving care to children, whose underdeveloped or disturbed psychological capacities, leave them helpless, unrelentingly needful, distressed and thankless - whether we are talking about parenting infants or providing professional care for distressed adolescents. What is understood and accepted from parent-infant research, is that these problematic and negative responses towards their children are not solved through critical, disciplinary or judgemental actions, but through re-nourishment, respite and the supportive and acceptant presence of another.

4.4 The role of gaze and observation in adolescent PICU

Mental health nursing literature has a justified tendency to problematise close observation practices: conceptualising it as a method of disciplinary power that preserves order and safety in the care setting, but at the expense of the experience of both service-user and nurse, stripping meaning from the therapeutic encounter (Holmes, 2001; Holylake, 2013).

However, the findings from **Foster and Smedley (2019a, 2019b)** lead to a different contention. Usual close observation practices within the adolescent PICU (observing young people every 5 minutes) were actually exploited by the staff to provide receptive and attuned care (**Foster & Smedley, 2019a**). The practical task of observing was used in a range of creative ways by staff to provide an important aspect of the psychological holding environment and maternal reverie through visual transaction (Schore & Schore, 2014).

How we are looked upon and handled in early life sets the register of our own internal observer/super-ego and the quality of our relatedness to our body (Lemma, 2009). Children who have not experienced care-giver's integrative mirroring of their feeling-states, or whose life experiences have disrupted this usual process, have difficulties creating representations of their own feelings which can lead to difficulties differentiating reality from fantasy and physical from 'psychic' reality (Fonagy, 2003). Without this capacity for symbol formation, children are left in overwhelming states of anxiety which lead them to rely on primitive or 'infantile' defences, such as splitting, denial, dissociation and discharging unbearable feelings through aggression to self and other (Klein, 1930, Segal, 1957). In addition, the presence of acceptant and reflective others is so important in adolescence because adolescence is characterised by a developmentally 'normal' preoccupation with self-examination in mirror-like or reflective surfaces (both literally and symbolically), in the pursuit of understanding one's emerging identity (Winnicott, 1971). The provision of receptive and acceptant looking upon, looking for, and making eye contact with, appeared to be additionally important in the adolescent PICU environment because the therapeutic use of touch is not readily available (**Foster & Smedley, 2019a**).

However, the impact of observation practices was on a continuum, from being 'seen' and 'taken-in', to being 'watched'. When observation levels moved from frequent intermittent observations to continuous arms-length observations, for acute risk management, the process and procedures associated with it constrained the movement of the staff and their abilities to act creatively to meet the needs of more than one young person at a time. Continuous observation geographically split the staff reducing their ability to support and communicate with each other. It also subjected both young people and staff to higher levels of scrutiny and regulatory practices (**Foster & Smedley, 2019b**). Analysis highlighted how the scrutiny associated with continuous observation policy became symbolically equated with the staff's worst fears at those times: that they were not doing a good enough job (**Foster & Smedley, 2019b**). Opportunities for patient introjection of nursing reverie through visual interactions were foreclosed, as the task of 'doing the observations' can become more akin to an 'Iron Gaze' (Holmes, 2001) or an empty mirror (Lebau, 2009), actually reducing young people's sense of emotional security and increasing the risk of incident (**Foster & Smedley, 2019b**). **Foster (2018)** found a statistically

significant reduction in staff-reported levels of compassion satisfaction at the time point in the sampling period in which there was a high level of continuous arms-length observations.

4.5 Professional quality of life in adolescent PICU

Foster (2018) used a longitudinal approach to measuring professional quality of life in adolescent PICU, utilising the commonly used validated measure, ProQOL V (Stamm, 2010). There is no baseline or pre-existing measure of professional quality of life in APICU nursing staff, so this study was exploratory in its nature, beginning the process of investigating the impact of work within this specific setting. There have been ProQOL studies undertaken with mental health nurses working in acute and secure mental health units for adults (Lauvrud, Nonstad & Palmstierna, 2009), and children's nurses in paediatric medical settings (Berger et al., 2015). The ProQOL V instrument also has benchmark data available, based on a very large data set, from a wide range of helping professions (Stamm, 2010). Based on a review of the benchmark data and these nearest available populations, the hypothesis was that adolescent PICU staff would have comparatively lower compassion satisfaction (CS) scores and higher burnout (BO) and secondary traumatic stress (STS) scores.

In fact, the study found the opposite. The adolescent PICU staff reported statistically significantly higher CS scores and lower BO and STS scores than the ProQOL V benchmark, or the nearest population comparison (**Foster, 2018**). The study showed stability in results over time, indicating that the results could be considered indicative of the experience of the workforce more broadly, rather than indicative of a particular moment in time (Sacco, Ciurzynski, Harvey & Ingersoll, 2015).

Foster (2020) asserts several factors that may have interacted to produce the results. The higher emotional and relational closeness needed by adolescents, exemplified in the interventions reported by **Foster and Smedley (2019a)** may serve to strengthen CS scores, as emotional distance is known to be negatively correlated with CS (Sondenaa et al., 2013). Higher CS scores in themselves can reduce the burnout effect of working with high levels of trauma (Stamm, 2010), alongside the

high staff/patient ratios associated with adolescent PICU (Lauvrud et al., 2009). However, the almost daily experience of violence and aggression in the adolescent PICU, may also result in staff under-reporting secondary trauma (**Foster, 2018**), as there is an amount of distance from traumatic experiences needed to be able to reflect upon them (Lauvrud et al., 2009). In addition, staff participating in this arm of the research study were also engaged in the PWDG, which has demonstrated a positive impact on individual and team level sense of wellbeing, efficacy and professional worth (**Foster, 2020**).

An item level analysis of individual participant ProQOL V measures highlighted four items within the tool that correlated directly with individuals reporting a more negative CS/BO ratio. These have potential to be used as early warning indicators for reduced staff wellbeing within the setting. They were: ‘feeling bogged down by the system’; ‘overwhelmed’, ‘worn-out’; and ‘preoccupied by some young people’. The strength of these items as early indicators within adolescent PICU setting is that they map onto the qualitative data from **Foster and Smedley (2019a and 2019b),** which also highlight that frustrations with elements of the care system, combined with the emotional labour of being in such close relational, psychological and physical proximity with the young people, sets the conditions to erode nursing team member’s sense of wellbeing, resilience and security.

4.6 Psychoanalytic work discussion as a method for enhancing staff capacities and providing support

4.6.1. Adapting to meet the specific needs of adolescent PICU – design of the Nursing Development Group

Several writers have observed that for PWDG to work in inpatient settings adaptations must be made (Johnston & Paley, 2013; Thomas & Isobel, 2019). However, the nature of those adaptations has not been explicitly articulated. **Foster (2020)** provides a detailed account of the adapted PWDG intervention designed for the nursing team within an adolescent PICU context, to begin to address this gap in the literature. The adapted PWDG method was named the Nursing Development Group (NDG). The underpinning rationale for these adaptations was developed from

the findings of **Foster (2009)** summarised on page 63, and **Foster and Smedley (2019b)**, summarised in Section 4.3.2. The adaptations were built on five principles:

1. Accommodating the specific workplace constraints and adversity present in the adolescent PICU environment, identified by **Foster (2018)** and **Foster and Smedley (2019b),** into the timing, setting, frequency, structure and design of the group process, as well as in the expectations of group members.
2. Attending to the impact of mentally distressed adolescents on staff states of mind and the attendant parallel processes (described in Section 4.3.1). This included recognising unconscious identification with feelings of deprivation and neglect.
3. Provision of reverie and emotional containment through exploiting the practical to enact the symbolic. In this case, using concrete symbols of nourishment and facilitator reliability to respond to latent communications of need from the nursing team (**Foster, 2009**).
4. Working to bridge the space between thinking and doing that can exist in adolescent states of mind and between the disciplinary culture of mental health nursing and psychotherapy.
5. Explicitly incorporating facilitator interventions to enable the nursing team to articulate their strengths, skills and contribution to care. This was based on findings that the nursing team attributed low levels of value to their own work (**Foster & Smedley 2019b**).

4.6.2. Impact of the adapted psychoanalytic work discussion group

PWDG have rarely been evaluated from the perspective of participants rather than facilitator (Thomas & Isobel, 2019). Using detailed qualitative interviews undertaken by independent interviewers and systematic cross-case thematic analysis, **Foster (2020)**, identified both the impact of the group and the mechanisms that led to the impact. There were eight domains of impact upon staff member's practice and experience of their work: 1) Knowledge and understanding; 2) Emotion management; 3) Personal efficacy; 4) Approach to challenging behaviours; 5) Therapeutic relationship with the young people; 6) Leadership; 7) Professional identity; 8) Team functioning. The impacts within these domains are elaborated in Table 3.

Table 3: Impact of the nursing development group

Knowledge and understanding	Emotion management	Personal efficacy	Therapeutic relationships	Challenging behaviour management	Leadership	Professional identity	Team functioning
Improved knowledge and understanding of individual young people	Can identify and name sources of frustration x2	Feel more prepared for working with patients	Developed a service-user perspective (empathy) x3	Think about my impact on the young people and alter approach x2	Helped me talk more confidently with HCAs	Makes us realize the importance and value of our job x4	Improved team cohesion x4
Helped me work with specific problems/conditions (e.g. trauma and dissociative symptoms) x2	Less tendency to enact frustrations towards the young people	More understanding of how to deal with young people on a day to day basis	Improved communication	Thinking about why we do things has made me consider alternative ways of doing things x2	Helped me help new staff to understand underlying issues	value you yourself more x2	More shared understanding between team members x4
Increased knowledge and confidence of working with adolescence x3	Perspective taking: take a step back when I get wound up	Helped me to have confidence	Positively changed my perception of young people that I have found difficult to nurse x2	I say 'lets talk' instead of 'stop doing that'	Greater appreciation HCAs; working more to empower them	helps you feel like you are making a difference x3	Team approach is streamlined
Understanding dynamics between young people and staff	Think about 'why?' before I act on my feelings x2	I feel more positive	Improved relationships with young people x2	Try different tactics, using light and shade – if normally I am firm, I try being a bit softer	Recognition of responsibility as staff nurse to lead by example	Makes a difference to the way you feel about your job x2	Between PWDG staff more likely to explore ideas together before acting x2
Extended practice from use of nursing process to manage the 'here and now', to incorporating young people's broader needs	Used to distance myself from emotion – now I try and embrace it a little more		Engagement with the young person as 'belonging to someone' –builds trust and reduces staff v patient dynamic	Staff articulate their frustrations and the source of them, instead of acting it out		Given me a sense of pride	Use insights from the group whilst on shift x2

4.6.3. Mechanisms that brought about change

Mechanisms that participants reported contributed to changes in their experience, perception and practice fell under themes of:

- Time to think, and space in which thinking was possible and facilitated.
- Being enabled and encouraged to speak, feel and wonder about their experiences, safely and freely.
- Being helped to contextualise young people's difficulties, by situating them in knowledge of the young person's biography, knowledge of specific mental health conditions, and greater understanding of adolescent development.
- Being supported to interrogate the underlying unconscious drivers for the feelings and actions of both the young people and themselves, to consider: 'Why they do it? Why we do it?';
- Learning about and with each other and having a mirror held up, to help them see their work and its value. (**Foster, 2020**)

In addition, (**Foster & Smedley 2019b**), analysed areas of learning and development recorded in the NDG units of analysis that were identified as helpful. Supporting the team process for generating practical strategies derived from discussions within the NDG and helping them set realistic outcomes and success criteria, congruent with the level of complexity of the client group, helped to lessen frustration and negative attributions towards patients.

Section 5: Critical analysis

The body of work presented within this report extends theory and practice in the field of child and adolescent mental health nursing through a process of progressive inquiry that utilises rigorous application of psychoanalysis as a clinical praxis to generate new research data in a previously unexamined field, and as a theoretical lens for data analysis.

It has been observed that the systems and cultures present in healthcare institutions fail to reward or acknowledge the contribution that sensitive and affectively attuned caregiving can make to service-users (De Frino, 2009; Schuengel et al., 2010). It has also been observed that mental health nurses often have to use extensive summarizing practices to manage the amount of detail involved in their work when communicating with others, undermining their ability to give sophisticated accounts of their expertise to other members of the multi-disciplinary team (Deacon and Cleary, 2012). The papers in this portfolio directly address these concerns, utilising a relationally focused approach to inquiry and systematic research methods to identify the specific impacts of mentally distressed adolescents upon nursing staff in hospital contexts. From this, a rich and detailed account of nursing task, intervention and identity in the specific context of adolescent PICU is generated. Original, psychoanalytically informed, research methods have been developed to meet the requirements of the research task.

In this section, the contribution of the papers is considered in terms of content (contribution to nursing theory and practice), process, method and impact. Firstly, the contribution of each paper and their cumulative contribution are mapped against the primary research objectives. Secondly, a thematic exploration of the contribution of papers as a whole body of work, to nursing and psychoanalytic theory, is undertaken to capture inductive learning that goes beyond the original research objectives. Thirdly, a critical appraisal of the methodological strengths and limitations is undertaken so that claims of new knowledge and contributions can be appropriately situated. This includes evaluating the suitability and validity of applying psychoanalytically informed data collection and analysis tools for researching the field of adolescent mental health nursing, thereby addressing the secondary research objective of the thesis.

5.1 Unique contribution of the published works to knowledge within the practice field, mapped against primary research objectives

5.1.1 The role of psychodynamic theory in understanding the interplay between mentally distressed adolescents, nursing staff, and their care contexts.

The overarching unique contribution of the portfolio of papers submitted in this thesis is the original application of learning from psychoanalytic understanding of early child development to the process of adolescent mental health nursing. This is not a new concept in psychotherapy, which is based on the application of learning from early life to understand problems in the here and now. However, its application to understand the nature of nursing, rather than the young people being nursed is novel. Previous studies have used psychoanalysis to examine and problematise nursing staff responses and defences toward challenging patients (Weightman & Smithson, 2020), but not as a method for systematically identifying and describing the nursing task, intervention, identity and the factors that influence them.

The papers in this portfolio have shown that the application of developmental object-relations theory to the phenomenon of nursing mental distressed adolescents in hospital settings provides a lens for generating new perspectives and knowledge. It is one that is not usually used for 'seeing' nurses, and troubles the frame through which mental health nurses, and the young people they care for, are read and through which nursing is performed (Butler, 2004); for example, as performers of prescribed concrete tasks and surveillance of psychiatric subjects.

Ironically, the maternal holding and growth promoting elements of nursing, and the relationship between adolescent mental health nursing and container-contained dyad of the primary carer-infant relationship, have always been hidden in plain sight. The term nurse originates from contraction of the Old French and Latin verbs to nourish (nutrire, nutrix), first applied to the physical and psychological nourishment of babies and children, and later to people who provided an analogous kind of care to the frail and infirm. As Esther Bick (1986) observed, the first psychic developmental task of the child is to introject the protective function of the nursing object, forming the basis for future good internal objects.

Refocusing on the intimate, sensory and relational components of the nursing team's interactions with young people, alongside all the other elements of the maternal holding environment (Winnicott, 1971), provided a mechanism for naming adolescent mental health nursing in a dynamic and detailed way, so that it can be available for thinking about. This is important because naming promotes coherence and agency for staff, and in becoming available for thinking about, their work becomes available for development and transformation.

Through detailed observation, **Foster (2009)** hypothesised the mutually constitutive relationship between young people, mental health nurses and the systemic and environmental context of the care setting; the iterative impact of distressed adolescent's and nurse's states of mind and psychological defence mechanisms upon each other; and the implications of these observations for providing effective emotional containment and support for nursing staff.

By integrating psychoanalytic theory and practice with rigorous qualitative and quantitative research methods, **Foster (2018)** and **Foster and Smedley (2019a, 2019b)** have generated a systematic account of the context of care in adolescent PICU, the presenting transdiagnostic needs and challenges of young people, the process by which nursing interventions are generated, the impact upon the staff group, and consequent effects on care provision, if not appropriately tended to. In **Foster (2020)** this new knowledge was used to design and implement a bespoke psychoanalytic intervention for staff that has been shown to positively impact upon nursing staff knowledge, confidence, personal and team efficacy and therapeutic approach with young people.

5.1.2 *What is the nature of adolescent mental health nursing and nursing intervention in adolescent PICU?*

Together, **Foster (2018),** and **Foster and Smedley (2019a, 2019b)** provide the first published research study providing a detailed examination and account of mental health nursing in adolescent PICU.

Caring for adolescents in restrictive hospital settings, such as PICU, is highly political. The absence of these care settings from wider political discourse and policy about prioritising mental health needs of children and young people, politicises them

even further: Young people who find themselves in PICU have, almost exclusively, lived socially disadvantaged lives, subject to physical, sexual and emotional harms, often from those who were meant to provide care and safety. Their mental distress is a function of these wounds that also signify our failings as adults, and the ongoing systemic violence towards women, children and anyone outside of the mainstream in society – where 'mainstream' is defined by those in power, to reflect them (e.g. white, male, heteronormative, neurotypical) and maintain their dominance. The impact of violence of this kind is a shattering or domination of young people's inside world (Garland, 2002b), which is then worn on or enacted through their body. When we cannot bear to look at it anymore, children's experience is psychiatrised, categorised by the application of norms of the 'idealised child' (Le Francois, 2013), subjected to control and scrutiny and locked away out of sight in psychiatric institutions. The fact that adolescent PICU and other locked care settings for mentally distressed young people are absent from the research literature replicates this process. As a result, spaces for understanding, holding to account and improving inpatient nursing care approaches for vulnerable young people, whose level of distress requires high levels of containment, are foreclosed.

Foster and Smedley (2019a) showed that behind the (many) procedural tasks of adolescent PICU nursing is an interfulgent system of dynamic and complex intersubjective interventions. These interventions are characterised by implementation of the aspects of the primary carer-child relationship that are understood to bring emotional and mental resilience to life. That is, the qualities of good-enough attachment-type relationships that can sooth and enable, providing a physical and psychological holding environment through the provision of every-day care. At the heart of these relationships is the management of unmanageable states, through an openness to get up close, to feel young people's 'felt difficulties' (Peplau, 1952) and find meaning within them; using one's own affective-cognitive-processing and emotional regulation ability to do so through a process of reverie. The application of reverie in this context creates a bridge from the sensory-somatic enactment of distress (e.g. self-harm, violence) to the mental world, where it can be named and made available for thinking about.

Whilst this is the requirement of all good-enough child care, the specificity of the task in the adolescent PICU environment is achieved 'under fire', against a backdrop of

previous attachment and care disruptions, acute psychological and behavioural disturbance, and an environment that acts as an echo chamber, providing overt reminders of the formative adverse and traumatic experiences that precipitated the distress in the first place (Minne, 2011).

The importance of the findings of the papers in this portfolio, is that mental health inpatient nursing for adolescents is rarely, if ever, conceptualised through the lens of the psychological apparatus needed by all children for the development of their own mental functioning and resilience. By doing so, dissonance between what is valued by the system (stabilisation of biomedically conceptualised psychiatric symptoms) and what is observed to make a difference (amelioration of the impact of adverse experience on regulatory and attachment systems) (Adshead, 2002), is revealed. The role of projective identification has been elaborated in previous literature, in relation to responding therapeutically to service users disturbed intersubjective patterns (Minne, 2011; Winship, et al., 2019). However, a unique contribution of this thesis is articulation of the central role of projective identification within adolescent mental health nursing, not just in the management of destructive and defensive projections, but as an ordinary component of adolescent communication that forges an essential link between the young people and staff, as they feel their way into the young person's place (Winnicott,1960).

Whilst the capacity to tolerate and understand service-users may be central to success, negative impacts upon levels of nursing compassion and care quality, that can lead to excessive use of restrictive practices, are also of important concern in inpatient settings (CQC, 2019). Using a psycho-social and inductive research approach, that gave space to staff to articulate their own processes and credence to the intimate and relational elements of care, **Foster and Smedley (2019b)** have generated a detailed account of the impact of the therapeutic task upon staff. The specific ways in which the therapeutic tasks can corrode the very capacities needed to sustain them have been articulated, elaborated further in Section 5.2.2. A particular contribution of **Foster and Smedley (2019b)** is the elaboration of how adolescent PICU nursing staff share something of the incarceration, restriction and disempowerment experienced by young people. This creates a common internal object (**Foster, 2009**) through which the psychic processes of projection and identification can work to activate primitive fears of persecution, annihilation and

envy. The paper tracks how this can lead to staff enactment of young people's disturbance through parallel processes (**Foster & Smedley 2019b**).

Foster (2018) is the first published study of professional quality of life of mental health nurses working in adolescent PICU. These new empirical insights are important because the domains upon which overall professional quality of life is based have the potential to impact directly on the quality of clinical care (Sinclair et al., 2017). Furthermore, the findings were not as expected in relation to benchmark data or the nearest populations available for comparison. Reinforcing the findings of **Foster and Smedley (2019a, 2019b)**, **Foster (2018)** revealed staff with significantly higher than expected levels of compassion satisfaction (associated with closer therapeutic relationships with service users), which appeared to some extent to offset levels of burnout and secondary traumatic stress. Although the study indicated a relatively high level of professional wellbeing, individual item analysis revealed a specific emotional toll for adolescent PICU nursing staff that reflects the role of projective identification dynamics in their day-to-day work, and the contextual stressors that were highlighted in the qualitative data arm of the research study (**Foster & Smedley, 2019a, 2019b**). The professional quality of life data in **Foster (2018)** also confirmed findings from the qualitative study; that implementation of 1:1 arms-length observation practice, for risk management purposes, creates a particular form of workplace adversity and moral distress for nursing staff.

5.1.3 *Conceptualising a novel model of mental health nursing with adolescent PICU settings*

Foster and Smedley (2019b) have proposed the first published model of adolescent PICU mental health nursing (Figure 3); synthesising understanding of the specific manifestation of how the mutually constitutive relationship between the young people's developmental and mental health needs, the PICU care context and the nursing task come together, to create a series of unresolvable tensions, that in turn produce nursing interventions. Synthesis of the findings of all of the papers in the portfolio have led to the assertion that a particular form of love is the primary method utilised in adolescent PICU mental health nursing, expressed by reverie (Bion, 1962a) and its concomitant actions (See Section 5.2.2).

By situating findings in extant literature from adult PICU and general adolescent inpatient nursing, the portfolio of papers has also illuminated the points of commonality and uniqueness of adolescent PICU, as a speciality on the borderland of both (**Foster & Smedley, 2019a**).

Rustin (2007) highlighted the importance of systematically produced descriptive accounts of clinical phenomena, as the essential first foundation for building a field of research in a previously unexamined area. Part of the contribution of this portfolio and thesis is to start the process of developing an archive – a detailed systematic disciplinary account – of adolescent inpatient mental health nursing. This will contribute towards the reclamation of the relational basis of mental health nursing identity, adding to the work of academic commentators, who have long called for mental health nursing praxis to be recentred along Peplau's interpersonal and psychodynamic frameworks (e.g. Delaney and Ferguson, 2014; Lopes and Cutliffe, 2018; Winship et al., 2009). Developing a professional archive is important, as it defends against regulating and silencing effects of historical amnesia (Nayak, 2015); effects that are reflected in the multiple reviews of mental health nursing (Butterworth and Shaw, 2017) and in the assertion within the Chief Nursing Officer's new joint action plan for mental health nursing, that mental health nurses struggle to articulate their profession (CNO, 2020).

The papers in this portfolio challenge an established binary wisdom that the difference between psychoanalysis and nursing is the difference between 'thinking about' and 'doing' (Winship, 1995). It should be noted that this is a view that I held at the beginning of the programme of research (**Foster, 2009**). However, the findings of **Foster and Smedley (2019a; 2019b**) point to a difference that is more analogous to the difference between the occupation of philosopher and parent. Both require high levels of complex thinking, reflection, analysis and self-interrogation. In the former the primary product is espousal of the outcome of one's thinking. In the latter the primary product is intentional action, in which the outcomes of one's mental work are encoded in a form that can be easily received by the child who is in direct need of it. It is symbolic, even if it is not always consciously symbolised in the mind of either party. Throughout this doctoral study I have been minded of Bion's (1962) statement that all people experience thoughts, but not everyone has the apparatus with which to think about those thoughts. This apparatus is a maturational achievement rather

than a developmental given (Winnicott, 1965), and for staff, just as for young people, it requires the tenderness and loving care of another to bring it into life.

5.1.4 Develop and test an original intervention to support and enable adolescent mental health nurses to articulate, enhance and sustain the therapeutic tasks of their work

Foster (2009) produced an understanding of the general principles needed to create effective support strategies for nurses looking after mentally distressed adolescents in hospital settings (summarised on page 63). **Foster (2020)** provides a rationale for why the psychoanalytic Work Discussion model is well aligned to meeting the needs of adolescent PICU nurses, and this was used as a basis for developing a bespoke intervention. Learning from **Foster and Smedley (2019a, 2019b)** about the nursing task and its impact, was systematically applied to design an adapted form of PWDG - the Nursing Development Group (NDG) - in which the adaptations were intended to symbolise and tend to an appreciation of the some of the adversity and anxiety experienced by the nursing team within the adolescent PICU environment (**Foster, 2020**).

The design of the NDG sought to provide an experience for the nursing team that paralleled their own methods for promoting growth and recovery in young people, in which they experienced a receptive, curious and tender (Ferenczi, 1949) gaze being brought to bear on the hitherto 'unseen' area of their practice. This included an intentional approach to addressing unhelpful or problematic elements of staff responses to young people that mirrored nursing interventions of *'decoding'* and *'side-stepping invitations to confirm worst fears'* (**Foster & Smedley, 2019a**). This was achieved by avoiding direct criticism, instead, taking interest in the underlying drivers to the response whilst nurturing alternative elements of the staff member's actions that were growth-promoting for the client and for them (Garland, 1982).

By explicitly articulating the process of design and implementation, and analysing the role and approach of the facilitator, **Foster (2020)** contributes not only a intervention for nurses working in adolescent PICU, but also a process by which PWDG can be adapted to meet the specific needs of mental health nurses in other clinical settings.

5.1.5 *Evaluate the impact of the Nursing Development Group on staff experience of their work and care provision*

Evaluation of the implementation of the NDG has provided evidence of positive impact on domains of staff knowledge and understanding; emotion management; personal efficacy; approach to challenging behaviours; therapeutic relationships with the young people; leadership; professional identity and team functioning (**Foster, 2020**). Although a direct cause and effect cannot be claimed, it is notable that staff who participated in the NDG reported higher levels of professional quality of life, than either the benchmark data for the ProQOL instrument or mental health nurses working in the nearest comparable clinical setting (**Foster, 2018**). This strengthens the case for the positive impact of the NDG and its potential efficacy as an intervention to help adolescent PICU nurses sustain their therapeutic work and to improve care-provision.

Foster (2020) addresses some of the criticisms of traditional, facilitator-led descriptive case study methods for evaluating PWDGs (Thomas & Isobel, 2019; Datler et al., 2018; Elfer, Greenfield, Robson, Wilson & Zachariou, 2018), by evaluating from the perspective of participants, using a rigorous qualitative cross-case analysis method. In addition, the method specifically sought to establish the elements of the intervention, or mechanisms within the group, that led to the positive changes reported.

Just as Hayes et al. (2019), found that shared lived experience with peers in inpatient units can reduce the sense of alienation that mental health disorder can bring to young people, so too it was for the nursing staff (**Foster, 2020**). Sitting, speaking, listening and thinking with each other provided a mechanism of making connections, increasing appreciation of each other, learning together and creating a collective sense of their approach to work.

In **Foster (2020)**, the theme of ‘freedom to think and wonder’ highlighted the parallels between the elements of the NDG that brought about change, and the elements of analytic groups as a course of clinical treatment. The importance of the NDG was that it provided an alternative system in which team members came together to think in a context in which different rules applied than within their usual system of nursing (Garland, 1982). The acceptance, reliability and curiosity

conferred through psychoanalytic facilitation methods created room for playfulness. Team members were able to play around with their ideas and understanding, without the immediate consequences that are the inevitable corollary of acting out one's thoughts in the ward environment (**Foster, 2020**). This simulative quality (Garland, 1982), combined with access to digestible chunks of developmental object-relations theory and receptive mirror-like reflections of their work, were reported by participants as change-producing components of the process.

5.2 Thematic exploration of emergent contributions to knowledge

5.2.1 Differences between adult PICU, adolescent PICU and general adolescent inpatient psychiatric settings

Findings from the portfolio show the absolute centrality of understanding adolescent psychosocial process in providing mental health nursing care to mentally distressed young people in hospital settings. The papers demonstrate the difference in adolescent affect-regulation and the role of adult relationships in enabling growth and change during this developmental period, that must be attended to, even before mental distress is added into the picture.

Whilst this may seem obvious, it is not reflected in previous published research, and is not covered in core standards for nursing proficiency, beyond reference to the need to be able to care for people at all stages of life (NMC, 2018), or the curricula that lead to these proficiencies. In the nursing team who participated in this study, the impact of this unspoken element of their work, set against the spoken task of stabilizing acute symptoms of mental illness, meant that they often reported feeling underconfident about whether the ways they were working to meet the needs of the adolescents were 'right'. This has potential to significantly undermine a nursing team's clinical efficacy.

Foster and Smedley (2019a; 2019b) highlight how adolescent PICU nursing is located on a borderland between adult PICU and general adolescent inpatient mental health nursing. Whilst tensions have been identified in Adult PICU (Bjorkdahl et al., 2010; Salzmann-Eriksson et al., 2011), the number that must be occupied in adolescent PICU is amplified. The function of the presence of tensions identified in

adult PICU is also characterised differently; as problems to be solved rather than a productive space. Whilst there were some domains of intervention identified that are common to all inpatient mental health nursing, the range of relational interventions, described within the categories of 'Emotional Containment', 'Attachment' and 'Personal Qualities' in **Foster and Smedley (2019a)** are distinct from those reported in previous studies that have explored mental health nursing in adult PICU and general CAMHS inpatient nursing.

Whilst adult PICU nursing has been characterised as focused on creating a trustworthy environment in which client's feel safe to tell their story (Ward and Gwinner, 2015), **Foster and Smedley (2019a)** assert that adolescent PICU nursing requires an understanding of the profound challenges adolescents experience in processing and expressing their affective, somatic and cognitive experiences, without adult assistance through relational proximity. Extensive 'emotional containment' nursing interventions are required because young people need to *'show'* their story (through actions and projection), to adults who are prepared to not just see it but also feel something of it, so that they can translate it into words or helpful responses. The provision of 'reverie' and 'holding' is essential to young people in any residential care setting. However, in adolescent PICU, it requires staff to withstand daily intrusion, violence and disinhibition (**Foster, 2018**) and to see these attacks as the primary means by which the young people communicate pain, vulnerability and need (**Foster & Smedley, 2019a**). They must also resist the drive towards concrete identification that shared experiences of the restrictive environment bring (**Foster & Smedley, 2019b**). The magnitude of the effect of these co-occurring attacks on linking (Bion, 1959), account in part for the centrality of specific personal qualities as nursing interventions in themselves and the differences in how advocacy and child-centred care is constructed, compared with general adolescent inpatient units (**Foster & Smedley, 2019a**). It also informs understanding of the differences in longer term psychological risks faced by nurses working in adolescent PICU.

Studies investigating quality of life in mental health nurses working in secure and acute adult settings have hypothesised that the technical and procedural approach to institutional care creates emotional distance in the nurse-patient relationship. This may protect nurses from burnout and secondary traumatic stress symptoms in the short term, but it also reduces compassion satisfaction (Sondenaa et al., 2013;

Lauvrud et al., 2009). So, in adult services, problems in care quality more frequently derive from emotional distance and lack of curiosity and openness to understanding patients' 'felt' difficulties (Doyle & Clarke, 2020, Weightman & Smithson, 2020). In contrast, the higher level of dependency and attachment needs of young people mean that increased levels of emotional identification and proximity are most likely to trigger problematic responses in staff in adolescent PICU (**Foster & Smedley, 2019b**). The positive effect of this is higher levels of compassion satisfaction. However, there is a risk that without in-depth observation and analysis, all can look fine on the surface, whilst the true impact of the adolescent PICU nursing task is hidden underneath (**Foster, 2018**).

In a similar way, the areas of overlap between adolescent PICU, adult PICU and general adolescent inpatient nursing can encourage a denial of the unique differences in adolescent PICU nursing, produced by the intersection of the specialties of PICU and adolescent mental health. This thesis makes a unique contribution to knowledge by systematically analysing and challenging this conception.

5.2.2 Love as method in adolescent inpatient mental health nursing

A central argument of this thesis is that the papers submitted in the portfolio of work have brought to light that a specific form of love is the primary method for enacting the responsibilities and therapeutic tasks of adolescent mental health nursing in hospital settings, and particularly so in adolescent PICU settings. This form of love is akin to the altruistic love of caritas, with the quality of 'Agape' - intentional extension of one's will to the betterment of strangers - and analogous to the development enabling qualities of the love provided by good-enough parental objects, through the container-contained relationship (Bion, 1962b). It is argued that a parallel process, of using love as a method, is needed to shine a light on and understand and enable the process of mental health nursing in these settings.

The practice of this rigorous and technical form of love requires commitment to continuously occupy irresolvable states of tension as generative spaces; to maintain close physical and relational proximity, even when the experience is disturbing; to maintain a receptive, realistic but tender gaze, accompanied by a capacity for

reverie; and to be able to set specific loves, for individual young people, against general principles of mental health nursing practice and adolescent development (e.g. boundaries, parameters, evidence based practice).

Love as a method has a specific quality that is characterised by a disciplined and active use of self, i.e. lending one's values, body, personal qualities and affective-cognitive processing system, in the service of the other. In adolescent inpatient mental health nursing, the lending of one's self in this way has to be done without any expectation of reciprocity, for a loved object that is not and will never be yours, and for whom you will unlikely to get to see the dividends of your efforts, later down the line. It requires the acceptance of loss and the limiting the expression of one's own feeling, in order to maintain the centrality and supremacy of the young person's first experience of love, their primary carer relationships. In adolescent PICU, all of this has to be achieved in physical and intrapsychic locations and systems that are actively hostile to the process.

Tension is a hyphen, or the space between the two ends, where something different and greater than the sum of its ends is created (Hogget, 2008). Just as Peplau noted that:

> "[*Nurses proximity to patients] creates tension and tension creates energy that is transformed into some form of behaviour"* (1952, p.8)

the findings in this thesis have highlighted that the irresolvable and inescapable tensions that adolescent PICU nurses occupy are the also the crucible in which their interventions are forged (**Foster & Smedley 2019a**).

Klein (1959) identified the tension between care and concern for others and their malicious destruction as central to the human struggle, with love acting as the constraining force against more destructive impulses. Young people being cared for in adolescent PICU are often carrying wounds from where this struggle has been dominated by more destructive and hostile impulses. The maturational achievement of Klein's (1946) depressive position is the emerging capacity to span the tension between loving and destructive impulses, integrating them, and recognising that they are always co-located, both in oneself and in others. By accepting the task of residing in a state of tension, with no prospect of relief from the discomfort it

engenders, something of the depressive position is potentially modelled for young people, by the nursing staff.

Adolescence is itself the hyphen between childhood and adulthood, characterised by the intensity of first romantic/erotic loves, set against the reworking and mourning of the sensual love between infant and primary carer. Psychosexual development is the integrating force (Shapiro, 2003; Williams, 2002), but it too results in a long period in which uncomfortable tension must be endured. As a result, adolescents require as much careful attention, attunement and reverie from their carer's as they did in infancy. Reverie is a shared state created in the hyphen between the adult and child. It is a third space in which connectedness, meaning and in time, the development of the child's own mental functioning and resilience is created. This is what Bion referred to as alpha function, the mental apparatus for decoding and thinking about one's own somatic/affective experiences and thoughts (Bion, 1962a). Essential to the supply of this 'psychological source of love' is the quality of the gaze in which we are held.

> *"[The] child's seeing the self in the mother's face and afterwards in the mirror gives a way of looking at the psychotherapeutic task…it is a long-term giving the patient back what the patient brings…a complex derivative of the face that reflects what there is too be seen… If I do this well enough the patient will find his or her own self…finding a way to exist as oneself, and to have a self into which to retreat for relaxation."* (Winnicott, 1971, p.117)

Being seen, accepted and understood as we truly are is a fundamental need in all of us, but never more so than in infancy and then adolescence. In this sense, to love is to be responsible for seeing the young person as they are, good and bad, without loving any less (Winnicott, 1971), whilst also engaging the sensory and affective components of our visual processing system (Haraway,1988) – as "it is only with the heart that one can see rightly" (de Saint Exupéry, 1943, p.72)

Whilst reverie is the taking in and digesting an other's experiences, it is not a merger. It is lending one's own apparatus in the service of the other, all the while recognising the other's separateness and seeing one's own position to that which is taken in and digested (Bion, 1962a, Segal, 1957). However, as the findings of the portfolio show, the close relational and physical proximity needed in adolescent PICU, combined

with projective identification being a major currency of unconscious communication for the young people in it, comes with the risk of nursing staff temporarily losing their integrative position and sense of separateness. In turn, this can result in problematic states of identification, shared states of mind and defences, which negatively impact on staff perception of young people and on care quality (**Foster, 2009; Foster & Smedley, 2019b**). As Peplau noted, expression of nursing frustration and anger can best be understood as the nurse and patient's mutually reinforcing anxiety (1952, p120).

