NURSING AN ADOLESCENT IN AN ADULT INPATIENT

MENTAL HEALTH UNIT

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ABSTRACT

In New Zealand many adolescents in need of acute mental health care are admitted to adult mental health units. This situation results in mental health nurses working in the inpatient setting, working with increasing numbers of adolescent patients. Nurses are therefore often presented with the challenge of how to meet, and address, the specialised health needs of this particular group of health consumers.

Nurses whose experience lies in adult mental health and who are not accustomed to nursing adolescents, may easily become frustrated or bewildered by the adolescent patient. Adolescent behaviour can be misinterpreted by nurses, and their physical appearances can misguide nurses into treating them either like a child or an adult. These misconceptions can often have a negative effect on the adolescent patient, and may impinge on their mental health as well as affecting their developmental growth.

This research paper reports on an exploration of the key elements nurses need to be aware of to effectively nurse adolescents in an adult inpatient unit. It describes the developmental needs and significant influences that affect this age-group, that when incorporated into nursing care, nurses can gain a therapeutic relationship with the adolescent. By means of a literature review, sharing my experience in nursing adolescents and through vignettes of practice, an illustration of some common situations that may occur during the adolescent's inpatient stay are described. These situations are explored and a perspective is offered on how nurses may be effective in their nursing of an adolescent patient from the point of admission through to discharge. More research is needed on adolescent mental health nursing, however nurses will be able to use this report as a helpful resource in their current practice.

ACKNOWLEDGEMENTS

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INTRODUCTION

Statistics reveal that there were 43,330 adolescents between the ages of 12-19 years living in New Zealand as at December 1997 (New Zealand Health Information Services, 1999). Adolescents who would require mental health services in New Zealand are estimated at a rate of 5-7% of this number, approximately two to three thousand adolescents (McGeorge, 1995). Given these numbers, it is highly likely that many mental health nurses will nurse adolescent patients within their work environment in an inpatient setting. Furthermore, with only three specialist inpatient adolescent units in New Zealand to serve those in need of acute mental health care, this likelihood is extended. Therefore adolescents requiring inpatient care for mental health problems are generally cared for in general adult wards or in psychiatric wards (Ministry of Health, 1998).

In my experience as a registered nurse in an adult mental health inpatient unit, it is a common occurrence for an adolescent to be admitted for acute inpatient care. An issue of concern to me is my belief that it may be a common (although possibly inadvertent) practice for mental health nurses to sometimes view adolescent patients as children and on other occasions as young adults. Theorists such as Erikson (1995) consider the adolescent as neither an adult nor a child, but as an individual who is at a developmental stage in their lives which is particularly complex and challenging.

Having recently completed a postgraduate course in child and adolescent mental health along with other mental health practitioners from throughout New Zealand, it was clear from our discussions, that this practice of viewing adolescent inpatients as either children or young adults was not an occurrence peculiar to my workplace.

This practice extended throughout the country in varying degrees. Having searched a variety of databases on the internet, there appears to be a paucity of information to aid New Zealand mental health nurses nursing adolescent patients in adult settings. This has prompted me to share my experiences and knowledge in working with adolescents in an adult mental health inpatient unit. In sharing this experience, I have attempted to explicate the various theoretical concepts that influence and inform my practice and how these are used in a nursing context.

As nurses accustomed to nursing adults in an inpatient mental health unit are at times having to nurse an adolescent, the nurses should be aware of the needs of the adolescent. What are the specific considerations a nurse should be aware of to provide safe nursing care to the adolescent in this environment? This report sought to explore and describe what is important in nursing the adolescent in an adult unit. This is achieved through the report by a discussion of contributions from developmental theorists, by sharing my experience of having nursed adolescents in both inpatient and outpatient settings and, where available, relevant literature is referred to. Lastly, through the use of vignettes of practice, I illustrate how nursing an adolescent in an adult inpatient setting does not necessarily have to be a negative experience for either the nurse or the adolescent.

There has not been any singular, precise event that has influenced my practice, but multiple influences which continue to subtly change how I deliver nursing care. It has been the culmination of these experiences that has prompted me to write about the different needs of the adolescent patient which might easily be overlooked by the nurse in a busy adult mental health unit.

The writing of this research report stemmed from my current position where I am employed as a registered comprehensive nurse in a child and adolescent mental health service. As there is not a specialist inpatient mental health unit in this region, part of my job is to support nurses in their practice of nursing adolescents admitted to the adult inpatient unit. I considered this would then be a relatively easy report to write as I would be writing about the work that I do every day. However, what transpired, was that this has been the most difficult paper I have had yet to write!

For the substance of this report my intention was to share my knowledge and skills that I had acquired from my experiences in nursing adolescent patients in an adult mental health unit. So before setting forth in the writing, I began to contemplate what is it that nurses do that is unique to the profession that differs from other disciplines, for example, psychiatrists or psychologists. More specifically I wondered what is it that I do in my practice as a nurse when nursing the adolescent? I began to realise that I didn't know precisely what informed my individual practice when working with adolescents with a mental illness. Following numerous conversations with family, friends and colleagues regarding their interpretation of what skills they believed pertain to nursing, I entered into a lengthy process of reflection.

Throughout the report the vignettes are written in italics and are based on typical scenarios of my practice when nursing an adolescent; names and details are purely fictional.

BACKGROUND: MY STORY

My indoctrination to the world of nursing began in the mid 1970s, when as a 17 year old I began an 18 month hospital based training programme to become an enrolled nurse. This introduction to nursing placed me in the environment of a hospital setting where there existed a hierarchical structure between the various disciplines. It was a culture on its own, with a very clear delineation of nursing practice being in the realms of a task-orientated, medical model of care, where the patient was commonly referred to by their body part or disease. I became firmly entrenched in this style of nursing.

Following this era of my career, I then embarked on what I consider a turning point in my practice as a nurse. Whilst living in France (in my early twenties), I obtained a position as a nurse in a psychiatric hospital. Despite this being an area of nursing that was foreign to me, I was willing to explore it. Of significance during this period, was when a catholic nun, who was quite psychotic at the time, yelled at me "you have to like your patients before you can nurse them". Regardless of whether her accusations were truly directed at me or were part of her disturbed mind, was beside the point. Her words had a significant impact on how I thereafter viewed nursing patients. My mechanistic viewpoint changed to seeing that patients were individuals with families, friends, jobs and so on, and their emotions and how they related to the world were extremely important to me. I felt humbled and privileged to be nursing in mental health as it taught me the true essence of what I considered nursing was, to see the core of a human being. Mental health nursing was a career I wished to pursue, as I felt the rewards and challenges of helping a patient recover from something so complex as mental ill health was an honour. I continued to work in mental health when my husband and I returned to New Zealand a few years later.

Upon my return to New Zealand, the next significant event that impacted upon and shaped my nursing practice, was when I became a mother. I observed that in this important job of being a mother, I was required to undertake quite diverse roles with many different skills to meet the needs of my children. As a mother my roles could range from being a chef, a schoolteacher, a psychologist to even a rugby referee and fashion designer. The variety of roles that were required from me in parenting my children, I assimilated into my practice as a nurse. I acknowledged that for the people I nursed, I had different roles to perform and that the timing of when, and in which circumstances to apply these roles, was critical to my effectiveness as a nurse. It enabled me to recognise that nurses may come from diverse backgrounds with different life experiences that will influence and shape their nursing practice. This experience of being a parent, was the catalyst that enabled me to further articulate my own philosophy of what I do as a nurse.

The final and most important event that has impacted on my nursing practice and has also been the catalyst for where I am today, was my undertaking tertiary study. Five years ago I registered as a comprehensive nurse gaining a bachelor of nursing degree. Following this, I commenced study towards achieving a master's degree. During the early years of my studies for my masters degree, I also completed a post graduate certificate in child and adolescent mental health. What prompted this (certificate) was the desire to specialise in the field of adolescent mental health and to gain specific training to improve my practice in working with this age group. The course, although not nursing specific, provided a systematic framework for understanding, evaluating and managing childhood and adolescent psychiatric disorders.

For a number of years I had been informally designated as the nurse who worked with the adolescent patients in the inpatient unit. I enjoyed working with this age group and despite my minimal training/education in nursing adolescent patients, colleagues had frequently commented on how well I worked with the adolescent, that I was able to establish a good relationship with the adolescent patients and was able to help them to achieve some positive health gains. The majority of the nursing staff had voiced that they preferred to work with the adult patients. These nurses often expressed to me the difficulties they had in understanding some of the behaviours the adolescents exhibited and that they didn't know how best to respond. Many of these nurses had grown up children of their own, and they would often compare the adolescent's behaviour to their own families. However, my view was that the adolescents in the inpatient unit were very unwell. My philosophy was that the behaviour of an unwell adolescent could not be interpreted or responded to in the same way as that of adolescents who were happy, healthy and living at home with their family. So it evolved that I became the unofficial 'adolescent nurse' within the unit, and in this role I attempted to support my colleagues as best I could.

