EXPLICATING PRACTICE KNOWLEDGE: A HERMENEUTIC INQUIRY INTO ADOLESCENT MENTAL HEALTH NURSING

Rene Geanellos RPN, RGN, Adolescent Mental Health Certificate, DNE, BHSc(Nurs), MNurs.

A Thesis Submitted in Total Fulfilment of
the Requirements of the Degree of
Doctor of Philosophy
(Vols 1 & 2)

School of Nursing and Human Movement
Faculty of Health Sciences
(Mackillop Campus)

Australian Catholic University
Office of Research
412 Mt Alexander Road,
Ascot Vale, Victoria 3032
AUSTRALIA
27th August 1997

AUSTRALIAN CATHOLIC UNIVERSITY
(Mackillop Campus) Sydney, NSW

CANDIDATE'S DECLARATION

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted, in whole or in part, from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

Name: Rene Geanellos

Signature: Rene Geanellos

Date: 26th August 1997

DEDICATION

This thesis is dedicated to my husband Leigh Russell who calmly suggested I should do a PhD and then proceeded to do whatever was required in order for me to achieve it; an extraordinary thing.

It is also dedicated to the memory of my mother Despina Sentas and my father Constantinos Geanellos. In a most unusual decision for a Greek household my father encouraged and supported my desire to complete high school and establish a career. It is difficult to put into words my appreciation of what he did and the impact it had on my life. My mother received three years of formal education. Her birth on an Aegean Island early this century set the pattern of her life. Shortly before her death my mother marvelled at my years of study and was proud of my achievements; she had come to value both education and the work I did. I wish my parents were here to share in what they started.

This thesis is also dedicated to the memory of Mark Brown. A mental health nurse and colleague of long standing whose sudden and unexpected death in 1995 was a loss to all who knew him. His contribution to this research was also lost and we who continued with it understand we did not replace what he had to offer. A sensitive, compassionate and open minded man with a laconic sense of humour he always said "cheery bye" at the close of telephone conversations. So, "cheery bye Mark, we miss you."

ACKNOWLEDGEMENTS

I would like to acknowledge with appreciation and sincere thanks the Australian Catholic University Postgraduate Award which supported me during my candidature. It allowed the pursuit of diverse scholarly endeavours including opportunities to research, publish and present. For all this, I am sincerely grateful.

My heartfelt thanks to Belinda, Lee, Elizabeth, Jane, James, Aloysius, Eamon, Catherine, Binkie, Lai, Origma, Brandon, Merlin and Maggie, for trusting me and for sharing your experiences with such openness and honesty.

Thank you to Professor Lesley Wilkes, principal supervisor, for your belief and trust in me and for help along the way.

Also, to Professor Susan Ronaldson, who joined the supervision team in the final year, thank you for your support, help, interest and gentleness.

A special thank you to the staff of the School of Nursing and Human Movement (Mackillop Campus) for your smiles, warm welcomes and continuing interest.

To friends Chris R, Pat, Jan and Jennifer who never stopped asking "how's it going?" and who supported me in a wide variety of ways, my deepest thanks. Also, Chris A and Chris W for long discussions philosophical, ethical and methodological, they were wonderful. To my family, Peter, Marea, Charles, Margaret, James and Susan, your pride in my endeavours is always encouraging.

To Di Stevens, Interlibrary Loans Librarian UWS: Hawkesbury, a sincere "thank you", I could not have done it without you.

Abstract

Through this hermeneutic study I sought to explicate the practice knowledge of nursing on residential adolescent mental health units. I did this by seeking to understand what nurse's and adolescent's stories of nursing, or being nursed, revealed about the knowledge informing practice within that context. Seven nurses and seven young people shared their experiences. Taped and written stories, and survey material, provided texts for analysis and interpretation. As stories centred around specific nurse-adolescent interactions they pointed to the knowledge informing practice within those encounters. Thus, practice knowledge was explicated through interpretation of the actual experiences of nurses and adolescents.

Study findings were conceptualised as sub-elements, elements and a meta-element of practice knowledge. Ninety one "sub-elements of practice knowledge" were identified and defined. These sub-elements illustrate how nurses work with adolescents. The sub-elements were grouped into four "elements of practice knowledge" and defined. The elements are: (1) engaging in therapeutic relationships, (2) providing a therapeutic milieu, (3) guiding the potential for change, and (4) facilitating positive outcomes. These elements point to the reasons behind nursing actions. Through examination of the sub-elements and elements the "meta-element of practice knowledge" was developed and defined. The meta-element "fostering a functional self" describes the aim and outcomes of adolescent mental health nursing practice by noting the way nurses foster the adolescent's reintegration and wellness.

A paucity of adolescent mental health nursing research has resulted in the knowledge informing practice within the specialty remaining virtually unknown. The study findings are thus salient as they: (1) reveal the practice knowledge of adolescent mental health nursing, (2) identify theories used in practice, (3) provide a basis for theory testing research, (4) assist nurse education by noting the how, what and why of practice and the therapeutic outcomes from the use of practice knowledge, and (5) attest to the contribution adolescent mental health nurses make to adolescents, families and society.

TABLE OF CONTENTS

(Volume 1)

1 Introduction

1.01 Research Question 1
1.02 Background to the Study 1
1.03 Significance of the Research 2
1.04 Methodology 3
Definitions and Explanations 4
1.05 Thesis Style 4
1.06 Explanation of Key terms and Concepts 5
1.07 Explanation of Hermeneutic Terms and Concepts 6
1.08 Explanation of Terms Generated Through the Research 8

2 Practice Knowledge: Adolescent Mental Health Nursing

2.01 Introduction 9
Practice knowledge 9
2.02 The Nature of the Knowledge of Practice 11
2.03 (Re)conceptualising Practice Knowledge 13
2.04 Preunderstandings Developed from this Section 16
Forestructures and Preunderstandings 17
2.05 Working out my Forestructures in Terms of 'The Things Themselves' 18
2.06 Statement One 20
2.07 Statement Two 20
2.08 Statement Three 20
2.09 Statement Four 21
2.10 Statement Five 21
2.11 Statement Six 22
2.12 Preunderstandings Developed from this Section 22
2.13 Bringing my Preunderstandings to Consciousness 23
2.14 Story One: Sandy 26
2.15 Preunderstandings Developed from Story One 28
2.16 Story Two: Maryanne 29
2.17 Preunderstandings Developed from Story Two 32
2.18 Preunderstandings Developed from this Section 32

3 The Sociopolitical Context of the Research

3.01 Introduction 35
3.02 Epidemiological Data 36
3.03 Funding, Services, Training and Education 37
3.04 Research 42
3.05 Nurse Education 45
3.06 Preunderstandings Developed from this Section 47
3.07 Conclusion 48

4 Adolescent Mental Health Nursing: A Literature Review

4.01 Introduction 50
4.02 Mental Health Nursing Research 50
4.03 Adolescent Mental Health Nursing 51
4.04 The Use of Borrowed Theory 52
4.05 A Review of Published Adolescent Mental Health Nursing Research 55
4.06 Preunderstandings Developed from this Section 61
4.07 Conclusion 63

5 Hermeneutics: Philosophy of the Methodology

5.01 Introduction 65
5.02 Translation 65
5.03 Understanding and Interpretation 67
5.04 Preunderstandings and their Methodological Implications 68
5.05 Working out Forestructures in Terms of 'The Things Themselves' 70
5.06 Hermeneutic Textual Interpretation 72
5.07 Objectivity, Consensus and Accuracy in Hermeneutic Interpretation 75
5.08 Evaluating Interpretations 77
5.09 The Hermeneutic Circle 78
5.10 Preunderstandings Developed from this Section 84

6 Method: Explicating Practice Knowledge

6.01 Introduction 86

6.02 Hermeneutics as Method 86
Hermeneutic Interviewing **89**
6.03 Why hermeneutic Interviewing? 89
6.04 The Influence of Hermeneutics on Research Interviewing 90
6.05 Hermeneutically Informed Research Interviewing 92
6.06 The Influence of Forestructures on Textual Construction 97
6.07 Using Forestructures to Review Research Interviews 98
6.08 Summation 100
Conducting the Research **101**
6.09 The Study Context 101
6.10 Participants 101
6.11 The Nurses 102
6.12 The Young People 104
6.13 The Researcher 106
Information Gathering Processes **107**
6.14 Demographic Data Questionnaire 107
6.15 Indepth and Follow up Interview 107
6.16 Written Story 110
6.17 Skills, Attributes and Knowledge Survey 110
6.18 Interview Feedback 110
Hermeneutic Interpretation **113**
6.19 Paul Ricoeur's Theory of Interpretation 113
6.20 The Hermeneutic Function of Distanciation 114
6.21 The Hermeneutic Function of Appropriation 116
6.22 Understanding and Interpretation 117
6.23 Explanation and Understanding 118
6.24 Guess 119
6.25 Validation 120
6.26 The Framework used in Textual Analysis 122
6.27 Developing the Sub-Elements, Elements and Meta-Element 122
Evaluative Criteria **123**
6.28 Acceptability 125
6.29 Consistency 126
6.30 Enhancability 126
6.31 Adequacy 126

6.32 Expandability 126
Ethical considerations **127**
6.33 Contextual Ethical Issues 127
6.34 Informed Consent 127
6.35 Empowerment and Autonomy 128
6.36 Confidentiality and Anonymity 128
6.37 Potential Adverse Effects on Participants 129
6.38 Security of Information 130

7 The Young People's Stories

Preamble to the Research Findings **132**

7.01 Introduction 134
7.02 Interpretive Decision Making 134
7.03 Level One Interpretation: the Sub-Elements of Practice Knowledge 137
7.04 Level Two Interpretation: the Elements of Practice Knowledge 156
7.05 Level Three Interpretation: the Meta-Element of Practice Knowledge 159
7.06 Conclusion 160

8 The Nurse's Stories

8.01 Introduction 161
8.02 Level One Interpretation: the Sub-Elements of Practice Knowledge 162
8.03 Level Two Interpretation: the Elements of Practice Knowledge 190
8.04 Level Three Interpretation: the Meta-Element of Practice Knowledge 193
8.05 Conclusion 194

9 The Practice Knowledge of Adolescent Mental Health Nursing: New Horizons

9.01 Introduction 195
9.02 Interpretive Difference and Research Findings 196
The Elements **197**
9.03 Engaging in Therapeutic Relationships 197

9.04 Providing a Therapeutic Milieu 204
9.05 Guiding the Potential for Change 207
9.06 Facilitating Positive Outcomes 210
The Meta-Element **214**
9.07 Fostering a Functional Self 214
9.08 Summation 218

10 Conclusion

10.01 What the Findings Reveal 220
10.02 Recommendations for Future Research 221
10.03 Limitations of the Study 222
10.04 Strengths of the Study 223
10.05 Summation 223

11 References 251

(Volume 2)

Appendices

Appendix A Interpreter Forestructures 252
Appendix B Interpreter Preunderstandings 257
Appendix C An Example of a Research Interview 271
Appendix D The Nurse's Information Package 305
Appendix E Storytelling Guidelines 314
Appendix F Examples of Identifying the Sub-Elements of Practice Knowledge 315
Appendix G A Summary of the Young People's Sub-Elements of Practice Knowledge 335
Appendix H A Summary of the Nurse's Sub-Elements of Practice Knowledge 368

(Volume 1)

List of Tables

7.1	Sub-Elements Identified in One Adolescent's Text	137
7.2	Sub-Elements Identified in Two Adolescent's Texts	141
7.3	Sub-Elements Identified in Three Adolescent's Texts	145
7.4	Sub-Elements Identified in Four Adolescent's Texts	149
7.5	Sub-Elements Identified in Five Adolescent's Texts	151
7.6	Sub-Elements Identified in Six Adolescent's Texts	152
7.7	Sub-Elements Identified in Seven Adolescent's Texts	154
7.8	Engaging in Therapeutic Relationships	156
7.9	Providing a Therapeutic Milieu	157
7.10	Guiding the Potential for Change	157
7.11	Facilitating Positive Outcomes	158
8.1	Sub-Elements Identified in One Nurse's Text	162
8.2	Sub-Elements Identified in Two Nurse's Texts	167
8.3	Sub-Elements Identified in Three Nurse's Texts	170
8.4	Sub-Elements Identified in Four Nurse's Texts	177
8.5	Sub-Elements Identified in Five Nurse's Texts	185
8.6	Sub-Elements Identified in Six Nurse's Texts	187
8.7	Sub-Elements Identified in Seven Nurse's Texts	188
8.8	Engaging in Therapeutic Relationships	190
8.9	Providing a Therapeutic Milieu	191
8.10	Guiding the Potential for Change	191
8.11	Facilitating Positive Outcomes	192

List of Figures

Figure 7.1: Adolescent Mental Health Nursing Practice Knowledge: demonstrating the interrelationship between the research findings and hermeneutic conceptualisations of tradition and knowledge 133

"It is because absolute knowledge is impossible that
the conflict of interpretations is insurmountable
and inescapable. Between [the desire for]
absolute knowledge and hermeneutics,
it is necessary to choose"
(Ricoeur, 1981b, p. 193).

Chapter One

1 Introduction

1.01 Research Question

Through this hermeneutic study I sought to explicate the knowledge informing nursing practice on residential adolescent mental health units. In doing this I was guided by the following question:

> What do nurse's and adolescent's stories, arising from experiences of nursing or being nursed on residential adolescent mental health units, reveal about the knowledge informing practice within that context?

1.02 Background to the Study

The unquestioning use of theory borrowed from the disciplines of psychiatry, psychology and social work, and the paucity of published nursing practice research in adolescent mental health nursing, has resulted in a meagre understanding of the knowledge informing practice within the specialty. For example, I found no research publications specific to adolescent mental health nursing from the United Kingdom or Australia, and two from America (Hinds, 1988; Weissman & Appleton, 1995). As my nursing experience included working on a residential adolescent mental health unit, I hoped to combine my interest in this type of nursing with a desire to uncover the knowledge nurses use in the conduct of their practice within the specialty. I thought of this knowledge as "practice knowledge" and, in turn, I reasoned that such knowledge could:

(1) generate theories of, and from, adolescent mental health nursing;

(2) provide a basis for further research;

(3) be disseminated and used in practice within the specialty; and

(4) provide a foundation for the education of people working with emotionally disturbed adolescents in health, welfare and education settings.

1.03 Significance of the Research

While a body of nursing literature exists concerning the practice of adolescent mental health nursing, there is little published research which supports this literature. Certain authors, like Delaney (1992), Jaffe (1991) and Scahill (1991), write from theoretical perspectives, some, such as Egan (1988), Hogarth (1985) and Pond (1988), write from experiences of working on adolescent mental healths units, others, for example, Holden, (1986), Rew and Shirejian (1993) and Scahill, Walker, Lechner and Tynan (1993), use a case study approach to inform their discussion, while others, like Niemela, Poster and Moreau (1992) and Peterson, Gray and Weinstein (1994), present program innovations from their workplace. These authors, and others (see Armstrong, 1987; Burns, 1982; Creedy & Crowe, 1996; Fishel, 1990; Hogarth, 1991; Kunes-Connell, 1987; Mintz, 1989; Niemela, Poster & Moreau, 1992; Puskar & D'Antonio, 1993; Puskar & Wargoe, 1992; Redston-Iselin, 1987; Weinberger, Sandiford & Rodine, 1988; West & Sieloff Evans, 1992), claim that adolescent mental health nursing requires the application of particular knowledge including orientations toward: establishing and maintaining a therapeutic milieu and therapeutic relationships, facilitating the developmental stage, self esteem building, role modelling, advocacy, therapeutic communication, surveillance, limit setting, overcoming resistance, skills training, crisis intervention, interpersonal sensitivity, counselling, teaching, referral and multidisciplinary collaboration. While this list of knowledge claims is undoubtedly incomplete there

is no published research in support of them. For instance, neither the research of Hinds (1988) nor of Weissman and Appleton (1995), the only published research found on adolescent mental health nursing, revealed knowledge in the areas that nurses claim is constitutive to the practice of the specialty. This may be because those studies focused on specific aspects of knowledge thereby limiting the scope of the research findings. For example, Hinds focused on the relationship between nurses' caring behaviours and the adolescent's development of hopefulness while Weissman and Appleton focused on the therapeutic aspects of acceptance. On the other hand, in explicating the knowledge of practice, the present study takes a broad rather than a focused perspective. In doing this, the study findings expand existing understandings and open up new horizons through which to understand the knowledge informing the practice of nursing on residential adolescent mental health units.

1.04 Methodology

Hermeneutic philosophy informed and guided the conceptualisation and conduct of the study. Hermeneutics is the science of interpretation whose concerns are both interpretation and understanding. I chose this philosophy because: (1) although directed toward epistemological endeavours it recognises and values the ontological dimension of all inquiry, and (2) the study was interpretive in nature and sought truth through understanding; the hallmarks of hermeneutics. In this way, hermeneutics provided the opportunity for me to pursue an epistemological inquiry using an intersubjective approach. Within the context of this study I use intersubjective to mean cocreated interpretive understandings.

Because the research was interpretive and I sought to explicate knowledge through understanding, it was essential to explore the concepts of interpretation and understanding in some detail. This

exploration is undertaken in the sections entitled "Philosophy of Methodology: Hermeneutics" (see Chapter 5) and "Hermeneutic Interpretation" (see Chapter 6). The use of philosophy to underpin methodology also necessitates the researcher demonstrate how they applied aspects of that philosophy to the research process. This demonstration is undertaken in the sections entitled "Practice Knowledge: Adolescent Mental Health Nursing" (see Chapter 2), "Hermeneutic Interviewing" and "Hermeneutic Interpretation" (see Chapter 6).

Definitions and Explanations

1.05 Thesis Style:

* words written in *italics* are the spoken or written words of the research participants;

* certain hyphenated words, for example, being-in-the-world, denote a relationship of each word with, and to, the other;

* words appearing in [square brackets] denote: (1) an addition to a quote or excerpt through which clarity and comprehension are enhanced, or (2) a correction to sexist language;

* to enhance clarity, registered nurses, whom the research participants referred to as registered nurses, nurses, workers, direct care, people or staff, are identified as nurse/s;

* similarly, adolescents, whom research participants referred to as adolescents, teenagers, kids, youngsters or children, are identified as adolescent/s or young person/people;

* the Macquarie (1991) dictionary is the reference source for spelling and word usage;

* the American Psychological Association (1995) publication manual was used in the production of this thesis.

1.06 Explanation of Key Terms and Concepts:

* as a developmental stage **adolescence** varies significantly depending upon personal, sociopolitical, cultural and historical contexts. As a concept, it is of recent origin in Western culture; in some cultures it does not exist. Adolescence denotes that transitional period between childhood and adulthood when the young person masters specific developmental tasks. Although debate continues about when adolescence begins and ends, consensus suggests it begins at puberty and ends following the mastery of developmental tasks. In turn, the completion of those developmental tasks is subject to individual variation and is not merely chronologically determined.

  In Western cultures, adolescence is generally accepted as occurring between the ages of 12 and 19, and as including cognitive, spiritual, psychosexual, physical and psychosocial development. Adolescence is further divided into three stages: (1) early: 12-13, (2) middle: 14-16, and (3) late: 17-19 years. Gender variation also occurs with girls, overall, achieving developmental milestones some 12-18 months before boys. Generally, young people aged 12 to 17 years are cared for by an adolescent mental health service whereas those aged 18 years and over are cared for by an adult mental health service.

* **adolescent mental health nursing**: is that nursing practiced in any mental health setting specifically designated for the care of adolescents experiencing emotional disturbance. In the context of this study, adolescent mental health nursing refers to that nursing practiced on a residential adolescent mental health unit.

* **mental health**: is the capacity of and opportunity for the individual to interact with the self, others, groups and environments in ways that promote: (1) personal, relational and sociopolitical well being; (2) optimal development of cognitive, psychosocial, spiritual, physical and psychosexual abilities; and (3) the achievement of individual and collective

goals consistent with notions of mutuality, justice, freedom, harmony and equality (adapted from the New South Wales Department of Health, 1991, p. 10).

* to avoid the confusion arising from the variety of terms used to describe problems with mental health, for example, mental illness, psychiatric disorder/problem, behavioural disturbance and emotional distress, the terms **emotional disorder** and **emotional disturbance** are used throughout the thesis. When discussion centres around a specific disorder, such as depression, then that term is used.

* **emotional disturbance**: is the marked and persistent presence of disturbed behaviour, and/or emotion, and/or thinking, and/or relationships within the individual's personal, cultural, historical and sociopolitical context, and which is accompanied by impaired personal, and/or interpersonal, and/or social functioning (adapted from the Human Rights & Equal Opportunity Commission, 1993, Vol 2, p. 605).

* **emotional disorder**: refers to a categorised emotional disturbance, such as, schizophrenia, depression or conduct disorder.

1.07 Explanation of Hermeneutic Terms and Concepts:

* **preunderstandings**: are also known as preconceived notions, presuppositions, preconceptions, prejudgments, prejudice/s and forestructures (see Gadamer, 1979; Heidegger, 1962; Ormiston & Schrift, 1990; Palmer, 1969). Preunderstandings arise from being-in-the-world and are prefigured by the tradition in which the individual lives. The individual's tradition is the shared history, language and culture in which they participate and which shapes their preunderstandings. Preunderstandings are important because they influence all aspects of the conceptualisation and conduct of the research.

* **preunderstandings developed from this section**: this heading appears throughout the thesis and relates to understandings I

develop from the work undertaken at that point. These understandings, in conjunction with my preunderstandings, inform and shape the research. In these sections, I attempt to bring my pre/understandings to consciousness in order to reflect upon them and note their influence on research processes.

* **fusion of horizons**: the notion that understanding occurs through a fusion of the horizon of the text and the horizon of the interpreter. Horizon, is all that can be seen from a particular vantage point as a result of being prefigured by the determinate tradition (Gadamer, 1979).

* **tradition**: the world of shared history, language and culture which prefigures preunderstandings (Gadamer, 1979).

* **historically effected consciousness**: the notion that understanding comes into being through history, it is effected by history, and simultaneously, that understanding is influenced by history, it is affected by history (Gadamer, 1979).

* **being-in-the-world**: a term signifying the everyday activities of people in their lifeworld and their understanding of that world through their immersion in it (Heidegger, 1962).

* **hermeneutics**: the philosophy and science of interpretation whose concerns include: (1) explication of the nature of understanding, and (2) textual interpretation. Philosophical schools of thought include Gadamer's (1979) hermeneutic of tradition, Heidegger's (1962) ontological and Ricoeur's (1974a, 1981a) epistemological hermeneutics. Perspectives on understanding include Caputo's (1987) radical, Gadamer's (1979) faith, Schleiermacher's (1990a & 1990b) romantic and Thompson's (1985a) critical theory of interpretive understanding. The work of Gadamer is foundational to the study while the work of Heidegger and Ricoeur is significant.

* **ontology**: the science of being whose concern is investigation

of the nature of being (Macquarie, 1991).

* **epistemology**: a term derived from the Greek words episteme meaning knowledge and logos meaning discourse. Thus, a discourse about knowledge (Bernstein, 1983).

1.08 Explanation of Terms Generated Through the Research:

* a **sub-element of practice knowledge**: refers to an individual unit of practice knowledge.

* an **element of practice knowledge**: refers to a group of sub-elements with shared meanings.

* the **meta-element of practice knowledge**: describes the aim and outcomes of nursing practice through application of the sub-elements and elements to practice.

* **practice knowledge**: the shared, intersubjective knowledge of the nurse developed through their traditions of living and nursing; it is dynamic, incomplete, perspectival and changing.

* **tradition**: unless cited with specific reference to Gadamer my use of tradition is expanded to include a sociopolitical and embodied dimension.

In the following chapter, entitled "Practice Knowledge: Adolescent Mental Health Nursing", I outline the way I brought my forestructures and preunderstandings of practice knowledge and adolescent mental health nursing to consciousness. I did this in order to take account of my forestructures and preunderstandings during the conduct of the research. My work on practice knowledge was guided by the writing of Gadamer (1979), Johnson (1987, 1989) and Polanyi (1958, 1983), my work on forestructures was guided by the writing of Heidegger (1962) and my work on preunderstandings was guided by the writing of Gadamer (1979).

Chapter Two

2 Practice Knowledge: Adolescent Mental Health Nursing

2.01 Introduction

In this chapter, I outline the way I brought my forestructures and preunderstandings to consciousness. This was necessary since through my engagement as an adolescent mental health nurse I hold preunderstandings about the phenomenon under investigation which inform and influence research processes. Thus, I needed to bring my preunderstandings to consciousness in order to reflect upon them. Gadamer (1979, p. 456) says reflection is integral to understanding because "it is always part of understanding that the view that has to be understood must assert itself against the power of those tendencies of meaning that dominate the interpreter."

This chapter is presented in three parts. In the first part, I bring to consciousness my preunderstanding of practice knowledge through a discussion of my conceptualisation of it. In the second part, I develop my forestructures in relation to my beliefs about adolescent mental health nursing. This part of my work was guided by Heidegger's (1962) writing on forestructures because he relates forestructures to getting "to the things themselves" in terms of the phenomenon under investigation. In the third part, I develop my preunderstandings of adolescent mental health nursing. This part of my work was guided by Gadamer's (1979) writing on the need for reflection on preunderstandings prior to textual interpretation.

Practice Knowledge

My understanding and conceptualisation of practice knowledge was influenced by literature from the disciplines of philosophy, education and nursing. The most significant influence on my thinking was exerted by Gadamer (1979) and to a lesser extent by

Johnson (1987, 1989) and Polanyi (1958, 1983). Through Gadamer's influence I developed a hermeneutic orientation to practice knowledge into which I incorporated Johnson's and Polanyi's ideas on embodiment. In the following discussion, I use the work of Gadamer, Polanyi and Johnson in an attempt to throw light on the question, "what is practice knowledge?"

According to Reed (1996, p. 32), "it is increasingly being recognised that practice knowledge as well as other patterns of knowing are integral to nursing scholarship." While this may be so, it is difficult to say what practice knowledge is. In the nursing literature the term practice knowledge is not commonly used while in general, practice knowledge is known by a variety of names such as practical, clinical, procedural, aesthetic, professional craft, personal-practical or personal knowledge (Benner, 1984; Biggs & Telfer, 1987; Carper, 1978; Higgs & Titchen, 1995; Johnson, 1989; Kidd & Morrison, 1988; Roy, 1995; Schultz & Meleis, 1988). As a notion, personal knowledge has a long and continuing history in the nursing literature (see Carper, 1978; Egan & Beckstrand, 1979; Jacobs-Kramer & Chinn, 1988; Moch, 1990; Smith, 1992b; Sweeney, 1994), particularly in relation to the writing of Michael Polanyi (1958). For example, Benner (1984) synthesised Polanyi's ideas on personal knowledge when she wrote about the knowledge of clinical nursing practice. Personal knowledge is sometimes construed as the knowledge of self but on the whole it is used to refer to the inseparability of the knower and known, in other words, the unique nature of knowledge within each individual. This is important because it relates closely to the way practice knowledge is conceptualised in nursing. That is, practice knowledge is seen as that knowledge which accrues over time through experiences of practice but which, nevertheless, is unique

and individual to each nurse. However, unlike Polanyi, who recognised the sociopolitical and historical dimensions of knowledge development, and from whose work nurses have developed notions of practice knowledge, some nurses ignore dimensions of knowledge development beyond the personal.

2.02 The Nature of the Knowledge of Practice

Smith (1992b) stresses the uniqueness of knowledge. She says each individual receives, interprets and integrates knowledge in ways that are different from other individuals therefore it is unique to them. For these reasons, nurses like Benner (1984), Jacobs-Kramer and Chinn (1988), Moch (1990), Smith (1992b) and Sweeney (1994) see practice knowledge as personal knowledge. However, if practice knowledge is conceptualised as personal, it is difficult to see how discipline specific knowledge can be identified because such knowledge will always reside uniquely within each individual. Do we need to ask each adolescent mental health nurse about the knowledge informing their practice before we can understand and say something about it? Moreover, when practice knowledge is represented as personal and unique, the focus remains on the individual rather than inclusive of broader linguistic, sociopolitical, historic and cultural contexts. Indeed, one criticism of nursing constructions of personal knowledge is that it seems to ignore the broader contexts within which each individual comes into being, learns and lives. Further, as the following discussion suggests, this dissociation of knowledge from the contexts of its development is not only found in constructions of personal knowledge but in the conceptualisation of other types of nursing knowledge as well.

Carper (1978) and Schultz and Meleis (1988) conceptualised nursing knowledge with virtually no reference to the sociopolitical,

linguistic, cultural and historic contexts of its development. The exception being Schultz and Meleis' limited acknowledgement of knowledge as historical. In such a construction knowledge is disconnected, singular and unrelated; a decontextualised entity. Robinson (1992, p. 211), in her discussion on the politics of knowledge, notes the relationship between the social context and the development of knowledge. She suggests "what is important is that we are aware of the links between our knowledge and the society in which we live." Vaughan (1992, p. 16) too considers sociopolitical and historical influences are significant as "gender issues, their perceived role in society and their subservient relationship to medicine" have to some degree oppressed nurses as a group. Gender, class, ideology, status, power and privilege all influence the way knowledge develops (or fails to develop) and whether knowledge is valued, suppressed, forwarded or marginalised.

In following the ideas of feminism, postmodernism and critical social theory some nurses have attempted to explicate relationships between what we know/what is known and the contexts of its development. They include notions of the sociopolitical, cultural, historic and linguistic in their discussions. Even so, much of this writing remains focused on the inseparability of knower and known from an individual perspective, or it relates to theoretical discourse, knowledge development and research rather than to practice knowledge (see Allen, 1985; Chinn & Wheeler, 1985; Doering, 1992; Dunlop, 1994; Gortner, 1993; Hall & Stevens, 1991; Lather, 1986; Thompson, 1985, 1987; Walker, 1994a; Watson, 1995; Wolfer, 1993). An additional problem for mental health nursing is that while some nurses are engaging in contemporary

epistemological debates (see Crowe, 1997; Fanker, 1996; Farrell & Grichting, 1997; Mason & Mercer, 1996; Stevenson, 1996), others are embracing moves back to traditional notions of science, philosophy and knowledge development (see Evans, 1995; Griffin-Francell, 1993; Lowery, 1992; McCrone, 1996). Perhaps the beginning nature of epistemological debate and research in mental health nursing, especially in Australia, means discussion on practice knowledge is somewhat preliminary. For whatever reason, practice knowledge is yet to appear as an issue in the mental health nursing literature.

2.03 (Re)conceptualising Practice Knowledge

There appear to be two distinct yet interconnected ways in which the knowledge of practice is discussed within the nursing literature. On the one hand, it is conceptualised as essentially personal and unique while, on the other hand, though not noted as personal, it is represented as disconnected from sociopolitical, cultural, historic and linguistic influences. In the final analysis, the knowledge of practice in both these representations lacks a context beyond that of the individual. In this regard, Gadamer's (1979) writing on tradition is useful in expanding this predominantly individual and decontextualised view of knowledge. According to Gadamer (1979), knowledge is always shared. This shift in emphasis from an individual to a shared understanding of knowledge occurred when Gadamer transcended the ontological primacy foundational in Heidegger's (1962) explication of Being and developed an intersubjective perspective of understanding. An intersubjective perspective of understanding presents knowledge as codetermined rather than individually determined. Moreover, knowledge does not reside within individuals but within tradition. This is because the individual only comes into being through

tradition. Tradition is the shared culture, history and language handed down to us from the past, it forms the present in which we live and shapes the future onto which it is handed. In this way, tradition provides the ground and background for the development of knowledge. Gadamer's conceptualisation of tradition focused on the historic, linguistic and cultural without explicating the influence of the political. Although, his analysis of the ascendancy of science is clearly a political critique (see Gadamer, 1975). (Gadamer further addresses political issues in the afterword of the 1989 edition of Truth and Method while the critical hermeneutics of Thompson (1985a) and the radical hermeneutics of Caputo (1987) take the political into account in the hermeneutic project). Ermarth (1981, p. 190) captures the significance of language and tradition in Gadamer's conceptualisation of knowledge when he says "our way of being and of understanding is a belonging to both language and tradition."