Conceptualising methods of intervention in adolescent PICU nursing as a form of love, founded on the dynamics of projective identification and the practice of reverie, has enabled a nuanced exposition of how and why things go wrong, and of what is needed by nursing staff to sustain their efforts and reduce the negative impacts of their work. In the same way as happens in primary carer-child dyads, the capacities for the kind of love described in this section are eroded by its very practice**.** Being able to preoccupy the mind of a significant adult is both a requisite component for development of mental resilience in children, and a validated indicator of compassion fatigue in professional helpers (Stamm, 2010). Despite having overall positive scores on the ProQOL measure, adolescent PICU staff were more likely to highly rate the item for feeling preoccupied by young people in their care **(Foster, 2018).**

The depletion caused by the provision of reverie can lead to an anti-love, anti-thinking position in carers and to defensive attacks on the links between child and adult, and behaviour and meaning. When this happens earlier harms can be repeated, or new wounds created. This is particularly so when caring for adolescents, given their propensity for surging emotionality, impulsivity, splitting, projection, and aggressive use of their body to solve conflicts (Waddell, 2018), which are all accentuated by acute mental distress.

The same as primary-carers, who are engaged in the unrelenting task of caring for helpless, dysregulated infants, adolescent PICU nurses need supportive others to bear witness to their endeavours, help to maintain belief in the cumulative value of the moment-to-moment small tasks they have to repeat over and over, and to act a as a third, when the intensity of relationship between primary-carer and infant becomes too intense. Adolescent PICU nurses need to be afforded the same level of

receptive observation, and acceptant, thoughtful curiosity about the good and the bad of their feelings and responses as they provide to young people. This needs to be provided in an environment that can assuage arousal and persecutory anxieties and confer a sense of value to them and their work. In other words, love as method is as important for nursing staff as it is for young people.

It has been interesting for me to reflect on my own anxieties, about asserting the role of love in adolescent mental health nursing as a central tenet of my PhD thesis, and to note what has been internalised in me as a woman, a nurse and an academic. Lurking within my own object-relations is a more positivistic position that privileges the rationale, the objective and the technical, which can activate a level of academic embarrassment and professional shame. There is a latent and ever-present anxiety, that trying to articulate love as a very specific and technical tool, will lead to me being read as someone with a lack of professional boundaries and academic rigour. It is in direct relation to the anxieties expressed by the nursing staff; that when they occupy a relational apace and loving attitude towards young people in their care, that they were not doing it 'right'. Yet, **Foster (2020)** demonstrates how adapted psychoanalytic praxis can be used as a means to provide evidence-based loving care as a staff intervention, and the positive impact it has on their capacity to care for young people.

5.3 Methodological contribution and critique

This section addresses the secondary objective of the thesis, to critically evaluate the suitability and validity of psychoanalytically informed data collection and analysis processes for researching the field of adolescent mental health nursing.

5.3.1 Qualitative research philosophy and methodology

Just as adolescent PICU nurses were found by the research in this portfolio to occupy a range of irresolvable tensions, and the concurrent risks and benefits of caring for mentally distress adolescents in hospital settings has had to be problematised (Hannigan et al., 2019; Hayes et al., 2019), the underlying philosophy and methodology of this research also exists in a state of tension.

The hierarchies of oppression that exist for staff and young people in restrictive inpatient mental health settings (Le Francois, 2013), and the unique effect of their intersection with each other (Crenshaw, 1989), mean that mental health nurses are both subjugated, and implicated in the subjugation of the young people for whom they care. Similarly, it is the stated intention of the research included in this thesis to use psychoanalytic theory and method as a transdisciplinary process to illuminate that which can't be seen using nursing disciplinary knowledge alone (Stenner and Taylor, 2008). Yet psychoanalytic praxis has its own implicated history of using normative and patriarchal concepts to denigrate and subjugate children, people who are different, and the people (women) who look after them. So, throughout the process, there has been an inherent risk of colonising the distinctiveness of mental health nursing, and of replicating the structures that have dominated it and hidden its contribution from view (De Frino, 2009), through the imposition of yet another privileged world view (Redman 2016).

Within the psychosocial research frame, the tension or hyphen between implication and subversion must be occupied and mapped, as the notion of stepping outside of it to adopt an objective or neutral stance is a myth (Haraway, 1988). It is having a position that enables sense-making.

"Observation and interpretation is necessarily theory-laden, to do either without a position is not neutral or a value free stance, but to exist in a state of mental disassociation and disintegration"

(Hammond and Wellington, 2013, p.119).

In critically reviewing the research methodology adopted, the questions then become: to what extent can a research method that is inescapably rooted in established hierarchies, use developmental theory that privileges the transformational qualities of maternal reverie, to trouble/subvert innately patriarchal and paternalistic healthcare structures? And to advocate for the developmental care needs of mentally distressed young people and for the contribution of nursing to young people's reparation and recovery?

Subversive acts can only come from an agency that is internal to the system, in this case the nursing team, weakening the dominating excesses of the system through patient and repeated local action (Butler,1999). The role of psychoanalytic theory

within the research process has been to provide an instrument of vision (Haraway, 1988), to make their acts of subversion (love) visible and legitimate, and to shine a light on them so that they can be named, elaborated, and their effect understood and amplified. By way of example, **Foster, (2009)** and **Foster and Smedley, (2019a, 2019b)** show how the inpatient environment, and the regulatory practices within it, subject staff to something of the same subjugation as the young people - expressed as 'feeling bogged down by the system' (**Foster 2018**). Despite this, **Foster and Smedley (2019a)** reveals the quiet, repeated and 'local' ways in which adolescent PICU staff forge interpersonal engagement, in which the young people lead the dance of communication and experience themselves as potent, despite being in a situation of material powerlessness (Winnicott, 1960).

"The Little Prince who asked me so many questions, never seem to hear [mine]. It was from the words dropped by chance, that little by little, everything was revealed" (de Saint-Exupéry, 1943, p.9)

This way of being is 'local' in the sense that it is in sharp contrast to the ways in which strategies to empower young people have been shown to work in less restrictive general adolescent inpatient mental health units (**Foster &Smedley, 2019a**).

The notion of achieving a feminist objectivity within research practice, rests upon the use of methods that seek to enable situated knowers to move from passive to active agents in the process of knowledge generation (Haraway, 1988). This includes developing sites of resistance to dominant and repeating dynamics that seek to maintain the status quo. Part of the process of implementation the NDG was to re-establish a space for thinking. Waddell (2005) asserts that, in services that are organised around excessive work rates and foster states of mindlessness in staff groups (paralleling the defensive strategies of distressed adolescents, **Foster, 2009**), keeping spaces for thinking alive is a radical act.

Transdisciplinarity, can itself be site of resistance, transforming existing knowledge spaces, by opening them up to new possibilities (Stenner and Taylor, 2008). However, this can only be so, if the relationship between the two disciplines is horizontal and distinct, akin to the use of countermelody in musical collaborations. In countermelody, there is a commitment to illuminate, scaffold and enhance meaning

and expression of the primary voice. However, the countermelody is distinct and independent (unlike harmony), showcasing mutual difference whilst affirming the visibility and value of both parties, enhanced by their connectedness (Saliers and Saliers, 2019). The overall impact of participating in the research process for the nursing staff, is demonstrated in detail in **Foster (2020)** and has been summarised in Section 4.6.2. However, in relation to the effectiveness of the application of psychoanalytic praxis as a transdisciplinary research method, it is important to bring attention to the theme of *'freedom to feel, think and wonder'* from within the findings of **Foster (2020).** The findings under this theme articulate the experience of the nursing team being enabled by the psychoanalytic frame to temporarily step outside of the usual regulatory practices that govern their work, in order to think creatively, beyond usual prescribed ways of understanding, and in collective dialogue with each other. This demonstrates the capacity of the methodology utilised to create sites of resistance, both in terms of enhancing connection within the nursing team, and through them speaking out their experience as a means of transforming silence into language and action (Lorde, 1977).

Accepting the need for a position, from which one can make sense, requires ownership of the fact that the representations of adolescent mental health nurses generated within my research are not value-free descriptions, but are versions of 'Other' constructed by me and therefore occupying the hyphen between self and other (Wilkinson & Kitzinger, 1996). Two key methods have been employed for occupying this tension:

1) critical interrogation of the relevance and influence of my autobiography on the research process (Section 3.6); and

2) intentional use of data collection and data analysis methods that are dialogic and seek to negotiate representations with those who are being represented (Haraway, 1988; Hollway, 2004; Wilkinson & Kitzinger, 1996).

PWDG's as a research method are inductive and co-productive in the first round of data analysis (Briggs, 2005), using social and relational encounter as the means of generating rich subjective accounts of real-world phenomena (Haraway, 1988). In addition, all units of analysis generated from the NDG were shared and agreed with the nursing team, prior to their use within the study. A full draft of the research report

(***Foster & Smedley, 2016***) was shared with the nursing team for comment and contribution before developing the papers for publication. The draft report was accompanied by a plain English summary of findings, produced in a number of formats (digital, hard copy, poster and oral presentation) to maximise the nursing team's engagement with the findings. This was important, given the constraints on their time identified by the research, and the range of education level amongst the HCA staff.

Despite these approaches to try and take *"the loving care"* that Haraway (1988, p583) asserts is needed to *"learn to see faithfully from another's perspective"*, the regulatory and potentially meaning-stripping function of the observing/researching gaze, cannot be entirely avoided (Stephenson & Cutliffe, 2006). In just the same way as subtle procedural shifts of focus in observation practices were shown to change the function of nursing observation for young people in PICU, from receptive looking to a blank hard stare (**Foster & Smedley, 2019a**), the way in which qualitative data collection and analysis methods are implemented can change the outcomes and participant experience of the research process.

Prior to the papers included in this thesis there were no published studies investigating mental health nursing in adolescent PICUs. Just as was seen in relation to the care of young people by mental health nurses (**Foster & Smedley, 2019a, 2019b**), the absence of an interested and receptive gaze is never neutral, but is felt to be attacking (Klein, 1946), and is delegitimising and anti-development in its impact. So, on the one hand, it can be argued that utilising a systematic and accepted research method to observe, record and categorise the nature of adolescent PICU mental health nursing has made an important contribution: it has made it visible within wider nursing and mental health scholarship, attributed value to it and addressed a knowledge gap. However, in the pursuit of being able to claim research validity and credibility, the potential for privileging theoretical concepts over participant experience, and for loss of important meaning, through the application of categorical frameworks to equivocal and continuous subjective data, is also ever present (Day, 2012; Frosh & Emerson, 2005).

Key criticisms of the qualitative content analysis methods used in **Foster and Smedley (2019a, 2019b)** are that they can be reductive of complexity, atheoretical,

break the links between related concepts and separate findings from their context (Vaismoradi, Turunen & Bondas, 2013). This is the trap, of prioritising “matters of great consequence” above everything else, that The Little Prince repeatedly warns us ‘grown-ups’ to guard against (de Saint-Exupéry, 1943), i.e. privileging the rationale (callous), hierarchical (power) and categorical (exclusion, denial of overlap, complexity and intimacy/sensuality). To do so is to subject participants and the community they represent to a form of ‘epistemic violence' (Spivak, 1988, p.280; in Dotson, 2011; Nayak, 2015), by excluding or disqualifying them and their complex subjective practices and knowledge from the research table (Haraway, 1988). For adolescent mental health nursing, the use of systematic coding mechanisms risks replicating the patterns in which the developmental and relational components of their work are disappeared via the adultist and biomedical framework of healthcare systems (Adshead, 2002; De Frino, 2009), and the detailed and nuanced accounts of their work are summarised for the benefit of others to the point of being meaningless (Deacon & Cleary, 2012).

However, methods of coding and quantifying relationally focused work cannot be just disregarded. Part of the mechanism that produces epistemic violence is that the invisibility of the disadvantaged group’s praxis is maintained by the assertion that it is immeasurable to the group with power (De Frino, 2009).Therefore, engagement with research methods that have an accepted level of credibility and validity is essential. Without utilising methods that enable the nature of nursing work to be recognised, organised and understood, it will remain invisible or rejected as being without scientific basis or value (Chambers, 1998; De Frino, 2009). It is a cycle that can continuously re-inscribe the positioning, in this case of adolescent PICU nursing, as an epistemically disadvantaged identity (Dotson, 2011). Instead, the associated methodological risks must be understood, explicitly stated and strategies for grappling with them must be devised.

By using an inductive but theoretically informed approach, findings in **Foster and Smedley (2019a, 2019b)** are data and participant driven, but also underpinned by a rigorous theoretical frame. Developmental object-relations and attachment theory specifically value intersubjective and relational skills and knowledge and elaborate the mechanisms by which they contribute to patient outcomes and recovery. Similarly, the thematic analysis method used within **Foster (2020)** explicitly articulate

not just outcomes, but the processes that enabled the identified outcomes. This is important, because knowledge of the link between the relational work of nurses and its positive impact on patient outcomes has been highlighted as an untapped source of power, available to nurses to compel external audiences to acknowledge the importance of their domain of knowledge (De Frino, 2009).

Definitions of, and criteria for including, units of analysis in **Foster & Smedley (2019a, 2019b)** were designed to ensure rich, thick data. The data analysis process, for both the content analysis and thematic analysis methods, included systematic tracking at each stage, to maintain the interrelatedness of different codes and concepts and the integrity of each data set as a whole (see Figure 4 and **Foster 2020**, Figure 1, p5). Concrete, specific examples were retained to illustrate and contextualise each abstract or theoretical interpretation, and the data analysis process included careful attendance to understanding the context of the care setting and its specific relation to nursing identity and intervention (**Foster, 2020**; **Foster & Smedley, 2019a; 2019b**).

By grappling with the tensions between the theoretical/intuitive, detailed/summarised, abstract/concrete, individual/general, I have sought to utilise the selected research methods and my own relative epistemic advantage, to enable the nurses to name their practice, in such a way as to be heard by an academic and multi-disciplinary audience. At the same time, I have worked to limit the extent of inevitable loss of detail that comes from the data analysis process. I am indebted to the generosity and understanding of the peer reviewers and journal editors who extended significant flexibility with word limits, in support of this endeavour.

One of the limitations of the qualitative methodology used, is that whilst it enabled the nursing team to articulate their work as a whole, it was not sensitive to capturing differences in individual participant's subjective experience, such as the impact of differences in gender, race, sexuality, and age. Sample size constraints mean that this limitation is replicated in the quantitative methods used in **Foster (2020),** discussed below. As a result, there is a risk of producing an idea of a homogenous adolescent PICU nurse (Day, 2012). Similarly, whilst **Foster (2018, 2020)** indicated differences between the experience and needs of HCAs and RMNs, further fine grain

analysis of these differences is indicated. Recommendations are made in Section 6 for how these differences can be explored in future research.

Overall, the overarching methodology has shown a number of strengths in relation to meeting the primary research objectives. Together, **Foster (2009, 2019a, 2019b and 2020)** have made a significant methodological contribution to the important question raised by Chambers (1998): what methods of research inquiry can capture the invisible components of mental health nursing intervention? As a lens for analysis, developmental object-relations theory has been shown to have a specific and applicable language available for naming the detailed work of adolescent mental health nursing, providing an instrument of vision to see that which was already going on, but which was invisible and therefore not attributed value. In part, this is because developmental object relation theory understands that professional helping relationships are always a complex derivative of the primary carer-child relationship (Winnicott 1960), and within that relationship, the affective-somatic-cognitive processing system of the adult is a conceived as a highly technical and sophisticated agent for growth and change (Delaney and Ferguson, 2014). In addition, developmental object-relations theory gives credence to adolescence as a distinct developmental stage and process.

With careful adaptation, the PWDG method for data collection successfully brought the nursing team together as ‘active knowers’ and provided a scaffold to support them to theorise and define their work on their own terms. By providing a mechanism for knowledge generation in which subject and object, and process and outcome, are held together, it has been shown to be a suitable method for addressing the research gap related to explicating interpersonal nursing care processes in adolescent inpatient nursing and their contribution to care quality (Delaney, 2019). Further, capturing something of the unconscious processes that occur in the third space created in the hyphen of nurse-adolescent relationships, has enabled elaboration of the mechanisms that undermine and corrode nurse’s capacity to successfully implement their relational expertise. The use of adapted PWDGs as method has wider potential for use within nursing scholarship, to challenge the unconscious attacks on linking (Bion, 1959) that have maintained mental health nursing’s epistemic disadvantage, and the refusal of dominant health care systems to

countenance the contribution of attuned care giving, except to lay blame when it goes wrong (Brush & Vasupuram, 2006; Schuengal et al., 2010).

Combining psychoanalytic praxis with systematic application of rigorous qualitative research methods for content and thematic analysis, that organise and code the knowledge and skills attitudes and beliefs essential to the nursing task, has enabled adolescent PICU nursing to start to take a place in peer-reviewed academic journals. However, critical analysis of these methods has also demonstrated the care and attention that needs be taken to address the pitfalls inherent within them in order to limit the replication of epistemic violence.

5.3.2 Quantitative methods

Quantitative data collection utilised a validated self-report psychometric instrument that is one of the most used professional quality of life tools in health and social care research. Scale validity and internal reliability of the ProQOL V has been calculated from over 200,000 participants (Stamm, 2010) and the commonality of use enables the results to be situated in an understanding of quality of life in other mental health nursing settings

The data collection method was further strengthened by using a longitudinal rather than cross-sectional design, to manage the impact of day-to-day fluctuations in acute care settings on the stability and therefore reliability of the data collected (Sondenaa et al., 2013). Friedman's test of difference on repeated measures was applied to provide a statistical measure of stability and reliability of results, over time, and therefore of validity of the data collection instrument. This is a contribution to methodological knowledge and practice. A review of all the published studies using the ProQOL tool in acute health care environments used cross-sectional data collection strategies. In **Foster (2018),** the questionnaire demonstrated relative stability over time indicating that it is an appropriate tool for use within the adolescent PICU setting.

A limitation of the quantitative method was the time lag between participants starting to attend the NDG and receiving ethical approval to administer the ProQOL data collection instrument. This meant that that there was no pre-intervention baseline measure administered, which has limited the strength of claim that can be made that

the much better than hypothesised quality of life scores for the participants were influenced positively by the impact of the NDG, even though the qualitative data supports this. However, research design principles have always to be balanced against research philosophy and ethical values. A central value espoused in this thesis is that research must be of benefit to participants, and it would therefore have been unethical to delay start of NDG, in the face of a high level of need, for a gain in research design principles.

Quantitative data analysis was undertaken systematically, utilising statistical representation and inferential statistical analysis appropriate to the research objectives, hypothesis, data type and sample size, reported with a high level of rigor and transparency (**Foster, 2018**). A strength of the paper is that, as this is the first professional quality of life investigation in the specialty of adolescent PICU, a detailed account is provided of the clinical context in terms of unit characteristics, patient demographic and frequency and severity of violent incidents at the time of data collection. This will provide baseline data for future research, allowing comparative analysis, that was not available to me when completing this study.

Foster (2018), makes a significant methodological contribution to further studies in this field. ProQOl scores within a sample are known to cluster tightly around the mean (Stamm, 2010), meaning that standard methods of data analysis, which rely on total sub-scale scores and sample means, can lead to generalisation of data to the point that individual and specific experience data is lost. This is particularly problematic when the process of change being explored is located in the individual (Wallerstein, 2009). In this case, at a whole sample level, relative levels of wellbeing appeared to be high. However, by completing an item level analysis of individual participant ProQol V scores, elements of workplace-distress commonly experienced by participants were established, that would have been missed by looking at mean scores alone. This creates additional data about the impact of the specific setting, which can then be used as a barometer for early warning signs of compassion fatigue.

The issue of sample size in **Foster (2018)** is complicated. On the one hand, in absolute statistical analysis terms, the sample of seventeen participants is small and has impacted upon the statistical power of the data analysis. So, although the study

shows statistical differences between the sample ProQOL scores and the ProQOL benchmark data, the positive predictive value and effect size of the findings are likely to be limited. The limited sample size also meant that it was not possible to investigate the effect of confounding variables in the staff group profile (gender, age, ethnicity, and length of experience), as collecting these data would have compromised participant anonymity. This warrants further investigation in future research, as there were observed differences in the experiences of the two subgroups that were identified (RMN and HCA).

The number of participants leaving for a new job or training opportunities during the data collection period also affected the statistical power of the study, by impacting on overall sample size at comparative time points, limiting the reliability of statistical tests to confirm true and significant effects. The use of a rolling recruitment strategy, allowing new staff to join at each time point, could have gone some way to mitigating against this unforeseen limitation.

When considered from the perspective of the degree to which the sample was representative of the population being investigated, evaluation the sample size shows considerable merit. It was purposive, aligned to the research question, and representative of whole population. Although only conducted in one unit, this represented approximately a fifth of the national workforce. 77% of the workforce within the unit participated in the study, and the proportional split between RMNs and HCAs indicate that the sample reflected the proportional spit in the workforce. Data from numerically smaller sample sizes, that accurately reflect and represent specialised, unique or niche populations can be as robust as from larger sample sizes (Wallerstein, 2009).

Section 6: Implications, recommendations and conclusions

In meeting the study objectives, through the development and publication of the five focused papers presented in this thesis, a unique and significant contribution to current literature has been established.

This portfolio includes the first published studies investigating the nature of mental health nursing within adolescent PICU settings.

The work addresses a gap in the extant literature and responds to academic and practice-based commentaries within the field, that research is needed to support all mental health nurses to articulate their identity and expertise (Butterworth & Shaw, 2017; CNO, 2020), and especially those working in adolescent and PICU inpatient services (Delaney, 2019; Gwinner and Ward, 2013). Not only has the nursing task, identity and intervention for one particular setting been elaborated, a methodology has been developed by which the process can be achieved in other settings through a co-productive process, without subjecting nurses to external imposition of definitions of their work by researchers.

Evidence has been provided of significant differences between the nature of hospital care provision for adolescents and adults, and argument made for urgent attendance to these differences, to improve care quality and outcomes for young people.

A passionate, evidence-based case is made for detailed, faithful and receptive observation (Bion,1962) of mental health nursing approaches that parallel, acknowledge and re-centre the place of a specific and disciplined form of love, as the method for creating the interpersonal conditions for recovery from acute and complex mental distress, especially when these manifest in young people.

Psychoanalytic understanding of the container-contained relationship role of mental health nursing is not yet/again widely accepted (Weightman and Smithson, 2020), despite a continued acceptance of the importance of the therapeutic relationship. This portfolio of works (re)bridges a gap between mental health nursing and psychoanalysis, exploring in detail the ways in which that relationship can function. More than that, the studies in this portfolio show that working in the shared intersubjective space and state of reverie, between young person and nurse, is a central part of the emergent nursing response to the needs of young people,

irrespective of whether it is consciously sanctioned or articulated (**Foster & Smedley, 2019a**).

Failure to take notice and consider the constitutive elements of the container-contained relationship (reverie, holding, projection, identification and introjection) and the problems that can occur within it, has serious implications for the workforce and for care quality. Nursing staff will find themselves more vulnerable to burnout, and compassion fatigue (**Foster, 2018**). They are more likely to become unresponsive, or problematically responsive, to unconsciously communicated needs of young people (**Foster & Smedley, 2019b**). In turn, this leads to an escalating cycle in which adolescents excessively rely on projective identification (Bion, 1959) and staff become concretely identified with mentally distressed adolescent states of mind (**Foster, 2009; Foster & Smedley, 2019b**).

A map of this tension, between states of adolescent mental health nursing as receptive or hard reflective surfaces, has been drawn out with specific regard to observation practices. The papers contribute a new understanding of the sensory affective components of nurse's use of observations, as a means providing emotional containment in lieu of physical touch. High frequency intermittent observations were shown to provide opportunities for young people to feel 'seen', taken in and understood. In contrast, procedural surveillance that can come with implementation of continuous special observations, provided practical mitigation of risks, but reduced the sense of relational security afforded to young people. Over time, it negatively impacted upon staff wellbeing and the quality of care provision.

The findings indicate a need for adolescent inpatient units to consider pre-planned support strategies that can be quickly employed at times when continuous observations have to be used, to facilitate the nursing team coming together at a time when the clinical task actually separates them along geographical and temporal lines. Strategies for bringing nurses together at these times are essential for them to be able use their discipline expertise, in conjunction with their collective knowledge of individual young people, to plan care strategies that serve to limit the period for which enhanced observations are needed to an absolute minimum.

The findings have implications for policy development in adolescent mental health inpatient care generally, and adolescent PICU specifically. Current adolescent PICU

service specifications and policies are not based on research evidence. Elaboration of a model of adolescent PICU nursing has provided a basis from which further work can be undertaken to understand and improve this speciality and the care delivered within it. Giving name to the nameless is an essential pre-requisite for it to be thought about and available for working on (Bion, 1962b). The model shows the intersectionality of environmental, systemic and developmental contexts that shape the primary task, manifesting as a series of unresolvable tensions that generate unique intersubjective interventions, which are hidden from view. Enhancing visibility to external audiences is key to attributing value to mental health nursing (De Frino, 2009); a key driver in the Chief Nursing Office's joint action plan for mental health nursing (in draft, CNO, 2020).

Understanding of the factors that promote and inhibit therapeutic engagement, provided within this thesis, provides a putative map for clinical nurse leaders in adolescent inpatient settings, to help them identify and mitigate risk points and amplify elements that enhance nursing care.

The findings of this thesis have implications for mental health nursing pre-registration education and curricula: A theoretical contribution is made re: the nature of mental health nursing intervention in adolescent PICU, and more broadly, the central role of projective identification in enabling therapeutic growth-promoting care and in engendering staff distress. Consideration needs to be given to how the how student mental health nurses can be prepared to manage the rigor of this profoundly emotional work

There are implications for adolescent PICU service delivery and workforce management, in terms of understanding the specific vulnerabilities re: professional quality of life and how these can be proactively monitored and attended to (**Foster, 2018).**

The next steps, following completion of this thesis will be:

- To present the findings to the National CAMHS PICU Network, a newly form group whose purpose is to improve policy, standards and practice in adolescent PICU (See Appendix 5)
- To develop the secondary analysis in this thesis, pertaining to love as method for nursing mental distressed adolescents in hospital settings, for peer reviewed publication

From the emergent findings of this thesis, recommendations are made for further research and development:

Consideration should be given to utilising the understanding of the characteristics of effective support in **Foster (2020)** to develop a manualised approach for providing adapted PWDGs for inpatient nursing teams, so that they can be implemented across multiple sites and their efficacy tested further. However, any standardisation should include a preparatory process for developing a detailed understanding of the specific care context and nature of nursing in each area, rather than a one size fits all approach.

Future research should be undertaken to test the model proposed in this thesis, but also to create equally detailed understandings of the similarities and differences in other PICU and adolescent mental health settings.

Larger scale studies are warranted, using a larger sample from multiple sites in order to see if the findings from this single clinical setting are replicated in other adolescent PICU settings, and to enable a more fine-grain analysis of potentially confounding variables. Using a single centre study limited the ability to consider the differential effects of length of experience, race, gender and other individual differences on staff identity and the impact of their work. This should be combined with an in-depth qualitative design, to gain understanding of the difference in experience of HCAs and registered nurses, and of the factors that may be enabling nurses within this setting to maintain their sense of compassion satisfaction, in spite of the challenges they face. Further research of this kind has potential to inform strategies for improving job satisfaction and care effectiveness within PICU settings.

In conclusion, a significant contribution has been made to research methodologies for elaborating the knowledge and skills of mental health nursing. The thesis demonstrates how the synthesis of psychoanalytic praxis with qualitative and quantitative research methods, within a psychosocial framework, provides both a lens for illuminating, and tool for producing, new understanding of the invisible, but essential, relational components of mental health nursing.

"What makes the desert beautiful is that somewhere it hides a well…What gives them their beauty is something that is invisible."

(de Saint-Exupéry, 1943, p.78)

The methods used have enabled an original, comprehensive and nuanced understanding of adolescent PICU nursing, a speciality that has been hitherto ignored by research. Finally, a systematic argument has been laid out for the development of 'love as method' as a legitimate, evidence-based nursing approach to caring for adolescents in hospital settings, who are experiencing acute and complex mental distress. As Dr Martin Luther King Jr. observed, amelioration of conflict and creation of the conditions for peace (internal or external), requires the development of *"a method which rejects revenge, aggression and retaliation. The foundation of such a method is love."* (Luther King, 1964).

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Appendix 1: Peer reviewed journal articles submitted as part of PhD by Published Works

Adolescents in Acute Mental Distress on Inpatient Pediatric Settings: Reflections From a Pediatric Liaison Practitioner

Celeste Foster, RMN, BSc (Hons), PGCE, MA

TOPIC: *The impact of adolescents in acute mental distress admitted onto inpatient pediatric settings: on the staff group caring for them and the adolescents' consequent experience of the service provided.*
PURPOSE: *To examine the impact that this client group can have on the staff, the environment, and wider professional system from an applied psychodynamic standpoint. The aim of this study is to identify practical strategies for providing effective child and adolescent mental health service consultation liaison for this complex and high-risk group.*
SOURCES: *This study draws on psychoanalytic theories of adolescent development, trauma, organizational dynamics, and reflections on personal experiences in the field of pediatric liaison. The challenges of providing effective support in this context are illustrated with clinical examples from the author's own practice.*
CONCLUSIONS: *The importance of attending to the very primitive anxieties and subsequent defense mechanisms aroused in staff caring for adolescents in the context described is highlighted. A case is made for the provision of mental health consultation and support that provides emotional containment for the young people and staff, and that incorporates understanding of the organizational issues that can contribute to the complexity of this work.*
Search terms: *Adolescents, inpatient, mental distress, pediatric liaison, psychodynamic*

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Introduction

In the United Kingdom and the United States, the number of adolescent psychiatric inpatient beds has decreased in response to fiscal and political pressures (Gowers, Clarke, Alldis, Wormald, & Wood, 2001). The shortage of specialist inpatient provision, apparent increase in prevalence of mental health problems in young people, combined with the high level of comorbid mental health difficulties in young people with physical health needs (Meltzer, 2000), mean that management of adolescents in acute mental distress in inpatient pediatric settings is an issue for child health service providers internationally.

Estimates on the numbers of young people admitted to pediatric wards due to mental health difficulties vary significantly according to sample methodology and geographical location. In the United Kingdom, it has been estimated that up to a third of adolescent psychiatric admissions are to adult psychiatric or pediatric beds (Worral et al., 2004), and a recent survey of adolescent service users found that 16% of those questioned had been placed on a pediatric ward (Street, 2004). While current policy agendas indicate a commitment to increasing the capacity of specialist child and adolescent mental health services (CAMHS) (Department of Health, 2004; Royal College Psychiatry, 2006), it will take a significant amount of time and resources to make this a reality. In the meantime, providing effective support, consultation, and education to pediatric inpatient units remains an important aspect of CAMHS provision. The pediatric liaison service referred to within this paper seeks to provide mental health consultation, education, assessment, and treatment services for young people in hospital-based pediatric departments as a means of addressing these issues.

The interplay of medical, societal, and political factors and local and national policy drivers means that providing care for young people with mental health difficulties is an

increasingly commonplace part of the work of pediatric inpatient wards (Department of Health, 2004; Meltzer, 2000; National Institute for Clinical Excellence, 2004; Watson, 2006). Yet the way in which children's medical services are organized and resourced continues to frame the care of adolescents with mental health needs as "additional work," extraordinary to the key tasks they are commissioned to provide.

Additionally, recent research indicates that a large number of pediatric nurses feel inadequately trained regarding the mental health of children, and lack confidence in their abilities to care for young people with mental health needs (Jones, 2004, Ramritu, Courtney, Stanley, & Finlayson, 2002). This suggests that pediatric nursing staff feel increasingly put upon to provide care for a group of young people who fall outside the realm of their perceived responsibility, whom in their experience regularly present with challenging behavior that disrupts the running of the rest of the ward, and whom they feel they do not understand nor have capacity to care for effectively. In contrast, CAMHS, whom the pediatric nurses perceive as being the team who really should hold responsibility for the care of these young people, often have no service provision outside of the nine-to-five Monday-to-Friday workweek, no on-call service, and no admission rights, meaning that responsibility for the adolescents is always shouldered by the pediatric team. With reference to a psychoanalytic understanding of adolescent identity development, which is rooted in a "gendered" conception of the family and its context, the CAMHS team can be felt as an absent father to a distressed adolescent and a jaded and overwhelmed mother (Burger, 1985). This creates high potential for splitting between the two services and can generate understandable resentments in the pediatric team, exemplified in the case examples presented further in this paper.

This paper examines the relationship between, firstly, the internal machinations of adolescents admitted in mental distress; secondly, the interpersonal processes between the adolescent and the pediatric nursing staff; and, thirdly, the wider systemic context within which these take place. A psychodynamic perspective is specifically adopted because its relational focus provides a helpful frame for exploring the interdependence of these three domains and the quality of the emotional intensity stirred up by this work. Focusing emphasis on the meaning of process rather than content, analysis of clinical material from this theoretical standpoint can enable the development of practical strategies for providing effective support.

Adolescence, Professional Defense, and Trauma: A Psychodynamic Interpretation

Despite providing care for children from infancy right through late adolescence, pediatric services predominantly require support from mental health services for adolescents (Deaton, 1998; Diler, 2003; Garralda, 2002).

The developmental stage of adolescence has been characterized as a reworking of earlier developmental stages, particularly infancy, triggered by or in the context of the rapid and wholesale physical, cognitive, emotional, and social changes of puberty (Anderson & Dartington, 1998; Briggs, 2002). This is summed up by Waddell (1998) as a time when:

> Old conflicts, especially those of infancy and of Oedipal struggles, are being re-worked (in the context of new genital drives), conflicts which test the quality of early containment & internalization. (p. 143)

Where containment is the concept of the caregiver's capacity to take in, digest, and make sense of the child's raw experiences and anxieties, giving them back to the child in a tolerable form (Bion, 1962). Over time, this continuously repeated process is internalized by the child as part of his or her own internal world and is essential in the child's development of the capacity to think and to tolerate emotional intensity or discomfort (Ingham, 1998; Reisenberg-Malcolm, 2001).

This developmental link between adolescence and infancy can often lead to adolescents reexperiencing the anxieties of this earlier stage—fears of persecution, annihilation, and destructive impulses triggered by vulnerability—and, therefore, relying heavily on the more primitive defense mechanisms of splitting, projection, and projective identification (Klein, 1946; Waddell, 1998). The psychological defense mechanisms linked to this state of mind, referred to as "the paranoid-schizoid" position or functioning (Klein), have been described as serving to "expel" pain rather than to contain it (Lemma, 2003; Waddell). It is the adolescent's enactment of these processes that can give rise to the emotional intensity that is often experienced by professionals working with adolescents. This is often compounded by young people's ability to put professionals working with them back in touch with the intensity of their own adolescence. The impact of adolescents on their surroundings has been described as equal to the impact of puberty on the adolescent (Bemporad & Wilson, 1978).

In relation to the young people being thought about within this paper, many of the requests received for consultation are for young people whose early experience of care has been disrupted in some way or who have experienced significant early adversity, meaning that the "quality of early containment and internalization" has been negatively impacted upon. Therefore, the persecutory anxieties of infancy and use of "paranoid-schizoid" defenses may be much more pronounced and their impact on the staff taking care of them also more dramatic. This is all against a setting in which images of parents nurturing their younger children are

everywhere, leaving these young people with no choice but to face the often painful contrast between these images and the realities of their own experiences of being cared for.

The persecutory anxieties of infancy and use of "paranoid-schizoid" defenses may be much more pronounced and their impact on the staff taking care of them also more dramatic.

The specific context of the pediatric ward in which the young people are being cared for may also contribute to the difficulties experienced. The predominant model is a medical one in which paternalism and expectations of patients and families to acquiesce to knowing experts are inherent, a model that is in much less conflict with earlier developmental stages of childhood, but that is in direct contrast to the adolescent's need for individuality and independence (Ramritu et al., 2002). Nurses can quickly be drawn into taking on direct power battles with the adolescent in an attempt to try and control disturbances and preserve the order and routine of the ward (Adamo, Iannazzone, Peyron, & Melazzini, 2004; Menzies-Lyth, 1988).

Menzies-Lyth (1988) highlighted that children in organizations invariably outnumber the staff group and collectively use primitive defenses to manage their pain (both physical and psychic). This makes it very difficult for staff to sustain and model more "mature" defenses and facilitate the containment and "working through" of problems. It has been argued that requests from pediatric services for psychosocial input initiated by a young person's distress often conceal the team's own need for emotional containment (Byron & Duff, 2005).

A body of work has identified that nurses as a professional group are subject to high levels of emotional intensity and stress and are often in intimate contact with death, illness, and trauma, considered above that which an ordinary person could bear (Lawrence, 1995; Menzies-Lyth, 1988; Meyer, DeMaso, & Koocher, 1996). Meyer et al. suggests that the stress experienced by pediatric nurses may be even more intense because of the level of variability in the kinds of patients they work with and the societal expectations that exist for children's health and lifespan.

Institutional or social defenses are employed to protect nurses against the fears of being overwhelmed or annihilated that can be stirred up by such work. These have been described as including the reduction of nurse–patient contact through task allocation, depersonalization of the patient and the nurse, ritual task performance, and avoidance of change (Menzies-Lyth, 1988). In my work with the children's inpatient units, it has become evident to me that concepts of "action" or "doing" are very highly valued. Ostensibly this seems to be an inevitable consequence of the speed and pressure of the work the staff have to undertake. However, the organization of services to promote excessive work rates and a tendency toward action in individuals can also be seen as a further defensive strategy that cuts out space for thinking and for digesting experience (Waddell, 2005). This bias toward substituting action for thinking where "doing" can effectively create a state of mindlessness, parallels the process of "acting out" typically associated with adolescent coping styles (Waddell, 1998).

On an individual level, the nursing staff appear to use their knowledge and experience of their specialized field as a way of coping with the stresses of their work. Their sense of competence and of knowing what to do in a crisis acts as a kind of armor and their knowledge base acts as a kind of internal container, helping them to take in and make sense of raw experiences that on the face of it seem intolerable. The admission of an adolescent in a mental health crisis can therefore be seen as a double blow to the nurse's defenses. First, their armor of knowledge is perceived by them as not fit-for-purpose, leaving them vulnerable to feelings of being overwhelmed by the adolescents and the emotional chaos and intensity that they bring. Second, the way in which the adolescents often communicate their distress—through action imbued with drama, high levels of risk taking, and excitation that cannot be ignored—intrudes upon the task-based action orientated routines of the ward, forcing the nurses to think about and feel something of the adolescent's internal world. The desire of the staff to defend themselves against or abdicate responsibility for the young person's internal world can be acted out in very concrete and visible ways.