Increasing numbers of adolescents were coming into the inpatient unit, and staff other than myself had to nurse them. The adolescents' age makes them vulnerable in an adult unit, and with staff not adequately trained or skilled in child and adolescent disorders, nor the therapeutic options available for managing these, makes this not the most ideal environment. However, the reality of rural areas is that when inpatient care is necessary, adult units are the only option.

Being unable to articulate what it was that enabled me to work so well with the adolescent patients, I felt I was only able to support my colleagues very minimally at

best.   The observed frustrations of some very experienced nurses, and the voiced frustrations of the adolescents prompted me to acquire specialist training in the field of child and adolescent mental health.   Following completion of this course I was able to support my colleagues in a more effective manner.

To our credit, my nursing colleagues and the adolescents in our unit now work more effectively together, and with continuing support, supervision and education, there is increasing interest amongst the nursing staff in the field of adolescent mental health nursing.   It is hoped therefore that other nurses reading this paper may be able to recognise issues that I and my colleagues had struggled with, and that this recognition may in some way benefit nurses in similar circumstances in their practice, and make the journey of their work with adolescents less bumpy.

The summation of knowledge gained from these experiences has allowed me to recognise that my practice as a nurse has been influenced by many different things; some unique and some shared by other nurses.   I believe acquiring knowledge which informs and shapes my practice as a nurse is not a stagnant process, but is ever changing and is influenced by what has occurred in the past, in the present, and will continue to develop into the future.   The journey I have travelled in writing this report has allowed me to achieve great personal and professional growth because, although I share commonalities with other nurses, my individuality as a person denotes that my method of delivering care is unique to my practice.   My practice as a nurse continues to develop because I learn something from each patient that I work with.

DEVELOPMENTAL NEEDS

Introduction:

At each stage of the human life-span, from infancy through to adulthood, there are specific needs to be met in order to achieve healthy growth and development. The needs during the period of adolescence are discussed in this section as some of the influences which facilitates the progression from childhood to adulthood. Although I refer to the works of classical theorists such as Erikson, Piaget, Bowlby, and Minuchin (as well as reference to nursing research), this is by no means suggesting that other theoreticians in the field are any less relevant or less valuable. My uncritical use of these classic theorists is used only as a tool to simply highlight that adolescents are in a developmental stage that has specific needs. Their concepts have helped me to organise this information which I believe is important for nurses to consider in their nursing of an adolescent.

Embedded in my practice are my roots in the medical model, as components of my nursing I believe, are orientated towards disease processes and medical interventions, such as medication for symptom management. However, as 'building blocks' to inform and guide my practice, it is how I adapt the theories to the nursing milieu that I consider important in the development of my nursing practice. In most inpatient settings, (as a discipline) nurses are the practitioners who have the opportunity to spend the most amount of time with patients; as a result nurses can see a multi-faceted, holistic side to the patient. The skills nurses obtain as a result of such familiarity I believe, is the art of knowing when to apply such an eclectic assembly of 'borrowed theories', and which aspect of a theory is needed at a particular given time.

In nursing the adolescent, nurses are able to become familiar with their physical, emotional and psychological needs. The following section discusses these various needs in some detail, and will incorporate a socio-political focus embedded throughout the different areas rather than these being treated separately.

Adolescence:

In Western society toddler-hood and adolescence have, from an anecdotal perspective, predominantly gained comparative focus as being particular age-stages which are the most challenging for adults to relate to. Adolescence is a period where the individual not only faces the stress of the physiological changes that puberty brings, but can also simultaneously experience age-stage factors which replicate earlier childhood years, such as toddler-hood (Puskar & D'Antonio, 1993). Developmentally there is the same rapid physiological growth and the maturation of skills and abilities that enables the adolescent to achieve independence and the mastery of autonomy in their environment, and to co-exist in a socially co-operative manner with (one's) peers (Erikson, 1995). This integration of skills and abilities, along with accrued life experiences, help adolescents form a sense of identity. Positive affirmations received from peers, family and the larger society assists adolescents to develop their social values (Erikson, 1995).

Psychosocial:

Erikson's (1995) theory of development across the life span from a psychosocial perspective proposes that there are eight stages of development, ranging from infancy through to late adulthood. At each stage, there are certain demands and unique challenges made upon the individual that must be successfully resolved in order to

move on to the next stage of development. These demands and challenges are referred to as 'psychosocial crises', and "...refers to a state of tension between the developmental needs of the individual and the social expectations of the culture" (Newman & Newman, 1979, p.93).

Erikson theorises that from infancy through to adolescence, the final stage of childhood, the process of resolving psychosocial crises, aids one to develop a sense of individual identity (Hales, Yudofsky, & Talbott, 1999). During infancy, the goal is the establishment of a nurturing relationship with the primary caregiver, and is termed, 'trust versus mistrust' (Erikson, 1995). In adolescence the crisis to be resolved is 'identity versus role diffusion' (Erikson, 1995). The goal of adolescence being the passage from childhood to adulthood whereby they establish autonomy and independence from parents, and achieve growth in identity formation.

Peer groups:

As the adolescent transcends the journey towards independence and autonomy from parents, they increasingly identify with the culture and norms of their peer group. They assume similar dress codes, styles of communication and behaviour, all of which are dictated by the norms of whichever peer group an adolescent belongs to (Erikson, 1995). The formation of peer relationships is an important task of adolescence, as it provides an environment for the adolescent to challenge personal characteristics, test how others perceive them, and to seek validation of themselves. It facilitates the opportunity for role experimentation, introspection, evaluating and testing one's personal values, morals and ethics that will define and consolidate their integrated identity (Erikson, 1995).

Cognitive:

Through introspection, the adolescent evaluates the outcomes of role experimentation. How successful an adolescent is in evaluating the usefulness of the different roles will largely depend on their level of cognitive development (Piaget & Inhelder, 1969). Piaget and Inhelder argue that during adolescence the cognitive changes that occur are the transition from 'concrete operations' to 'formal operations'. Typically this maturity in thinking is demonstrated by the ability to combine a variety of multiple concepts, and hypothesise what might eventuate given the information one has (Piaget & Inhelder, 1969). The adolescent progressively develops this cognitive capacity to think in abstract terms. They are increasingly able to demonstrate a more sophisticated ability in problem-solving and decision-making compared to the concrete, dichotomous style of thinking exhibited during childhood (Hales, Yudofsky, & Talbott, 1999).

The cognitive ability to modify and adjust one's behaviour during this period of role experimentation suggests this demonstrates the use of formal operations, as it involves the evaluation of multiple variables, where choices are made depending on the evaluation of the alternatives (Taylor & Muller, 1995). Hales, Yudofsky and Talbott (1999) believe that being able to problem-solve in the more effective and sophisticated manner that signifies the cognitive achievement of formal operations, is not uniformly acquired at a specific age. Their research findings suggest that by the age of 16 to 17 years, only 35% of adolescents have attained the cognitive skills of formal operations. The influences that may impede or facilitate cognitive development arise from the successes and failures and the confidence gained when trying these new skills in a variety of situations (Geldard & Geldard, 1999).

Environmental influences:

Cognitive, emotional and interpersonal skills are influenced by external environmental variables such as peers, family and society. Parents contribute an important influence to a child's development, in the provision of what type of social, emotional and intellectual environment the child grows up in (Shaffer, 1989). Contributions from Bowlby (1965) support this view and he views that "the quality of parental care which a child receives in his earliest years is of vital importance for his future mental health" (p.13). Bowlby theorises that the relationship that initially occurs between the infant and mother (or mother-substitute) is significant in that this early social relationship plays an important role in healthy psychological development. Varied by relationships with the father, brothers and sisters, the child develops skills of positive social interaction with others, which is reinforced by the people in its environment.

The effect of the relationship a child develops with the primary caregiver has consequences in adolescence. Unsatisfactory relationships can have a negative effect on how an adolescent deals with stressful situations and have been associated with poor self-image, early or high-risk sexual activity, substance abuse, anxiety disorders and eating disorders (Geldard & Geldard, 1999).

