Exploring nursing identity and intervention within an adolescent psychiatric intensive care unit and evaluating the contribution of a psychoanalytic nursing development group within this context

Phase 1 Report: – Understanding the nature of mental health nursing within Adolescent PICU and identifying nursing interventions that contribute to the recovery journey of Young People

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Introduction

This document presents the findings from the first phase of a three-strand research study that sought to understand the nature of mental health nursing in an Adolescent Psychiatric Intensive Care Unit (PICU). In order to provide a context for the findings, a brief overview of the overall study is given.

The overall research project centres on the design and implementation of a psychoanalytic nursing development group (NDG) within an Adolescent PICU. This initiative is based upon the adaptation and application of a psychoanalytic work discussion model (Jackson, 2006; 2008). The purpose of the NDG is to:

- Enable the nursing and health care assistant team[1] to articulate their team identity through identification of the principles, processes and craft of their work as Adolescent PICU mental health nurses
- To reducing compassion-fatigue and burnout by providing psychological support in relation to the level of psychological disturbance, violence and interpersonal attacks to which the staff are subject.
- To develop the capacity 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 behaviour of their patients

Reflective practice-focused, externally facilitated psychoanalytic groups for those working with adolescents experiencing mental distress have been shown to be a helpful and effective forum for developing practitioner understanding of and capacity to cope with challenging and hard to manage behaviour(Briggs, 2009; Jackson, 2008). A small scale qualitative evaluation of their impact in community settings has shown attendee-perceived improvements in positive management of stress, understanding of and confidence to respond to challenging behaviour (Warman & Jackson, 2007). However, groups based on this model have not been implemented before in inpatient PICU nursing contexts. As such, in order to deliver a psychoanalytic work discussion group within this context a number of adaptations needed to be made. As a new initiative, its effectiveness also needed to be evaluated. Phase 2 of the research study will document the adaptations made and present the results of the evaluation.

The nursing development group on is a weekly breakfast group (immediately after morning handover). The timing of the meeting and provision of breakfast is intended to acknowledge the impact of the 24 hour cycle of care and the high levels of deprivation and disturbance expressed by the young people through violence, upon the nursing team's sense of worth and wellbeing, symbolising a responsiveness to the nursing staff's own needs for care and nourishment. It is facilitated by an adolescent psychotherapist and mental health nurse, and co-facilitated by the unit CBT therapy assistant. It is open to all those members of the nursing team who are not required on the ward at that time to meet the minimum clinical observation levels. The topic of discussion is set by each meeting's participants, rather than set by the facilitator or driven by external pressures from other parts of ward life or the wider organisation. The facilitator's focus is on use of psychoanalytic and developmental theory to support shared

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[1] From this point the term 'nursing team' will be used to denote both qualified nurses and health care assistants

thinking and development of collective understanding of the young people and dynamics within the ward. This includes: the underlying function of their more challenging behaviours; the relationship between their presentation on the ward and their life experiences/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. This includes raising awareness of how aspects of the young people's difficulties can become located in, or enacted by, the nursing team. The understanding developed within the meeting is then used to generate whole team approaches for nursing care management (often converted into care plans by key nurses).

Overview of the overall research study

The research study's focus is:
- Exploration of nursing identity and treatment model within an adolescent psychiatric intensive care unit
- Investigation into the contribution of a novel psychodynamic nursing development group to improving professional quality of life and clinical practice
- Gain a better understanding of the specific support needs of the nursing team within the PICU context

Using a mixed methods approach, comprising of:

Phase 1) A qualitative content analysis of the minutes of the first 6 months of the nursing development group, for the purpose of establishing the nature of nursing interventions within the unit and their contribution to young people's recovery

Phase 2) Administration of the Professional Quality of Life Questionnaire V (Stamm, 2009) at 3 intervals over a 9 month period, to gain an understanding of the relative levels of compassion satisfaction, burnout and secondary trauma experienced by members of the nursing team

Phase 3) Thematic analysis of interviews carried out with members of the nursing team about their experience of the NDG, their understanding of its impact, and their ideas for improving both the NDG and wider staff support mechanisms within the adolescent PICU setting.

This report presents the findings of **Phase 1** of the study: the content analysis aimed at understanding the nursing team's identity, approach to care of the young people, and the interventions they use to achieve this

Background

To provide a context for this study, a comprehensive search of the literature was undertaken. This section summarises the results of the literature search that are relevant to the first phase of the research study.

The literature search was undertaken in accordance with the search strategy recommendations for mental health subject areas by Brettle and Long (2001). A full description of the search, retrieval and analysis method is provided in appendix 1.

State of the research in adolescent PICU

Adolescent psychiatric intensive care units (PICU) are a small and highly specialised component of the portfolio of child and adolescent mental health service delivery in the UK. There are currently 4 adolescent psychiatric intensive care units in the UK (Smith and Hartmann, 2002). Although numbers of specific units are small, they play an important part in the recovery journey of a significant cohort of children in any twelve month period due to the model of care being based on time-limited admission, resulting in high patient turnover. In addition, 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. The literature search highlighted a significant dearth in the literature in relation to adolescent PICUs. This is reinforced by the results of a recent systematic review of the evidence relating to nursing in PICU environments, which found no adolescent orientated research studies (Gwinner& Ward, 2013). Given that the numbers of children and adolescents being admitted into inpatient services for containment of the risks that they present to themselves and others is increasing (Young Minds, 2011); this suggests that it is an important area, worthy of research.

The limited evidence that was located by the literature search highlights that Adolescent PICUs appear to provide for a more complex and diverse client group than their adult counterparts. This seems to be as a result of the patchy nature of community & crisis services for young people and the paucity of appropriate therapeutic placements for young people with multiple diagnoses, including those with underlying developmental difficulties (Jasti et al, 2011; Smith and Hartman, 2010). This observation has been reflected in the recently published draft National CAMHS PICU standards (Page and parker, 2015) and means that the adoption of the traditional emergency medicine/acute symptom stabilisation model of adult PICU is unlikely to be fit for purpose to meet the needs of the young people admitted to adolescent 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 and 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 (Musto and Schreiber, 2012; Rasmussen, 2012). Rasmussen (2012) argues that because much of 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. This is the primary aim of part 1 of this research project, which uses an inductive approach to articulating nursing intervention, through a content analysis of the notes from the Nursing Development Group.

The body of evidence in relation to Adult PICU's is much better established (Gwinner and Ward, 2013). However, a number of 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 in relation to nursing care in these environments (Gwinner and Ward, 2013; Bowers, 2012; Crowhurst and Bowers, 2002).

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, 2008, Gentle, 1996). 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 health care support workers. 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 (Johnston et al, 2012). Other studies have noted a lack of respect and inadequate resources being provided to nurses working in PICU settings (Gwinner and Ward, 2013). Burnout or compassion fatigue in health care staff is associated with reduction in reflective capacity, indifferent and hard responses toward patients and a reduction in their own mental wellbeing (Coetzee and Klopper, 2010). Therefore, understanding the specific support needs of staff working in PICU environments is as important to developing effective and high quality patient care strategies, as understanding of evidence-based clinical interventions.

Nursing approaches to treatment and care within PICU settings

The evidence that is available implies that well elaborated paradigms for a nursing approach to recovery may actually be instrumental in helping staff surmount the highly demanding nature of the environment, and have the potential to significantly improve clinical outcomes (Gwinner and Ward, 2013). However, this hypothesis has neither been tested nor evaluated. In keeping with this finding, one of the secondary outcomes of part 1 of the research study is to use the primary research data generated to inform the development of a model of nursing care.

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), and a limited but significant amount of evidence to suggest that treatment outcomes are positive for patients who are in acute psychiatric distress (Gwinner and Ward, 2013). This situation warrants a critical examination of what it is that nurses are doing to achieve these outcomes? And of how it can be amplified, generalised and maintained?

Intensive staff-patient interaction and the use of using multiple sophisticated interventions, has been observed (Crowhurst & Bowers 2002), but the nature of these has not been accurately characterised, analysed or tested. Managing the tension between regulating the environment to ensure safety and interpersonal interventions which support and promote recovery for clients, is well documented in adult-orientated literature that has attempted to capture something of the nursing task (Ward and Gwinner, 2015; Salzmann-Eriksson et al 2011; Bjorkdahl, 2010; Salzmann-Krikson et al, 2008). Studies that have sought to identify nursing practice in both adult PICU settings and 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 (Ward and Gwinner, 2015; Rasmussen, 2012). However, studies of this kind have yet to be undertaken in an adolescent 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 and Ward, 2013), and which can reduce the primary function of the PICU to the suppression of aggressive and violent behaviour (Dix, 1995; 2012). 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 (Ruszczynski, 2012; Bjorkdahl, 2010, Salzmann-Eriksson et al 2011).

In light of the findings of the literature review, phase 1 of the research study seeks to address the unanswered questions regarding what is the nature of mental health nursing in Adolescent PICU setting? The results from Phase 1 will be developed in the second and third components of the research study, which will evaluate whether a staff intervention (NDG) that specifically seeks to promote the integrative position between therapeutic care and control can make an effective contribution to the treatment of young people and welfare of nursing staff within this setting

Aims and objectives of Phase 1 of the research study

- To elaborate the 'nature' of mental health nursing within an adolescent psychiatric intensive care unit
- To build a model of mental health nursing within an adolescent PICU setting by describing the phenomena, identifying critical processes and understanding meaning through distillation of words/text into content related concepts.

Research Method

An inductive conceptual analysis of the material generated within the nursing development group over the first six months of its running was undertaken (August 2013- February 2014). This was to articulate 'what are the characteristics of nursing in this setting?' in order to hypothesise an emergent model of mental health nursing with adolescent PICU contexts. Within this study, 'Nature' is operationally defined as pertaining to: Tasks and actions, role, knowledge, skills, theory and practice, professional values and beliefs and philosophical position.

This was undertaken in accordance with the Content Analysis method elaborated by Elo and Kyngäs (2007). 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 particular concepts. As in this instance, inductive methods of content analysis are particularly indicated to build up a conceptual system or enhance understanding when there is insufficient pre-existing knowledge of the issue or the knowledge available is fragmented (Elo and Kyngäs, 2007).

Data collection and analysis

Before undertaking the analyses, the unit of analysis and unit of coding (what is being named or counted) were defined. Each set of notes capturing the content of one nursing development group meeting was identified as a unit of analysis. Over a period of six months this mean there were 26 units of analysis. No data sampling method was employed as all units of analysis within the given period needed to be read as a complete data set in order to capture as much detail as possible about the nature of the nursing task. The unit of coding was specified as all emerging concepts or themes within the given text of each unit of analysis, utilising the idea of a 'conceptual cluster', 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.