Lawrence (1995) states that uncertain or changing environments can be experienced by staff groups as persecutory, which can also reignite infantile anxieties leading individuals to interpret the world from a more paranoid-schizoid position. The admission process for adolescents in distress is not only uncertain due to its unplanned nature and the fear of the unknown that the adolescents' difficulties themselves provoke, but because there are often no operational systems or agreements between the CAMHS and the pediatric team for such cases. Each case is therefore admitted against a political backdrop of difficult negotiations in which the pediatric team feels backed into a corner because there is no alternative provision available. Not only is the nursing team often absent from this decision-making process, but they have often overtly expressed their fears that they will be unable to cope with the demands of both the physically sick children they are expected to care for and the distressed adolescent to be admitted. In my experience, it is not unusual for them to have specifically requested that an alternative solution be found only to find that their request has not been

heard and the young person is to be admitted anyway. In these cases, the level of uncertainty combined with the nurses' sense of powerlessness mean that the admission of an adolescent in acute distress in to the ward can be experienced as not just anxiety provoking but traumatic.

Trauma has been described as an event that overwhelms existing defenses against anxiety in a form that also provides confirmation of an individual's deepest anxieties. It can be seen as a "wound" that pierces our protective shield or internalized container and prompts regression to primitive coping responses (Freud, 1922; Garland, 1998a). Many experienced pediatric nurses have experienced a catalogue of young people being admitted in these circumstances, where the "parental figure" of the service's management team has not been able to tune into and bear their fundamental anxieties about being overwhelmed or destroyed, and where their worst fears have subsequently been realized in the disturbance that the young person brings to bear on the ward environment. They are left feeling abandoned by the authority figures that put them in such an untenable position. Similarly, the young people they are being asked to care for have often had experiences of disappointing or frustrating carer's that have not been available or able to take in, digest, and lend meaning to their anxieties. This can mean that the staff and adolescents experience intense resonance with each other's states of mind. This leaves the staff vulnerable to receiving and identifying with the young people's projections, leading to a high likelihood of enactment of the transference/countertransference relationship.

Regression to a more paranoid schizoid position triggered by this trauma additionally means that the nurses experience significant difficulty tolerating the ambivalence and rapidly changing states of mind that are typical of the adolescents in distress (Lawrence, 1995). This can often lead to them questioning the authenticity and validity of the young person's distress and, therefore, experiencing the young person's behavior as increasingly attacking and persecutory. It is not hard to see how this self-perpetuating cycle can escalate quickly.

Additionally, the breach of the internal container associated with the experience of trauma can damage the individual's ability to symbolize (Garland, 1998b). Symbolic functioning is an essential tool in the development of the capacity to communicate and to tolerate feelings of mourning and guilt, pivotal to progression from the paranoid schizoid to the depressive position (Di Ceglie, 2001; Klein, 1946; Segal, 1957). It is hypothesized by Menzies-Lyth (1988) that symbolization is the key adaptive tool that nurses have to master the anxieties inherent in their work: transformation of concrete experience into mental representations of the experience means it is available for processing or "working though." When responding to a request to help with a young person in crisis, it is common to experience both an intense pressure and responsibility to fix every thing and a concurrent cynicism and doubt about personal capacity to tolerate the ambivalence within the system and to be of any use (i.e., to be concretely identified with an ineffectual and disappointing parent, who will be no different to those already experienced by both the adolescent and the staff). Without a model for understanding these processes, this double bind can evoke intense countertransference feelings in supporting mental health practitioners of loneliness and anger at the invalidation of their attempts to help.

The cumulative traumatic impact of caring for mentally distressed adolescents on the nursing staff, in this context, is that the fabric of their defenses is attacked on all sides and unravels. This means that they are not just overwhelmed by their anxieties about caring for the young person, but that they are also forced to face the anxieties relating to the emotional stress of their "everyday" work that under usual circumstances they feel sufficiently defended against. When attending the units in response to such emergencies, it is not uncommon for staff to tell me repeatedly "we have sick and dying babies here you know, how can we be expected to care for them?" as though the full extent of the impossibility of what they are being asked to do has only just been revealed to them.

The cumulative impact of the trauma of caring for adolescents in mental distress in the context described on the nursing staff is that the fabric of their defenses is attacked on all sides and unravels.

Clinical Examples

I was called to one of the wards to undertake a series of urgent consultations over a period of 5 days with regard to a young woman called Sarah. On the first day I arrived, Sarah was in a bed in one of the central observation bays in the middle of the ward, and could be seen at all times from the nursing station. Initially she had presented in a very hostile and aggressive manner, but as the days progressed she became increasingly sad and tearful until a point where she would sob and cry out for hours at a time, which the nursing team found very difficult to bear. Each day I visited the ward, Sarah's bed had been moved progressively further away from the nursing station, reportedly due to the observation/care needs of other children. One day I visited to find that she had been moved to a single side room at the end of a corridor at the furthest end of the ward. The nurse

designated to take care of Sarah stood in the corridor outside her room, seemingly unable to go in, while inside the room Sarah sobbed. My suggestion to move Sarah into a more central place in the ward, as I thought it might be important for her distress to be acknowledged and heard, was met with a very dismissive response.

In this instance my agenda was to try and encourage interest in the young person's internal world and, therefore, directly at odds with that of the pediatric staff who were (perhaps unconsciously) actively trying to avoid thinking about her distress. This vignette exemplifies the culture difference that can exist between children's medical and mental health services: the difference between engaging with an adolescent's internal world and defending against it and between "doing" and "thinking." This is a split that has been observed to be exacerbated by young people who "bring their own dynamic of violent conflict into the system" (Sprince, 2000, p. 417) and which must be carefully attended to by consulting mental health practitioners.

A 15-year-old girl, Jennifer, was admitted to the children's medical unit due to acutely unstable blood sugars, which had led to her collapsing on a number of occasions, one of which was felt to be life threatening. Jennifer was diabetic and had been a patient of the unit for many years. She had been experiencing bullying at school, was actually due to leave school in a couple of months, and she was due to be transferred to the adult diabetic services in time for her 16th birthday. On admission it became apparent that Jennifer had been intentionally taking too much of her insulin. Once on the ward, she refused to go home, saying that she would keep overdosing on her insulin if they tried to send her home, and she refused to speak to anyone regarding the difficulties she was experiencing. A request was made for me and a colleague to assess Jennifer on the ward. The nursing staff had threatened Jennifer with discharge if she didn't comply—a threat she tested out and the staff were unable to follow through, due to her blood sugars remaining very unstable.

On our first meeting Jennifer was marched down the ward to the interview room by two nursing staff and was instructed to sit down and talk to us. Jennifer was able to tolerate an oblique approach in which we tried to avoid opportunity for direct power struggles by providing information about our service and offering her the opportunity to visit the following day in order to decide whether she would like to attend, to which she agreed. We left the meeting feeling pleased with ourselves and the outcome, only to find that our request to leave the ward (the door is operated by an electronic key at the nursing station) was denied and we had been surrounded by a group of furious nurses, shouting at us for trying to leave without taking Jennifer with us, for doing nothing as usual, and for being manipulated by her and undermining them. All this while Jennifer looked on from further down the corridor.

Hinshelwood and Skogstad (2000) describes how feelings can sweep across a group who possess a common internal object. In this case, Jennifer and the pediatric staff could be described as having an abandoning parental figure in common—a child who is furious at feeling abandoned by the pediatric team and by her childhood, and a pediatric nursing team who is furious about an abandoning CAMHS team. Jennifer's shortly arriving 16th birthday and transition to adult services have stirred up adolescent conflicts of childhood versus adulthood and dependence versus independence in a context of chronic illness, and bullying that have evoked strong feelings of powerlessness in her. In the transference, Jennifer's insulin overdoses and refusal to engage with help offered are powerful attacks on the service, which has provided her with care for most of her childhood and which is now passing her on to someone else.

Dubinsky (2004) argues that in fragile adolescents, the anxiety of not being up to the task of growing up can generate self-hatred and hatred of parents and authority figures who have failed to provide them with what they needed to grow up. This has evoked strong countertransference in the nursing team of anger, confusion, and powerlessness. The split of Jennifer's inner world has been projected into the staff group and acted out in the dynamic between the pediatric and CAMHS staff, illustrating how young people's projections can be so powerful that staff can become so identified with them that they are unable to think and have to pass the feelings on (Meyer et al., 1996; Sprince, 2000).

Practical Guidance for Providing Effective Support and Consultation

Based on the arguments presented, the fundamental task of providing effective support in such situations is to be a containing figure that can withstand and think about the experiences of both the young people for whom the request is made and the staff taking care of them. I have experienced very painfully the consequences of thinking only about the adolescent's distress: either leaving the staff with powerful feelings of envy, leading them to respond in a very hostile way, and perceiving my interpretations of the child's communication as a "pseudoanalytic" attack on them (Joseph, 1985; Meyer et al., 1996) and conceptualizing me as easily manipulated (Sprince, 2000) or conversely, putting them in touch with the pain of the child's internal world to such an extent that they feel overwhelmed and paralyzed by it.

Equally the limitations of the mental health practitioner's experience and knowledge of working with transference/countertransference relationships can make them very vulnerable to losing their own capacity to think and to contain their own anxiety. This can lead to being unwittingly drafted into roles within the drama being played out—dynamics that are

often only identifiable away from the environment in which they are enacted.

There are two key challenges to providing useful consultation: how to get pediatric staff to invest in the internal world of a young person who is causing them so much distress, and how to translate psychodynamic constructs that support understanding of the interpersonal processes occurring in a way that can be practically applied and that does not reinforce the pediatric staff's feelings of "confoundedness." In considering these two challenges, it is important to acknowledge the limitations of trying to engage staff in exploring the meanings of behavior "in the moment," where personal survival is the main priority as illustrated in the clinical examples. Joseph (1985) identifies the importance of understanding that what is said is always responded to according to the recipient's position at the time, and not according to the intention of the person offering the intervention. In particular, she notes that people operating with more primitive defenses are more likely to hear our offers of help in an attacking or critical way.

Two measures, over and above providing a timely response to crises, have been effective in addressing these issues within my own practice. First, the development of a monthly forum for providing training, case discussions, and a containing space for sharing ideas and thinking about commonly experienced dilemmas together. The impact of this has been to improve interpersonal relationships between CAMHS and pediatric staff and to increase the pediatric staff's confidence in their capacity to care for young people with mental health needs. It also provides an opportunity to give pediatric staff positive feedback about the value of their role in caring for young people with mental health needs. More importantly, it has supported the development of a shared understanding of the challenges facing both the young people and the pediatric staff group, which can then be drawn upon during times of crisis to help reduce splitting between the two teams and to help the staff to invest in the young person's internal world (Sprince, 2000).

Second, the provision of direct access to daily nine-to-five telephone availability from the same practitioner has over time given the pediatric staff a sense of being "held in mind," which has also served to contain some of their anxieties.

Acknowledging the very real constraints and pressures that are placed upon the inpatient team has been pivotal in any success that these strategies have had. For example, the monthly forum takes place at a time specified by the pediatric nursing team as most convenient to them and that is outside of the CAMHS team's normal working hours. This gives a clear message of the importance of the service provided by the ward, acknowledges the challenges of a 24-hr cycle of care, and communicates a willingness to be flexible on the part of the CAMHS team.

Conclusion

Based on my observations of working with two pediatric inpatient units, it is the central argument of this paper that the specific organizational context of the children's inpatient units, the pediatric nurses' experience of their position in the system's hierarchy, and the mechanism's by which adolescents with mental health needs are admitted to the ward mean that the nurses and the adolescents are psychologically and emotionally linked. That is, linked by their shared experience of the traumatic way in which adolescents come into the units; by aspects of their internal world, in particular views of their "self-other" relationships; and by their dominant form of coping (doing or acting out). This can lead to adolescent fears, processes, and states of mind being recreated or mirrored in the staff group with phenomenal accuracy and intensity. In these circumstances, not only is it difficult for the nurses to sustain and model more adaptive defenses, but they are so vulnerable to the powerful projections of the teenagers that they experience a regression to a more paranoid-schizoid position and become equally reliant on primitive defenses of splitting, projection, and projective identification. As such, the team's capacity to contain their own anxieties, let alone those of the young person, is significantly disabled.

. . . the nurses and the adolescents are psychologically and emotionally linked.

Furthermore, the individual and organizational, often task-based, defenses that the nurses have developed to manage and avoid thinking about the high-degree emotional stress they encounter in their "everyday" work of caring for physically sick children are interrupted and rendered ineffective by the adolescent's frequently chaotic and disruptive behavior. This puts them in touch with the sheer emotional force and impossibility of the tasks that their ordinary work consists of, which has been compared to "participating in active warfare" (Woolston, 1994, as cited in Meyer et al., 1996).

The core tasks of the consulting practitioner are therefore to try to provide emotional containment for both the young person and the staff, and to be able to think about and make sense of their experiences: in a system of which they are an inherent part, which is filled with intense and continually shifting transference relationships (Joseph, 1985), and which exerts a phenomenal pressure to "do something" in an environment where "thinking" is often perceived as "doing nothing" (Waddell, 2005).

Drawing on models of consultation and support that promote nurturing of the nursing staff's hopeful internal

objects outside of periods of crisis (e.g., through regular staff support meetings) and respect for their defenses as essential mechanisms for surviving the institution of which they are part, combined with strategies that integrate the thoughtful and the practical, can be helpful in managing the challenges of the processes described (Adamo et al., 2004; Byron & Duff, 2005; Menzies-Lyth, 1988; Meyer et al., 1996).

Successful containment offers an opportunity for the adolescent's development of self, through introjective identification with positive models of situations, individuals, and relationships, and the reconciliation of "splits" or integration of good and bad aspects of the object that is considered essential to the adolescent's successful journey into adulthood (Klein, 1946; Lemma, 2003; Menzies-Lyth, 1988).

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Investigating professional quality of life in nursing staff working in Adolescent Psychiatric Intensive Care Units (PICUs)

Celeste Foster

Abstract

Purpose – *The purpose of this paper is to investigate professional quality of life of mental health nursing staff working within an adolescent psychiatric intensive care unit (PICU) setting. Professional quality of life is important, as there is a correlation between staff wellbeing and the quality of healthcare services delivered, particularly within mental health settings. Mental health nursing staff in adolescent PICU services deal with a wide range of physically and emotionally demanding challenges when providing care, yet the potential impact of this demanding work upon staff in this context has not been explored.*

Design/methodology/approach – *The study used a longitudinal non-experimental design with a purposive sample. Quantitative data were collected from a total of 17 registered mental health nurses and healthcare assistants (HCAs) working in an adolescent PICU in the North of England. Repeated measures were administered at three consecutive intervals, three months apart, using a validated self-report measure, the Professional Quality of Life Scale V (ProQOL V, Stamm, 2010). Data were analysed using descriptive and inferential statistical analysis using benchmark data from the ProQOL V instrument for comparison.*

Findings – *Analysis of results compared to ProQOL V benchmark data showed significantly higher than expected levels of compassion satisfaction, and lower than expected levels of burnout and secondary traumatic stress for adolescent PICU nursing staff within the study. There were no significant differences between qualified nurses and HCAs. Potential explanations and practice implications of these findings are discussed.*

Originality/value – *This is the first published study to investigate professional quality of life within the mental health nursing population working in adolescent PICU, providing empirical insights into a previously unexplored mental health context.*

Keywords *Psychiatric Intensive Care Unit (PICU), Adolescent, Mental health*

Paper type *Research paper*

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Introduction

Adolescent psychiatric intensive care units (PICUs) are a small and highly specialised component of the portfolio of child and adolescent mental health service delivery in the UK. Adolescent PICU services are usually mixed gender, "secure" inpatient environments for the short-term containment and treatment of young people detained under the Mental Health Act (1983). Young people detained in PICUs typically display symptoms and behaviours associated with a serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability (NHS England, 2016). An environment in which multi-disciplinary care and treatment can be delivered safely is created through high levels of physical, relational and procedural security, for which nursing staff often carry the burden of responsibility. Physical, procedural and relational security are interrelated concepts that together create a form of therapeutic security, essential for both the maintenance of safety and the promotion of recovery (Tighe and Gudjonsson, 2012). Physical security relates to both the design and maintenance of the environment and its fittings (e.g. locks and alarms) and the staff resources required for the safe operation of them. Within this, procedural security is created through implementation of the policies, procedures and systems for maintaining patient safety, for example, patient observations and checks (Kennedy, 2002).

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Quantitative elements of relational security include the staff/patient ratio and the amount of face-to face contact time between staff and patients. Whilst qualitative domains of relational security have been described as a detailed understanding of those receiving care and of how to manage them, delivered within the context of positive therapeutic relationships (DH, 2010).

There are currently five adolescent PICUs in the UK. In addition, to meet the demand for inpatient services that can contain the risks presented by adolescents experiencing acute psychiatric disturbance, an increasing number of "open" adolescent inpatient mental health units are developing PICU-type resources within their establishments (NHS England, 2014). Although the number of specific adolescent PICU inpatient units is small, they play an important part in the recovery journey of a significant cohort of children in any 12-month period. This is because the time-limited admission model of care used results in high patient turnover, meaning PICUs provide for a significant number of young people annually. In 2014, NHS England (2014) reported that there were 96 PICU beds in England, with an average admission length of 70 days and a bed occupancy rate of almost 80 per cent. This approximates to provision for 300–400 admissions a year. The relative success of a PICU admission can be pivotal in deciding whether a young person's trajectory is towards a return to community care or towards longer-term restrictive or secure mental healthcare. In addition, the number of young people requiring PICU beds appears to be increasing (NAPICU, 2015). Despite these factors, there has been no published research in relation to nursing care provision within adolescent PICU services to date.

Research from adult PICU environments highlights that they are largely organised around the provision of short-term care within a highly contained environment for those experiencing acute psychiatric distress who are usually a risk to themselves or others (Bowers *et al.*, 2008; Gentle, 1996). The environment and the high levels of violence and aggression within it are often managed through relatively high nursing staff levels, of which the dominant workforce is unqualified healthcare support workers. The care of service users who present with high levels of violence is known to be complex, often provoking difficult feelings and contributing to negative work experience (Sondenaa *et al.*, 2013). In a survey of morale amongst adult mental health workers in England, PICU staff were identified as at particularly high risk of emotional strain and burnout because of an interaction between high job demand, low perception of autonomy and poor support (Johnson *et al.*, 2012). Studies in adult PICU settings have also noted a lack of respect and inadequate resources being provided to nurses working in PICU settings that adversely affect staff satisfaction at work (Gwinner and Ward, 2013). In addition, adolescent PICU environments are known to provide for a population with more diverse and complex presentations (Page and Parker, 2015) and general adolescent psychiatric inpatient units have been identified as environments that can place nursing staff in significant moral distress (Musto and Schreiber, 2012). Therefore, it can be reasonably expected that the impact of adolescent PICU environments upon mental health nursing staff may well be comparable to those working in adult PICU contexts.

Compassion fatigue is constituted of two related dimensions: burnout and secondary traumatic stress (Stamm, 2010). In healthcare staff, it is associated with reduction in reflective capacity, indifferent and hard responses towards patients and a reduction in staff's own mental wellbeing (Coetzee and Klopper, 2010). The cumulative work-related stress experienced by healthcare providers has been shown to impact upon the delivery of healthcare services (Sinclair *et al.*, 2017). Burnout is a psychological syndrome, characterised by exhaustion, frustration, anger and depression associated with professional life (Stamm, 2010) that occurs in response to chronic uncontrollable work demands when providing a service (Maslach *et al.*, 2001). It is most common in workers who have to give something of themselves emotionally (Sondenaa *et al.*, 2013). Conversely, levels of compassion satisfaction – the degree of pleasure derived from being able to do one's work effectively (Stamm, 2010) – have been correlated with reduced risk of burnout (Ray *et al.*, 2013). More specifically, in the adult PICU environment, a study by Verhaeghe *et al.* (2016) found that perceived self-efficacy in mental health nurses, in relation to the management of aggression, was positively correlated to compassion satisfaction and negatively correlated to perceived secondary traumatic stress.

Therefore, understanding the impact of the clinical task on, and the specific support needs of, nursing staff working in an adolescent PICU environment is potentially an important component of

developing effective and high-quality patient care strategies. This study aims to investigate both the positive and negative dimensions of professional quality of life for nursing staff within an adolescent PICU setting.

Research objectives and hypothesis

The primary research objective for the current study was to determine relative levels of compassion satisfaction and compassion fatigue reported by registered mental health nurses (RMNs) and unqualified healthcare assistants (HCAs) working in an adolescent PICU.

The secondary objective was to compare the levels of compassion satisfaction and compassion fatigue in the participant group with benchmark data and data from similar workforces, in order to identify potential similarities and differences that may warrant further investigation.

Hypothesis: the group would experience higher levels of compassion fatigue and less compassion satisfaction, as compared to the normative benchmark data for the instrument being used. This hypothesis was based on:

- The fact that high job demand and low autonomy have previously been identified as characteristic of roles within restrictive care environments (Johnson *et al.*, 2012).
- That service users within adolescent PICU present with symptoms of severe mental health disorder which are associated with very high levels of adverse life events including psychological and physical trauma (Smith and Hartman, 2003), and that the secondary traumatic stress experienced from caring for severely ill children has been identified as a contributor to compassion fatigue (Berger *et al.*, 2015).
- That there are very high levels of service user enacted violence within the adolescent PICU environment, which have been shown to contribute to a negative working experience and feelings of fear and anxiety within staff groups (Sondenaa *et al.*, 2013). The prevalence of traumatic stress in mental health nurses who have been subject to violence has been shown in a previous study to be high (Richter and Berger, 2006).

Method

The study used a longitudinal, non-experimental design with a purposive sample. Quantitative data were collected from a sample of the entire staffing complement, qualified nurses and HCAs, working in an adolescent PICU in the North of England ($n = 22$). A total of 17 members of staff consented to participate. Repeated measures were administered at three consecutive intervals, three months apart, using a validated self-report measure, the Professional Quality of Life Scale V (ProQOL V, Stamm, 2010). Data collection at multiple intervals was used in order to manage prior observations that cross-sectional design in acute environments that uses data from a single point in time is limited in its reliability, due to the degree of day-to-day fluctuation that can affect staff perception (Sacco *et al.*, 2015; Hooper *et al.*, 2010).

Ethical considerations

Both the University Ethics Committee (HSCR14/19) and the Research Governance Committee of the participating healthcare organisation (non-NHS) granted ethical approval. All those who chose to participate provided informed consent. Participants were informed of their right to withdraw from the study at any point and that data would be stored securely and anonymously in accordance with the Data Protection Act (1998). All data were anonymised and only reported in an aggregated form to maintain confidentiality.

Procedure

All HCAs and qualified nurses within one adolescent PICU were invited to participate in the study by completing the self-report measure at three intervals, 12 weeks apart. Participant information and consent forms were distributed. Measures were distributed to those who completed consent forms.

They were completed anonymously and collected in a sealed postbox to maintain anonymity. A digital version via Bristol Online Survey software was also available. Participants chose a nickname so that their questionnaires from each time point could be matched, and to facilitate withdrawal of data if necessary.

Data collection and research instrument

Data were collected via administration of the anonymous self-report psychometric instrument Professional Quality of Life Questionnaire Version 5 (ProQOL V) (Stamm, 2010). This is a 30-point instrument using a 5-point Likert scale (1 = never, 5 = very often). The measure is comprised of three 10-item subscales: compassion satisfaction, burnout and secondary traumatic stress. Together the burnout and secondary traumatic stress subscales give a measure of compassion fatigue.

The Concise ProQOL Manual (Stamm, 2010) defines compassion satisfaction as the pleasure an individual derives from being able to do their work well. Compassion fatigue is defined as feelings of unhappiness, disconnectedness and insensitivity to the work environment. Burnout is described as exhaustion, frustration, anger and depression associated with professional life, and secondary traumatic stress is a negative feeling driven by fear and primary or secondary work-related trauma (Stamm, 2010).

Although definitions of the concepts of compassion satisfaction and fatigue have been identified as problematic (Berger *et al.*, 2015), the ProQOL V has been noted as a useful tool for monitoring healthcare provider wellbeing, as it enables comparisons between facilitating and inhibiting factors associated with caring, as well as comparison across healthcare disciplines and contexts (Sinclair *et al.*, 2017).

Internal reliability of the scale is good with Cronbach's α reliability estimates reported as 0.88 for compassion satisfaction, 0.75 for burnout and 0.81 for secondary traumatic stress. Scale validity has been calculated from over 200,000 participants from around the globe (Stamm, 2010).

Data analysis

Responses were coded and entered into the statistical software package SPSS (version 23). Scale scores were summed for compassion satisfaction (CS), burnout (BO) and secondary traumatic stress (STS) for each participant as per the instrument manual (Stamm, 2010). As the total number of missing values was very small (less than 5 per cent of the total sample), they were replaced with the respondent's mean for that particular subscale, in accordance with the suggestion by Tabachnick and Fidell (2007, p. 63). Descriptive statistics were calculated. Frequency analyses and mean scores were calculated for both individual items and the three subscale constructs (CS, BO, STS) for each of the two subgroups – registered nurses and HCAs. A nominal significance level (p-value $\leqslant 0.05$) was established *a priori*.

Data were not normally distributed and so non-parametric tests were selected to undertake analysis of statistical significance. Relative stability of the scores over the three time points was analysed using a non-parametric Friedman test of differences among repeated measures. Differences between the two subgroups (HCA and RMN) were compared using the Mann–Whitney *U* test.

Box plots of the median, quartile and extreme values for each subscale at each time point were used to undertake the frequency analysis and initial comparison with benchmark data, using the cut points for the ProQOL instrument. Pearson's χ^2 test was used to determine whether statistically significant differences existed between participants in the current study and the published benchmark data for "normal populations" in the "ProQOL V Manual" (Stamm, 2010).

As individual's total scores were expected to cluster closely around the instrument mean (Stamm, 2010), individual item scores were also analysed for trends. This was in particular regard to the potential sensitivity of individual items to picking up early signs of the dimensions that make up compassion fatigue, i.e. burnout or secondary traumatic stress. Although the term compassion fatigue was originally used in reference to nurses experiencing burnout

(Ray *et al.*, 2013), a meta review of the concept has identified that one of the limitations of systematic definitions of compassion fatigue is that they tend to be drawn from the more narrow discipline of counselling and psychotherapy. This means that the items for compassion within validated scales such as the ProQOL are also narrowly defined (Sinclair *et al.*, 2017). This raises questions regarding sensitivity of the ProQOL measure items for groups outside of those from which it was devised indicating the need for an item-level analysis.

A literature search of CINAHL, Medline and PsychInfo databases and a hand search of the comprehensive bibliography of studies using the ProQOL measure (Stamm, 2016) revealed that no studies have been undertaken with directly comparable populations. Instead, as well as being compared to the ProQOL benchmark data, findings from the study were compared with research findings from a sample of forensic inpatient mental health nurses, specifically investigating the association of high frequency violence within a secure inpatient setting with post-traumatic stress disorder (PTSD) symptoms and their impact upon quality of life (Lauvrud *et al.*, 2009). This is the closest working environment and discipline group for adolescent PICU mental health nursing staff, in which professional quality of life has been investigated using the ProQOL measure.

Results

Context

The unit in which the study was located is a ten-bedded adolescent PICU. Criteria for admission are young people aged 12–18 years old, presenting with severe mental disorder and associated actual harm to self and other who cannot be safely contained in a less secure adolescent inpatient environment, and who are detained under the Mental Health Act (1983). During the period of study, the age range of patients was 14–18 years old.

Whilst it has been estimated that between 23 and 50 per cent of patients in general adolescent inpatient units are involved in violent incidents (Baeza *et al.*, 2013), the prevalence of violence within the PICU group generally and within this specific unit at the time of study is much higher. NHS England commissioners coordinate referrals to adolescent PICU in England, as the service provision is commissioned at a national level. Adolescent PICU bed scarcity (NHS England, 2014) means that referrals need to carefully screened to ensure that they meet the criteria for high levels of clinical acuity and risk. Mental health Act (1983) requirements of least restrictive practice mean that it must have been demonstrated that patient's level of actual and potential violence to self and others, or vulnerability to others, cannot be managed in a more open environment. This means that the percentage of patients in PICU who are involved in violent incidents during their admission more closely approaches 100 per cent. Incidents on the unit under study typically occurred daily, with multiple incidents commonly occurring within one period of nursing duty (12 h).

Analysis of the patient profile during the period of data collection (Foster and Smedley, 2016) revealed that the patient population was constituted of young people experiencing psychotic and mood disorders, neurodevelopmental disabilities, suicidality, complex PTSD and the impact of chronic or multiple childhood adverse experiences.

The participating staff were all part of one nursing team providing care within the adolescent PICU, and were employed to work in the adolescent unit specifically. During the period of study (nine months), the team experienced one temporary period of staffing shortage lasting several weeks and had two different ward managers in post. However, the leadership team also included a very experienced senior nurse who had worked on the unit since its opening, eight years previous.

Post-incident debriefs were implemented on the unit in accordance with the hospital policy. During the period of study, as part of the nursing team wellbeing strategy, a weekly externally facilitated clinical supervision group was implemented. It was based on a psychoanalytic work discussion model (Jackson, 2008) and facilitated by an adolescent psychotherapist. The group runs at a time to maximise nursing team access (early in the morning). It is open to all

those members of the nursing team who are not required in the clinical area at that time to meet the minimum clinical observation levels. A full description of the model of delivery can be found in Foster and Smedley (2016).

Participants

The initial response rate was high (77 per cent), with 17 of the 22 staff working on the unit at the time consenting to participate and returning questionnaires. This comprised 5 RMNs and 12 HCAs. Although the sample was skewed towards HCAs, the 30:70 split between RMN's and HCA's in the sample closely approximated the proportional split within the workforce in the unit (proportion RMNs = 32 per cent). No other demographic data were recorded, due to the small sample size meaning that any additional demographic data may have compromised participant anonymity.

Across the nine-month period of the study, eight participating staff left the service. Reasons for leaving were recorded in case this gave any secondary information regarding staff quality of life and wellbeing. Five staff left for promotion opportunities and three HCA staff left to undertake professional healthcare practitioner training programmes (Table I).

Differences between time points

The mean and standard deviation for questionnaire subscales at each time point are presented in Table II.

Comparing mean scores for the whole sample at each time point demonstrated no change in secondary traumatic stress (STS), a decrease in compassion satisfaction (CS) and an increase in burnout (BO) (see Figure 1).

However, a Friedman test of differences among repeated measures was conducted and revealed no statistical significance in observed differences (Table II), indicating that scores showed stability over time.

Levels of compassion satisfaction (CS), burnout (BO) and secondary traumatic stress (STS)

Respondent scores for the three subscales were compared with the normative benchmark data from the ProQOL V manual (Stamm, 2010) in Figures 2–4. The horizontal lines indicate cut points for the bottom and top quartile from the benchmark data.

Table I Sample and participation rates

	n	*As a percentage of the sample group*	*As a percentage of the total workforce*
Number participants completing 1 interval	17	100	77
Number participants completing 2 intervals	9	53	41
Number participants completing 3 intervals	7	41	32
Total number of ProQOL measures completed	33	/	/

Note: "/" was used to denote that these is no data to go in these cells

Table II Mean scores, standard deviation for each time point and Friedman test of differences

	Time 1 (n = 17)			*Time 2 (n = 9)*			*Time 3 (n = 7)*			*Total (n = 33)*					
Subscale	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	*Mean*	*SD*	*Range*	χ^2 *value*	*df*	*p-value*
CS	40.59	5.22	18	36.3	2.83	8	41.71	5.57	14	39.69	5.18	19	1.714	2	0.424
BO	23.59	4.23	17	26.50	4.41	13	21.86	4.34	12	23.94	4.47	18	2.533	2	0.282
STS	19.47	3.47	15	18.75	5.73	16	18.86	5.05	15	19.16	4.32	17	1.200	2	0.549

Figure 1 Mean results for compassion satisfaction (CS), burnout (BO) and secondary traumatic stress (STS) over the three time intervals

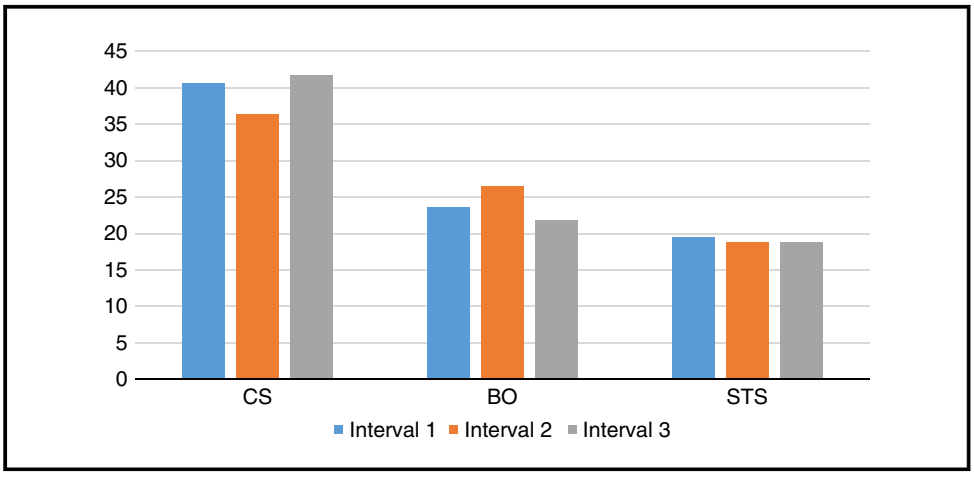
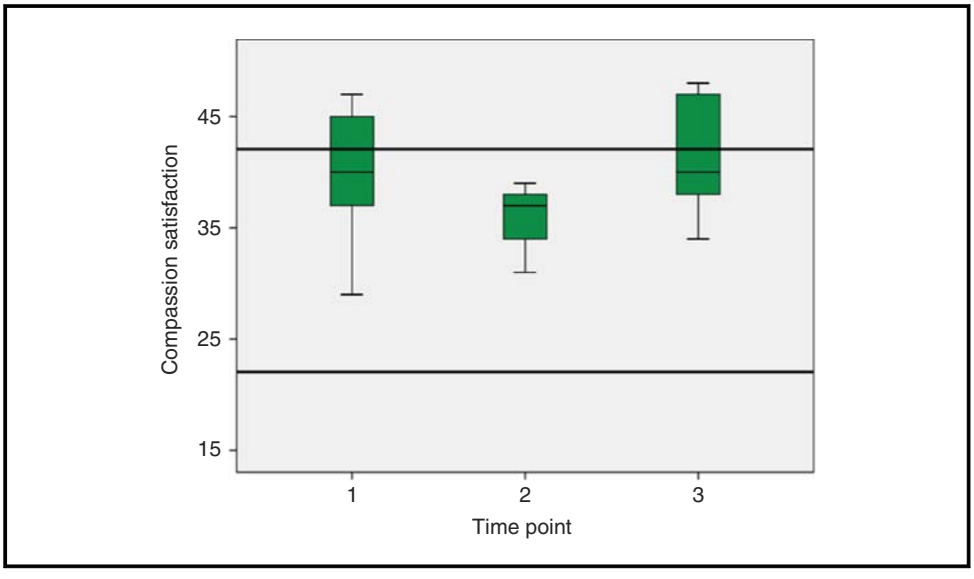


Figure 2 Box plot indicating median, quartiles and extreme values for compassion satisfaction at each time interval



The box plots clearly indicate that the scores of participants in this study are not closely aligned to the expected distribution based on the ProQOL manual baseline data. A Pearson's χ^2 test of goodness of fit was conducted to compare frequencies with expected frequencies from the questionnaire manual. Differences between respondent scores and instrument norms were statistically significant ($p \leqslant 0.01$) for each of the three subscales. The sample group reported higher than expected levels of compassion satisfaction (CS), and lower than expected burnout (BS) and secondary traumatic stress (STS) (Table III).

Differences between HCA and RMN scores

RMNs reported higher levels of compassion satisfaction, and higher levels of secondary traumatic stress and burnout (Table IV). However, Mann–Whitney *U* tests indicated that these differences were not significant (CS = 0.313; BO = 0.239; STS = 0.170).