Gadamer (1990, p. 147) claims "language is the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world." It is through language that we come to know all that we know; language gives us our world as we grow into it. Intersubjective knowledge arises through the shared world of language, culture and history, which is tradition. In this way, tradition prefigures knowledge. Thus, knowledge arises from being-in-the-world, of past and present, and is shaped by the tradition in which the individual lives. This conceptualisation of knowledge is fundamentally different, for example, to the way personal knowledge is represented in the nursing literature. When knowledge is seen as intersubjective, shared and communal as opposed to subjective, private and individual there is a greater ability to understand such knowledge within the contexts of its

tradition. I do not use tradition to denote some type of single, unifying or overarching model. Traditions coexist with other traditions. For example, to be a Greek immigrant in Australia will place the individual within multiple traditions but these traditions will be different for the Asian refugee in Australia. In the same way, these traditions will be different in the 1920's in comparison to the 1990's. Thus, in the hermeneutic sense, tradition is always shared, plural and changing.

Nurses have conceptualised the knowledge of practice as personal, individual and unique. In doing this they have drawn on the writing of Polanyi (1958, 1983). To say the individual shapes knowledge, as Polanyi (1983) and Johnson (1989) do, is to ignore Gadamer's (1979) insight that it is the individual who is shaped (by tradition). It could be said that the individual having been shaped by tradition, in turn, shapes their own knowledge. To say this, is to forget that the shaping of knowledge always takes place in relation to an other, whether that other is a sociopolitical system, book, family dynamic or teacher. Tradition, is background and ground. Knowledge, is shared and intersubjective. Nevertheless, while hermeneutics allows such an understanding of knowledge development, on the notion of embodiment, hermeneutic writing is silent. This silence is problematic as people are embodied beings. Thus, it is important to reunite the hermeneutic discourse on knowledge to the source of thinking, feeling and action; the body. In the discussion that follows, I attempt to incorporate the notion of embodiment into my hermeneutic orientation of knowledge by expanding Gadamer's (1979) concept of tradition.

For Polanyi (1983, p. 15), our body is the ultimate instrument of all our knowledge. Further, Altheide and Johnson (1992, p. 52) speak of the deep structures of memory passed from one generation

to the next while Johnson (1987, 1989) develops his ideas on knowledge in relation to embodiment. For these writers, the body is the locus for complex interactions between the individual and experiences of the past, present and future. All that we are, and can be, is bound to and at one with our body. Since embodiment erases the dualism of ontology/epistemology, emotion/cognition and body/mind, it is a unifying notion. When we speak of coming into being, it is not some disembodied entity we are referring to; to come into being is to do so in our body. In order to accommodate the notion of embodiment into Gadamer's (1979) conceptualisation of tradition, requires recognition of our bodily inheritance. Such an inheritance is historical, being handed down from generation to generation; it is cultural, having as its basis ethnic diversity; and it is sociopolitical, as gender struggles and attempts to extinguish certain ethnic groups has demonstrated. Bodily inheritance is intersubjectively given and it changes over time and place in the same way as other traditions. For all these reasons, the notion of embodiment enriches hermeneutic understandings of knowledge by reuniting knowledge with the house of its being; the body.

2.04 Preunderstandings Developed from this Section

Practice knowledge is intersubjective, shared, embodied and communal. This is because the development of practice knowledge proceeds through traditions of shared and embodied cultural, historic, linguistic and sociopolitical experience. Knowledge is not singular, insular or unchanging rather it is shaped by traditions of the past and present and, in turn, will shape the future. This is a dynamic representation of knowledge. In the same way that interpretation is never final, complete or static so too understandings of practice knowledge remain open, partial, changing and incomplete. Hermeneutically, ongoing dialogue

permits no final conclusion thus practice knowledge is always in the process of changing; of becoming different. This conceptualisation of practice knowledge situates it within the multiple contexts of its development and allows us to understand that even though traditions of nursing practice knowledge may be somewhat different and somewhat the same, they will not stay the same. In understanding practice knowledge this way, we confront the anomaly of searching for fixed, unique knowledge through which specialty domains of nursing can be claimed and guarded.

Forestructures and Preunderstandings

In the remaining sections of this chapter, I outline the way I brought my forestructures and preunderstandings to consciousness with regard to adolescent mental health nursing. As interviewing was the primary method of gathering information and generating a text, and as interpretation was the primary mode of explicating practice knowledge from the text, I saw these two processes as integral to the research. Thus, I sought to develop ways to address my preunderstandings prior to engagement in these processes. I used two approaches to do this. First, I developed forestructures in terms of "the things themselves" (Heidegger, 1962) in which I took account of my beliefs about the specialty prior to interviewing the research participants. I did this by generating statements about adolescent mental health nursing which I then expanded into forestructures. As this was a lengthy process, I present several examples within the text and include the remainder in the appendices (see Appendix A). Second, I addressed preunderstandings by writing stories about my practice as an adolescent mental health nurse from which I extracted statements of preunderstandings. In this way, I tried to take account of views that could lead me to premature interpretive closure. This too was

a lengthy process therefore several examples are presented within the text with the remainder in the appendices (see Appendix B).

2.05 Working out my Forestructures in Terms of 'The Things Themselves'

According to Heidegger (1990, p. 125), there are basic conditions which make interpretation possible and these relate to the interpreter's entry into the hermeneutic circle. He says:

> If the basic conditions which make interpretation possible are to be fulfilled, this must rather be done by not failing to recognise beforehand the essential conditions under which it can be performed. What is decisive is not to get out of the circle but to come into it in the right way.

The hermeneutic circle of understanding is not a random orbit of knowledge but an expression of the interpreter's forestructures. To come into the circle the right way requires the interpreter work out their forestructures in terms of the phenomenon under investigation. Forestructures consist of: (1) forehaving, background practices from the lifeworld which make interpretation possible; (2) foresight, background practices that carry with them a point of view from which an interpretation is made; and (3) foreconception, background practices that create expectations about what might be anticipated in an interpretation (Heidegger, 1990, p. 126). In bringing my forestructures to consciousness I answer the question, "what do I believe is most important about the way adolescent mental health nurses actualise their practice?"

Twenty statements were generated through a spontaneous, reflective process and thus taken as suggestive of my most strongly held beliefs about nursing practice within the specialty. It was not sufficient to merely generate the statements as this would only result in superficial understanding. For example, in making the

statement "the nurse participates in creating a stable, cohesive, secure milieu", I realise that I think the milieu is significant and I believe nurses contribute, in some way, toward creating the milieu. Nevertheless, the statement does not assist me to understand why I believe the milieu is important nor what implications I believe it has to the practice of adolescent mental health nursing. However, in reflecting on each statement and analysing its significance to my understanding of practice, I bring forward assumptions concerning such practice. The final step, in the process of developing my forestructures, was to interpret each statement and reconceptualise it as a forestructure of the phenomenon under investigation. Thus, each statement includes my interpretations and the forestructures I developed from it. Although the statements are numbered this does not imply any order of significance.

In completing my work on forestructures prior to conducting the interviews I became aware of ways I might direct the interviews and influence information gathering. I am not suggesting I brought all my forestructures to consciousness nor that I did not participate in cocreating the text. Indeed, it is because I acknowledge my presence in cocreating the text that it was important to work out my forestructures before rather than after the interviews. In doing this, I was attempting to become conscious of my forestructures and to examine them reflectively so that the phenomenon under investigation could speak (Thompson, 1990, p. 244). Later, I returned to my work on forestructures and sought a deeper understanding of them prior to interpreting the text.

In the discussion on forestructures I use the words "she" and "her" to acknowledge it is myself I am referring to. I say "the nurse" instead of "I" as to say I suggests that I actually did all that I wrote. For ease of expression I refer to adolescents and nurses, however,

in no way is this meant to diminish the contribution of parents, siblings, friends and others, like teaching or ancillary staff, to the practice of adolescent mental health nursing.

2.06 Statement One: the nurse participates in creating a stable, cohesive, secure milieu.

Interpretation: because the adolescent is experiencing personal, interpersonal, familial and societal destabilisation it is important to balance this with a predictable, stable and safe environment. Such an environment is created through the combined thoughts, feelings and actions of all the people in it. A secure and cohesive milieu acts to contain out of control feelings and behaviours. Because the milieu is stable, predictable and safe it engenders trust and allows the nurse and adolescent to begin their work toward change.

Forestructures: the energy the adolescent previously used to defend or protect the self can now be harnessed by them to work toward change. The nurse understands that every action within the milieu has the capacity to stabilise or destabilise it. She appreciates also that her thoughts, feelings and behaviours embody this capacity. She establishes boundaries and sets limits with firmness, flexibility, consistency and thoughtfulness.

2.07 Statement Two: the nurse has a genuine love of adolescents and an ability to foster this in them.

Interpretation: adolescents are often represented as antiauthority, antiestablishment, undisciplined and difficult; they are rarely described as lovable. Emotionally disturbed adolescents often come from abusive and chaotic backgrounds where love is missing or not articulated. They perceive themselves as alienated from loving relationships, feel unlovable and unworthy of being loved. They blame themselves for this believing they are somehow responsible; they feel the shortcomings and failings reside within them. If they are worthy of being loved or befriended by a nurse they may come to love themselves and, in turn, to give love to others.

Forestructures: the capacity to give in relationships comes from receiving. The nurse appreciates that in assisting the adolescent to feel loved and lovable she sets in motion a cycle of giving and receiving which forms the basis of all relationships.

2.08 Statement Three: the nurse is accepting.

Interpretation: the adolescent comes from a background of failure, rejection and ostracism which results in low self esteem, feelings of unworthiness and a devaluing of self. Acceptance of the adolescent, though not necessarily of their behaviour, and an appreciation of the position they find themself in, allows the adolescent to feel understood and affirmed and to experience approval. Acceptance

fosters the adolescent's belief in themself and their life.

Forestructures: the nurse demonstrates a preparedness to accept the adolescent as they are and is aware that acceptance is a powerful force in allowing the adolescent to accept and come to terms with themself. It gives the adolescent permission to be themself and allows them to relax and feel comfortable within the milieu. Acceptance has the outcome of removing barriers, of creating bridges of understanding and of fostering trust in the development and maintenance of relationships.

2.09 Statement Four: the nurse perseveres.

Interpretation: adolescents vacillate between the thoughts, feelings and behaviours of a child and those of an adult. The struggle to overcome emotional disturbance also involves forward and backward movement. These two complex processes interplay often resulting in feelings of frustration, anguish and apprehension in the nurse. As these feelings are also experienced by the adolescent the nurse's experience allows her to develop empathy toward the adolescent.

Forestructures: in assisting the adolescent to move forward, both developmentally and functionally, the nurse stays engaged and present and doesn't give up. She joins with the adolescent and helps them to understand the normality of their journey toward adulthood and wellness. To facilitate this understanding she shares her own stories and experiences from her work with other adolescents. She shares and respects the disappointment, anxiety, anger and despair of the adolescent but does not take these into herself. She highlights their struggle, strength, resilience and achievement thereby engendering hope for the present and future.

2.10 Statement Five: the nurse has a good working knowledge of normal adolescent development.

Interpretation: during their experience of emotional disturbance adolescents continue to progress from one developmental stage (childhood) to another (adulthood), even though in some this process may be hindered to a greater or lesser degree. In their transition to adulthood adolescents achieve specific developmental milestones, for example, emotional, ideational and behavioural autonomy, self identity, peer group relationships, advanced skills of cognition.

Forestructures: in her therapeutic work with adolescents the nurse appreciates the need to facilitate the adolescent developmental stage. There is a need to understand the difference between normal and abnormal adolescent behaviour. For instance, normal variations of mood versus marked, sustained mood swings; egocentricity versus narcissism; challenging authority versus abusive behaviour. The nurse needs to guard against pathologising normal adolescent developmental behaviours because they occur in tandem with emotional disturbance.

2.11 Statement Six: the nurse develops self knowledge and insight.

Interpretation: the nurse-adolescent relationship is complex and dynamic. It is a therapeutic relationship but mimics a parental relationship and those relationships the adolescent has with authority figures and adults in general. The nurse juggles these aspects of her relationship with the adolescent by reflecting on her interactions with and responses to the adolescent's thoughts, feelings and behaviours. In this process she comes to understand, more deeply, aspects of her own adolescence, her relationship to her parents and authority figures and herself. She confronts unresolved emotions, her primary way of operating in the world, knowledge deficits, assumptions and belief systems. She receives the opportunity for such learning from the adolescents with whom she works and from the milieu in which she finds herself.

Forestructures: the nurse is aware of and understands her presence, influence and capacity within the therapeutic relationship. This calls for the development of expertise, insight, honesty, humility and mutuality. In looking at herself, and beyond herself, the nurse comes to appreciate the collective skill, wisdom and knowledge of the adolescents, their parents, her colleagues and peers.

2.12 Preunderstandings Developed from this Section

While the entire section on forestructures (including Appendix A) is a laying out of my preunderstandings, there are patterns in my work pointing to three main assumptions concerning the specialty:

(1) working with adolescents experiencing an emotional disturbance involves understanding, balancing and managing the adolescent developmental stage and the adolescent's specific disorder;

(2) the nurse uses the self therapeutically to foster personal integration in the adolescent and to assist them to learn more functional and satisfying ways of relating on an interpersonal and social level. In this context, the self refers to all the nurse brings to her interactions with others; it encompasses the dynamic entity she has become, the knowledge, skill and wisdom garnered through her experiences of living and how she operates in the world; and

(3) the milieu, that environment within which the therapeutic relationship is enacted, is of primary significance. It includes: (a) the landscape, physical buildings, the natural environment, light, furniture, furnishings, equipment and structures; (b) rules, routines and procedures that structure, bound and determine daily activities, for example, participation in activities and regular times for meals, school

or going to bed; and (c) the combined influence of the individual's milieu and how this impacts on the overall milieu.

These forestructures point to some of the major assumptions I hold regarding the practice of adolescent mental health nursing. I used my work on forestructures to review the participant's interview transcripts. In doing this, I attempted to recognise areas where I directed and influenced the interview process thereby leading participants into providing information which confirmed my assumptions. In other words, I tried to prevent myself from only finding what I already assumed I would find about the practice of adolescent mental health nursing. In the section entitled "Hermeneutic Interviewing" (see Chapter 6), I provide some examples of the way I used my forestructures to examine the interview transcripts. In the following section, I discuss my work on preunderstandings.

2.13 Bringing my Preunderstandings to Consciousness

Gadamer (1987, p. 134) suggests understanding always involves the interpreter bringing their preunderstandings to the interpretive process and that this process "never ceases to be determined by the anticipatory impulses of pre-understanding." He also suggests preunderstandings are facilitative or blocking. Bringing preunderstandings to consciousness is an attempt to maximise their facilitative aspect since it allows the interpreter to examine them and to see where they originate and how adequate and legitimate they are in relation to the: (1) phenomenon under investigation, and (2) interpretation of the text. Interpretation involves a confrontation between the horizon of the interpreter and that of the text. Every textual interpretation sets something new, the horizon of the text, against something old, the interpreter's horizon or preunderstandings. "In every case it remains open in

principle whether the new will prevail - that is, will truly become experience - or whether the old, accustomed, predictable will be confirmed in the end" (Gadamer, 1987, p. 88). Thus, interpretation must overcome the entrenchment of preunderstandings or fail because of them. The interpreter cannot look at or beyond their preunderstandings if they have not brought them to consciousness. A different or new interpretation would not be new if it did not have to assert itself and prevail against something else, such as, a predictable interpretation based on unexamined preunderstandings. In this regard Gadamer (1987, pp. 129 & 133) says:

> every authentic interpretation must provide itself against the happenstance arbitration of baroque ideas and against the limitations caused by unconscious habits of thought [therefore] it is indispensable that consciousness take account of its secular prejudices and prevailing anticipations.

According to Gadamer (1987), unqualified preconceptions deprive the text of an opportunity to manifest its own truth. In order to grant the text this opportunity interpreters adopt a hermeneutic attitude. A hermeneutic attitude requires interpreters consciously designate and qualify their preunderstandings because a preunderstanding "... cannot get hold of us unless we are sufficiently unconscious of it" (Gadamer, 1987, p. 137). Accordingly, all "textual interpretation must begin then with the interpreter's reflection on the preconceptions which result from the hermeneutical situation in which he [or she] finds him [or her] self (p. 130)." I reflected on my preunderstandings of the hermeneutic situation in which I found myself by writing stories about my practice as an adolescent mental health nurse. Seven stories were written arising from two separate periods in which I worked on a residential adolescent

mental health unit. They concerned adolescents with major and minor emotional disorders. In writing the stories I was guided by the question, "what experiences with adolescents remain memorable and what is their significance to me?" In attempting to understand the stories I wrote down the meaning each one held for me. For example, why was it important? What did it represent? What did I learn from it? In this way, I tried to understand the implications each story had with regard to my preunderstandings regarding the practice of adolescent mental health nursing. I recognise it is not possible to bring all my preunderstandings to consciousness and that some will inevitably remain unknown. More importantly, bringing preunderstandings to consciousness is not an attempt to eradicate them, rather it is an attempt to enter the hermeneutic circle in a way that enhances the interpretive endeavour.

It was important to write my stories prior to engaging with the research participants as I wanted to capture my own understandings rather than merely to reproduce stories which supported or reflected understandings I gained from them. This also allowed me to interpret my stories and to develop my preunderstandings prior to interpretation of the text. The preunderstandings developed from this part of my work are presented after each story. I use the words "I believe" with each group of preunderstandings as this allows comments to be made in the first person and recognises my preunderstandings are interpretive and not necessarily demonstrated in the stories. Again I use the words "she" and "her" to acknowledge my own gender. When I say "nurse" or "nurses" I am referring to myself and to other nurses. This is because I acknowledge my preunderstandings to be true in relation to myself specifically and to adolescent mental

health nursing in general. It also affirms that I inevitably bring to my preunderstandings the knowledge gained from and witnessed in other nurses. In the following section, I present two of my stories and the preunderstandings I developed from them.

2.14 Story One: Sandy

> I remember this experience because I see it as special and I suppose it reminds me that working with young people means you both give and receive. Now I see more clearly the reciprocity that occurs between the adolescent and nurse but at the time I didn't understand that as well. Unusually, there was a larger proportion of girls living on the unit than boys and this gave some of us the opportunity to form a group and do things together. It was the interest Sandy and I shared in trampolining that led to the formation of our trampoline group, of which there were six. Sandy was a brash girl bordering on aggressive in her manner of relating with others, she was the kind of girl people referred to as acting tough and she took an aloof, standoffish attitude to the nurses. Beneath this veneer she was unsure, serious and compassionate. I had a love of trampolining and Sandy was an excellent and enthusiastic trampoliner; it was through this shared interest that our relationship was established. I could do lots of things on the trampoline but I couldn't do somersaults, she could do a lot more than me but there were one or two things I'd put together that she hadn't thought about doing. I really did admire her ability to somersault but it also provided a vehicle for me to foster her self worth and relate with her in a positive way. After a few weeks of trampolining together she offered to teach me to somersault, I saw this as a landmark in our relationship but was actually too frightened to take up her offer, in return though I taught her the tricks I'd created. The other girls took an interest in our goings on and though not keen to learn anything in particular they liked to jump for the exhilaration and fun of it. We felt comfortable together jumping around on the trampoline and we had a lot of fun, it was a happy time of screeching and laughter. Sandy apparently decided she was going to get me somersaulting and enlisted the support of the other girls in her plan. This had the wonderful outcome of bringing them closer together as friends and of providing Sandy with much needed companionship. Later, they told me how they'd planned and schemed many days over their plot, using homework time to great advantage in the evenings. One afternoon we were around the trampoline and Sandy said again that I should try somersaulting but she said it in a different way, it wasn't her usual casual comment but somehow more insistent. I said I was too frightened of falling

off so the other girls and Sandy volunteered to form a human barrier around the trampoline. I was very unsure but they heaped encouragement on me and formed this shield around the trampoline trying as hard as possible to link hands and provide my safety net. I didn't see how I could resist their smiling expectant faces especially when they pointed out how I encouraged them to face their fears. That sealed it! Fortunately, learning to somersault was a two stage process and you learnt the easy way first. It didn't take long to master my fear and once I'd mastered that it was really quite easy to learn how to somersault. I can't describe the screams and cheers that went up when I succeeded and the resultant tumble of girls jumping onto the trampoline to give Sandy and I many hugs. We all jumped around together alternately jumping, bumping, falling, getting up and laughing. By this time night had fallen and our group collapsed onto the trampoline reclining all over it and tentatively over each other. We talked for a long time about the things we most feared and about the barriers that got in the way of overcoming them, it was one of the most successful group experiences I've ever been involved in and it came out of the bond we'd formed from achieving something together. More importantly it laid the foundation for a warm, affectionate and cohesive group and for what Sandy dubbed our "trampoline therapy." It's impossible to know how many discussions we had under the stars on that trampoline but we covered just about everything from sexuality to families, abuse, the struggles of adolescence, school, careers and the meaning of life. I couldn't share in all these discussions because I had no experience of them, although I did share what I'd learnt from other adolescents and I certainly told a lot of stories about growing up in my family and the trials of my own adolescence. I think this type of reciprocity is important, although it needs to be appropriate to the context and the adolescent, because it helps reduce the distance between you and the adolescent. My most vivid memory is of the way we sprawled around so each of us was touching at least one other person. We came to know ourselves and each other better and I think to love and value each other as well. I don't think there was ever any doubt about who was the adult in the group but we created a feeling of equality and sharing that was unique. Of course I had the role of monitoring the emotions and how quickly the group moved to deeper levels of disclosure, there was a delicate balance to be maintained between too much and too little involvement. It's very easy when you're inexperienced for too rapid movement in the group to produce uncontrolled anger, rage, despair, anxiety or sadness. It was at such times that I felt the responsibility of what we had begun. When you work with adolescents you need to be comfortable with emotions, you can't feel overwhelmed by anger or despair, you must be able not only to defuse anger but also to engender hope, to instil a belief that life will move beyond what it is

now and that that life, whatever it may be, will be worth living. At times life for these young people was black and bleak, so unworth living, I think this is why you need you own reserves of well being, you yourself must have this genuine sense of happiness and feeling of hope in the future. I prepared the group for separation but we still found it sad to part. I knew I would miss the unique relationship we had created and made sure they realised this too; I wanted them to appreciate the significance of their contribution to each others well being and renewed sense of self. On our last few nights we talked about what we had gained from our friendship and I really came to understand the power and quality of therapeutic work that had been facilitated through the group, not that I didn't find this depth of relationship with other kids but this had occurred in a group and sustained itself over the entire school term. That was unique in my experience. We parted with many tears and with pledges to keep in touch. Fortunately our unit encouraged gradual termination of the therapeutic relationship so there was a lot of visiting while the adolescents made their transition from their relationships with us to new relationships and getting on with their lives. When I look back on this experience I remember it as something very special from which I learnt a great deal. I came to see the power of group work and to understand the healing that was possible within such a context. I learnt that everything within a milieu could be harnessed for the therapeutic good including, or perhaps especially, the adolescents. My training had been heavily influenced by the medical model and I was encouraged to believe it was only what health professionals did that was therapy or therapeutic, usually it was other health professionals too that's why they were called therapists and we were called nurses or direct care staff! Now I know differently and it was this group of adolescents who helped me to learn it. I also learnt about the trust, cooperation, safety, tenderness, affection, anger, sadness and pain that's experienced when a group of adolescents decide to share their vulnerabilities in the hope of finding acceptance, sustenance and healing. But my greatest learning came from Sandy, she helped me see there was give and take in the therapeutic relationship. As a nurse you assume you are the one who will give and the client is the one who will receive but that isn't the case. I helped Sandy overcome her sense of worthlessness and difficulty relating to others while she helped me overcome my fear of somersaulting and form a therapeutic group. We both gave to and received from each other. It was lovely.

2.15 Preunderstandings Developed from Story One

I believe:

* the relationship between the adolescent and nurse often leads to reciprocity, to them giving and receiving;

* shared activities are opportunities for therapeutic work;

* the therapeutic relationship contains significant landmarks which guide my work with an adolescent;

* sharing contextually appropriate information about myself and my work with other adolescents reduces the distance between myself and the adolescent;

* while equality and the sharing of power are important in my work with adolescents I remain the professional/adult in charge;

* group work comprises a delicate balance between too much and too little involvement; movement that is too rapid can produce extreme anger, rage, despair, anxiety or sadness. In my work with adolescent groups it is my responsibility to monitor group process;

* nurses need to be comfortable with emotions when working with adolescents; you cannot feel overwhelmed by anger or despair. You must be able to defuse anger and also to engender hope, to instil a belief that life will move beyond what it is now and that that life, whatever it may be, will be worth living;

* nurses need their own reserves of well being, a genuine sense of happiness and feelings of hope in the future to sustain them in their work with adolescents whose lives are often bleak and black;

* it is necessary to prepare adolescents for separation from the unit and from therapeutic relationships and having developed an attachment to an adolescent, through a therapeutic relationship, I too will need to resolve the loss of that relationship;

* it is important to use the therapeutic relationship to highlight the gains and contributions the adolescent has made to their own well being and to the well being of others;

* everything within a milieu can be harnessed for the therapeutic good, especially the adolescents. It is not only health professionals nor those with the title therapist who have therapeutic potential, nurses too are therapists and therapeutic;

* adolescents experience trust, cooperation, safety, tenderness, pain, affection, anger and sadness when they share their vulnerabilities in the hope of finding acceptance, sustenance and healing. The nurse monitors and works through such feelings with the adolescents;

2.16 Story Two: Maryanne

> This story concerns a 15 year old called Maryanne whose depression resulted from unresolved grief over her grandfather's death. Maryanne and I got on well together and the relationship we developed was light and affectionate. We

didn't talk in detail or depth about her problems but I knew her history from case review meetings and her file. We did day to day things together like activities or just hanging out and talking about life in general. One afternoon, when all the adolescents had returned to school, I was at the desk and looked up to see Maryanne leaning casually against the door frame. There was a look of uncertainty on her face but she was definitely there for a purpose as this was not a typical pose nor typical behaviour for her. I said "hi there, nice to see you" and she smiled shyly and wriggled around shifting her weight from foot to foot. From her behaviour I knew there was something she wanted to talk about, I call this behaviour "hanging around to see what kind of response I'll get" and it's typical of adolescents when they have something on their mind. It's important to notice these differences in behaviour because they act as cues and if you miss them you may not offer the young person the opportunity to deal with their concerns. I felt she wanted to talk but was discomforted so I started with management issues first. I asked if the school knew where she was and found out she'd received permission to come and see me; this gave me the lead in I needed so I asked her to come in and sit down. I phoned the other nurses to let them know what was happening and the school principal to say that Maryanne would be with me for a while. After putting a "do not disturb" sign on the door I contacted the receptionist and asked her to take messages so that Maryanne and I would not be disturbed. We both sat on a lounge in the office. I knew I needed to warm up to whatever she wanted to tell me so I asked about school, life on the unit and her family. After a while she seemed more relaxed so I said "you look like something's worrying you, is that why you wanted to see me?" I was surprised at the conversation that followed because I wouldn't have thought she would choose me for it, I wasn't aware she trusted me at this level. In a long story she told me about her relationship with her grandfather; what he meant to her, how she felt when he died and the impact his death had had on her. Although Maryanne was not tearful she spoke with sadness and longing. During our discussion she said, "you know, I didn't even get to say goodbye to him before he died." I saw this as significant in relation to the rest of the conversation and thought it might be something we could help with. I wondered if Maryanne could gain some benefit from saying goodbye to her grandfather symbolically so I explored avenues through which to do this. I asked her how she would have liked things to have been or what she would like to have said to him. She was unable to articulate this very clearly so I suggested drawing. I said something like "sometimes it's hard to put things into words so may be you could draw it." She responded enthusiastically saying she would do that and take it to him at the graveyard, that she would use that as a way of saying goodbye. We spent a while trying to work this out and I suggested she might draw things

he or she liked. This lead to a lengthy discussion about the things he liked to do and the things they liked to do together. The final drawing was going to look quite interesting because he had a liking for beer, so a beer can was to form the centrepiece, their portraits and smaller drawings would surround this and a poem would complete the work. Maryanne was keen to use drawing as a way of symbolically communicating with her grandfather and I hoped it would allow her to feel a sense of completion because I felt strongly that action was required. By now it was after 3 pm and school would soon be over so I walked Maryanne to her room to wait for the other kids. When we reached her bedroom she entered first and I was the one who lounged around the door looking into her room. I noticed she had several smallish soft toys and commented on them; she said she liked the feel of them and that holding her teddy bear was comforting. I was touched by her response and felt there was deep sadness in it. Suddenly I had an idea. I walked into the room, gave her a cuddle and told her not to leave until I returned. There was a paediatric unit nearby and I went to see their nursing unit manager to speak with him about Maryanne. They had the biggest, softest teddy bear I'd ever seen and I asked him if we could borrow it for a week or two; he readily agreed and I remember carrying back this bear which must have been a metre high, shaggy haired, brown, beautiful and a proper armful. I'll never forget the look on Maryanne's face when I walked into her bedroom; I pushed teddy into her arms and she buried her face into him with tears in her eyes, "it's all yours for two weeks, look after him and I hope you enjoy him" I said. She put her arm around my neck and hugged me, she said "thanks and don't worry he's in good hands." I felt Maryanne's tension lesson and experienced a feeling of relief. It seemed the right thing to do and came about because I felt so strongly her need for comfort which we could not always provide for her and it also fitted in with a method of comforting she had chosen for herself. Maryanne produced her poem and drawing and chose to go to the grave site with one of the unit staff; when they returned they came to tell me how well it went and that they planned to go again. Eventually, Maryanne decided she didn't need to visit the grave anymore; she thanked me for helping her and said she felt she had worked through a lot of the problems associated with her grandfather's death. I remember this experience because it reminds me how important it is to put things aside when young people seek you out; if I'd said I was busy and asked her to come back I don't think the outcome would've been the same. I think it demonstrated to Maryanne that I took her seriously and that I cared enough to interrupt my routines; it comes down to putting the adolescent before other things, showing them they're important, letting them know they matter. Also, it taught me a single interaction can have a significant therapeutic impact; before this experience I was inclined to think more sustained work and deeper

relationships were required to achieve such outcomes. I'd rediscovered how significant each interaction has the potential to be.

2.17 Preunderstandings Developed from Story Two

I believe:

* the nurse keeps up to date with the history, progress and management of adolescents with whom she is not working directly through file notes and case review meetings;

* relationships with adolescents are founded on being together, talking and engaging in shared activities;

* interpretive communication is the hallmark of therapeutic relationships. Such communication is facilitated by knowing the adolescent well, by listening in an engaged way and by making time to be together. Interpretive communication includes the interpretation of words, behaviours and symbols and it allows me to assist the adolescent to make sense of their thoughts, feelings and actions;

* communicating with colleagues and peers assists the conduct of therapeutic work by reducing conflict or confusion in the milieu. If several adults work with an adolescent they replicate the parental role so their communication should be unambiguous and consistent;

* affection and touch is often demonstrated by adolescents and nurses in the therapeutic relationship;

* the nurse and adolescent work in partnership to address and resolve concerns, distress and difficulties. The most effective and powerful interventions are those which link in with positive coping strategies already being used by the adolescent;

* engaging with an adolescent at times of need demonstrates understanding, caring and the ability to put the adolescent before routine tasks. This confirms to the adolescent that they are important and that their concerns matter to me;

* a single interaction can have a significant therapeutic impact. In joining with an adolescent to work on their concerns I demonstrate my trust and belief in them, they in turn, learn personal responsibility and the ability to take control of their life.

2.18 Preunderstandings Developed from this Section

Through completion of my work on preunderstandings (which includes Appendix B) I became aware of five strongly held beliefs I will take to my interpretation of the text:

(1) the nature of the relationship which develops between the adolescent and nurse is central to all they can achieve together. The hallmark of that relationship is its nonhierarchical nature and its foundation of mutuality, friendliness, affection, being together and engaging in activities. The relationship contains elements normally found in relationships with one's parents and friends;

(2) in her work with young people the nurse fosters developmental milestones and therefore the transition from childhood to adolescence and from adolescence to adulthood;

(3) activities and communication are the primary vehicles through which the nurse engages the adolescent therapeutically;

(4) the nurse's ability to work therapeutically with adolescents, and collaboratively within a team, are influenced by her self and her capacity to work through unresolved personal issues; and

(5) all these processes take place within a milieu whether the unit milieu or one created, as for example, at a camp.