Family functioning:

Children are born into families which may be comprised of two-parent, single-parent or step-family households. In many ways children are reliant on the effective functioning of their parents and/or other significant adults, for their survival and emotional health (Johnson, 1995). The relationships that families as a unit have with each other, plays a significant role in healthy growth and development. It is

considered that a family functions as a social system, with each member influencing one another in providing a training ground that facilitates growth towards adult independence and autonomy (Minuchin, 1974). The family provides an environment like that of a 'mini society', where patterns of social behaviour can be learnt that will enable one to function adaptively as a member of the society in which one lives (Minuchin, 1974).

Within the structure of a family individuals have a role to perform, that of a parent (or primary caregiver), spouse (or partner), sibling or child. Each role has its own associated rules and boundaries which serve to maintain a protective barrier in family functioning (Minuchin, 1974). When boundaries between family members become blurred or are not established, maladaptive relationships, disequilibrium and family instability can result. For example, the husband/wife dyad are generally accepted in Western society, as the authority figures within a family. If a child/child dyad assumes a power hierarchy above that of the parents, this can affect the whole family functioning and problems may occur (Minuchin, 1974).

Ineffectual communication within a family can cause disharmony and problems in the interpersonal relationship between its members. If the roles, rules and boundaries of the family system are not established, are inflexible or inconsistently reinforced by parents, confusion of the hierarchical structure can lead to manifestations of family instability (Minuchin, 1974).

How a family functions can depend on the quality of the parental relationship. Grossman and Rowat (cited in Geldard & Geldard, 1999) found in their study of a

number of families, that the importance of whether the parents were married, separated, divorced, or in new blended families was less significant to the adolescent than was the quality of the relationship between the parents.

Parenting styles:

Parents, parent differently. Some models of parenting are conducive to the 'healthy' development of a child while others are not. Being aware there are many forms of child abuse, parenting styles considered to have an adverse influence on the psychological development of a child are 'authoritarian' and 'permissive' parenting (Taylor & Muller, 1995). Styles of parenting where there is poor communication, inflexible rules, control and expectation of obedience are authoritarian; and 'permissive' parenting styles are where little authority is exerted. Both these parenting styles are considered to have an adverse influence on child development (Johnson, 1995). Adolescents from these backgrounds typically have low self-esteem, are more aggressive, are more irresponsible and erratic in behaviour, and have difficulty in confidently seeking independence from family (Taylor & Muller, 1995). Positive developmental outcomes can be achieved by the adolescent whose parents "are supportive, encourage positive rational and interactive communication while they use firm and constant discipline. In other words, the parents are authoritative" (Geldard & Geldard, 1999, p. 26)

As they develop, adolescents will test limits and boundaries in their attempt to challenge rules that they consider they have outgrown. In their striving to gain the autonomy and independence permitted in adulthood, the adolescent may make mistakes in their behaviour. Unless they receive cues from the environment (family,

peers, society) to indicate what is, and what is not socially acceptable, they may enter adolescence with little or no guidelines (Taylor & Muller, 1995). Confusion may result for an adolescent if, for example, they receive cues from parents who are authoritarian; the inflexibility of such an environment will not foster self-confidence or promote independence (Taylor & Muller, 1995).

For an adolescent to derive self-confidence and independence in negotiating the developmental tasks of adolescence depends on how well they are equipped to confront the developmental challenges encountered. The implications of adolescents' experiences during childhood within the family environment, and their relationships with peers and society, will have some effect on how successful they are. Geldard and Geldard (1999) express that "when an adolescent is unable to confront and deal with a developmental challenge successfully there are likely to be unhelpful psychological, emotional and behavioural consequences" (p. 2).

Development of mental health problems:

The challenges of coping with the developmental tasks of adolescence can often result in considerable unhappiness. In the processes of trying to establish an identity, separating from parents, career choices, friendships and romantic relationships to name but a few, the adolescent will experience some failures as well as successes (Kronenberger & Meyer, 1996). Most adolescents are able to cope with the developmental challenges that adolescence brings. However, when psychological or emotional responses become maladaptive, symptoms of illness are likely to develop, with the adolescent exhibiting symptoms of a mental health disorder such as anxiety, depression (Geldard & Geldard, 1999).

There are many theories that exist to explain the development of mental illness. What causes some individuals to develop a mental illness and not others, is largely unknown. There are various studies indicating that biological or genetic inheritance may increase an individual's vulnerability for developing mental illness (Keltner, Schwecke, & Bostrom, 1999). Kronenberger and Meyer (1996) discuss the role genetics play in the development of depression, but state that although there is evidence which supports this theory, environmental and other biological factors are necessary for depression to develop. Most theoreticians agree the causes of mental illness are multifactorial, and may be influenced by a complex interplay between genetic factors, environmental and family experiences, trauma, and temperamental factors (Barker, 1995).

Given the multiple explanations that contribute to mental illness developing in adolescents, there are many treatments and therapies to address symptoms of mental illness. Many adolescents with mental illness get involved with the mental health service and some require admission to an inpatient setting. Inpatient units are generally for those patients whose symptoms are severe and/or are in need of protection for their own safety, or for the safety of others (Keltner, Schwecke, & Bostrom, 1999). It is in nursing the adolescent in an adult inpatient unit that I am now going to move on to.

NURSING CONTEXT

Introduction:

Admission to adult inpatient units occurs because sometimes this is the best option to maintain an adolescent's safety. Not only does becoming an inpatient pose significant stress upon an adolescent, it also places the nurse in the position where she/he must be an advocate for the adolescent patient to ensure their needs are met. The vulnerability of the age group, and the exposure to adults who are mentally unwell, will involve intense work from staff to not only meet the developmental requirements of the adolescent, but to also impose interventions to maintain their safety whilst being therapeutic. By providing a safe, structured, adolescent-focused environment, I believe nurses in their multifaceted roles can promote the health and well-being of the adolescent patient, and in addition can support their developmental requirements.

The nurse's role with the adolescent is integral in achieving therapeutic success throughout the entire period of hospitalisation. For this next section I have separated the 'journey' of an adolescent coming into hospital into three stages: the **admission**, the **inpatient stay**, and **discharge**. For each stage, with the use of vignettes, I have discussed aspects of developing a relationship with the adolescent that can be obtained if consideration is given to their developmental needs. I have been succinct in my descriptions of many aspects of care and treatment in the vignettes, as it is intended that the scenarios are interpreted for the purpose of prompting nurses to learn more about adolescent nursing. The intention of the vignettes is not to pronounce any particular practice as being 'the only way to nurse adolescents', but rather to share interventions I have developed over the years that have had positive outcomes.

Admission:

Admission to a mental health facility can impose stressors, in addition to that of having an illness, which may inhibit progress in the adolescent's recovery. Causey, McKay, Rosenthal and Darnell (1998) in their research, identified hospital-related stressors that cause adolescents problems in adjusting to such a facility. These stressors included separation from friends/family, loss of autonomy, and fears of being 'locked up' in a psychiatric setting and the associated stigma attached to this. The admission procedure offers an important chance for negative expectations to become a positive experience (Scharer, 1999), and can present the nurse with a valuable opportunity to build a relationship with the adolescent patient. In admitting the adolescent it is helpful that a nurse is well grounded in developmental theory to enable them to differentiate between "...age-typical responses to stress and which behaviours represent alterations in development and/or psychopathology" (DeSocio, Bowllan, & Staschak, 1997, p. 24).

The reaction an adolescent may have to being admitted to an adult psychiatric ward may further threaten a sense of self-worth. It may further reinforce a self-image that they have hidden from others, as being 'weird', 'crazy' or 'different' from peers (Creedy & Crowe, 1996). The adolescent's cognitive immaturity, or mental ill health may inhibit their ability to comprehend why they needed to come to hospital. This may result in further compounding an adolescent's internal sense of powerlessness (Creedy & Crowe, 1996).

The following vignette will illustrate how, in being sensitive to the needs of an adolescent, the key to a successful introduction to an adult inpatient unit can be

achieved. The vignette developed is a typical presentation that is seen in our inpatient unit and most probably in other units around New Zealand. The vignette commences after the decision has been made to admit the adolescent to the inpatient unit. For the purpose of simplicity, there are areas where I provide minimal details or have not discussed, such as the rationale for admission, or the inquiry around physical/sexual abuse. This is because knowledge and skills of these are embedded into the practice of all mental health nurses, and the focus of this report is intended to highlight the importance of nurses acquiring knowledge specific to the developmental needs of adolescents. The background data provided is anticipated to be used by the nurse as part of the initial 'picture' when gathering collateral information to assist in their process of formulating a plan of nursing care.