Figure 3 Box plot indicating median, quartiles and extreme values for burnout at each time interval

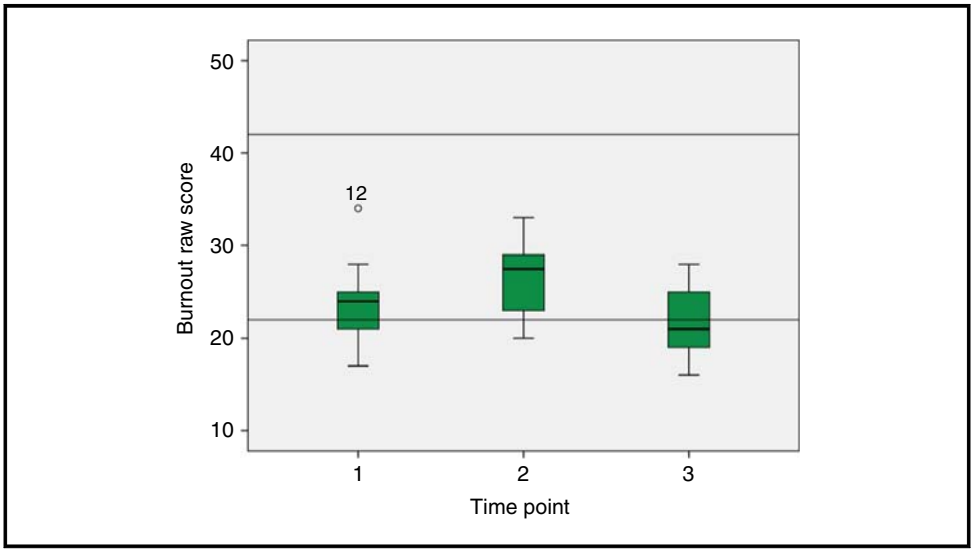
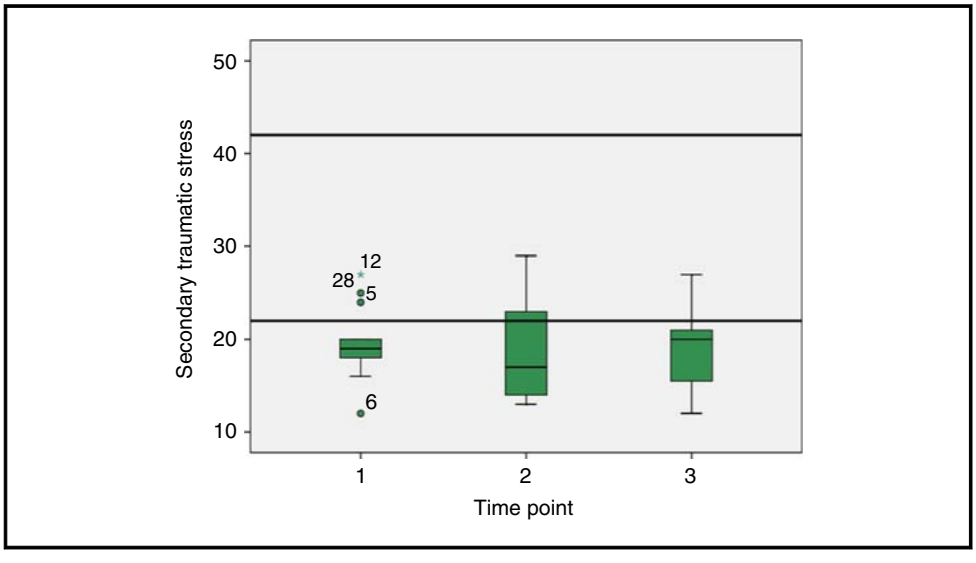


Figure 4 Box plot indicating median, quartiles and extreme values for secondary traumatic stress at each time interval



Item-level analysis of respondent scores

Frequency analysis and ranking of item-level responses for each participant at each time point revealed that four specific questionnaire items appeared to reflect the common stresses experienced within the adolescent PICU setting. These items were also sensitive to changes in individual participant's overall sense of compassion fatigue (BO+STS) (Table V).

Discussion and conclusions

This study provides new insights in the to the professional quality of life of mental health nurses and HCAs working in adolescent PICU settings.

Table III ProQOL V subscale frequency counts

Variable	Registered mental health nurse % (n = 9)	Healthcare assistant % (n = 23)	Total % (n = 32[a])	Baseline benchmark studies % (n = 1,187)	χ^2	df	p-value
Compassion satisfaction							
Low (< 22)	0.00 (0)	0.00 (0)	0.00 (0)	25	10.60	2	< 0.01
Medium (23–41)	66.7 (6)	65.2 (15)	65.6 (21)	50			
High (> 42)	33.3 (3)	34.8 (8)	34.4 (11)	25			
Burnout							
Low (< 22)	22.2 (2)	43.5 (10)	37.5 (12)	25	10.89	2	< 0.01
Medium (23–41)	77.8 (7)	56.5 (13)	62.5 (20)	50			
High (> 42)	0.00 (0)	0.00 (0)	0.00 (0)	25			
Secondary traumatic stress							
Low (< 22)	66.7 (6)	82.6 (19)	78.1 (25)	25	46.25	2	< 0.01
Medium (23–41)	33.3 (3)	17.4 (4)	21.9 (7)	50			
High (> 42)	0.00 (0)	0.00 (0)	0.00 (0)	25			

Note: [a]One respondent did not specify their role

Table IV BO, CS and STS comparison by group

ProQOL V subscale	HCA or RMN	n	Mean	SD	SE mean	p-value
Burnout	HCA	23	23.48	4.689	0.978	0.239
	RMN	9	25.11	3.855	1.285	
Compassion satisfaction	HCA	23	39.13	5.480	1.143	0.313
	RMN	9	41.11	4.256	1.419	
Secondary traumatic stress	HCA	23	18.52	4.316	0.900	0.170
	RMN	9	20.78	4.116	1.372	

Table V ProQOL V ranked by highest frequency of response

ProQOL V Questionnaire item	Subscale	Percentage of responses of "Sometimes" or more (score of ⩾ 3) (%)	Percentage of responses of "Often" or "Very Often" (score of ⩾ 4) (%)
I feel bogged down by the system	BO	87	40
Overwhelmed by workload	BO	75	40
I feel worn out because of my work	BO	70	40
I am preoccupied by more than one young person I care for	STS	67	20

The findings dispute the study's original research hypothesis that nursing staff working in this setting would experience lower levels of compassion satisfaction and higher levels of compassion fatigue than the normative data for the ProQOL V instrument. This was based on assumptions about the likely impact of relatively higher levels of violence and secondary traumatic stress to which staff are subject compared to the general population of people in carer positions, and assumed parallels with the experience of caring for adults in PICU settings. In fact, reported levels of compassion satisfaction were significantly higher than the benchmark data and reported levels of burnout and secondary traumatic stress were significantly lower.

Reported levels of compassion satisfaction within this study were higher still when compared to the findings of a study that administered the ProQOL instrument to 70 mental health nurses working within similar secure settings but with adults, which found CS scores to be significantly below the normative data average (Lauvrud *et al.*, 2009). Anecdotal clinical evidence has always indicated a number of differences between the experience of nursing adults and children within PICU settings

because of the biological, developmental and social aspects of childhood and adolescence (Milavic, 2009). However, this is the first published study to provide some data with which similar adult and child inpatient mental health settings can be compared.

Although the levels of compassion satisfaction in the adolescent PICU context were higher than expected when compared to adult secure mental health inpatient settings, they are in keeping with observations that compassion satisfaction tends to be highest in populations who are working with children and young people (Stamm, 2010). Studies investigating quality of life in mental health nurses working in secure adult settings have hypothesised that the technical and procedural approach to institutional care is responsible to creating emotional distance in the nurse patient relationship, which may not only serve to reduce compassion satisfaction but also protect nurses from burnout and secondary traumatic stress symptoms (Sondenaa *et al.*, 2013; Lauvrud *et al.*, 2009). In contrast, the higher level of dependency and attachment needs in young people have been noted as requiring a much closer emotional relationship between children and inpatient mental health nurses (Rasmussen *et al.*, 2012). What is interesting in this study is that although the higher CS scores are in keeping with this hypothesis, the low burnout and secondary traumatic stress scores are not.

The levels of reported burnout and secondary traumatic stress are particularly low when compared to both the ProQOL benchmark data, which highlights that workers working with children and families in traumatic circumstances tend to show the highest burnout rates of all groups (Stamm, 2010), and studies in paediatric medical inpatient settings, which have shown that workers witness to children experiencing physical and psychological trauma are prone higher than average levels of secondary traumatic stress (Berger *et al.*, 2015). As previously noted though relatively higher levels of compassion satisfaction serve as a protective factor against burnout and secondary traumatic stress (Ray *et al.*, 2013), which may go some way to explaining these unexpected results.

However, when compared with data from high frequency violence secure settings with adults (Lauvrud *et al.*, 2009), the results of this study follow the same trend and are significantly lower that the ProQOL benchmark data. High patient/staff ratio and a sense of mutual experience within the staff group have been suggested as possible explanations for lower than average levels of burnout and secondary traumatic stress in adult PICU and secure settings (Lauvrud *et al.*, 2009). Although it is not possible to determine a relationship in this study, these factors are also common to adolescent PICU. Furthermore, staff completing the questionnaire continued to be regularly exposed to new violent or traumatic encounters with young people during the data collection period, which could potentially account for an under-reporting of secondary traumatic stress symptoms. Lauvrud *et al.* (2009) highlighted that staff who continue to be exposed to secondary trauma or violence at the time of completing the ProQOL instrument tend to under-report its impact. This is thought to be due to the need to continue to function in their role and therefore possibly distance themselves from the true impact of it, as well as some temporal and psychological distance being needed to process and develop a perspective on the impact of one's experiences. This phenomenon has been referred to as "still being in the trenches" (Lauvrud *et al.*, 2009, p. 35).

Although data analysis shows that the participant group reports below average levels of burnout and secondary traumatic stress overall, item-level analysis has highlighted that participants commonly identified with feelings of being bogged down, overwhelmed and worn out by their work, at the same time as feeling preoccupied with some of the young people for whom they care. If this is a state of norm in which nurses in adolescent PICU have to practice, it raises significant questions for adolescent PICU nursing management systems. How to enable staff to identify times when they are experiencing characteristics indicative of compassion fatigue and secondary traumatic distress? How to provide effective strategies to counter their effects, when it is not possible to reduce actual levels of clinical incident and acuity within the patient group? It is also of note that within the unit in which this study was conducted, nursing staff had regular access to externally facilitated group clinical supervision as part of a newly implemented staff wellbeing strategy. Facilitated reflective practice and supervision groups have been reported to lessen the extent of emotional exhaustion in mental health nurses (Edwards *et al.*, 2006). A qualitative evaluation of the impact of the clinical supervision group on staff wellbeing and quality of life is currently in progress and results will be published in due course.

Although they did not reach the level of statistical significance, it is noteworthy that descriptive differences in mean scores at Time Point 2 (lower compassion satisfaction and higher burnout scores), correlated with a period of increased clinical acuity on the unit and an associated increase in levels of enhanced nursing observation. Enhanced, special or close nursing observations have been identified as having a negative impact upon nursing staff wellbeing and satisfaction (O'Brien and Cole, 2004; Holyoake, 2013). How and why increased levels of enhanced observation negatively impact upon nurses wellbeing within the adolescent PICU context has been investigated within a concurrent qualitative arm of this research study (Foster and Smedley, 2016).

Although not statistically significant, the findings also suggest that the domains of stress may be different between RMNs, who showed comparatively higher burnout, and HCAs, who showed comparatively lower levels of compassion satisfaction. This observation warrants further investigation, as the lack of statistical significance may be due to low statistical power of this study, particularly with regard to the small number of RMNs in the sample.

Strengths, limitations, next steps and further research

The strength of this study is that it is the first published study to investigate professional quality of life within the mental health nursing population working in adolescent PICU. This is an important area of investigation because the domains upon which overall professional quality of life is based have the potential to impact directly on the quality of clinical care provided in this setting. Although only conducted in one unit, this represents approximately a fifth of the national workforce. The initial response rate as a proportion of the total population and the proportional split between RMNs and HCAs indicate that the sample is reasonably proportionate. In addition, the use of a longitudinal rather than cross-sectional design has strengthened the findings (Sondenaa *et al.*, 2013). The ProQOL V Questionnaire demonstrated relative stability over time indicating that it is an appropriate tool for use within the setting. However, the small sample size has limited the statistical power of the study. In particular, although the study shows statistical differences between the sample ProQOL scores and the ProQOL benchmark data, the positive predictive value and effect size of the findings are likely to be low. The statistical significance (or not) of observed differences between the experience of RMNs and unqualified HCAs identified could not be fully quantified due to the low sample size in each sub-group. The limited sample size also meant that it was not possible to investigate the effect of confounding variables in the staff group profile (gender, age and length of time in service), as collecting these data would have compromised participant anonymity.

The number of participants leaving for a new job or training opportunities during the data collection period has also affected the statistical power of the study, by impacting on overall sample size at comparative time points, limiting the reliability of statistical tests to confirm true and significant effects. The use of a rolling recruitment strategy, allowing new staff to join at each time point, could have gone some way to mitigating against this unforeseen limitation.

As this study has highlighted some significant differences between the reported levels of compassion satisfaction and compassion fatigue in the workforce when compared to benchmark data and the closest comparable workforce available, further larger scale studies using a larger sample from multiple sites are warranted. To see if the findings in this single clinical setting are replicated in other adolescent PICU settings, and to enable a more fine-grain analysis of potentially confounding variables that may explain the unexpected results of this study. In addition, the use of qualitative design, to gain understanding of the difference in experience of HCAs and registered nurses, and the factors that may be enabling nurses within this setting to maintain their sense of compassion satisfaction in spite of the challenges, is recommended to inform strategies for improving job satisfaction and care effectiveness within PICU settings.

Within the specific setting in which the study was undertaken, findings from this study, in particular understanding of the questions within the ProQOL questionnaire that appears to be sensitive indicators of changes in staff wellbeing, have been shared with the unit's leadership team and incorporated into the clinical supervision strategy. In addition, a qualitative research investigation into the impact of the clinical supervision group upon staff wellbeing and quality of life has begun.

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ORIGINAL RESEARCH ARTICLE

Understanding the nature of mental health nursing within CAMHS PICU: 1. Identifying nursing interventions that contribute to the recovery journey of young people

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Child and adolescent mental health services psychiatric intensive care units (CAMHS PICU) are a small, specialised, but important component of the portfolio of child and adolescent mental health service delivery in the UK. There has been no published research in relation to nursing care provision within CAMHS PICU and little or nothing is known about nursing identity and intervention within these settings. This research study investigated the nature of mental health nursing in a CAMHS PICU setting, to propose a conceptual model of CAMHS PICU mental health nursing. A qualitative conceptual text analysis from an externally facilitated psychodynamic work discussion group over a period of six months was undertaken using a theoretically informed inductive content analysis method. This, the first of a two part paper, investigates the context of CAMHS PICU and the nursing interventions developed within it. Findings indicate that CAMHS PICU nursing contains elements that are unique from either general adolescent mental health inpatient settings and adult PICU settings. The primary nursing task of enabling developmental growth and reparation, for young people who are experiencing acute psychiatric disturbance during a critical phase of their maturation against a back drop of chronic adversity, complex trauma and learning difficulties, manifests as a series if irresolvable tensions within the clinical environment. Interventions are required that explicitly engage with young people's dependency and the inherently dialectic nature of adolescent development. Part 2 of this research explores nursing staff experience of their work and of the clinical environment, and their support needs.

Key words: PICU, CAMHS, adolescent, mental health nursing, identity, intervention

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Declaration of Interests: Unpaid honorary contract (as above) within the service in which the research was carried out.
Ethics: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Introduction

State of research on CAMHS PICU

Child and adolescent mental health services psychiatric intensive care units (CAMHS PICU) are a small and highly specialised component of the portfolio of child and adolescent mental health service delivery in the UK. Although numbers of specific units are small (the NHS England (2014) Tier 4 CAMHS review identified 92 beds) they play an important part in the recovery journey of a significant cohort of young people in any 12-month period due to the model of care being based on time-limited admission, resulting in high patient turnover. The relative success of a PICU admission can be pivotal in deciding whether a young person's trajectory is toward a return to community care or towards longer-term restrictive or secure mental health care (Foster 2018). In addition, a shortage of CAMHS PICU beds has been recognised by NHS England with a commitment to increase the number of CAMHS PICU services available (NAPICU 2015). Despite these factors, there has been no published research in relation to nursing care provision within CAMHS PICU services to date. The numbers of children and adolescents needing to be admitted into PICU and high dependency services appears to be increasing (NAPICU 2015), suggesting that it is an important area worthy of research investigation.

The limited published evidence and guidelines available highlight that CAMHS PICU appear to provide for a more complex and diverse patient group than their adult counterparts (NAPICU 2015; NHS England 2016). This seems to be because of the patchy nature of community and crisis services for young people and the paucity of appropriate therapeutic placements for young people with multiple diagnoses or complex conditions, including those with underlying developmental difficulties (Jasti et al. 2011). This means that the adoption of the traditional emergency medicine/acute symptom stabilisation model of an adult PICU is unlikely to be fit for purpose to meet the needs of the young people admitted to CAMHS PICU settings, without significant adaptations being made. However, this assumption has not been tested through research.

Similarly, although the challenges faced by mental health nurses working with adolescents have been identified as unique (Musto & Schreiber 2012), it has been asserted that the lack of research into nursing philosophies and ideologies in adolescent mental health settings means that the contribution of nurses to the wider multidisciplinary team care provision is poorly defined and understood (Rasmussen 2012; Musto & Schreiber 2012). Rasmussen (2012) argued that because much of adolescent mental health nursing is tacit and of limited visibility to those looking at it from the outside, mental health nurses need to be enabled to articulate their own identity, within the particular context in which they operate.

The body of research evidence in relation to adult PICU is much better established (Gwinner & Ward 2013). However, several studies have concluded that there remains no evidence regarding the efficacy of treatment approaches in PICU environments and there is an absence of clearly articulated principles and practices of nursing care in these environments (Bowers 2012; Gwinner & Ward 2013; McAllister & McCrae 2017).

PICU environments are largely organised around the provision of short-term care within a highly contained environment for those experiencing acute psychiatric distress who are usually a risk to themselves or others (Bowers 2012; NHS England 2016). The environment and high levels of violence and aggression present are often managed through relatively high staffing levels, of which the dominant workforce is unqualified nursing assistants, working alongside registered mental health nurses. An environment in which multidisciplinary care and treatment can be delivered safely is created through high levels of physical, relational and procedural security, for which nursing staff (qualified and unqualified) often carry the burden of responsibility (McAllister & McCrae 2017). Despite the lack of coherency or underpinning ideology identified, there is little evidence to suggest that quality of patient care is compromised, as compared to other inpatient settings (Lemmey et al. 2013). There is a limited but notable amount of evidence to suggest that treatment outcomes are positive for patients who are in acute psychiatric distress (Gwinner & Ward 2013), but an absence of understanding of the mechanisms that bring about change (Hayes et al. 2017). Hence the situation warrants a critical examination of what it is that nursing teams are doing to achieve these outcomes. How can it be amplified, generalised and maintained? And what are the specific demands of caring for adolescents in PICU contexts?

Nursing approaches to treatment and care

The research evidence from adult PICU settings implies that well elaborated paradigms for a nursing approach to recovery may be instrumental in helping staff surmount the highly demanding nature of the environment and have the potential to significantly improve clinical outcomes (Gwinner & Ward 2013). Intensive staff–patient interaction and the use of using multiple sophisticated interventions have been observed (Crowhurst & Bowers 2002) but the nature of these has not been accurately characterised, analysed or tested. A recent study investigating the therapeutic role of nurses within adult PICU found that a lack of clarity over the meaning of therapeutic engagement/intervention remains, impacting upon the ability of nurses to deliver it even when patients and nurses hold it as a central component of care (McAllister & McCrae 2017).

Managing the tension between regulating the environment to ensure safety and interpersonal interventions which support and promote recovery for patients, is well documented in adult-orientated literature that has attempted to capture something of the nursing task (Salzmann-Erikson et al. 2008, 2011; Björkdahl et al. 2010; Ward & Gwinner 2015). Studies that have sought to identify nursing practice in adult PICU settings, and also more generic child and adolescent mental health settings, have both found communication, education, observation and risk management to be core domains of required knowledge and skill (Rasmussen 2012; Ward & Gwinner 2015). However, studies of this kind have yet to be undertaken in a CAMHS PICU setting.

In the absence of elaborated paradigms or clearly defined principles and practices, it has been argued that the nursing task and approach tends to be significantly influenced by organisational and physical structures which are often conflicting (Gwinner & Ward 2013), and which can reduce the primary function of the PICU to the suppression of aggressive and violent behaviour (Dix 2016). Whereas it has been hypothesised that the optimum conditions for mental health recovery are supported by an integrative position in which both therapeutic care and control are held in the mind of the nursing team (Björkdahl et al. 2010; Salzmann-Erikson et al. 2011; Dix 2016).

Aims and objectives

Considering the findings of this literature review, the qualitative study reported on here aimed to address the question 'What is the nature of mental health nursing in a CAMHS PICU setting?' and to propose a conceptual model of CAMHS PICU mental health nursing.

We explore the nursing task within an adolescent PICU and identify nursing interventions and their contribution to young people's recovery. A second paper will report on the impact of the nursing task on identity, the support needs of the nursing team and a proposed model of mental health nursing for CAMHS PICU settings (Foster & Smedley 2019).

Design

A qualitative conceptual analysis of the notes from a weekly externally facilitated work discussion group was undertaken from a period of six months. The method of content analysis elaborated by Elo & Kyngäs (2007) was adopted, using a theoretically informed but inductive approach.

Content analysis has been shown to be a relevant and effective qualitative research methodology in the field of nursing, as a systematic means of describing phenomena and establishing relational links between concepts. Inductive methods of content analysis in which data is analysed through a theoretical lens to support understanding and meaning-making are particularly indicated to build up a conceptual system or enhance understanding when there is insufficient pre-existing knowledge of the issue (Elo & Kyngäs 2007; Reavey et al. 2017). The study was conducted in one 10-bed mixed gender CAMHS PICU in the North of England.

Data collection

The study collected data from the nursing team (registered mental health nurses and non-registered health care assistants) through the implementation of a weekly, externally facilitated reflective work discussion group (Jackson 2008).

The group was facilitated by an adolescent psychotherapist and mental health nurse and was open to all those members of the nursing team who were not required on the ward at that time to meet the minimum clinical observation levels. The focus of discussion was set by each meeting's participants. The facilitator's focus was to support shared thinking and development of collective understanding of the young people and dynamics within the ward, and to facilitate participant-led articulation of the skills, interventions and underlying principles of approach used by the nursing team. Notes of the content of discussion from each group were made by the facilitator, shared and checked with the nursing team.

Sample

The unit of analysis was defined as the set of notes from one work discussion group. There were 26 units of analysis spanning a six-month period. No data sampling method was employed as all units of analysis within the given period needed to be read as a complete data set, to capture as much detail as possible about the nature of nursing in the specific context being investigated. The unit of coding was specified as all emerging concepts or themes within

the given text of each unit of analysis. The idea of a 'conceptual cluster' was adopted, in which related words cluster around a broader term or idea (Berg 2002). This meant the units of coding could be individual words, a short word string or a whole sentence or phrase that captured a particular idea.

Data analysis

The coding process. This was performed in a stepwise fashion. To understand the data as a coherent whole, all units of analysis were read and re-read as a complete data set with the key research question in mind. Within the study, 'Nature' was operationally defined as pertaining to: tasks, actions, role, knowledge, skills, theory and practice, professional values, beliefs and philosophy. An open coding process was undertaken, in which codes within each unit of analysis were identified and marked in the margins of the text, using the framework recommended by Strauss (1987). Coding continued until no new codes appeared within the data set (saturation). The frequency of repeating codes across the data set was also recorded (Elo & Kyngäs 2007). Codes were then grouped and tabulated on one coding sheet, retaining information regarding the location of codes within the raw data.

Categorisation. Higher order concept categories, categories and subcategories, under which to group concept codes from across all units of analysis, were generated. These were defined by combining related topics and content areas. From this, main theme headings under which these concept categories fell were named. The relatedness of individual codes across different categories were then identified and mapped within the tables. Once the codes were organised under final concept categories and main theme headings, the raw data was used to identify illustrative examples.

Abstraction. Psychoanalytic, attachment and developmental theories were applied to the categorisation and abstraction process, to generate a conceptual model of mental health nursing within the specific setting from the outcomes of the content analysis. The choice of theoretical lens reflects the fact that the care of adolescents always needs to be rooted in an understanding of development and that mental health nursing and support work is fundamentally psychodynamic in nature, in that it is within the quality of the therapeutic nurse–patient relationships that change occurs (Gallop & O'Brien 2003). This means that the nursing and support work team come to have a uniquely detailed sense of the young people on the ward, based on what it feels like to be in their company, in a range of different contexts across the 24-hour cycle of care. This knowledge is often tacit or embodied rather than articulated through language. As a result, it has been argued that the work involved in nursing and other roles involving nurturing and maintaining the well-being of patients tends to involve physical and emotional elements that are hard to define and invisible to others; 'noticed only when it is not provided at the expected level or quality' (Brush & Vasupuram 2006, p. 181). Psychodynamic theory has a language for interpersonal and relational processes that can be used to help name and make use of this unique knowledge to illuminate and understand the work of the nursing team in detail (Gallop & O'Brien 2003).

Internal verification and reporting. A transparent record of each step of the coding and categorisation process was kept using tables and schematics (Elo & Kyngäs 2007). A co-researcher with knowledge of the clinical context from which data was drawn, but who was independent of the work discussion group and the coding process, was identified to establish relative trustworthiness of the codes and categories and ensure they remained grounded in the data from which they were drawn. This was done by systematically working backwards from the theme headings, categories and codes into the raw data. Presentation and reporting of results were undertaken in accordance with the recommendations for reporting content analysis data made by Elo et al. (2014) and O'Brien et al. (2014).

Ethical approval

The University Ethics Committee (HSCR14/19) and the Research Governance Committee of the participating healthcare organisation (non-NHS) granted ethical approval. All those who chose to participate provided informed consent. Participants were informed of their rights in respect of voluntariness, information access and that data would be stored securely and anonymously in accordance with data protection regulations. There was no identifying patient material included in the study. Material regarding clinical issues discussed within the work discussion group were recorded as part of the group process in aggregated themes, with staff and patient identifiers removed.

Results

A total of 150 distinct codes were identified within the data, set across seven main theme headings of: (1) presenting difficulties; (2) complexity within the clinical environment; (3) tensions; (4) nursing interventions; (5) frustrations; (6) staff experience; (7) learning and development.

Figures 1–2 provide a summary of the analysis results. The themes of Frustrations, Staff experience and Learning & development are presented in Foster & Smedley (2019).

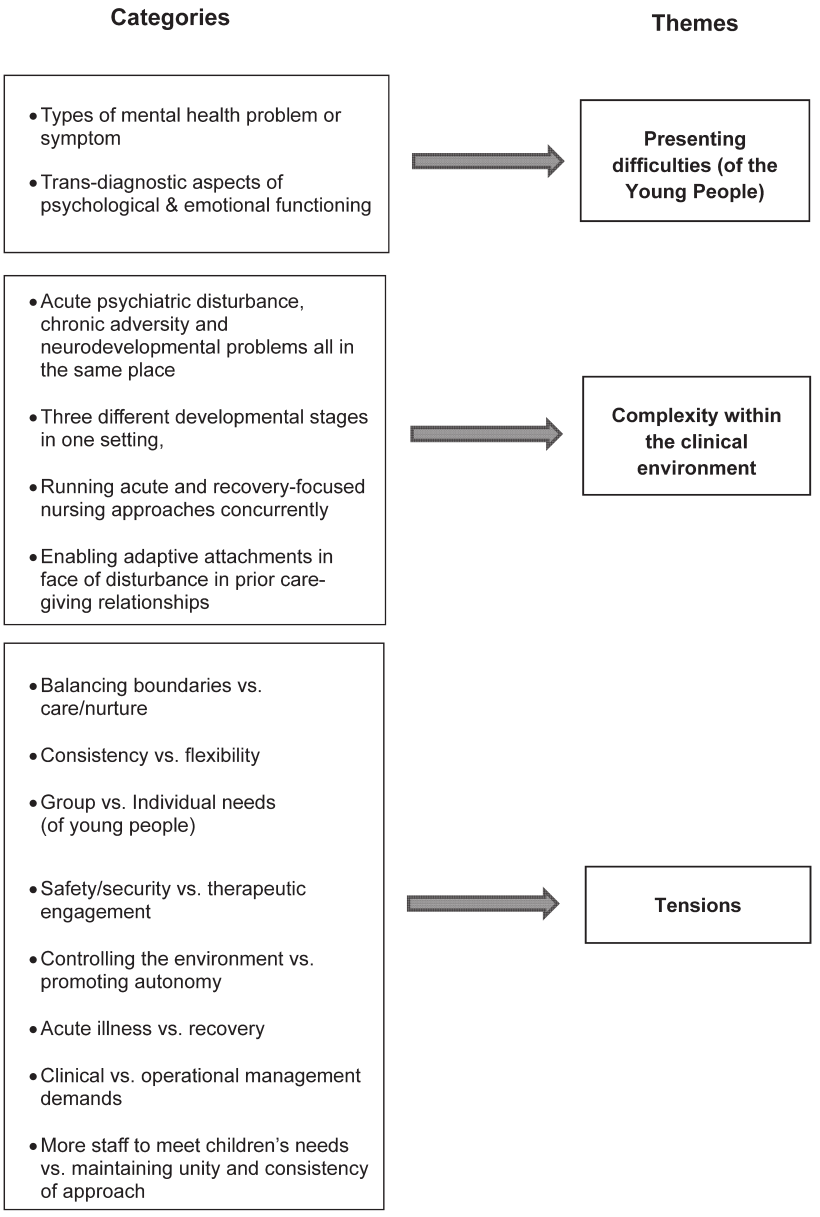

Fig. 1. Summary of the Presenting Difficulties, Complexity and Tensions themes.

Presenting difficulties

This theme comprised two categories: presenting problems brought to the group for discussion that can be described as symptoms of a mental health disorder. Secondly, broader aspects of the young people's psychological and emotional functioning that were not tied to any specific mental health diagnosis, but which were nevertheless characteristic of their psychological distress.

The types of mental health problem or symptom identified (in order of frequency of discussion) were: (1) anxiety symptoms; (2) neurodevelopmental/social communication difficulties; (3) complex post-traumatic stress and the impact of multiple adverse childhood experiences (often relational in nature); and (4) psychotic symptoms.

Trans-diagnostic aspects of psychological and emotional functioning included: (1) unconscious defences especially splitting (of own states of mind and of staff) and attempts to control the environment, to mitigate feelings of powerlessness and anxiety; (2) self-doubt/disgust/criticism and shame dressed up as boisterousness, disinhibition or omnipotence; (3) expressions of self-loathing or null self-worth; (4) disturbance of adolescent identity or sexuality expression including ganging dynamics; (5) envy, sensitivity to injustice and to being treated unfairly; (6) loss of, or failure to ever achieve, pleasure from social

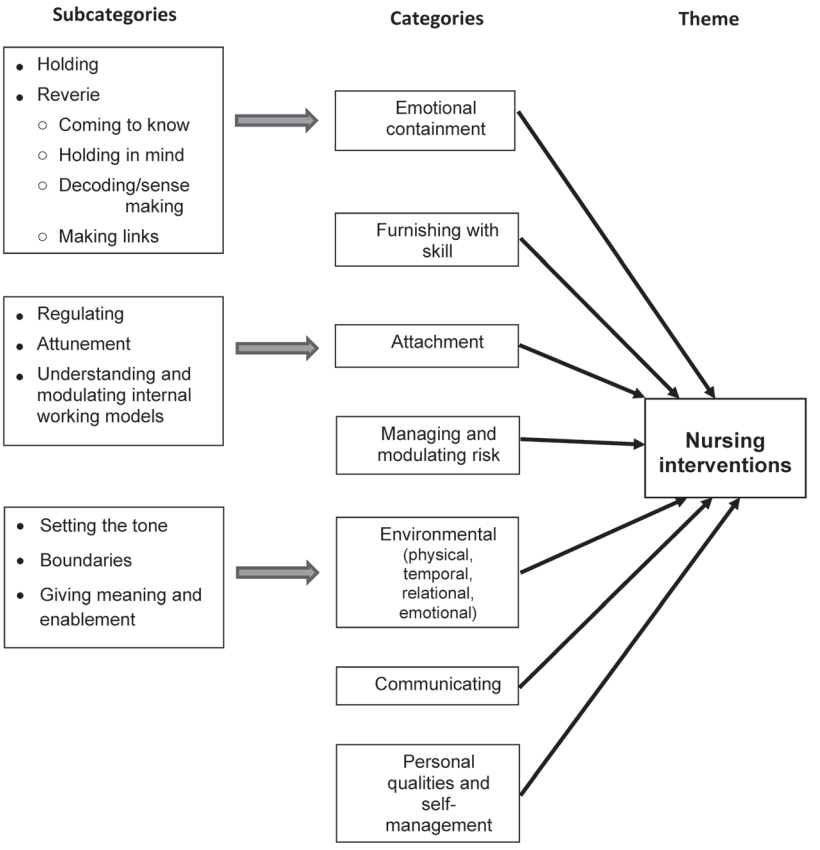

Fig. 2. Summary of the Nursing Interventions theme.

activity, presenting as withdrawn or 'cut-off'; and (7) violence, sometimes reflecting anger or aggressive and destructive impulses but often also reported as a communication of fear, anxiety, or a request for help.

Complexity

Four domains of complexity were repeatedly identified.

The diversity and co-morbidity of the young people's presenting difficulties meant that staff were providing for young people with acute psychiatric disturbance, the longer-term impact of chronic adversity and underlying neurodevelopmental/learning problems, in the same (highly contained) place. However, the care strategies indicated for each of these difficulties are often contrasting.

The impact of delays in discharge care pathways for young people no longer needing a PICU environment meant that the team were required to run two different nursing approaches concurrently: a more reactive, acute illness-focused approach alongside a more pre-emptive, planned, recovery-focused approach for young people awaiting discharge. The latter being at continual risk of being impinged upon by the unpredictability of the needs of the young people whose difficulties were acute.

At any one time the patient group could be made up of young people in three different developmental stages (early, mid and late adolescence), each requiring a different approach (Waddell 2002); including strategies to manage potential safeguarding risks.

The task of enabling and regulating adaptive attachment relationships (required by all young people not yet self-sufficient, to meet their basic care needs) was described as complex in the face of frequent disturbance in relationships with their primary attachment figures, often compounded by significant geographical separation.

Tensions

Eight key tensions faced by the nursing team, emerged from the analysis*:* (1) boundaries versus care/nurturing; (2) consistency versus flexibility; (3) whole group versus individual needs; (4) safety/security versus therapeutic engagement; (5) controlling the environment versus promoting young people's autonomy; (6) acute illness versus recovery; (7) numbers of staff on shift (increased resource to meet needs versus maintaining unity and consistency of approach); and (8) clinical versus operational management demands.

Clinical versus operational demands were reported by

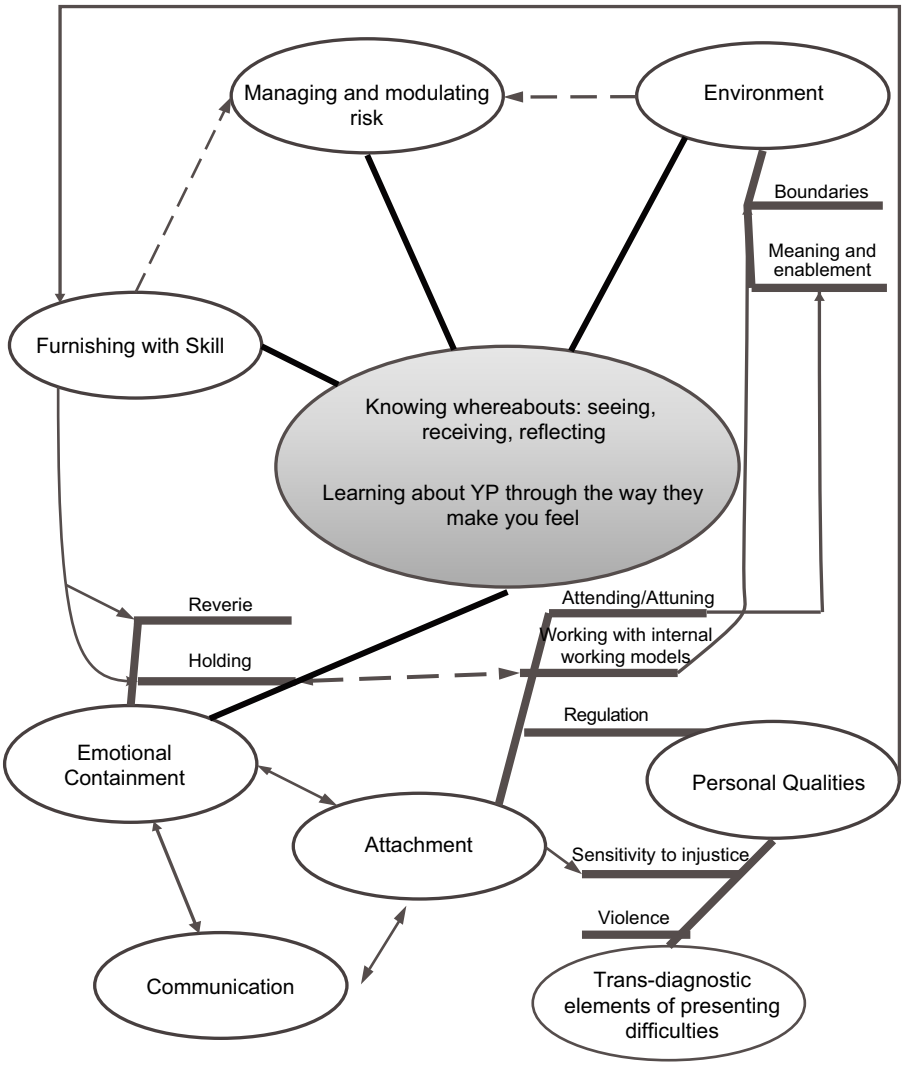

Fig. 3. Conceptual relationship between content analysis categories of the Nursing Interventions theme.

shift coordinators as upward pressure from frontline nursing staff versus downward pressure from the organisation to comply with adult focused policies and procedure that were often perceived as ill-fitting for their setting.

Analysis of the repetition of these tensions within the data indicated that they required continued attendance and active management by the nursing team with no final point of resolution and all eight tensions were active at once. The nursing team described working continuously to find and sustain an optimal position between the two poles of each dialectic, operating within an ongoing state of tension. The findings of this study suggest that these tensions are the crucible in which the nursing interventions specific to CAMHS PICU are forged.