The coding process

The content analysis was performed in a stepwise fashion. To understand the data as a coherent whole, all 26 units of analysis were read and re-read as a complete data set with the key question in mind (what is the nature of mental health nursing in this context?), until it felt familiar and well known.

Secondly, an open coding process was undertaken, in which codes within each unit of analysis were identified and marked in the margins of the text. This was done utilising the framework recommended by Strauss (1987):

- Keep the original question in mind
- Analyse minutely – more is better at this stage, can be collapsed and distilled in next phase
- Interrupt coding to make theoretical notes as ideas are triggered by the coding process
- Don't assume relevance or significance of any previously or traditional established factor or code until it shows its self to be true within the data (common examples of this would be assumptions about variables such as gender, class and age)

A record was kept of whether the codes were 'in-vivo' or 'analyst-coined', i.e., taken directly from the text or those formulated by the researcher in response to reading the text. Coding continued until no new codes appeared within the data set (saturation). The frequency of repeating codes across the data set was also recorded as this can (but not necessarily) offer some information regarding the relative magnitude or significance of a particular concept (Elo and Kyngäs, 2007). The frequency is reported within the findings in instances where this adds transparency to claims of significance. Codes were then grouped and tabulated on one coding sheet, retaining information regarding the location of codes (i.e., in which units of analysis do they appear).

Categorisation and abstraction

Higher order concept categories, categories and sub-categories, 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. Psychoanalytic, attachment and developmental theory was applied to the categorisation and abstraction process, in order to generate a conceptual model of mental health nursing within the specific setting. Once the

codes were organised under final concept categories and main theme headings, the raw data was used, in order to identify illustrative examples.

Use of psychoanalytic, attachment and developmental theory as the lens of analysis

This choice of theoretical lens reflects both the fact that the nursing development group under study is based on psychoanalytic principles and that 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). 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. However, 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 peoples' well-being 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" (p181, Brush and Vasupuram, 2006). Psychodynamic practice is based on theories, language and interpersonal process-based techniques that can be used to help name and make use of this unique knowledge (Ruszczynski, 2012). It is therefore intended that the application of psychoanalytic concepts and language within this study will be used to help illuminate and understand the details of the work of the nursing team.

Verification/establishing trustworthiness of results

This part of the process was especially important, given the involvement of the lead researcher in facilitation of the Nursing Development Group, in order to reduce the risk of result bias or skew. A transparent record of each step of the coding and categorisation process was kept using tables and schematics (Elo and Kyngäs, 2007). A co-researcher (Dr Kirsty Smedley), with knowledge and expertise regarding the clinical context from which data was drawn, but who was independent of the nursing development group, 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 checking all concept codes, categories and abstractions back against the original data set
- Clarifying and resolving any anomalies or ambiguities with the lead researcher
- Corroborating any inferences or deductions regarding latent content, made by the researcher, with documentary evidence from within text, applying Casement's (1985) criteria for appropriate use of latent interpretations.

Presentation and reporting of results

This was undertaken in accordance with the recommendations for reporting content analysis data made by Elo et al. (2014), for the purpose of improving validity and reliability.

Ethical Considerations and Approval

The overall research project was screened using the Health Research Authority Decision Tool (http://www.hra-decisiontools.org.uk/ethics/) and confirmed as not requiring NHS IRAS ethical approval, due to falling under the national research ethics advisory service description of

service evaluation (NRES, 2009) and involving no patient information or their involvement in any primary data collection. The study was approved through the University of Salford, College of Health and Social Care Research Ethics and Governance Committee and The Priory Group Operational Research and Development Policy (OP20).This included completion of the Priory Group research passport, in order to ensure minimum governance standards were met. Local Service Approval was given by Cheadle Royal Young People's Service Governance Committee and subsequent to approval from the University of Salford ethics committee, final organisational approval was given by The Priory Executive Director for Research & Development and the project was logged with The Priory 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) and the University of Salford research information governance policy (http://www.salford.ac.uk/research/research-data-management/policy).There is no identifying patient material included in the study. Material regarding clinical issues discussed in the Nursing development group is recorded as part of the group process in aggregated themes, with staff and patient identifiers removed. This is 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 has access this information as part of their usual employment, when on the hospital site. All data collection and analysis of this material was undertaken on the Priory Hospital site.

All components of the research study were conducted in accordance with the Nursing and Midwifery Council Code of Conduct (2008); the British Association of Counselling and Psychotherapy: 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 (http://www.salford.ac.uk/chsc/research/staff-pgr-students-research-ethics).

Findings

Overview

A total of 150 distinct concept codes were identified within the data, set across 7 main headings of:

1. Presenting difficulties
2. Complexity within the clinical environment
3. Tension
4. Nursing Interventions
5. Frustrations
6. Staff experience
7. Learning and development

The distribution of codes across the categories and headings is illustrated in appendix 2. The uncategorised, 'raw' codes have not been included in this report due to their length. However, anyone wishing to review this original data can contact the principle investigator using the email address provided at the beginning of this report.

Figures 1a and 1b provides a summary of the analysis results

Categories

Theme

• Types of Mental Health Problem or Symptom • Trans-Diagnostic aspects of Psychological & emotional functioning	Presenting difficulties (of the Young People)

• Acute psychiatric disturbance, chronic adversity and neurodevelopmental problems all in the same place • 3 different developmental stages in one setting, • Running 2 different nursing approaches concurrently -Acute and recovery focused: reactive vs pre-emptive • Enabling adaptive attachments in face of disturbance in prior care-giving relationships	Complexity within the clinical environment

• Balancing boundaries vs. care & nurturing • consistency vs. flexibility • group vs. individual needs (young people) • Safety/security vs. therapeutic engagement • Controlling the environment vs. promoting autonomy • Acute illness vs. adolescents in recovery • Clinical vs. operational management demands • Iincreasing numbers of staff on shift: more resources to meet children's needs vs. harder to maintain unity and consistency of approach	Tensions

• Difficulties naming nursing • Emotional labour of sustaining the therapeutic task • Consistency/unity • Personal requirements • Identification with neglect/maltreatment/with the aggressor • Longer term emotional impact	Staff experience

• Systemic • Limited Space (Physical, temporal and interactional) • Impact of Enhanced observations	Frustrations

• Opportunities for learning for YP through preparation for and reflection on endings of relationships • Effective use of language to step outside of invites to enact/react in ways that are unhelpful • Setting, monitoring goals, outcomes, success criteria • information giving re: systems and process in CAMHS service delivery and commissioning • Developmental perspectives • More detailed understanding of attachment theory and its application in inpatient settings • Understanding Autistic spectrum characteristics and social communication difficulties • Understanding psychological impact of experiencing trauma • Understanding indirect methods of communication (projective identificatory processes) and affective responses to young people	Learning and development

Figure 1a Summary of the analysis

Sub-Categories

- Holding
- Reverie
  - Coming to Know
  - Holding in Mind
  - Decoding/sense making
  - Making Links

- Regulating
- Attunement
- Understanding and modulating internal working models

- Setting the tone
- Boundaries
- Giving meaning and Enablement

Categories

Emotional Containment

Furnishing with Skill

Attachment

Managing and Modulating Risk

Environmental
(Physical, temporal, relational, emotional)

Communicating

Personal Qualities and Self-Management

Theme

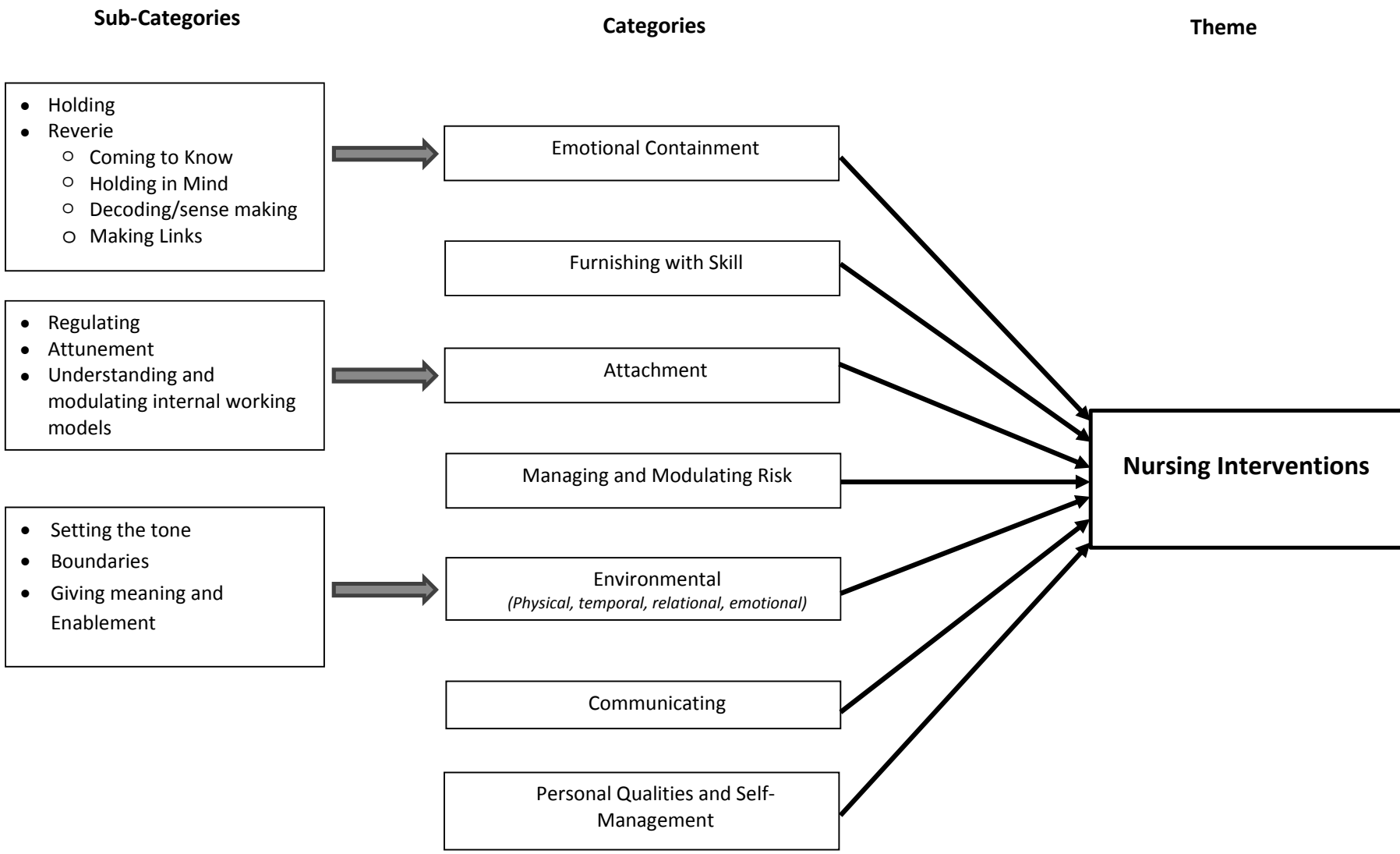**Nursing Interventions**

Figure 1b Summary of the analysis: Nursing Intervention categories

1. Presenting difficulties of the young people

This heading was comprised of 2 sub-groups: Those presenting problems brought to the group for discussion that can be described as a mental health disorder or a symptom of a specific mental health disorder, and secondly, those broader aspects of the young people's psychological and emotional functioning that are not tied to any specific mental health diagnosis, but which are nevertheless a characteristic of the young person's psychological distress.