Vignette:

Shelly was a 15 year-old adolescent who had been causing her parents concern for some time. Her parents gave an account of Shelly, who up until a few weeks ago, was usually a very courteous and sociable person, an above average student and was well-liked by her teachers and peers alike. However, she had increasingly been spending most of her time in her bedroom, had little contact with her friends, and had been frequently in trouble at school for not completing her work. She was always irritable and despite her parent's patience and efforts to communicate and help Shelly, nothing appeared to be working, but rather getting worse. Her parents were at the point of seeking professional help, when they found Shelly attempting to take her own life. She was treated in hospital until she was medically stable, then assessed by the child and adolescent psychiatrist.

The responsibility and decision to admit someone to the inpatient unit is always that of the psychiatrist. The child psychiatrist believed Shelly to be still at risk, and having considered the negative effects of admission to the adult inpatient unit, felt it was the safest available option. Shelly's parents agreed with this as they were frightened she may try to attempt suicide again. The psychiatrist informed the nurses of the details regarding Shelly's past and presenting history, and arranged her admission.

I met Shelly while I was working an evening shift as a registered nurse on the inpatient unit. It was an extremely busy shift with 26 patients, one of whom had become extremely unwell and was being accompanied by the nurses to the seclusion room for safety purposes. The unit was noisy, staff were rushing around, and with more patients than usual it felt quite claustrophobic. It was at this point 15-year-old Shelly, Shelly's parents and the doctor arrived on the unit.

Whilst being mindful of the patient and staff in the seclusion area, I greeted Shelly and her parents in a calm, relaxed and friendly manner and ushered them into the interview office away from the commotion of the patient area. In the setting of the office, we introduced ourselves and the psychiatrist advised that Shelly was being admitted for safekeeping, due to her depressed mood and thoughts of self-harm. The psychiatrist then excused himself and retreated to the nurses' office to write an admission history in Shelly's file, leaving me with Shelly and her parents.

Shelly was sitting in her chair with slouched shoulders, head downcast and nervously twisting a bracelet on her wrist. There was little emotion displayed on her face, she looked drawn and tired, tears not far from the surface. During the first few minutes Shelly would not engage in any communication with me nor make any eye contact, however towards her parents she indicated her anger with them for bringing her into the mental health unit, but gave the impression of being resigned to being here.

The initial impression an adolescent receives of the inpatient unit can be effectively influenced during admission, so a careful attention and a positive welcome by the nurse may assist with the anxiety and fears of being there (Howe, 1980). Often adolescents do not come to our inpatient unit by choice, but are coerced by their parents. Shelly's angry manner towards her parents I interpreted in part as being her means as an adolescent, of communicating her anger and her anxiety at being admitted to a mental health unit. Congruent with a depressive illness, her demeanour could also be an indicator of her level of un-wellness. She possibly lacked the cognitive maturity to reason the need for hospitalisation. Kovacs (1997) reported that depression can have a negative effect on a child or adolescent's cognitive development.

Although the symptoms of depression in adolescents are not that dissimilar to those in adults, the symptoms observed are slightly different. For example some adolescents may respond to depression by externalising their feelings. Such externalising may include behaviour that is aggressive or hostile, exhibiting agitation or voicing physical complaints (Kronenberger & Meyer, 1996). Kronenberger and Meyer (1996) argue

that common features often seen in depressed adolescents include:

> sadness, irritability, negative thinking, guilt, worthlessness, low self-esteem, worthlessness, 'bored', poor concentration, sleep and appetite disturbance, fatigue, social withdrawal, decline in academic ability or social functioning, oppositionality, suicidal ideation.   Occasional features include suicide attempt, oppositionality, poor peer relationships, psychomotor agitation or retardation (p.162).

The information provided by Shelly's parents and the psychiatrist regarding the precipitating events leading to admission, was symptomatic of depression, but indicated there may also be many negative effects from aspects of Shelly's development.   For example, the effects of depressive symptoms (e.g. poor concentration, lack of motivation, sleep disturbance, irritability) may account for Shelly being accused by teachers/parents, as being lazy.   The decline in her schoolwork may have snowballed into conflict at school and home, leading to increased feelings of hopelessness, isolation and loss of friends and social standing within the classroom; thus perpetuating a negative cycle.   Often when an adolescent is depressed, the ambiguous behaviours of their peers in response to their symptoms may further reinforce feelings of worthlessness and negativity (Kronenberger & Meyer, 1996).

As peer relationships and positive environmental affirmations are essential in adolescent development of autonomy and individual identity, the cues that Shelly may have received whilst depressed could have a negative impact on this. The effects of depression and its impact on cognitive maturity, combined with the adolescent

tendency to not want to appear 'different' or 'abnormal', often results in the adolescent hiding from others what they are feeling inside (Kronenberger & Meyer, 1996).

It could be safe to assume that the depression may have impacted on Shelly's social skills, self-esteem, her sense of autonomy and individuality, so alongside the foremost goal of safety, my aim was to help restore these deficits that would allow Shelly to regain some control of her life again.

Vignette:

The first goals during admission were to try and reduce Shelly's (and her parents) anxiety, promote a sense of safety, and to begin the process of helping Shelly to enhance her sense of autonomy and individuality. To achieve this at this point of our meeting, I directed my explanations outlining the safety precautions, rules and routines, confidentiality, as well as some activities that normally take place on the unit, primarily to Shelly, as I wanted her to see that my full concentration was on her as an individual. I did however, assure my accessibility to Shelly's parents and ensured they felt included and part of the process. So as not to appear too scary or official, as I showed them around the unit, I chatted in a friendly manner to Shelly about superficial topics that were common to her age group like music, television and fashion. Simultaneously, I evaluated how she reacted to my style of communication, as it was important she felt comfortable with me in the process of our building a therapeutic relationship together. Although not very communicative, Shelly and I identified that enjoying the same television show was something we

shared in common and she began to relax a little with me from then on.

Once Shelly was familiar with the layout of the building, I showed her and her parents to her bedroom. I encouraged her to have her family bring in some of her trinkets from home to make her feel more comfortable. I talked about that although not home, normalisation of her environment (as much as possible under the circumstances) would be beneficial. I explained that friends and family were most welcome to visit at any time, that the mental health unit of today wasn't a 'prison', and that eventually she could go on outings with her parents. This reassurance is very helpful, as most people have no indication other than what they have seen in movies, a stigmatised version of what an in-patient mental health unit is like; often envisaging straight-jackets and padded cells.

As our unit has only a few single rooms with the others being four beds or dormitory, I always endeavour to provide an adolescent with a room of their own. This not only addresses the adolescent's tendency to need their own 'space and privacy' (DeSocio, Bowllan, & Staschak, 1997), but also helps them feel more secure as they (as well as parents) are often quite concerned and unsure about the adult patients in the unit. A single room also provides the adolescent with some protection against the influences of adults who, may not be good role models for the adolescent to be spending any length of time with. However, if other adolescents happen to be in the unit at the same time, generally they befriend each other after a few days, and ask to share a room together. This can be beneficial as it can foster a mutual sense of security being with peers their own age, as well as recovering social skills through talking with each other.

Vignette:

I reassured Shelly and her parents that I had nursed many adolescents in the unit and told them of a few common feelings and thoughts these adolescents had expressed to me. Many had said they felt nervous and scared coming into the unit, but felt a little more relaxed after a couple of days once they had got to know the routines and the staff. Not knowing Shelly's nor her parents level of understanding around depression, providing some common features and symptoms experienced by other adolescents, was beneficial. It gave some reassurance to Shelly that the symptoms she had been experiencing were not a sign she was abnormal, or that she should feel isolated or different from her peers. Shelly and her parents had relaxed a little since first arriving, so it was timely to be more detailed about some things she might expect to happen while she was here. I explained that as her nurse I would be available to her when I was on duty and that at other times, two other nurses familiar with her care would be part of the 'team' of nurses primarily working with her.

Many parents bringing their child into a mental health setting are often at the 'end of their tether'. They are tired, exhausted and stressed and have often been trying to cope with their distressed adolescent at home, desperate to help them but sometimes finding they have insufficient resources or knowledge of what to do anymore. They often blame themselves and struggle with the idea that their child needs psychiatric care (Scharer, 1999). By giving my undivided attention to their daughter, despite a busy unit environment, Shelly's parents were able to observe my invested interest and competence in nursing their daughter. Her parents needed support and reassurance as well, because they too, were very concerned and apprehensive.