Nursing interventions

A total of 75 nursing intervention codes were identified, constituting seven key categories of practice (Fig. 2): (1) emotional containment; (2) communication; (3) attachment; (4) personal qualities and self-management; (5) furnishing with skill; (6) environmental; and (8) managing and modulating risk.

The results for this theme heading are most clearly presented in a linear manner, organised by category. However, it is important to recognise the conceptual links and points of overlap between many of the categories, as nursing interventions are complex and not made up of discrete parcels delivered in a step-wise fashion. A schematic map illustrating the points of connection between the categories of nursing intervention is provided in Figure 3.

41% (n = 31) of the codes describing nursing interventions fell under the categories of Emotional Containment and Attachment. These categories describe different dimensions of the same phenomenon; the therapeutic relationship. Codes within Emotional Containment describe internal

cognitive and emotional skills used by the nursing team to understand and respond to the young people's communications in ways that seek to assuage distress and promote growth and recovery. Codes within the Attachment category describe ways in which the staff used their relationship with the young people to create moments of change.

Emotional containment

This is a term coined to describe the interaction processes that occur firstly between the infant and their primary carers (Bion 1962) and then as the child moves into adolescence, between them and the adults who people the systems and organisations in which they live and learn (Waddell 2002). It is the capacity of the carer to be attuned and responsive; accepting of all aspects of the child, communicated through the way in which the child is handled and held within the carer's gaze (Winnicott 1971, pp. 111–118; Bowlby 1988) and the intersubjective space between carer and child (Schore & Schore 2014). These processes govern both the child's experience of anxiety and development of their cognitive, emotional and interpersonal functioning, resilience and understanding of themselves (Reisenberg-Malcom 2001).

The internal working models for understanding ourselves and the world around us, developed from the experience of being known, and the learning within our important relationships have a significant impact upon mental health and wellbeing across the course of life (Schore & Schore 2014). So it follows that the transformational quality of the processes described have an equally important potential to contribute to recovery from mental distress and the role of mental health nursing practice (Adshead 2002).

The intervention codes within this category have been organised into subcategories based on the different components that are known to characterise 'good enough' emotional containment: (1) holding; and (2) reverie.

Holding. This subcategory is described as the whole routine of ordinary care provided through the day and night (Winnicott 1960). In good-enough circumstances it provides an experience of being both physically and emotionally held, in a way that anxiety is assuaged sufficiently to facilitate mental and physical maturation.

Interventions under this subcategory were:

- Being the only place that can hold the young person's distress at that time.
- Containing the young person's worst fears regarding their own capabilities – meeting them at their darkest.

These codes particularly related to the early phases of admission in which young people were often in a very chaotic and dysregulated state. It included being able to keep young people safe from their own destructive impulses

- Helping young people bear their pain, fears, hopelessness, loss, frustration, guilt and shame.

Participants described acting as literal containers for feelings that were acted out and directed at nursing staff, until they could help the young people develop skills to manage the feelings for themselves.

- Exploiting the practical to enact the symbolic.

Multiple examples were identified of staff using seemingly every day aspects of care to speak to aspects of young people's more fundamental underlying needs that 'as yet have no words' (Alvarez 1999).

The act of knowing a young person's whereabouts, including specifically knowing the hiding places of individual young people, was repeatedly highlighted as an important tool for conferring a sense of security, value and positive regard for young people, not just for ensuring physical safety. This appeared to be particularly important in an environment where the use of touch, more ordinarily associated with provision of a 'holding environment', was not readily available to the nursing team outside of carefully prescribed processes for the physical management of violence and aggression. One way this was enacted in practice was through performance of general observation duties. This task was understood to be about far more than physical safety: staff described differentiating their approach to entering each young person's space in accordance with their knowledge of individual preferences and vulnerabilities related to prior relational trauma, sensory sensitivities and current mental state. This included changing their footsteps on approach, knock, means of entry, proximity to, and process of, verbally or visually connecting with the young person.

Reverie. This describes the carer's receptiveness to all aspects of the child's communications (verbal and non-verbal), including those that feel hostile, and their ability to make them understandable, without being overwhelmed by them (Waddell 2002). In the short term this helps soothe anxiety, and in the longer term supports the development of the child's own ability to hold and process their feelings and experiences. This concept can be divided into three ideas: (1) coming to know; (2) holding in mind; and (3) decoding.

Coming to know was described as a 'gathering up the pieces' from individual interactions to develop detailed 'whole-team' knowledge and understanding of young people, from the experience of being with them. 'Learning about young people through the way they make you feel' was identified in 11 out of the 26 units of analysis (43%).

This process of projective identification is our most

primitive means of communication. In infancy, the innate ability to stir up feelings in our carers through non-verbal processes enables us to communicate and get rid of unbearable states of being, and have our needs met. So essential is it to our survival that although it is increasingly replaced by language as we get older, it is never completely dispensed with and is often returned to during times stress. Adolescence is a developmental period in which there is a return to reliance on this communication mechanism, due to the mismatch between the intensity of the emotions young people experience and their not yet fully developed language (Briggs 2009). Its success is dependent upon adults being receptive to receiving and thinking about what they are being invited to feel.

The code of 'Holding your nerve' described the related process of trying to bear the destructive, hostile and provocative parts of young people, without being permanently hurt or overwhelmed by them, or without being pushed into critical or punitive reactions.

Holding in mind was described in three different ways, linking directly to the 'trans-diagnostic presenting difficulties' subcategory and utilised in 'management and modulation of risk':

- Keeping in mind the needs of young people whose difficulties were of a more internalised nature, who could easily be forgotten in a very noisy and distress-filled environment. Examples included: persisting with making interpersonal approaches to children whose history of emotional neglect and deprivation had resulted in them presenting as shutdown and withdrawn; remembering the prior trauma acted upon young people whose behaviour appeared to be intentionally provocative of dismissive or neglectful responses from adult*s;* and keeping symptoms in mind when they can't be seen (e.g. psychotic thinking, delusional beliefs in young people who were guarded).
- Using this knowledge pre-emptively at times when young people weren't able to actively seek engagement or help from staff.
- Holding up a receptive and accepting mirror to all parts of young person. For young people in split or fragmented states of mind, remembering the good in the face of the bad and vice versa. This was described as reflecting back a more integrated/compassionate version of self as times when young people are self-berating and not forgetting latent risks at times when they presented with an idealised 'all-good' version of self.

Codes in the subcategory of Decoding describe the work undertaken by staff to try and understand the underlying meaning and function of what they see rather than responding to it at face value. Decoding was characterised by hearing the feeling/request without reacting to *how* it has been communicated, for example, de-escalating threats of violence by naming and responding to underlying fears or needs. 'It's not what it looks like' described decoding the idiosyncrasies of each young person's pattern of emotional expression. For example, that one young person's expressions of boredom in fact denoted agitation and emotional dysregulation, whereas for another, giddiness and elation signified unbearable feelings of sadness.

'It's not what it seems' labelled a process of extracting meaning and coherence from concrete or seemingly bizarre expressions. For example, coming to understand that a young person's report of being in a sexual relationship with a well-known film action hero represented a means of managing emerging feelings of desire towards a peer, which in turn activated anxieties for the young person that she may be vulnerable to unwanted sexual approaches from that peer.

Communication

Codes within this category described mechanisms for achieving the interventions above and for using the knowledge gained in the process of emotional containment to promote recovery:

- Communicating understanding of what is really going on under the face-value behaviours to the young person: putting words to the behaviour
- Communicating knowledge and understanding of young person to themselves and to others (e.g. family, MDT, staff in future placements); this included holding and sharing information about the small details of patient's needs and preferences ('their little ways')
- Providing narrative on progress as an intervention to counter feelings of hopelessness expressed by young people.

Attachment

Attachment is the evolutionary mechanism by which we socially and physiologically connect with others to regulate our internal feeling states through the arousal/relaxation cycle (Schore & Schore 2010). It is also the process though which children's experience-dependent developing brains receive (or not) the stimulus that drives them to develop their own capacities to regulate emotions and manage their arousal levels independently. In time this develops into the capacity to think about one's own mind and the mental experiences of others (Adshead 2002).

Attachment-based interventions were described in the data as working to provide meaningful relationships for young people that carried the helpful characteristics of attachment, in lieu of the carers and family members from whom they were separated, but that could also be clearly distinguished from their primary carer relationships (neither competing with or repeating unhelpful elements).

This category comprised of three subcategories: (1) regulating; (2) attunement; and (3) understanding internal working models

Regulating. This involved acting to helping young people calm down, get back in control. This was exemplified by considered intentional use of physical and emotional proximity of staff to young people to down-regulate or soothe distressing emotions, or to up-regulate positive emotions. This was done by giving clear prompts and direction to take young people through a guided process that supported them calming down in accordance with assessment of mental state.

An important part of the process identified within the content analysis was 'Coming alongside obliquely to find and hold a middle ground'. This was exemplified by a strategy used with a young person who experienced significant discomfort and distress when people tried to engage him in social encounters. His discomfort led to him isolating himself and simultaneously expressing beliefs about being treated less well than other young people, due to perceiving (correctly) that staff were spending less time with him. The young person's care plan was altered to ensure members of staff sat side-by-side with him whilst he played computer games (preferred leisure activity), occasionally commenting on the game rather than to him, so that he could experience being with others, without having to make direct eye contact or speak.

Staff described intervening in established ways of coping that served to escalate the young people's arousal rather than promote relaxation, to break negative self-reinforcing cycles. This included 'managing unconscious defence mechanisms' that young people employ to manage distress in the short term, but which in the longer term serve to maintain the problem.

An example of this was an intervention with a young man for whom high levels of arousal would lead to misidentification of staff as perpetrators of harm, prompting violence towards staff, followed by denial of any memory of his actions (related to difficulties tolerating guilt) and a subsequent increased risk of perceiving staff as intending him further harm (due to fear of retaliation). Physiological indicators of anxiety (increased respiration, pallor change) were used to alert the young person as early as possible in the arousal cycle to changes in his affect, and to trigger staff to give him extended personal space whilst also giving continuous verbal direction to support him in self-managing his arousal levels. In the relaxation phase of the cycle, opportunities were used to provide reflective feedback on what staff had observed during the period in which the young person reported memory loss, to promote the linking together of the split-off aspects of himself.

Attunement. This category describes the process of looking, noticing (non-verbal cues), taking in what is seen, and responding accordingly. Interventions under this category included amplified communications of interest in and curiosity about the young person, to try to pique interest in their own internal experience and the social world around them. For young people with neurodevelopmental difficulties and/or impact of profound deprivation this was described as trying to bring deadened internal worlds to life. For young people with previous frightening experiences of adults, this was for trying to stir pleasure rather than anxiety in social encounters. Whereas, for young people experiencing acute psychotic symptoms who were trapped in a frightening internal world, the focus was on helping them find a way of 'looking out' and making connections with the external world. In all interventions of this kind, knowing and playing to a young person's strengths and interests was seen as key.

Understanding internal working models. Internal representations or working models of individual's most important attachment relationships, are often reactivated by being in hospital, as hospital admission and the process of separation from family members constitutes a source of threat (Adshead 2002). Interventions in this subcategory were based on noticing recurrent themes in encounters with staff, as representative of important relationships young people have with others outside of the hospital setting. Then, working to moderate these patterns of interaction through relational experiences.

Unlike more direct strategies typically used in psychological therapy, challenging unhelpful relational assumptions (e.g. men hurt you, women are weak, others can't bear me) was not undertaken by naming or challenging them. Instead, staff described consistently seeking to conduct themselves in ways that side-stepped young people's invitations to confirm their worst fears, to offer an alternative experience. Similarly, knowledge of family issues and past events in a young person's life story were used to understand triggers in the 'here and now' that symbolised underlying precipitants of their difficulties.

Personal qualities and self-management

Throughout the data a set of personal qualities, reported by team members as integral to successful nursing intervention, were repeatedly articulated. These were identified as direct interventions in themselves for particular aspects of presenting difficulties (e.g. young person sensitivity to injustice and management of violence). They were also identified as essential prerequisites to effective emotional containment and attachment interventions. The qualities were*:* (1) consideration (defined as thinking before doing); (2) tenacity and persistence (being able to sustain emotional and physical effort, including being able to

tolerate indifference to, or active rejection of their attempts to help); (3) patience and tolerance; (4) conducting oneself in a way that upholds the principles of fairness; (5) acting to preserve young people's dignity (helping them save face); and (6) mediating one's own response (verbal, proximal, behavioural, affectual) according to the young person's arousal levels. Examples of this were being able to keep fear responses under control in the face of physical threat and aggression and withdrawing engagement in response to non-verbal cues that indicated the young person needed less stimulus, when their natural instinct was to try and help more.

Furnishing with skill

This category describes the ways in which staff supported young people to learn emotional and relationship management skills. It highlighted that staff supported learning through showing, doing-with and with high levels of repetition; providing scaffolding to support a step-wise move over time from staff to self-regulation of distress. The skills most commonly identified were: (1) skills for coping (distress-tolerance, distraction, problem solving); (2) emotion identification; (3) interpersonal relationship role-modelling; (4) how to make reparation (including not just how to say sorry, but managing the feelings that go with it, e.g. guilt, vulnerability, shame and humiliation); and (5) helping young people with misperception.

In acute states of mental distress, or in the case of young people who have not had good-enough experiences of their perception and feelings being reflected back to them, there is a tendency for a phenomenon that has been coined 'psychic equivalence' (Fonagy 2003), in which the young person's perception and external reality are felt to be identical (how it seems is how it is). Examples were recorded in the text of the ways in which staff worked to help young people notice the differences between what they think they saw/heard and what was actually happening, and how their underlying beliefs, worries and feelings could have affected their perception.

Environmental (relational, physical and temporal)

This category comprised three subcategories: (1) setting the tone; (2) meaning and enablement; and (3) boundaries.

Setting the tone. Staff recognised that PICU for many young people was a 'last-chance saloon', their last chance to find a way towards recovery before a decision to place them in a much longer-term restrictive environment may be reached. Contributing to creating an environment in which young people can come back from the brink, was valued as an important component of their role: described as always working to give young people a second (third or fourth) chance, laying out a map of ways in which they could put mistakes right, or giving multiple opportunities to change one's mind.

Ensuring reliability and clarity were repeatedly identified as mechanisms for setting a helpful tone within the environment. This was achieved by working to create predictability in individual and team responses, in the structure of the day, and within individual young people's care, through care planning. Young people were helped to know what to expect and how to navigate the ward, through setting out expectations and rules in advance, and by giving information in simple terms and manageable chunks.

Meaning and enablement. This category relates to structuring the passage of time through interventions that give the day shape. Examples include supporting and motivating young people to get up and engage with education and the therapeutic day, supporting mealtimes, enabling meaningful leisure activity and a sense of achievement in a very restricted space.

This process incorporated actions aimed at promoting young people's autonomy and choice in a restrictive environment. Examples of interventions of this kind were: joint care planning; taking advance instruction from young people about how they would like to be managed during times of distress/violence; activity planning; advocacy in meetings; taking a position of giving all requests reasonable consideration re: feasibility, before saying 'no'; and partnering 'no' with explanations.

Enabling interventions also included working to buffer young people against the stress of the many points of transition in their care that could activate anxiety, not just the obvious transition associated with discharge. These included being nursed on different parts of ward, on different observation levels, developmental transitions (including birthdays), mealtimes, medication changes, access off the ward and visits (from outside to inside the ward, being with and then without family).

Boundaries. These were intrinsically linked with Attachment. Implementing boundaries has been identified as essential for creating safety in environments where there are high levels of unregulated feelings (Adshead 2002).

Effective use of boundaries was characterised by: implementing strategies for safety in a proactive, planned, neutral way, and avoiding reactive consequences where possible as these were understood to be prone to interpretation as punishment by young people; applying rules and boundaries in an intentional and judicious manner, using general principles that could be adapted to individual needs; accommodating knowledge of a young person's attachment patterns and internal working models into setting and implementing boundaries (understanding how they would be perceived by particular young people and

adapting accordingly); and considering timing of implementation of boundaries commensurate with the young person's mental state.

Although the nursing team often carried the lion's share of responsibility for implementing boundaries (as a function of the 24-hour cycle of care), the data also reflected that boundary setting was a process supported by the wider multidisciplinary team.

Managing and modulating risk

The identified strategies for managing and reducing individual and whole group risks on the ward, relied upon application of detailed knowledge of young people, developed through the previous relationship-focused interventions:

- Identifying early warning signs and triggers that at first glance seem imperceptible (based on detailed observation)
- Knowing young people's whereabouts; noticing absence and knowing their likely whereabouts
- De-escalating aggression through counterintuitive responses based on knowledge of individual young people
- Reacting/adapting to crisis; understanding that safety takes precedence in the hierarchy
- Pre-empting, avoiding and contingency planning for individual and group flashpoints
- Continuous risk assessment, using detailed observation of young people and their environment, particularly their rooms; recognising change of any magnitude as potentially significant
- Application of team knowledge of safe management of violence.

Themes and categories up until this point have described the clinical context of the nursing team's work and the interventions developed to enable young people within it. To some extent, the nursing intervention codes describe the work of the team 'at its best'. Foster & Smedley (2019) presents findings regarding the organisational factors identified by participants that impact upon the team's perception of their ability to provide care at the level to which they aspire, the impact of the clinical work itself upon staff sense of self, and their ability to keep going with the interventions that characterise the team 'at its best'.

Discussion

This study provides a rich account of the nature of nursing task and intervention in the previously unexamined practice area of CAMHS PICU nursing.

Interventions have been shown to be given birth to by the manifest tensions of the primary nursing task of enabling developmental growth and reparation for young people who are experiencing acute psychiatric disturbance during a critical phase of their maturation against a back drop of chronic adversity, complex trauma and learning difficulties. As the nursing task is fundamentally relational and developmental in nature interventions are required that explicitly engage with young people's dependency and the inherently dialectic nature of adolescent development.

It has been observed that the systems and cultures present in healthcare institutions fail to reward the contribution that sensitive and affectively attuned caregiving can make to patients (Schuengel et al. 2010). It has also been observed that mental health nurses often have to use extensive summarising practices to manage the amount of detail involved in their work when communicating with others, undermining their ability to give sophisticated accounts of their expertise to other members of the multidisciplinary team (Deacon & Cleary 2012).

This report is therefore unapologetic in its detailed account of what has been learnt about nursing intervention through the course of the study, contributing to a process of supporting mental health nurses to more clearly articulate their own identity and expertise.

Similarities and differences with adult PICU nursing and other forms of CAMHS inpatient nursing

The concept of tension is central to understanding the nature of nursing identity and the interventions employed by the team within the CAMHS PICU. This parallels findings in adult PICU literature (Salzmann-Erikson et al. 2008; Björkdahl et al. 2010).

A key difference, however, is that studies in adult PICU identify managing the tensions within the environment as the nursing intervention; whereas this study contends that tensions arising in CAMHS PICU are an ever-present manifestation of the fundamental care needs of the patient group from which a range of specific nursing interventions are given birth.

The fundamental tension identified in adult-focused studies can be characterised as: maintaining security and creating stability, through control, surveillance and structuring of the environment, versus initiating therapeutic relationships to give intensive assistance and to soothe distress (Salzmann-Erikson et al. 2008, 2011; Björkdahl et al. 2010; Ward & Gwinner 2015). This study has also borne out the presence of this tension within in the CAMHS PICU environment. However, it is one amongst eight co-occurring dialectics that have to be continuously occupied by the nursing team.

The broader range of tensions that have to be managed are in part accounted for by the nature of presenting difficulties identified within this study. The findings mirror previous work highlighting that multiple diagnoses, co-morbid neurodevelopmental problems and experiences

of fragmented/unsuccessful care and abuse, are the norm within CAMHS PICU (NAPICU 2015; NHS England 2016).

We argue that 'tensions' as the producer of nursing interventions reflects how CAMHS PICU nursing is itself located on the boundary of two nursing specialisms: PICU nursing and CAMHS nursing. Comparison of the findings of this study with a study exploring adult PICU nursing (Ward & Gwinner 2015) and a study of CAMHS open inpatient nursing (Rasmussen 2012), shows that communication, teaching skills, observation and managing risk are common to all three settings. However, the range of additional interventions, described within the categories of 'emotional containment', 'attachment' and 'personal qualities' are distinct from those reported in either adult PICU or the CAMHS inpatient nursing studies.

Ward & Gwinner (2015) characterised the aim of adult PICU nursing interventions as creating a trustworthy environment so adults can *tell* their story. This study found that the emotional and cognitive development needs of adolescents means that extensive 'emotional containment' nursing interventions are required to create relational conditions in which young people can *show* their story to adults who are prepared *feel* something of the story not just see it, so that they can translate it into words or helpful actions and give it back in a form that the young person can understand. This process of 'reverie' requires staff to withstand and make sense of a high level of intrusion, violence and disinhibition as a primary means by which the young people communicate pain and vulnerability. These are characteristics that appear to set them apart from more general CAMHS inpatient settings.

In Rasmussen's (2012) study of CAMHS inpatient nursing intervention, advocacy was described as making a case for young people who staff felt needed to move on, due to their behaviours and risks being too difficult to manage. In contrast, in the 'last-chance saloon' context of CAMHS PICU, advocacy was conceptualised as 'sticking with', not giving up on young people no matter the degree of risk, in the knowledge that there is nowhere else for them to be 'moved on' to. This was followed by convincing other care-providers of young people's positive capacities, and the emotional and developmental gains made, in order to advocate for them moving out of PICU.

The concept of child/patient-led care may also be constructed or enacted differently within CAMHS PICU. Although the care systems in place on the unit did seek to involve children in their care in a variety of ways, the high level of control, boundaries, scrutiny and legal and physical restriction to which the young people are subjected, places significant constraints upon the opportunities for promoting the participatory and emancipatory characteristics usually associated with the term 'child-led' (Winkworth & McArthur 2006). However, there was evidence in several categories (Attachment, Boundaries, and Personal requirements) of staff being led by young people within the frame of their individual interpersonal encounters and approach to relationship building. This parallels the way in which Bowlby (1988) observed 'good-enough' mothers allowing themselves to be led by their infants as a means of enabling them to develop reciprocal communication, empathy and social adaptability. The ability of a carer to create a relational setting in which the child experiences themselves as potent in the face of material powerlessness has been identified as essential to the development of sense of selfhood in children (Winnicott 1971; Lebau 2009), the ultimate aim of participatory and child-led approaches. In the innately paternalistic and patriarchal context of the CAMHS PICU (LeFrancois 2013) child-led nursing approaches might therefore be said to reside within the use of 'maternal' functions within the small details of the 'to and fro' of interpersonal encounters. This provides relational spaces for young people that mitigate the impact of the unit's safety-focused restrictions on the young person's sense of personal power and agency, which nurses are also responsible for executing.

Attachment and nurture in CAMHS PICU nursing interventions

The nature of nursing interventions described in this study can be best described using attachment and object relations theory, which characterises the aspects of the primary-carer–child relationship that are understood to bring emotional and mental resilience in life. That is, either trying to use the characteristics found in good-enough attachment relationships to understand, soothe and enable, or understanding the ways in which aspects of ward setting and relationships may act as overt reminders of previous attachment disruptions. (Adshead 2002; Minne 2011).

Adshead (2002) argued that the treatment of mental health disorder is innately linked to the promotion and enablement of development, and amelioration of the impact of less than optimal experiences upon the social, emotional and interpersonal stress regulating functions of an individual's internalised attachment representations. Whilst this is true across the life course, it is especially so during adolescence. It is increasingly recognised that care of young people in any residential setting necessarily needs to address issues of care, dependency and attachment to be most effective (NICE 2015). Adolescence is a time in which the attachment patterns and internal working models set up in infancy are tested and re-worked, drawing on the mental functions developed through the primary-carer relationships experienced in earlier developmental stages (Waddell 2002).

The length of stay in PICU for some young people, the stability it can provide for young people whose biography

has been characterised by insecurity, the way in which illness and hospital activate attachment seeking/regulating behaviours and the intensity of the difficulties for which the young people are being treated, mean that the formation of strong bonds between young people, staff and the ward itself are to expected (NAPICU 2015).

Against this backdrop, perhaps it is not surprising that the nursing interventions that have emerged to meet the needs of young people explicitly attend to the need for attuned, responsive carers who can forge relationships that soothe and promote growth and recovery. What is noteworthy is that ostensible descriptions of CAMHS PICU or similar secure mental health service models tend not to explicitly name this aspect of treatment instead focusing much more on acute psychiatric symptom management and pragmatic approaches to conferring safety (DH 2010; NHS England 2016).

One possible reason for this is that western medical accounts of illness which are usually rooted in understanding adult populations, can stigmatise the notion of dependency as they 'presume a [prior] normal state of independence interrupted by a discrete, time-limited period of abnormality and dependence' meaning that 'appropriate care-seeking and care-giving is conceptualised as aiming to restore normality and independence.' (Adshead 2002, p. S42).

Experiential knowing and receptive looking: reconceptualising the role of observation practices

Two codes were threaded through all the nursing intervention categories (Fig. 3): (1) learning about young people through the way they make you feel; and (2) knowing the whereabouts of young people.

A significant finding of this study is the way in which the practical task of high intensity observation (five-minute observations as standard) is enacted to extend beyond the task of harm prevention, in the service of the process of emotional containment and regulation/modulation of young people's mental representations of self.

Openness to receiving, and a preoccupation with making sense of, a child's indirect communication of feelings via projective identification, is a fundamental component of 'good-enough' care giving, described as feeling oneself into the place of the infant to develop an almost magical understanding of need (Winnicott 1960). Neuropsychological studies have shown how emotional distress and dysregulated affect are rapidly communicated through unconscious body-based intersubjective communications, before words can be found for them (Schore & Schore 2014). The ability to track verbal and non-verbal moment to moment fluctuations/rhythms in young people's internal states and to continuously modify one's own behaviour and responses, in order to be in synchrony with these, has been asserted as the foundation of effective therapeutic relationships (Schore & Schore 2010), highlighting the importance of this aspect of intervening within acute psychiatric care settings.

In the mental health nursing literature, the purpose of high intensity or close observation practices is predominantly seen as harm prevention and risk assessment (Holylake 2013). As a result, close observation nursing practices are also often critiqued. Regulation by policy of observation as a task rather than a personal encounter has been said to privilege physical safety over emotional safety, to objectify patients and depersonalise nursing care (Stevenson & Cutliffe 2006; Holylake 2013). As a form of surveillance, observation has been criticised as seeming to signify safety, whilst actually being an institutional instrument of power used against both patients and staff (Holmes 2001). Within CAMHS PICU standards (NAPICU 2015), the interpersonal component of observation is recognised but only in so far as its contribution to developing clinical intuition that can be used to prevent harm. However, the findings of this study reveal that the practical task of observing appears to be used by the nursing team to provide an important aspect of the psychological holding environment and maternal reverie, through visual transaction (Shore & Schore 2014).

How we are gazed upon and handled by our carers confers love and acceptance (Winnicott 1971), and is the foundation of the value we come to attribute to ourselves (Lemma 2009). Winnicott conceptualised the therapeutic task involved in working with individuals in mental distress as a 'complex derivative' of the original face (primary carer) whose role it was to reflect back all that the infant/patient brings. A sense of selfhood is forged through the work of looking and of being looked upon (Lebau 2009). Fundamental to this is the idea that 'being seen' is the experience of not just being looked at, but of being taken in, recognised, and reflected back by a receptive other (Winnicott 1971), which in itself serves a containing function (Alvarez 1999). In good-enough circumstances this is the internalisation of an 'other' who sees us for all that we are and still cares for us. Whereas, in circumstances where children have developed within a hard, critical or disorganised carer-gaze, they may become identified with a harsh, ruthless or chaotic internal observer (Lemma 2009); demonstrated through the self-loathing and self-destructive impulses evident in the codes describing the difficulties of the young people within the PICU setting.

Though linked to early developmental stages, the presence of acceptant and reflective others in adolescence is so important because adolescence is characterised by a developmentally 'normal' preoccupation with self-examination in mirror-like or reflective surfaces in the pursuit of understanding one's emerging identity (Winnicott 1971). The experience of being looked upon receptively is an

invitation to engage (Alvarez 1999) and has a bodily-experienced component to it that can instil a more benign appraisal of self which also equates to a hopefulness that other people can like them too (Lemma 2009).

That is not to say that the problems with enhanced observations, identified within the published literature, are not also present within CAMHS PICU. Increasing levels of observation from five minutes to 1:1 or 2:1 were used to increase safety and relational security for young people in crisis. However, periods of enhanced observation of this kind were identified as a frustration for staff, significantly impacting upon staff appraisals of their usefulness. An issue that will be elaborated upon further in the second part of this series (Foster & Smedley 2019).

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ORIGINAL RESEARCH ARTICLE

Understanding the nature of mental health nursing within CAMHS PICU: 2. Staff experience and support needs

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In the UK and other western countries, child and adolescent care is increasingly understood as a distinct speciality. Internationally, inpatient units are the most widely used element of acute adolescent mental health services. Child and adolescent mental health inpatient nursing has been identified as unique, and yet there is dearth of research investigating the role of nursing in adolescent mental health inpatient units and its impact. This is the second of a two papers presenting findings from a first of its kind, qualitative study investigating into the nature of mental health nursing within a child and adolescent mental health service psychiatric intensive care unit (CAMHS PICU). A qualitative conceptual analysis design was used. Findings relating to understanding of staff experience of their work and their support needs are presented. Results indicate there is significant emotional labour generated from the detailed and intense relationally-focused work with young people; responsible for both a sense of value and job satisfaction, and corrosion of staff capacity to sustain these interventions over the longer term. The central role of projective identification and the specific support requirements that emerge from these intrapersonal dynamics are explored. A conceptual model of CAMHS PICU nursing is proposed, synthesised from findings in the two parts of this series.

Keywords: PICU, CAMHS, adolescent, mental health nursing, identity, support

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Declaration of Interests: Unpaid honorary contract (as above) within the service in which the research was carried out.
Ethics: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Introduction

In the UK and other western countries, adolescent care is increasingly understood as a distinct speciality (WHO 2015). Internationally, inpatient units are the most widely used element of acute adolescent mental health services (Hayes et al. 2017). Adolescent mental health inpatient nursing has been identified as unique (Matthews & Williamson 2016) and yet there is dearth of research investigating the role of nursing in adolescent mental health inpatient units and its impact.

The study reported on in this series of papers is the first of kind, investigating the nature of mental health nursing within a child and adolescent mental health service psychiatric intensive care unit (CAMHS PICU). Foster & Smedley (2019) reported on the context of CAMHS PICU, the demands placed upon the nursing team by the context and the specific nursing interventions used within it. The focus of this paper is on understanding staff experience of their work, the impact of the demands of the nursing role and related staff support needs. Findings from both papers are synthesised and a model of CAMHS PICU nursing is proposed.

CAMHS PICU are a small and specialised component of child and adolescent mental health service delivery in the UK. They are usually mixed gender, 'secure' inpatient environments for the short-term containment and treatment of young people detained under the Mental Health Act (1983). Young people detained in PICU typically display symptoms and behaviours associated with a serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability (NHS England 2016). The significance and relevance of CAMHS PICU to the wider child and adolescent mental health care pathway has been outlined elsewhere by Foster (2018).

The care of patients who present with high levels of violence is known to be complex, often provoking difficult feelings and contributing to negative work experience (Sondenaa et al. 2013). Furthermore, threats to personal wellbeing in the working context have been identified as negatively impacting upon mental health nursing job satisfaction and sense of identity (Seed et al. 2010; Cusack et al. 2016).

There appears to be an iterative link between mental health nursing identity and the impact of the work that constitutes this identity, brokered by the concept of emotional labour. A recent systematic review found that the emotional labour associated with mental health nursing was both a source of satisfaction associated with the role and a factor that directly influences rates of burnout (Edward et al. 2017). The emotional labour expended in the intense psychological tasks associated with caring for those in mental distress has been conceptualised as a form of workplace adversity in itself (Delgado et al. 2017). A strong sense of professional identity is thought to protect against the negative effects work place adversity of this kind (Edward et al. 2017) and yet the nebulous nature of the work has also been identified as contributing to mental health nurses suffering from a lack of coherent professional self-perception (Sercu et al. 2015). Perhaps this is not so surprising given that the focus of emotional labour in mental health nursing is in the development of therapeutic relationships, in which nurses are concurrently managing their own emotions and the emotions of others (Edward et al. 2017). A task comprised of many specific affective and psychological interventions (elaborated on in Foster & Smedley 2019) that are often invisible to others and to nurses themselves (Rasmussen 2012).

In a survey of morale amongst mental health workers in England, PICU staff were identified as at particularly high risk of emotional strain and burnout as a result of an interaction between high job demand, low perception of autonomy and poor support (Johnson et al. 2012). Health care assistants working in general adolescent mental health inpatient settings have been described as subject to high demand that causes significant moral distress (Matthews & Williamson 2016). Other studies have noted a lack of respect and inadequate resources being provided to nurses working in PICU settings (Gwinner & Ward 2013).

Burnout in mental health nursing staff is associated with reduction in reflective capacity, indifferent responses toward patients and a reduction in their own mental wellbeing (Coetzee & Klopper 2010; Edward et al. 2017). Therefore, understanding the specific support needs of staff working in CAMHS PICU environments is as important to developing effective and high-quality patient care strategies, as understanding of evidence-based nursing interventions.

General organisational factors that can build and sustain nurses' resilience have been identified as support, personal and professional development, and a perceived sense of personal and psychological safety (Cusack et al. 2016). However, investigation is needed to into the particular demands of the mental health nursing role within CAMHS PICU, and the specific support needs that they engender.

Aims and objectives

The qualitative study reported on in this series of papers aimed to address the question 'What is the nature of mental health nursing in an CAMHS PICU setting?' and to propose a conceptual model of CAMHS PICU mental health nursing.

Here, we report on: (1) the impact of nursing tasks and interventions on staff working identity; (2) the support needs of the nursing team within a CAMHS PICU; and (3) a proposed model of mental health nursing within CAMHS PICU settings.

Findings relating to understanding the specific clinical

context and nursing interventions used within it are presented in Foster & Smedley (2019).

Design

A qualitative conceptual analysis of the notes from an externally facilitated work discussion group was undertaken from a period of six months. The method of content analysis elaborated by Elo & Kyngäs (2007) was adopted, using a theoretically informed but inductive approach. The study was conducted in one 10-bed mixed gender CAMHS PICU in the North of England.

A more detailed elaboration of the research design and methods is provided in Foster & Smedley (2019).

Data collection

The study collected data from the nursing team (registered mental health nurses and non-registered health care assistants, HCA) through the implementation of a weekly, externally facilitated reflective work discussion group (Jackson 2008). The group was facilitated by an adolescent psychotherapist and mental health nurse and was open to all those members of the nursing team who were not required on the ward at that time to meet the minimum clinical observation levels. Notes of the content of discussion from each group were made by the facilitator, shared and checked with the nursing team. The unit of analysis was defined as the set of notes from one work discussion group. There were 26 units of analysis spanning a six-month period. The unit of coding was specified as all emerging concepts or themes within the given text of each unit of analysis.

Data analysis

The coding process. Content analysis was performed in a stepwise fashion. To understand the data as a coherent whole, all units of analysis were read and re-read as a complete data set with the key research question in mind. An open coding process was undertaken. Codes within each unit of analysis were identified and marked in the margins of the text, using the framework recommended by Strauss (1987). Coding continued until no new codes appeared within the data set (saturation). Codes were then grouped and tabulated on one coding sheet, retaining information regarding the location of codes within the raw data.

Categorisation. Higher order concept categories, categories and subcategories were generated, under concept codes from across all units of analysis were grouped. These were defined by combining related topics and content areas. From this, main theme headings under which these concept categories fell were named. The relatedness of individual codes across different categories were then identified and mapped within the tables. Once the codes were organised under final concept categories and main theme headings, the raw data was used to identify illustrative examples.

Abstraction. Psychoanalytic, attachment and developmental theories were applied to the categorisation and abstraction process, to generate a conceptual model of mental health nursing within the specific setting from the outcomes of the content analysis. The choice of theoretical lens reflects the fact that the care of adolescents always needs to be rooted in an understanding of development and that mental health nursing and support work is fundamentally psychodynamic in nature, in that it is within the quality of the therapeutic nurse-patient relationships that change occurs (Gallop & O'Brien 2009). Psychodynamic theory has a language for interpersonal and relational processes that can be used to help name and illuminate and understand the work of the nursing team in detail (Ruszczynski 2012).

Internal verification. A transparent record of each step of the coding and categorisation process was kept using tables and schematics (Elo & Kyngäs 2007). A co-researcher with knowledge of the clinical context from which data was drawn, but who was independent of the work discussion group and the coding process, was identified to establish relative trustworthiness of the codes and categories and ensure they remained grounded in the data from which they were drawn. Presentation and reporting of results were undertaken in accordance with the recommendations for reporting content analysis data made by Elo et al. (2014) and O'Brien et al. (2014).

Ethical approval was gained from The University Ethics Committee (HSCR14/19) and the Research Governance Committee of the participating healthcare organisation (non-NHS). All those who chose to participate provided informed consent. Participants were informed of their rights in respect of voluntariness, information access and that data would be stored securely and anonymously in accordance with data protection regulations (Data Protection Act, 1998/GDPR, 2018)

Results

A total of 150 distinct codes were identified within the data, set across seven main theme headings of: (1) presenting difficulties; (2) complexity within the clinical environment; (3) tensions; (4) nursing interventions; (5) frustrations; (6) staff experience; (7) learning and development.

