


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

Financial support: This work was supported by the University of Salford (Vice Chancellor Early Career Research Scholarship Fund). The funding source had no involvement in the study design or implementation.

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

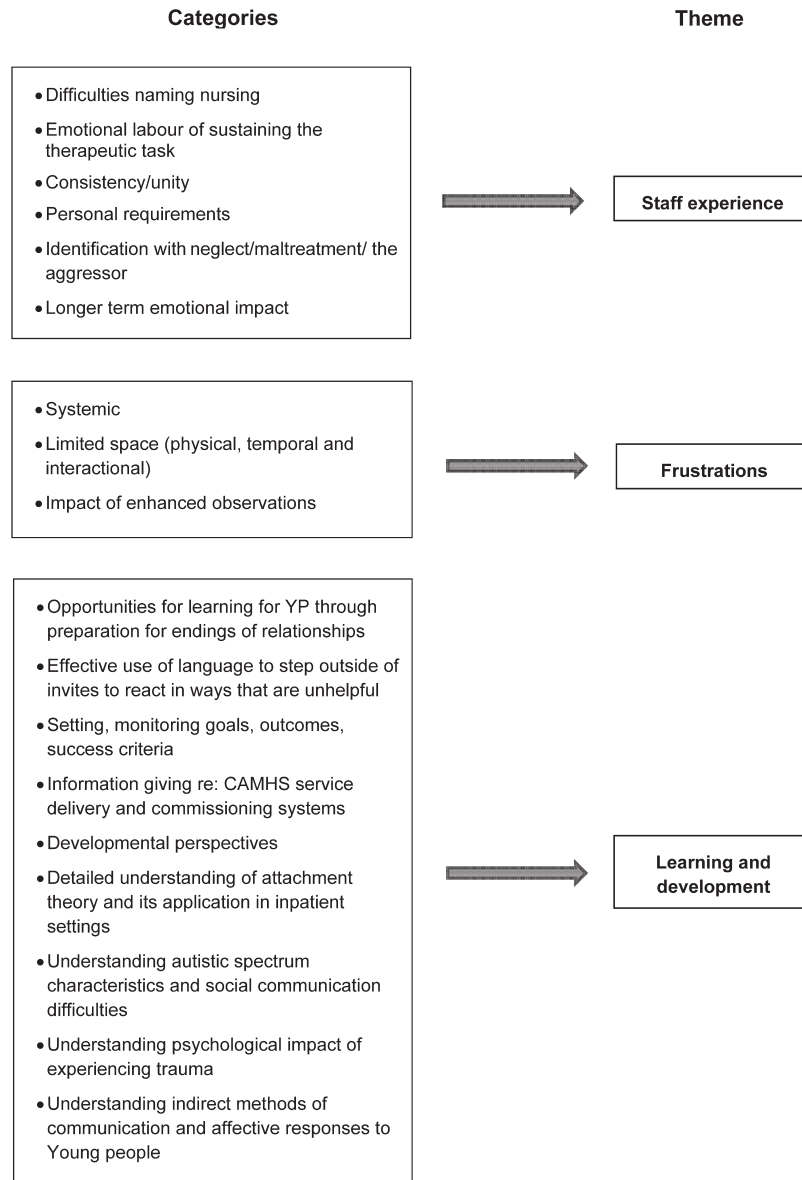


Fig. 1. Summary of content analysis results.

(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 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 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 bitter-sweet. 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 difficul-

ties 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), Ruszczyński (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 (Ruszczyński 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 primi-

tive 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

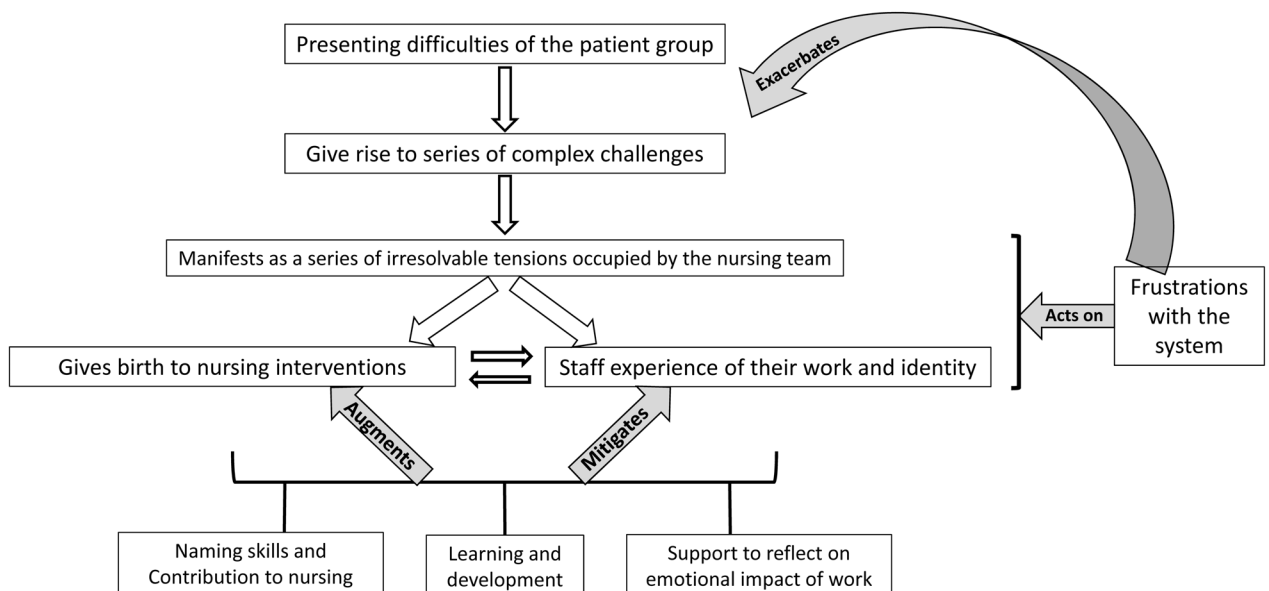


Fig. 2. A model of mental health nursing in CAMHS PICU.

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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