Parents throughout the inpatient stay should be encouraged to feel comfortable to talk with staff of their emotional needs, and to seek information (DeSocio, Bowllan, & Staschak, 1997). Some parents may have feelings of inadequacy or feel guilty having their child admitted to the inpatient unit, or feel that they have failed as parents. Nurses should endeavour to establish a trusting relationship with the parents, and let them know their contribution is valued and respected.

By being aware of Shelly's illness and the effects this may have on developmental processes, I kept my interactions at quite a concrete level, giving her a great amount of detail, leaving as little to the imagination as possible. Her anxiety toward hospitalisation was obvious to me, and becoming a patient didn't need to be yet another 'proof' of a negative self-image. Considering the importance of attachment relationships and the relevance this has on fostering social functioning and independence (Bowlby, 1965), my dialogue therefore was carefully chosen so that my response to the anxiety Shelly communicated was reciprocated with a soothing tone and positive content. This behaviour enhances the prospect of a healthy relationship developing between us. Shelly's sense of autonomy and individuality was encouraged as I enabled her to see that although her parents were adults like myself, my primary focus was on her, the adolescent. I tried to communicate with her at 'her level' so as not to appear superior to her.

Shelly's reluctance to be in the unit posed some difficulty in establishing a relationship with her. As her age was 15 years, her legal right to consent to treatment had been over-ruled by her parents. When, and when not to involve the adolescent in such a decision is not always as simple as this. In New Zealand persons under the age

of 16 years are considered minors, and therefore, do not have the legal right to consent to or refuse treatment (Bouchier, 1997). This situation puts the nurse in an awkward position, as the adolescent is often angry, anxious and reluctant to participate in any form of treatment. The adolescent may also feel the nursing staff are in collusion with their parents and the doctor, and resist attempts to engage them in interacting. Acknowledging the adolescent's feelings, being sensitive and providing consistent reassurance can help to over-come this initial resistance to inpatient care. I have nursed extremely angry adolescents who refused to even talk with the nurses when they were first admitted. But persistent attempts to engage the adolescent in conversation, displaying a friendly and empathetic approach and being frequently available, can eventually break through these barriers and reduce their anxiety of being in hospital.

Understandably, the anxiety an adolescent experiences during the admission period is a common feature. In acknowledging this anxiety in a forthright and honest manner, permits the adolescent to see that their feelings are important and that the nurse has tried to be sensitive to their needs. It has been my observation and experience that most adolescents when they first come to the unit want to know who they can trust and depend on, and if they will be accepted for who they are and what they are feeling. They can be frightened, and be feeling that their world is falling apart. They need to feel they are safe until their internal strengths and resources are restored. Therefore I consider the admission process as being an extremely important period that requires a lot of time, patience and sensitivity, but if done well, can lay the foundation for a therapeutic relationship and successful hospital stay. As the adolescent exhibits a gradual acquisition of new skills, and maturity in development is gained, family

involvement is an integral aspect of the inpatient stay and is essential for a successful discharge.

The duration of the hospital stay will vary according to each individual, and may depend on how responsive they are to treatment, but will also be influenced by how successful the nurse is in his/her relationship with the adolescent. I will now move on to discussing aspects of the inpatient stay that are important for a nurse to consider.

Inpatient Stay:

Nurses experienced in working in adult psychiatric wards, and perhaps unaccustomed to/unfamiliar with the developmental needs of adolescents, may easily perceive the adolescent patient as a child or an adult. This perception occurs because the adolescent may have the physical appearance of an adult. Also "many adolescents participate in adult behaviour: manage homes, drive automobiles, use alcohol and drugs, are sexually active..." (Lamb, Puskar, & Tusaie-Mumford, 2001, p. 43). It is therefore not unrealistic that nurses may inadvertently expect them to behave like adults, and may treat them with the same maturity and understanding as that of an adult. Alternatively, if the adolescent displays argumentative, defiant or oppositional behaviour with the nurse, it might be assumed the maturity level of the adolescent is that of a child, and the nurse may treat them accordingly, and be quite controlling in working with the adolescent. In such circumstances an adolescent may resort to behaviours they are familiar with and accustomed to exhibiting in their home environment, and challenge this nurse's authority by refusing to go to bed for example (Geanellos, 1997).

The following vignette, again a typical scenario, is used as an example of when nursing an adolescent in an inpatient setting, the relationship that the nurse gains with the adolescent, can have a significant influence on health outcomes. Recognising and promoting the developmental needs in their nursing of an adolescent, nurses can not only achieve therapeutic gains, but also can promote a safe and structured adolescent-focused environment

Vignette:

Shelly had been in the acute adult inpatient mental health unit now for two weeks and was beginning to get to know the routines and nurses on the unit. Her depression had been partially responsive to medication and her mood was beginning to improve. She still had periods of sadness and her self-esteem was still low, and she lacked confidence in herself. For several days now she reported she no longer felt the suicidal ideas as being so prominent and her safety, although being carefully monitored, was becoming less of a prominent feature of nursing interventions. Her level of observations had decreased from one-on-one 'specialling' (a nurse with her 24-hours a day), to checks every 15-minutes.

Thus far in my relationship with Shelly, I was allowing her to guide me in how fast we progressed in the development of a therapeutic relationship. This I gauged by her maintained reluctance to engage in anything other than superficial conversation. I respected that she wasn't totally comfortable with me up till now, and didn't 'push' her to talk about anything sensitive if she wasn't yet ready. I felt it was important to allow her to work at her own pace in establishing who she could trust with her feelings without fear of being 'judged' or not be accepted for her individuality. So Shelly and I would spend time together doing activities or sitting watching television. Sometimes I would just sit on the end of her bed chatting and laughing about funny things my children had done over the weekend. It was my observation that she enjoyed this, and would use these times to ask questions sometimes about my life, not probing personal questions, but ones that were usually aimed at

getting to know me better as a person.

Adolescents, like other patients, need to know that they are safe, that the nurse is genuinely interested in them and will persevere despite their possible attempts to put up communication barriers so as not to reveal how they are feeling (Creedy & Crowe, 1996). The periods spent with the adolescent doing activities or having conversations can increase their sense of self-worth, that the nurse is interested in them enough as a person to be spending time with, and not solely intent on 'formal' therapy (Geanellos, 1997). It is also important to recognise that every interaction a nurse has with the adolescent is a therapeutic intervention, as even my vocabulary and mannerisms reflected a friendliness and portrayed a willingness to understand her stage of development, without over-identifying or trying to act like an adolescent myself. Interpreting communication, verbal and non-verbal, and being sensitive to behaviours, is important to understand as sometimes surface behaviours (like Shelly's unwillingness to discuss her emotional state) are often an adolescent's means to disguise their emotionally sensitive state (Creedy & Crowe, 1996). Subsequently a nurse needs to decipher what 'message' the adolescent is sending them in order to be effective in his/her nursing care and work with what the underlying message is saying (Geanellos, 1997).

Although it might appear the adolescent is not making any forward progress, it is important to accept that the adolescent patient generally needs to set the pace. Sometimes the adolescent may only demonstrate advancements that may seem minor to the nurse, but which are, for the adolescent, major achievements (Brunger, 1986).

Vignette:

After a while Shelly would ask questions about other patients in the unit and I discussed with her about confidentiality and respecting every patient's privacy. This appeared to be another 'test' of whom she could trust, but also an indication she was taking a more active interest in her surroundings and getting ready to move forward in our relationship. As Shelly was becoming more visible around the unit and not staying in her room as much, it was inevitable that she would converse with the other patients. I encouraged her to seek a nurse if she was concerned or confused about other patients' behaviours as sometimes it could be quite disturbing to witness some of the happenings on an adult unit. I also advised Shelly that the mere exuberance of adolescence is sometimes not well tolerated by adult patients, and they may voice their irritability at an adolescent patient (maybe inadvertently reinforcing a negative self-image to the adolescent), but with certain rules and boundaries to use as guidelines for expected behaviour, everyone can generally get along quite well despite the differences in age groups.

As the adolescent vacillates between childhood and adulthood, relationships they experience with others provide some assistance to evaluate themselves and how others perceive them. A depressed adolescent will typically hold a negative self-view and be in a vulnerable frame of mind. When they are with adult patients who are also unwell, there is the potential they may receive messages about themselves that might not be positive. I have commonly observed that the adolescent's cognitive maturity inhibits their ability to reason that the adult is unwell. Additionally the adolescent may observe distressed adults and need reassurance and comfort to see that the nurse

can calmly and effectively care for these patients as well as be there for the adolescent (DeSocio, Bowllan, & Staschak, 1997). The adult patients and the adolescent patients equally require an environment that supports their individual needs. It can sometimes become a fragile balance for the nurse to provide and maintain equilibrium in an inpatient setting, for both age-groups to co-habit collaboratively.