The results for the themes dealt with in this paper

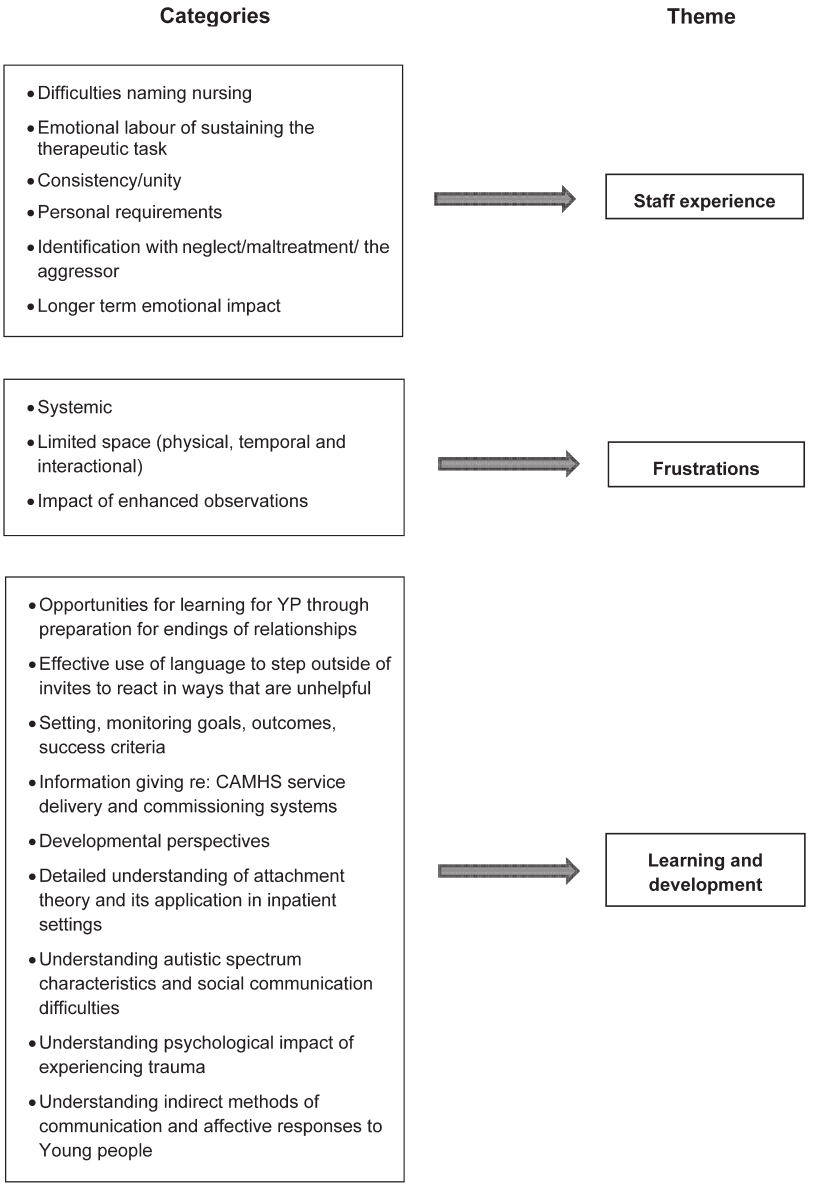

Fig. 1. Summary of content analysis results.

(frustrations, staff experience and learning and development) are summarised in Figure 1. The context of nursing and the interventions provided by the nursing team are reported in Foster & Smedley (2019).

Frustrations

Identified frustrations were noted to exacerbate the tensions within which the nursing team have to operate. Frustrations fell across subcategories of: (1) systemic; (2) limitations on space; and (3) enhanced observations.

Systemic. A key repeated frustration was caring for young people who get 'stuck' on the ward, despite improvements in their clinical presentation, as a function of problems within the wider children's mental health care pathway negatively impacting on discharge planning. This finding mirrors previous work identifying that perceived lack of patient progress has a direct negative impact on perceived job role and satisfaction (Seed et al. 2010).

Limitations on space. These were both physical and temporal in nature. The structure of the shift patterns (long days) and required levels of observations to maintain the minimum safety requirements for young people were reported to limit time and foreclose spaces for handover, whole team discussion, communication and debrief between the nursing team through the day. This was seen by team members as having the potential to impact on team cohesion and on consistent delivery of care plans.

Physical environmental factors that were described as impacting upon on the nursing approach were: limited separate or flexible physical spaces in which young people could be nursed apart from each other when required, and ward occupancy levels. Specifically, these factors appeared to limit resources available to manage the domains of complexity identified in Foster & Smedley (2019, Fig. 1).

Enhanced observations. Across the 26-week period covered by the data analysis, there were four periods in which the ward was using a higher than usual level of nursing observation to manage the safety of particular young people. Standard observation practice on the ward was for young people to be observed every five minutes. The ways in which this observation level fostered frequent contact between staff and young people, used by staff to enact emotionally containing care approaches, has been outlined in detail in Foster & Smedley (2019). Enhanced observation denoted a change from frequent but intermittent observations, to young people being continuously observed by one or sometimes two members of staff. During each period in which there were young people being nursed in this way, codes were identified within the data revealing the problematic impact of enhanced observations on care management tasks and team working.

The allocation of staff to enhanced observations was described as organising the shift and the nursing team approach. At these times a degree of moral distress and emotional conflict was reported by team members. Moral distress was generated by having to prioritise continuous observation and other essential safety-orientated tasks over the more 'therapeutic' or 'care-focused' tasks, particularly for those young people who were not on enhanced observation levels (See Staff Experience, below). In one unit of analysis, participants observed the predicament of increased levels of observation. Increasing observation levels was the only mechanism for increasing numbers of staff on shift, as means of responding to increased acuity of patient need, yet it served to increase constraints upon the ways in which the staff complement could be used. The net result was that it could lead to feeling that there were even less staff available than usual.

High of levels of enhanced observation were described as literally and psychologically splitting the team on any given shift. Staff were geographically split, often in different parts of the ward with limits upon their abilities to move, leading to a reduction in opportunities to be, talk and think together. A high potential for splitting between HCA and staff nurses was identified in these episodes, because of feelings of envy and resentment that could emerge from the allocation of different tasks that served to make each group's work invisible to the other. HCAs would be allocated the lion's share of 1:1 observation at these times sometimes covering observations back-to-back, leading to feelings of exhaustion and entrapment. Staff nurses would be managing the remainder of the care delivery tasks for young people not on enhanced observations, plus the care management, medicines administration, risk assessment, administrative, record-keeping, family and multidisciplinary team (MDT) liaison tasks. Continuous observation meant that there were fewer available HCA staff to whom they could delegate. These tasks were often undertaken out of sight of an HCA on enhanced observations. In both groups, fantasies were expressed regarding how much easier the other group's job was at these times, alongside worries about how little the other group understood or cared about the burden put upon them. A quantitative study of professional quality of life of nurses within the CAMHS PICU that was undertaken over the same period revealed notably lower levels of compassion satisfaction and higher levels of compassion fatigue and vicarious trauma during the period in which enhanced observations were at their highest (Foster 2018).

Staff experience of their work

Difficulties naming nursing. Significant difficulties were reported by staff in relation to naming and noticing what it was they were contributing to the care context as a nursing team. Direct invitations from the group facilitator to identify their contribution to the wider MDT care were usually followed by staff reporting how hard it was to see anything other than 'ordinary-ness' in their day-to-day work. However, detailed discussions of nursing contributions based on individual cases, generated very detailed accounts of nursing intervention. This prompted staff reflections on how much their work was based on the small details, which in turn made it even harder for them to notice or explain it. Having a lack of language with which to name their work was reported by some as equating to a lack of value being attributed to it: 'if there aren't names for what we do, how can it be important?'

Emotional labour of sustaining the therapeutic task (in the moment). Directly recorded expressions of the feelings that staff had for their work are best summarised as bittersweet. Overwhelmingly, team members described feeling pride in their work and gaining enjoyment from it, but these descriptions were also qualified by comments regarding the emotional toll of the work.

A number of factors were identified which attacked staff members' capacity to sustain therapeutic interventions. These were: the unending emotional toll of the therapeutic interventions themselves; being unstintingly busy; feeling 'stretched' (relating to perceived ratio of available staff to the volume of tasks that needed doing); hostile approaches from young people; having little or no

time to recover after difficult encounters; multiple competing demands of young people; and the physical environment of the ward.

The distress that comes from 'bearing witness to young people's illness and pain' was coded as a repeating source of emotional burden. Watching the deterioration of a young person's condition was identified as being particularly impactful source of personal distress, as it challenged staff sense of being useful/helpful. This was particularly evident in cases where staff perceived that the young person was continuing to deteriorate despite their best efforts. For example: young people who had been admitted in the early stages of a developing severe psychotic illness that was still progressing; when a young person's presentation worsened in the face of discharge delays; and when a young person deteriorated in the context of disclosing historical traumatic events.

Violence was identified as a threat to well-being, security, regard for self and other. Overall there were many examples in the text of the management of physical violence being conducted in a coordinated, competent and effective manner. However, in three units of analysis the emotional impact of dealing with violence was raised. This was in relation to two specific dimensions of managing violence. Firstly, the painful experience of having no choice but to intervene in a restrictive manner, knowing that physical intervention was likely to activate traumatic memories for the young person. Secondly, the individual experience of being physically assaulted by young people and having to manage the temporary impact this could have, on one's sense of regard for the young person and appraisal of one's own competence.

Identification. In the face of difficult experiences that are too painful to think about, identification is a basic human coping response (Garland 2004). Identification can be with aspects of the original aggressor or source of maltreatment; momentarily relieving the young person of their feelings of humiliation and powerlessness and giving them the gratification of revenge, by shoving these awful feelings back at or into another. In this instance nursing staff are vulnerable to being repositories for the feelings of low worth and resentment that come with being hurt, neglected or deprived. Or, in moments in which young people are in touch with their hurt/victimised selves, the staff themselves can experience identification with the primary aggressor or neglecter (Ruszczynski 2010).

This subcategory links with the intervention subcategory of *'Coming to know'* (Foster & Smedley 2019). It is the inevitable other side, or risk, of being open to learning about the aspects of young people that they are only able to communicate indirectly, by unconsciously acting to locate or stir up emotions within the staff group through the ways in which they behave.

Identification with neglect or maltreatment. Parallels were observed between the perceived neglect by staff in young people when they experienced delays in needs being met (e.g. hot drinks), and perception of neglect by the organisation in staff, when they were not provided with resources required to tend to young people's needs (e.g. a sufficient supply of safe disposable cups in which to give young people drinks).

For HCA staff, who were often not present in clinical decision-making forums, absence of information or lack of communication of the rationale for counterintuitive clinical decision making by the MDT or senior nursing team had potential to prompt identification with maltreatment. In the absences of explanation, individuals tended to make their own deductions about the 'true' reasoning behind hard to comprehend decisions. Deductions were often of a persecutory nature (e.g. medication has not been increased because 'the MDT does not care about us getting hurt', in the absence of being informed that the safe or licenced limit of dosage has been reached). In turn, these assumptions could be seen to stir up feelings of deprivation and perceived low worth in eyes of others and the organisation.

A similar process was observed within the data in relation to staff perceptions of young people. Young people whose presentation was both difficult to manage and outside of staff member's model of understanding of mental health conditions, were much more likely to be appraised as acting to cause harm intentionally, having conscious control over their behaviour and/or gaining some form of satisfaction from behaviours that were troubling or harmful to staff. Understandings of this nature tended to leave staff feeling subject to the young person's maltreatment.

In units of analysis that cover both of the above phenomena, the notes reflect that the priority within the work discussion group at those times was to provide information that could support participants to understand the function of both counterintuitive or counter-logical decisions and clinical presentations, in order to bring some relief from the feelings of neglect and maltreatment. This mirrors observations that have been made that an understanding of patients sustains positive attitudes, and motivation to maintain a connection with them is an important component psychological resilience in mental health nurses (Cusack et al. 2016).

At times of increased use of 1:1 observations, concerns of working for a critical or unfeeling management team or organisation were more likely to be expressed. In part, 1:1 observations come with a higher burden of paperwork at a time of increased busy-ness, and so at a concrete level staff were more likely to be prompted about administrative errors or omissions by their managers. However, detailed exploration in one unit of analysis revealed a more complex

dynamic. Prompts from managers to undertake overlooked tasks resonated with underlying 'worst fears' staff were carrying at these times. Worst fears expressed as 'no matter how hard you try you not good-enough', related to a specific aspect of being allocated to 1:1 observations. Accounts were given of how in following the movements of one young person, staff would walk past other young people in whom they could recognise early indicators of distress but would not be able to intervene due to the requirement to stay with the young person to whose observations they had been allocated. These encounters were described as activating feelings of powerlessness, loss of one's own capacity to help and worries about being a neglectful other. Unspoken worries were exacerbated by managerial prompts that further alerted them to what they had not done.

The concomitant feelings to perceptions of deprivation and neglect were envy and resentment. For members of the nursing team, whose movement on the ward is dictated by minimum numbers of staff required for safety and observation levels, members of the MDT who can come and go on to the ward could become sites onto which these feelings could be projected.

Identification with the aggressor. Codes that exemplified the phenomenon of staff becoming identified with the aggressor were characterised by critical and exacting staff appraisals of their own performance, prompted by strong feelings of empathy for young people and a concomitant wish to extinguish their pain.

Staff identified feeling responsible for causing, maintaining or worsening young people's difficulties, even when there were clear external precipitants and triggers. This feeling was expressed as 'We did this', What have we done to them?' or 'This is our fault'. This was often in the context of understanding the impact of having to exert control over young people upon their sense of powerlessness and what else this might link to in past experiences. In turn this led staff to feel the burden of responsibility for re-enacting elements of original trauma.

Knowledge of individual histories of deprivation and trauma were noted to act upon staff capacity to implement boundaries. For example, declining requests for a hug or other forms of touch or saying 'No' were felt, in the moment, to be 'the same as' repeating young people's experiences of having care withheld and were described as feeling awful or like being an 'awful person'.

Knowing what needs to be done and not knowing how to do it with the resources available was identified as leading to feelings of being 'not good-enough'. Feelings that were concretely equated with worries by staff that they may actually be causing harm.

Consistency/unity. Team consistency and unity was repeatedly associated with participant perception of team effectiveness and satisfaction. Inconsistency in approach was equated with feelings of isolation and vulnerability amongst individual staff. Times or specific cases in which there was felt to be a lack of clarity in team approach were associated with perceived stress. More challenging patients were described as exposing chinks in the nursing team's approach. Although this was recorded as feeling bad it was also noted by some staff to be a kind of adversity that could actually prompt a return to staff unity.

The challenges of working to achieve consistency were also related to the processes of Identification. An example was given of a young person with a particularly painful history of physical punishment and deprivation from his carers. A split was observed to have appeared between staff. Some staff appeared to have become identified with the aggressor and found themselves instinctively driven to respond to the young person's challenges with more harsh consequences than would be usual for them. Other staff found themselves acutely aware of their tendency to respond in a more permissive way than they would for other young people on the ward.

Longer term emotional impact. Vulnerability to feelings of powerlessness and hopelessness in this setting seemed to be particularly activated by the contrast between the supposed short stay nature of a PICU admission, versus staff members' awareness of the complex and long-term nature of many young people's difficulties. Having to work to sustain a sense of effectiveness in the face of seemingly insurmountable problems was sometimes expressed within the text as 'but, what can we do?'

Loss was identified in a number of different ways: (1) having to adjust to the rapid turn-over of patients; (2) the impact over time of being up close to the many loss and separation–based issues that young people were facing; (3) for longer-term patients, wondering about whether the next place would look after them as well; and (4) rarely getting to see the end-product of their work, as most young people were still relatively unwell as the point of their discharge.

In one unit of analysis, the issue of loss was directly linked to the difficulties staff had in reflecting on what the team had done well. One participant observed that reflecting on what has gone well required team members to think about young people who have left the unit, which in turn required them to be in touch with feelings of sadness in the face of loss of young people whom they had cared so much about.

Difficulties winding down/turning off, were reported as a function of the high level of stimulus, patient acuity, shift length and sense of responsibility for the safety of the environment, even when not on the ward ('have I handed over everything?', 'did I make sure the shampoo bottle tops were back on', 'did I count everything back in?'). Some staff reported experiencing difficulties winding down

or turning off between shifts, sometimes impacting upon sleep. Other staff members described specific mechanisms for turning off and separating work/home life. For example, use of particular types of music for the journey to and from work, listening to different radio stations on work days and days off, allocating the journey home for reflecting on the day, so that it could be left at the front door, once home.

Learning and development

This theme contains codes that described discussion content and information-giving by the facilitator within the work discussion group, that was observed to help participants manage some of the frustrations, anxiety and emotional labour experienced in their work. The codes within this theme have been organised into: (1) supporting a team process of generating strategies for intervening; and (2) supporting with information and knowledge development.

Supporting a team process of generating strategies for intervening. This involved helping staff providing young people opportunities for learning by preparing them for and reflecting upon the emotional component of endings of relationships with the nursing team. This was in contrast to avoiding termination of therapeutic relationships, which had been the team tendency prior to the implementation of the work discussion group. The group was also used by staff as a space in which they could collaboratively generate and rehearse effective use of language to respond to invitations from young people to enact/react in ways that are unhelpful. At the same time, a process of supporting staff to set and monitoring realistic and achievable goals, outcomes and success criteria that were congruent with the level of illness and complexity present in the patient group can be traced through the units of analysis. The scale of these goals and success criteria were significantly more conservative than the hopes for absolute recovery to which the staff group understandably and admirably aspired.

Supporting with information and knowledge development. The most frequently record domains in which the facilitator provided direct information to support staff knowledge development were: (1) information giving re: systems and process in CAMHS service delivery and commissioning outside of the unit; (2) understanding of attachment theory and its application; (3) understanding of autistic spectrum characteristics and social communication difficulties; (4) understanding the psychological and developmental impact of trauma in childhood; (5) understanding how indirect methods of communication (projective identification) and one's own affective responses can be used as a source of helpful information about young people (countertransference); and (6) developmental perspectives.

Supporting understanding of young people's difficulties using a developmental lens to understand adolescent behaviours and developmentally regressive behaviours, alongside an illness-focused model, was noted to help lessen frustration and negative attributions towards young people.

Discussion

Analysis of accounts of staff experience of their work within CAMHS PICU has revealed four key findings that will be explored here: (1) the emotional labour that comes from the detailed and intense relationally-focused work with the young people brings, is responsible for both a sense of value and job satisfaction and corrosion of staff capacity to sustain these interventions over the longer term; (2) the central role of projective identification in both enabling nursing staff receptiveness to young people's needs and in engendering distress in staff; (3) the specific support requirements that emerge from these intrapersonal dynamics; and (4) the effect of continuous or enhanced observations upon nurse's perception of their work.

Impact of enhanced observations

Increasing levels of observation from usual five minutes intermittent to continuous observation levels were used on the unit to increase safety and security for young people in crisis. However, in contrast to standard observations which were identified by Foster & Smedley (2019) as enabling a range of emotional and relational-focused interventions, enhanced observation was identified as a significant frustration. The impact upon staff members' perceived abilities to perform their job to their own standards, their perception of additional criticism and scrutiny from managers, and the experience of being geographically split as a team reflects assertions by other writers that enhanced observations can segment the nursing task, stripping meaning from it (Holylake 2013). This subjects the observer as much as the patient to scrutiny (Holmes 2001) and can cause a particular form of moral distress due to staff fears that there are insufficient resources available to provide 'attentive, competent and ethical care' (Musto & Schreiber 2012, p. 138) for all of the young people, not just those on enhanced observations.

This study's findings suggest that there is a point at which the experience of enhanced observations by young people can move from 'being seen' (i.e. needs recognised, taken in and responded to) to being experienced as surveillance (i.e. 'being looked at'). Opportunities for patient introjection of nursing reverie-based interventions risk being foreclosed as the task of 'doing the observations' can become more akin to an 'iron gaze' (Holmes 2001) or an empty mirror (Lebau 2009), reducing young people's sense of emotional security within the environment.

Analysis of the text from the four periods of high levels of enhanced observation revealed that it was often the use of nuanced and detailed knowledge of young people to inform therapeutic risk management strategies (drawn from the experiential knowing associated with usual observation practices outside of crisis periods) that actually enabled reduction in enhanced observations levels to take place.

This is not an argument against the availability of enhanced observation practice for times of high clinical acuity in the patient group. Being able to employ continuous observations for short periods clearly provides essential prevention from harm at times of crisis. However, the findings of this study do indicate a need to consider pre-agreed strategies that facilitate nursing teams coming together at a time when the clinical task actually separates them, and that can be quickly employed at times of increased observations, so that they can use their discipline expertise, in conjunction with their collective knowledge of the young people, to plan care strategies to limit the period for which enhanced observations are needed.

Projective identification: two sides of the same coin

An overwhelming finding of this study is that effective care and that which erodes it are two sides of the same coin. Being able to respond to the young people's indirect communication of need and of their internal emotional and cognitive states (projective identification), is the both the basis of the nursing team's intervention and identity, and a direct challenge to their ability to sustain the very same interventions.

This finding mirrors literature on the emotional experience of working with adolescents more generally and within adult PICU settings. Working with adolescents has been noted to be characterologically different to providing mental health intervention to other groups across the life span (Musto & Schreiber 2012; Matthews & Williamson 2016;). High levels of emotionality, reliance upon body-based solutions to psychological conflict and distress, a developmental tendency towards doing rather than thinking, combined with reworking of much earlier infantile experiences of care in the pursuit of independence and identity formation, mean that much of the interpersonal communication that occurs between patient and worker is via non-verbal, unconscious mechanisms of projective identification and transference–countertransference (Waddell 2002; Briggs 2009). Winship (1998), Ruszczynski (2012) and Smith & Hartman (2003) all argued that PICU and similar restrictive environments specifically require nurses to have training to understand the unconscious processes to which they are subject. It is argued, that these are as a result of the very high level of histories of abuse, disruption to early care and boundary transgression that the population of individuals admitted to intensive care or other contained psychiatric environments carry with them (Ruszczynski 2012). Furthermore, aspects of the restrictive environment itself are understood to feel similar to, and therefore can become concretely equated with, disturbing elements of the person's past which then get repeated within the transference (Minne 2011).

Nursing staff working in both an adolescent and a PICU context are subject to a 'double-whammy' effect. The impact of which is that effective nursing interventions and the challenge to effective nursing care are two sides of the same coin, constituted of the same thing: the emotional labour involved in providing emotional containment and attachment-based interventions. The openness to receiving the young person's projections, also inevitably creates a risk of being stirred up and identified with them, reacting to them in the moment before having an opportunity to think about the meaning of them.

When the process works well, study findings show how staff can see, respond to and sometimes name transference, noticing and using their own emotional experiences as information (categories 'Reverie' and 'Decoding'). However, the emotional labour involved in this process means that doing it can diminish the resources needed to keep doing it (Edward et al. 2017), as shown in the category Staff Experience. Whilst it can be argued that this is the case for any members of the MDT who engage with the young people, there are some distinct differences for inpatient nursing teams, that may make them particularly vulnerable to the risks of being subject to the processes of projective identification. Firstly, the length of time they spend in close proximity to the young people (Adshead 2002). Secondly, that they also share something of the young people's experience (symbolically), in that they are not able to freely come and go from the ward environment in the same way as other MDT members. Thirdly, that being responsible for maintaining observation requirements may inadvertently exclude them from some decision-making arenas (Musto & Schreiber 2012). As a result, the nursing team too know something of the incarceration, restriction and disempowerment that is inherent in the setting for young people.

Against this backdrop, the study identified a number of parallel processes between the ways in which the patient group's difficulties manifest and staff responses to the demands placed upon them:

1. Anxiety can drive control and dominance as mechanism to try and assuage distress. Nursing staff may tend towards more restrictive practices to maintain safety; other members of the MDT may tend towards trying to direct nursing care.
2. Envy can lead to splitting and feelings of resentment towards the 'other'. For young people the focus is on other young people who may seem to be getting a

better deal. For nursing staff this may be directed towards other members of the MDT or between health care assistants and qualified nursing staff.

3. Identification with neglect and deprivation: staff levels of sensitivity to perceived deprivation of care from their management team or the organisation were noted to be higher when the level of experiences of maternal deprivation in the patient group was also observed to be high.
4. Identification with the aggressor. In the young people this was expressed through violence to self and other. For nursing staff this manifest as feeling responsible for young people's distress, its exacerbation, or experiencing worries about doing harm.
5. Demands placed upon staff by high levels of enhanced observations at times of high acuity can lead to staff worries about, or actual reductions in, the degree to which young people's needs are attended; mirroring their past experiences of carers whose own difficulties may have diminished their capacity to attend to their children's needs.

Staff support needs

Findings show the importance of 'decoding' or 'sense making' to support staff sense of relational security, self-esteem in relation to effective fulfilment of their role and positive conceptualisations of the children in their care. This is just as 'decoding was identified by Foster & Smedley (2019) as an important nursing intervention to assuage young people's frustration and reduce employment of infantile defence mechanisms.

It is argued that knowledge and understanding of the ways in which the psychological processes of Identification with the aggressor or with neglect and maltreatment can play out in parallel process between the nurses and young people is an essential requirement of anyone providing support for nursing teams in this setting. Analysis of the work discussion data showed a strong staff commitment to trying to understand all aspects of the young people's presentations. However, on occasions when a young person's presentation fell outside of a personal or collective framework for understanding, it was observed that staff were more likely to fall back on more concrete, behavioural or judgemental attributions to make sense of what they were seeing (e.g. attention seeking, doing it on purpose), or to express feelings of being intentionally targeted by young people. Similarly, counterintuitive MDT clinical-decisions, where a rationale was either perceived to be missing or to be opaque, were much more likely to activate persecutory anxieties that the decision represented a lack of care for the nursing team, on behalf of the rest of the MDT.

Non or mis-recognition is understood as a universally troubling experience with the potential to activate primitive anxiety states (such as fear of persecution and annihilation) in us all, and creates an absence in which fantasy can grow (Mitchell 1998). A key finding of this study is the need to maximise access to the rationale for clinical decision-making, not just the outcome, to all parts of the nursing team including the unqualified staff. This includes the importance of providing knowledge and training, particularly for health care assistants who do not always have a background knowledge or training in mental health, regarding psychological ways of understanding symptoms of mental health disorders in young people. Difficulties in understanding 'what is wrong' was identified as a significant precipitant of frustration, and of its corollary, negative attributions towards the patient as a means of defending against it). Increased education and involvement in shared decision making has been shown to development of emotional resilience in staff that reduces the need to rely on such defences (Edward et al. 2017).

Noticing and naming what nursing is

The nursing team's capacity for persistence and tenacity in the face of highly disturbed behaviour with no certainty of improvement and the seemingly impossible help me/don't help me conundrum that many of the young people's behaviour engenders, was identified as a significant contributor to young people's care. It was also shown to be available as a psychological defence against pain that could blind the nursing team to an understanding of the exact nature of their work. Just as the experience of good-enough care can put young people in touch with feelings of rage, pain and humiliation in the knowledge of what they have previously been deprived (Kenrick 2000), for staff, reflecting on what they have done well was identified by some as putting them in touch with feelings of loss for the young people who have been discharged. Avoiding preparing for endings, not talking about what has passed and always focusing on what is next, were observed to be elements associated with the pace of the PICU setting that were also available to staff as a means of defending themselves against the feelings of loss. Whilst focusing on the present or the immediate future can be seen as highly functional in a setting of such clinical acuity, lack of reflection upon the nursing team's strengths and successes also comes with the risk of leaving its members unsure of their contribution and more prone to feeling depleted.

Providing and placing value upon the intense emotional, relational and attachment-focused interventions elaborated on in this study (Foster & Smedley 2019), that make up the 'What' of adolescent mental health nursing, may be particularly difficult for nursing staff working with acute psychiatric contexts which still tend to privilege biomedical understandings of mental distress and undervalue the contribution of affectively attuned care giving to patient recovery (Schuengel et al. 2010). Within the content

analysis, the impact of a more medical model of understanding mental illness and of the clinical task of the unit could be seen in the degree of uncertainty and diversity of views held by staff members about the extent to which fostering helping relationships and attachments with the young people could be helpful or harmful. Staff expressed being unsure about whether the relationships they forged, and the emotional labour they undertook within these relationships were a legitimate and contributory factor in a young person's recovery journey.

Whilst there is evidence in the literature that in specific cases, or when poorly managed, attachment bonds developed with staff in mental health institutions can be harmful to young people (Schuengel & Van Ljzendoorn 2001), contemporary attachment research has also highlighted the important function of attuned carer responses in the development or re-establishment of the child's own emotional regulation capacity (Schore & Schore 2014). One way of supporting adolescent nursing teams to be more intentional and confident in their use of the attachment-informed interventions identified in this study could be through the introduction of frameworks to outline the characteristics of a milieu that can function as a secure base for all young people and support decision-making about when and how to use more explicit attachment relationship-based interventions (Schuengel & Van Ljzendoorn 2001). In the organisation in which this study was undertaken, the findings have been used to inform the development of staff training for all its child and adolescent services, which specifically includes understanding attachment and nurture-focused approaches as essential components of mental health care provided to young people.

Synthesis of findings: a model of CAMHS PICU mental health nursing

Based on analysis and synthesis of findings from the study presented in this paper and in Foster & Smedley (2019), a model of the way in which nursing interventions and nursing team identity emerge and are maintained within the CAMHS PICU setting is proposed (Fig. 2).

It is asserted that the tensions identified (Foster & Smedley 2019, fig. 1) are a manifestation of the specific difficulties with which the young people present and of the complexities that caring for these within the environment creates. That is, the task of enabling developmental growth and reparation for young people who are experiencing acute psychiatric disturbance during a critical phase of their maturation, often against a back drop of neurodevelopmental challenge and/or chronic adversity and complex trauma, within a restricted physical environment that cannot avoid carrying echoes and shadows of prior traumas endured by the young people.

The specific nursing interventions identified within this study (Foster & Smedley 2019, fig. 2) are understood to be conceived by the mutually constitutive elements of which the tensions are made, and the requirement to occupy all of them, all of the time. These tensions can never be resolved. The proximal relationship between the two elements of each tension can only be understood and an optimal position, in which the two elements must be held in relation to each other, continuously strived towards.

The nursing task is fundamentally relational and developmental in nature. It requires explicit engagement with the young person's attachment and dependency needs and

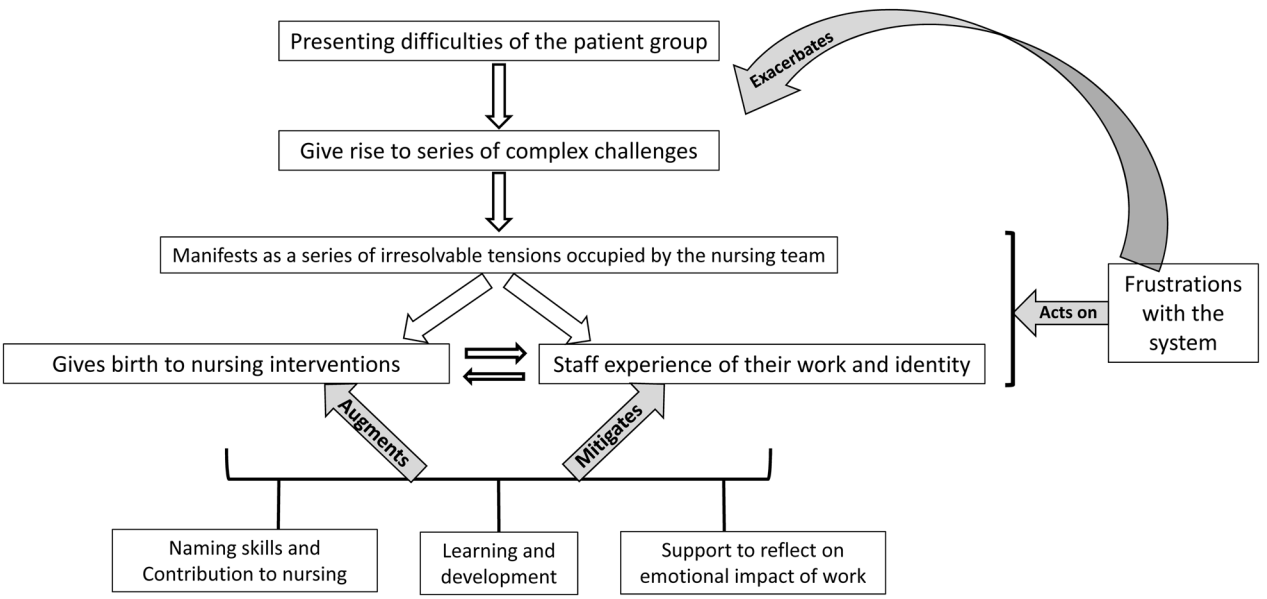

Fig. 2. A model of mental health nursing in CAMHS PICU.

has to be carried out in the face of personal, interpersonal, group, clinical, organisational and environmental pressures, pushing the nursing team towards one direction or the other.

Nursing team identity is therefore shaped by the experience of two forms of emotional labour: acting as a collective container and sense-maker for the indirectly transmitted emotional components of young people's communication (projective identification) and doing so whilst continuously residing within a state of tension. The result of which is that the factors that enhance or impede recovery are often two sides of the same coin; i.e. the emotional toll of the unrelenting nature of the nursing interventions required actively serves to corrode or undermine staff capacity to keep going with these interventions.

Supporting nursing staff with the process of naming their work and contribution to care, with opportunities for learning about underpinning theory and evidence to help make sense of theirs and the young people's experiences, and with access to supported reflective space in which to think together about their work, can contribute to helping the nursing team sustain themselves.

A more rigorous and systematic qualitative evaluation of the impact of the facilitated work discussion group is currently under way.

Conclusion

Just as much of the young people's emotional and cognitive disturbance is expressed in the way they behave, leaving the staff with the task of trying to decode the meaning of their behaviour, the findings of this study show how much of the psychological nursing intervention is also hidden in affective processing and non-verbal responsiveness or embodied in 'the doing' of practical but symbolically representative tasks, making it hard to see.

It has been said of primary carer–child relationships, of which this study has shown mental health nursing in CAMHS PICU is a high complex derivative, that '[carers] live in a universe that has not been accurately described. The right words have not been coined' (Stadlen 2005). Similarly, within nursing theory there is a tendency to identify the therapeutic relationship as an essential prerequisite, which once established is the vehicle through which clinical treatments are effectively delivered, rather than it being *the treatment*, meaning that it also is without a language with which it can be accurately described.

Within psychoanalytic theory there is an inherent and specific language available for naming the detailed work involved in interpersonal encounters and relationships. It is hoped that bringing this language to bear on the observation of mental health nursing practice within CAMHS PICU that it has gone some way to starting a much richer conversation about the profound contribution of mental health nursing to the recovery of young people in this unique care setting, and to coin the significant and specific impacts that providing this care has on professional identity and personal wellbeing for members of the nursing team.

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Investigating the impact of a psychoanalytic nursing development group within an adolescent psychiatric intensive care unit (PICU)

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A B S T R A C T

Objective: To evaluate the impact of an adapted psychoanalytic work discussion group for mental health nurses working in adolescent PICU.

Background: There is no prior research investigating interventions that effectively support and enable adolescent PICU nursing teams to sustain the therapeutic tasks of their work and their own sense of wellbeing.

Methods: A bespoke psychoanalytic work discussion group was implemented within an adolescent PICU. Data was collected using in-depth semi-structured interviews with participants, about the impact of the group upon their practice. Data analysis used thematic analysis.

Results: The group positively impacted upon participant knowledge and understanding, emotion management, personal efficacy, therapeutic relationship building, managing challenging behaviour, leadership, professional identity and team cohesion.

Conclusion: Mechanisms by which these outcomes were achieved are elaborated utilising the concepts of projective identification, emotional containment and 'temporary outsider-ship'. There is a need to account for the interplay between adolescent defense mechanisms, nursing anxieties and setting-specific organisational dynamics, in the design of effective support interventions for adolescent mental health nurses.

Background

The World Health Organisation (WHO, 2015) has identified the care of adolescents as a distinct specialty. Internationally, inpatient units are the most widely used element of acute adolescent mental health services (Hayes et al., 2017). Inpatient mental health environments that provide care for adolescents are unique and demanding care settings (Matthews & Williamson, 2016), which can engender significant moral distress in staff (Musto & Schreiber, 2012), contributing to burnout. The challenge for staff is related to the two-fold task of adolescent care: treating and managing the young person's presenting mental health disorder at the same time as supporting normal adolescent development, which has often been delayed and disrupted by those mental health difficulties (Kahila et al., 2004).

Psychiatric intensive care units (PICU) provide short-term care for people with acute and severe mental health needs, typically associated with high levels of risk of aggression to self and other (Foster, 2018). The care of service-users who present with high levels of violence is known to be complex, often provoking difficult feelings and contributing to negative work experience (Sondenaa et al., 2013). Nursing staff working in PICU have been identified as being at particularly high risk of emotional strain and burnout (Johnson, 2012).

Adolescent PICU services are at the intersection of the specialties of adolescent inpatient mental health care and PICU. Adolescent PICU environments are known to provide for a population with more diverse and complex presentations than either general adolescent psychiatric inpatient units or adult PICUs (NAPICU, 2015). Discharge pathways are more challenging and result in longer admissions (Jasti et al., 2011).

Understanding and preventing burnout in staff is important. It is associated with indifferent and hard responses towards patients, a reduction in staff mental wellbeing (Coetzee & Klopper, 2010) and has been shown to impact negatively upon the delivery of healthcare services (Sinclair et al., 2017). Yet there is no research investigating interventions that effectively support and enable mental health nursing teams working in adolescent PICU to sustain the therapeutic tasks of their work, and their own sense of wellbeing (Foster & Smedley, 2019b).

At the heart of sustaining the therapeutic task of mental health nursing is the concept Emotional Labour (Delgado et al., 2017). Emotional labour is the effort consumed by suppressing one's own emotions to care for others effectively whilst also caring for oneself (Edward et al., 2017). Edward et al. (2017) found that investment of emotional labour in mental health nursing is double faceted. It is a requirement for promotion of growth and satisfaction for both clients and staff, but it also contributes to staff burnout and attrition. Furthermore, that the mitigating factor between these two positions is emotional intelligence. In the context of adolescent mental health care provision in PICU settings, emotional intelligence must necessarily include awareness and

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understanding of the dynamics of emotional containment within attachment-like relationships, and a capacity to sustain 'thinking under fire'. Therefore, staff require support that permits expression of concerns in a supportive environment (Edward et al., 2017), as well as opportunities for learning and for developing psychological capacities to help them manage the specific demands of the work (Winship et al., 2019).