Types of Mental Health Problem or Symptom (in order of frequency of discussion)
- Anxiety
- Neurodevelopmental problems/Autistic Spectrum Characteristics/social communication difficulties
- Complex post-traumatic stress and the impact of chronic and/or multiple adversities (often relational in nature). In particular:
  - dissociative symptoms, dysregulated mood and interpersonal relationship difficulties
- Psychotic symptoms

Trans-Diagnostic aspects of psychological and emotional functioning
- The role of anxiety and uncertainty in the young people's presentation:
  - Overwhelming states of anxiety which lead them to rely on unconscious defences, especially splitting (of own states of mind and of staff)
  - Self-doubt/disgust/criticism, shame and anxiety dressed up as boisterousness, disinhibition and/or denial.
- Attempts to control the environment as a means of controlling anxiety and to mitigate feeling small and powerless
- Expressions of self-loathing or attribution of null-worth to self
- Disturbance of adolescent identity or sexuality expression
- Envy, sensitivity to injustice and to being treated unfairly
- Loss of, or failure to ever achieve, pleasure from social activity, presenting as being withdrawn or 'cut-off'
- Violence: Sometimes reflecting anger and hostility or aggressive or destructive impulses, but often also reported as a communication of fear, anxiety, or a request for help
- Adolescent group/ganging dynamics

2. Complexity

Four domains of complexity were repeatedly identified. These appear to be as a result of the interaction between the nature and diversity of the difficulties outlined above, the impact of these upon the point in the young person's recovery journey at which discharge is indicated, and the age range of the young people.

These were:
- Providing for young people with acute psychiatric disturbance, the longer term impact of chronic adversity and neurodevelopmental/learning problems, all in the same (highly

contained) place, when the care strategies indicated for each of these difficulties are often different.

- Being required to run two different nursing approaches concurrently: a more reactive, acute illness-focused approach alongside a more pre-emptive, planned, recovery-focused approach. The latter being at continual risk of being impinged upon by the unpredictability of the needs of the young people whose difficulties are acute.

- At any one time the client group may be made up of young people in three different developmental stages (early, mid and late adolescence), each requiring different approaches (Waddell, 2002). With potential on some occasions for the older group to present a safeguarding risk to those at the younger end of the spectrum.

- The task of enabling and regulating adaptive attachment relationships, required by all young people not yet self-sufficient in order to meet their basic care needs, in the face of separation from their preferred attachment figures and/or disturbance in prior primary caregiving relationships, carried by young people into the ward environment.

3. Tensions

8 key tensions, faced by the nursing team, emerged within the analysis:
- *Balancing boundaries versus care/nurturing/engagement*
- *Consistency versus flexibility*
- *Whole group versus individual needs*
- *Safety/security versus therapeutic engagement*
- *Controlling the environment versus promoting autonomy in young people*
- *Acute illness versus adolescents in recovery*
- *Clinical versus operational management demands (reported by shift coordinators as upward pressure from frontline nursing team staff versus downward pressure from the organisation)*
- *Increasing number of staff on shift = more resources to meet children's needs versus harder to maintain unity and consistency of approach*

Analysis of the repetition of these tensions within the text indicated that they require continuing attendance and active management by the nursing team. What this means is that there is no final point of resolution, instead the nursing team have to work continuously to find and sustain an optimal position between the two poles, operating within an ongoing state of tension. As such, it is argued within this study that these tensions are the crucible in which the nursing interventions specific to the adolescent PICU environment (outlined below) are forged.

4. Nursing interventions

75 distinct nursing intervention codes were found with the content analysis, constituting 7 key categories of practice (illustrated in figure 1b):
- Emotional Containment
- Communication
- Attachment
- Personal Qualities and Self-Management
- Furnishing with Skill
- Environmental
- 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. As such, a schematic map illustrating the points of connection between the categories of nursing intervention is presented in figure 2.
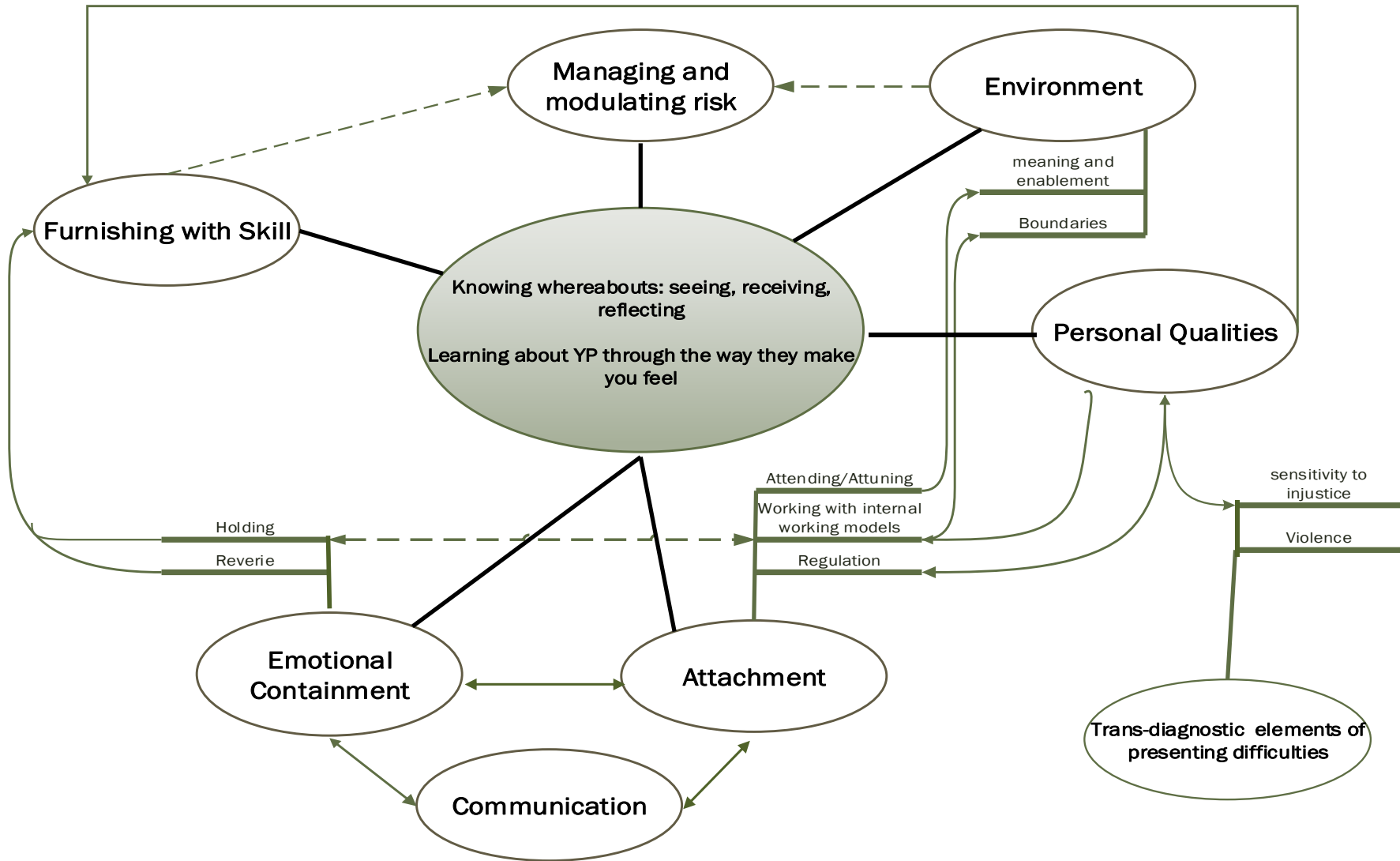
Figure 2 Schematic Map of Links between Nursing Interventions

The diagram contains the following elements:

- Managing and modulating risk
- Environment
- Furnishing with Skill
- Knowing whereabouts: seeing, receiving, reflecting — Learning about YP through the way they make you feel
- Personal Qualities
- meaning and enablement
- Boundaries
- Attending/Attuning
- Working with internal working models
- Regulation
- Holding
- Reverie
- sensitivity to injustice
- Violence
- Emotional Containment
- Attachment
- Communication
- Trans-diagnostic elements of presenting difficulties

41% (n= 31) of the codes describing nursing interventions fell under the categories of Emotional Containment and Attachment. In many ways these categories describe different dimensions of the same phenomena – that is the therapeutic relationship. The codes have been organised within the 2 separate categories in order to make sure that the subtle details and differences in the range of approaches recorded within the raw data were not lost.

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 of using the relationship and intersubjective space between them and the young people therapeutically.

The results in these 2 categories are organised using psychoanalytic terms, because there are no equivalent words in nursing language. So an explanation has been provided for each heading, prior to the results being presented.

4.1 Emotional Containment

In psychoanalytic theory, emotional containment (or 'the container-contained relationship', Bion, 1962), is the term coined to described the interaction processes between infant and their primary-carers. These processes govern both the infant's experience of anxiety and development of their cognitive, emotional and interpersonal functioning, resilience, and understanding of themselves. This includes their relation to the world around them and the figures it is peopled by (Reisenberg-Malcom, 2001; Klein, 1959). In good-enough circumstances this process is characterised by the carer's capacity to notice, take in, tolerate and make sense of the infant's non-verbal communications (good and bad), without being overwhelmed or seeking retaliation (Waddell, 2007; Klein, 1930). In attachment theory terms, this is the capacity of the carer to be attuned and responsive; accepting of all aspects of the baby. This acceptance and understanding is communicated by the carer through the way in which the baby is handled and held within the carer's gaze (Bowlby, 1988; Winnicott 1971) and within the intersubjective space between carer and baby, via tactile and gestural cues of the body (Schore and Schore, 2014).