My preunderstandings point to some of the major assumptions I hold regarding the practice of adolescent mental health nursing. Having brought my preunderstandings to consciousness I considered their presence during textual interpretation. Their presence prompted me to question their origin, adequacy and legitimacy and it alerted me to look beyond them to other interpretations which were not foremost in my thinking. I also used my work on preunderstandings to assist me to analyse my influence on information gathering. The way in which I did this is presented in the section entitled "Hermeneutic Interviewing" (see Chapter 6).

Still, hermeneutics is oriented toward contexts greater than the individual so it was not sufficient to bring forward only those preunderstandings arising from the interplay between myself and the phenomenon under investigation. Accordingly, in the following chapter entitled "Sociopolitical Context of the Research",

I review sociopolitical factors influencing adolescent mental health and adolescent mental health nursing in Australia. Through this review I developed understandings beyond my own engagement with the study and an appreciation of the broader dimensions within which adolescent mental health nursing is situated.

Chapter Three

3 The Sociopolitical Context of the Research

3.01 Introduction

Hermeneutic research is contextual although as Gadamer's (1979) conceptualisation of tradition demonstrates, context is neither individual, singular nor static. The context of this study therefore includes not only its situatedness within intersubjective, temporal and historical dimensions but also sociopolitical ones. Accordingly, the examination of sociopolitical issues allows the study to be placed and understood within its broader context. In this chapter, the examination of sociopolitical issues takes place through the presentation and analysis of the following aspects: epidemiology, funding, services, training and education, research and nurse education, all of which influence the practice of adolescent mental health nursing. Initially however, it is important to remember that a proportion of emotionally disturbed adolescents and adults develop their disorders during childhood (see Rutter, Graham, Chadwick & Yule, 1976), and therefore, while this study focuses on adolescent mental health the interrelationship of mental health throughout developmental stages should be kept in mind.

By way of introduction to sociopolitical issues influencing adolescent mental health, I point to the fact that: (1) Tasmania, the Northern Territory and the Australian Capital Territory have no beds allocated specifically for emotionally disturbed children or adolescents (Commonwealth Department of Human Services & Health, 1995a, p. 228); (2) the Northern Territory, Western Australia, Tasmania and the Australian Capital Territory have no plans or strategies developed to improve child or adolescent mental

health services (p. 69); (3) only Victoria, Queensland and Tasmania have a representative for youth issues in their Consumer Advocacy Group (these groups advise Government ministers on matters influencing mental health care) (p. 95); and (4) Commonwealth Government plans and strategies focus on youth suicide at the expense of other adolescent mental health issues.

3.02 Epidemiological Data

The Human Rights and Equal Opportunity Commission (1993) inquired into the rights of people with mental illness and published a two volume report of its findings. While the Commission noted the paucity of Australian epidemiological research on emotional disturbance in adolescence, one of the first of such prevalence studies was conducted in Heyfield, Victoria in the 1960's (Krupinski, Baikie, Stoller, Graves, O'Day & Polke, 1967). This research suggested 16% of adolescents had some form of emotional disorder and its findings are consistent with later studies. For example, Leslie's (1974) research, conducted in an industrial town, found a 17% prevalence of adolescent disturbance while Rutter, Graham, Chadwick and Yule (1976) found a 14-15% incidence on the middle class Isle of Wight. Through studies such as these, it is generally accepted that 15% of adolescents, or approximately 300,000 Australian adolescents, have a diagnosable emotional disorder (Australian Bureau of Statistics, 1991; Human Rights & Equal Opportunity Commission, 1993; Waters, Molony & Vandenberg, 1992). However, data collected between 1980 and 1994 indicates a steadily rising rate of suicide in adolescent males aged 15-19 years (Australian Bureau of Statistics, 1995; Davis, 1992) and an increasing rate of attempted suicide for this age group. Further, Davis and Kosky (1991) assert that statistics on attempted suicide in adolescence are significantly underestimated

because of variations in hospital classifications and because many young people who attempt suicide never present at hospitals where data collection takes place. Accordingly, rising rates of attempted and completed suicide, particularly in the 15-19 year old age group, suggests an increasing incidence of emotional disorder in Australian adolescents. Nevertheless, despite this incidence, the funding and services required to meet the needs of adolescents experiencing emotional disturbance are decidedly inadequate.

3.03 Funding, Services, Training and Education

Insufficient budgets and inadequate bed numbers indicate child and adolescent mental health services are low priorities in health care. For instance, money to help children and adolescents experiencing emotional disturbance most often comes through agencies other than health (Commonwealth Department of Human Services & Health, 1995b). Moreover, programs for children and adolescents receive less than 10% of mental health budgets despite the fact that they form 33% of the mental health population (Davis, 1992). Consequently, throughout Australia, there are less psychiatry beds for children and adolescents than for all other groups. For example, general psychiatry has 5,340 beds, geriatric psychiatry 1,628, forensic psychiatry 281 and child and adolescent psychiatry 216 (Commonwealth Department of Human Services & Health, 1995a, p. 50). The interesting comparison here is with geriatric psychiatry. People 65 years and over, who form 12% of the population, are allocated 1,628 psychiatry beds while children and adolescents, who form 25% of the population, are allocated 216 beds (Australian Bureau of Statistics, 1995). This anomaly is partly explained by the prevalence of dementia disorders in advanced old age but more so by a 12.4 million dollar Commonwealth Government grant to geriatric psychiatry in 1994-1995 (Commonwealth

Department of Human Services & Health, 1995a, p. 7). This grant was provided even though, prior to this time, the Human Rights and Equal Opportunity Commission had noted severe deficits in adolescent mental health services (1993, Vol 2, p. 932). In their report, the Commission emphasised that adolescent mental health services were grossly underfunded and that serious deficiencies existed in the provision of staff, services and programs for adolescents experiencing emotional disturbance. As the following data indicates, one outcome from these deficits is that adolescents with emotional disorders receive treatment from services and staff who are insufficiently prepared to work effectively with them.

In 1988-1989, 1,436 adolescents aged 12-17 years were discharged with a psychiatric diagnosis from New South Wales hospitals. Of these, 35.7% were discharged from general hospitals, 33% from adult psychiatric units or hospitals, 2.5% from paediatric wards and 6.2% from adolescent psychiatric units (Waters, Molony & Vandenberg, 1992, p. 142). These statistics demonstrate that the majority of adolescents with emotional disorders are treated in general hospitals or adult psychiatric units and hospitals, despite longstanding consensus that adolescent specific mental health services are the most appropriate for adolescents experiencing emotional disturbance (Bennett, 1984; Human Rights & Equal Opportunity Commission, 1993; Sawyer, Meldrum, Tonge & Clark, 1992; Waters, Molony & Vandenberg, 1992). Adolescents participating in the present study provide strong support for the notion that an adolescent mental health unit is the most appropriate health facility for a young person requiring residential care. For example, Elizabeth spent three weeks on a children's ward prior to being admitted to an adolescent unit and she described the differences between the two environments in this way:

> *Looking back now I know they weren't trained in that way, to look after me in the way the [adolescent unit nurses did], they didn't specialise ... I was in a children's ward, I was with just normal everyday nurses who work in hospitals ... they didn't know how to handle me ... it just wasn't a happy experience for me ... and I expected when I went to the [adolescent] unit, I thought that it would be the same, so I went into it thinking "it's going to be bad from the start" and it just wasn't like that.*

On the other hand, Belinda, who was admitted to a psychiatric hospital and an adolescent unit, provided the following insights into those environments and the nurses working in them:

> *It was 50 times worse than I expected, it was just crazy people, about 100 crazy people shoved into a big room for the whole day ... I just sat in the corner, I didn't talk to anybody, I wouldn't even talk to the staff at the psychiatric hospital ... the nurses [on the adolescent unit] weren't what I'd expected ... they were just like the kids, they jumped on the trampoline with the kids ... that's why the were easy to get along with ... they'd talk about whatever we were talking about. At the psychiatric hospital everybody was looking at every move to see whether it's normal or not but on the unit they didn't sit there and analyse you, it was different.*

Lee also spoke of differences between the nurses working on the adult and adolescent mental health units to which she was admitted. And, although both units were part of a hospital setting, Lee perceived the adult and adolescent unit nurses quite differently:

> *Robyn didn't wear a uniform for a start and she was more like a person than a nurse, and I suppose nurses in a hospital have to give you medication and take your temperature and all that sort of stuff, so she was more like a friend that was there when you needed her.*

For Eamon, the nonhospital nature of the adolescent unit and nurses was important:

> *I don't remember nurses ever wore uniforms or*

> *anything like that which was terrific, and I think the environment being a homey set up, it wasn't that authority thing ... I was so lucky there was a place like that to go to. I suppose if I was a few years older I might have had to go to a psychiatric hospital or more of a clinical set up ... I reckon it was just a terrific [place].*

Aloysius also felt the physical environment was important and he suggested the combined effect of the environment and the nurses created an atmosphere for healing:

> *It was big, it was open, it was airy, it was a comfortable place ... there were fields at the back, you'd lie down on the hill ... it was already really peaceful ... it was just grass and space and people who were quite prepared to talk to you whenever you wanted them to ... a great atmosphere for healing.*

Nevertheless, as hospital bed numbers indicate, the majority of emotionally disturbed adolescents will be treated outside adolescent mental health services. For instance, Australia wide, per 100,000 of the population, there are 3.4 acute and 1.1 nonacute beds for children and adolescents with emotional disorders (Commonwealth Department of Human Services & Health, 1995a, p. 228). Even so, Tasmania, the Northern Territory and the Australian Capital Territory have no such beds. Further, 34 of the 89 New South Wales beds are rehabilitation beds and 18 of the 28 Queensland beds are extended care beds thus they are only suitable for adolescents with severe disorders such as schizophrenia (Commonwealth Department of Human Services & Health, 1995a, p. 229). As a result, 164 acute and subacute beds are available to meet the needs of the 15% of children and 15% of adolescents with emotional disorders. While it is acknowledged that not all these children and adolescents require hospitalisation, it is generally agreed that 1 to 2% of them will be in urgent need of treatment. This is evidenced

by the fact that 16,000 adolescents alone are diagnosed each year with schizophrenia or some other form of psychosis (Human Rights & Equal Opportunity Commission, 1993, Vol 2, pp. 603-604).

As an example, Queensland data demonstrates how inadequate services are in meeting the needs of children and adolescents with emotional disorders. In 1992, 1,988 children and adolescents were discharged from Queensland hospitals following inpatient treatment for emotional disorders (Australian Bureau of Statistics, 1992). Clearly, their 28 child and adolescent psychiatry beds cannot begin to meet this need. Again, this highlights that emotionally disturbed children and adolescents do not receive care within appropriate mental health services. As a result, staff in diverse settings such as juvenile justice, welfare, general health, adult mental health and paediatrics work with emotionally disturbed adolescents (Kosky, 1992; Human Rights & Equal Opportunity Commission, 1993; Waters, Molony & Vandenberg, 1992), despite an apparent lack of knowledge with which to do so. This point was made by the Human Rights and Equal Opportunity Commission (1993, Vol 2, p. 932) who said there was "an alarming lack of knowledge among many mental health, health, education, welfare and juvenile justice professionals" with regard to emotionally disturbed adolescents. Moreover, despite the Commission's (1993, Vol 2, pp. 933-934) recommendation for the expansion of adolescent specific services and for urgent increases in the funding of existing services, Governments have not provided and are unlikely to provide sufficient services for adolescents with emotional disorders. Thus, young people will continue to receive assistance from nonadolescent specific services making it essential that staff in those services receive sufficient education to assist them in their work.

The need for increased education for all professionals working

with emotionally disturbed adolescents was noted by the Human Rights and Equal Opportunity Commission (1993). In addition, the Commission noted the importance of students receiving training in adolescent mental health although it only recommended medical students receive such training. Thus, "all medical students should receive training in adolescent mental health" (1993, Vol 2, p. 334). Does this mean doctors are the most deficient in such knowledge? Considering the Commission's findings regarding the lack of knowledge amongst health, welfare, education and juvenile justice professionals this is clearly not the case. Does the recommendation imply that doctors are more prominent than other disciplines in providing health care for adolescents experiencing emotional disturbance? This too is not the case as the greatest number of mental health care providers are not doctors but nurses. On average, nurses represent 53% of the Australian mental health care workforce while doctors represent 7% and all other health professionals collectively represent 14%. Moreover, in rural and remote areas nurses represent 67% of the mental health care workforce (Commonwealth Department of Human Services & Health, 1995a, p. 121). Nevertheless, even if the Commission suggested students of all disciplines should be educated to work with emotionally disturbed adolescents, it is difficult to see where such knowledge would come from. Indeed, it is with regard to education and practice that the scarcity of research in practice disciplines, like adolescent mental health nursing, is especially problematic since without such research the knowledge informing practice cannot be discovered, taught or learnt.

3.04 Research

According to the Commonwealth Department of Human Services and Health (1995b), which reviewed research issues in mental

health, the need for research in adolescent mental health is critical. How much Australia spends on mental health research annually is not known although estimates suggest a minimum of 11 million dollars in 1993-1994. This is a minimum estimate as it excludes data from Tasmania, Western Australia and the Northern Territory where information on research spending was not available (Commonwealth Department of Human Services and Health, 1995a, p, 140). While this amount is considered far below requirements, the majority of mental health research funding is awarded to biomedical research or to studies of severe disorders like psychoses and schizophrenia. Although these disorders may be especially disabling, they only account for 1-2% of all emotional disorders including those of adolescence (Human Rights & Equal Opportunity Commission, 1993, Vol 2, p. 605). Thus, researchers investigating other disorders compete for very limited funding. For example, the National Health and Medical Research Council (NHMRC) funds a Schizophrenia Research Unit with an entirely biomedical focus and the Governments of Victoria and Queensland spend two million and one million dollars respectively on the same type of research. The NHMRC also funds a Social Psychiatry Unit although again its focus is medical. In 1994 the New South Wales Government granted the Garvan Medical Research Institute three million dollars for mental health research and the New South Wales Institute of Psychiatry 100,00 dollars for research fellowships. In addition, the Commonwealth Government allocated five million dollars, between 1992-1997, to neuroscientific mental health research. On the other hand, the Research and Development Grants Advisory Committee (RADGAC), who fund nonbiomedical research, received only 150,000-180,000 dollars in research funds until 1995 when their funding was increased to 1.5 million dollars; a small part of

the supposed minimum 11 million dollars available (Commonwealth Department of Human Resources & Health, 1995a, p. 141). This bias toward biomedical research is further noted in the NHMRC's structure and funding. For example, two main NHMRC committees oversee research funds, the Medical Research Committee (MRC) is biomedically oriented and it allocated 101 million dollars for research in 1992. The Public Health Research Development Committee (PHRDC) is nonbiomedically oriented and it allocated 4.8 million dollars for research in the same year (Human Rights & Equal Opportunity Commission, 1993, Vol 2, pp. 827-836). This focus on biomedical research disadvantages mental health nurses whose primary interest is in the human sciences. Also, it is disturbing to note, in a report as significant as the National Inquiry into the Human Rights of People with Mental Illness, that research is presented as either biomedical or medical and that only psychiatrists and psychologists are mentioned as researchers (Human Rights & Equal Opportunity Commission, 1993, pp. 821-824). In this regard, nurse researchers are invisible. Although, as the following discussion suggests, this may be because mental health nurses have either not engaged in or not published research.

Throughout Australia, mental health nurses work with emotionally disturbed adolescents in community and inpatient settings yet no research publications were found on adolescent mental health nursing. Similarly, no such publications were found from the United Kingdom and only two were found from America. Accordingly, the knowledge informing adolescent mental health nursing practice remains unresearched and unpublished. Discovery of this knowledge could be of benefit in two ways. First, it would allow the dissemination of knowledge for use by nurses and others working with emotionally disturbed adolescents in the hope

of improving health care outcomes. Second, it could form the basis of courses on adolescent mental health thereby going some way toward fulfilling the Human Rights and Equal Opportunity Commission's (1993) recommendation that education, health, welfare and juvenile justice professionals receive education in adolescent mental health to assist them in their work. Although, it is interesting to note that while the Commission recommended increased education for a variety of disciplines, the implementation of this recommendation has resulted in a focus on nurse education (Commonwealth Department of Human Resources & Health, 1995a).

3.05 Nurse Education

In 1983, 13 years before the National Inquiry into the Human Rights of People with Mental Illness published its report, the National Health and Medical Research Council (1983) expressed similar concerns about the availability of adolescent health services and the need to educate a variety of disciplines with respect to: (1) health issues relevant to adolescents, and (2) knowledge with which to work with adolescents. Bennett (1984) outlined three levels of preparation in adolescent mental health for medical practitioners. They occurred at undergraduate, postgraduate and advanced postgraduate level when doctors were students, practitioners or specialists. In the National Mental Health Report, 1994 (Commonwealth Department of Human Resources & Health, 1995a) similar recommendations were made for the education of nurses. These recommendations stemmed from reports by the Human Rights and Equal Opportunity Commission (1993) and a National Review of Nurse Education in the Higher Education Sector (Nurse Education Review Secretariat, 1994). In particular, it was proposed that "all undergraduate nursing programs have a significant mental health component, and post registration courses be provided to

prepare comprehensively educated nurses for specialist [mental health] nursing practice" (Commonwealth Department of Human Resources & Health, 1995a, p. 126). In their research, Farrell and Carr (1996) present some worrying findings with regard to this issue and nurse education in the higher education sector.

Farrell and Carr (1996, p. 77) sought information on the mental health component of undergraduate curricula from all university schools of nursing in Australia and received an 84% response rate. They reported great variability in the number of mental health theory and practice hours in undergraduate nursing courses. For example, theory hours ranged from zero to 225 and practice hours from zero to 200 (1996, p. 79). These figures do not support the recommendation that all undergraduate nursing programs have a significant mental health component. Such low levels of mental health nursing theory and practice hours is problematic since undergraduate nursing curricula are supposedly comprehensive, having developed from a fusion of registration courses in General, Mental Retardation (now Disability) and Psychiatric (now Mental Health) Nursing. In this regard, the mental health component of undergraduate nursing curricula should be 30% not 0-15%. Taking Farrell and Carr's research into consideration, it is questionable how many undergraduate nursing courses assist in providing "an adequate supply of nurses skilled to work in the mental health field" (Commonwealth Department of Human Resources & Health, 1995a, p. 126). Moreover, Farrell and Carr's research on postgraduate mental health nursing courses is equally troubling since such courses purport to produce specialist nurses.

According to Farrell and Carr (1996, p. 80), only eight graduate diploma courses were conducted in mental health nursing throughout Australia in 1994. In these courses, theory hours ranged

from 42 to 362 and practice hours from zero to 721. Combining all the worst case scenario figures on undergraduate and graduate diploma courses, a student could graduate with a comprehensive undergraduate nursing degree and a graduate diploma in mental health nursing with 42 hours of theory and zero hours of practice (1996, p. 79-80). All this aside, how many graduate courses in mental health nursing provide "comprehensively educated nurses for specialist [mental health] nursing practice?" (Commonwealth Department of Human Resources & Health, 1995a, p. 126). As the following data from Waters, Molony and Vandenberg (1992, p. 142) suggests, the issue of undergraduate and graduate nurse education is critical since: (1) 35.7% of emotionally disturbed adolescents were discharged from general hospitals, and 2.5% from paediatric units, thereby highlighting the need for comprehensively prepared undergraduate nurses with a significant mental health component in their curricula; and (2) 33% of emotionally disturbed adolescents were discharged from adult psychiatric units, pointing to the need for comprehensively prepared graduate mental health nurses with a significant adolescent mental health component in their curricula. This is especially important in Australia since no course is available in adolescent mental health nursing at this time (Yardley, 1996).

3.06 Preunderstandings Developed from this Section

Within the health care system the acute deficiency in services for emotionally disturbed adolescents suggests adolescent mental health is in a relatively powerless sociopolitical position. In turn, these deficiencies result in the displacement of emotionally disturbed adolescents into services that are not age appropriate and that are inadequately prepared to work with them. Moreover, an appreciation that adolescents require age appropriate services, in the same way that children do, appears only to have been

understood in the most rudimentary way. Thus, while children's units and high dependency units are common, adolescent units are uncommon and high dependency units unheard of. There are two specialist children's hospitals in New South Wales alone yet where is the specialist hospital for adolescents? More often than not adolescents are nursed in adult units. Adolescents, however, are neither children nor adults rather they are in transition from the former to the latter. Nurses who work with adolescents learn how to juggle the contradictions and inconsistencies in feeling, thought and behaviour that herald movement between childhood, adolescence and adulthood. And, while this may be a part of the practice knowledge of adolescent mental health nursing, how many generalist and other specialist nurses have these skills?

3.07 Conclusion

With regard to adolescent mental health, this review suggests several areas of concern at both planning and service level. In the first instance, Commonwealth and State Government planning is problematic as it concentrates on specific adolescent mental health issues, like youth suicide or psychoses, at the expense of all other disorders. In order to be effective in preventing emotional disturbance, and in caring for adolescents who develop emotional disorders, all areas of adolescent mental health require attention, especially research.

Research is significant as decisions regarding funding, services and education may be more accurately made through the use of research findings. Some data is already available in Australia and explains present Government directions. For example, research findings on completed and attempted adolescent suicide have resulted in a focus on youth suicide. On the other hand, epidemiological studies are required if the prevalence and nature of

adolescent disturbance in Australia is to be thoroughly understood. Available data suggests emotionally disturbed adolescents are cared for in a variety of health, welfare, education and juvenile justice services. Yet, little is known about the way the various disciplines work with adolescents or how adolescents perceive these services. Accordingly, what can be learnt from adolescents, and those who work with them, about the nature and knowledge of their work? And, how can this knowledge be used to educate people to work therapeutically with emotionally disturbed adolescents?

Because emotionally disturbed adolescents are nursed in a variety of health care settings, decisions regarding the educational preparation of nurses are significant. Undergraduate and specialist graduate education needs to prepare nurses to work effectively with adolescents experiencing emotional disturbance. While it is problematic that little nursing practice research exists in the specialty to guide educators, there is no shortage of theoretical and anecdotal literature. Accordingly, in the following chapter entitled "Adolescent Mental Health Nursing: A Literature Review", research and literature is examined with specific reference to mental health and adolescent mental health nursing.

Chapter Four

4 Adolescent Mental Health Nursing: A Literature Review

4.01 Introduction

Hoffman and Bertus (1992) assert that the theory and practice of mental health nursing has been shaped by the discipline of psychiatry and by the behavioural sciences. Carter (1986) supports this assertion although Liaschenko (1989) argues that the dominant influence, through psychiatry, has been medical. Reed (1987) suggests domination by other disciplines is problematic because it limits nursing's perspective whereas I will argue the greater problem is that it limits nursing's development. Reed also suggests there is an overuse of borrowed theory and that this has arisen because nursing has failed to provide theories of its own. In this chapter, I address the issues of inadequate nursing research and the use of borrowed theory through a review of mental health nursing research. Following this review, I examine literature and research relevant to adolescent mental health nursing and I argue that the overuse of borrowed theory within the specialty is linked to inadequate nursing research and publication which, in turn, perpetuates a reliance on borrowed theory. In the final section, I discuss my preunderstandings in relation to the literature review.

4.02 Mental Health Nursing Research

In America, following a review of 24 journals over a 15 year period, Jones and Jones (1989, pp. 99-100) found 153 published mental health nursing research reports. This means America's 48,000 mental health nurses published 10 research reports annually, even though 12,500 were prepared at masters or doctoral level and 600 more were graduating yearly from such programs

(Killeen, 1990). More recently, Merwin and Mauck (1995, pp. 314-322) found 77 mental health nursing research publications following a review of all nursing research and mental health nursing journals for the years 1989 to 1994, suggesting a slight increase to 13 research publications annually. This is despite the availability of five specialty journals in which American mental health nurses can publish. Similarly, in Australia, research publication within the specialty remains low.

Mascord's (1990, p. 25) review of Australian publications revealed six mental health nursing research reports published over several years. In a recent review of The Australian and New Zealand Journal of Mental Health Nursing, I found 15 research publications in a three year period between 1994 and 1997. This number included nursing practice research and research about nurses or nurse education. While this remains a low level of research publication, it is also encouraging as Australia's 5,400 mental health nurses publish five reports annually while America's 48,000 nurses publish 13 (Australian Bureau of Statistics, 1991; Killeen, 1990). With regard to the United Kingdom, recent data was unavailable however Davis' (1986) earlier review found 23 published and unpublished reports between 1980 and 1984. Nevertheless, while low levels of mental health nursing research and publication are of concern, these issues are especially problematic in adolescent mental health nursing.

4.03 Adolescent Mental Health Nursing

A search of available data bases suggests a scarcity of published research in adolescent mental health nursing. Two publications were found from America despite there being 574 certified child and adolescent mental health nursing specialists from diploma, masters and doctoral programs (Pothier, 1992, p. 47). No research publications were found from either the United Kingdom or

Australia. As a result, the knowledge informing adolescent mental health nursing practice is essentially unresearched and unpublished (Gilbert, 1992; Hogarth, 1991; McBride, 1992; Pothier, 1992). Further, while Australian mental health nurses work with emotionally disturbed adolescents in community and inpatient settings, they do not appear to write about their practice. The two exceptions are Holden's (1986) and Creedy and Crowe's (1996) articles. As these were the only articles found on adolescent mental health nursing in Australia, they are reviewed briefly here.

4.04 The Use of Borrowed Theory

In her article, Holden (1986) reviews the care of 13 year old Christos using sociological theory. This discourse fails to illuminate nursing knowledge because such knowledge is entangled within borrowed sociological theory. Analysis of Holden's paper suggests notions like limit setting, fostering self worth and developing therapeutic relationships may have been fruitfully explored from a nursing perspective. While such knowledge may originate in theory borrowed from other disciplines, it is how nurses use those theories in nursing contexts that requires explication. In reviewing Holden's article, the influence of borrowed theory on mental health nursing is demonstrated. Drawing on the work of Belenkey et al, Kidd and Morrison (1988) refer to the use of borrowed theory as the stage of "received knowledge." Received knowledge implies nurses perceive themselves as capable of receiving knowledge from external authorities but as incapable of creating it. As mental health nurses borrowed theory from the disciplines of psychology, psychiatry and sociology, Holden's use of such theories to discuss adolescent mental health nursing is readily understood. On the other hand, the continuing reliance on borrowed theory, as for example, in Creedy and Crowe's article (1996) is troubling.

In their article, Creedy and Crowe (1996) discuss the therapeutic milieu by drawing on the work of Gunderson (1978). A psychiatrist, Gunderson based his ideas on psychoanalytic and interpersonal relations theory. He identified five processes including: structure, containment, support, involvement and validation as being integral to the establishment and maintenance of a therapeutic milieu. Delaney (1992) applied Gunderson's theory to a discussion on child milieus while Creedy and Crowe applied it to their discussion on adolescent milieus. The processes in Gunderson's theory are readily recognisable to mental health nurses as they are part of the language of practice, yet this in itself is problematic since it suggests an uncritical acceptance of untested, borrowed theory. For instance, where is the research evaluating the applicability of Gunderson's theory to the practice of mental health nursing? In their article, Creedy and Crowe provide a useful discussion on adolescent milieus but they do this in an unquestioning way through the use of untested, borrowed theory. Thus, adolescent mental health nursing continues to borrow theory rather than to generate and test its own. The educational preparation of adolescent mental health nurses in America is quite different to their preparation in Australia, yet as the following discussion demonstrates, outcomes from excessive reliance on borrowed theory and inadequate nursing research are similar in both countries.

Child and adolescent psychiatric nursing is the oldest mental health nursing specialty in America. Further, certification as a child and adolescent psychiatric nurse requires postgraduate preparation. Pothier (1992, p. 47) noted that, in 1988, postgraduate courses in child and adolescent psychiatric nursing were graduating 40 nurses each year and there were 574 such clinical nurse specialists. Even so, in her review of the specialty Pothier claimed the crucial task of

providing an underlying base of nursing research remained undone. While acknowledging this deficit, Gilbert (1992, p. 50) maintains this has arisen because "there is a paucity of doctorally prepared nurse researchers in [the] specialty." Some three years earlier, in 1989, a task force on psychiatric nursing suggested three areas required attention: (1) preparing psychiatric nurse researchers, (2) supporting research careers, and (3) providing links for nurses to existing research systems (Bush, 1992). Nevertheless, a national workshop convened in 1992 to plan future directions for child and adolescent mental health nursing, produced 10 extensive recommendations for education, 11 lesser ones for practice and six in point form for research. Further, only three of the six recommendations related to the conduct of research (Finke & de Leon Siantz, 1993). Thus, research remains at the lowest level of priority. On the other hand, while it is concerning that research is given low priority at the level of a national workshop, the research directions proposed by nurses are equally concerning.

Griffin-Francell (1993, p. 33) asserts that the knowledge base of adolescent mental health nursing needs to change, including changes to "nursing textbook content, certification questions and lecture outlines used in education and continuing education." She claims the borrowing of systemic family therapy, psychoanalytic and interpersonal relations theory should be viewed as an historical antecedent to new scientifically based knowledge. This new knowledge involves research into the biological causation of disorders such as depression and schizophrenia. While theories of illness causation are important in mental health nursing, it is of concern that past and present directives have placed so much emphasis on knowledge developed within other disciplines. In the past, theories were borrowed from psychiatry and the behavioural

sciences while in the future it appears neurological and biomedical theories may come to the fore. Further, McBride's (1992) emphasis for nursing research in child and adolescent mental health nursing, although more broadly based than Griffin-Francell's, also focuses attention away from research into nursing practice. For instance, of the 10 questions she poses for nurse researchers only one concerns clinical practice, namely, "how can we reliably assess the mental status of young children?" (1992, p. 42). All other questions have sociological, psychological or developmental perspectives. While these are valid areas of inquiry for nurse researchers such research should not be conducted at the expense of nursing practice research, nor should it become the focus while so many nursing questions remain unasked and unanswered. For example, what knowledge informs the practice of adolescent mental health nursing? What nursing interventions result in positive health care outcomes for adolescents experiencing emotional disturbance? Can theory developed from nursing practice research inform a philosophy of nursing science for the specialty? What theories guide and influence the practice of adolescent mental health nursing? Killeen (1990, p. 118) suggests nurses can no longer choose whether to participate in research as they must "all be consumers and producers of new knowledge", while this may be so it seems equally important to focus nursing research onto the practice of nursing. This is especially important considering the scarcity of published nursing research within the specialty.

4.05 A Review of Published Adolescent Mental Health Nursing Research

A literature search revealed three research publications claiming relevance to adolescent mental health nursing. The first study investigated the relationship between nurses' caring behaviours and

the adolescent's development of hopefulness (Hinds, 1988), the second inquired into nurses' use of intuition (Rew, 1991) and the third explored the use of therapeutic acceptance within the nurse-client relationship (Weissman & Appleton, 1995). Rew excluded clients from her study while Hinds, and Weissman and Appleton, excluded nurses from theirs. Thus, no research included the perspectives of both clients and nurses. Hinds, and Weissman and Appleton, conducted their study with adolescents on adolescent mental health units while Rew conducted her study with nurses from a professional organisation for mental health nurses. These three publications are reviewed in the following discussion.