Vignette:

To progressively increase Shelly's autonomy, Shelly had input into developing her plan of care. This plan structured her day and incorporated private time to herself (to sleep in, listen to music, read, watch television), and times to socialise with friends, talk on the phone, enjoy leisure activities and outings with the staff. It also included some school work, and allocated time with her nurse each shift. Importantly an area had been arranged within the unit (away from the patient area), where Shelly could socialise with her friends or take her family when they came to visit.

At her own pace, Shelly had increasingly began to discuss some of the feelings she had been experiencing, and how this had affected her life both at home and at school. Together the nursing team worked on interventions aimed at increasing her self-esteem where she would achieve some successes in activities and gain improvements in her schoolwork. With the aid of both the hospital teacher and the teacher from her school. Shelly was catching up on her educational needs, which resulted in a more positive attitude and increasing confidence in Shelly.

The process of the nurse and the adolescent working in partnership on a structured programme that aims to create a therapeutic and supportive environment reduces the eventuality of boredom, over-stimulation and isolation. Where an adolescent is alone too often they may become overwhelmed by their emotions, and present this distress in the form of behavioural problems (Geanellos, 1997). Adolescents are accustomed to having structure at school, so structure within the unit will provide a predictable routine that the adolescent has some control over (Brage, 1995). It can also provide inexperienced nurses, when first working with an adolescent with a predictable programme so they too are not overwhelmed by behaviour they don't yet understand (DeSocio, Bowllan, & Staschak, 1997). My experience in nursing adolescents has shown me that by providing structure that incorporates adolescent-focused activities, not only ensures that excess energy is expended, but it also facilitates the opportunity to discuss the rules and boundaries with the adolescent in a respectful manner.

Establishing boundaries is essential in the relationship with the adolescent patient as it provides them with a sense of containment, security and clear expectations of acceptable behaviour that can be tolerated within an inpatient setting (Geanellos, 1997). I have observed that the adolescent responds very well when nurses clearly establish the rules and boundaries, and give the opportunity for the adolescent to gain control and take responsibility for their actions. The nurse may feel pulled between a balance of promoting autonomy and letting a situation escalate into an out-of-control and unsafe situation. However, safety must supersede all, and the nurse must judge when it is necessary to step in and take control. If taking control is done in a calm and non-judgemental manner, can usually be effective if the therapeutic relationship exists between the nurse and adolescent (Geanellos, 1997).

Vignette:

> *Shelly voiced that she didn't get on too well with some of the nurses, felt they*
> *didn't understand her, that some were quite bossy and controlling with her,*
> *while others she felt very comfortable with and felt they were like family or*
> *friends.   On one occasion she got quite angry with a new nurse whom she felt*
> *was being extremely domineering, insisting she go to bed, which Shelly*
> *reacted to by losing control of her behaviour and becoming angry and*
> *disruptive.   This incident escalated.   Unfortunately the nurse (possibly due to*
> *her inexperience) reacted by asserting her authority and power, insisting on*
> *rigid obedience.   This resulted in Shelly running to her room, slamming her*
> *door and spending the next while crying.*

Adolescents can be very sensitive in detecting whether a nurse is honestly committed to them (Creedy & Crowe, 1996) and may resort to maladaptive behaviours in order to gain a response from the nurse.   Such behaviours may occur as a means of an adolescent communicating their internal emotional anguish, and how a nurse responds to such behaviours, can have an important influence in what message the adolescent will receive about himself or herself (Creedy & Crowe, 1996).

This behaviour may also be misinterpreted by nurses unaccustomed to adolescent patients, and result in their being 'labelled' by their behaviour as 'manipulative', 'selfish' or 'they're just acting-out', and can evoke responses in nurses that are counter-therapeutic to the adolescent.   Nurses in a research study conducted by Geanellos (1997) in an Australian adolescent mental health inpatient residence, reported that often this 'labelling' of an adolescent, founded on the adolescent's

behaviour, occurred amongst some nurses.

Essential in nursing an adolescent is to receive regular supervision by informed senior staff so as to detect any personal issues that might be replayed by the nurse in his/her interactions with the patient (Creedy & Crowe, 1996).

Vignette:

As Shelly gradually recovered from her depression, she began to demonstrate more confidence in herself. She had learned new ways of dealing with stressful events and her problem solving skills had increased. Friends would come to visit and they would play music, laugh and generally enjoy themselves together. She began to test the rules of the unit and would push the nurses to see how much she could get away with, especially in front of her visiting peers. Examples of this were her going for walks with friends without informing staff, or she would become argumentative over which television channel everyone should be watching. One nurse started to become disgruntled with the attitude Shelly displayed towards her and voiced to me that her behaviour was becoming problematic with the older adult patients. Recognising that Shelly had demonstrated remarkable progress from the person who first arrived, this nurse and I discussed these challenging incidents to explore possible reasons behind this behaviour. To ensure this was not a counter-transference difficulty (that is, personal issues/influences from the nurse's past that are negatively impacting on how he/she responds to the patient), the nurse and I used these encounters as a supervision session. The nurse explained in detail the interactions exchanged between herself and Shelly on the occasions when

she felt her behaviour unacceptable. It became apparent to us both that the nurse's approach had been somewhat passive. The nurse reflected that because the friends were present she acknowledged that she didn't want to cause a 'scene' in front of them, so instead would back down when Shelly asserted herself. We discussed options for how she could best manage these situations in future, such as taking Shelly aside and firmly, but kindly, reinforcing the limits and rules of the unit. We then discussed these issues with the rest of the nursing team, as a cohesive team approach is essential at any point when confronting an adolescent on any socially unacceptable behaviour.

I have observed over the years that from the point of admission right through to discharge, the adolescent must have the experience of a cohesive nursing team. Once again I compare this to how a family functions. If parents (the authority figures) present a united, cohesive front when addressing behaviour that is socially unacceptable, the adolescent receives consistent guidance when they make these mistakes while testing rules and boundaries. As the nurse above exerted little authority in her attempt to assist Shelly to observe the rules of the inpatient environment, she gave Shelly an opportunity to assume a power hierarchy over their relationship, thus reducing the effectiveness of the educative role that the nurse holds.

Differentiating between age-congruent behaviour and that of an adolescent displaying emotional turmoil by their behaviour is important to recognise, as not all behaviour will be associated with their illness (DeSocio, Bowllan & Staschak, 1997). As the inpatient stay progresses, adolescents will test nurses, push the limits to see if the

reaction the nurse gives is an indication that he/she can be trusted with the feelings they are experiencing. A therapeutic relationship created throughout the inpatient stay facilitates limit setting and disciplining, and if the relationship is based on trust and mutual respect, is more readily accepted by the adolescent (Geanellos, 1997). I have commonly found that by providing the adolescent with the opportunity to modify unacceptable behaviour, they are empowered to test newly developed skills and try out responses suggestive of maturity.

Vignette:

> *Shelly tended to discuss her more sensitive issues with me that required carefully chosen responses. She described the incident with the new nurse as something that made her feel like she was back at home, the way her parents treated her. She clearly indicated that she needed some clarity around this incident as this uncharacteristic behaviour of hers had disturbed her. Being careful not to undermine my colleague, nor collude with Shelly, we discussed the incident, separating the behaviour from the person, suggested that maybe both she and the nurse could learn something from this incident. We explored ways in which Shelly may have responded to the situation differently. She was angry with her parents, believing they (like the nurse) still treated her like a baby. Shelly recognised that she had responded to the nurse as she had done in her home with her parents. We were able to work together on this issue, and used this incident for Shelly to learn to new ways of communicating her feelings. Shelly felt that she would start by expressing to the nurses what her needs are (that is not to be treated like a child), that it would be a good 'training ground' to help prepare her for her parents.*

Shelly expressed she had quite different relationships with each of the nurses. Through these individual relationships and the conversations she had with the varying nurses, Shelly voiced she had discovered qualities about herself she hadn't considered before. She was able to see that each nurse she had contact with, she valued for different reasons. Some felt like they were friends, some like members of her family, but each nurse had different strengths and Shelly enjoyed different things about them.