Although these processes are often described in terms of the parent-infant relationship, they continue to operate throughout all stages of development (Klein, 1959) and as the child moves into adolescence the task of containment becomes the function of its wider community and the adults who people the systems and organisations in which they live and learn (Waddell, 2007). The internal maps that we develop for understanding ourselves and the world around us, termed 'internal working models' or object relations, develop from experiential learning and the experience of being known within our important relationships. These maps have a significant impact upon mental health and wellbeing across the life course (Schore & Schore, 2014). As such, it follows that the transformational quality of the processes described have an equally important contribution to make to recovery from mental distress and illness, and the role of mental health nursing practice (Adshead, 2002).

The intervention codes within this category have been organised under sub-headings based on the different components that are known to characterise emotional containment.

4.1.1 HOLDING

The holding environment was coined by Winnicott (1956, 1960, 1971). It is described as the whole routine of ordinary care provided through the day and night. 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 and a move from unintegration to a more integrated and secure sense of being located within one's own body and mind. As such, within Winnicott's developmental theory disruption to the good-enough holding environment was a significant risk factor for mental ill health. Therefore its provision within health settings was seen as pivotal to recovery from mental ill health.

Nursing intervention codes that related to the concept of holding were:
- *Being the only place at that time that can actually hold the young person's distress.*
- *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 may be in a very chaotic and dysregulated state and included being able to keep young people safe from their own destructive impulses

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

Literally acting as a container for these feelings that are acted out and directed towards nursing staff, until they can help the young people develop skills to do this for themselves (see 'Furnishing with Skill)

- *Exploiting the practical to enact the symbolic.*

This code related to repeated examples of staff utilising seemingly every day aspects of care, in order to speak to aspects of young people's much more fundamental underlying needs that "as yet have no words" (Alvarez, 1999). An example of this included understanding the ways in which being made hot drinks (or not) through the day can be symbolically representative within a young person's mind of their comparative value (with other young people) and of carer availability. In turn this knowledge is used by team members to try and promote equality of provision, and wherever possible to limit delays between requests and providing a hot drink, or to provide information and explanation when delays cannot be avoided.

Similarly, the act of knowing a young person's whereabouts, including specifically know 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 the purpose of ensuring physical safety. This appears to be particularly important in an environment where the use of touch, more ordinarily associated with provision of a 'holding environment', is not readily available to the nursing team outside of carefully prescribed processes for the physical management of violence and aggression. One example of how this was enacted in practice by team members was whilst discharging their general observation duties, a task that was understood to be about far more than just establishing physical safety: staff described differentiating their approach to entering each young person's bedroom (approaching footsteps, knock, means of entry, proximity to, and process of verbally or visually connecting with the young person), in accordance with their knowledge of individual preferences and vulnerabilities related to prior relational trauma, sensory sensitivities, and current mental state.

The process of knowing the young people's whereabouts links with the categories of 'Attachment' and 'Managing and modulating risk' and will be discussed in more detail within the Discussion section of this report. The receptive and reflective mirroring that is involved in this process is also evident in the sub-category of 'coming to know', below.

4.1.2 REVERIE:
Reverie is a term coined to describe the aspect of emotional containment that is the carer's receptiveness to all aspects of the child's communications, including those that feel hostile, and their ability to make them understandable, without being overwhelmed (Waddell, 2007). It can be thought of as the 'lending' of your brain and thinking power to the child. 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 own feelings and experiences.

- *Coming to know:*
This was described as a 'gathering up the pieces' from individual interactions in order to develop detailed collective team knowing and understanding of young people, from the experience of being with them.

'*Learning about young people through the ways they make you feel'* was identified in 11 out of the 26 units of analysis (43 %).

This process, in psychoanalytic theory termed 'Projective Identification', is our most primitive means of communication. It is an innate ability to stir up feelings in our carers through non-verbal processes that in infancy enable us to communicate and get rid of unbearable states of being, and have our needs met. This process is so essential to our survival, that although it is increasingly replaced by language as we get older, it is never completely gotten rid of, and is often returned to during times stress. In particular, adolescence has been identified as a developmental period in which there is a return to reliance on this mechanism of communicating, due to the mismatch between the intensity of the emotions being experienced by young people and their not yet fully developed language (Briggs, 2009).

Linked to this was another code referred to by nursing staff within the text as *'holding your nerve'*, which described the process of being able to bear the destructive and hostile parts of young people, without being permanently hurt or overwhelmed by them, or without being pushed into reacting in critical or punitive ways - no matter how arousing the young person's behaviour might be.

- *Holding in mind*
This intervention was described in three different ways, linking directly to the 'trans-diagnostic presenting difficulties' category and also utilised in 'management and modulation of risk':
  1. Keeping in mind the needs of young people whose difficulties were of a more internalized nature, who could easily be forgotten in a very noisy and distress-filled environment. Examples included
     a. *Persisting* with making interpersonal approaches to children whose history of emotional neglect and deprivation had resulted in them presenting as shutdown and withdrawn, including collecting up any clues about the young people's areas of interest.

      b. *Remembering the prior trauma*, adversity and brutality acted upon young people, whose behavior appears to be intentionally provocative of dismissive or neglectful responses from adults

2. Using this knowledge pre-emptively at times when young people aren't able to actively seek engagement or help from staff
3. *Holding up a receptive and accepting mirror to all parts of young person:*
      a. For young people in split or fragmented states of mind, remembering the good in the face of the bad and vice versa: reflecting back a more integrated/compassionate version of self as times when young people are self-berating, not forgetting latent risks at times when presented with an idealized 'all-good' version of self.
      b. *Keeping symptoms in mind when they can't be seen* (e.g. psychotic thinking, delusional beliefs in young people who are guarded)

- <u>*Decoding/making sense:*</u>

Codes in this category 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

Hearing the feeling/request without reacting to the means by which it has been communicated, e.g. Deescalating threats of violence by naming and responding to underlying fears or needs. A particular example illustrating this was an incident in which a young person was aggressive to the environment, seemingly without warning (smashing a window). By noticing the young person's parent approaching at the end of the hospital drive, delaying the decision to physically intervene to contain the young person in favour of naming for the young person that staff understood that they were acting on an impulse to fight to get to their carer, the incident was resolved without any physical or pharmacological intervention.

'*It's not what it looks like'* – decoding the idiosyncrasies of each young person's pattern of emotional expression. For example, coming to understand that for one particular young person expressions of boredom in fact denote agitation and emotional dysregulation, whereas for another giddiness and elation actually signify unbearable feelings of sadness .

'It's not what it seems' - 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.

It is notable within the raw data analysed that this particular aspect of decoding young people's communication appeared to be the most difficult for staff to do 'in the moment', and was a key way in which they chose to make use of the opportunity to talk and think with each other within the nursing development group meetings.

- <u>*Making links:*</u>

Linking knowledge of mental health conditions with specific detailed knowledge of the individual young person is evident within the text as an important mechanism by which qualified nurses support healthcare assistants, using it to help the team understand behaviours

and to identify strategies within nursing care plans for managing distress, challenge and violence.

Similarly, using knowledge of family issues and past events in a young person's life story to understand their presentation on the ward; particularly how triggers in the 'here and now' are representative of or symbolically equated to underlying precipitants of their difficulties, are used particularly in relation to identifying risk factors and potential 'flashpoints' for individual young people (see managing risk)

4.2 Communicating
Codes within this category describe mechanisms for achieving the interventions above and for using the knowledge gained in the process 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, helping them 'find' the underlying feeling
- *Communicating knowledge and understanding of young person* to themselves and to others (e.g. family, MDT, staff in future placements)
- Holding and understanding information about the small details of client's needs and preferences *("their little ways").*
- *Providing narrative on progress* – as an intervention to counter feelings of hopelessness expressed by young people

4.3 Attachment
Attachment is the evolutionary mechanism by which we socially and physiologically connect with others in order to regulate our internal feeling states (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 - empathy (Adshead, 2002).

Attachment-based interventions are described in the data as working to providing 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 (seeking to neither compete not repeat)

4.3.1 REGULATING
Codes under this heading refer to 2 components of intervening in the attachment arousal/relaxation cycle (Schore and Schore, 2010):

Acting to helping young people calm down, get back in control

- Staff actively managing physical and emotional proximity to young people in order to down-regulate or soothe distressing emotions or to up-regulate positive emotions
- Giving clear prompts and direction to take young people through a guided process that supports them calming down, them in accordance with assessment of mental state

Breaking negative reinforcing cycles, i.e. intervening in established ways of coping that served to actually escalate the young person's arousal rather than promote relaxation:

- *Coming alongside obliquely, finding/holding a middle ground*
  This is exemplified by a strategy used with a young person who experienced significant discomfort and distress when people tried to engage him in social encounters, leading to him isolating himself, but who also expressed beliefs of being treated differently/less well than other young people, due to perceiving (correctly) that staff tended to spend less time with him. The young person's care plan was altered to ensure members of nursing team sat side-by-side with him whilst he played computer games (his preferred leisure activity), occasionally commenting on the game rather than him – so that he could experience being with others, without having to make direct eye contact or speak.

- *Managing infantile defences*– denial, splitting, and projection– 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 to use early physiological indicators of anxiety (increased respiration rates, pallor change)to trigger intervention early in the arousal cycle of a young man for whom high levels of arousal would lead to misidentifying staff as perpetrators of harm, prompting violence towards staff, followed by denial of any memory of his actions (related to difficulties tolerating guilt) and subsequently increasing risk of perceiving staff as intending him further harm (as a result of fear of retaliation). This was done in the arousal phase of the cycle by giving the young person extended personal space but continuously giving verbal direction to support himself managing his arousal levels. In the relaxation phase, opportunities were used to provide reflective feedback on what the nursing staff had observed, during the period in which the young person reported memory loss, in order to promote the linking together of the split aspects of himself.

4.3.2 ATTUNEMENT/ATTENDING

This category is linked to the codes relating to *'knowing young people's whereabouts'*. In that it describes the process of looking, noticing (non-verbal cues), taking in what is seen, and responding accordingly that was repeatedly recorded in the text (n = 8).