Rew's (1991) study investigated how psychiatric nurses define and act on intuition. Her article is interesting as it raises several important questions. For example, she says her study sought to "explore how psychiatric-mental health nurses define and act on intuition in clinical practice with children and adolescents ... and [has] implications for psychiatric-mental health nurses working with high-risk children and adolescents" (p. 110). Nevertheless, 19 of the 53 examples the participants provided for analysis related to adults. Further, while the study involved interviewing 16 nurses with current or prior experience with child or adolescent psychiatric clients, only eight were certified psychiatric nurses and none were certified child and adolescent psychiatric nurses (p. 111). In this regard, 35% of the material did not relate to the group she purported to study and 50% of the nurses had no certification within the specialty. As Rew does not differentiate the data on adults from that on children and adolescents, it is difficult to determine how applicable the findings are to child and adolescent mental health nursing. Moreover, Rew's research raises questions concerning the nature of nursing specialties. For

instance, as America has certification in mental health nursing should nurses without such certification be described as mental health nurses? Australia too has to answer such questions. Here, nurses with varied qualifications work side by side in mental health settings. Some are graduates of mental health nursing courses while others are not. Are they all mental health nurses? The constitution of the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) was recently amended to state, a "Mental Health Nurse is a specialist nursing classification and shall mean a Registered Nurse who holds a recognised specialist qualification in mental health nursing" (ANZCMHN, 1996, p. 2). Under these circumstances who, in research studies, can be called a mental health nurse? Will studies differentiate between mental health nurses with and without specialist mental health nursing qualifications? Moreover, as there is no course in adolescent mental health nursing in Australia, how will nurses working in this specialty be differentiated? Such questions bear directly upon research purporting to represent a nursing specialty and as such are important questions for future consideration and debate.

While the preceding discussion raises questions regarding aspects of Rew's (1991) research, her findings extended prior research on the use of intuition in nursing practice. For example, intuition was previously described in nurses working in critical care (Benner & Tanner, 1987) and neonatal intensive care settings (Schraeder & Fischer, 1987). Rew's findings suggest that nurses working in mental health settings also use intuition in their practice. Rew used a descriptive design with content analysis of audiotaped interviews to identify 11 themes. The most frequently noted phrases defining intuition were: (1) a strong feeling about something, (2) knowing what will happen, and (3) [knowing]

without objective data or reasoning (1991, p. 112). In conclusion, further research may be useful in clarifying aspects of Rew's study in relation to nurses working in adolescent mental health nursing.

Hinds (1988) explored the relationship between nurses' caring behaviours, the development of feelings of hopefulness in adolescents and positive health care outcomes. Hinds conducted her research on a 16 bed adolescent substance abuse unit using both qualitative and quantitative methods. She collected quantitative data at three points: (1) 24-48 hours after admission, (2) 96-120 hours prior to discharge, and (3) 4-5 weeks after discharge. Twenty five adolescents participated in the research which showed a statistically significant increase in hopefulness between data collection points one and two. The qualitative part of the research involved adolescents being asked a set of open ended questions regarding nurses' caring behaviours and their relationship to hopefulness. Responses were analysed and developed into positive or negative categories.

Categories related to nursing behaviours having a negative influence on adolescent hopefulness included: (1) nurses harass and distort: adolescents see nurses as antagonistic, as finding fault over minor issues and maintaining inaccurate beliefs about them; (2) just doing a job: adolescents see nurses as not being interested in their well being but as being present due to work related expectations; (3) nurses are negative about me: adolescents believe nurses see them as having attitudinal problems which need changing; and (4) checking on us and taking from us: adolescents see nurses as intruding on feelings, monitoring interactions and confiscating belongings. On the other hand, categories related to nursing behaviours having a positive influence on adolescent hopefulness included: (1) helping me get through: adolescents believe nurses

promote the attainment of individual or treatment goals; (2) we get along: adolescents believe nurses have special feelings of fondness for them which are reciprocated; and (3) nurses kept on trying: adolescents see nurses as persisting and as not reducing efforts throughout treatment.

Hind's (1988) findings suggest adolescents saw certain nursing behaviours as caring. These behaviours included not giving up, being nonjudgmental, genuinely interested and helpful. In turn, such behaviours were said to positively influence the development of hopefulness. The findings from Hind's study demonstrate that caring is perceived in a variety of ways and the study's strength resides in having identified, in part, what caring was perceived to be within that context. Still, Hinds does not discuss the positive health care outcomes she linked to the relationship between nurses' caring behaviours and the development of hopefulness. In the final paragraph two statements relate to this issue. First, Hinds says that evidence of a positive relationship between nurses' caring behaviours and the development of hopefulness in adolescents supports the "assertion that nurse-patient transactions promote positive patient outcomes" (p. 28). This assertion would be strengthened if data noting these purported relationships were presented. Second, Hinds says "nurses are able to use interpersonal skills to promote a more positive future view in adolescents" (p. 28). Yet in the article there appears to be no support for this conclusion, especially in relation to the use of interpersonal skills by nurses. Nonetheless, particular nursing behaviours were identified as engendering hopefulness and this knowledge could inform the practice of adolescent mental health nursing. Moreover, as the first research publication within the specialty, Hind's (1988) article was a landmark in providing information for nurses working with young

people experiencing problems with substance abuse. Seven years later Weissman and Appleton (1995) published their study findings.

Weissman and Appleton (1995) explored the therapeutic aspects of acceptance. In their phenomenological study, six adolescents from an adolescent mental health unit shared their experience of being accepted by nurses. Weissman and Appleton interpreted data from audiotaped interviews and developed three themes pointing to the meaning of acceptance for those adolescents. The themes were: (1) friendship: the nurse who shows acceptance is seen as a friend; (2) well being: acceptance generates a sense of well being; and (3) security: acceptance produces feelings of comfort with the nurse. Weissman and Appleton suggest acceptance has the therapeutic outcome of helping adolescents gain a sense of well being, safety, security and freedom which, in turn, allows them to feel at ease and to draw upon their inner strength to develop a sense of mastery. Nurses are said to achieve this by being present, approachable, responsive, understanding, competent, trustworthy, supportive and by using humour. Weissman and Appleton (1995, p. 23) use excerpts to support thematic interpretations yet there appears to be no support for the conclusion that acceptance empowers adolescents "to draw upon their inner strength and develop a sense of mastery." Moreover, in their discussion of the three themes, inner strength and mastery are not mentioned. Even so, Weissman and Appleton's findings suggest acceptance has a therapeutic effect in the care of emotionally disturbed adolescents and as such it provides a valuable adjunct to Hind's (1988) study. In relation to adolescent mental health nursing these two studies are significant because they provide:

* insight into the perceptions of adolescents nursed on mental health units,

* a beginning foundation for future research,
* knowledge through which practice could be informed, and
* an appreciation of the need for further research.

4.06 Preunderstandings Developed from this Section

Preparation of the literature review required extensive reading and through this reading I developed preunderstandings in relation to adolescent mental health nursing. My preunderstandings are both enabling and disabling. They are enabling because they create the opportunity for interpretation through the embodied historic, cultural, linguistic and sociopolitical knowledge of which they are composed. For example, while I can interpret a 1990's text about mental health nursing in Australia I could not interpret an 1890's text about mental health nursing in France. My preunderstandings are also disabling since they direct attention toward a particular interpretation at the expense of another thereby resulting in premature closure. For example, I may favour a particular interpretation because it fits in with my preunderstandings. As a result, it was important to bring the preunderstandings I developed from the literature review to consciousness. In the following discussion, I use one theme from the findings of Weissman and Appleton's (1995) research, with a story from the adolescent participant Belinda, to demonstrate the way I did this.

Weissman and Appleton's (1995) theme "friendship: the nurse who shows acceptance is seen as a friend", creates a link between acceptance and friendship. Thus, during my interpretation of Belinda's story about the nurse Erin, I must keep in mind that meanings other than friendship may also be linked to acceptance.

> *Erin never put me down or anything, even if I did something stupid like slit my wrist, oh she'd probably say that was stupid but she'd just accept that and help*

> *me with it rather than tell me off about it. Other nurses would say "oh that was really stupid and really put you down" whereas she'd say "that was stupid but why did you do it and how can we help so it doesn't happen again?" ... no matter what nurses think, if they think you're a stupid little bitch, well fair enough, but as long as they can still accept you ... and still be your friend, like guide you with it and give you advice but not tell you off, that way you know you can trust them. If anything does happen again, or if you feel like doing it again, you can go to them because you know you're not going to get your head bitten off or whatever.*

Through preunderstandings developed from Weissman and Appleton's (1995) findings I could interpret Belinda's story as meaning that a nurse who accepts the adolescent's behaviour under all circumstances remains her friend. Thus, the comment *"they've got to be honest but still accept you and still be your friend"* could lead me toward Weissman and Appleton's friendship theme at the expense of other possibilities. For example, in the comment *"Erin never put me down or anything, even if I did something stupid like slit my wrist ... other ones would say oh that was really stupid and really put you down"*, could reside the notion that nurses affirm the inherent worth of the adolescent through acceptance of them despite their behaviour. On the other hand, another meaning could be that nurse's responses to acting out behaviour can foster the development of trust. Thus, *"... you can trust them. If anything does happen again, or if you feel like doing it again, you can go to them because you know you're not going to get your head bitten off or whatever."* Of course, other interpreters will interpret the text differently and give different names to the meanings they develop. Nevertheless, with regard to myself, each interpretive decision is important since choices made in one part of the text (one interview) create preunderstandings that influence choices in another part of the text (other interviews). In endeavouring to

address the influence of preunderstandings and provide the text with an opportunity to reveal itself, I am guided by Gadamer (1987, p. 132) who says:

> ... the hermeneutical attitude supposes only that we self-consciously designate our opinions and prejudices and qualify them as such, and in so doing strip them of their extreme character. In keeping to this attitude we grant the text the opportunity to appear as an authentically different being and to manifest its own truth, over and against our own preconceived notions.

This hermeneutic attitude is a critical part of hermeneutically informed research but it has proven problematic for some nurse researchers; a point further discussed in the following chapter.

4.07 Conclusion

With so little Australian literature on adolescent mental health nursing much of this review relied on publications from America. Nevertheless, as nurses develop their ideas through engagement with the work of others, there are many similarities in the writing of nurses from one country to another. For example, Holden (1986) addressed issues later discussed by Hogarth (1991), Peterson, Gray and Weinstein (1994) and West and Sieloff Evans (1992) while Creedy and Crowe (1996) addressed issues previously discussed by Hogarth (1985) and Delaney (1992). More importantly, the literature review highlighted the scarcity of published nursing research within the specialty.

One issue arising from this lack of research is the overuse of borrowed theory. For instance, Holden (1986), Creedy and Crowe (1996), Delaney (1992), Griffin-Francell (1993), McBride (1992), Peterson, Gray and Weinstein (1994) and Scahill, Walker, Lechner and Tynan (1993) discuss adolescent mental health nursing using theory borrowed from psychiatry, medicine and the behavioural

sciences. This is problematic as adolescent mental health nursing has failed to articulate its own practice based theory. Research within the speciality is important as it would allow the practice knowledge of adolescent mental health nursing to be explicated, disseminated and taught. Moreover, such knowledge could be useful in preparing other practitioners to work with emotionally disturbed adolescents. In this way, nursing practice research could make a contribution toward reducing the "alarming lack of knowledge among many mental health, health, education, welfare and juvenile justice professionals" (Human Rights and Equal Opportunity Commission 1993, Vol 2, pp. 932).

In the following chapter entitled "Philosophy of the Methodology: Hermeneutics", I review literature relevant to hermeneutic interpretation and understanding, and I critique nursing research in relation to the use of hermeneutic philosophy to inform research methodology and method.

Chapter Five

5 Hermeneutics: Philosophy of the Methodology

5.01 Introduction

"We can only be satisfied with immediate understanding when dealing with the meaningless"
(Schleiermacher, 1990b, p. 94).

Understanding and interpretation, and all that they involve, are the primary concerns of hermeneutics. Included in these concerns are: (1) the nature of understanding: what it is and how it comes into being; (2) textual multiplicity: the many layers of meanings able to be construed from a text; (3) textual plurality: that interpreters, influenced by preunderstandings, interpret the same text differently; and (4) interpretive accuracy: the evaluation of interpretations including criteria by which they may be judged. Through all of this, the task of bringing the text into understanding remains the heart of the hermeneutic endeavour.

In this chapter, I critique nursing research in relation to the use of Gadamerian and Heideggerian philosophy to inform methodology and method and I point to particular implications arising from this critique. I also review literature relevant to hermeneutic understanding and interpretation, and to textual interpretation. During this process I draw on the work of Gadamer (1979, 1987, 1990), who had a profound influence on my thinking, and to a lesser extent on the work of Heidegger (1962, 1990) and Ricoeur (1974a, 1976a, 1981a) who were nonetheless significant. Prior to this, I discuss the issue of translation in relation to the use of hermeneutic philosophy to inform research methodology.

5.02 Translation

Throughout this study I have drawn heavily on the work of

Gadamer (1979, 1989) and to a lesser extent on the work of Heidegger (1962) and Ricoeur (1974a, 1976a, 1981a). However, all these works come into the English language through translation. While this in itself is problematic, multiple translation of the same text, as with Gadamer (1979 translator Glen-Doepel [no translator's name appears in Gadamer's 1979 text, Glen-Doepel's name is noted as the original translator of Truth & Method in the 1989 revised edition of that text]; 1989 translators Weinsheimer & Marshal), or the use of multiple translators for the same author, as with Ricoeur (1974a translator McLaughlin; 1981a translator Thompson; 1973a, 1973b, 1973c, 1973d translator Pellauer), results in reduced continuity in the work of such authors. For instance, translators note the difficulty of their task with regard to choices over consistency and variation, over differences between the author and themself, or over having no author to consult regarding inconsistencies and doubts. Further, at the same time that translators are grappling with the interpretation of a language they are endeavouring to understand and interpret complex philosophical thought [see translators notes in Gadamer (1989); Heidegger (1962); Ricoeur (1981a)]. Thus, translation includes both the interpretation of language and the determination of meaning. As a result, my understanding of hermeneutics arises through my interpretation of a translator's interpretation of an author's interpretation; on top of which readers of the thesis will add another layer of interpretation. To understand another's thoughts is always a difficult undertaking but translation makes such understanding even more difficult. Hermeneutic research attempts to deal honestly and respectfully with the words and thoughts of others yet, in every respect, this is a complex and challenging endeavour.

5.03 Understanding and Interpretation

Because hermeneutics is both the philosophy of understanding and the science of textual interpretation, hermeneuticists have developed a twofold interest. The first interest involves investigation into the nature of understanding, an orientation reflected in the work of Gadamer (1979, 1989), Heidegger (1962) and Ricoeur (1971a, 1974a, 1976a, 1981a), whereas the second interest involves the interpretation of texts, an orientation reflected in the work of Schleiermacher (1990a, 1990b), Gadamer (1979) and Ricoeur (1971a, 1973a, 1983). Interpretation is an attempt to grasp and recreate meaning in order that more complete or different understandings occur. It seeks to make clear or bring to light that which is fragmentary, confused or hidden (Taylor, 1971). It also has explanatory power in that it describes, reveals or illustrates how a particular understanding came into being. This is most often noted when researchers use textual excerpts to illustrate their interpretations. Moreover, it is not only textual meanings that must be negotiated but their significance as well. Accordingly, decisions are made regarding the standing of particular meanings within a text. Paradigm cases and exemplars, as well as major and minor themes, all represent ways of allocating significance to meanings (see Benner, 1985, 1991), and in all such interpretive processes, the interplay between ontology and epistemology becomes apparent.

Textual interpretation reveals knowledge but this includes knowledge of the phenomenon under investigation and knowledge of the self. Buker (1990) refers to the relationship that develops between textual interpretation and self interpretation as the two directions in which hermeneutic research moves forward. In this way, the interpretive process reveals biases, alters perspectives and

modifies beliefs providing renewed understanding through which other horizons come into view. Thus, each return to the text allows a transformation through which an opportunity exists for different understandings of self and text. Di Censo (1990, p. 146) refers to this as the "truth [that] appears at the intersection of epistemology and ontology, at the point where knowing and being codetermine one another." In hermeneutic research, access to truth is only granted when the interpreter fulfils particular obligations. Obligations which, as the following discussion suggests, have proven problematic for some nurse researchers.

5.04 Preunderstandings and their Methodological Implications

Through Heidegger (1962) and Gadamer (1979) nurses have increasingly accepted the centrality of hermeneutic understanding to being-in-the-world (see Benner, 1984, 1994; Koch, 1993; Leonard, 1989; Taylor, 1991; Thompson, 1990; Walters, 1992). Even so, some nurses fail to take account of fundamental hermeneutic tenets thereby omitting them from their discussions. Such tenets include: (a) the nature of interpretive understanding, (b) the influence of preunderstandings, (c) perspectival questioning of the text, and (d) the debate over the evaluation of interpretations (see Eco, 1990; Gadamer, 1979; Gombrich, 1969; Heidegger, 1962; Hirsch, 1967, 1976; MacLaughlan & Reid, 1994; Palmer, 1969; Ricoeur, 1976a). With regard to nursing research, the most significant omission concerns the hermeneutic imperative to identify, challenge and qualify interpreter preunderstandings. Such omission occurs, for example, in the work of Allen and Jensen (1990), Benner, Tanner and Chelsa (1992), Brown (1986) and Morse and Carter (1995). The need to address preunderstandings is especially important for researchers using Heideggerian hermeneutic phenomenology because inherent in Heidegger's

writing is the notion that interpretation involves a background of presuppositions from which the interpreter can never be free. What Buker (1990, p. 28) refers to as being value oriented. In this regard Heidegger (1990, p. 123) says, "an interpretation is never a presuppositionless apprehending of something presented to us [rather] interpretation will be founded especially upon fore-having, fore-sight and fore-conception." Forehaving refers to background practices from the lifeworld which make interpretation possible, foresight to background practices that carry with them a point of view from which an interpretation is made, and foreconception to background practices which create expectations about what might be anticipated in an interpretation. This notion of forehaving, foresight and foreconception Heidegger termed forestructures and while he acknowledged that forestructures could never be made completely explicit he nevertheless insisted:

> ... our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves (Heidegger, 1990, p. 126) .

Consequently, researchers using Heideggerian hermeneutic phenomenology are obliged to demonstrate the working out of their forestructures (also referred to as preconceptions, presuppositions or preunderstandings) in terms of the phenomenon under investigation. Plager (1994, p. 72) notes this obligation when she says, "... the investigator lays out preconceptions, biases, past experiences ... that may affect how the interpretation takes shape." Yet, on the whole, hermeneutic phenomenologic nurse researchers omit this aspect from their work (see Astrom, Norberg, Hallberg &

Jansson, 1993; Nehls, 1994; Walters, 1994). Further, as the following discussion suggests, even those researchers who acknowledge forestructures fail to demonstrate how they addressed them in the conduct of their research (see Appleton, 1993; Benner, 1984; Benner & Wrubel, 1989; Taylor, 1991; Walters, 1992).

5.05 Working out Forestructures in Terms of 'The Things Themselves'

In his thesis, Walters (1992, p. 5) spoke of the "many strong presuppositions" he brought to his investigation of the phenomenon of caring in an intensive care unit. Such presuppositions were exemplified in a list of aspects of intensive care nursing he believed would require examination in the explication of the phenomenon (1992, p. 7). These presuppositions arose from his experience as an intensive care nurse and from the "background of previous [and] prior understanding on the part of the interpreter." Thus, he rightly says he approached the research and interpretation from an informed position and brought "... to the research process a lived world which is included in the study" (1994, p. 25). In following Heidegger (1990, p. 126), Walters was required to demonstrate the working out of his presuppositions in terms of the things themselves, that is, in terms of intensive care nursing. Yet there is no discussion of presuppositions nor how they influenced his interpretation. As Walters (1995, p. 798) notes, in a later article, nurse researchers should relate philosophical assumptions to their research methodologies; an issue which is also of importance in Taylor's (1991) research.

Taylor's (1991, pp. 30-32, 84-86, 159) research was guided by the work of Heidegger and Gadamer, and her textual interpretation by Gadamer's fusion of horizons. She notes that presuppositionless

understanding and interpretation is contrary to the work of the two philosophers (pp. 5, 96, 159) and says, "I had some sense of what 'the thing' ordinariness in nursing might be ... and where ordinariness in nursing might reveal itself" (pp. 4-5). Thus, in failing to address her presuppositions concerning the phenomenon of ordinariness in nursing she fails to "... make the scientific theme secure by working out these fore-structures in terms of the things themselves" (Heidegger, 1990, p. 126). Taylor (p. 5) says, "I did not feel the need to be free from all my presuppositions, given my inevitable immersion in my own preconceptions, by virtue of my Being-in-the-world of nursing and everyday things." In part Taylor is correct, preconceptions cannot be eradicated but as Gadamer (1987, p. 132) stresses, unqualified preconceptions deprive the text of the opportunity to manifest its truth. Accordingly, we must:

> ... self-consciously designate our opinions and prejudices and qualify them ... In keeping to this attitude we grant the text the opportunity to appear as an authentically different being and to manifest its own truth, over and against our own preconceived notions.

Taylor (1991) says she wrote impressions of interactions in a personal/professional journal which she used to form part of the text. This could also have provided a vehicle through which she reflected on her presuppositions and how they influenced the interpretive process. Koch (1993, 1994) used a research journal in this way writing about it in her thesis and a subsequent journal article. Drew (1989) also, in a landmark article, wrote of using a research diary as a means of reflecting on her presuppositions and understanding their influence on data gathering. In this way:

> the researcher documents personal reactions, noticing that his or her own horizon is operating in the way the

> interpretations are made, and documenting differences in the way the researcher analyses events versus the meaning those events have in their natural context (Thompson, 1990, p. 257).

Nevertheless, beyond this issue of interpreter preunderstandings, another uneasy tension exists in Taylor's (1991) use of Gadamer's fusion of horizons as her method of textual interpretation.

Taylor (p. 98) describes how interpretive meanings of observed interactions between nurses and clients were "shared and checked" at the time of occurrence. Also, a draft of each set of interactions was given to the nurses so they could "check the validity of my impressions against their own impressions ..." Thus, participants "validated their own impressions" of Taylor's interpretations. Koch (1994, p. 977) too endorses this as a means of establishing credibility. Such procedures suggest an independent, external and valid reality or truth, in this case, that of the research participants. Further, the procedures reinforce correspondence theory notions of truth as static and unchanging rather than coherence theory notions of truth as plural, changing and incomplete. In addition, this notion of interpreter's checking or validating interpretations is reflected in a broader hermeneutic debate surrounding the question of whether textual interpretation seeks the meaning of the text or the meaning of the author. Through the fusion of horizons Gadamer (1979) radically reconceptualised interpretation and hermeneutic thinking on this point. For Gadamer, meaning resides not with the author but with the text. In this regard, Taylor's desire to check or validate interpretations with the author (the research participant) is in contradiction with her use of Gadamer's fusion of horizons.

5.06 Hermeneutic Textual Interpretation

Prior to Gadamer (1979) the interpretation of texts was spoken

of as an attempt to reconstruct the original thoughts or meanings of the author. Accordingly, Ast (1990, p. 49) claims the explication of a text means discovering the idea the author originally had in mind. To this Schleiermacher (1990b, p. 91) adds that interpretation only begins after successful identification of the author's original meanings. In this way, the interpreter comes to "... understand the author better than he [or she] understood him [or her] self " (Dilthey, 1990, p. 113). Gadamer moved beyond this hermeneutic theory of understanding and in the process he reconceptualised textual interpretation. He asserted that a text is understood not through the author's meaning but through itself. For Gadamer (1979, p. 264), not occasionally but always, the meaning of a text goes beyond its author. Therefore:

> when we understand a text we do not put ourselves in the place of the other, and it is not a matter of penetrating the spiritual activities of the author; it is simply a matter of grasping the meaning, significance, and aim of what is transmitted to us [in the text] (Gadamer, 1987, p. 127).

As a result, the interpreter becomes a mediator between the text and all the text implies but not the interpreter of what the author meant.

In Taylor's (1991) study, the text produced from research interviews and observations is, from Gadamer's perspective, free of its authors who in this situation are the research participants. In other words, it is the content of the text rather than the research participant's meanings which the interpreter seeks to understand. In this interpretive dialogue between the text and the interpreter resides the foundation of the fusion of horizons, which is "a fusion of the text's horizon with that of the interpreter" (Hekman, 1986,

p 111). Moreover, as Hekman (p. 152) notes, "because interpretations necessarily change with interpreters and are the result of the fusion of horizons, one correct interpretation is not a possibility for Gadamer." This plurality of interpretation occurs because each interpreter's horizon is influenced by all they bring to the text including their prejudices. Although, for Gadamer, prejudices are both an obstacle and an aid to understanding.

Prejudices lead to errors of understanding when all aspects of a situation are not carefully examined. This is like an unsubstantiated judgment. With regard to texts, prejudices create barriers to interpretive understanding through: (1) reliance on traditional authority, such as the dominant view; (2) inadequate knowledge, for example, of a culture, language or discipline; (3) unchallenged and unqualified preunderstandings, like biases; (4) unconscious preunderstandings; (5) premature interpretive closure, due to a lack of reflection during interpretation; and (6) sociopolitical constraints, for instance, ideological regimes disallowing the expression of certain ideas or privileging certain ideas over others. On the other hand, prejudices simultaneously constitute our ability to experience the world and interpret a text. Prejudices do this because they exist in the shared linguistic, historic and cultural backgrounds (traditions) which are handed down and participated in. Prejudices constitute the preunderstandings through which interpretation becomes possible. Accordingly, interpretation "... always implies a preunderstanding which is in turn prefigured by the determinate tradition in which the interpreter lives and that shapes his [or her] prejudices" (Gadamer, 1987, p. 87). As a result, preunderstandings influence the fusion of horizons (between the text and interpreter) thereby resulting in different interpretations of a text from one interpreter to another. Thus, researchers using

Gadamer's fusion of horizons do not need to check interpretations with research participants. This was the main reason I departed from my original intention to obtain feedback on my interpretations from the research participants. In the following discussion, other reasons are presented for my change of decision, including the notion that checking interpretations with others (peers, researchers or participants) suggests "bias control" through "consensual agreement."

5.07 Objectivity, Consensus and Accuracy in Hermeneutic Interpretation

In their articles, Diekelmann (1992), Gullickson (1993), Kondora (1993) and Rather (1992) discuss the use of interpretive teams, consisting of three to six people, to participate in the process of interpreting research texts. They all used Heideggerian hermeneutic phenomenology in the conduct of their research. Reasons given for using a team to determine and review interpretive meanings included the desire to achieve "bias control" (Diekelmann, 1992, p. 74; Kondora, 1993, p. 13) and "group consensus" (Gullickson, 1993, p. 1388; Kondora, 1993, p. 13; Rather, 1992, p. 48). Bias control is associated with quantitative research and reflects attempts to achieve objectivity by distancing the researcher from their engagement in the study and their participation in cocreating data and meaning. Such researchers demonstrate an objectivist approach to interpretation in order that their work is judged as valid. Hermeneutically, the way of allowing a text to manifest itself is not by controlling researcher bias but by working out preunderstandings, an issue that Diekelmann, Gullickson, Kondora and Rather do not mention. Moreover, how the preunderstandings of an entire team could be identified, qualified and legitimised is difficult to foresee. Equally as problematic, on

the other hand, is the notion of interpretive consensus.

Hermeneutically, interpretation is always an approximation which is never final or complete. This insight is noted in the earliest hermeneutic writing. For example, Schleiermacher (1990b, p. 97) in his 1819 lectures, said "no individual inspection of a work ever exhausts its meaning; interpretation can always be rectified. Even the best is only an approximation of the meaning." Moreover, interpretation varies from interpreter to interpreter. In this way, the same text interpreted by a feminist, phenomenologist, ethnographer and post modern deconstructionist would produce interpretive diversity. So would the same text interpreted by a several hermeneuticists. This diversity exists because of: (1) the perspective from which the interpreter approaches the text, or how the text is questioned; and (2) the embodied linguistic, cultural, historic and sociopolitical preunderstandings each interpreter brings to the text, or how the text is listened to. More importantly, the same text interpreted by the same interpreter, at another time, would also produce differences in understanding. This is not a weakness as understanding always has the potential to change and increase; the ability to understand differently is not a backward but rather a forward movement. It is "the nature of both understanding and life" (Dilthey, cited in Howard, 1982, p. 17) which results in interpretive change and approximation. In this regard, what interpreters bring to a text and the way they question the text influences the understandings they receive.

Taylor (1971, pp. 3-4) says texts embody multiplicity and plurality and because their meaning is meaning for someone, each someone may find a different yet faithful meaning in a text. Thus, in hermeneutic research, the desire to reach valid interpretations through interpretive consensus is inappropriate. Language not only

creates interpretive multiplicity and plurality it also produces uncertainty; this is the epistemological predicament of interpretive research. Schleiermacher (1990a, pp. 68 & 76) notes this aspect of language when he says:

> consider what can be learned from the fact that a word can be synonymous with another while at the same time having a plurality of meanings of its own ... the standard meaning of a word is a model, a shiftable perspective. One should not confuse the initial use of the word with its subsequent meaning. Just as a word is affected by the inflections of the surrounding language, so also is its meaning. One especially shies away from pinning down the meaning of very important things.

Nevertheless, in the conduct of interpretive research the major task for the interpreter is to make manifest the meanings of the text. Yet, if textual meanings are tentative and changing how can interpretations be evaluated?

5.08 Evaluating Interpretations

Hirsch (1967) argued the only valid interpretation was the one that guessed what the author meant. This is not appropriate as it represents an appeal to external authority and discounts the plural, changing and approximate nature of understanding. Alternately, Walters (1995) suggested researchers should provide sufficient excerpts to allow readers to decide for themselves how well the researcher's interpretations reflect the text. While this may be so, it does not mean the researcher's interpretations are flawed if a reader rejects them. This is because interpretive understanding is always perspectival; it resides within and emerges from a certain perspective. It is inevitable therefore that interpretive differences will arise. Gadamer (1979) believes dialogue provides a vehicle for resolving differences in understanding. Yet dialogue may prove difficult when understanding is approached from different

perspectives. Kuhn (1962) made this point when he noted how ideas arising from opposing paradigms of thought are often unable to be reconciled. As a result, failure to reach agreement about interpretations may have more to do with irreconcilable perspectives preventing meaningful dialogue than it has with flawed interpretations. Taylor (1971, p. 6) is sympathetic to this view. He says our ability to bring someone to an appreciation of our interpretation is only possible if at some juncture they share our understanding. Shklar (1986, p. 473) is even stronger in her assertion since she says we can never "convince those who have made different choices" methodologically or philosophically. Shklar also questions the need for interpretive agreement and wonders why different understandings of a phenomenon are problematic. I too have argued that interpretive diversity is inevitable, but it is also desirable if conversations about understanding are to continue rather than close down through the pursuit of interpretive agreement. This is in keeping with Gadamer's (1989, p. 579) notion that interpretation is an open and ongoing dialogue that permits no final conclusion. Moreover, the only way to reach interpretive understanding is by allowing the text the opportunity to reveal its truth and the interpreter does this by engaging with the text inside the hermeneutic circle.

5.09 The Hermeneutic Circle

When the hermeneutic circle was first described is not known however it was not described by Heidegger, Schleiermacher or Dilthey as is sometimes inferred (see Koch, 1993, p. 106; Koch, 1995, p. 831; Reeder, 1988, p. 209; Taylor, 1991, p. 72). In his review of hermeneutics Dilthey (1990, p. 108) cites the work of Flacius, from 1567, whom he quotes as saying "the individual parts of a whole everywhere draw their comprehensibility from their

relationship to that whole and to the other parts." In this statement is embodied the relationship between the whole and its parts, which became the foundation of the hermeneutic circle. Ormiston and Schrift (1990), and Palmer (1969), begin their discussions on hermeneutics and the origins of the hermeneutic circle with Ast. In his 1808 paper Ast (1990, pp. 43-44) says:

> the basic principle of understanding is to find in the particular the spirit of the whole and to comprehend the particular through the whole ... both are posited only with and through each other. Just as the whole cannot be thought of apart from the particular as its member, so the particular cannot be viewed apart from the whole as the sphere in which it lives. Thus neither precedes the other because both condition each other reciprocally ... [and] only in this manner is it possible that I will comprehend the particular through the whole and, conversely, the whole through the particular; for both are simultaneously given in all their particularity.

This movement between the parts and the whole means no true starting point for understanding exists because understanding of the whole presupposes understanding of the parts, in the same way that understanding of the parts presupposes understanding of the whole, even though such understanding may be preliminary. Since Ast (1778-1841), individual hermeneuticists have developed particular understandings of the hermeneutic circle but the backward and forward shifting between the whole and its parts remains its hallmark.