As a nurse, I often view that the structure of an inpatient unit can replicate an environment similar to that of a family, and can serve to function as a 'mini-society'. The inpatient unit is staffed by a multi-disciplinary team. Members within the team, nurses, doctors, social workers and so forth have specific roles to perform, with each role governed by their own set of rules and boundaries. Adolescents interact with all these different staff members. Adolescents have advised me that they observe each of the staff's individual styles of communication, patterns of behaviour, or even methods of resolving conflict or negotiating boundaries. The adolescent will watch how staff talk to each other as well as other patients. They quickly learn which nurse appears to be in charge, and which nurse isn't confident, and how these roles are effectively managed by the nursing staff. Adolescents tell me they usually place doctors and nurses as being the members of the team as 'in charge' of their care.

Rene Geanellos (1997), an Australian nurse researcher discusses that when working with an adolescent the nurse is seen by the patient to replicate many roles, that of a being like a friend, a sibling or a parent substitute. Often these present the adolescent with a chance to engage with an adult and gain a different experience from what they

have had in the past, providing an opportunity for them to learn from. For example, the attitudes an adolescent holds towards their family members may be reflected in their behaviour towards staff (Crouch, 1998), so if there had been discord within the home, this empowers the nurse to model alternative methods of communicating with adults that does not eventuate in a power struggle.

As in a family system, the functional stability of this simulated 'inpatient family' requires each members role to have rules and boundaries that are flexible, but still maintaining a cohesive relationship between the individual members. Like the authority figures in families, nurses may make mistakes in their nursing care of an adolescent, boundaries may become blurred, they may become over-involved with the adolescent. The adolescent may on occasions look to the nurse as a 'parent-figure' and the nurse may unconsciously assume a parent-like role, and regard the adolescent as they would an adolescent in their own families. Or a nurse may have primarily become the adolescent's friend, forgetting that he/she has developed this relationship principally because they are the nurse. This may have consequences as the nurse's personal and professional boundaries then become blurred and this may interfere with the professional relationship that is needed to maintain a balanced perspective. The nurse is not the adolescent's friend, nor are they their parent. They are purely in a professional capacity and they may choose to assume parent-like or friend-like roles. I have seen, on occasion, an adolescent to allow nurses to treat them like they were their parents, and the adolescent would behave towards the nurse accordingly. This would usually result in the adolescent making little progress towards autonomous independence.

Having worked with adolescents for several years, it has been illustrated to me that enforcing the rules and placing limits and boundaries is a very complex task when helping the adolescent achieve growth towards adult independence and autonomy. There can be a very fine line between providing the adolescent with the opportunity to gain increases in independence and autonomy, while not attending to the needs of someone who is unable as yet to make adult decisions. The approach I have found successful has been in my being honest and open to negotiation, giving clear explanations and having realistic expectations of the adolescent (they need to achieve not fail). This approach usually achieves mutual respect and has generally been pivotal in dealing with conflict arising over limits and rules and crossing boundaries. Nurses should be observant for developmental changes that are indicative of an adolescent's growth towards adult independence, as flexibility in the rules needs to reflect these changes in maturity.

Vignette:

> *Within the nursing team we discussed Shelly's achievements and acknowledged that she was probably testing the limits as part of normal adolescent behaviour, and that this expression of independence may be indicative of developmental progress. Shelly had been having overnight leave periods at home, and had adapted and coped very well with this. She was independently structuring her day with a variety of activities and requiring less of the nurse's contribution. Shelly's school work was being accomplished with ease, she was becoming bored and voicing she was ready to go home.*

Often changes may appear very minimal, at best, to the nurse but for the adolescent they are paramount, so having realistic expectations and working at the adolescent's pace is necessary (Brunger, 1986). It must however, be observed that the adolescent doesn't become 'stuck' and hesitant to keep moving forward in their recovery, as what may develop is a dependency on the inpatient unit and fears of leaving for the outside world. The relationship the nurse builds with the adolescent should foster their preparedness for discharge.

It is the process of discharge that I will now move on to.

Discharge:

Although discharge is placed as a final section of this paper, the preparation for this in actuality, commences on admission and continues for the duration of the inpatient stay. The adolescent's level of dependence on the nurse when they arrive on the inpatient unit can be quite significant at first. They are usually very apprehensive, they are vulnerable and frightened, and will often look to the nurse as their source of protection, safety and support in this environment (Geanellos, 2000). Assessment of the adolescent's individual differences and needs is occurring throughout the entire inpatient stay. Areas the adolescent may need some assistance with are identified and interventions aimed at gradually reducing the need for this assistance. When increasing and well timed opportunities for independence are presented to the adolescent, this results in their making incremental steps in becoming more self-empowered, autonomous and confident. The adolescent's ability to care for and meet their own needs increases and their reliance on the nurse decreases by the time they are ready for discharge (Delaney, Pitula, & Perraud, 2000).

The planning of the adolescent's discharge from the inpatient unit involves the evaluation of their readiness to return home (if this is where they will go), to school, and for some, re-establishing peer relationships. In my current role as a nurse in a community-based child and adolescent mental health service, the adolescents have discussed with me the issues they face when discharged from the inpatient unit. Common feelings are fears on how they will cope in the 'real world' outside the sheltered and supported environment of the inpatient unit. They have concerns of being accepted back into the peer group, worried that the stigma attached to mental illness will cause peers to treat them differently or estrange them from the group

altogether. They also voice feelings of being nervous returning to school, wondering if the whole school knows about them. Unfortunately discrimination against people with (or recovering from) mental illness is very real and occurs in all groups of people (Mental Health Commission, 1998). Lastly, adolescents are also unsure if there will be any changes to their family dynamics when they return home. Therefore, to ensure that the transition from hospital to home will go smoothly, the nurse not only nurses the adolescent, but also has an important role to play with their family, friends and perhaps staff from school.

In developing the vignette I have drawn on the feedback I have received from adolescents, parents, school counsellors, and address issues considered important for a successful discharge from the inpatient unit.

Vignette:

Shelly was well on the road to recovery from her depression and had made significant progress in her self-confidence and self-esteem. Shelly had been prepared that not everyone at school may be understanding of her being in a mental health unit, that some may even tease her. We had discussed strategies of how best to deal with this eventuality, and she was well prepared in how she might respond to this. She thought she might try ignoring any teasing and just carry on as normal, as she felt that if she reacted any other way, she might invite further teasing. To her closer classmates, if they asked, she decided she would simply explain she'd been in hospital for depression and that she was now better. Shelly's confidence in herself to make these decisions indicated her ability to be autonomous and independent. The

assistance she needed from me in respect to this issue was minimal. I told Shelly that adolescents I had nursed in the past had informed me of some commonalities that happen when they returned to school. They reported that initially the kids at school are unsure of how to treat you when you return to school. Some classmates may think that because you have been in a mental health unit, that you might be fragile, different, or a number of other stigmatising stereotypes of mental health patients. However, adolescent patients had said that this can be quickly rectified if you show them you're a 'normal' adolescent who is now feeling and acting much happier. This behaviour also advertises to other adolescents that mental health problems are nothing to be ashamed of. Classmates will see the difference between how you were before hospital and how you are now. Shelly could identity with this, as she recognised how unsociable and quiet she was prior to coming into the inpatient unit.

Developmentally, belonging to a peer group is an important task of adolescence, for that reason assisting the adolescent to successfully re-establish peer relationships will be a significant feature of discharge planning. How I have managed this with adolescents in the inpatient unit, is to occasionally spend time with the adolescent and their friends when they come to visit. Interacting with the adolescent and their friends in a relaxed and friendly manner not only shows that the nurses and/or the inpatient unit are not fearsome entities, but can also provide a constructive forum for discussion and education around mental health, inpatient care, or answer any questions friends may have.

Friends of the adolescent in hospital usually have many questions to be answered, especially in relation to mental health and how best they can support their friend. Some friends question whether they may have contributed to their friend's ill health, or express guilt that they should have noticed their friend was unwell. This time spent with the adolescent and their friends is invaluable in preparing the adolescent for discharge. Not only does it helps the adolescent to strengthen peer relationships and increases their confidence in leaving hospital, but it also an opportunity to provide education on mental illness to the adolescent amidst their peer group.

Along the path in recovering from a mental illness, not only is education around symptom management, medication and follow-up care discussed with the adolescent, but also topical issues relevant to this age-group such as drug/alcohol misuse, sexuality, peer pressure can be discussed with the adolescent as part of the discharge process. The adolescent's ability to deal or cope with these issues prior to admission can often be hindered due to the protracted symptoms of their illness before treatment is sought. Cognitive development, psychosocial development, peer relationships, may have been affected by their illness, all of which are important in providing adolescents with 'tools' to test personal values, morals and ethics (Erikson, 1995). However, as the adolescent progresses towards discharge if the nurse has attended to the developmental needs, maturity and development in cognitive and psychosocial skills enables the adolescent to be more effective in evaluating their choices about drugs, alcohol.