Interventions under this category included using curiosity and amplified communication of interest in the young person to try to pique their 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 the purpose of stirring pleasure rather than anxiety in social encounters. Whereas for young people experiencing acute psychotic symptoms 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, playing to a young person's strengths and interests was a key component described.

4.3.3 UNDERSTANDING AND MODULATING 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 to the young person (Adshead, 2002).

One particular form of attachment-based intervention identified was firstly: *noticing recurrent themes in encounters with staff* as representative of relationships individual young people have with important others outside of the hospital setting. Then secondly: *working to moderate these through relational experience.* Unlike more direct strategies typically used in psychological therapy, challenging the unhelpful relational assumptions held by young people (e.g. men hurt you, women are weak, others can't bear me) was not undertaken through the nursing team naming or addressing of these issues, but rather through ways in which staff consistently sought to conduct themselves, in order to side step a young person's invite to punish, chastise, reject or shame them. As such, this intervention appears to rest upon the personal qualities detailed below.

4.4 Personal qualities and self-management

Throughout the text 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. These were

- *Consideration* - defined in this context as thinking before doing
- *Tenacity and persistence* - this is related to being able to sustain emotional and physical effort, including being able to tolerate knock backs and indifference to, or active rejection of, their attempts to help
- *Patience and tolerance*
- *Conducting oneself in a way that upholds the principles of fairness*
- *Acting to preserve young person's dignity* - helping them save face
- *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; withdrawing engagement in response to non-verbal cues that indicate the young person needs less stimulus, even when your instinct is to try and help/do more; maintaining composure in face of persistent approaches from young people that are intended to provoke a reaction.

4.5 Furnishing with skill

Codes relating to the ways in which staff supported young people to learn emotional and relationship management skills highlighted that staff supported learning through showing, doing-with and with high levels of repetition. The skills most commonly identified were:

- *Skills for coping* (distress-tolerance, distraction, problem solving)
- *Helping young people name feelings*

- *Interpersonal relationship role modelling*
- *Teaching how to make reparation* – not just how to say sorry but managing the feelings that go with it, e.g. guilt, vulnerability, shame and humiliation
- *Scaffolding:* supporting a step-wise move over time from staff-regulation of distress to self-regulation (examples in the text of this relate both to physical and verbal interventions)
- *Helping young people with mis-perception* (of other and environment).

In acute states of mental distress or in the case of young people who have not had good enough experiences of a their own 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 work 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.

4.6 Environmental (relational, physical and temporal)

4.6.1 SETTING THE TONE
- *Reliability*

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

- *Ensuring Clarity*

Setting out expectations and rules, giving information– including translating into simple terms. Helping newly admitted young people know what to expect and how to navigate the ward

- *'Last-chance Saloon'*

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

4.6.2 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 and enabling meaningful activity and a sense of achievement in a very restricted space.*

This process incorporates actions aimed at promoting young people's autonomy and choice in a restrictive environment. Examples of interventions of this kinds 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 young people's 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 can 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 and visits: from being outside to inside the ward, being with and then without family and vice versa.

4.6.3 BOUNDARIES

This category is intrinsically linked with the attachment category in that 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 described in the data as characterised by:

- *Implementing strategies for safety in a proactive, planned neutral way* - avoiding reactive consequences where possible, as these were understood to be interpreted as punishment by the young people.
- *Intentional judicious application* – using general principles that can be adapted to individual needs, not blanket rules.
- *Accommodating knowledge of a young person's attachment patterns & internal working models* into setting & implementing boundaries: understanding how they will be perceived by particular young people and adapting in accordance with this knowledge
- *Timing of implementation* – commensurate with move from acute to non-acute presentation and back again, as many times as required.

Although the nursing team often carry the lion's share of responsibility for implementing boundaries (as a function of the 24 hour cycle of care), the data also reflects that boundary setting is a process supported by the wider Multi-disciplinary team (MDT).

4.7 Managing and modulating risk

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

- *Identifying early warning signs and triggers* that at first glance are imperceptible (based on detailed observation), deescalating
- *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-empt, avoid, mitigate individual and group flashpoints and risks*
- *Continuous Risk assessment*(using very detailed observation of young people and their environment, particularly their rooms, scanning for any changes)

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- *Application of Team knowledge & understanding re: safe management of violence*

The themes up until this point have described the clinical context of the nursing team's work and the interventions developed to enable young people in their care within this context. To some extent the nursing interventions codes describe the work of the team 'at its best'. The next two themes serve to highlight organisational factors identified by participants as impacting upon the team's perception of their ability to provide care at the level to which they aspire, followed by understanding of the impact of the clinical work itself upon team members ability to keep going with the interventions that characterise the team 'at its best'.

5. Frustrations

Identified frustrations were noted to exacerbate the tensions within which the nursing team continuously have to operate

5.1 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 impacting on discharge.

5.2 Limitations on space

Limitations on space were both physical and temporal in nature.

The structure of the shift patterns 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 nursing team discussion, communication and debrief between nursing team through the day. This was seen by team members as having potential to impact on team cohesion and consistent delivery of care plans

Physical environmental factors described as impacting upon on nursing approach were: limited separate physical spaces in which young people could be nursed apart from each other, and ward occupancy levels. However, it should be noted that at the time of the study the organisation had already identified issues with regard to the physical environment and ward occupancy levels and was in the process of addressing the stated issues with a programme of improvement works to the ward.

5.3 Enhanced Observations

Across the 26 weeks covered by the data analysis period there were four periods in which the ward was using a higher than usual level of enhanced observations (greater than level 2(5)), to manage the safety of the young people. In each episode NDG minutes reflected team member's observations of the impact of enhanced observations on management of care tasks and team working.

The allocation of staff to enhanced observations and essential roles such as security nurse, were 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 regarding the impact of having to prioritise these essential safety-orientated tasks over the more 'therapeutic' or 'care' based tasks (e.g. 1:1 sessions, supporting young people in distraction activities, facilitating access off the ward), particularly for young people not on enhanced observation levels (Also see 'staff experience' below).In one unit of analysis, participants observed the irony, that whilst increasing young people's observation levels was the only mechanism for increasing numbers of staff on a shift, as means of responding to increased acuity of patient need, it in fact served to increase the constraints upon the ways in which the staff complement could be used, meaning that it could sometimes lead to it feeling as though 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, think together. The task of handing over clinical concerns about young people on 1:1 observations at the changeover of observing staff was noted as particularly complex, as staff were unable to move away from the young person to speak to the staff member taking over from them – result in the use of complex indirect communication undertaken in front of the young person. A high potential for splitting between HCA and staff nurses was also identified in these episodes as a result of feelings of envy and resentment that could emerge from the allocation of different tasks that served to make each groups work invisible to the other: HCA's would be allocated the lion's share of 1:1 observations 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 MDT liaison tasks, often with fewer available HCA staff to whom they could delegate. These tasks are often undertaken out of sight of HCA staff on enhanced observations, and for tasks such as CPA reviews and MHA tribunals also off-ward. 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 upon them.

6. Experience of staff

6.1 Difficulties naming nursing
Codes under this category relate to the difficulties reported by staff of naming and noticing the 'what' of nursing in their context. This was highlighted by direct invitations from the group facilitator to identify their contribution to the wider MDT care, which were usually followed by staff reporting how hard it was to see anything other than 'ordinary-ness' in their day-to-day work. Detailed discussions of nursing contributions based on individual cases, also tended to

generate staff reflections on how much their work is based on the small details, which in turn can make it hard for them to notice or explain. Related to this, 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 their own work.

6.2 Emotional labour of sustaining the therapeutic task (in the moment)
Directly recorded expressions of the feelings that staff had for their work can be best described as bitter-sweet: overwhelmingly team members described feeling pride in their work and gaining enjoyment from it, but these descriptions are also qualified by comments regarding the emotional toll of the work.

Factors that attacked staff member's capacity to sustain the therapeutic tasks
These were: the *unending emotional toll of the therapeutic tasks* themselves (as described in Section 4), 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 and incidents, multiple competing psychological/behavioural demands of young people*, and *the physical environment of the ward.*

An emotional burden was characterised as *the distress that comes from bearing witness to young people's illness and pain*. Watching the deterioration or worsening of young people's condition was identified as being particularly impactful upon staff member's sense of personal distress, as it challenged their sense of being useful/helpful.

This was particularly present in cases where young people had been admitted in the early stages of a developing severe psychotic illness; when young people's presentation worsened in the face of discharge delays; and when young people deteriorated in the context of disclosing historical traumatic events.

Violence as threat to staff sense of well-being, security, regard for self and other
Although there were many examples in the text of the management of physical violence being conducted in a coordinated, competent and effective fashion, there were three units of analysis in which the emotional impact of dealing with violence was raised. This was in in relation to:
- The painful experience of having no choice but intervene in a restrictive manner with young people, where staff knew physical intervention was likely to activate traumatic memories for the young person,
- The individual experience of being physically assaulted by young people and having to manage the temporary impact this could potentially have on one's sense of regard for the young person and appraisal of one's own competence in their role.

6.3 Personal requirements
These codes were either givens that team members felt they had to accept or requirements that needed to be provided by the wider organisation in order to do their job effectively:
- *Respect for the fact that client need drives ward life* and management approach – having to give up ground, be led by young people's needs, over one's own. This especially related to not seeking to impose authority over young people to meet one's own needs.
- Leading to *a need to be adaptable and responsive to changes in client group*

- *The need for time to reflect on experiences together as a team* – recorded in the data as mourning the absence of time of this kind.

6.4 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/neglect: 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 case leaving the staff vulnerable to being repositories for the feelings of low worth and resentment that come with being neglected or deprived. Or, in moments in which young people are back in touch with their hurt/victimised selves, the staff themselves can become identified with the primary aggressor or neglecter (Ruszczynski, 2010).

This concept code was directly identified 8 times within the data set, with many more implicit references to it threaded throughout. It links with the intervention category of 'coming to know' and 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.

6.4.1 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 polystyrene cups).

For HCA staff in particular, who were often not present in clinical decision making forums, absence of information or lack of communication of the rationale for counter-intuitive clinical decision making by the MDT or senior nursing team, had potential to prompt deductions about the 'true' reasoning behind hard to comprehend decisions of a persecutory nature (e.g. medication not increased because MDT does not care about staff getting hurt, rather than knowledge that safe or licenced limit of dosage has been reached). In turn these assumptions can be seen to stir up feelings of deprivation and perceived low worth in eyes of others and the organisation.