Schleiermacher (1768-1834) advanced hermeneutics from its focus on the interpretation of classical, biblical and legal texts to an examination of understanding itself. Because language was the fundamental unity of all texts he reasoned that a general hermeneutics could be developed by formulating the principles of understanding language. In this way, "everything to be presupposed

in hermeneutics is only language and everything to be found also" (cited in Palmer, 1969, p. 92). In turn, Schleiermacher's thoughts on language, and hermeneutics as the art of understanding, influenced Gadamer's conception of a philosophical hermeneutics. For Schleiermacher (1990a & 1990b), the hermeneutic circle of understanding precedes through the interrelationship of the whole, which defines and gives meaning to the individual parts, and through the parts, which together form and give meaning to the whole. In this way, for example, the meaning of a sentence is understood through the individual words of which it is composed while the meaning of individual words is understood in the context of the sentence as a whole. Thus, the hermeneutic circle of understanding continued to be seen as an interpretive shifting between the whole and the parts of a text; a constant back and forth movement. Following Schleiermacher, it was Dilthey who radically altered the direction of hermeneutics.

With Dilthey (1833-1911), came the beginning ontological and historical dimensions of hermeneutic philosophy. Dilthey perceived understanding as contextual, existential and situated within time and place. He saw experience as existing before subject and object and so the world and our experience of it were together. On this issue Dilthey (cited in Palmer, 1969, pp. 108-109) says:

> the way in which 'lived experience' presents itself to me is completely different to the way in which images stand before me. The consciousness of the experience and its constitution are the same: there is no separation between what is there-for-me and what in experience is there-for-me. In other words, the experience does not stand like an observer over against its experiencer, but rather its very existence for me is undifferentiated from the whatness which is present for me in it.

Accordingly, Palmer (1969) rightly asserts that Dilthey provided the impetus to the hermeneutic interest in historicality in which modern hermeneutics finds its foundations. In this regard, neither Heidegger's (1962) temporality of self understanding, nor Gadamer's (1979) temporality of understanding are conceivable except in terms of historicality. For Dilthey, understanding was historical because the object to be understood, and the interpreter, were always historically situated. Moreover, understanding comes out of life itself because "... nothing can appear in an unfamiliar, individual form of expression which was not also contained in the quality of living that comprehends it" (Dilthey, cited in Rasmussen, 1971, p. 12). In this way, Dilthey's writing on historicality and his desire to understand life out of life itself, provided foundations upon which Heidegger built, and in the process, he gave the hermeneutic circle an ontological turn.

Heidegger's (1889-1976) hermeneutic related to understanding the mode of being of that Being which exists through understanding. Within the context of the lifeworld in which Being exists, understanding is constitutive. Such understanding occurs within a set of already interpreted relationships because "interpretation operates in Being towards a totality of involvements which is already understood" (Heidegger, 1990, p. 123). In this way, understanding is prefigured through being-in-the-world. For Heidegger, interpretation is something had in advance, in forehaving, something seen in advance, in foresight and something grasped in advance, in foreconception. Accordingly, "interpretation is never a presuppositionless apprehending of something presented to us" (1990, p. 123) rather interpretation is predetermined by the forestructures of the interpreter. Moreover, while Palmer (1969, p. 95) suggests Schleiermacher and hermeneuticists before him

pointed to the significance of presuppositions in understanding, it was Heidegger who explicated this issue. He made it clear that "we understand in terms of what we already know [because without that] there would be no understanding at all" (Packer & Addison, 1989a, p. 34). As a result, the hermeneutic circle was no longer an epistemological and methodological device but a description of the ontological nature of understanding. Following Heidegger, and from the work of Schleiermacher, Dilthey and Heidegger, Gadamer developed a hermeneutic philosophy in which preunderstandings remained central to the question of understanding and interpretation.

Gadamer (1900- ....) (1979), though significantly influenced by the work of Heidegger (1962), moved beyond the ontological primacy foundational in Heidegger's explication of Being to an intersubjective view of understanding (according to Di Censo this move overcame the unresolved dilemma in Heidegger's work of how Being maintains primacy in the world since it comes into being in a world not of its making). For Gadamer, it is not Being which is the source of truth rather culture, history and language, as the matrices of human existence, provide the tradition in which intersubjective truth is codetermined. Truth does not reside within individuals but in, and through, tradition. Tradition is handed down, thus it comes from the past, it is what we live in, thus it forms the present, and it is handed on, thus it shapes the future. In this way, tradition "is the ground and background of all possible meaning" (Ermarth, 1981, p. 189). Accordingly, understanding comes into being through history, it is "effected" by history and simultaneously understanding is influenced by history, it is "affected" by history. Gadamer's term for the influence of history on human consciousness is wirkungsgeschichtliche Bewusstsein. Interpretive difference is

exemplified with this term which is interpreted as "authentically historical consciousness" (Palmer, 1969), "effective historical consciousness" (Gadamer, 1979), "effective history" (Di Censo, 1990) and "historically effected consciousness" (Gadamer, 1989). Palmer (1969, p. 191) defines wirkungsgeschichtliche Bewusstsein as "consciousness in which history is ever at work." Thus, consciousness is ever open to the affect of history; and so too is language. As Ermarth (1981, p. 190) says, our way of being and of understanding is a belonging to both language and tradition.

Gadamer (1990, p. 147) claims "language is the fundamental mode of operation of our being-in-the-world and the all-embracing form of the constitution of the world." Language prefigures our understanding of history, culture and self; language gives us our world. Texts too are linguistic and historic objects since they are produced within specific traditions and disclose standpoints from within those traditions. As a result, textual understanding, through the fusion of horizons, is a dialectical question and answer of the tradition of the interpreter and the tradition of the text. Palmer (1969, p. 208) explains that the fusion of horizons is only possible because the belongingness to language, of the interpreter and text, allows a common horizon to develop. For Gadamer (1979), understanding is linguistic, historic, cultural and dialectic. Intersubjective understanding arises through the shared world of language, culture and history, which is tradition. This does not mean there is only one tradition but rather that Gadamer uses the word tradition to denote this concept. Through tradition the interpreter's intersubjective preunderstandings are developed and shaped. In this regard, Gadamer (1987, p. 130) says "every textual interpretation must begin then with the interpreter's reflection on the preconceptions which result from the hermeneutical situation

in which he [or she] finds him [or her] self." This imperative to reflect on preunderstandings does not mean reflection occurs in a once and for all way rather it requires that I review preunderstandings as they are held, for example, from the past and as they develop, for example, in the future (through continued reading, writing and interpretation). Accordingly, reflection on preunderstandings is an ongoing process in which I attempt to take account of old and new learning (my old and new self).

5.10 Preunderstandings Developed from this Section

Understanding and interpretation is dynamic, ongoing and incomplete and interpretive diversity provides one example of its complexity. Interpretive diversity results because interpreter preunderstandings give rise to textual plurality and multiplicity and because interpreters question the text from particular perspectives. Understanding and interpretation are always perspectival because they arise through embodied linguistic, historic, cultural and sociopolitical preunderstandings. In following Gadamer, I accept the notion that interpretation seeks to manifest textual meanings rather than individual ones. The only way to make manifest textual meanings is to engage with the text within the hermeneutic circle. In order to gain the most effective entry into the circle I continue to address my preunderstandings. In turn, I: (1) make the scientific theme secure by working out my forestructures in terms of the phenomenon under investigation; (2) assess preunderstandings for origins, adequacy and legitimacy; and (3) provide readers with the opportunity to review methodological processes.

In the following chapter, entitled "Method: Explicating Practice Knowledge", I review methodological processes by outlining the way I applied hermeneutic philosophy to the conduct of the research. The most significant application of hermeneutics to research

method resides in my use of Gadamer's (1979) work to develop a method of hermeneutic interviewing (for information gathering) and my use of Ricoeur's (1974a, 1976a, 1981a) work to develop a method of hermeneutic interpretation (for textual analysis). I also discuss the study, its participants, ethical issues and the development of criteria through which the research may be evaluated.

Chapter Six

6 Method: Explicating Practice Knowledge

> "... we miss the whole truth of the phenomenon when we take its immediate appearance as the whole truth" (Gadamer, p. 268, 1979).

6.01 Introduction

This chapter reviews the processes through which the practice knowledge of adolescent mental health nursing was explicated. The philosophy of hermeneutics underpins the methodology and method used in the study. Philosophy is taken to be the canons of a particular tradition of thought, methodology to be the philosophical thought guiding research processes and method to be the way research is conducted. In this way, philosophy informs research from inception to completion. The writing of Gadamer (1979), Heidegger (1962) and Ricoeur (1974a, 1976a, 1981a) was foundational to the way I conceptualised and conducted the research. In the following discussion, I review the use of hermeneutics as method then examine hermeneutic interviewing and interpretation. After this, the research processes are outlined with particular reference to research participants, contextual and ethical issues, information gathering and evaluative criteria.

6.02 Hermeneutics as Method

Allen and Jensen (1990), Benner and Wrubel (1989), Cushing (1994) and Schutz (1994) appear to consider ontology and epistemology to be separate entities. This is problematic as it replicates the Cartesian split between subject (ontology/being) and object (epistemology/knowledge). When nurses using hermeneutic methodologies claim "nursing would profit from considering the question of what it is to be a person before considering questions of

epistemology" they uphold positivist views of knowledge (Leonard, 1989, p. 41). Leonard's statement suggests, for example, that exploration of what it is to be a person is not an epistemological question, not a form of knowledge. Even in contemporary empirical science this is a legitimate form of knowledge (see Schumacher & Gortner, 1992). And, while "hermeneutics is not concerned primarily with amassing verified knowledge, such as would satisfy the methodological ideal of [certain types of] science - yet it too is concerned with knowledge and with truth" (Gadamer, 1989, p. xxi).

Hermeneutics recognises that ontology and epistemology are codetermined (Di Censo, 1990). In following Gadamer (1989) and Heidegger (1962) nurses accept that who we are and what we know is inseparable. To say ontology has primacy, in the Heideggerian sense, is to lose Gadamer's insight that we come into being through participation in tradition, we do not come into being on our own. Nevertheless, to claim ontological primacy is not the same as arguing that ontological questions (what it is to be a person) are not epistemological (to do with knowledge). In the hermeneutic sciences knowledge does not merely refer to something that can be verified, it also refers to understanding through disclosure. Because of this, and because it recognises the coexistence of ontology and epistemology, hermeneutics was well suited to the research I wished to conduct.

Through this study I sought to explicate the practice knowledge of nursing on residential adolescent mental health units; to make that knowledge visible within its context. As this was an epistemological endeavour and hermeneutics is an epistemologically innervated philosophy, there was a fittingness between the study aim and the philosophy. Moreover, the use of storytelling, interviewing and interpretation as the methods of information

gathering and processing, necessitated the use of a philosophy which recognised and valued the inherent ontological dimension within such methods. The work of Gadamer (1979, 1989) and Ricoeur (1974a, 1976a, 1981a) provided a philosophical basis from which I could develop a methodology suited to this purpose. In this regard, the hermeneutic imperatives that epistemology and ontology are codetermined, plural, incomplete and constantly in a dynamic process of change, provided appropriate foundations for the conceptualisation and conduct of the study. Over and against this however was the problem that hermeneutics is essentially unconcerned with method.

Hermeneutic philosophy has, on the whole, offered little direction regarding the use of hermeneutics as a research methodology or method. Heidegger (1962) went directly to an ontology of understanding, "no longer as a mode of knowledge, but rather as a mode of being" (Ricoeur, 1974b, p. 7). Gadamer, (1989, p. xxviii) did not seek "to produce a manual for guiding understanding" in the human sciences because he perceived hermeneutics as transcending the problem of method. His concern was "not what we do or what we ought to do, but what happens to us over and above our wanting and doing" (p. xxviii). As a result, I had to determine how I would actualise the processes of information gathering and processing in a way that took account of the study's philosophical foundations. I did this by extrapolating from the work of Gadamer (1979, 1989) to develop a method of hermeneutic interviewing and from the work of Ricoeur (1974a, 1976a, 1981a) to develop a method of textual interpretation. In the discussion that follows, I present my conceptualisation of hermeneutic interviewing.

Hermeneutic Interviewing

> "Our failures to listen may show us forms in which distortion may occur ... recognising our failures may make us more sensitive to ways we go wrong ... so we may succeed and listen" (Forester, 1980, p. 227).

6.03 Why Hermeneutic Interviewing?

Information on the technique and nature of research interviewing has increasingly become available (see Benner, 1994; Drew, 1989; Field & Morse, 1985; Gilchrist, 1992; Gordon, 1980; Minichiello, Aroni, Timewell, & Alexander, 1990; Mischler, 1986a; Morse, 1991a; Walker, 1985). Authors have written about particular aspects of research interviews, for example, ethical issues (Smith, 1992a), the interview relationship (Oiler-Boyd, 1993; Lowenberg, 1993), approaches to interviewing (Drew, 1993), methods of analysis (Honey, 1987), modes of understanding (Kvale, 1983), role analysis (Gilbert, 1980) and peer group interviewing (Platt, 1981). However, in relation to research interviews, there is limited information describing how a chosen philosophy guides the conduct of such interviews, for example, as Sorrell and Redmond's (1995) article does. This is important as the extrapolation of philosophy to research methodology requires congruence in its application to all aspects of the research. Thus, as research methodology evolves from a philosophical tradition, the design and implementation of research interviews should be appropriate to the philosophical foundation (Sorrell & Redmond, 1995, p. 1118). In the following discussion, I review Gadamer's (1979) concepts of conversation, and question and answer, from which I developed the notion of hermeneutic interviewing. After this, I examine my interviewing technique in relation to those hermeneutic concepts. Finally, I demonstrate the way I used my work on forestructures to review the research interviews and note the influence of my forestructures

on interview processes.

Twenty eight interviews were conducted ranging in length from 30 minutes to two hours. Each person was interviewed twice and I transcribed all the interviews myself. Following transcription of the first interview I sent each participant an edited transcript, of that interview, in preparation for a second interview. This edited transcript contained questions arising from the first interview and it was these questions that formed the basis of the second interview. A covering letter requested that participants read the transcript and add their own questions as desired. Eventually, three transcripts were produced for each participant; one from the initial interview, a second containing questions for a follow up interview, and a third from the follow up interview. As it is not possible to include all interview transcripts, the transcripts of one adolescent, Elizabeth, are included with the appendices (see Appendix C). In order to include Elizabeth in this decision she examined her transcripts prior to giving permission for them to be used in this way. Inclusion of Elizabeth's transcripts provides the reader with an opportunity to see how this part of my work was conceptualised and to review the way I conducted the research interviews. In the section that follows, I discuss the nature of hermeneutic interviewing.

6.04 The Influence of Hermeneutics on Research Interviewing

Gadamer (1979) grounded the nature of hermeneutic understanding in language, history and culture. This grounding of understanding in tradition carries with it significant implications in hermeneutic interviewing. Essentially, it means the interviewer strives to understand the content of the communication rather than the person with whom they are in dialogue. Naturally, the content of the communication is shaped by the dialogue between the

interviewer and interviewee, nevertheless, "the understanding of what someone says is not ... something which pertains to the speaker but to what is spoken" (Gadamer, 1979, p. 445). This is because, in the first instance, communication always exceeds the meaning ascribed to it by any one individual, and in the second instance, because understanding arises through tradition. As tradition is linguistically constituted we are in the world through language; language introduces us, as we grow into it, to our world (Gadamer, p. 401). On the other hand, language only comes into being through its representation of our world. This coconstitution of language and tradition is a difficult notion but it is this conceptualisation of understanding (through language and tradition) which allows Gadamer to assert that hermeneutics is not subjective since understanding is constituted through tradition rather than the self. Ricoeur (1973b, p. 127) put it this way, "history precedes me and my reflection, I belong to history before belonging to myself." In this way, the conversation between the interviewee and interviewer comes down through linguistically constituted tradition and this common ground (of linguistically constituted tradition) allows a fusion of their horizons and, as a result, understanding. Equally significant, in the application of Gadamer's theory of understanding to research interviewing, is the concept of dialectic.

Gadamer (1979) spoke of a dialectic of interpretation and a dialectic of question and answer. A dialectic of interpretation seeks to remove the onesidedness that arises through the interpreter's prejudiced horizon. It relates to the taking on and letting go of interpretations in the search for interpretations which accurately reflect the text. Its hallmark is a speculative, undogmatic, openness and a willingness to be instructed to another point of view; to be instructed to another horizon. The second dialectic of

interpretation relates to the epistemological and ontological interplay between the text and the interpreter (the self). This dialectic highlights the way self understanding is transformed through the interpretive endeavour and in turn enhances that endeavour. Such a dialectic fosters both understanding of the text and understanding of the self; it discloses new ways of being by giving the interpreter an opportunity for the renewal of self (Ricoeur, 1974d, p. 107). With regard to a dialectic of question and answer, Gadamer (1979, p. 326) perceives this as the way all knowledge development proceeds.

A dialectic of question and answer is the core of the hermeneutic interview and it takes place within the context of a conversation. This conversation is characterised by its interactive quality and by the predominance of the subject matter under discussion over the participants. In other words, the content of the conversation leads the participants into exploration and understanding rather than the participants imposing themselves onto and dominating the conversation. Conceptualised through tradition, conversation "is neither subjective nor objective, neither totally relative nor fixed" (Deetz, 1978, p. 21), rather conversation has meaning over and above that of the participants engaged in it. This point is further explored in the following discussion.

6.05 Hermeneutically Informed Research Interviewing

The hermeneutic interview is different from other types of interviews; there are no predetermined questions and it is open ended and unstructured. This is because predetermined questions establish the direction of the conversation instead of allowing the subject matter to do so. Moreover, such questions impose the researcher's preunderstandings onto the phenomenon under investigation thereby closing down rather than opening up the

possibility for different understanding. As Gadamer (1979, p. 266) says, "the essence of the question is the opening up and keeping open of possibilities." Unlike the phenomenological interview which is descriptive and allows data "to speak simply for itself" (Oiler, 1982, p. 179), or the hermeneutic phenomenological interview where "the interviewer wants the respondent to describe the experience rather than interpret it" (Sorrell & Redmond, 1995, p. 1120), the hermeneutic interview seeks understanding through interpretation. In this interpretive process meaning is cocreated. Generally, the cocreation of meaning occurs when the interviewer offers an interpretation of the interviewee's comment or seeks clarification of it. Further, in recognising that understanding occurs through the interviewer's preunderstandings rather than in spite of them, hermeneutics values the role of preunderstandings.

Since hermeneutic aims are epistemological they transcend the temporality and subjectivity of lived experience and "the meaning it holds for each subject" (Drew, 1989, p. 431). When a hermeneutic interviewer seeks clarification of a comment, their intention is not to discover the meaning for the interviewee but to discover its meaning in language. Thus, "the hermeneutical problem is ... the proper understanding of that which takes place through language" (Gadamer, 1979, p. 346). Reflective and conversational in nature, the hermeneutic interview is characterised by active listening and proceeds via question and answer (Deetz, 1978; Forester, 1980; Gadamer, 1979). Such conversation is an opening to the world of understanding which occurs between people, or between people and texts, and in all respects this conversation takes place through tradition.

According to Deetz (1978, p. 19), the genuine hermeneutic conversation "is characterised more by giving in to the subject

matter and allowing it to develop in the interchange." In this way, the conversation develops through the force of the subject matter under discussion (the phenomenon under investigation) rather than the will of the participants. This quality of hermeneutic conversation leads to an earnest discussion of the matter at hand as the participants immerse themselves in dialogue. While following the content of a conversation does not sound like an onerous task, it proved to be quite difficult since during the interviews I sometimes found myself following my own thoughts rather than staying with the dialogue as it evolved. Moreover, even though my thoughts arose within the context of the conversation, the questions I generated from those thoughts often took the conversation in another direction. Reviewing the transcripts of the first interview, and sending the participants an edited copy, allowed us both to see where I had redirected the conversation. In turn, the second interview provided an opportunity for us to readdress the issues that were originally under discussion.

At those times when the interviewer's questions shift the focus of the conversation the participants begin talking at cross purposes (Gadamer, 1979, p. 330). This subverts the aim of the conversation which is to ensure that the participants are in it together. In being in the conversation together, the interviewee is also in an active role. Such a conversation, of two people striving to understand each other, is demonstrated in a dialogue between the adolescent Lee and myself. At this point in the conversation, Lee questioned my understanding then clarified it when my response was not in tune with her meaning. In all the following examples, my comments are in plain (brackets), the interviewee is outside the brackets and other events, like {pauses}, are in fancy brackets.

> *(So, if the nurse doesn't pick up on those cues that you're giving them?) Then you'll give up because you have to make up another excuse to talk to them and each time you have to have that much courage to do it (I see) especially because it's an older person, do you get what I mean? (It's difficult for adolescents to approach adults?) No, it's difficult for adolescents to approach anybody they don't know (uhu) because it's a challenge, they're so worried about how they're perceived.*

The way this dialogue proceeded, through question and answer, demonstrates the constitutive foundation of the hermeneutic interview. However, Gadamer (1979) suggests it is not enough simply to ask questions as the person who seeks to understand must question behind what is said and therefore beyond what is said. Questions seek to bring forward the undetermined possibilities of the subject under discussion. Thus, the interviewer strives to understand more than the spoken word (Forester, 1980). This skill is reflected in the interviewer's ability to reformulate the content of a conversation into an interpretive summary or question, which provides an opening for a fuller response. It is a difficult skill as it calls for intense listening and spontaneous interpretation and I often felt frustrated by my inability to provide short, clear, descriptive statements or questions. On the other hand, I was sometimes close to the type of questioning that Gadamer (1979) suggests opens up possibility. The possibility of understanding through attentive, respectful listening and thoughtful questioning. An example from the adolescent Belinda's interview follows:

> *(Why do you think adolescents test limits like that?) ... to see how much this nurse is going to put up with, like whether they will stick around. You push the limits, someone might be able to handle [only] one overdose or handle you telling them off once (mm) and then you think "well they're not going to stick around if something worse happens." (ah) Like Erin stuck around through all my shit. (Why is it important for adolescents to know that nurses will stay with them through all the*

> *shit?) ... it's important because they need somebody who is going to be their friend because they want to be their friend not because they want something off them. (How do you think it helps having someone like that?) ... it makes you think "I can have a friend" ... it's nice to know someone's going to stick around just because they want to, because they like you, everyone needs that.*

In this interview excerpt the use of "why" questions is evident. Koch (1993, p. 168) suggests why questions are not appropriate because they close doors rather than open them. She goes on to say such questions are more consistent with positivist approaches because they infer causality. It is unclear why the experience of living should preclude causal thinking. People often seek to make sense of experience through cause and effect noting, for example, how one thing led to another and was experienced in a sequential way. This type of thinking is not disengaged nor decontextualised rather, as research in cognition demonstrates, different cognitive demands produce divergent ways of thinking (see Dowie & Elstein, 1984; Dreyfus & Dreyfus, 1986; Mischler, 1979). Therefore, it is important not to devalue different ways of thinking as a means of accessing information and understanding. In a postscript to her thesis, Koch reconsiders nondirective interviews suggesting that "open ended questions could be followed by focused clarifying inquiry" so as to "check the interpretation concurrently" with the interviewee (pages unnumbered). Koch rightly notes that why questions allow the interviewer to access interpretive understanding. In the interviews, and especially in the second interviews, I most often used why questions to probe an aspect under discussion for deeper understanding, significance or meaning. I am not suggesting I did not participate in determining meaning and cocreating the text. Indeed, it is recognition of this cocreation that obliged me to address the influence of my

forestructures on textual construction and interview processes. Thus, in the following sections I note the way I did this.

6.06 The Influence of Forestructures on Textual Construction

My influence on the construction of the text did not begin with information gathering but with my conceptualisation of the study. In this regard, factors influencing textual construction include: (1) the research focus; (2) directions, information and instructions given to participants; (3) the nature of the interview, whether structured, semistructured or conversational; (4) probes and exploratory questions, which in determining the focus and direction of the conversation also determine what is received; and (5) the researcher's relational and interviewing skills. The participant's influence is equally significant since, for example, they determine to what and how they will respond and where they put the emphasis in their reconstruction of past events which, in turn, determines where the researcher is inserted into the conversation. This is important because where the researcher is inserted into the conversation determines all that follows from that point including questions, dialogue and interpretation. For all these reasons, the researcher and participant cocreate meaning and text (Mischler, 1986b) thereby highlighting the researcher's obligation to address forestructures.

I completed my work on forestructures prior to conducting the research interviews. I did this in order to become conscious of my forestructures and note their influence on interview processes. In this way, I attempted to recognise whether I was following the participant's conversations or leading them into providing information which confirmed my preunderstandings of adolescent mental health nursing. Thus, rather than seeking to eradicate my presence as cocreator of the text, I sought to understand and take

account of my presence.

6.07 Using Forestructures to Review Research Interviews

In the very first interview with the nurse Maggie, I learnt how the imposition of forestructures interferes with the flow and process of an interview. I was following Maggie's conversation when I suddenly imposed a question about adolescent development. As Maggie was focused on an unrelated topic she was not prepared for the change of direction and found it difficult to collect her thoughts and answer my questions. After this episode, it took a little time to return to the conversational rhythm we had created. Gadamer (1979, p. 266) suggests understanding begins when something addresses us but this requires the fundamental suspension of our forestructures in order that we are able to experience the other's claim to truth and make it possible for them to have full play. I did not approach the interview with specific thoughts in mind yet clearly the danger that forestructures will intrude is ever present. Following interview transcription, I saw the problem and examined my work on forestructures. Through this examination I found a strongly held belief that adolescent mental health nursing involves understanding, balancing and managing the adolescent developmental stage. As a result, I attempted to modify such future occurrences by reviewing my work on forestructures prior to each interview. Nonetheless, obstacles still arose.

In my first interview with the adolescent Jane, she was speaking about the nature of her relationship with a nurse and mentioned the words friend and friendship. Instead of exploring her friendship with the nurse I imposed my forestructures regarding the nonauthoritarian nature of the nurse-adolescent relationship. As a result, my next question included the word "authority" in it which predetermined the direction of Jane's response. A poor question

always predetermines direction whereas a genuine question allows the possibility of several directions and answers (Gadamer, 1979). For me, such experiences helped me to realise that attempts to moderate the influence of my forestructures would be ongoing. This is because while all forestructures cannot be brought to consciousness, each additional search for them uncovers more. My work on preunderstandings demonstrates this point.

I completed my work on preunderstandings to aid me with textual interpretation but this work also allowed me to identify instances where I imposed preconceived ideas during an interview. For example, at our first interview the adolescent James was speaking about the losses he experienced at discharge but I neglected to follow up the point on loss because my beliefs about the way the therapeutic relationship should be terminated took precedence in my mind. As a result, my next question addressed the termination of the nurse-adolescent relationship rather than the losses James had experienced. I noticed this issue after reviewing the first interview, and at the second interview when I refocused attention onto the losses James had been speaking about, he said:

> *every friend we had was at the unit ... they were also the only people who understood the problems we had and who we really were inside. All of a sudden we're losing all of those friends all in one go, it's not like a gradual thing, it's not like going through the disappointment of losing one friend ... you lose all your friends, you lose the environment you know ... you lose everything that was familiar and everything new becomes foreign.*

Thus, effective interviewing allows participants to explore those parts of an experience which were significant to them and to the study. I found hermeneutic interviewing difficult but this was not necessarily due to a lack of effort on my part rather it was due to my

situatedness in tradition. Gadamer (1979, p. 279) makes this point when he says:

> we are always within the situation and to throw light on it is a task that is never entirely completed ... this is not due to a lack in the reflection, but lies in the essence of the historical being which is ours ... all self knowledge proceeds from what is historically pre-given ... and hence both prescribes and limits every possibility of understanding.

6.08 Summation

Hermeneutic interviewing proved a challenging experience. On the one hand, the unstructured nature and conversational style suited well the relaxed, informal atmosphere I sought to create. The focus on question and answer also suited my notion of engaged conversation. On the other hand, the requirements of intense listening and simultaneous interpretation were extremely difficult skills to sustain. When I allowed uninterpreted conversation to proceed I felt possibilities were restricted rather than opened up. This is because my understanding at that point was reduced and thus interpretation of the text would be more difficult; more influenced by my horizon. The imposition of forestructures was always a concern because the conversational nature of the interview, and the way it proceeded through interpretive question and answer, constantly created opportunities where this could occur. I learnt I had strongly held forestructures and there was a need for constant vigilance. In turn, this understanding prompted me to approach textual interpretation with even greater caution. Hermeneutics acknowledges preunderstandings as the basis from which all understanding proceeds. Accordingly, "... we must always already have a horizon in order to be able to place ourselves within a situation" (Gadamer, 1979, p. 271). Within this reality resides the

possibilities and the limitations of hermeneutic research.

Conducting the Research

6.09 The Study Context

The context of qualitative research is especially significant as it provides the milieu in which shared experience takes place. Further, the influence of context in shaping such experience is acknowledged. While similarities may be found across residential adolescent mental health units differences will also arise. Such differences highlight the richness of human experience and the inability of any research to capture experience in its entirety.

This study was not conducted within any one setting thus the context of the research was nursing, or being nursed, on residential adolescent mental health units. These units cater specifically for emotionally disturbed adolescents and their families. They include a range of services including residential, day, outpatient and follow up programs. Special schools are situated within the grounds as the majority of adolescents will be school attenders. Residential adolescent mental health units are staffed by multidisciplinary teams. These teams include the disciplines of nursing, youth work, psychiatry, social work, teaching, occupational therapy and psychology. Ancillary staff, for example, gardeners, cleaners and kitchen staff are also part of the milieu and often provide significant therapeutic experiences for adolescents. Programs usually centre around schooling, skills development, therapy and therapeutic activities (such as camping, groups, outings, sport, craft). Nurses are engaged, to a greater or lesser degree, in all these programs.

6.10 Participants

The research participants were seven registered mental health nurses with experience working on a residential adolescent mental health unit, and seven young people who, as adolescents, had

experienced being nursed on such a unit.

6.11 The Nurses

The nurses chose to be known as Catherine, Maggie, Brandon, Lai, Origma, Binkie and Merlin. They are experienced nurses who share the following characteristics. An average of:

* Fifteen years of nursing experience,
* Nine and a half years of mental health nursing practice,
* Four years experience on residential adolescent mental health units.

The nurses were from diverse ethnic backgrounds including Maltese, Irish, English, Chinese and Australian. All were educated in hospital training schools and five have multiple nursing certificates. Six have completed tertiary studies or training in counselling, welfare or nursing and their qualifications include certificates and diplomas. One of the nurses has a bachelors degree and one has a bachelors and a masters degree. All the nurses worked on residential adolescent mental health units for a minimum of two years. Three nurses worked on several different residential units in New South Wales (NSW) and one worked on units in Australia and the United Kingdom. Due to the ethical obligation of confidentiality the unit names are withheld. The only nurse to have worked outside Australia was Catherine.

In the following section, I introduce the nurses:

Catherine Atepi

Catherine is a Registered Psychiatric and General Nurse who holds a Diploma in Tropical Nursing and has 13 years of nursing experience. She has worked for eight and a half years as a mental health nurse with five years on adolescent mental health units. Catherine has worked on such units in Australia and overseas.

Maggie O'Brien

Maggie is a Registered Psychiatric, General and Geriatric Nurse who is presently completing a Diploma in Counselling. She has 19 years of nursing experience. Maggie has worked for 12 years as a mental health nurse including two years on an adolescent mental health unit.

Brandon White

Brandon is a Registered Psychiatric and General Nurse who has completed Direct Care Workers and Protective Behaviours Courses. Brandon has 12 years of nursing experience. He has worked for eight years as a mental health nurse with three of those years on an adolescent mental health unit.

Lai Chun

Lai is a Registered Psychiatric and General Nurse who holds a Bachelor of Arts degree in social welfare. She is also trained in Reality, Gestalt and Family Therapy. Lai has 15 years of nursing experience. She has worked for 10 years as a mental health nurse with five years on adolescent mental health units.

Origma Fern

Origma is a Registered Psychiatric and General Nurse who holds a Bachelor of Arts degree in psychology and a Master of Arts in counselling. Origma has 17 years of nursing experience. She has worked for 12 years as a mental health nurse with four of those years on adolescent mental health units.

Binkie Rinpoche

Binkie is a Registered Psychiatric Nurse. She has 12 years of nursing experience having worked all those years as a mental health nurse. Binkie spent two years working on an adolescent mental health unit.