There is a growing awareness of the prevalence of drug and alcohol use in adolescents with mental health disorders (Ministry of Health, 1998). As part of the discharge

process, nurses should provide education on the effects drugs and alcohol may have on the adolescent's recovery from mental illness. Additionally, it is also common for the adolescent to be taking medication when they leave the inpatient unit, so it is important they understand the effects drugs and alcohol can have with their medication. Where alcohol and drugs has played a role in the adolescent's life, it can be important to enlist the support of staff from the drug and alcohol service as part of the discharge and community follow-up plan. With education and support from both the nurse and the drug and alcohol service, the adolescent can be helped in managing any difficulties in relation to refraining from drugs and alcohol.

Vignette:

Shelly had been having overnight leave at home with her family as part of the transition towards discharge. Initially she expressed it felt quite odd being home with her parents and younger sister, that everyone was being so polite and nice to each other. Even Shelly herself felt she was on her best behaviour. After a few more occasions of staying overnight at home, she felt that her parents had begun to relax and they stopped treating her like an 'invalid'. She would invite friends over to the house and they would talk and listen to music in her bedroom. She started to feel like her life was getting back to normal again.

In talking with Shelly's parents when they brought her back to the inpatient unit following leave at home, they too felt their daughter had recovered and was back to her old self again. They felt comfortable having her home permanently and that the need for inpatient treatment was no longer

necessary.   At a meeting between Shelly, her parents, myself and the psychiatrist, it was concluded that she could be discharged home and follow-up care would be provided in the community by the child and adolescent psychiatrist.

Family involvement is an integral part of nursing the adolescent in an inpatient unit. In my experience the role the nurse plays, revolves around helping the parents manage their child's problems, and perhaps helping them to identify areas of their parenting that may need to be changed or modified.   Throughout the inpatient stay, in talking with the adolescent while family members are present, my example of communication patterns, perhaps methods of negotiation may be different than what parents are accustomed to.   Parents can learn from this difference.   Many parents have discussed with me the changes their adolescent may have made as they approach discharge, usually they have grown up somewhat, and are more confident and happier in themselves.   Adjusting to these changes requires the nurse to spend time with parents, supporting them, and discussing how the family will function with respect to these changes.

Common fears that parents have voiced to me are their concerns taking their son/daughter home, especially following a suicide attempt.   Some parents worry that their child may try and harm themselves again, or feel they may miss the signs of deteriorating mental health.   They sometimes feel they must treat their child with 'kid gloves' for fear of 'saying the wrong thing' which could trigger a relapse.   I talk to the parents and adolescent about these common experiences, that often when the adolescent is discharged home, it takes time for parents to achieve the right balance in

'trusting' themselves as well as their child. These valid concerns of parents can be alleviated to some degree by the progressive periods of leave the adolescent spends at home. This allows the family time to experience and adjust to these common anxieties while at the same time being able to receive support, reassurance, and education from the inpatient staff.

Siblings also will often need support and education about the rationale for the admission to hospital. From my experience siblings often view mental health disorders as being somewhat 'mysterious' as they can't be seen, and will often assume responsibility and blame themselves. Depending on their age, some believe that because they had been arguing or teasing their sibling, that they had caused their brother or sister to become unwell. A younger sibling can often be overlooked (especially when the parental focus is on the child in hospital) and it may not be noticed that they are harbouring such feelings. It is therefore necessary for the nurse to ensure that careful age-appropriate explanation and education be given to the siblings in these families (as well as to the parents) so that the needs of siblings are also met. Generally I suggest to parents that they initially provide some form of explanation to siblings in their own manner, and towards discharge I talk with siblings as they usually have questions that may need further clarification or expanding on. Giving education and support to the whole family may need to extend beyond the inpatient stay, but the role the nurse undertakes with the family during the period in hospital, can help achieve a successful discharge. Often the duration of the inpatient stay does not allow enough time to completely meet all the needs of the adolescent and their family. Much more work may need to be continued after hospitalisation. However, the time the nurse has with the adolescent, he/she can accomplish

significant headway in laying a firm foundation that will assist community-based clinicians with any further treatment that may be necessary.

CONCLUSION

This report discusses the key elements to be considered in nursing an adolescent patient in an adult inpatient mental health unit. As there was no established New Zealand literature on nursing an adolescent in adult mental health units, reliance on personal experience, literature on specialist units overseas, and developmental theory was necessary to develop and describe effective methods of delivering nursing care. What is evident from this information suggests the need to provide nursing care to the adolescent that is developmentally focussed, within a safe and structured environment; and that the nurse/adolescent relationship is a significant feature for a successful inpatient stay.

The multiple roles that nurses engage in, in their relationship with the adolescent, can achieve many therapeutic benefits if this relationship is founded on trust, honesty and mutual respect. The nurse may at times be seen as a surrogate parent, friend, teacher and so on. When nurses employ these roles effectively, they may be instrumental in influencing the adolescent's development of independence and autonomy and the formation of individual identity. Use of these different roles may be helpful in teaching the adolescent adaptive coping strategies, or perhaps highlighting new ways of thinking about problems and communicating their emotions.

An important point that has been highlighted from this report is the need for nurses to be aware of the different ways an adolescent may exhibit symptoms of emotional disturbance. The adolescent may be unable to verbalise their feelings and may communicate their emotional anguish through their behaviour. Some of these behaviours can be misinterpreted by nurses, and may attract negative labels such as a

'disruptive', 'troublesome' or 'manipulative' patient. It is important for nurses to appreciate that behaviours can be the instrument by which adolescents communicate their difficulties, and nurses should try to understand the underlying 'message' the adolescent is trying to tell them. This reinforces the absolute necessity that nurses who are nursing the adolescent patient acquire clinical supervision from senior staff to ensure they are safe and therapeutic in their nursing care.

Nurses should be familiar with the developmental needs of adolescents, and recognise the important features unique to this age-stage, and the significant roles peers, school, and family members play. If these are acknowledged and incorporated into their nursing care of an adolescent, nurses will establish a therapeutic relationship that will not only contribute to their recovery from mental illness, but can also influence the adolescent's progress in their transition from childhood to adulthood.

Although this report is limited because it shares the experience of only one nurse, and in many areas is unsupported by the literature, it should provide a valuable resource for other nurses to use. Further investigation of nursing the adolescent in an adult mental health inpatient unit needs to be carried out, and there is also a need for an enquiry into the adolescent experience of admission to these units. The prevalence of admission to adult units will continue to occur until there are sufficient specialist inpatient services that can cater to this age-group. Until there are more specialist adolescent inpatient units, there needs to be better facilities for adolescents when nursed in adult units. Therefore, every nurse must sincerely acknowledge whether or not their current knowledge base is sufficient to safely nurse the adolescent patient. As advocates for the patients we nurse, it is our responsibility to ensure that all

patients across the age-spectrum receive developmentally appropriate nursing care that meets the individual's needs.

As a nurse, the writing of this report has been extremely valuable as I have been obliged to evaluate and critique my nursing practice in nursing an adolescent. This has resulted in improving my ability to articulate this knowledge and skills, in a more sophisticated and scholarly manner. This has improved my effectiveness as a nurse, but also in my role of supporting other nurses in my workplace in nursing the adolescent patient. Ultimately, the adolescents in our inpatient unit now receive an even higher standard of care.

An adolescent patient, now discharged from our inpatient unit, recently presented to the staff a wonderful poem. I was extremely honoured to be given permission to include this in my report. I felt the poem summarised many points in what this report had to say about nursing adolescents:

Faces Along The Road

You have all been faces,

Along the road I've had to ride.

An overwhelming feeling of gratitude,

I feel from deep inside

I want to thank you all so much,

Your hopes kept me alive.

And without you and your support,

I don't think I'd have survived.

I want you to know what you've done for me,

How you've kept that hope inside.

And gave me strength when I needed it,

And courage to no longer hide.

When I have had to follow,

New directions you were there.

When the world was hard on me,

You always seemed to care.

When nothing held together,

Or made the slightest bit of sense.

You have always helped me restore,

My inner confidence.

I know myself, without your help,

I would not be lying here.

If not for your positive thoughts,

And the power of your heartfelt prayer.

Everybody needs someone,

Who's reliable and true,

Through the moments I have endured

I'm grateful there was you.

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