A parallel process was observed within the data in relation to 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 needs and disorders, 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 enjoyment from those behaviours that were troubling or harmful to staff – leaving 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 NDG at those times was to provide information that could support participants to understand the function of counter-intuitive or counter-logical decisions and clinical presentations.

At times of high levels 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 business, and so at a concrete level staff were more likely to be prompted about administrative errors or omissions by their managers. However, more detailed exploration in one unit of analysis revealed a more complex dynamic. Prompts from managers to undertake overlooked tasks, were seen to resonated with underlying 'worst fears' staff were carrying at these times of "no matter how hard you try you not good-enough", related to a specific aspect of being allocated to 1:1 observations. An account is given of how in following the movements of a young person to whom they were allocated, staff would walk past other young people in whom they could recognise early warning signs or indicators of distress, and yet 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, which in turn were exacerbated by managerial prompts that further alerted them to what they had not done. This phenomenon of becoming 'identified with the neglecter'

The concomitant feelings to perceptions of deprivation and neglect are 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 MDT who can come and go on to the ward could become sites onto which these feelings could be projected.

6.4.2 IDENTIFICATION WITH THE AGGRESSOR
- Feeling responsible to causing, maintain or worsening young people's symptoms/ difficulties, even when there are clear and tangible external precipitants and triggers – expressed in the data as *"We did this"* or *"this is our fault"*

- Strong feelings of regard or empathy for young people prompting very *critical and exacting staff appraisals of their own performance.*

- Understanding *the impact of having to exert control over young people upon the young people's sense of powerlessness* (and what else this might link to in young people's past experiences) – feeling the burden of responsibility of this.

- *Knowing what needs doing, not knowing how to do it with staff resources available*, worrying about clinical quality – feeling 'not good-enough' - equated to worries that may actually be causing harm and periods of low job satisfaction

- *Impact of knowledge of individual histories of deprivation and trauma upon staff capacity to implement boundaries*/hold a line (e.g. in relation to declining young people requests for a hug or other forms of touch, or saying 'No') – in the moment feels 'the same as' or a repetition of harms/withholding care previously done, and described as feeling awful or like an 'awful person'.

6.5 Consistency/unity
Team consistency and unity was strongly and repeatedly associated with team effectiveness and satisfaction. Inconsistency in approach of team members was equated with feelings of isolation and vulnerability amongst individual staff. Times or specific cases in which a lack of

clarity of team approach was perceived were associated with perceived stress. Challenging clients were described as exposing chinks/splits in 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. In one unit of analysis, this observation had prompted wondering about whether this dynamic could actually activate young people to be challenging, as a means of trying to regulate their environment through activation of the staff group?

Within another unit of analysis, the challenges of working to achieve consistency were identified as related to the processes of identification described above. In that, for 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 in which some staff appeared to have been identified with the aggressor and find themselves instinctively driven to respond to the young person's challenges with more harsh consequences than would be usual for them, whilst 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.

6.6 Longer Term Emotional Impact
- *Feelings of powerlessness*

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

- *Difficulties winding down/turning off*

This was reported as a function of the high level of stimulus, patient acuity and sense of responsibility for the safety of the environment, even when they are not on the ward there (have I handed over everything? did I make sure the shampoo bottle tops were back on, did I count everything back in?..), combined with the length of shift; some staff reported experiencing difficulties winding down or turning off between shifts, sometimes impacting upon sleep. Other staff described specific mechanisms for turning off and separating work/home life. E.g. use of particular types of music in the car, 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 behind at the front door of home

- *Loss*

The issue of loss for staff was identified in a number of different ways: having to adjust to the rapid turn-over of clients and staff coming in and out of the ward, being continuously up close to the high level of loss and separation–based issues that young people are facing, for longer term clients, wondering about whether next place will be able to look after them as well, and rarely getting to see the end product of their work, as most young people are still unwell as the point of their discharge. In one unit of analysis the issue of loss is directly linked to difficulties for nursing staff of reflecting on what the team has done well; one participant observes that reflecting on what has gone well requires team members to think about those young people who have left the unit, which in turn requires them to put themselves in touch with the feelings of sadness for young people that they have cared about so much, and whose loss they have had to bear.

7. Learning and development

This category contains codes contained within the minutes that describe discussion and information-giving by the facilitator within the nursing development group, that was observed to help participants manage some of the frustrations, anxiety and stress already described as associated with their role. These will be analysed and discussed in greater detail in Phase 3 of the research study, in conjunction with the results of the interviews undertaken with staff who have participated in the nursing development group.

- Providing young people opportunities for learning by actively preparing them for and reflecting upon the emotional component of *endings of relationships with the nursing team*
- Collaboratively generating and rehearsing within the group, effective use of language in *responses to step outside of invites from young people to enact/react in ways that are unhelpful*
- *Setting and monitoring realistic and achievable goals, outcomes and success criteria* - that are congruent with the level of illness and complexity present in the client group, rather than the hopes for recovery to which the staff group understandably and admirably hold on.
- *Information giving re: systems and process in CAMHS service delivery and commissioning* outside of the unit, to lessen frustration, give context, loosen reliance on own deductions
- *Developmental perspectives* – understanding YP difficulties using this lens alongside rather than exclusively using an illness lens including understanding regression in acute states of distress
- More detailed understanding of *attachment theory and its application*. In particular:
  - o The ways in which the PICU environment can activate attachment seeking/regulating behaviours
  - o The ways in which the attachment arousal/relaxation cycle can be actively used by staff to help children develop self-regulatory capacity
  - o That within this model repetition is part of the treatment process rather than a marker that interventions haven't worked
- Understanding *Autistic spectrum characteristics and social communication difficulties*
- Understanding the *psychological and developmental impact of experiencing trauma in childhood.*
- Understanding how indirect methods of communication (*projective identificatory processes*) and one's own affective (emotional) responses can be used as a source of helpful information about young people.

Synthesis of Findings: A proposed model of adolescent PICU mental health nursing

Figure 3 Proposed model of the emergence and maintenance of mental health nursing intervention within adolescent PICU
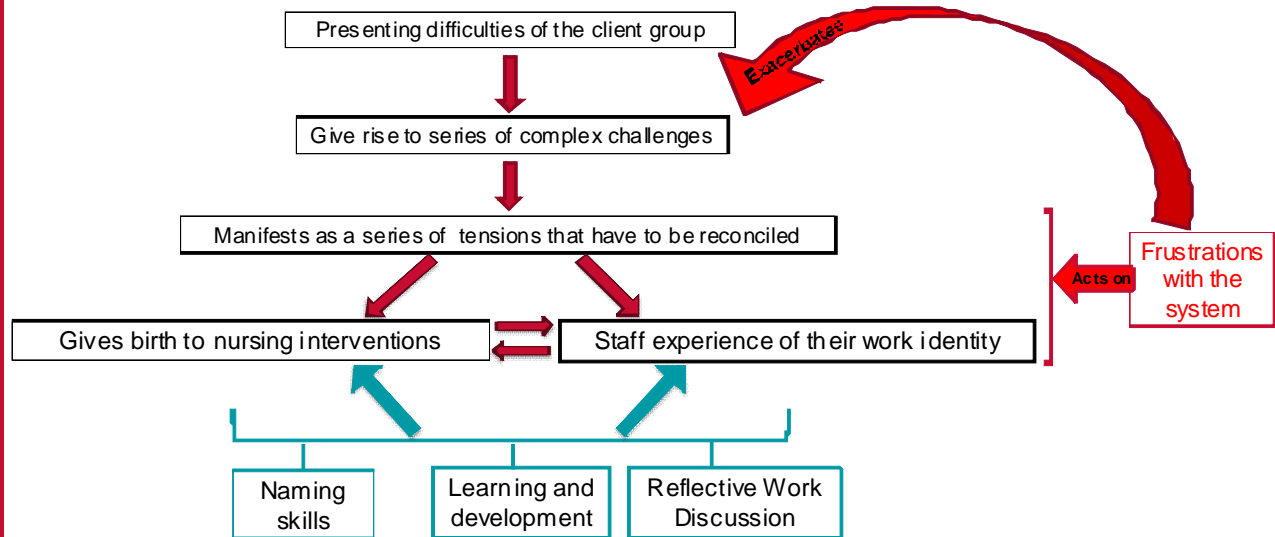
The last part of content analysis is to bring together the findings to undertake an analysis of the relatedness of the codes and category concepts within it (Figure 2) and to build a map. This is referred to as abstraction. Figure 3 proposes model of the way in which nursing interventions and nursing team identity emerge and are maintained within the adolescent PICU setting.

It is asserted that the tensions outlined in the results section 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.

As such, the specific nursing interventions reported upon within this study are understood to be given birth to by the mutually constitutive elements of which the tensions are made, and the requirement to manage all of them, all of the time.

That is to say that these tensions can never be resolved – only the proximal relationship between the two elements of each tension understood and an optimal position in which the two elements must be held in relation to each other, continuously worked towards by the nursing team, using the range of interventions described in the finding.

As the nursing task is fundamentally relational in nature, requiring explicit engagement with young people's attachment and dependency needs, this 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 (frustrations and staff experience).

Nursing team identity is therefore informed by the experience of having to continuously reside within a tension or occupy and span the space at the margins of two apparently counter or conflicting positions, whilst also acting as a collective container and sense maker for the indirectly transmitted emotional components of the young people's communication (projective identification). The result of which is that the factors that enhance or impede recovery are often two sides of the same coin. I.e., that the emotional toll of unrelenting nature of the nursing interventions required also actively serves to corrode or undermine staff capacity to keep going with these interventions.

Early indicators from the content analysis suggest that supporting nursing staff with the process of naming their work and contribution to care, alongside opportunities for learning about underpinning theory and evidence to help make sense of their and the young people's experiences, and access to supported reflective space in which to think together about their work, can make a contribution to helping the nursing team sustain themselves in the face of the significant demands placed upon them by their work. However, this needs to be evaluated more rigorously in the next 2 phases of the research study.

Discussion

This study provides a comprehensive account of the nature of nursing identity and intervention in the previously unexamined practice area of Adolescent PICU nursing. It also gives a rich account of the 'intensive and sophisticated interactions' (Cowhurst & Bowers 2002) that have been hinted at in previously published work on nursing in PICU settings, but which have yet to be fully elaborated.

One of the challenges of writing and for reading this report is how to capture/take in the sheer breadth, depth and complexity of the nursing team work that has emerged from the study. It has been observed by other authors 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. In turn, this has been identified to undermine nurse's ability to give sophisticated accounts of their expertise to other members of the multi-disciplinary team (Deacon and Cleary, 2012). As such, this research report is unapologetic in its inclusion of all of the details of what has been learnt about nursing intervention through the course of the study, as part of a process of supporting the nursing team to more clearly articulate their own identity and expertise.