Merlin Dunn

Merlin is a Registered Psychiatric Nurse. He has also completed

courses in counselling, psychodrama and training. He has 11 years of nursing experience with nine years as a mental health nurse. He has worked for five years on adolescent mental health units.

6.12 The Young People

The young people chose to be known as Jane, Elizabeth, Belinda, James, Aloysius, Eamon and Lee. They share the following characteristics. An average of:

* Four months on a residential program,
* Five months on a day program,
* Six months on an outpatient program,
* Three months in an exstudent's group, and regarding work,
* Five years of full time employment.

All the young people are Australian. Two completed the Higher School Certificate (HSC), one is currently enrolled in the HSC, three completed the School Certificate (SC) and one completed Year 9. The young people have attended various education and training courses with one holding a bachelors degree and one presently studying for such a degree. Three of the young people own and operate their own business, one is an actor, one a clerical assistant, one a full time student and one a full time parent. To maximise confidentiality the ages of the young people and the year they were nursed on an adolescent unit are not included. The name of the units are withheld for the same reason, especially as there are so few such units in NSW.

In the following section, I introduce the young people:

Jane Doe

Jane was admitted to an adolescent mental health unit when she was an early adolescent. She spent five months on that unit. At the time of admission Jane was experiencing a psychotic episode. Her behaviour included withdrawal, paranoia, fear and hallucinations. Jane's suspicion, withdrawal and fearfulness meant trusting

relationships were difficult to form.

Elizabeth Arnold

Elizabeth was an early adolescent when she was admitted to an adolescent mental health unit. She spent nine months on that unit. Elizabeth came from an unsettled family and lived for several years in institutions. Because of her unsettled childhood Elizabeth found it difficult to trust adults. Her primary difficulties were with anger, acting out behaviours and depression.

Belinda Smith

Belinda was admitted to an adolescent mental health unit when she was a middle adolescent. She spent three months on that unit. Belinda experienced sexual abuse from childhood and had suicidal feelings, self harming and acting out behaviours. She was awkward, angry and abusive and had difficulty developing trusting relationships.

James Brown

James was a middle adolescent when he was admitted to an adolescent mental health unit. He was admitted with a depressive disorder and spent six months on that unit. James was withdrawn, discouraged, unmotivated and unhappy. He had difficulty relating to adults and peers, a confused sense of identity, low self esteem and feelings of isolation.

Aloysius Abercrombie

Aloysius was admitted to an adolescent mental health unit when he was a middle adolescent. He spent eight months on that unit. Aloysius had substantial difficulties at school, which he had stopped attending, and a conflicted relationship with his father. He had difficulty relating to and establishing friendships with peers. Aloysius was socially awkward and interpersonally insular and aloof.

Eamon Bandas

Eamon was a middle adolescent when he was admitted to an adolescent mental health unit. He spent three months on that unit.

Eamon was admitted during a psychotic episode. He was alternately manic and depressed and experienced delusions and paranoia. Eamon was either confused, frightened, preoccupied and socially inappropriate or active, lucid and socially appropriate.

Lee Vouden

Lee was admitted to an adolescent mental health unit when she was a middle adolescent. She spent five months on that unit. From childhood through to adolescence Lee experienced several different episodes of sexual abuse. She had suicidal feelings, self harming and acting out behaviours. Establishing and maintaining relationships with peers was especially problematic for her. Lee was socially inappropriate at times, impulsive, angry and aggressive.

6.13 The Researcher

When hermeneutics is used to inform research method the researcher's situatedness in tradition is acknowledged. In the first instance, this means that I, the researcher, through engaged practice as an adolescent mental health nurse, bring an informed perspective to the phenomenon under investigation. In the second instance, the situatedness of the researcher in tradition precludes any objectively valid, disengaged knowledge. Hermeneutically, there is no atemporal, ahistorical or acontextual knowledge because all understanding and interpretation is grounded in being, language, history and culture.

Throughout the study I was a full time doctoral candidate. My 24 years of nursing experience is divided into 13 years of full time clinical nursing practice, four years of full time teaching in the hospital sector and seven years of part time teaching in the tertiary sector. I have worked on a residential adolescent mental health unit on two separate occasions and my last four years of clinical practice were as an adolescent mental health nurse.

Information Gathering Processes

The strategies I used to gather information differed in only one respect from my original conceptualisation; in the end I did not seek feedback from participants on my interpretations. This occurred because I chose to follow Gadamer's (1979) and Ricoeur's (1973a, 1973c) theory of textual autonomy. In doing this, congruence was maintained between philosophy, methodology and method. On the other hand, I did seek feedback from participants regarding their experience of being interviewed. This provided participants with an opportunity to share their thoughts and feelings regarding their involvement in the research and it allowed me to modify my interactions, especially during the second interview, in an attempt to meet their needs. Altogether, I used six strategies to gather information:

(1) demographic data questionnaire,
(2) indepth interview,
(3) follow up interview,
(4) written story,
(5) knowledge, skills and attributes survey, and
(6) interview feedback.

6.14 (1) Demographic Data Questionnaire:

Information on demographic data (see Appendix D, p. 309) was gathered to provide myself and readers with some understanding of the participants.

6.15 (2) & (3) Indepth and Follow up Interview:

Participants were telephoned to organise a time and place for the initial interview. Two participants lived interstate and these conversations were audiotaped over the telephone. All except one person chose to be interviewed in their own home and this person

received permission to be interviewed at their workplace. As the interviews were audiotaped I spent a lot of time talking with and visiting people prior to beginning the interviews. Often, we would share lunch, reminisce and look through photos thereby creating a more relaxed environment for the interview to take place. At this time I would also answer questions and discuss, in a general way, the nature of the research and how it was progressing.

Interviews were nondirective, conversational, unstructured and interpretive. The follow up interviews were conducted because transcription of the first interviews revealed that my understanding needed to be enhanced. All 14 participants agreed to be reinterviewed and an edited transcript of the first interview, with added questions or comments, provided the basis for the second interview. The 28 interviews resulted in 32 audiotaped hours and 700 pages of conversation and storytelling. Inevitably, stories began long before the tape recorder was turned on. Interruptions were also inevitable, especially for those conducting businesses from home or with young children who could not be cared for by others. Although interruptions disrupted the flow of thought and conversation, it was essential to be wholly accepting of them so as not to make people more uncomfortable than they already were about such interruptions. As it was, stories were told and interviews were richly informative despite interruptions.

Participants were encouraged, in a variety of ways, to tell their stories. First, the information package (see Appendix D) contained details on the interview and storytelling. Second, additional guidelines were sent following the uncertainty expressed by several participants about the nature of storytelling (see Appendix E). Third, when participants spoke generally about some issue during the interview I would try to contextualise what they said by asking

them to tell me a story about it. For instance, when Elizabeth alluded to testing behaviour she had engaged in with Antoinette I said, *(You were talking about Antoinette and locking her in [the kitchenette] can you tell me that story and what happened?)* In response she told a story which began *"I remember doing cooking, I think we were cooking cakes ..."* This was a strategy I also used on the edited transcript (of the first interview) when I tried to encourage participants to tell a story (in the follow up interview) about a point they had been making. For example, when Binkie spoke about the way adolescents test nurses she said, *"... so they would test us to the limit, to see what they could get away with and see what, you know, what controls we would put on them."* In response I asked, *(Can you tell me a story which shows how you set limits or resisted such challenges?)*

Livo and Rietz (1986) believe stories transmit and preserve history, culture, meaning and knowledge because they are a means of remembering and of saving the memory of things past. Similarly, stories about nursing are opportunities to transmit nursing culture, knowledge and ethics, to explore the teachings and learnings of the stories and to preserve their contextual sociopolitical, historical and linguistic meanings and memories. In this way, stories provide a way of capturing the knowledge of nursing embedded within storied experience. Moreover, stories are a natural part of how people talk about experiences of living. For all these reasons, I chose storytelling as a means of gathering information from the research participants. Even so, not all participants were keen storytellers. When participants expressed concerns about storytelling, which were not allayed through discussion, I suggested they said what they wanted to in their own way. These participants helped me to understand that everything they said was their story; it was one

large story. When I saw things this way I found myself valuing everything participants said and not simply listening for stories. I learnt to listen differently. Still, most participants found storytelling an easy and engaging process so many stories were told.

6.16 (4) Written Story:

While interviewing was the primary method of information gathering participants were asked to write a story because I wanted to provide them with a variety of ways of sharing their experiences (see Appendix D, p. 311). Ten of the 14 participants provided written stories. The other participants were reminded on several occasions after which I assumed they did not wish to complete this part of the research. Those participants who did not write stories generally said, "I'm going to do it but I haven't had time" or "talking is much easier than sitting down and thinking about what to write."

6.17 (5) Skills, Attributes and Knowledge Survey:

This tool (see Appendix D, p. 312) gave participants another way to think about and provide information on the research phenomenon. Participants generated brief statements about the nature of adolescent mental health nursing practice and these formed part of the information for analysis and interpretation.

6.18 (6) Interview Feedback:

Ford and Reutter (1990) suggest there is insufficient information available about the way participants experience their involvement in research. I found it valuable to ask participants about being interviewed because I gained information about my interviewing style and insights into what was important for each participant in the interview process. In this way, I attempted to tailor the interview to the person. Most importantly, asking for feedback allowed me to see there were two participants who experienced their involvement in the research in a unpleasant way, and while

this experience was usually superficial and transient, it reminded me of my ethical obligation as a researcher. This obligation arises because people agree to be involved in the research and be interviewed by you. Sometimes they only agree because it is you who asks. This was the case with Lee who said:

> *I found it hard to recall much else [other] than the strong emotional times with the nurses as I've spent a lot of time forgetting that stage of my life. When I think back it is hard to realise that it was me. I don't think I could have done the interview with anyone else.*

In order to become aware of and act on such information there has to be an avenue through which participants can share their thoughts and feelings with you. You have to ask.

The beginning of the interview was usually difficult for participants. For example, Jane wrote, *"before the interview I felt nervous not knowing what I was going to be asked. After the first few questions I relaxed, the questions were straight forward, recalling events and what I felt at the time. I felt comfortable."* Origma too experienced initial apprehension, she said, *"it's not easy for me to allow myself to be interviewed ... [but] after the initial little while I was able to say what I wanted ..."* Jane's and Origma's feedback reinforced the need to make introductory questions general and nonthreatening in order to allow the interviewee to ease their way into the interview. As a result, I strove to go at the interviewee's pace; when they were ready for deeper engagement and exploration I followed their lead. Even so, I was always aware of the need to monitor interviewee's responses to disclosure and their continuing level of comfort with such disclosure. This feedback also reminded me to affirm people's contributions and to strive to make the interview a positive experience. Although, participants

experienced their interviews as positive for different reasons.

For Binkie my manner of interacting with her was important, she wrote, *"I think your enthusiasm ... made me feel that my contribution was valuable and useful."* However, Lai's feedback suggests rapport can make being interviewed an enjoyable experience, she said,*"I felt comfortable and free to say what I wanted ... I did not have any hesitation or concern during the interview. I did enjoy the interview as there was a connectedness between you and I."* On the other hand, several young people found the interviews provided an opportunity to review their experiences and to understand the person they had become. In this regard, James said:

> *Being interviewed was a good chance to go over some of the things I hadn't thought about for a long time, and it's helped me to understand how I've become the kind of person that I am now.*

Eamon found the interview enriching but he also hoped it had been helpful thus, *"the chance to be interviewed about a past experience was very enriching for me ... I appreciate the opportunity and hope that the interview has been helpful in some way."* This notion of being helpful was mentioned by several young people. Belinda, for example, put it this way:

> *I don't mind being interviewed and if it's going to teach nurses, like all these adolescents doing these interviews, nurses are going to learn first hand what adolescents want ... I don't mind being interviewed if it's going to help things like that.*

While engaged in research it is easy to feel participants are giving a great deal yet receiving little, so I found it helpful to be reminded that participants also thought of their involvement in the research

as rewarding. Like other experiences of living, research involves giving and receiving. For instance, in giving a rich and informative interview Merlin received an opportunity for self understanding, in this respect he said:

> *Regarding my own experiences of the interview, I found it nonjudgmental which allowed me to get beyond my own guardedness of thinking ... when you have someone who's listening beyond what they think is right or wrong it allows you to explore those untapped areas within yourself ... I learnt a lot about myself.*

On the whole, participants enjoyed the experience of being interviewed. Binkie's comment characterises the feelings of the nurses, she wrote:*"the interview also brought back a lot of memories of the unit and how much I enjoyed working there ... it's brought back a lot of good memories."* Elizabeth's comment typifies the feelings of the young people, she said: *"it was really really good because ... it reminded me of good times that I'd forgotten about ... it's brought some really good memories back."*

In this section, I reviewed the way I developed and used a style of hermeneutic interviewing founded on Gadamer's (1979) dialectic of interpretation and dialectic of question and answer. In the following section, I review the way I used Ricoeur's (1976a, 1981a) theory of interpretation to inform textual analysis.

Hermeneutic Interpretation

6.19 Paul Ricoeur's Theory of Interpretation

Ricoeur sought to redirect hermeneutics in an epistemological direction (Di Censo, 1990; Ricoeur, 1974a, 1981a). He focused on textual interpretation as the primary aim of hermeneutics and developed a theory of interpretation which took into account hermeneutics, psychoanalytic theory, semantics and reflection

(Ricoeur, 1973b, 1974b). Rather than ask, as Heidegger did, what kind of being is it whose being consists of understanding? (1974b, p. 6) or as Gadamer did, how is understanding possible in being? he asked, through what means is textual understanding possible? In this way, Ricoeur sought to explicate an epistemology of interpretation. Through this process he hoped to reunite truth, the characteristic of understanding, with method, the operation through which interpretive understanding occurs. He also attempted to graft the traditional function of hermeneutics, that of textual interpretation, onto its contemporary ontological insights. He appreciated that interpretive epistemology was ontologically animated; he did not return to the Cartesian subject/object split. Thus, Ricoeur (1974b, p. 23) suggested interpretation was caught inside the circle formed by the conjunction of interpretation and interpreter. In recognising this conjunction, Ricoeur's (1976a, 1981a) theory of interpretation provides a suitable method to guide textual analysis in hermeneutic research.

For Ricoeur (1974c, p. 66), "interpretation is the hinge between language and lived experience." In this comment resides the central tenet of Ricoeur's (1974b) hermeneutic interpretation, the interrelationship between existence, language and understanding. His single most radical move was the objectification of the text. In this process Ricoeur completes the removal of authorial intent that Gadamer (1979) began. Gadamer began the removal of authorial intent (the meaning of a text always goes beyond its author) but then personified the text by representing it as a Thou in dialogue with an I (the reader/interpreter). It is this subjectification of the text, in conversational dialogue as if with another, that Ricoeur removed.

6.20 <u>The Hermeneutic Function of Distanciation</u>

Philosophically, 'distanciation' (putting something at a distance)

has its roots in Gadamer's (1979) concepts of historically effected consciousness and the fusion of horizons. Ricoeur (1973b, p. 127, 1973c, pp. 160-161) argues that historical consciousness contains within it a tension between the near and the far and that such consciousness takes place under the condition of historical distance. In the fusion of horizons resides a similar notion of a distance (horizon) capable of being narrowed or enlarged through understanding or misunderstanding. According to Ricoeur, this is the distance between the self and the alien, the near and the far that interpretive understanding attempts to reduce. Methodologically, distanciation objectifies the text by freeing it from the author's intent and giving it a life of its own. Ricoeur is not suggesting distanciation produces verifiable objective knowledge since his theory of interpretation links the knower with the known. Rather, he is suggesting distanciation "is a form of putting something at a distance rather than being at a distance" (1976b, p. 691). In this way, the author is put at a distance and the text exemplifies communication at a distance.

Distanciation exhibits four forms: (1) fixation of the spoken into the written word: dialogue is recorded as writing and the meaning of what was said becomes more important than the actual words; (2) eclipse of the author's intention: the written word makes the text autonomous, it is now open to unlimited reading and interpretation; (3) emancipation of the text: the text is freed from the tradition of its creation, it can be read within different sociopolitical, historical and cultural traditions; and (4) differences between spoken and written words: spoken dialogue is face to face whereas the written word expands its audience beyond the individual or personal (Allen & Jensen, 1990; Ricoeur, 1973a, 1973c; Thompson, 1985b). In this way, distanciation is not a methodological imposition "rather

it is constitutive of the phenomenon of the text as written" (Ricoeur, 1973a, p. 133). Thus, distanciation leads to distancing of the text from its author, the situation of the discourse and the original context and audience. With regard to method, the four forms of distanciation allow the interpreter/researcher to approach the text without concern for authorial/research participant's intent. Consequently, interpretation involves the interpreter (any reader) appropriating the meaning of the text (Ricoeur, 1973d).

6.21 The Hermeneutic Function of Appropriation

Philosophically, appropriation finds its foundations in Gadamer's (1979) concept of tradition. Through participation in the tradition in which we exist we gain a sense of the familiar and of belonging. Tradition is not alien; it is something into which we have grown, something we have appropriated through engaged living in the world. The appropriation of textual meaning operates in the same way. When the interpreter appropriates the meaning of the text it is no longer alien, it becomes familiar. In this way, appropriation and distanciation provide a dialectic of interpretation, between nearness and distance, the familiar and unfamiliar, the known and the foreign. This conceptualisation relates well to the notion that hermeneutic interpretation strives to reveal the hidden, unknown, alien and fragmented within a tradition.

Interpretation allows actualisation of the meaning of the text and for Ricoeur this occurs through appropriation. Appropriation means making one's own what was initially alien (Ricoeur, 1981b, p. 185). What is made one's own is the world of the text, and as a result, the horizon of the interpreter (what may also be referred to as being, consciousness or knowledge) is expanded. In this way, interpretation opens up the possibility of difference and therefore of alternative ways of orienting oneself in the world. Accordingly,

"interpretation is the process by which disclosure of new modes of being ... gives to the interpreter a new capacity of knowing him [or her] self" (1974d, p. 107). This link between experience, understanding and self understanding grounds Ricoeur's theory of interpretation in existence. It takes account of being and the relation of being with others so that "every hermeneutics is thus, explicitly or implicitly, self understanding by means of understanding others" (Ricoeur, 1974b, p. 17). On the other hand, understanding is not possible if the interpreter projects themself or their preunderstandings onto the text. Indeed, appropriation is not so much an act of possession of the text but rather a moment of dispossession of the narcissistic ego (Ricoeur, 1981b, p. 192) and in the space created by this dispossession of ego resides the opportunity for interpretation; for the text to reveal its world.

6.22 Understanding and Interpretation

The research text, through its foundation in language as discourse, stands on the boundary between the expressed and the unexpressed (Ricoeur, 1974d, p. 105). Interpretation, begins with a naive understanding of the meaning of the text as a whole, after which the interpreter proceeds to a deeper understanding through recognition of the relationship of the parts to the whole. Although, any naive understanding means the interpreter has already constructed some schema or expectation of meaning which may or may not be confirmed as interpretation proceeds. In this way, interpretation goes forward in stages with continual movement between the parts and the whole allowing understanding to be enlarged and deepened. Thus, a dialectic exists between understanding and interpretation, they both work through each other to unfold meaning. Noting this relationship between understanding and interpretation does not provide a method of

textual interpretation. On the other hand, Ricoeur's (1976b) conceptualisation of explanation and understanding goes some way toward fulfilling this need.

6.23 Explanation and Understanding

"Interpreting a text means moving beyond understanding what it says to understanding what it talks about" (Ricoeur, 1976a, p. 88). Embodied in this quote are the two stages of Ricoeur's theory of interpretation, they are: (1) explanation: or what the text says; and (2) understanding: or what the text talks about. Accordingly, explanation is directed toward analysis of the internal relations of the text (naive interpretation) while understanding is directed toward grasping the meaning the text discloses (depth interpretation). For example, in explaining Alice in Wonderland (Carroll, 1988) I could say it concerned a young girl who followed a rabbit down a hole and had many interesting adventures. I might recall that those adventures included meeting some animals, going to a tea party and speaking with a caterpillar. In doing this, I extract events from the text then note them, their relationship to each other, and their relationship to the text as a whole. As a result, I begin interpreting the text and through explanation or naive interpretation I develop an appreciation of "what it says." To go beyond this to "what the text talks about" requires understanding or depth interpretation.

Ricoeur says an interpretive construction relies on clues contained within the text. These clues (themes, categories) act to permit an interpretation because they make sense, or to inhibit it because they don't fit. In this way, one interpretation will seem more probable than another, it will account better for the qualitative convergence between the clues for which it takes account. In other words, the interpretive themes or categories will fit well with the

clues within the text that pointed to their meaning. This fit allows the text to mean all it can mean without being too narrow or too farfetched (1974d, p. 104). Ricoeur does not present explanation and understanding as independent rather he stresses the overlapping relationship between them. This interdependent relationship between explanation and understanding is demonstrated by Alice when she is questioned by the caterpillar. "What do you mean by that?" said the Caterpillar sternly. "Explain yourself!" "I can't explain, I'm afraid Sir," said Alice ... "for I can't understand it myself to begin with" (Carroll, 1988, pp. 40-41). In Ricoeur's construction of distanciation, appropriation, explanation and understanding, and in the concept of the hermeneutic circle, resides a method of hermeneutic interpretation for research texts. However, Ricoeur's theory contains several discontinuities, for example, the notions of guess and validation.

6.24 Guess

Ricoeur says the only way to access the meaning of a text is to guess (1976a, pp. 75-76, 1971a, pp. 547-548). He says this because he believes we cannot know what the author meant. Even so, it is unclear why textual interpretation must be reduced to guessing simply because we are no longer seeking the author's original meaning. In this regard, Gadamer's (1979) concepts of prejudice, tradition and the fusion of horizons are of benefit in expanding Ricoeur's theory of textual interpretation.

Prejudice develops through the interpreter's participation in tradition and is not an obstacle but rather a precondition to understanding. Further, common aspects of tradition, in the horizon of the interpreter and the horizon of the text, allow the fusion of horizons to occur. In the tension of nearness and distance within tradition, the fusion of horizons and prejudice (what Ricoeur

called appropriation and distanciation) is the situatedness from which the interpreter accesses textual meanings. Within the context of this study I gained access to textual meanings through: (1) participation in the traditions of living and nursing in Australia, (2) preunderstandings developed through adolescent mental health nursing practice, and (3) the process of addressing forestructures and preunderstandings so as to minimise their projection onto the text. This foreknowledge, and preparation to receive the text, is quite different to Ricoeur's assertion that only guessing allows access to textual meaning. Thus, while I used Ricoeur's (1976a) theory of interpretation for textual analysis I was also influenced by Gadamer's (1979) hermeneutics of understanding and by Heidegger's (1962) hermeneutics of being-in-the-world.

6.25 Validation

Within Ricoeur's (1976a, pp. 75-79, 1971a, pp. 547-553) notion of validation resides an inherent contradiction between the plurality of textual interpretation and a desire for criteria through which to judge between interpretations. On the one hand, Ricoeur accepts the plurality of texts, he notes the polysemic, ambiguous nature of sentences and words, acknowledges the changing and incomplete character of interpretation and agrees that texts are interpreted through tradition. On the other hand, he desires a method of arbitrating between competing interpretations. Ricoeur stresses that validation is not verification as verification is an inappropriate measure through which to judge hermeneutic knowledge. Still, he says not all interpretations are equal because some interpretations will be more probable than others (1976a, pp. 78-79, 1971a, pp. 549-550). This may be so, yet it appears to discount the possibility that different interpretations might do equal justice to the text depending on the question asked; tradition, ideology, perspective

and focus are significant influences here. There is not one reality but many. Indeed, different interpretations bring richness to the text representing it as they do from varying perspectives. Further, the desire for a method to validate interpretations disregards the hermeneutic insight that no single interpretation ever exhausts the meaning of a text. Interpretative understanding is dynamic and incomplete and therefore constantly changing.

With regard to interpretation, Koch (1993, p. 176) suggests readers should be able to understand how interpretations were arrived at even though they may not agree with the interpreter's construction. Accordingly, she provides an example of the process of interpreting a segment of a text (pp. 225-232). When such examples are used to demonstrate methodological processes they are useful and appropriate but when they are used to demonstrate the valid way interpretations are arrived at, they are hermeneutically inappropriate. With interpretations, the best an interpreter can achieve is to show, by example, how in certain instances they arrived at particular interpretations, or to support such interpretations with interview excerpts. It is not possible to account for all the competing decisions and interpretive choices an interpreter makes in any body of work. If conflicts arise over interpretations people can attempt to negotiate meaning. In the final analysis, readers will decide whether to accept, modify or reject an interpreter's construction. Often, this decision depends on how effectively an interpretive account provides understanding of the phenomenon under investigation. Even so, it is important to remember that there is no absolute, unchanging knowledge. If this were not so it would be difficult to account for continuing epistemological debates over various philosophies and scientific theories, and for shifting theories resulting from knowledge

development. Most importantly, hermeneutic research and interpretation is a way of continuing rather than closing down conversations over understanding. In this regard Gadamer (1989, p. 579) reminds us, "the ongoing dialogue permits no final conclusion. It would be a poor hermeneuticist [or any scientist] who thought he [or she] could have, or had to have, the last word."

6.26 The Framework used in Textual Analysis

The following summary notes the steps I used in textual analysis. Steps 1, 2 and 4 represent analysis in terms of explanation (what the text says), steps 3, 5 and 6 represent analysis in terms of understanding (what the text talks about) and step 7 represents the application of hermeneutic philosophy to method through my use of forestructures and preunderstandings. Regarding textual analysis I:

(1) engaged with the text by reading it in its entirety. This allowed me to develop an appreciation of the whole of the text and its parts;

(2) analysed each young person's and nurse's information then identified and documented examples of common representations called sub-elements of practice knowledge;

(3) defined each sub-element of practice knowledge;

(4) grouped the sub-elements of practice knowledge with shared meanings into units called elements of practice knowledge;

(5) defined each of the elements of practice knowledge in relation to the sub-elements of which they were composed;

(6) developed and defined the meta-element of practice knowledge by examining the sub-elements and elements (the parts) and all the information provided by the young people and nurses (the whole);

(7) scrutinised interpretations by reviewing my forestructures and preunderstandings in order to note and take account of their influence on the interpretive process.

6.27 Developing the Sub-Elements, Elements and Meta-Element

The sub-elements, elements and meta-element of practice knowledge, like themes, are representations within a text requiring

discovery in order for understanding to occur (van Manen, 1990, p. 98). For me, the sub-elements, elements and meta-element pointed to meanings and captured aspects of the phenomenon I was seeking to understand. In this way, they resulted from my desire to make sense of the text and as such they reflect the interplay between the text and myself. While the understandings I developed are a reduction of meaning they nevertheless allowed the discovery, naming and sharing of meanings which may otherwise have remained unknown. In this way, the sub-elements, elements and meta-element of practice knowledge came into being.

I developed the sub-elements, elements and meta-element of practice knowledge by using: (1) a particularistic approach, during which I searched for parts of the text, like words or sentences, which pointed to specific meanings; and (2) a wholistic approach, during which I focused on the text as a whole in an attempt to capture overall meanings. This approach to textual analysis reflects the metaphor of the hermeneutic circle where interpretation occurs through an understanding of the whole of a text in relation to its parts and of the parts in relation to the whole.

In the following section, I discuss the evaluation of interpretive research and outline the criteria I developed in relation to evaluation of the present study.

Evaluative Criteria

Packer and Addison (1989b), Sandelowski (1995a, 1995b) and Smith (1984), suggest the search for criteria to evaluate interpretive research is misplaced. They say this because of the intersubjective nature of interpretive research and because such research does not hold to the notion of a single or enduring truth. Rather, it accepts multiple realities while seeking to deepen

understanding by keeping conversations going about what those realities may be and what they may mean. Interpretive research also accepts that reality is changing, approximate and incomplete. Understanding does not stand still, it is different from person to person, transformed within the same person and alters over time and place. Interpretive research attempts to recreate understanding thus truth, in this endeavour, relates to uncovering and revealing. Returning to Heidegger we are reminded:

> ... everything depends on our steering clear of any conception of truth which is construed in the sense of 'agreement' ... entities of which one is talking must be taken out of their hiddenness; one must let them be seen as something unhidden; that is, they must be discovered (1962, p. 56).

In this regard, it is not agreement which is sought but research which reveals, uncovers or explains that which was confused, fragmented or hidden. What is vital is "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1962, p. 58). Accordingly, effective interpretive research provides understanding of the phenomenon which motivated the inquiry and does this in a respectful way by not imposing the researcher's perspective onto it. While I agree with the foregoing argument, I believe it relates more to the nature of interpretation than it does to the conduct of interpretive research. In this regard, I incline toward Guba (1981), and Lincoln and Guba's (1985) argument that interpretive research requires evaluation but only through appropriate criterion measures.

Whereas correspondence theory of truth provides relevant criterion measures for quantitative research (Bernstein, 1983; Schultz & Meleis, 1988) the most congruent criterion measures for

qualitative research reside within coherence theory of truth (Koch, 1993; Sandelowski, 1991). Coherence theory of truth is founded on the premise that internal consistency and the relationship of the parts to the whole produces a parsimonious, coherent and aesthetic outcome. In extrapolating these notions to the development of research criteria I am suggesting that consistency needs to occur in the relationship between the parts and the whole of the research. In other words, there will be a coherent and aesthetic unity in the research from its conceptualisation to conduct. For example, when hermeneutic philosophy underpins the research as a whole, then the methodology and method, as the parts, must be internally consistent with the philosophy. I attempted to achieve such unity by developing methods of interviewing and interpretation consistent with the work of Gadamer (1979) and Ricoeur (1976a, 1981a) and by addressing preunderstandings within each section of the work. However, the main criterion I strove to achieve was "transparency." Transparency requires research to be visible in its completeness thereby providing readers with opportunities to examine and evaluate it. In an attempt to achieve transparency I documented processes through which readers could determine whether I met the subcriteria of: (1) acceptability, (2) consistency, (3) enhancability, (4) adequacy, and (5) expandability. In developing these subcriteria I have drawn on the work of Guba (1981), Guba and Lincoln (1981, 1982) and Lincoln and Guba (1985).

6.28 (1) Acceptability: the research was contextually ethical and relevant.

Ten sections entitled: Background to the Study, Significance of the Research, Research Question, Methodology, Ethical Considerations, The Study Context, Participants, The Nurses, The Young People, Information Gathering Processes, and Appendices D and E, address this criterion.

6.29 (2) Consistency: there was internal unity and coherence in the relationship between philosophy, methodology and method.

Eight sections entitled: Sociopolitical Context of the Research, Philosophy of Methodology: Hermeneutics, Working out my Forestructures in Terms of 'The Things Themselves', Bringing my Preunderstandings to Consciousness, Preunderstandings Developed from this Section, Method: Explicating Practice Knowledge, Hermeneutic Interviewing, Hermeneutic Interpretation, and Appendices A, B, C, D, E and F, address this criterion.

6.30 (3) Enhancability: appropriate strategies were used to reflect upon and optimise the conduct of the research.

Five sections entitled: Working out my Forestructures in Terms of 'The Things Themselves', Bringing my Preunderstandings to Consciousness, Preunderstandings Developed from this Section, Interview Feedback, Hermeneutic Interviewing, and Appendices A and B, address this criterion.

6.31 (4) Adequacy: research methods, such as interviewing and interpretation, were competently conceptualised and performed.

Five sections entitled: Hermeneutic Interviewing, Hermeneutic Interpretation, Information Gathering Processes, The Young People's Stories, The Nurse's Stories, and Appendices C, D, E, F, G and H, address this criterion.

6.32 (5) Expandability: the research is sufficiently detailed and descriptive to allow other researchers to use its method and explore its findings.

Eight sections entitled: Introduction, Practice Knowledge: Adolescent Mental Health Nursing, Adolescent Mental Health Nursing: A Literature Review, Method: Explicating Practice Knowledge, The Young People's Stories, The Nurse's Stories, The Practice Knowledge of Adolescent Mental Health Nursing - New Horizons, Conclusion, and Appendices C, D, E, F, G and H, address this criterion.