Work Discussion is a psychoanalytic model for delivering a specific form of reflective practice groups. Work discussion originated as a means of providing psychoanalytic perspectives for professionals for whom psychoanalysis is not their primary training (Rustin, 2008a). Psychoanalytic work discussion groups (PWDG) span the boundary of staff support and staff development. The focus is exclusively upon the emotional dynamics of the experience of work. As such, they provide a mechanism for support, whilst also working as a pedagogical approach to promote understanding of one's own emotional processes and the emotional processes of others (Datler et al., 2018; Winship et al., 2019).

PWDG are externally facilitated by someone with psychoanalytic training and psychoanalytic praxis is the primary model of engaging the group in shared thinking (Jackson, 2006). This includes setting an emotionally containing structure/frame around the group in order to hold strong and potentially distressing emotions, the application of psychanalytic theory to make sense of and work through clinical experiences, and the use of facilitator observations and interpretations regarding conscious and latent communications and group processes that hold important clues for understanding the care needs of the young people. Participants are invited to think about their work role and undertake a detailed reflection upon their experience, with an expectation that learning from this process can be applied back to work. Central to this process, group members are required to provide a detailed account or observation of their work for discussion, as part of the aim of PWDGs is to support participants to increase the range of what they notice in patient interactions (Rustin, 2008a). The focus of discussion is therefore generated by the preoccupation of attendees rather than pre-selected.

There are several arguments for the relevance of psychoanalytically informed support and development interventions for adolescent PICU nursing staff. Mental health nursing work can be described as fundamentally psychodynamic in nature (Gallop & O'Brien, 2003). Nursing staff provide emotional containment of distress, make emotional and psychological sense of what patients are doing and restore purpose (Flynn, 1998). Central to this process is the belief that change occurs within the quality of the relationships and relational environments that nurses forge (Delaney, 2017; Peplau, 1952). Nurses in hospital settings develop a uniquely detailed sense of the people they care for based on what it 'feels like' to be in their company (Foster & Smedley, 2019a). However, this knowledge is often tacit or embodied rather than articulated through language. Psychodynamic group facilitation applies theories, language and interpersonal techniques that can help to name and make use of this unique knowledge.

Winship et al. (2019) and Ruszczynski (2012), argue that PICU and similar restrictive environments require staff to have training to understand the unconscious processes to which they are subject. This is due to the very high level of childhood adversity, abuse and boundary transgression that the population admitted to intensive care, or other secure psychiatric environments, carry with them (Ruszczynski, 2012).

Similarly, working with adolescents has been noted to be distinct from providing mental health and psychotherapeutic intervention to other groups across the life span (Waddell, 2018). High levels of emotionality, reliance upon body-based solutions to psychological conflict, and a developmental tendency towards doing rather than thinking, combine with reworking of much earlier infantile experience, in the pursuit of independence and identity formation. The result is that much of the interpersonal communication that occurs between adolescent patient and worker is via non-verbal, unconscious mechanisms (Briggs, 2008; Waddell, 2018). The application of psychoanalytic technique with staff groups, utilising the concepts of developmental object relations and projective identification, can help to give voice to this unspoken form of communication and support staff to develop intentional interventions and therapeutic responses to young people (Ruszczynski, 2012; Winship et al., 2019).

Psychoanalytic work discussion groups (PWDG) have been shown to be a helpful and effective forum for education and social care staff working with distressed adolescents in non-hospital settings (Briggs, 2009; Ellis & Wolfe, 2019; Jackson, 2008; O'Sullivan, 2019). A qualitative evaluation of their impact for staff working with young people in a community setting found attendee-perceived improvements in positive management of stress, understanding of, and confidence to respond to, challenging behaviour (Warman & Jackson, 2007). Therefore, the literature suggests that PWDGs could be useful for nurses working in adolescent PICU and that they have the potential to provide a mechanism for staff development and support. However, this has not yet been tested or evaluated.

Johnston and Paley (2013) have highlighted that significant adaptations technique are required to implement psychoanalytic reflective practice groups in inpatient settings. These are needed to manage cultural differences between the disciplines of psychotherapy and mental health nursing, and to accommodate the impact of the inpatient environment. In addition, there have been calls to find ways to move beyond descriptive single case study approaches for reporting on the effects and potential benefits of PWDG (Datler et al., 2018). This requires research methods that can be sensitive to capturing the intensely subjective nature of work discussion groups, whilst also adhering to the characteristics of evaluative research that ensure rigour and objectivity (Elfer et al., 2018). There is little research in existence that focuses on the experience of PWGD participants (Thomas & Isobel, 2019) and no research that focuses on PWDG or other forms of reflective practice group within Adolescent PICU settings. This study seeks to address these gaps in the existing literature.

Study aims

The study aimed to implement and evaluate an original psychoanalytic work discussion group intervention, to meet the needs of nursing staff within an adolescent PICU setting. The purpose of the study was to:

- Articulate the adaptations needed to PWDG method for the specific context of Adolescent PICU
- Evaluate the experience of group participants.
- Investigate its impact upon them and their practice
- Understand the elements of the intervention that contributed to any reported positive experiences and outcomes.

Methods

Design

The study used a cross-sectional, qualitative non-experimental design with a purposive sample. The evaluation took place when the PWDG had been running for 6 months. It was the qualitative arm of a larger mixed methods study that included a quantitative investigation of professional quality of life within adolescent PICU (Foster, 2018), and a conceptual analysis of the nature of mental health nursing within adolescent PICU settings (Foster & Smedley, 2019a, 2019b).

Setting

The research took place in an Adolescent PICU in the North of England. This was a mixed sex service providing services for young people aged 12–18 years, from across England and Wales.

Intervention

The intervention was an adapted PWDG. It was named the Nursing Development Group (NDG) to denote its adaptation and to communicate to participants that its intention was beyond solely providing staff support. The NDG met once a week for 1 h. It took place immediately after the morning nursing handover and breakfast was provided. The facilitator was an adolescent psychotherapist and experienced child and adolescent mental health nurse. It was open to all members of the nursing team (qualified and unqualified) who were not required on the ward at that time to meet the minimum clinical observation levels.

Aims of the Nursing Development Group:

1. To develop the capacities of the nursing team to utilise their observational skills and reflection upon their own emotional experiences as a means of deepening their understanding of, and their capacity to collectively manage, the complex behaviours of their patients
2. To contribute to the prevention of staff compassion-fatigue and burnout, by providing psychological support in relation to the psychological disturbance and violence to which they are subject.
3. To enable the nursing team to articulate their discipline expertise, values and team identity

A central foundation of psychoanalytic reflective practice facilitation is the suspension of judgements of good and bad. In setting the frame for the group, the facilitator role to communicate and embody a position that all emotion and action from both parties within staff-adolescent dyads is information - what matters is to explore with an open-minded curiosity the underlying meaning and drivers. The facilitator's focus was on application of developmental and psychoanalytic theory and engagement techniques, to support shared thinking and the development of a collective understanding of the young people and the dynamics within the ward. This included the underlying function of young people's more challenging behaviours; the relationship between their presentation on the ward, their life experiences/stage and psychological formulation; reflection upon skills and interventions implemented by the team that have been successful; and the impact of the young people's difficulties upon team dynamics.

Adaptations to the PWDG model: Typically, within the PWDG model facilitators will provide verbal interpretations to help members feel their indirect needs are heard and understood. Foster and Smedley (2019b) outline how the 24-hour cycle of care, lack of freedom of movement from the clinical area, and the prolonged close proximity with disturbed young people that are associated with adolescent PICU, can leave nurses vulnerable to feelings of deprivation and neglect and to concrete identification with adolescent states of mind. This can include a sensitivity to injustice and a tendency towards 'acting-out' rather than 'thinking about' (Foster, 2009). To address these issues in direct work with adolescents, the provision of emotional containment comes from using seemingly everyday aspects of care to speak to and symbolically represent/fulfil aspects of their fundamental underlying needs that "as yet have no words" (Alvarez, 2012). In a parallel process, a number of adaptations were made to the work discussion group structure and facilitator behaviour to attend to this phenomenon in the staff:

The timing of the group was selected to acknowledge that the nursing team are working before and after the rest of the MDT's working day. It was also the quietest point of the shift to maximise the number of staff that could attend. The provision of breakfast was intended to symbolise a responsiveness to the nursing staff's own needs for care and nourishment. In recognition that not all the nursing team were able to attend the group each week, breakfast was provided for all staff on shift, not just those who attended.

Before commencement of the group, the team expressed their worries about their needs being neglected or not understood as a pessimism about the group's sustainability and the facilitator's commitment. On this basis, an intentional facilitator response was planned for days when the group could not run due to staff difficulties attending at times of high clinical acuity or staff shortages. The facilitator would go on to the ward for the usual period of the group, using the time to provide breakfast and individual contact with each member of the team. This was intended to maintain facilitator visibility, and to symbolise care and appreciation for the adversity that the team were facing.

Usually, within PWDGs participants take turns to bring a detailed written account of an element of their practice (Rustin, 2008a). In recognition of the unending demands of patient observation upon the nursing team's time, this was not required of the NDG participants. Instead, at the commencement of each group they were invited to reflect on the last week and identify pressing issues that came to mind and select an issue common between them. Members were then asked to individually speak to their experience of the issue, to develop a detailed collective narrative, highlighting commonalities and points of difference.

The cultural difference between psychotherapy and nursing, and adulthood versus adolescence, can be crudely characterised as the difference between prioritising 'thinking about' and prioritising intentional action or 'doing'. Focusing on pragmatic action-focused solutions is also a mechanism by which nursing teams defend themselves from being overwhelmed by the distress and disturbance to which they are subject. This can lead to active resistance to exploring underlying meaning and feeling (Foster, 2009). Group facilitation therefore employed a scaffolding process to try to bridge the gap between 'thinking about' and 'doing'. Towards the end of the group, participants were invited to think about the practical implications of their discussions for their practice back on the ward. This was intended to help participants see the value of exploring the emotional content of their work and to also provide a transitional space, in which the defences needed to return to the clinical area and complete their shift could be re-engaged. Unlike a traditional PWDG, the NDG also had an explicit aim of articulating the skills and strengths of the nursing team. This was intended to address findings from research in Adult PICU that nursing staff found it difficult to name what they "did" and "how" they "did it"? (Ward and Gwinner, 2015).

Evaluation process

Sample

Qualitative data was collected from a sample of the entire staffing complement of qualified nurses and healthcare assistants (HCA), working in an Adolescent PICU Unit in the North of England ($n = 22$). All staff members on the unit had attended some NDG groups over the six-month period on average individual staff attended once or twice a month.

Based on the focused nature of the study aims, specificity of sample, interviewer experience and intention to use questions that generate shadowed data (Morse, 2001), a purposive sample of 6–10 interviewees that reflected the diversity of roles within the team was identified in advance as needed to provide sufficient information power to address the research aims (Malterud et al., 2016; Morse, 2000, 2001). A total of seven members of staff (32% of the total group participating in the intervention under investigation) consented to participate and were interviewed. The sample represented all components of the nursing team complement, in proportions that approximated the make-up of the team. There were 3 HCAs; 1 preceptee nurse; 1 experienced staff nurse; 1 senior nurse and 1 HCA employed through the nursing bank, but who worked on the ward on a regular basis.

Ethical considerations

The University Ethics Committee (HSCR14/19) and the Research Governance Committee of the participating healthcare organisation

Table 1
A priori coding framework.

Code 1	**Label**	**Group characteristics**
	Definition	Elements of group identified as helpful/unhelpful
	Description	Process, content and structural issues
Code 2	**Label**	**Experience of group**
	Definition	Subjective evaluation of individual experience of participating in the group
	Description	Account of being in the group, the nature of the group and thoughts and feelings about the group (good and bad)
Code 3	**Label**	**Effect of group**
	Definition	Perception of characteristics of ways in which helpful elements of the group have affected the individuals and the wider team
	Description	Includes learning, awareness, understanding and behaviours
Code 4	**Label**	**Impact of group**
	Definition	The ways in which data under 'effect of group' is understood by participants to have impacted on how they think, feel, behave in relation to their work role
	Description	Individual and group
Code 5	**Label**	**Limitations**
	Definition	Constraints, drawbacks, understanding of negative elements
	Description	Includes barriers, challenges, problems and suggested solutions/improvements
Code 6	**Label**	**Other**
	Definition	Any emergent codes from the transcriptions, not covered by the a priori codes

(non-NHS) granted ethical approval. All those who chose to participate provided informed consent. Participants were informed of their rights in respect of voluntariness, information access and that data would be stored securely and anonymously in accordance with data protection regulations. There was no identifying patient material included in the study. Material regarding specific clinical issues and service users discussed were anonymised, with staff and patient identifiers removed.

Data collection

Data was collected through in-depth semi-structured interviews. Interviewers were independent of the work discussion group intervention to maintain rigour and reduce bias. However, interviewers were also experienced mental health clinicians in the field, with detailed understanding of the context and intervention being evaluated. This was intended to improve interview dialogue quality - one of the dimensions that is known to decide interview data quality and usability (Malterud et al., 2016).

The fundamental question in evaluative research is "has the intervention achieved its anticipated goals?" (Bryman, 2004). The interview schedule was therefore informed by the stated aims of implementing the Nursing Development Group.

In keeping with the requirement for semi-structured interview questions to be sequenced to support progression through to full elaboration of the subject under study (Galletta, 2013); the sequence of questions was informed by the domains outlined as significant in King's (2014) Professional Development Impact Evaluation Framework. This progresses from 'experience' to 'learning', to 'into practice' (behaviours and outcomes).

The interview schedule was structured around exploring participant perception of: 1) experience of the group (positive and negative); 2) effects of participation on their thoughts, feelings and behaviour; 3) impact of group participation at an individual and team level; 4) characteristics of the group that were helpful or facilitative of any perceived effect and impact; 5) limitations/ways in which the intervention could be improved. Interviews were digitally recorded with participant consent and transcribed verbatim.

Data analysis

Interviews were analysed using thematic analysis. A hybrid inductive/deductive coding method outlined by Fereday and Muir-Cochrane (2006) was employed utilising cross-case analysis. The choice of analytic method was underpinned by the fact that the research aim was realist and evaluative in nature, focused on answering questions about perceived effect and impact. Utilising an entirely inductive approach to understanding emerging phenomenon would therefore be disingenuous, as a structured approach for summarising and organising features of the data that relate to the research questions was required (King, 2004; Nowell et al., 2017). At the same time, the study was exploring a previously unexamined area, so capturing all aspects of participant experience was also important (King, 2004).

A data-driven approach was employed to initial coding, in order to understand and 'safeguard' participant perspective and insights. (Fereday & Muir-Cochrane, 2006). Prior to commencing initial coding, an a priori coding framework was created to facilitate second level analysis of initial coding, in order to answer the evaluative research question (Fereday & Muir-Cochrane, 2006). Both data-driven and a priori codes were reported.

Process for establishing trustworthiness

Whilst it is not possible to eliminate subjectivity within qualitative data analysis methods, adhering to principles of being systematic, transparent and reflexive can ensure rigour within the process (Elfer et al., 2018). To this end a research plan outlining all data sources was constructed. The facilitator of the NDG was not involved in the interviewing process. An archive of all data and full descriptions of the approach to analysis was created. A record of personal reflections and notes was kept through the coding and data analysis process.

The process and steps for establishing trustworthiness as outlined by Nowell et al. (2017) were followed. The thematic analysis was undertaken by one researcher. The researcher familiarised themselves with the whole data set, by reading all transcripts documenting theoretical and reflective themes and thoughts about themes. An a priori coding framework (Table 1) was developed and tested against case (interviewee) one. Initial coding was undertaken on a case-by-case basis. This was followed by cross-case analysis (to identify transferability of codes), with a clearly documented process for audit purposes (dependability). Themes were identified and detailed process notes re: relationship between concepts and themes were kept. Themes were then reviewed by test for referential adequacy (credibility), i.e. that they were clearly aligned to the raw interview data. Initial themes were triangulated utilising findings from the quantitative and content analysis arms of the wider research study (Foster, 2018; Foster & Smedley, 2019a, 2019b), and the NDG facilitator's reflective notes on the process. Themes were then defined and named, and a peer internal verification process was undertaken by a person independent of the PWDG and of the data analysis process (Confirmability). Findings are reported in line with the COREQ checklist for reporting qualitative research (Tong et al., 2007).

Findings

Elfer et al. (2018) assert that for PWDGs to become established evidence-based interventions, analysis of potential causal relationships between intervention and outcomes is needed. In line with this, findings

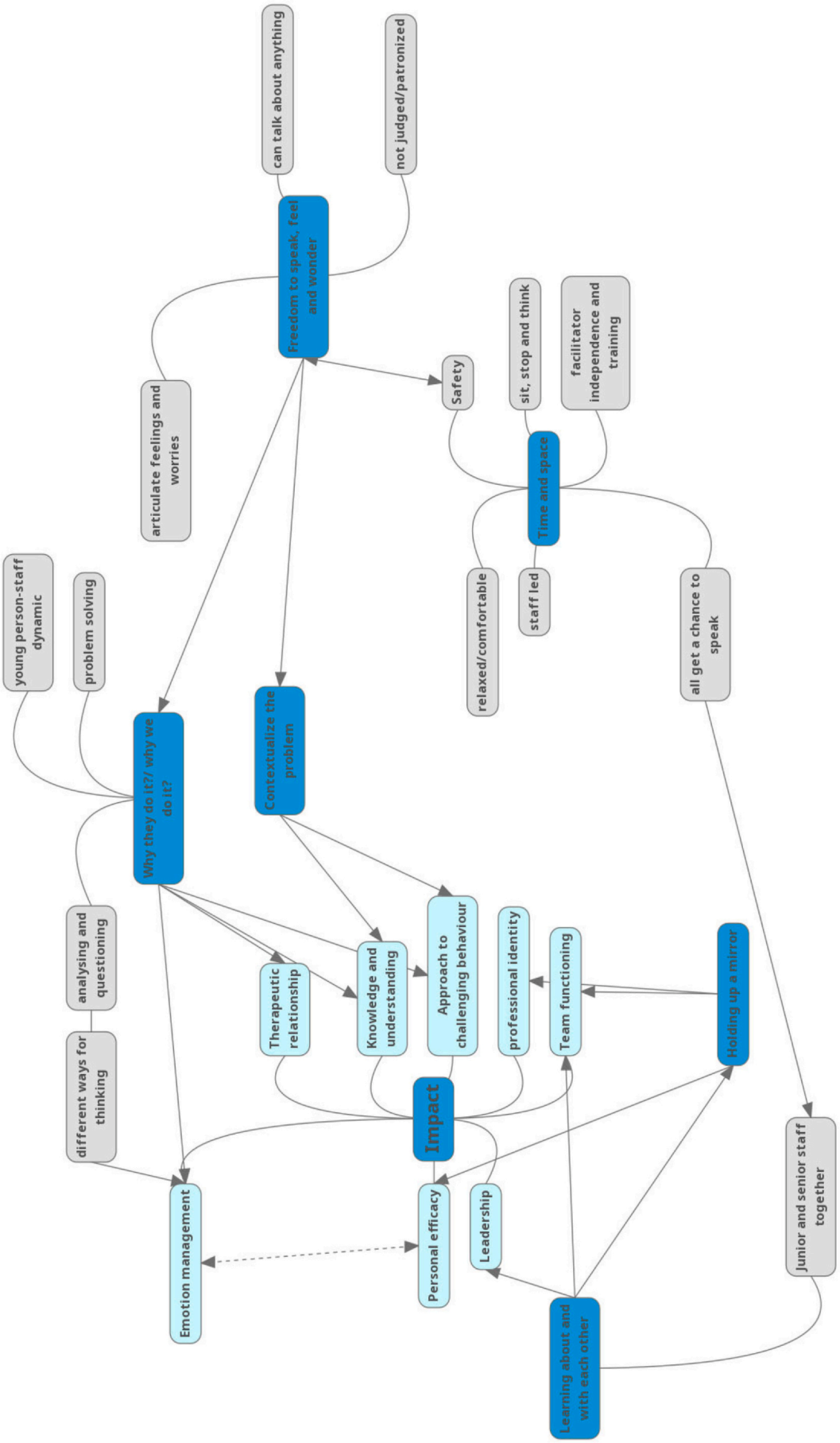

Fig. 1. Schematic map of relationship between outcomes and elements of the group process that led to the outcomes.

Table 2
Impact of the nursing development group.

Knowledge and understanding	Emotion management	Personal efficacy	Therapeutic relationships	Challenging behaviour management	Leadership	Professional identity	Team functioning
Improved knowledge and understanding of individual young people	Can identify and name sources of frustration x2	Feel more prepared for working with patients	Developed a service-user perspective (empathy) x3	Think about my impact on the young people and alter approach x2	Helped me talk more confidently with HCAs	Makes us realize the importance and value of our job x4	Improved team cohesion x
Helped me work with specific problems/conditions (e.g. trauma and dissociative symptoms) x2	Less tendency to enact frustrations towards the young people	More understanding of how to deal with young people on a day to day basis	Improved communication	Thinking about why we do things has made me consider alternative ways of doing things x2	Helped me help new staff to understand underlying issues	Helps you feel value you yourself more x2	More shared understanding between team members x4
Increased knowledge and confidence of working with adolescence x3	Perspective taking. Take a step back when I get wound up	Helped me to have confidence	Positively changed my perception of young people that I have found difficult to nurse x2	I say 'lets' talk' instead of 'stop doing that'	Greater appreciation HCAs; working more to empower them	helps you feel like you are making a difference x3	Team approach is streamlined
Understanding dynamics between young people and staff	Think about 'why?' before I act on my feelings x2	I feel more positive	Improved relationships with young people x2	Try different tactics, using light and shade – if normally I am firm, I try being a bit softer	Recognition of responsibility as staff nurse to lead by example	Makes a difference to the way you feel about your job x2	Between PWDG staff more likely to explore ideas together before acting x2
Extended practice from use of nursing process to manage the 'here and now', to incorporating young people's broader needs	Used to distance myself from emotion – now I try and embrace it a little more		Engagement with the young person as 'belonging to someone' –builds trust and reduces staff v patient dynamic	Staff articulate their frustrations and the source of them, instead of acting it out		Given me a sense of pride	Use insights from the group whilst on shift x2

are organized by outcome focussed impact statements, followed by explanatory pathways or mechanisms of impact and then limitations or areas for improvement. Fig. 1. provides a detailed outline of the domains of impact. Table 2. provides a schematic map to illustrate the iterative relationship between the impact themes and the themes that describe elements of the group structure, process and content that underpin those impacts.

Impact

Eight domains of impact were identified: 1) knowledge and understanding; 2) emotion management; 3) personal efficacy; 4) approach to challenging behaviours; 5) therapeutic relationship with the young people; 6) leadership; 7) professional identity; 8) team functioning.

Pathways to impact

Six inter-related themes were identified relating to characteristics of the group process that contribute to participant experience and outcome. The themes identified were: 1) time and space; 2) freedom to speak, feel and wonder; 3) contextualising the problem; 4) why they do it/why we do it? 5) learning about and with each other; 6) holding up a mirror: helping us see our work.

1) Time and space

This theme describes the characteristics of the group frame, structure and facilitation, that participants identified as enabling engagement. Overwhelmingly participants reported that the group provided space to stop and think. Space referred to both practical elements and the setting of a relational environment that promoted thinking and reflection.

Within the setting, clinical close observation practices meant that staff time was often organized into five- or fifteen-minute segments. An uninterrupted hour of group time was in stark contrast to everyday life on the ward. For almost all interviewees, the 7:45 am timing facilitated this thinking space as the ward was quieter with less disturbance and interruption.

> "*you know, having time to sit down for an hour at the start of the day, because, I think it starts you off really well, it gets you thinking.*" (*P7*)

However, one participant also recognized the challenge of this timing:

> "*It was challenging in the fact that it was first thing in the morning. There is very little time otherwise, so it was the ideal time, it was just a challenge!*" (*P3*)

A balance between being relaxed and productive was highlighted as important by four interviewees. Feeling welcomed and settled into the group at the beginning facilitated engagement and group productivity.

> "*it is quite informal which is nice, but at the same time it is quite productive*" (*P1*)

> "[*The group*] *is quite relaxed and you feel comfortable to speak about whatever is bothering you…* [*The Facilitator*] *makes you feel at home and relaxed and calm*" (*P5*)

Several interviewees perceived that the participant-led approach to identifying the focus of discussion was an important facilitating factor.

> "*The model of the group was really helpful…staff were encouraged to bring up what they wanted to talk about. And then that would lead to a wider discussion regarding a particular topic…it would lead other members of staff to give input and their opinions and from that we'd build more of an understanding of the things that were going on.*" (*P4*)

Participants liked the equal status of group members.

"[*The facilitator*] *would chair it essentially, there was no hierarchy or line manager or 'this is what goes'. It was all listening to each other, listening to what we all had to say and then talking about it.*" (*P2*)

Group and facilitator reliability were highlighted as a positive feature which contrasted with previous staff support groups that had been trialed.

"*I've been here seven years and it's been up and down… sometimes we'll have loads of support and then sometimes very minimal. So, to have that on a regular consistent basis helped a lot*" (*P2*)

"*Having it on the same day every week…because I know* [*the facilitator*] *will be here and we will have breakfast…I know that if I have asked for things at the end of the group* [*the facilitator*] *will bring them next week*." (*P5*)

Facilitation by someone external to the organisation was important as it allowed for a level of impartiality and intersubjective distance; providing a sense of safety for the staff to be able to speak frankly about their feelings and experiences.

"*Because they are independent, people feel confident in speaking what they actually feel, rather than it being a manager attached to the ward*" (*P1*)

"*I think it helped, having someone you didn't really know, but felt comfortable enough to talk to.*" (*P2*)

Three participants specifically felt that facilitator dual-training as a nurse and a psychotherapist added value. This was expressed by participant 1 as '*they understand but see things differently*.'

"[*The facilitator*] *challenged our ways of thinking….it was welcomed – in an inpatient/nurse environment it is very easy to get stuck within the nursing model.*" (*P3*)

2) Freedom to speak, feel and wonder

This theme reflects the ways in which the group process combined with the characteristics described in theme 1 to create a sense of safety and containment. In turn this was described by participants as enabling a level of freedom and creativity within the group's thinking processes.

Participants reported feeling free to express themselves and talk about whatever was on their mind, especially, expressing underlying feelings and receiving support to explore those feelings safely. This contrasts with large swathes of the clinical day that requires mental health nurses to suppress and actively manage difficult emotions stirred up by nurse-patient interactions (MacLaren et al., 2016).

"*I think until we had the NDG there was a lot of personal feelings that staff had regarding certain patients, that were going unsaid and left underlying. I think people were of the impression that we need to keep that under wraps.* [*patients*] *stir up uncomfortable feelings or you are frustrated, it's like 'well we just need to get on with it because that's our job'. The NDG allowed staff to open up and go actually its ok to have those feelings, and more to the point, how do we address them and move forward*?" (*P4*)

Central to this was security in the idea of not being judged, which came through the way the group was set up "like brainstorming to help each other out" (P5) and through facilitator communication of some core group conditions:

"*It was never patronizing if you don't know something, you were never laughed at*" (*P2*)

"*The language of facilitator is accessible and relatable*" (*P5*)

Having chance to ask questions, that maybe other team members were thinking about too, was highlighted as an important opportunity that was not always afforded whilst on the ward.

"*It's alright if I don't know something, instead of* [*the ward*] *which is dead busy and some people don't want to ask questions, because they think other people are* [*too*] *busy*." (*P2*)

Some participants felt that having the chance to talk about how situations had made them feel and have the facilitator put their concerns into words, had helped to build confidence in the wider team to articulate how they felt, share struggles and manage frustrations outside of the group setting (P1, P3, P6).

The following themes of 'contextualising the problem' and 'why they do it/why we do it' refer directly to facilitation of discussions that enabled staff to see the relationship between current states of mind and behaviours of young people, and their early experiences. This was achieved through sharing pertinent elements of the young people's biographies and providing accessible explanations and applications of the concepts of object-relations, projective identification, transference and countertransference, adolescent defense mechanisms and attachment and internal machinations associated with specific mental health conditions.

3) Contextualising the problem

All participants felt that sharing information about the biography of young people in their care was an important aspect of the group, that brought about changes in how they thought about and interacted with them.

"*It helped staff get to a bit more about why certain kids were are with us, why they act the way that they act.… It is not always easy on a busy ward to try and read the notes and understand the history*" (*P2*)

HCA staff considered that access to this kind of contextual information gave them a better understanding of the young people and of the characteristics of different types of mental health conditions, supporting them to take a more service-user focused perspective in relation to difficult to manage patients.

For qualified members of staff, it was the chance for more in-depth reflection, combined with application of theory and evidence to help understand particular behaviours.

"*It has definitely helped me with looking at trauma….and with dissociation, I feel confident talking to people about* [*young person's*] *presentation and why they are presenting like that.*" (*P1*)

"*It keeps you remembering the evidence-base around things, rather than just: 'you do it because you do it'*" (*P7*)

4) Why they do it/why we do it?

This theme highlights that participants considered the focus on the intersubjective interactions in staff-patient dyad valuable, as opposed to a solely patient-focused discussion.

Participant 6: "*I think that was really positive about the group, that the focus was quite a lot on the team itself, rather than just the patients….I think it helped as well to think about how you are interacting with them, and what they might be getting back from what you are saying.*"

Most participants described how the group helped to enhance nursing formulation of the young people's issues, to include a focus on explanation rather than just description, identifying it as an important supportive element. This was described both in terms of having opportunity to use collective team knowledge of the young people to think about why they were behaving in particular ways, and to consider their own responses and practice as a staff group.

"*It gives you opportunity to think about why a particular person might be presenting that way.*" (*P1*)

"*The group has opened us up to a different way of thinking…to analyzing our work.*" (*P4*)

"*It's made me thing about things more. Think about why we do things? Thinking about other ways of doing things*". (*P7*)

One participant observed that the team's understanding of the dynamics and behaviours associated with adolescence had also improved.

"*It certainly benefitted me and other members of the team who don't have as much experience working with adolescents…. I'd go so far as to say I think the staff are more confident in managing some of the adolescent behavior*." (*P4*)

An example of this was given in which staff were struggling with a young person experiencing a psychotic illness who persistently claimed that they were in a sexual relationship with a well-known film action hero. This was understood initially by staff as an intentional deception that undermined how they appraised the legitimacy of the rest of her symptomatology. In the group, exploration of the young person's current peer-relationships on the unit, the emotional and physical changes of puberty associated with the young person's developmental stage of early adolescence and their prior history of sexual trauma, enabled the team to re-formulate their understanding. The team came to hypothesise that the confabulation may have represented a means of managing emerging feelings of desire towards a male peer that appeared to be reciprocated, defending her against potential anxieties that she may be vulnerable to unwanted sexual approaches from that peer. By understanding that the confabulation rendered the young person unavailable and under the protection of an omnipotent other in her own mind, staff members were able to alter their approach in the direction of conferring safety and giving the young person opportunity to express her thoughts and feelings about her relationship with the peer.

Understanding or working through 'why' something might be happening was reported to reduce feelings of frustration or 'being stuck', as application of new understandings provided new practical strategies for managing. For example, understanding underlying fears and needs that drive young people's threats of violence helped staff to de-escalate young people by naming and responding to the underlying drivers, rather than focusing on extinguishing the behaviour.

"[*The group*] *gets different things out of you*: *when we have all sat together and talked it out*, *we can think how we are going to manage it*" (*P1*)

"Problem solving" (P1), "generating new ideas" (P3), "responding to threatening and aggressive behaviour" more effectively (P7), and "having tools to work on setting up therapeutic relationships" (P5), were identified as outcomes of exploring what was happening underneath.

5) Learning about and with each other

This theme describes how participants felt that having all grades of nursing team members together was an important part of how the group brought about positive changes. Nearly all participants highlighted that it was something that did not happen on the ward often. The only other place where this would occur would be handover. Handover's focus is reporting of information to ensure safe care, rather than discursive.

Having different grades of staff together sparked more plural conversations and gave a seldom available chance to air and understand differences.

"*Because we had nurses*, *and HCAs and sometimes managers in there… because a nurse has a different view* [*of the ward*], *to the HCA*, *to the manager. So being able to talk openly about that…sometimes the managers might not have realized what we were having to deal with… I think it was just a circle where we're all learning from each other*." (*P2*)

Hearing all perspectives of the team was identified as helping to develop shared understanding of young people's needs and the care approach. Improvement in team cohesion and a more streamlined approach to care was attributed to this function of the group.

"*To be able to go through everyone's thoughts…being able to put it all together from different areas of the team. That really helped*". (*P6*)

This concept of learning by listening to each other, extended to learning about each other. Several participants reported developing a greater appreciation of individual team members knowledge and expertise. One staff nurse described the luxury of being able to talk with, rather than directing, the HCAs that she was responsible for leading.

"*Made me think about empowering HCA's*, *because*, *this isn't going to sound very nice*, *but I don't mean it to*; *sometimes when they speak I would be surprised at their level of understanding*, *and maybe more fool me that I didn't know that.. I'd think 'God*, *you are really good*!" (*P7*)

Although participants were keen to state that the team was supportive of each other generally, a number felt that increased empathy for how others were feeling enhanced their capacities to support them, and the feeling of being supported.

6) Holding up a mirror: helping us see our work

This theme reflects the element of the group facilitation process that participants felt improved team morale and attributed value to their work. That is being invited to notice and articulate their skills and contribution to young people's recovery, not just the challenges.

For some participants, the establishment of the nursing development group itself demonstrated appreciation of the nursing team's work and need for support.

For others being encouraged to reflect on the patient journey, in order to shine a light on the elements of their work that had contributed to progress was important,

"*All the day-to-day things we don't think about*; *the de-escalation skills and the skills we use to keep kids entertained*, *the language*, *body language*, *that we don't realise that we are doing.* [*The facilitator*] *gets us to reflect on them and talk about them*, *so that we understand what job we are actually really doing.*" (*P5*)

"*We are so used to doing the practicalities of our role*, *taking a step back and going 'actually we are doing a good job'… it can be really hard*, *but if we strip it back and look*, *it's really complex and elaborate work that has got an enormous amount of positives*." (*P4*)

The chance to highlight strengths was contrasted with the essential focus of ward life on mitigating risks and preventing mistakes.

"*We spend so much time going we did this wrong, and this wrong, it is difficult to think about the positive things…because we've got such risky and such complex kids*". (*P7*)

Limitations of the group

The biggest limitation highlighted by participants, was the fact that not all staff members on shift could attend, even though the time was selected to maximise the number of available staff. Participants lamented the fact that partial attendance meant not all perspectives within the team were accounted for. To mitigate, a written account of the discussion was made available for all staff to comment on between groups.

One participant observed that when the group was needed most (high clinical acuity and frequent serious incidents) was when it was most difficult to release staff to attend.

Suggestions for maximizing attendance included, increasing the frequency of the group, running 2 shorter consecutive groups, closer monitoring to ensure attendance was distributed fairly across the whole team, and gaining help from neighboring wards or managers to cover

the ward.

Whilst five participants reported that the positive impacts of group could be seen and felt in staff approaches to young people on the ward, one participant observed that the sheer volume and pace of work within the PICU setting (psychological and procedural) could limit the speed with which staff could apply learning in the moment.

Discussion

This paper makes a unique contribution to the field of adolescent mental health nursing and to psychoanalytic practice. To the author's knowledge, it is the first study to investigate the feasibility of implementing PWDGs for nurses in Adolescent PICU settings, a clinical specialty that has received little attention from research. This study has evaluated the suitability of the application of the work discussion model to an adolescent mental health inpatient PICU nursing team and its impact. The type of bespoke adaptations that can be put in place to promote sustainability and staff engagement with the intervention have been outlined. For nurses working with adolescents in restrictive inpatient settings, this study has illustrated that adaptations need to provide emotional containment through the process of 'reverie' (Bion, 1962). That is: noticing, taking in and make sense of conscious and unconscious staff communications, giving them back in a digested and digestible form, symbolised through intentional action in terms of how the group is set up. Adaptations that were used to successfully engage the staff in this study were developed by attending to the specific challenges of the adolescent PICU environment, but more importantly, to the impact of mentally distressed adolescents on staff states of mind and the attendant parallel processes.

The impact statements reported in the findings have shown that the NDG not only attended to staff wellbeing needs but also increased their capacity to deliver the therapeutic tasks of their work. All participants in the study reported that their experience of the NDG was positive; impacting upon their practice with young people, and their sense of professional identity. Improvements were reported in eight domains: knowledge and understanding; emotion management; personal efficacy; approach to challenging behaviours; therapeutic relationship building; leadership; professional identity; and team functioning.

Positive professional identity and a sense of value in one's work is known to protect against burnout in mental health nurses (Edward et al., 2017), which has been shown to negatively impact upon quality of healthcare delivery (Sinclair et al., 2017). The reported improvements in participant sense of personal efficacy are particularly important in adolescent PICU, where the frequency of high intensity aggression is daily (Foster, 2018). Personal efficacy is a key factor in effective management of violence and aggression and is positively correlated to staff compassion satisfaction scores and negatively correlated to secondary traumatic stress scores (Verhaeghe et al., 2016). Similarly, team cohesion is a protective factor for staff working in high-aggression environments (Lauvrud et al., 2009).