The discussion that follows examines key elements of the nursing interventions identified, in order to consider the differences between adolescent and adult PICU mental health nursing interventions, the mechanisms by which they may contribute to young people's recovery journey and the challenges posed by them.

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 Adolescent PICU. This is in keeping with findings in the adult focused literature (Bjorkdahl et al, 2010; Salzmann-Kriksson, 2008).

A key difference however, is that studies in adult PICU environments identify managing the tensions within the environment as the nursing task. Whereas, this study contends that tensions arising in Adolescent PICU are an ever-present manifestation of the fundamental care needs of the client group from which the 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 (Ward and Gwinner, 2015; Salzmann Eriksson, 2011; Bjorkdahl et al, 2010; Salzmann-Krikson et al, 2008). This study has also borne out presence of a very similar tension within in the Adolescent PICU environment. However, it is but one amongst a much bigger number of tensions faced by the nursing team within Adolescent PICU.

The broader and more complex range of tensions that have to be managed can in part be accounted for by the nature of presenting difficulties identified within this study. The findings mirror previous work highlighting that multiple diagnoses, co-morbidity of neurodevelopmental and learning problems, alongside experiences of fragmented/unsuccessful care and abuse, are the norm within adolescent PICU environments, compared to an adult PICU focus on stabilisation of acute symptoms of psychiatric disorder (Page and Parker, 2015; Smith and

Hartman, 2002).This is further compounded by lengthier admissions and the co-location of acute and complex presentations, as a result of national/regional referral routes and limited discharge pathways in adolescent services (Jasti et al, 2011).

It may also be that 'Tension' as the producer of nursing interventions reflects that Adolescent PICU nursing is itself located on the boundary of two nursing specialisms – PICU nursing and child and adolescent mental health (CAMHS) nursing. Comparison of the findings of this study with a study exploring adult PICU nursing (Ward and Gwinner, 2015) and a study of CAMHS inpatient nursing (Rasmussen, 2012), highlight communication, teaching skills, observation and managing risk as common to all three settings. However, there are a range of additional interventions within adolescent PICU, described within the categories of 'emotional containment' and 'Personal qualities & self-management', that are distinct from those reported in either adult PICU or the CAMHS inpatient nursing studies.

Ward and Gwinner (2015) characterise the aim of adult PICU nursing interventions as creating a trustworthy environment so adults can 'tell' their story. Whereas, this research study found that the emotional and cognitive development needs of adolescents means that the 'emotional containment' nursing interventions identified are required to create relational conditions in which young people can 'show' their story within care-relationships with adults who are prepared feel something of the story not just see it; in order for them to translate it into words or helpful actions - giving it back in a form that the young person can understand (Reverie).

This process requires staff to withstand and make sense of a higher level of intrusion, violence and disinhibition - as a primary means by which the young people communicate pain and vulnerability. Which also appears 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 those young people who were felt to need to move on, due to their behaviours and risks being too difficult to manage within the setting. This is in direct contrast to the findings of this research study. In the context of Adolescent PICU being a 'last chance saloon', advocacy in this setting can be conceptualised as 'sticking with' and 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. When the time is right, this is followed by convincing other care providers of the young person's positive capacities and the emotional and developmental gains they have made, in order to advocate for the young person moving out of PICU.

Similarly, it is notable that the concept of child/service-user-led care may also be constructed or enacted differently within Adolescent PICU. Although the care systems in place on the unit do 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 collaborative, participatory and emancipatory characteristics usually associated with the term 'service user/child-led' (Winkworth and McArthur, 2006). However, there is evidence in a number of categories ('Attachment', 'Boundaries' and 'Personal requirements') where team members are led by the young people within the frame of their individual interpersonal encounters, or their approach to relationship building. This has parallels with the way in which Bowlby (1988) observed 'good-enough' mothers allowing themselves to being led by their infants as a means of enabling them to develop reciprocal communication, empathy and social adaptability

"[she] lets him call the tune and by skilful interweaving of her own response with his, creates a dialogue" (p7, 1988)

Whether this is via attending to the direct and indirect communications of a young person, such that the encounter is exclusively led by the expressed needs and motivations of the young person rather than the adult's agenda, or by intentionally adopting a one-down position such that young person experiences themselves as able to exert their knowledge and personal power in order to influence something of their environment; 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 (Lebau, 2009; Winnicott, 1979). This is the ultimate aim of participatory and service-user led approaches

Therefore, in the innately paternalistic and patriarchal context of the adolescent PICU (LeFrancois, 2013) child-led nursing approaches might be said to reside within the use of 'maternal' functions within the small details of the 'to and fro' of interpersonal encounters, in order to provide relational spaces for young people in which the usual 'adultist' and 'sanist' hierarchies are for a moment rearranged or challenged. It was observed that in this way staff seek to mitigate the impact of the unit's safety-focused restrictions, for which they are also responsible for executing, upon the young person's sense of personal power and agency.

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

Adshead (2001, 2002) argues 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 social, emotional and interpersonal stress regulating functions of an individual's internalized attachment representations. Whilst this may be 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 in order to be most effective (NICE, 2015). Adolescence is a time in which the attachment patterns, object-relationships and internal working models set up in infancy are tested and re-worked – a 'second individuation' - that draws on the mental functions developed through the primary-carer relationships experienced in earlier developmental stages (Waddell 2002, Blos, 1967).

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 cares and the ward itself are to expected (Page and Parker, 2015).

Against this backdrop, perhaps it is not surprising that the nursing interventions that have emerged within the team to meet the needs of the young people explicitly attend to their needs

for attuned, responsive carers who can forge relationships that soothe and promote growth and recovery. However, it is very noteworthy that ostensible descriptions of PICU or similar acute secure mental health service treatment models do not tend to explicitly name this aspect of treatment – focusing much more on acute treatment of psychiatric symptom management and pragmatic approaches to conferring safety. Even the Department of Health Relational Security model (DH, 2010), designed explicitly to support the management of the balance between security and care in secure mental health settings, does not directly address issues of attachment and dependency needs.

Adshead (2002) argues that Western medical accounts of illness, which are also usually rooted in understanding adult populations, tend to stigmatise the notion of dependency, as they "presume a 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." (pge.S42). It has also been observed that the systems and cultures present in healthcare institutions can fail to reward the contribution that sensitive and affectively attuned caregiving can make to service users (Schuengel et al, 2010).

Within the content analysis, the impact of a more medical model of understanding mental illness and 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. It also appears to adversely mitigate against the nursing team's ability identify their contribution to the young person's recovery; as they report being unsure about whether the relationships they forge, and the emotional labour they undertake within these relationships are a legitimate and contributory factor in a young person's recovery journey.

Whilst there is evidence within 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 and Schore, 2014). This occurs not just through down-regulating distress via calming and soothing responses, but also through 'up-regulating' positive emotions, through stimulating interest and pleasure (Schore and Schore, 2014). Both of these modes of attachment-informed interventions are evident within the findings of this study.

One way of supporting the nursing team to be more intentional and confident in their use of the attachment-informed interventions highlighted by this study could be through the introduction of a framework to support decision-making about when and how to use more explicit attachment relationship-based interventions for particular young people, over and above the contribution of all staff to trying to establish an environment that can function as a secure base for all young people. For an example of a framework of this kind see Schuengel and Van Ljzendoorn (2001)

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

Two codes were threaded throughout all of the different nursing intervention categories (Illustrated in Figure 2):

- 'learning about young people through the way they make you feel'
- 'knowing the whereabouts of young people '

The 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 "the mother feeling herself into the infant's place" (p304, Winnicott, 1956). 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). As such, 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.

A significant finding of this study is the way in which the practical task of high intensity observation (5 minute observations as standard) extends beyond the task of harm prevention, in the service of this process of emotional containment and regulation/ modulation of young people's mental representations of self.

In the mental health nursing literature, the purpose of high intensity or close observation practices is predominantly seen as harm prevention and risk assessment (Salzmann and Eriksson, 2012). As a result, close observation nursing practices are also often critiqued. Regulation of observation as a task by policy, rather than a personal encounter has been said to privilege physical safety over emotional safety, to objectify patients and depersonalise nursing care (Holylake, 2013; Stevenson and Cutliffe, 2006). As a form of surveillance, observation practices have been criticised as seeming to be a signifier of safety, whilst actually being an institutional instrument of power used against both patients and staff (Holmes, 2001). In the draft CAMHS PICU standards (Page and Parker, 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. Whereas, the findings of this study show how 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 and 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, 2008). Winnicott in particular conceptualised the therapeutic task involved in working with individuals in mental distress as a 'complex derivative' of the original face (i.e. the primary carer) whose role it was to reflect back all that the infant/patient brings'. In this model 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, recognized, and reflected back by a receptive other (Winnicott,1971), which in itself serves a containing function (Alvarez, 1999). Through this visual interplay comes the installation of an 'observer' within our own minds (sometimes experienced as an internal commentary or voice on our thoughts and actions). In good-enough circumstances this can be thought of an 'other' who sees us for who we are and still cares for us. Whereas, in circumstances in which

children have developed within a hard, watchful, critical or disorganised gaze, they may become identified with a harsh and ruthless or chaotic internal observer (Lemma, 2008); demonstrated through the self-loathing and self-destructive impulses evident in the codes describing the difficulties of the young people within the PICU setting.

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 children left in overwhelming states of anxiety which lead them to rely on primitive or 'infantile' defences (Splitting, denial, dissociation, discharging unbearable feelings through aggression to self and other). 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 (both literally and symbolically), in the pursuit of understanding one's emerging identity (Winnicott, 1971). The experience of being looked upon receptively, is both an invite to engage (Alvarez, 1999), and has a bodily-experienced component to it that can install a more benign appraisal of one's own body-self. In young people whose internal observer is hard and ruthless, being held in a receptive and acceptant gaze of professionals can equate 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 literature, are not also present within the adolescent PICU environment. Increasing levels of observation from 5 minutes to 1:1 or 2:1 are used on the unit to increase safety and relational security for young people in crisis. However, periods of enhanced observation of this kind were also identified as a frustration for staff. The impact upon staff member's perceived abilities to perform their job to their self-set 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" (P138, Musto and Schrieber) 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 can move from the being experienced by young people as 'being seen', i.e. recognised, taken in, and responded to, to being experienced as surveillance, i.e. 'being looked at'. In turn, opportunities for patient introjection of nursing reverie 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 and therefore increasing the risk of further incident. As Mitchell, (1998) points out, we are secure in familiar places and insecure in strange ones because the known environment sees us and the unknown one does not. This can be further compounded due to the need to increase staff numbers at times of enhanced observations which increase the likelihood of young people being nursed by staff by whom they are less well known.