In this way, the criterion of transparency and the subcriteria of acceptability, consistency, enhancability, adequacy and expandability provide guidelines through which I and others can review and evaluate the research processes and outcomes.

In the following section, I discuss ethical issues of particular relevance to the study. Areas under discussion include the ethics application, informed consent, empowerment and autonomy, confidentiality and anonymity, potential adverse effects and security of information.

Ethical Considerations

In October 1994 the Research Ethics Committee of the Australian Catholic University (NSW Division) approved the protocol for the study. The application submitted to the committee followed National Health and Medical Research Council guidelines and included:

* formal application outlining participants, recruitment, study location, external approval, research procedures, benefits to participants and humanity, data recording and security, dissemination of results, and ethical issues related to informed consent, confidentiality, interviewing, audiotaping and potential adverse effects to participants; as well as
* general information regarding the research;
* examples of the information letter and package, consent form and covering letter;
* examples of the questionnaire and survey forms; and
* specific information about each of the six research steps.

6.33 Contextual Ethical Issues

Taking into consideration the nature of the study particular attention was given to the ethical issues of: (1) informed consent, (2) empowerment and autonomy, (3) confidentiality and anonymity, (4) potential adverse effects, and (5) security of information.

6.34 (1) Informed Consent

After receiving written approval to conduct the research, I telephoned prospective participants to inform them of the study and seek their permission to send an information package (see

Appendix D). It was important to send this package as it provided people with an understanding of their participation in the research and a foundation from which they could ask questions and seek information. I hoped the information would also allow participants to give informed consent although I acknowledge that the indeterminate nature of unstructured, research interviews makes such consent imprecise (Ramos, 1989). A copy of the consent form was included for the participant's perusal. The package was the same one submitted to the ethics committee with minor amendments to improve wording. I did not contact participants until several weeks elapsed following their receipt of the information package thereby giving them time to consider their response.

6.35 (2) Empowerment and Autonomy

I tried to achieve this by:

* providing participants with detailed information so that they had a good understanding of the research and their involvement in it,

* presenting information and structuring research processes in ways that acknowledged and valued the participants' contributions,

* providing information about an avenue for complaint,

* highlighting the right of participants to terminate interviews or their involvement in the research,

* continually seeking feedback and contributions and maintaining regular contact to share developments and keep people informed.

6.36 (3) Confidentiality and Anonymity

In order to enhance confidentiality participants chose a pseudonym by which to be known. Only I know the relationship between the real person, the pseudonym and the information they provided. The research setting was withheld due to the limited number of such settings in the state of NSW and details regarding the age of participants and the year they nursed, or were nursed, on

adolescent units were withheld for the same reason. While confidentiality was a reasonable aim within the context of the study anonymity was not possible. This is because I know all the participants and the information they provided. I use this definition of anonymity in keeping with that outlined by Jackson (1986, p. 37).

6.37 (4) Potential Adverse Effects on Participants

In speaking about past lived experience it was possible for people to become distressed about aspects of that experience, especially if it had been traumatic. In order to reduce this eventuality participants chose the experiences about which they would speak. Nevertheless, it was important to be prepared for possible distress by being sensitive to the impact of awakening disturbing memories and by being respectful of people's wishes not to discuss or explore certain topics. In addition, there was a need to be skilled at working with distress and deciding when to terminate the interview and deal with issues that had arisen. As a mental health nurse I felt I had those skills but I nevertheless engaged in a series of role training sessions in order to review and enhance my skills. I also had a list of names and telephone contacts for counselling services should further intervention be required. On the whole, participants enjoyed their involvement in the research. Even so, one young person experienced adverse effects because speaking about the past awoke traumatic memories from that time in her life. This distress was not immediately apparent nor acute rather it was distress resulting from remembering what she had tried, or was still trying, to forget. Until those feelings subsided I maintained regular contact. She was also able to contact me and on a few occasions she chose to do so. Several weeks later she felt the experience was resolving so contact became increasingly irregular. My intervention at this time, was in keeping with Fox's (1976)

suggestion that researchers should be willing to do whatever is necessary to remedy distress experienced by participants as a result of reliving the past for the purposes of research. Further, it allowed me to maintain the integrity of my self in my role as researcher, that is, it allowed me to take my therapeutic nurse/self into my role as researcher (Wilde, 1992) and therefore to be myself.

6.38 (5) Security of Information

Information provided by participants was recorded and stored on audiocassette, in writing and on computer disk. All interview transcripts were edited to remove identifying features, such as, time, person or place. The audiotaped interviews will be erased following completion of the research as it is impossible to remove all mention of participants, and others, without excessive loss of information and meaning. Originally, a coding system was used to cross reference the information that each participant provided but this system was destroyed following my mastery of it. Thus, no information can be traced to an individual. I am the only person with access to the participant's information which is stored in a locked filing cabinet.

Of the people invited to participate in the study only one declined to do so. All the participants completed their involvement in the research except one nurse whose sudden and unexpected death occurred in the second year. As his contribution was incomplete it was excluded from the research but he and his contribution were greatly missed. At a later stage, another nurse was approached and agreed to be involved.

In this chapter, I outlined the conceptualisation and conduct of the research. Particular attention was paid to the notions of hermeneutic interviewing and hermeneutic interpretation as these were the primary methods of information gathering and processing.

Emphasis was also placed on the use of hermeneutics as methodology, on ethical considerations and on criteria by which the research could be evaluated. In the following two chapters, entitled "The Young People's Stories" and "The Nurse's Stories", I present and discuss the research findings. Prior to doing this, in a "Preamble to the Research Findings" at the beginning of the chapter dealing with the young people's stories, I provide an overview to the findings and to their development.

Chapter Seven

Preamble to the Research Findings

Through this study, I sought to explicate the knowledge informing nursing practice on residential adolescent mental health units. This knowledge was conceptualised as practice knowledge. Practice knowledge was developed from the nurse's and young people's information and conceptualised as sub-elements, elements and a meta-element. Individually and collectively, these elements describe the knowledge nurses used in their work with adolescents within the context of the study, and they were developed through three levels of interpretation. At the first level of interpretation I developed and defined the sub-elements of practice knowledge. A "sub-element of practice knowledge" refers to an individual unit of knowledge. Examples of sub-elements include: (1) nurses are flexible, and (2) feeling safe and secure. Fifty five sub-elements were identified from the information provided by the young people and 80 from the information provided by the nurses. Of the sub-elements identified, 41 were identical and four were the opposite of a common sub-element, for example, "setting limits" and "failing to set limits." Accordingly, 10 sub-elements were unique to the young people and 35 to the nurses.

At the second level of interpretation I developed and defined the elements of practice knowledge. An "element of practice knowledge" is a group of sub-elements with shared meanings. For example, the element entitled "guiding the potential for change" is composed of the following eight sub-elements of practice knowledge: (1) nurses negotiate consequences, (2) becoming hopeful, (3) nurses encourage independence and responsibility, (4) making sense of things, (5) getting on with life, (6) feeling in

control, (7) nurses try to create change, and (8) nurses are role models. Through this process, four elements of practice knowledge were developed from the young people's sub-elements and four from the nurse's sub-elements.

At the third level of interpretation, I examined the sub-elements and elements then developed and defined the "meta-element of practice knowledge." One meta-element was developed and it describes the aim and outcomes of adolescent mental health nursing through use of the sub-elements and elements in practice. In this way, the findings were developed through a shifting focus from the specific to the broad, that is, through development and definition of the sub-elements, elements and meta-element of practice knowledge. At this point, I hermeneutically conceptualised the practice knowledge of adolescent mental health nursing and this conceptualisation is diagrammatically represented in the following way:

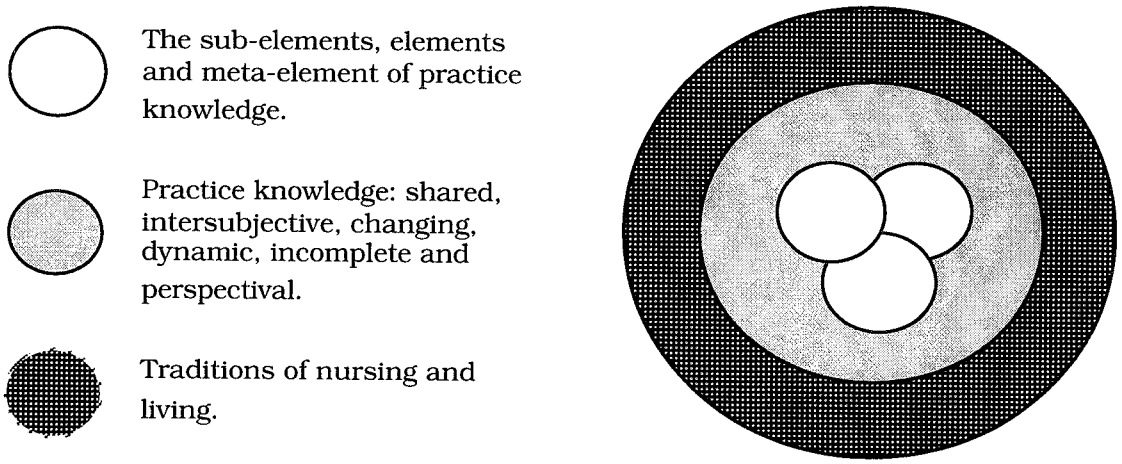

Figure 7.1: Adolescent Mental Health Nursing Practice Knowledge: demonstrating the interrelationship between the research findings and hermeneutic conceptualisations of tradition and knowledge.

7 The Young People's Stories

7.01 Introduction

Written and oral information received from the seven young people provided the text for interpretation. Interpretation was conducted on three levels. At the first level of interpretation, I identified the sub-elements of practice knowledge from each young person's information (see Appendix F, pp. 314-322) resulting in the identification of 55 sub-elements. I then defined the sub-elements. This part of the work is presented in the section entitled "Level one interpretation: the sub-elements of practice knowledge." The second level of interpretation involved grouping the sub-elements of practice knowledge with shared meanings into elements of practice knowledge. Four elements of practice knowledge were developed from the 55 sub-elements. I then proceeded to define the elements by examining the individual sub-elements of which each element was composed. This part of the work is presented in the section entitled "Level two interpretation: the elements of practice knowledge." At the third level of interpretation, I examined my definitions of the elements and sub-elements in order to develop the meta-element of practice knowledge. One meta-element was developed and defined and this part of the work appears in the section entitled "Level three interpretation: the meta-element of practice knowledge." At all levels of interpretation I made decisions regarding competing interpretations, the naming of elements, and the selection of excerpts through which to provide support for my decisions. In the following section, I provide a brief example of the interpretive decision making process I confronted and engaged in.

7.02 Interpretive Decision Making

Because there are multiple meanings within a text, interpreters are required to make choices about competing interpretations. In

the final analysis, interpretive decisions are accounted for by the meanings developed from a text and by the names used to describe those meanings. I most often named sub-elements by using the words participants used themselves. In the following example, for instance, I chose three possible names for the sub-element including: (1) providing encouragement, (2) giving positive feedback, and (3) highlighting difference and change.

> *You'll be encouraging ... giving positive feedback [about] how they were getting on with the other adolescents, how they were able to participate and their level of achievement in what they were doing ... if that was something new they weren't able to do before ... [highlighting] changes where kids have moved on from behaviours or how they related to other adolescents ... [you might say] "Jonothan, last week when you came here it was really difficult for you ... this week you and Tony are playing well together and planning the next game, that's a real difference to what happened last week and it's great." Highlighting where they've come from initially will add more weight to positive feedback.*

I chose to name this sub-element "highlighting difference and change" because I saw this meaning as more significant than the alternatives. This occurred because I decided the act of highlighting difference and change would inherently contain aspects of positive feedback and encouragement while giving encouragement and providing positive feedback would not necessarily highlight difference and change. On the other hand, another interpreter may have chosen the name encouragement or positive feedback, they may have given this excerpt three meanings instead of one, or they may have found other more significant meanings in the text. With regard to interpretive decision making we should remember that interpretive understanding is plural, dynamic, incomplete and changing. Multiple interpretations can do justice to a text and interpretation is always perspectival. Moreover,

the work documented in this thesis, and in the appendices, represents a small part of the information provided by the research participants therefore all interpretive decisions cannot be demonstrated or supported even if one accepts, that is, that such a process is either desirable or possible.

In the work that follows, I define the 55 sub-elements of practice knowledge. Throughout the process of definition I attempt, on the one hand, to define the sub-elements and, on the other hand, to describe what their use in practice either allows or disallows. While textual excerpts are provided with each definition, consideration of the thesis length allows the use of only one excerpt with each sub-element. Under these circumstances, there are instances where the excerpt used with a definition is not wholly representative of that definition. In such instances, a review of the summary of sub-elements (Appendix G) may assist the reader to better understand those definitions. Nevertheless, while the summary in the appendix may be helpful, it does not represent all the examples of the sub-elements in the text. This is because some examples are only a few words long, or they form part of another sub-element, or they are interwoven over a large part of a text.

The sub-elements of practice knowledge represent therapeutic and untherapeutic experiences. For example, the sub-element "experiencing containment" demonstrates a therapeutic experience while the sub-element "experiencing a lack of containment" demonstrates an untherapeutic experience. While nursing practice is focused toward a therapeutic end, the inclusion of examples where this does not occur allows understanding by highlighting difference. In recognising the untherapeutic it is possible to come to understand the therapeutic and vice versa. Finally, it is important to note that as I am attempting to explicate the practice

knowledge of nursing, my definitions of the sub-elements are oriented toward nurses and nursing.

In the following section, the sub-elements are presented in a table and defined in order of their frequency of occurrence. In this regard, I begin with the sub-elements identified in one young person's text and finish with those identified in all seven.

7.03 Level One Interpretation: the Sub-Elements of Practice Knowledge

In the following table, the 13 sub-elements of practice knowledge identified in one adolescent's text are presented.

Table 7.1: Sub-Elements Identified in One Adolescent's Text

Experiencing a lack of containment	A helpful and caring environment	A protective environment
Being pressured	Feeling blamed	Having your own space
Experiencing concern	Receiving individualised care	Nurses are flexible
Nurses encourage independence and responsibility	Nurses negotiate consequences	Nurses discipline through relationships
Experiencing attachment		

Experiencing a lack of containment: refers to the nurse's inability to contain out of control feelings in the adolescent and thereby to prevent acting out or self harming behaviour and a devaluing of self.

> *Tricia would come up and see me at the punching bag, [I was] trying to take my frustration out that way. She would turn up ... and she would see that I was angry ... and show her feelings. She used to always show that she was scared of me and that used to get me the most ... it's not a nice feeling to have, for fear to be in somebody's eyes when you're looking at them ... I felt like hurting myself.*
>
> *I started to over react ... I knew Tricia couldn't deal with it, she didn't really know how to talk to me, she was all right when I did have a problem and I wasn't*

uptight but as soon as I was really uptight she showed that she wasn't in control ... I smoked a lot more and I didn't sleep very much and I didn't go to school and I think I got more violent, definitely.

A helpful and caring environment: refers to a milieu characterised by caring and helping through which adolescents are provided with a contrast to their experiences of violence and to feelings of facing difficulties alone.

Even though the residents were predominantly male the atmosphere was predominantly female ... that effects you ... the masculine's like "this is something hard you have to go through and you'll get over it" [whereas] the feminine thing is "this is something hard you have to go through, I'll help you as much as I can" ... so many kids are coming from such violence and then having something ... almost so opposite to that is good, just to get the balance ... there wasn't the power aspect, that went and the more caring one came through.

A protective environment: refers to a milieu which sets up the opportunity for healing by providing adolescents with protection from influences which harm and intimidate.

You've entered into the unit with some sort of wound and straight away you're protected from outside influences ... and intimidation, just because you're with nurses who don't do that ... It was protection from harm, healing requires that ... I mean you can't heal without protection.

Being pressured: refers to the nurse's inability to discern and respect the adolescent's desire for choice over the disclosure of information and the development of relationships.

Sandra would come into my room ... and [say] "what's bothering you?" and really push me to talk, it would be "why don't you tell me?" ... She really pushed me to know what was going on in my life ... the more you push somebody to talk the more they're gonna close up. Katherine might've come and said "what's up today?" but if I didn't want her to [know] that was fine. With Sandra ... if I said I didn't want to talk about it, it was "but why won't you talk to me, why can't you talk to me?" If you said to Katherine "I don't want to talk about it she'd just say "okay, well when you're ready come and talk." Most of the time, five minutes later, I would go

and talk to her.

Feeling blamed: refers to the nurse's inability to justly determine the circumstances of an event as a result of which the adolescent experiences feelings of hurt and blame.

> *[Kieran] started screaming at me ... and went berserk and tore all the pictures off his wall. I remember the nurses coming in [saying] "what did you do to him Elizabeth, what have you done?" and it's like "I haven't done anything!" ... I just felt like the nurses [blamed] me ... I remember being really upset ... like I was to blame for it all.*

Having your own space: refers to the nurse's ability to provide the adolescent with a space of their own where they can be themself, find privacy and solitude and express their individuality.

> *You had your own bedroom, it was your own space, you could go in there and slam your door and [it meant] keep out kind of thing, it was your own private space ... it wasn't like you had everyone trampling through there, it was ours, the inpatients. It was your own space ... we painted pictures and we put pictures on the wall.*

Experiencing concern: refers to the nurse's ability to verbally and behaviourally demonstrate concern for the adolescent in a way that allows the adolescent to experience that concern as genuine.

> *You could see their concern was for real, like I still remember them [saying] "where were you all? we were so worried" and like staying back ... they also had families to get back to and other things to do but they stayed back ... it wasn't like "oh, it's 6 o'clock in the morning and my shift ended at 6 [so] it's your problem now" ... they stayed back and it was good.*

Receiving individualised care: refers to the nurse's ability to provide a fundamental sameness in the care of all adolescents while recognising their unique individual needs and paying attention to them in order to maximise nursing care.

> *Well they did treat you different but the same as well ... we weren't all treated exactly the same ... it showed that they paid attention because they'd know not to treat everyone the same and what worked for one wouldn't work for others. Like an individual.*

Nurses are flexible: refers to the nurse's ability to provide a sense of freedom within the environment through a flexible approach to the routines of daily living.

> *I don't like it being too rigid but it was fairly flexible ... you don't want to seem like you're in gaol or something really rigid, like it was pretty flexible. Like we had to do our laundry every day but it's not like "you have to do it at 8 o'clock", it's like, "you have to do the laundry today but when it fits in with you." I like things like that.*

Nurses encourage independence and responsibility: refers to the nurse's ability to allow the adolescent to learn behavioural autonomy while offering assistance and being available if required.

> *You did your washing ... the showering and looking after our own rooms ... it was up to us to get ourselves to breakfast, to look after our clothes and do our homework. I remember the nurses always offered us help if we wanted it, like if we wanted help it was there but they would let you be independent, let you do things on your own.*

Nurses negotiate consequences: refers to the nurse's ability to foster personal autonomy by engaging adolescents in discussions and decisions about discipline and consequences.

> *Whenever I was given punishment it was always fully explained to me why and I was always given options, and that was quite a different experience, someone saying to me "you can either have this, this or this", like I might have a loss of privileges or I might want to do something [else]. It was hard to choose ... I think a lot of it was being fair ... like did I think the punishment fitted the crime, like what I'd done, so I was given options.*

Nurses discipline through relationships: refers to the nurse's ability to develop effective relationships through which they have the power to discipline adolescents, and to their ability to modify approaches to discipline in order to obtain cooperation from adolescents while that relationship is being developed.

> *In the beginning, if they'd have tried to discipline me in the way they did in the end I probably would have taken off or reacted in a different way, but because I had grown quite used to them ... and we had such a good*

relationship, they could discipline me ... and even though I hated it I could handle it a lot better. Like their approach to things was different in the beginning but as time went by and I did things they could discipline me.

Experiencing attachment: refers to the nurse's ability to foster a close, continuing relationship through which the adolescent experiences connectedness and fondness.

I got quite fond of quite a few of them ... I became very attached to some of the nurses ... when I look back Beth was the one I was attached to most ... after I left I still had a lot to do with her.

In the following table, the 14 sub-elements of practice knowledge identified in two adolescent's texts are presented.

Table 7.1: Sub-Elements Identified in Two Adolescent's Texts

Working through issues in groups	An open and accepting environment	Experiencing a lack of concern
Making sense of things	Getting on with life	The people and the place
Experiencing the loss of trust	Specialist nurses	Nurses take time and make time
Testing nurses	Working in partnership	Mismatched adolescent/primary nurse relationships
Feeling in control	Being neutral	

Working through issues in groups: refers to the process of sharing distressing experiences and dealing with problems in a comfortable, open and accepting environment in order to facilitate disclosure, provide support and work toward resolving issues.

I remember being in the bean bag room ... and talking, they were pretty good sessions ... it was good, comfortable, we used to relate ... sometimes it got a bit awkward when someone was really angry or upset ... most of the time it was fine. We had sessions in the mornings ... they were great because if we had a problem with anyone we were associating with, in the

> *school or in the lunch hour or within the groups, we could bring that to a head and generally the problem is solved.*

An open and accepting environment: refers to an encouraging and accepting milieu in which adolescents can set aside feelings of vulnerability to speak in safety about their deepest concerns.

> *It was a pretty open and accepting environment, you didn't have to put on a front, you could be yourself. You could sit down with a nurse and talk about how you felt about things ... it was just a natural thing to do ... when you step into a situation like that ... it's easy to become that way yourself ... it was the environment set up by the nurses I guess and that's the feelings that were going around.*

Experiencing a lack of concern: refers to the nurse's inability to demonstrate understanding and provide comfort in order to relieve the adolescent's feelings of abandonment, fear or distress.

> *They took me to the casualty department and fixed my wrist up then the doctor came and said I had to go to this psychiatric hospital and the nurse just left me ... she just left me there ... She could've been nicer and understanding to me, she could've explained what was going to happen ... If she'd been nicer and explained to me ... [I'd have known] somebody cared and I wasn't just being chucked in there, cause that's how I felt, I felt they were putting me in there to get rid of me so they didn't have to bother with me.*

Making sense of things: refers to the nurse's ability to assist adolescents to think through and clarify issues, and to solve problems, in order to foster understanding and relieve tension.

> *Robyn sort of settles you down, doesn't let the feelings get in the way. She made me think more than act, not like "how do you feel?" but just "tell me what's going on and then I'll see if I can sort it out" and sort of like "well, is it this?", "why are you feeling like this?" or "does this happen because of that?", more than saying "tell me how you feel."*

Getting on with life: refers to the nurse's ability to help the adolescent construct a different perception of self in order to look beyond the past, live in the present and plan for the future.

> *The nurses focused on the positive side, you know, what you're hoping for, what you're aiming at and how you're going to go about it. It's not just you as the victim or you as the bad bugger, it's like you have another side not just the victim ... it's your hopes, your dreams, what you're doing on the weekend, it's getting on with life.*

The people and the place: refers to the combined healing power of the nurses, who were available and willing to engage with adolescents, and the physical space which was open, natural and unrestricted.

> *It was the whole place, it was big and open, there was nothing around it ... it was airy, it was a comfortable place ... there were fields at the back [and] you'd lie down on the hill ... it was peaceful all the time ... The nurses were with it, that was the thing, they were there, the two were together. It was grass and space and people who were quite prepared to talk to you whenever you wanted ... it's a great atmosphere for healing.*

Experiencing the loss of trust: refers to a breach of trust by the nurse which reflects prior trauma experienced by the adolescent and leads to a rupture in the nurse-adolescent relationship. This occurs because the adolescent feels hurt and betrayed, experiences doubts, and questions the nurse's trustworthiness.

> *After the lecture about food nutrition we went to the unit to get our costumes to go swimming ... she said "no, it's too late now you can't go", we were all pretty pissed off about that. We're there because people betrayed us and here we have someone who we're supposed to trust who bribed us with an out and out lie. We said to her "you promised and that was the deal" and she said "no, no, it's too late now you can't, another time." Well, there's not gonna be another time, you're not gonna trust her again are you?*

Specialist nurses: refers to the way adolescent mental health nurses use their particular knowledge and skills to relieve the pain of emotional disturbance and provide effective care.

> *I wasn't in with [specialist] nurses ... I was with normal, everyday nurses who work in hospitals, they didn't know how to handle me, they just went about their job and it wasn't a happy experience ... when they told me*

> *I was going to the [adolescent] unit and they tried to explain it was like "oh, no!" ... being part of a hospital and having nurses looking after me I thought it would be the same so I went into it thinking "it's going to be bad from the start" and it just wasn't like that.*

Nurses take time and make time: refers to the preparedness of nurses to spend time with adolescents, and put them before tasks, in order that the adolescent feels cared for, acknowledged and valued.

> *Whatever the nurses were doing ... they could come back to later and didn't mind doing that ... and they sort of let you know that. Like if someone's doing a report or something like that and I came up it was usually put the report down and "what do you want to do?" That was really good, having someone who was prepared to put aside work to talk to me, that's a boost to your self confidence at least.*

Testing nurses: refers to the way adolescents test and judge the nurse's ability to respond with neutrality to challenging behaviours and remain engaged with them despite continual testing.

> *We did quite naughty things to see what limit you could push them to and see how they responded ... I think that's how I judged them, on how they responded to the stupid things I did, how they handled certain situations ... if I did something stupid and they were to get angry with me I would stay away from them ... it was just to get a reaction, to see how they would react to me, just to test them.*

Working in partnership: refers to the nurse's ability to unite with adolescents and parents in a supportive way in order to deal with the problems adolescents are experiencing.

> *It wasn't that the kids were to be conquered it was the problems of the kids that were to be conquered, but the problems were to be conquered by everyone ... you weren't there struggling to keep your head above water, you had a couple of nurses beside you who were pushing you up as well.*

Mismatched adolescent and primary nurse relationships: refers to the need to reallocate nurses and adolescents if they are unable to work together effectively in the primary nurse-adolescent

relationship.

> *I was allocated two nurses, Tania and Sylvia, I don't know whether it was because of being paranoid or not getting along with them [but] I preferred not to have anything to do with them. I made friends eventually with the male nurse James. They were both feminine women and I felt uncomfortable with them ... all my life my closest friends were blokes so I got along with blokes more than I do with females, so it was uncomfortable for me to talk with them.*

Feeling in control: refers to the nurse's ability to encourage, rather than force change and cooperation, so that adolescents develop a sense of mastery over events occurring in their lives.

> *The control was placed in my hands. Most of us are there because someone has taken control and abused that and we're paying for it ... to feel that you have some control in your life is utmost important ... with James not pushing and giving me control I [could] see he was a genuine person. He would give you the feel that you've got the reins, that you're in control ... he encouraged you ... he guided you, he never drove you.*

Being neutral: refers to the nurse's ability to respond with neutrality to the adolescent's angry and challenging behaviour. In doing this, nurses provide a safe, accepting and supportive environment.

> *I remember fighting with them every now and then, you know, usually because I didn't like authority, that was the only thing but they were never, never rude or anything like that, never nasty ... [I] was very angry and just took it out on them but they responded pretty well all the time, I was never abused, like yelled at or anything, they always had a really good approach, always some good way to handle it.*

In the following table, the 11 sub-elements of practice knowledge identified in three adolescent's texts are presented.

Table 7.3: Sub-Elements Identified in Three Adolescent's Texts

Inappropriate admission to child or adult units	Having attention	The unit was homelike
Feeling normal	Having fun	Nurses are seen as family

Nurses persevered	Experiencing mutuality	The nurses were there
Feeling safe and secure	Experiencing containment	

Inappropriate admission to adult or child units: refers to the need for adolescents to be cared for in adolescent specific facilities where they are less susceptible to exploitation, less likely to feel afraid and where nurses have developed expertise in working with them.

> *Once I got there it was 50 times worse than what I expected. It was just crazy people, about 100 crazy people shoved into a big room. The whole time I was there I just sat in the corner, I didn't talk to anybody, I wouldn't even talk to the staff at the psychiatric hospital.*

Having attention: refers to the nurse's ability to be interested in the adolescent and to provide them with attention in order that they experience that attention as a reflection of their worthiness.

> *You were never short of attention, there was always someone there to give their full attention to you. I used to look forward to it ... [you're] not forgotten about. They were there for you ... it was good, you felt kind of important because they were there to find out how you feel and they were interested.*

The unit was homelike: refers to the comfort and familiarity of a nonhospital and nonclinical environment where adolescents feel at home and are able to be themselves.

> *It wasn't so much a hospital set up, it was quite comforting I suppose in a way, it looked a bit homey to go into ... the environment being a homey set up with a pool and everything ... right away you related to your family home or something similar ... in a sense it's comforting like that ... the best thing was just that home environment, that home sort of set up.*

Feeling normal: refers to the nurse's ability to enhance the adolescent's feelings of self worth and well being by accepting their problems and behaviours as contextually reasonable and by assisting

adolescents to see them the same way.

> *It was good because they gave you time to cool down and knew that it was something you had to do. If you went off like that in a psychiatric hospital they'd give you a needle to put you to sleep for a few hours, whereas [on the unit] they knew you had to get it out of you. They let you do what you had to do, oh it's hard to explain, they let you be angry, they let you cry, they let you do whatever without putting a psychiatric illness to it ... they knew that it was normal.*

Having fun: refers to the way nurses participate in activities with adolescents in order to create a lighthearted atmosphere through which they take the focus off the adolescent's problems.

> *Beth always came on the trampoline with me, so did Simon, so did Edward ... they used to always want to do fun things, it wasn't like you had to ask them, they were always there ready to do fun things. It wasn't just based around [problems], when they were there they weren't always just focused on problems ... it was like we'd have fun, we'd go for bike rides ... it wasn't like we're going in for a therapy session, or we're going in there to have a big talk, we're just going to have some fun.*

Nurses are seen as family: refers to the nurse's ability to develop a close, communal relationship with the adolescent and through which the adolescent experiences the nurse as a sister, brother or family member.

> *I had grown quite used to them and it was in a way kind of like a family, you know, you see them all the time and we had such a good relationship.*

The nurses persevered: refers to the nurse's ability to accept challenging, rejecting and disturbed behaviour while continuing to encourage adolescents so they come to believe the nurse will always be there for them.

> *Even when I was hiding the nurses would come and find me and ask if I'd want to join them, and in the beginning I always refused but they never gave up, and they always gave me the opportunity if I wanted to join them ... The fact that they didn't push me or drag me out of there meant I didn't feel threatened. It was very important, they always made me feel they wanted me to be part of the group but when I was ready.*

Experiencing mutuality: refers to the way the nurse shares personal information with adolescents so they perceive the nurse's humanity and encounter mutuality in relating to them.

> *They'd tell you about their lives and when they'd felt bad and I really liked that, they were very human, acted human ... I remember lots of them telling me things that weren't so great for them, especially when you're feeling really sorry for yourself, they'd say "well everyone has bad things happen to them and things that they don't like" and they'd tell you some, it was good.*

The nurses were there: refers to the way the nurse's presence and preparedness to be there for, and with, adolescents provides comfort and companionship and engenders feelings of togetherness.

> *Robyn seemed to be there when I needed her ... [with] Tricia I had to go look for her ... I don't think Robyn spent anymore time [with me] but she just seemed to be there when I [needed her]. I told Robyn and I told Tricia that the main time I was upset was before I went to bed and after [therapy] sessions and Robyn seemed to be there at those times ... A lot of times Tricia was busy talking to somebody else or doing paper work or going to a meeting or something like that and that would make me build up more ... With Robyn when I had something to say she was there, if I just wanted to walk around she was there ... she just seemed to be there at the right times and say the right things and be able to work it out the right way.*

Feeling safe and secure: refers to the way a sensitive, predictable, safe and moral environment provides a sanctuary for adolescents and opportunities for change.

> *When I was on the unit I felt safe, like he [my dad] couldn't get to me, I was safe and nobody could hurt me there and that's exactly how the unit felt. He told me that it happened everywhere and so I figured no one was going to stop him if it was such a normal thing. On the unit they knew that it was wrong and it's the first place I've ever been where they knew that kind of thing was wrong ... just being safe and all that stuff it means heaps.*

Experiencing containment: refers to the nurse's ability to deal with escalating feelings in a calm, neutral and accepting way, and to provide anger reduction strategies through which adolescents

experience decreased anxiety and tension and an increased sense of control and well being.