The findings from the qualitative study in this paper are validated by findings of the quantitative arm of the research study, which measured professional quality of life of the nursing team during the period in which the NDG was running (Foster, 2018). A sample of 17/22 nursing staff within the clinical setting reported higher compassion satisfaction and lower burnout and secondary traumatic stress scores than either mental health nurses in comparable settings, or the benchmark data for the ProQol V scale that was used in the study (Foster, 2018).

The findings, regarding the elements of the NDG that staff reported contributed to its outcomes, are discussed here in relation to projective identification of adolescent emotion, attendant psychological defences, and the role of emotional containment for staff in creating what Briggs (2008) has termed "temporary outsider-ship". Temporary outsider-ship describes the range of ways in which adolescents, and those who care for them, need to be able to flexibly span the boundary of inside/outside in relation to the mind of self and other and family and social groups, without getting stuck on either side, in order for the essential tasks of adolescent development to be achieved.

The organisation of young people's inpatient services along paternalistic and biomedical lines, directly challenges adolescent need for individuality and autonomy (Foster, 2009). This can activate defense mechanisms, such as acting-out, splitting-off and projecting unbearable emotions into others, to help the teenager achieve temporary relief through a state of 'mindlessness' (Waddell, 2018). In a parallel process, high work rates and focus on rapid risk mitigation cut out space for thinking and for digesting experience in staff too (Waddell, 2005). Nursing staff in adolescent PICU have been shown to be particularly vulnerable to unconscious identification with the young people's unthinking states of mind and defences. Close observation requirements create geographical and temporal splits in the team, and the restrictive environment subjects them to some of the same feelings of incarceration and disempowerment (Foster & Smedley, 2019b). The themes of '*time and space*' and '*learning about and with each other*', in which participants talked about the importance of a space to think together, highlight the value of the NDG in creating a relationally-focused space that countered the adolescent and organisational drives towards 'just doing'.

The findings show that group and facilitator fidelity and reliability were central to creation of a relational space in which there could be sufficient candour and freedom to express the often difficult and disturbing feelings evoked by the client group. Just as direct work with adolescents needs to provide a space that is distinct from the family, but not cut off from it (Briggs, 2008), the NDG appears to have been successful because the adaptations (e.g. timing, membership, structure and process) created a space that appreciated and accommodated ward life, but did not replicate it. Participants noted elements that contrasted with the ward - relaxed, predictable, undisturbed, with no task-based demands. This included setting a tone in which all contributions were equally valid, and in which usual hierarchies within the nursing team did not apply. This concept of the horizontal exchange of ideas in groups of mixed intellectual, educational and professional levels, to increase plurality of perspective, is at the heart of the PWDG model (Rustin, 2008a).

The theme *of* '*Why they do it, why we do it*' elaborated the role of emotional containment in providing staff support and in developing their capacities to contain and manage the feelings of the young people. Emotional containment has been described as a stepping-stone for development (Bion, 1962). Work with severely disturbed adolescents necessarily involves being subject to unconscious communications as young people split of and project feelings, for which they have no words or cannot bear (Foster & Smedley, 2019a). In this context, emotional containment means that workers need to be actively receptive to feelings being projected into them, validate them and elaborate their meaning, so that this understanding is available to them and the adolescent, to inform actions or make changes (Alvarez, 2012). However, the impact of being continuously up-close to violence and trauma can also push mental health nurses to emotionally distance themselves as a survival mechanism, in order to be able to continue to function in their role (Lauvrud et al., 2009). Examples given within the findings demonstrate how the application of key psychoanalytic ideas, within a safe space in which their feeling were received, helped staff move away from concrete appraisals of behaviour and instead utilise understanding of underlying drivers to modulate their responses. Participants discussed how being in a group that is acceptant of emotion and that privileged thinking about 'why?' before rushing to an action (Winship et al., 2019), not only reduced feelings of frustration, and increased openness to emotion, but also generated intentional actions and an outcome of improved emotion management.

A further example of the importance of emotional containment is located within the theme of '*Helping us to see our work*'. Being held within an acceptant, receptive gaze that confers regard for one's worth,

is a central component emotionally containing relationships in early life (Winnicott, 1971). It has been argued that feeling as though one's work has no value is a greater source of pain to mental health nurses than the continuous threat of physical and psychic assault (Johnston & Paley, 2013), and directly impacts upon self-esteem in the workplace (Edward et al., 2017). Experiencing a thoughtful and curious other, who invited them to think about their contribution, was described by participants as helping them understand their work in its complexity and to sustain them in their role beyond the experience within the group. The data from participants in this theme directly parallels findings from the conceptual analysis arm of the research study in which provision of receptive and attuned nursing interactions in which young people were offered a nuanced and realistic reflection of who they are, were identified as critical therapeutic nursing interventions (Foster & Smedley, 2019a).

Findings under the theme of '*freedom to speak, feel, and wonder*' point to underlying persecutory anxieties within the staff group that are commonly encountered in staff working with emotionally disturbed adolescents, who themselves are often hiding fears that they are not performing their adolescent role correctly (Briggs, 2008). Participants reported that feeling safe from feelings of shame, fear of being judged, or falling short in some way, were pre-requisites to being able to explore what Rustin (2008a) called "*the omnipresent, beneath-the-surface phenomena*" (p5) within the group. This is in keeping with observations from educational settings, that have found PWDGs useful for working with persecutory and paranoid feelings stirred up by work (Hulusi & Maggs, 2015). In part, this can be accounted for by the psychoanalytic principle explicitly communicated in the frame of PWDG: candid expression of feelings is encouraged, because they serve a purpose. They contain important clues about young people's difficulties and needs. By noticing and naming links between young people and staff anxieties and ways of coping, one can be used to help illustrate the other.

However, the findings of this study also reveal how important the borderland position of the facilitator was in supporting the thinking process. If temporary outsider-ship is the creation of transitional space where one can use multiple perspectives and disentangle one's own feelings and the feelings of others, it is facilitated by relationships that have 'freedom of movement' within them, created by sufficient inter-subjective space (Briggs, 2008). Participants described the importance of a facilitator that understood their work but saw things differently, and of being comfortable but not too familiar with them.

Spanning the border between psychotherapy and nursing 'ways of seeing', was created firstly by translating latent communications about the nurse's emotional needs into concrete communications of care (e.g. breakfast). Secondly the border was bridged through a facilitator who was both a registered mental health nurse and an adolescent psychotherapist, external to the service. This may not always be possible, or necessarily ideal - work discussion groups usually rely on inter-disciplinary membership as part of the process of shining a light on each other's practice (Rustin, 2008b). However, it does highlight that successful facilitation of PWDGs for nursing teams requires facilitators to take the time to understand the disciplinary culture of mental health nursing, whilst also maintaining a level of separateness from it and the organisation.

Study limitations and strengths

Whilst interviews were undertaken by interviewers independent of the NDG intervention – a strength in terms of reducing bias - participants did not receive any other form of team support at the time of the study. There may have been therefore, tendency towards a collective unconscious bias of evaluating the group well, for fear of losing the only support they were getting.

This was a single centre study; therefore, results have potential to reflect the specific culture of the unit in which it was conducted. Although it had been difficult to sustain, there was a prior history in the unit of attempting to provide nursing staff support groups of some kind. The staff group may have been more accustomed to the idea of engaging in reflective group processes, which may have contributed to the group's success. Future research repeating in a range of adolescent PICU units is indicated.

There is a risk of self-selection bias within the findings. The NDG group attendance was not mandatory, and all interview participants had chosen to attend. Future research, replicating this intervention in other settings, would benefit from actively seeking to recruit participants who chose not to attend the NDG, to understand the reasons for their decision.

However, overall, the sample representation is a strength of the study. The participants represented 32% of the whole nursing team within the unit. They represented all the roles within the nursing team and in proportions equivalent to distribution within the team. Although NHS England has been seeking to increase the adolescent PICU provision (NHS, 2016), at the point of data collection, the unit was one of only 5 dedicated adolescent PICUs in England. It therefore represents a significant proportion of the national workforce in this specialised field.

Another strength was the rigorous internal verification process combined with validation of the qualitative findings with two other data sources: the data from the quantitative arm of the research study and the facilitator reflective field notes, serving to validate the outcomes and themes emerging from the interviews.

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Ethics

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Declaration of competing interest

Unpaid honorary contract within the clinical service in which the research was carried out.

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Appendix 2: Statements outlining and confirming the extent to which the works are based on the candidate's own independent work

The candidate has made a unique and independent contribution in each of the papers and it is this contribution that should be under scrutiny. These contributions are outlined in Table 1 and are specified in detail in the statements on the next page, confirmed and signed by co-authors.

STATEMENT OF COLLABORATING RESEARCHERS: Confirmation of contribution and extent to which the associated published works are based on the candidate's own independent work

Study: Exploration of nursing identity and treatment model within an adolescent psychiatric intensive care unit, and an evaluation of the contribution of a psychoanalytic nursing development group within this context (mixed methods study)

Principle Investigator: Celeste Foster

Lead Organisation: School of Health and Society, University of Salford

Co-Researchers: Dr Kirsty Smedley, Consultant Clinical Psychologist, The Priory Hospital Cheadle Royal; Dr Shelly Allen, Senior Lecturer, The Unversity of Salford

Partner Organisation: The Priory Hospital Cheadle Royal

Funding: Study supported and funded through University of Salford Vice Chancellor's Early Career Researcher Scholarship Fund

Research Supervisor: Dr Alison Brettle

Collaborating Researchers Contribution

Task	Unique Contribution	Joint Contribution
Overall study conception and design	Celeste Foster	Supervision and advice re: application from research supervisor Dr Alison Brettle
Overall Project Management	Celeste Foster	/
Local oversight and governance monitoring for practice partner organisation	Dr Kirsty Smedley	/
University of Salford and The Priory Organisational Ethical Approval	Celeste Foster	/
Priory Hospital Cheadle Royal organisational agreement and research governance adherence	/	Celeste Foster Dr Kirsty Smedley
Papers (No's 4 and 5 in Thesis): Foster C. & Smedley K (2019) Understanding the nature of mental health nursing within CAMHS PICU. Part 1: identifying nursing interventions that contribute to the recovery journey of Young People. *Journal of Psychiatric intensive care,* 15(2),87-102. https://doi.org/10.20299/jpi.2019.012 Foster C. & Smedley K (2019) Understanding the nature of mental health nursing within CAMHS PICU. Part 2: Staff experience and support needs. *Journal of Psychiatric intensive car,* 15(2),103-115. https://doi.org/10.20299/jpi.2019.013		

Method 1: Content Analysis - Data Collection - Inductive Content Analysis - Abstraction/model development - Internal verification of content analysis and abstraction - Interpretation of findings in relation to theoretical frameworks - Authorship of project report - Writing of pair of journal articles from the project report	 Celeste Foster Celeste Foster Celeste Foster Dr Kirsty Smedley Celeste Foster Celeste Foster (lead) Celeste Foster	 Dr Kirsty Smedley contribution to attachment theory focused components of results and co-editing of discussion.
Paper (No 3 in Thesis): Foster C., (2019) "Investigating professional quality of life in nursing staff working in Adolescent Psychiatric Intensive Care Units (PICUs)", *The Journal of Mental Health Training, Education and Practice,* Vol. 14 Issue: 1, pp.59-71, https://doi.org/10.1108/JMHTEP-04-2018-0023		
Method 2 - Quantitative Survey: - Recruitment - Data Collection - Statistical Data Analysis - Interpretation and reporting of findings - Authorship of journal article	 Celeste Foster - all	/
Paper: Foster C. (2019) Investigating the impact of a psychoanalytic nursing development group within CAMHS Psychiatric Intensive Care. Intended journal Journal psychiatric and mental health nursing. Dr Shelly Allen, acknowledged.		
Method 3 – Qualitative Analysis of Interviews: - Recruitment - Design of Data Collection Tool (interview schedule) - Data Collection (interviews) - - Data Analysis (Thematic analysis) - Interpretation of Findings - Internal verification of thematic analysis - Authorship of journal article	 Celeste Foster Celeste Foster Celeste Foster Celeste Foster Dr Shelly Allen Celeste Foster	 Dr Kirsty Smedley & Dr Shelly Allen
Synthesis of Mixed Methods Data and Findings including Final project report	Celeste Foster	

Celeste Foster	Dr Kirsty Smedley	Dr Shelly Allen
Date: 23.08.19	Date: 22/08/19	Date: 23.08.19.

Appendix 3: Systematic scoping review literature search strategy

Prior to commencing the research study (2014), a systematic scoping review was undertaken to establish the current state of the evidence and the policy context in the field of adolescent PICU nursing.

The search strategy was designed to cover the 3 key domains of the research study:

- Adolescent psychiatric intensive care (PICU) nursing
- Professional quality of Life in nurses working in adolescent PICU
- Implementation of psychoanalytic Work Discussion/reflective practice groups in adolescent PICU

Findings from the search have been used to inform the research questions and design, the background for papers 2-5 (**Foster, 2018; Foster & Smedley, 2019a; Foster & Smedley, 2019b; Foster 2020**), and to inform the final thesis background chapter.

Search strategy

As it was identified early on in the search process that there was no published research specifically related to adolescent PICU nursing, searches had to be organized by constituent component, collated and then refined using pre-defined inclusion/exclusion criteria (see Table A2).

The constituent components were:

- Psychiatric intensive care
- Adolescence
- Inpatient mental health nursing
- Professional quality of life
- Psychoanalytic Work Discussion/ reflective practice groups

The Joanna Briggs Institute guidelines on conducting systematic scoping reviews were followed to ensure adherence to a reproducible and transparent method. (Peters et al., 2015)

Searches were conducted in databases: Medline, Cinahl, Psychinfo, Cochrane Library, Science direct, and PepWeb. Database selection was informed by work of Long and Brettle (2001) highlighting the limited coverage of single databases and low overlap of citations between databases in the field of mental health. This meant

a multiple database search was required covering medical (nursing and psychiatry), psychological, psychoanalytic and social science field of research.

Web searches were conducted in websites of organisations that publish policy, practice guidelines and resources in the field of adolescent mental health nursing: the Department of Health and Social Care; NHS England, National association of psychiatric intensive care (NAPICU) and the Association Child and adolescent mental health (ACAMH).

Hand searches of specialist journals most likely to publish research in the field were conducted. These were:

- Journal of PICU
- Journal of child and adolescent psychiatric nursing
- Child and adolescent mental health
- Journal of mental health education, training and practice (workforce-focused)
- Journal of Child Psychotherapy (CYP psychoanalytic intervention focused)

To ensure that any new emerging evidence was included, searches were repeated at intervals throughout the research study implementation and dissemination/ publication period (2016, 2018, 2019 and 2020),

Table A1: Search terms and synonyms

	1	2	3	4	5	6
Primary search term	**Adolescent**	**Psychiatric intensive care**	**Inpatient**	**mental health nursing**	**Professional Quality of Life**	**Work Discussion**
Synonyms	Adolescen* *Or* Young People *Or* CAMH* *Or* CYP *Or* Youth *Or* Teen *Or* P(a)ediatric *Or* Child*	PICU *Or* High dependency unit *Or* HDU *Or* Secure *Or* Locked	Hospital* *Or* Ward *Or* Unit	Psychiatric nursing	ProQol *Or* Emotional Labour *Or* Compassion fatigue *Or* Compassion Satisfaction *Or* Burnout Or Job satisfaction Or Staff wellbeing	Psychoanalytic Work Discussion *Or* Work Discussion groups (WDG) *Or* Reflective Practice Groups

Searches were completed in 3 stages:

- Search terms 1-3 were combined to identify paper's focusing on mental health nursing approaches to adolescent/PICU inpatient nursing
- Search terms 1-4 were combined to identify sources focusing on the impact of working in the specified settings upon nurse's professional quality of life and wellbeing
- Search terms 1, 2, 3, 4 and 6 were combined to identify sources focusing on psychoanalytic and reflective practice focused interventions to enable nursing staff

Boolean logic operators were used to optimize, focus and refine the search (Ref) In each stage of the search, synonyms were combined using Boolean operator OR to collect synonyms and reduce the chance of relevant sources being missed. Collected synonyms for each term were then combined in the sequences described above for each stage, using Boolean operator 'AND' to focus and refine the search.

Eligibility criteria

Studies were limited to English language studies from January 2000 – January 2020. Due to the narrow and multi-determined nature of the search focus and the specialism of the practice area under study, no limits were placed on study type – in order to maximise the inclusivity of the search. However, at the screening stage editorials, clinical commentaries and policy documents were separated from primary research studies.

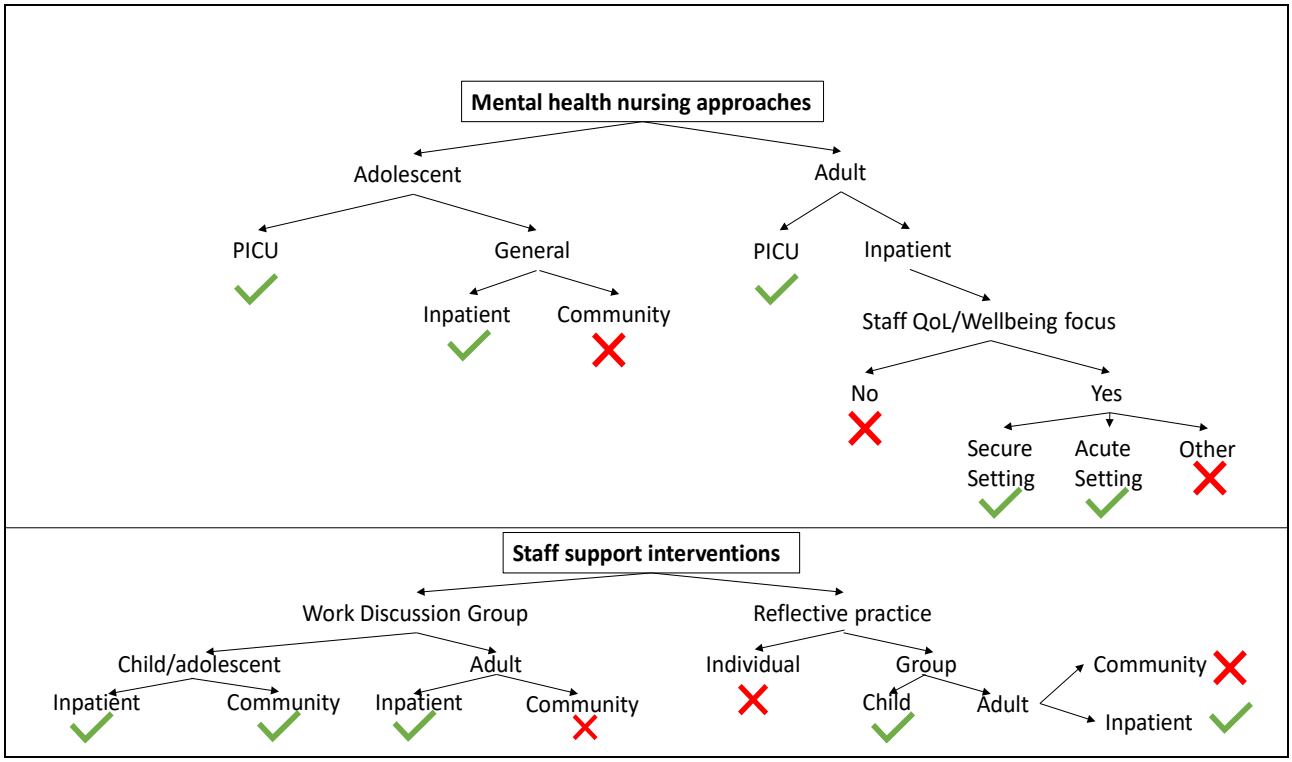
Table A2: Eligibility criteria

Inclusion	**Exclusion**
English Language	Non-English language Pre 2000
All study types	Focused on pharmacological intervention Paediatric (physical health) intensive care
Mental health nursing focused	Community settings Focus on specific patient conditions
Post 2000	Focus on evaluating treatment programmes to reduce specific symptoms Exclusive focused on patient outcomes (not nursing focused)

Study selection

Titles and abstracts were screened by the reviewer against the pre-defined inclusion and exclusion criteria (Table A2). Full text articles were screened for relevance to the research focus in accordance with the algorithm in Figure A1.

Figure A1: Full text decision making algorithm



Data extraction and synthesis

A table was used to collate study aims, methodology and design, focus (e.g. type of intervention, age, condition and setting), outcomes and findings.

Findings were synthesized using thematic analysis (Kastner et Al., 2012) of the purpose of the thesis background and context chapter. Findings were presented under themes of:

- State of research in adolescent PICU
- Mental health nursing approaches and models of care in PICU settings
- Adolescent mental health inpatient settings
- Impact of acute and intensive care inpatient work mental health nurses
- Work Discussion and reflective practice for nursing teams

Results

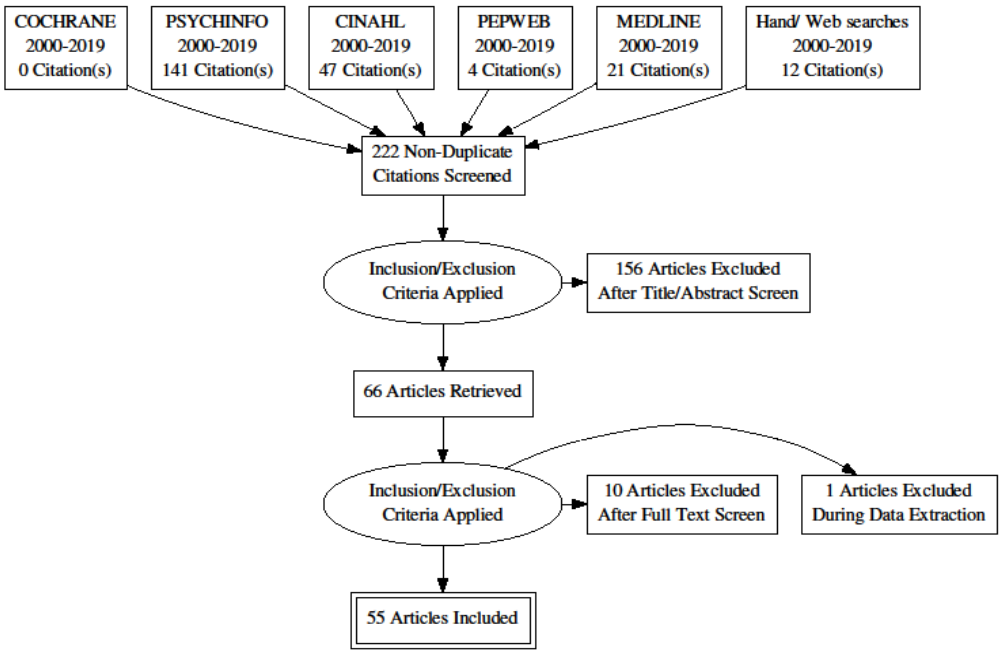
A total of 225 articles were retrieved. After title and abstract screening, 66 records were kept for full-text retrieval and full-text review.

Table A3: initial search results

Source	Hits	Duplicates	Relevant
CINAHL	47	1	30
Medline	21	1	5
Psychinfo	141	1	19
PepWeb	4	0	2
Cochrane Library	0	0	0
Web/Hand searches	12	0	10
Total	225	3	66

11 studies were excluded after screening by full text. The reasons for exclusion at full text screening were: Focus on critically physically ill children and their carers; assessment tools; reduction on violent incidents, seclusion, restraint; non-relevant settings (e.g. community) and individual reflective practice strategies.

Figure A2: Prisma flow diagram of study selection process



Total number of sources included in the literature review: 55 of which 43 included primary and secondary research data and 12 were book chapters, editorials and policy documents (see Table A4 for breakdown). Two papers were linked to the same research study, reporting on different elements of the study (Gwinner and Ward, 2013, 2014). Primary and secondary research studies comprised of 9 systematic or other forms or literature review with a clearly articulate method; 3 mixed methods studies, 9 quantitative studies (survey or validated psychometric measure data) and 14 qualitative studies (interview, focus group, observational). Studies originated from the UK, Finland Sweden, Australia, Canada and the USA.

As part of the search three papers using psychoanalytic theory to explore emotional dynamics within adult PICU settings were also identified. The focus of these were medical and psychological therapy elements of PICU care provision, rather than nursing, so were excluded from the scoping review. However, they were kept as important reference documents for discussion of findings of my own studies (Terry 2005; Connor 2006; Winship 1998).

Table A4: **Breakdown of included studies by subject, study type, population context**

Subject	Total number of sources included	Type of study	Other document sources	Population/ context
Adolescent PICU nursing	6	0 Primary Research	2 Policy documents 3 Descriptive accounts of aspects of service 1 Book chapter	Adolescent PICU 5 UK 1 Finland
Adult PICU nursing	13	2 systematic reviews 2 mixed methods 1 quantitative study 5 qualitative studies	3 editorials/ commentaries	Adult PICU 5 UK 5 Sweden 3 Australia
Adolescent inpatient nursing	9	1 systematic review 1 conceptual review 5 qualitative	2 editorials	2 UK 3 Australia 1 Canada 3 USA
Professional quality of life inpatient nurses	13	5 systematic review/evidence synthesis 8 Quantitative studies	/	0 adolescent PICU 0 adolescent mental health inpatient 1 included Adult PICU 1 Child medical inpatient 1 critical care inpatient 5 adult acute/locked inpatient MH units
Psychoanalytic Work Discussion groups	14	1 Mixed methods study 4 qualitative studies 8 descriptive case studies	1 Book (edited papers)	5 child or early years education 2 child social work 1 pediatric medical inpatient 1 adult acute psychiatric inpatient 1 adult locked inpatient (prison health wing)
Total	**55**	**43**	**12**	/

References of sources included in systematic scoping review:

Subject Area: Adolescent PICU Nursing	Date	Title	Evidence Type	Source
Jasti M., Khan F., Jacob G.	2011	Journey through an adolescent PICU, three years on...	Service description	European Psychiatry
Kahila K., Kilkku N., Kaltiala-Heino R.	2004	Psychiatric treatment and research unit for adolescent intensive care: the first adolescent forensic psychiatric service in Finland.	Service description	Journal of Psychiatric and Mental Health Nursing
Milavic G.	2009	The interface with the Child and Adolescent Mental Health Services	Book Chapter	Beer M., Pereira S., Paton C. (Eds) Psychiatric Intensive Care, 2nd Edition.
NAPICU	2015	National Minimum Standards for Psychiatric Intensive Care Units for Young People, National	Policy	Association of Psychiatric Intensive Care and Low Secure Units
NHS England	2016 (Draft) 2018	C11/S/d tier 4 CAMHS Psychiatric Intensive Care Unit Service Specification.	Policy	NHS England Publications
Smith L., Hartman D.	2003	Implementing a community group on an adolescent psychiatric intensive care unit.	Intervention Description	Mental Health Practice,
Adult PICU Nursing				
Bjorkdahl A., Palmstierna T. Hansebo G.	2010	The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care.	Qualitative study	Journal Psychiatric and Mental Health Nursing
Bowers, L.	2012	What are PICUs for?	Commentary	Journal of Psychiatric Intensive Care
Crowhurst N. & Bowers L	2002	Philosophy, care and treatment on the psychiatric intensive care unit: themes, trends and future practice	Systematic review	Journal of Psychiatric and Mental Health Nursing
Dix R.	2016	The PICU: personality without disorder.	Editorial	Journal of Psychiatric Intensive Care
Gwinner, K., & Ward, L.	2015	Storytelling, Safeguarding, Treatment, and Responsibility: attributes of recovery in psychiatric intensive care units.	Qualitative study	Journal of Psychiatric Intensive Care
Gwinner K., Ward L.	2013	P.I.C.U, H.D.U., A.O.A. What treatment do we provide? Current descriptions of the function of intensive care for inpatient psychiatric health.	Systematic review	Mental Health Review Journal
Lemmey, S.; Glover, N.; Chaplin, R.	2013	Comparison of the quality of care in psychiatric intensive care units and acute psychiatric wards	Quantitative study	Journal of Psychiatric Intensive Care

McAllister S., McCrae	2017	The therapeutic role of mental health nurses in psychiatric intensive care: A mixed-methods investigation in an inner-city mental health service.	Mixed methods study	Journal Psychiatric Mental Health Nursing
O'Brien L., Cole R.	2004	Mental health nursing practice in acute psychiatric close-observation areas.	Mixed Methods Study	International Journal of Mental Health Nursing
Ruszczynski S	2012	What makes a secure setting secure?	Commentary: Book Chapter	Adlam, Aiyegbusi, Kleinot, Motz and Scanlon (Editors), The Therapeutic Milieu Under Fire.
Salzmann-Eriksson M., Lutzen K., Ivarsson A-B., Eriksson H.	2011	Achieving Equilibrium within a Culture of Stability—Cultural Knowing in Nursing Care on Psychiatric Intensive Care Units	Qualitative Study	Issues in Mental Health Nursing
Salzmann-Krikson, M., Lutzen, K., Ivarsson, A., Eriksson, H.	2008	The core characteristics and nursing care activities in psychiatric intensive care units in Sweden	Qualitative study	International Journal of Mental Health Nursing
Ward L., Gwinner K.	2015	Have you got what it takes? Nursing in a psychiatric intensive care unit.	Qualitative study	The Journal of Mental Health Training, Education and Practice
Adolescent inpatient nursing				
Delaney, K. R., & Hardy, L.	2008	Challenges faced by inpatient child/adolescent psychiatric nurses.	Commentary	Journal of psychosocial nursing and mental health services
Delaney, K. R.	2017	Nursing in child psychiatric milieus: What nurses do: An update.	Conceptual review	Journal of Child and Adolescent Psychiatric Nursing
Delaney, K. R.,	2019	Child inpatient treatment: Moving it out of the shadows	Editorial	J Child Adolesc Psychiatr Nursing
Hayes, C., Simmons, M., Simons, C., & Hopwood, M.	2017	Evaluating effectiveness in adolescent mental health inpatient units:	A systematic review	International Journal of Mental Health Nursing
Hayes, C., Simmons, M., Palmer, V. J., Hamilton, B., Simons, C., & Hopwood, M.	2019	The unheard voice of the clinician: Perspectives on the key features of an adolescent inpatient model of care.	Qualitative study	Journal of Child and Adolescent Psychiatric Nursing
Matthews, H. and Williamson, I.	2016	Caught between compassion and control: exploring the challenges associated with inpatient adolescent mental healthcare in an independent hospital.	Qualitative study	Journal of Advanced Nursing
Musto, L. and Schreiber, R.	2012	"Doing the best I can do": moral distress in adolescent mental health nursing	Qualitative study	Issues in Mental Health Nursing
Rasmussen, P., Henderson, A., Muir-Cochrane, E.	2012	An analysis of the work of child and adolescent Mental Health nurses in an inpatient unit in Australia.	Qualitative study	Journal of psychiatric and mental health nursing
Reavey, P., Poole, J., Corrigall, R., Zundel, T., Byford, S., Sarhane, M., ... & Ougrin, D.	2017	The ward as emotional ecology: Adolescent experiences of managing mental health and distress in psychiatric inpatient settings.	Qualitative study	Health & place

Professional quality of life – inpatient nurses				
Berger J., Polivka B., Smoot E., Owens H.	2015	Compassion fatigue in Paediatric Nurses	Quantitative Study	Journal Paediatric Nursing
Coetzee S.K. and Klopper H. C.	2010	Compassion fatigue within nursing practice; a concept analysis	Evidence synthesis	Nursing & Health Sciences
Cusack, L., Smith, M., Hegney, D., Rees, C. S., Breen, L. J., Witt, R. R., ... & Cheung, K.	2016	Exploring environmental factors in nursing workplaces that promote psychological resilience: constructing a unified theoretical model.	Evidence synthesis	Frontiers in psychology
Delgado, C., Upton, D., Ranse, K., Furness, T. and Foster, K.	2017	Nurses' resilience and the emotional labour of nursing work	Integrative literature review	International Journal of Nursing Studies
Edward, K.-L., Hercelinskyj, G. and Giandinoto, J.A.	2017	Emotional labour in mental health nursing	Systematic review	International Journal of Mental Health Nursing
Hooper C., Craig J., Janvrin D. R., Wetsel M. A., Reimels E., Greenville A., and Clemson, S. C.	2010	Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialities	Quantitative study	Journal of Emergency Nursing
Johnson, S., Osborn, D., Araya, R., Wearn, E., Paul M., Stafford, M., Wellman, N., Nolan, F., Killaspy, H., Lloyd-Evans, B., Anderson, E., Wood, S	2012	Morale in the English mental health workforce: questionnaire survey.	Quantitative study	British Journal of Psychiatry
Lauvrud C., Nonstad K., Palmstierna T.	2009	Occurrence of post-traumatic stress symptoms and their relationship to Professional Quality of Life (ProQol) in nursing staff at a forensic psychiatric security unit:	Quantitative study	Health and Quality of Life Outcomes
Ray S., Wong C., White D., Heaslip K.	2013	Compassion Satisfaction, Compassion Fatigue, Work Life Conditions, and Burnout Among Frontline Mental Health Care Professionals	Quantitative Study	Traumatology
Sacco T.L., Ciurzynski, S. M., Harvey M.E., Ingersoll G.L.	2015	Compassion Satisfaction and Compassion Fatigue Among Critical Care Nurses	Quantitative study	Critical Care Nurse
Seed, M. S., Torkelson, D. J., Alnatour, R.	2010	The role of the inpatient psychiatric nurse and its effect on job satisfaction	Quantitative study	Issues in Mental Health Nursing
Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., Smith-MacDonald, L.	2017	Compassion fatigue: a meta-narrative review of healthcare literature	Meta-narrative review	International Journal of Nursing Studies
Sondenaa, E., Lauvrud, C., Sandvik, M., Nonstad, K., Whittington, R.	2013	Resilience and professional quality of life in staff working with people with intellectual disabilities and	Quantitative study	Health Psychology Research

		offending behaviour in community based and institutional settings		
Psychoanalytic Work Discussion groups				
Datler W., Datler M., Wininger M.	2018	Evaluating the impact of Work Discussion techniques on the formation of psychoanalytic skills and attitudes: research designs and first results	Qualitative study	Infant Observation
Elfer, P., Greenfield, S., Robson, S., Wilson, D., Zachariou, A.	2018	Love, satisfaction and exhaustion in the nursery: methodological issues in evaluating the impact of Work Discussion groups in the nursery	Qualitative study	Early Child Development and Care
Ellis, G., Wolfe, V.	2019	Facilitating Work Discussion groups with staff in complex educational provisions.	Action Research Study	Open Journal of Educational Psychology, 4.
Hulusi, H. and Maggs, P.	2015	Containing the containers: Work Discussion group supervision for teachers – a psychodynamic approach.	Descriptive Case study	Educational and Child Psychology
Jackson, E.	2008	The development of Work Discussion groups in educational settings	Descriptive Case study	Journal of Child Psychotherapy
Jackson E.	2005	Developing observation skills in school settings: The importance and impact of 'Work Discussion groups' for staff Infant Observation.	Descriptive Case study	Infant Observation: International Journal of Infant Observation and Its Applications
Johnston J. & Paley G.	2013	Mirror on the ward: who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings	Descriptive Case study	Psychoanalytic Psychotherapy
O' Sullivan W.	2019	Creating space to think and feel in child protection social work; a psychodynamic intervention	Descriptive Case study	Journal of Social Work Practice
Rustin, M., Bradley, J. (eds)	2008	Work Discussion: Professional Practice with Children and Families	Book	Tavistock Clinic series: Karnac Books
Thomas M., Isobel S.	2019	A different kind of space': Mixed methods evaluation of facilitated reflective practice groups for nurses in an acute inpatient mental health unit	Mixed methods Study	Archives of Psychiatric Nursing
Trelles-Fishman A.	2019	Towards emotional containment for staff and patients: developing a Work Discussion group for play specialists in a paediatric ward	Descriptive case study	Journal of Child Psychotherapy
Warman, A., & Jackson, E.	2007	Recruiting and retaining children and families' social workers: The potential of Work Discussion groups	Qualitative Study	*Journal of Social Work Practice*
Winship G., Shaw S., and Haigh R.	2019	Group supervision for prison officers: an orthopedagogical approach to emotional management	Descriptive case study	The Journal of Forensic Psychiatry & Psychology

Appendix 4: Ethical approval letter

Research, Innovation and Academic
Engagement Ethical Approval Panel

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1 April 2014

Dear Celeste,

RE: ETHICS APPLICATION HSCR14/19 – An evaluation of the contribution of a psychoanalytic nursing development group to nursing practice in an adolescent psychiatric intensive care unit

Based on the information you provided, I am pleased to inform you that application HSCR14/19 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Appendix 5: Supporting conference presentations

National CAMHS PICU Network, inaugural meeting, 3rd December 2020

Keynote Speaker: Caring for adolescents with acute and complex mental health needs in CAMH PICU: conceptualising and enabling nursing identity, task and intervention

National Association PICU National Quarterly Meeting, May 2018

Invited Paper: Psychoanalytic Exploration of mental health nursing identity and intervention within an adolescent psychiatric intensive care unit *(Co-presented with Dr K. Smedley, C/o The Priory Hospital Group)*

11th International Conference on Child and Adolescent Psychopathology (ICCAP2016), Roehampton University, UK, July 2016:

Psychoanalytic Exploration of mental health nursing identity and intervention within an adolescent psychiatric intensive care unit *(Co-presented with Dr K. Smedley, C/o The Priory Hospital Group)*

Northern School of Child and Adolescent Psychotherapy 3rd Psychoanalysis and Education Conference, University of Sheffield, United Kingdom, October 2015:

Learning about looking: an exploration of different qualities of nurse's looking, seeing and watching, and their influence on the construction of relational spaces in an adolescent psychiatric intensive care unit.

4th European Mental Health Conference, Riga, Latvia, September 2015:

Exploration of mental health nursing identity and intervention within an adolescent psychiatric intensive care unit *(Co-presented with Dr K. Smedley, C/o The Priory Hospital Group*