The increased risk of incident and adversarial interaction between young people and staff can in turn lend itself to yet further employment of enhanced observations as a means of the staff group needing to find a way to re-establish a sense of control over the client group and the environment.

Analysis of the text from the four periods of high levels of enhanced observation reveals that it is often the use of the nuanced and detailed knowledge of young person - drawn from the experiential knowing that comes from 'seeing' associated with usual observation practices outside of crisis periods - to inform the therapeutic risk management strategies that actually enables reduction in enhanced observations levels to take place.

For clarity, this is not an argument against the availability of enhanced observation practice for times of high clinical acuity in the client group – being able to employ 1:1 observations clearly provides essential prevention from harm at times of crisis. However, the findings do indicate a need to consider pre-agreed strategies that can be quickly employed at times of increased enhanced observations, to facilitate the nursing team coming together, at a time when the clinical task actually separates them. This is in order for them to be able use their discipline expertise in conjunction with their collective knowledge of the young people, to plan care strategies that serve to limit the period for which enhanced observations are needed.

Effective care and that which erodes it are two sides of the same coin

An overwhelming outcome of the study is identification of the degree to which 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 interventions, and of the challenge to their ability to sustain their interventions. This finding mirrors literature on the emotional experience of working with adolescents and within PICU settings

Working with adolescents has been noted to be characterlogically different to providing mental health and psychotherapeutic intervention to other groups across the life span (Musto and Schreiber, 2012; Waddell, 2002). High levels of emotionality, reliance upon body based solutions to militate 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-counter-transference (Briggs 2008; Waddell 2002; Bradley, 1998).

Ruszczynski (2012), Winship (1998) and Smith and Hartman (2002) all argue 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 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, that aspects of the restrictive environment itself can feel similar to and become concretely equated with disturbing elements of the young person's past which then get repeated (Minne, 2011), via the mechanism of transference:

"an established pattern of relating and emotional responding [in the young person] that is cued by something in the present, but often times calls up both an affective state and thoughts that may have more to do with past experience that present ones"

(Maroda, 2005, p134)

There is therefore arguably a 'double-whammy' effect for nursing staff working within an adolescent PICU context. The impact of which is that effective nursing interventions and challenges to effective nursing care are two sides of the same coin, constituted of the same thing. The openness to receiving the young person's projections, also inevitably creates a risk of being stirred up by them and reacting in the moment, before having an opportunity to think about the meaning of them.

When the process works well, staff can see, respond to and sometimes name transference, noticing and using their own emotional experiences as information (See 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. Whilst this could be said to be true for all 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 and being responsible for maintaining observation requirements may inadvertently exclude them from some decision making arenas (Musto and Schrieber, 2012). This means that the nursing team too know something of the incarceration/restriction inherent in the setting.

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

- Anxiety - drives control and dominance as mechanism to try and assuage (e.g. nursing staff may tend towards more restrictive practices to maintain safety; other members of the MDT may tend towards trying to direct nursing care)
- Envy - leading to splitting and feelings of resentment towards the 'other' (for young people the focus is upon other young people who may seem to be getting a better deal, whilst for nursing staff this may be directed towards other members of the MDT or between HCA staff and RMN staff)
- Staff levels of sensitivity to perceived deprivation of care from their management team or employing organisation were noted to be higher when the level of experiences of maternal deprivation in the client group were also observed to be high.
- Identification with the aggressor (young person violence to self and other; staff feeling responsible for young people's distress or its exacerbation)
- 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.

Findings in the staff experience category show the importance of 'decoding' or 'sense making' to supporting staff sense of relational security and positive conceptualisations of the children in their care. This is just as 'decoding was identified within the study as an important intervention in helping assuage young people's frustration and reducing employment of infantile defence mechanisms. Whilst analysis of the NDG notes showed a strong staff commitment to trying to understand all aspects of the young people's presentations; 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, or to express feelings of being intentionally targeted by young people (e.g. attention seeking, doing it on purpose, they enjoy it). 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. This was seen to be more likely for the HCA staff, who often did not have the chance to sit in decision making forums and who do not always have a background knowledge or training in mental health.

In psychoanalytic theory, mis or non-recognition is understood as a universally troubling experience with potential to activate primitive anxiety states (fear of persecution and annihilation) in us all, and creates an absence in which fantasy can grow (e.g. "The medical team won't increase the young person's medication because they don't care about us getting hurt", whereas in fact the decision may have actually been made due to prescribing licence limits, but this information was not available to HCA staff). Therefore, a key finding of this study is the need to maximise the availability of the rationale for clinical decision making, not just the outcome, to all parts of the nursing team including the unqualified HCA staff. This includes the importance of providing knowledge and training, particularly for health care assistants 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).

The nursing team's capacity for persistence and tenacity (Personal qualities category) - sticking with a young person in 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 the young people's care, but also as having the capacity to corrode the staff group's resources.

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 focussing 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.

This appears to be compounded by another parallel with the young people's experience. 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 to try and decode the meaning of their behaviour; the findings of the study also show how much of the psychological nursing intervention is also located in a non-verbal responsiveness or embodied in 'the doing' of practical tasks This appears to have impacted upon the team's ability to make nursing interventions visible and valued, even by themselves.

Within nursing theory there is a tendency to identify the therapeutic relationship as an essential pre-requisite, which once established is the vehicle through which clinical treatments are effectively delivered, rather than it being the treatment. Perhaps similarly, it has been said of primary carer-child relationships, of which this study has shown mental health nursing in adolescent 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)

Whereas within psychoanalytic theory there is an inherent and specific language available for the detailed work involved in all interpersonal encounters and relationships. It is hoped that bringing this language to bear on the observation of mental health nursing practice with Adolescent PICU that it has gone some way to starting a much richer conversation about the contribution of mental health nursing to the recovery of the young people for whom the service provides.

Limitations

The research findings are based on a single adolescent PICU site. It is therefore not possible to claim generalisability of the results to all adolescent PICU settings. However, the theory generated from the results of this study may well have applicability beyond the unit in which it was conducted (Yin, 2003). To test this further, research in other adolescent PICU units is indicated, using a deductive framework based on findings from this study.

One of the potential problems of the study is the issue of what is not brought for discussion to the NDG by the nursing team – as this will by default be excluded from the data analysis. To address this, a relatively long (six month) data collection period for qualitative work of this kind was used, to reduce the risk of important aspects of nursing team work being absent for the units of analysis.

A fundamental limitation of this study is that the researcher is situated within the context being described. A number of steps have been added into the research method in order to try and mitigate the impact of this:
- The selection of an appropriate qualitative research method of which researcher subjectivity is an integral component of the analysis process.
- Explicit articulation of researcher assumptions and the theoretical underpinnings of the lens of analysis used within the research methodology
- A clear process of rigorous internal verification of the results
- Employment of critical reader/listeners– results have been presented in draft form to the nursing team through staff development days and presented to the senior management team. A Summary report was circulated to all team members for comment and feedback.

Conclusion

This study has demonstrated that the nature of nursing interventions within adolescent PICU is unique. They are 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, often against a back drop of chronic adversity and complex trauma. Adolescent PICU nursing interventions are

fundamentally relational in nature and yet are often delivered through attending to the small details of how highly practical and concrete actions are completed. They require explicit engagement with young people's dependency and unconscious communications, meaning that the factors that enhance or impede recovery are often two sides of the same coin. This needs to be explicitly considered in the planning of staff support strategies. High levels of enhanced observations (i.e. level 3 (1:1) or higher) for prolonged periods present a specific risk to both young people and staff's sense of self and relational security.

The challenges of articulating the 'what' and 'how' of mental health nursing in this setting have been addressed by drawing on language & theory outside of nursing, in order to name and organise the details components of the phenomena and interactions described by nursing team members when reflecting on their work, into a conceptual model of Adolescent PICU nursing.

Next Steps

- Development of an Adolescent PICU nursing model of care that is built around the relational/attachment/developmental ways of understanding the nursing contribution to young people's recovery. This will be undertaken in partnership with the nursing team. This can be aligned with the Priory Philosophy and the 7 C's. and linked with wider work being undertaken within the hospital, in relation to philosophies of care.
- Completion of Phase 2 and 3 of the research study evaluating the effectiveness of the Nursing Development Group

Recommendations

Consider using a framework to inform decision-making and greater team consensus in relation type of attachment or nurture based nursing interventions selected for individual young people (e.g. Schuengel and Van Ljzendoorn, 2001), given the complexity and heterogeneity of the attachment needs of young people within the setting;

Creating greater number of spaces for the nursing team to be physically together to share their collective knowledge and understanding of the young people and to use this for planning nursing care strategies.

Specifically looking for ways to enable spaces in which the nursing team to come together during periods of unavoidably high enhanced observations, for support and to find creative solutions to the challenges presented by the observation levels.

Development of support strategies for the nursing team that recognise the 'on and on-ness of it all' and the ways in which identification processes, essential to developing understanding of indirect communications and needs of young people, also cause distress and can have a detrimental effect on team members sense of worth and professional identity.

Increased training during induction re: understanding role of indirect communication (projective identification) in the ways in which the young people relate to staff and vice versa

Importance of information giving and communicating underlying rationale of decision making and formulations (particularly in relation to nursing interventions which are counterintuitive to logical or naturalistic reasoning - reduce risk of persecutory and negative interpretations of YP behaviour and splits between aspects of MDT

Through clinical supervision, helping staff identify what can realistically be done, and the worth of their contribution for young people with long term needs, for whom PICU is going to be only one component of their inpatient treatment journey

Actions already taken since commencement of the study to try and address the recommendations:

- Introduction of a weekly psychological formulation sharing meeting for HCA staff
- Inclusion where possible of HCA staff in the MDT review and ward round meetings.
- Seeking to ensure that a member of qualified staff (and preferably a member of the senior nursing team) participate in the Nursing Development Group.
- Feedback via staff development days of the provisional findings of the study, leading to greater dialogue within all parts of the team regarding the attachment and relational focus of the nursing team's work.
- The Priory is already in the process of devising staff training for the therapeutic approach within its CAMHS services and elements of the findings from this study will be used to inform the 'nurture' strand of this training.

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