> *After the meetings with [my therapist] Richard ... like [I talked] about actual events and what they did and everything so of course that's going to upset me ... But when I talked to Robyn it was all right in an hour or two, I was all right and I was calmed down and there was nothing wrong. What Robyn would do [was], we used to walk around really slowly and talk and she used to say "you don't have to rush it, you can just talk slowly and we'll walk slowly and just keep talking and when you want to stop we'll stop and if you want to keep walking we'll keep walking."*

In the following table, the seven sub-elements of practice knowledge identified in four adolescent's texts are presented.

Table 7.4: Sub-Elements Identified in Four Adolescent's Texts

The pressure was taken off	The peer group is supportive	Nurses are role models
Receiving understanding	Becoming hopeful	It's more than a job
Experiencing loss through termination and separation		

The pressure was taken off: refers to the light, unhurried, patient and accepting environment created by nurses, in which adolescents feel a sense of ease and a decreased need to get well quickly.

> *They were very patient ... there was no hurry, may be no hurry to get better ... I didn't need a quick fix ... the nurses just went along and were open to what you had to do or what you had to say or what you were going through, [I] didn't feel rushed or pressured.*

The peer group is supportive: refers to the way nurses foster a therapeutic peer group which provides adolescents with a sense of belonging, friendship, acceptance, community and hope.

> *There were a few that were fairly quiet and seemed on their own the same as I ... you tend to home in on them and make friends with them so you felt you weren't the odd one out or you didn't feel alone. There was someone there who you could talk to around your own*

age and who's been through something similar so you have that bond.

Nurses are role models: refers to the nurse's ability to provide adolescents with examples of new ways of thinking, feeling and behaving in order to assist them to develop different and positive representations of adulthood.

I've just been given such a strong masculine thing straight along and all of a sudden there was this other thing that I'd never felt or experienced before, that men aren't all [the same], don't all have to be super strong [they] don't have to be like that. That was an opening. I was around 14 or 15 ... it was a good experience at the right time.

Receiving understanding: refers to the nurse's ability to deal with challenging and disturbed behaviour in a neutral and accepting way so that adolescents feel comforted and permitted to exhibit their distress which, in turn, allows the nurse to identify areas for therapeutic work.

I don't think I realised how good I had it on the unit until I left ... how good it was and how understanding nurses were. Katherine would give me time to calm down ... She'd give me time to do what I had to do whether it's swear or punch a wall and then she'd talk to me once that was over. She didn't go off at me about losing my temper ... with her it's something that's happened, it wasn't a big deal.

Becoming hopeful: refers to the nurse's ability to assist adolescents to develop hope in their capacity for change by sharing personal and professional anecdotes of success and by helping adolescents to believe in the unit and nurses.

When you know someone else has been through the same and they've succeeded in changing or getting somewhere it's not an excuse to stay the way you are, you can still get on with life no matter how bad your problems are, [when] nurses can do it ... [it gives you] hope, everyone needs a little bit of hope.

It's more than a job: refers to the way the nurse's committed and enthusiastic approach to their work, and enthusiasm in it, leads adolescents to believe they choose and prefer the work they do.

> *They could well have been nurses ... in a hospital treating other people in a completely different environment, they didn't have to do the youth work they were doing ... they were there because they chose to be ... They gave their time towards [youth work], I mean, they could well have been working somewhere else, they gave sacrifices.*

Experiencing loss through termination and separation: refers to the sadness, fear, abandonment and distress the adolescent experiences at discharge, despite foreknowledge of the event, through their loss of a familiar environment and significant attachments. It emphasises the need for gradual and agreed separation from people and place.

> *That was the hardest thing, when it came time to leave, cause at the time I honestly didn't think I was going to make it ... To a certain extent I felt a bit deserted, like intellectually I knew why I couldn't stay but emotionally it was just hard to deal with. It's not just one friendship that you're ending it's relationships with ... the kids and the nurses and you've got the change of physical environment as well. It's almost like your life as you knew it is ending and you're starting from scratch again ... it's very traumatic making such a sudden change.*

In the following table, the three sub-elements of practice knowledge identified in five adolescent's texts are presented.

Table 7.5: Sub-Elements Identified in Five Adolescent's Texts

The distress of therapy	Relating to nurses	Developing trust

The distress of therapy: refers to the hostile and negative perceptions adolescent's held about formal therapy and the trauma and distress they experienced due to difficulties relating to therapists, the focus on past problems, and a lack of trust through infrequent contact and poor relationships.

> *I don't think the fact that it's called therapy necessarily means you're finding it therapeutic ... I don't think it was beneficial at all ... It's very confrontational, you almost feel like you're going in there for a fight ... it's as though it's forced on you. I found that I wasn't comfortable speaking with the therapist ... so it was never really going to work ... It's not something you look forward to and then coming away from it you feel really*

depressed ... it wasn't positive, it was all very negative.

Relating to nurses: refers to the way nurses relate to adolescents in order that therapeutic work can occur. Nurses use common interests, their disposition, shared personal conversation and the lack of a perceived professional role or jargon to enhance relating.

> *Some people you talk to, you want to open up more to than others ... just the warmth ... you can feel like a concern or a warmth and a bit of that caring thing ... I remember Erin had a smile, like she had a good laugh, that's sort of warm too ... it's just Erin's disposition [and] I think you can see when someone's with you and concerned for you ... being with you.*

Developing trust: refers to the nurse's ability to spend time with the adolescent and work slowly toward building a comfortable, helping relationship with them so the adolescent feels the nurse can be relied upon to remain engaged and to understand.

> *You don't have to start dealing with important issues [straight away], you're working into it ... If you can start off with something trivial and unimportant, until you get your feet wet and feel more comfortable with that nurse, I think it really helps. The best thing is just be there when the kids are ready ... be available ... the kids will be able to trust you ... That's why I was more likely to speak to one of the nurses than I was to one of the therapists ... you don't know them, you have no reason to trust them.*

In the following table, the four sub-elements of practice knowledge identified in six adolescent's texts are presented.

Table 7.6: Sub-Elements Identified in Six Adolescent's Texts

Nurses provide and take opportunities	The stress of admission	Nurses are people
Nurses try to create change		

Nurses provide and take opportunities: refers to the nurse's ability to make themself available to create opportunities for therapeutic work in ways that are acceptable to adolescents, and to take such opportunities when they arise through shared activities of living.

> *The first camp we went to was only a couple of weeks after I went there ... I had the nightmare and I punched somebody ... I took a runner as soon as I woke up properly and Robyn went and sat in front of the fireplace and that's where I ended up. When I walked into the room she looked around like invitingly not like "you bitch, get fucked" and so I went and sat next to her and we made coffee and that and we were talking.*

The stress of admission: refers to the suspicion, confusion, shame fear and distress experienced by adolescents prior to and at the time of admission. Such feelings arise because of the adolescent's problems and through a lack of comfort or familiarity with the new environment, people and routines.

> *The first time I went there was for the interview and I hated it and I was crying and I didn't want to be there ... I remember feeling a little miserable and hating it and not giving anything a go, [I] didn't want to eat, didn't want to do anything ... I can remember my first day really clearly, I hated it. I thought it was like a psychiatric hospital ... that everyone would think I was sick cause I was there.*

Nurses are people: refers to the nurse's ability to use their personal qualities to assist adolescents to see them as people and engage therapeutically with them. Such qualities include being honest, gentle, accepting, egalitarian, happy, committed, well adjusted, playful, having integrity and a good sense of humour.

> *[Simon] got right into things like trampolining and playing around ... he was just a soft person, like really nice not aggressive, he's an assertive person, he was so soft. He used to have a really good approach to things and he was funny, he could laugh, he used to laugh a lot. [Edward] was one of my favourites ... you could have lots of fun with him, he was always really good to me ... He was so nice, he put himself out ... I think he had a good sense of humour.*

Nurses try to create change: refers to the nurse's ability to engage with adolescents in order to assist them to deal with the present, rework the past and focus on working toward change.

> *One day he turned around and he pointed out that it made it hard to include me in a conversation when I was walking behind him, he said it was like I was*

excluding myself and he didn't want that, he wanted me to be part of the group but it was up to me. He simply quoted, "do not walk in front of me I will not follow, do not walk behind me I will not lead, walk beside me and be my friend" and he left it at that. So, over the next few weeks I summed up the courage to start to walk beside him and became a part of the group and I eventually felt comfortable, like I belonged.

In the following table, the three sub-elements of practice knowledge identified in seven adolescent's texts are presented.

Table 7.7: Sub-Elements Identified in Seven Adolescent's Texts

Being accepted	Experiencing equality	Nurses are friends

Being accepted: refers to the nurse's ability to be nonjudgmental, open, patient and inclusive in order that adolescents experience the freedom to be themselves and to express their thoughts and feelings without judgment, guilt, blame or diminution of self. Being accepted by the nurse allows adolescents, in turn, to come to terms with and accept themselves and their difficulties.

[They] were not judgmental, you were who you were and they accepted you as you were. The only thing nurses would find unacceptable at times were behavioural things, violence and foul language ... Nurses were accepting of the faults and problems ... It's easy to feel bad about not liking your parents, to feel bad when you don't get on with other kids ... but if nurses are accepting of those problems you learn to accept them in yourself.

Experiencing equality: refers to the way the nurse's preparedness to be with adolescents and participate in activities and interactions with them in nonauthoritarian and nonhierarchical ways, fosters feelings of comfort, trust, respect and mutuality while removing barriers which constrain communication, sharing and therapeutic engagement.

When you're young and in that situation you have a lot more respect for someone if they're on your level and do the same things as you, like you don't want to feel inferior or have nurses being superior to you ... you don't want to tell your fears and secrets to someone

> *[like that]. It creates a good atmosphere being equal ... They talked with me not always to me ... like when you go to school and things like that the teacher talks to you, not with you, [but the nurses] they were always talking with me not at me.*

Nurses are friends: refers to the nurse's ability to assist adolescents to feel befriended so they experience comfort, shelter, intimacy, companionship and feelings of worthiness while receiving an opportunity to learn, in a supportive and unpressured environment, how to establish and maintain friendships. Nurses do this by engaging in activities with adolescents which adolescents normally share with friends and by looking and behaving not like nurses but like ordinary people.

> *You feel like you're friends with that nurse, you're doing the sort of thing friends would normally do together. It helps by taking the pressure off thinking "oh gees, I don't have any friends, I can't socialise", you're not constantly nervous around everybody, you feel like you've been set free. It's a friendship on a different level, it's not the kind of friendship the nurses would have with people their own age outside of the job ... but just being able to relate to somebody or to think of them as a friend and be accepted as a friend, meant something, it was valuable.*

As the foregoing material demonstrates, the sub-elements of practice knowledge were noted with varying frequency. For example, "experiencing attachment" was identified in one text, "it's more than a job" in four and "experiencing equality" in all seven. Thus, certain sub-elements may be more representative of practice knowledge than others. On the other hand, a more exhaustive schedule of interviews, or more focused questioning, may have allowed all the sub-elements to be revealed in every text. Yet again, as each young person's experience of being nursed is unique, it may be that the nurses did not need to use all the sub-elements of practice knowledge to nurse them. For instance, Elizabeth was disciplined in response to testing behaviours whereas James did not exhibit testing behaviour and therefore was not disciplined. Still,

some sub-elements may be foundational to adolescent mental health nursing. For example, while nurses worked with Elizabeth and James using different sub-elements of practice knowledge they may use the same sub-elements, for instance, "experiencing equality" to assist in the development of all nurse-adolescent relationships. These issues were unable to be addressed within the parameters of this study and provide questions for further research. At this point, having identified and defined the sub-elements of practice knowledge, I proceeded to the second level of interpretation where I developed and defined the elements of practice knowledge.

7.04 Level Two Interpretation: the Elements of Practice Knowledge

At the second level of interpretation I clustered the sub-elements of practice knowledge with shared meanings into elements of practice knowledge. From the 55 sub-elements, four elements of practice knowledge were developed and defined. In the following section, I present the four elements and the sub-elements of which they are composed, after which I present their definitions.

In the following table, the 14 sub-elements of the element "engaging in therapeutic relationships" are presented.

Table 7.8: Engaging in Therapeutic Relationships

Experiencing mutuality	The nurses were there	Relating to nurses
Experiencing attachment	Developing trust	Experiencing the loss of trust
Nurses are people	Nurses are seen as family	Experiencing equality
Being pressured	Nurses discipline through relationships	Working in partnership
Mismatched adolescent/primary nurse relationships	Experiencing loss through termination and separation	

Engaging in therapeutic relationships: refers to the nurse's ability to develop, engage in and terminate the therapeutic nurse-adolescent relationship in ways that enhance mutuality, trust, familiarity and partnership.

The following table lists the 13 sub-elements of which the element "providing a therapeutic milieu" is composed.

Table 7.9: Providing a Therapeutic Milieu

The stress of admission	Having your own space	The unit was homelike
The pressure was taken off	Nurses are flexible	Having fun
The peer group is supportive	Being neutral	A helpful and caring environment
A protective environment	An open and accepting environment	Feeling safe and secure
Inappropriate admission to adult or child units		

Providing a therapeutic milieu: refers to the nurse's ability to participate in developing an environment which is experienced by the adolescent as homelike, accepting, unconstrained, safe, stable, lighthearted and enabling.

In the following table, the 10 sub-elements of the element "guiding the potential for change" are presented.

Table 7.10: Guiding the Potential for Change

Nurses encourage independence and responsibility	Becoming hopeful	Making sense of things
Getting on with life	Feeling in control	Working through issues in group
Nurses try to create change	Nurses negotiate consequences	Nurses are role models
The distress of therapy		

Guiding the potential for change: refers to the nurse's ability to facilitate the adolescent's capacity toward personal, interpersonal and social wellness by fostering development, assisting the adolescent to understand their experience and focusing on forward movement.

The following table lists the 18 sub-elements of which the element "facilitating positive outcomes" is composed.

Table 7.11: Facilitating Positive Outcomes

It's more than a job	Specialist nurses	The people and the place
Nurses are friends	Receiving understanding	Receiving individualised care
The nurses persevered	Experiencing containment	Experiencing a lack of containment
Nurses provide and take opportunities	Feeling normal	Being accepted
Nurses take time and make time	Having attention	Testing nurses
Experiencing concern	Experiencing a lack of concern	Feeling blamed

Facilitating positive outcomes: refers to the nurse's ability to intervene therapeutically through positive, informed, moral and engaged practice, and through their capacity to endure and deal with challenging behaviours in order to contain the adolescent's distress and foster the adolescent's self worth and belief in themself.

Following development and definition of the elements of practice knowledge, I proceeded to the third level of interpretation where I examined all my previous work in order to obtain an understanding of the meta-element of practice knowledge.

7.05 Level Three Interpretation: the Meta-Element of Practice Knowledge - Fostering a Functional Self

At the third level of interpretation, I examined my definitions of the sub-elements and elements of practice knowledge in order to understand what occurred in adolescent mental health nursing through the use of that knowledge. I did this by continuing to shift my focus from the specific to the broad. For instance, when I identified and defined the 55 sub-elements of practice knowledge I focused my attention on specifics. I used words from the text and tried to highlight particular aspects of the information the young people provided so that my definitions related to actual experiences in a precise way. I wanted the definitions to be clear and explicit.

On the other hand, with the development and definition of the four elements of practice knowledge, I focused my attention on trying to extract the overall meanings imparted by all the sub-elements within an element. In doing this, I moved away from explicit examples to an interpretive summary. When developing and defining the meta-element of practice knowledge, I continued the move toward trying to take account of practice in its broadest sense. Thus, while aspects of the sub-elements and elements are integrated into the meta-element, they are not as explicit. In this way, the meta-element describes, in a wholistic way, what occurs in adolescent mental health nursing when the sub-elements and elements are applied to practice.

With regard to practice knowledge, I use the word "meta" in relation to its dual meaning of coming after, or behind, but also together with. Accordingly, the meta-element "Fostering a functional self" comes after the elements and sub-elements but is together with them.

Fostering a functional self: refers to the way nurses break through the barriers restraining change and assist adolescents to develop more functional ways of thinking, feeling and acting in personal, interpersonal and social contexts and through which, in turn, adolescents experience reintegration and wellness. Nurses do this by working against the background of an enabling milieu, through the therapeutic relationships they engage in with adolescents and through their capacity for therapeutic intervention.

7.06 Conclusion

While the practice knowledge of nursing on residential adolescent mental health units was explicated through a review of its parts, it should be considered hermeneutically, that is, by taking account of the whole as well as its parts. For example, an understanding of "what" nurses do and "how" they do it is represented in the sub-elements. The elements, on the other hand, provide understanding of "why" nurses apply the sub-elements to practice, and the meta-element describes the "aim" and "outcomes" of practice through use of the sub-elements and elements. Thus, the fullest understanding of adolescent mental health nursing practice knowledge is achieved when the sub-elements, elements and meta-element are considered in relation to one another.

In this chapter, I presented the findings developed from the information provided by the young people. In the following chapter, entitled "The Nurse's Stories", I present the findings developed from the information provided by the nurse participants.

Chapter Eight

8 The Nurse's Stories

8.01 Introduction

The written and oral information received from the seven nurses provided the text for interpretation. Interpretation was conducted on three levels. At the first level of interpretation, I identified the sub-elements of practice knowledge from each nurse's information (see Appendix F, pp. 322-333) resulting in the identification of 80 sub-elements. I then defined the sub-elements. This part of the work is presented in the section entitled "Level one interpretation: the sub-elements of practice knowledge." The second level of interpretation involved grouping the sub-elements of practice knowledge with shared meanings into elements of practice knowledge. Four elements of practice knowledge were developed from the 80 sub-elements. In turn, I defined the elements of practice knowledge by examining the individual sub-elements of which they were composed. This part of the work is presented in the section entitled "Level two interpretation: the elements of practice knowledge." At the third level of interpretation, I examined my definitions of the elements and sub-elements then developed and defined the meta-element of practice knowledge. This part of the work is presented in the section entitled "Level three interpretation: the meta-element of practice knowledge."

In the work that follows, I define the 80 sub-elements of practice knowledge. Throughout the process of definition I attempt to define the sub-elements and describe what their use in practice either allows or disallows. While I use textual excerpts with each definition, the thesis length allows the use of only one excerpt with each sub-element. Thus, the reader is directed to the appendices

(see Appendix H) where further examples of the sub-elements are provided. Still, the appendix does not contain every example of the sub-elements as some appear within other sub-elements, some are a few words long and some are incorporated over large parts of a text.

The sub-elements of practice knowledge demonstrate both therapeutic and untherapeutic experiences. For instance, "setting limits" is an example of a therapeutic experience whereas "failing to set limits" is an example of an untherapeutic experience. While practice is directed toward a therapeutic end, the inclusion of examples of breakdown in practice can enhance understanding by identifying the consequences of such breakdown. In recognising untherapeutic practice it is possible to come to understand how practice should be actualised in order to be therapeutic.

In the following section, the sub-elements are presented and defined. In this regard, I begin with the sub-elements identified in one nurse's text and finish with those identified in all seven.

8.02 Level One Interpretation: the Sub-Elements of Practice Knowledge

In the following table, the 14 sub-elements of practice knowledge identified in one nurse's text are presented.

Table 8.1: Sub-Elements Identified in One Nurse's Text

Failing to provide safety and security	Failing to respond appropriately	The distress of therapy
Failing to provide attention	Providing adolescents with their own space	Failing to set limits
Nurses discipline through relationships	Being tolerant	Experiencing attachment
Therapeutic touch	Demonstrating concern	The nurses are not there
An unethical environment	An uncooperative, inconsistent/noncohesive environment	

Failing to provide safety and security: refers to the way negative labelling on the part of the nurse results in their inability to respond therapeutically to the adolescent's need for reassurance and comfort with resultant feelings of aloneness, fear and anxiety.

> *He often framed her behaviour as manipulative [so] it became a safety issue ... when she felt unsafe, like she was hearing voices or needed reassurance or needed to make contact or connect up with someone this nurse wasn't available to her and kind of [closed off] ... If a kid says "I'm feeling unsafe" you have a real responsibility to provide them with safety.*

Failing to respond appropriately: refers to those times when an inappropriate response on the part of the nurse results in an untherapeutic encounter with the adolescent.

> *We were trying to get Geoffrey to take some medication and I remember him saying something to me like "look at her she's laughing at me, she's got a smirk on her face" and I actually did because I thought it was humorous ... [I learnt] just keep your expression blank ... because Geoffrey was quite suspicious and paranoid at times.*

The distress of therapy: refers to the problems adolescents experience in formal therapy due to difficulties relating to therapists, infrequent contact, a lack of trust, poor relationships and a focus on management issues.

> *The doctor doesn't relate to Michelle very well because they only see each other for five minutes a week ... what sort of relationship can the doctor build with the kid in five minutes, and that five minutes is usually of an interrogative nature ... the whole focus is medical and it's all around whether the medication's working or not ... Michelle said "I find it really hard to talk to her."*

Failing to provide attention: refers to those times when the nurse's failure to demonstrate an interest in the adolescent results in the adolescent feeling unworthy and neglected.

> *Some of the quiet adolescents are missed, they can go for days without having any attention ... and that does not help them, they just withdraw even more [like] "no one cares so they're not talking to me." All the kids*

> *need attention, the quiet kid needs the nurse to go and sit down and say "how are you feeling today?" and see where that leads them.*

Providing adolescents with their own space: refers to the nurse's ability to provide adolescents with time for privacy, solitude and individual interests through which the adolescent is replenished.

> *Give adolescents some space, they need space like any of us, whether it's time away listening to music, writing some letters, reading [or] painting. They need some space of their own ... Maybe they're feeling a little bit tense within the group and, you know, you get to know when they need some time out on their own.*

Failing to set limits: refers to the nurse's failure to intervene to set limits on escalating behaviours with the result that those behaviours become out of control.

> *There's some kids who you're fearful are going to act out so you let things go ... you could have stopped things getting to that point. [You think] ... I should have intervened earlier, this has gone on too long, rather than letting them escalate each other and hype each other up you could've, with some intervention, have stopped things getting to that point.*

Nurses discipline through relationships: refers to the nurse's ability to develop effective relationships through which they have the power to discipline adolescents, and to modify approaches to discipline in order to obtain cooperation from adolescents while that relationship is being developed.

> *Discipline always works better ... [if] it comes from the relationship you have. It gives you more power to intervene or more right to intervene ... it always works better for someone who has cared for that adolescent ... [Also] the work and trust you put in facilitates intervention when limits have to be set, there's that trust built up between you. When someone comes in initially you would tolerate more disturbance because they haven't learnt anything yet or been exposed to what we would be expecting is the norm ... that relationship and feedback hasn't been there.*

Being tolerant: refers to the nurse's ability to accept a certain amount of acting out behaviour as normal and to intervene when

such behaviour begins to escalate or become unsafe.

> *With kids like that, [conduct disordered kids], if they did something ... you know, in their language or carrying on ... you allow a certain amount and have a tolerance for what is normal but there would be a certain point where that would be as far as you think is appropriate that they go.*

Experiencing attachment: refers to the nurse's ability to develop close, continuing relationships through which connectedness and affection is experienced.

> *It so happened that I was one of the few nurses that stayed on full time during that [holiday] time so during that eight or nine weeks she and I formed a very strong attachment to each other and I still remember her with great affection.*

Therapeutic touch: refers to the nurse's ability to use touch in a neutral and affirming way in order to relieve tension and foster connectedness, comfort and mutuality.

> *He was really edgy one night and I said "come on Martin sit down and I'll massage your head." He sat in front of me and I massaged his head and he was going "oh that's really good, it's made me feel good" ... it was relaxing and neutral ... it was them being touched in a positive sort of way which made them feel good ... A lot of the kids wouldn've had many cuddles ... someone giving them a rub on the head or a pat on the back, just those little contacts.*

Demonstrating concern: refers to the nurse's ability to understand the adolescent's perspective and resolve conflict in order to maintain the relationship and relieve distress and disappointment.

> *Sarah came up and said "are we going to go out tonight?" and I said "well yeah it's Tuesday, we'll have to sit down and talk about where we're going" and then something happened and we couldn't go out ... She told Alison I had really disappointed her because I had promised her we'd go somewhere and we didn't ... [Later] I approached Sarah and said "I'm really sorry about the other night, I should've come and explained why we couldn't go out", and after I explained she was much better.*

The nurses are not there: refers to a lack of preparedness on the part of the nurse to spend time with, and be there for, adolescents resulting in distance and division between them.

> *The kids will hang out with each other and the nurses will hang out in the office and look like they're busy making phone calls, doing paperwork ... putting programs together that look good on paper. It begins to polarise the kids [away] from the nurses.*

An unethical environment: refers to an environment characterised by entrenched, inflexible perspectives and a lack of honesty in dealing with challenges and skills deficits. Such an environment is often untherapeutic, maintains the status quo and lacks accountability.

> *There's never a question of the efficiency or the productiveness of the process that's going on but more a rationalisation or an excuse ... There's no accountability within the system. You're not really working with the best thing that works for the kid, you're working with the best thing that works in keeping the status quo so that people's pride and personalities and status is maintained.*

An uncooperative, inconsistent and noncohesive environment: refers to an environment where the work with adolescents is undermined by divisions, rivalry and conflict and by a lack of cooperative practice and support for professional development.

> *I work in this environment much more in isolation .... Often when you work alone no one else knows what's going on so when it comes to major decisions other members of the multidisciplinary team [make] decisions based on very poor information ... so it actually interferes with the case. There were some kids I had a relationship with but I didn't know what I was doing with them, I didn't know what direction I was going ... In this culture that's seen as being incompetent, weak or unskilled.*

In the following table, the 12 sub-elements of practice knowledge identified in two nurse's texts are presented.

Table 8.2: Sub-Elements Identified in Two Nurse's Texts

The stress of admission	Being honest	Nurses take time and make time
Intuition	Inappropriate admission to adult or child units	A secure, accessible and unconstrained environment
Facilitating termination and separation	Striving for consistency	Highlighting difference and change
The adolescent developmental stage	Working through issues in groups	Mismatched adolescent/primary nurse relationships

The stress of admission: refers to the difficulties, distress and fear adolescents experience at the time of admission due to feelings of loneliness and loss, and due to their lack of familiarity with the environment, people and routines.

> *The first couple of weeks is a settling in period in a residential unit ... they may be very lonely, be upset being away from home, possibly for the first time, getting used to all the routines, getting used to the staff and how different nurses react in different situations.*

Being honest: refers to the nurse's ability to share openly with the adolescent in order that a respectful and mutual understanding develops about the issues at hand.

> *Be quite honest with them, be open with them, sometimes they might ask you awkward or difficult questions but be as honest as possible ... and if something's not possible then obviously to say so because they will understand, I think they know when things are difficult for you as well.*

Nurses take time and make time: refers to the preparedness of nurses to spend time with adolescents, and put them before tasks, in order that the adolescent feels cared for, acknowledged and valued.

> *He used to talk all the time with me and I'd always make sure I had 15-20 minutes up my sleeve to go and sit in his room and talk to him ... I think you've got to [make time] when you're working with adolescents.*

Intuition: refers to the ability the nurse develops, through repeated experience, to respond effortlessly and without conscious thought to the eventualities of day to day practice.

> *I find I work very intuitively ... it doesn't require a lot of my conscious, thinking abilities to know how to respond in a moment cause I've had to do it so many different times ... If someone asks me why did I do something I have to sit down and think about it [but] I can get in touch with the rationale quite easily.*

Inappropriate admission to adult or child units: refers to the need for adolescents to be cared for in adolescent specific facilities where the care is personalised, the environment is less disturbed and more dynamic, and the stigma associated with mental illness is reduced.

> *I felt that to put an adolescent into an adult institution ... was not helpful for her. I had experience taking kids up there and it was an awful atmosphere, it wasn't suitable for youngsters and I felt we had a responsibility not to put them in an adult, chronic, psychiatric system. The message was this is what you're going to become and we can't cope with you, your turmoil is too big for us and I think that's a huge message.*

A secure, accessible and unconstrained environment: refers to a milieu characterised by freedom of movement and engagement and by a sense of security developed through feelings of belonging and familiarity.

> *I think the adolescents felt the place was very accessible ... they had that feeling of belonging, that sense of space belonging to them ... they felt free in their environment, free access to things. Once they got to know the unit they felt very comfortable in the environment.*

Facilitating termination and separation: refers to the nurse's ability to assist the adolescent to gradually reduce their attachment to the unit and staff both prior to and after discharge. Gifts and events, such as graduation celebrations, act as symbols of separation and moving on while visits, exstudent groups and phone calls allow continuing assistance and contact.

> *We also had an [ex]student's group, we slowly separate*

> *in that way ... it's a way of reassuring the adolescents that they're not completely separate from the unit once they're discharged, it's a way of weaning off rather than suddenly cutting off ... In a way it's to let them know we still have contact ... but it's also time for them to be independent a bit and have their life outside.*

Striving for consistency: refers to the way nurses attempt to provide consistency in their management of behaviour so that adolescents develop an understanding of rules, expectations and routines and experience the environment as predictable, cohesive and fair.

> *Consistency is always difficult where you have a lot of nurses or different nurses managing [behaviours] ... tolerance to certain behaviours [varies] ... there would need to be certain things that would be consistent [like] violence where there would be a real stand taken but some other less damaging behaviours there'd be a more variable response in how you'd manage those.*

Highlighting difference and change: refers to the nurse's ability to assist adolescents to recognise areas of improvement by noting changes in thinking, feelings or behaviour. The nurse does this by acknowledging and praising such change which, in turn, allows adolescents to experience hope and a sense of achievement.

> *You'll be encouraging, giving positive feedback [about] how they were getting on with the other adolescents, how they were able to participate and their level of achievement in what they were doing ... if that was something new they weren't able to do before ... [highlighting] changes where kids have moved on from behaviours or how they related to other adolescents [saying] "Jonothan, last week when you came here it was really difficult for you ... it's great this week you and Tony are playing well together and planning the next game, that's a real difference to what happened last week and it's great." Highlighting where they've come from initially will add more weight to positive feedback.*

The adolescent developmental stage: refers to the way knowledge of adolescent development allows nurses to understand adolescents, to have age appropriate expectations of them and to use age appropriate interventions to assist them to change.

> *There's a very definite maturity that happens with adolescents ... you can see the physical maturity, then*

> *the emotional maturity, then the mental-cognitive maturity. It makes a big difference and that makes me aware of what I'm dealing with because that helps me to help the adolescent in their behaviour. I've got that situation now where I've got 17 year olds in with 12 year old ... the 17 year old will see the 12 year old as very silly and immature ... it reminds me again "oh, he's only 12 years old!" ... so my interventions have to be streamlined to the age appropriateness of that kid.*

Working through issues in groups: refers to the way nurses deal with problems and provide learning experiences in order to enhance communication and foster adolescent development.

> *They had a big group meeting with the kids ... if someone did something last night we'd debrief it with the kids in the morning so every kid's not wondering "what the hell's going on" and got their own interpretation, you can talk about it [and] work through it and everyone has a general understanding of what's going on.*

Mismatched adolescent and primary nurse relationships: refers to the need to reallocate nurses and adolescents if they are unable to work effectively together in the primary nurse-adolescent relationship.

> *I usually get articulate kids, I don't work as well with kids that can't articulate ... Joshua related to the macho sort of image and I'm discussion and talking [oriented] and a gentle approach, he needed to link up to models he could relate to ... You're aware that the kid can't relate to you and you're finding it very hard to relate to this kid because of different conditions, backgrounds and understandings.*

In the following table, the 22 sub-elements of practice knowledge identified in three nurse's texts are presented.

Table 8.3: Sub-Elements Identified in Three Nurse's Texts

Being supportive	Adolescents are people	Nurses are people
Getting on with life	The unit was not clinical	Building the nurse-adolescent relationship
Providing mutuality	Identifying behaviours	Building confidence and self esteem

Seeing and responding to what's underneath	Monitoring behaviour	Nurses are flexible
Relating to adolescents	Nurses persevere	Being neutral
Nurses are seen as family	Nurses are role models	Expanding nursing practice knowledge
Devalued nursing practice knowledge	A cohesive, consistent/cooperative environment	The ethics of practice
Nurses are friends		

Being supportive: refers to the nurse's ability to assist adolescents to recognise, make sense of, become informed about and work through their problems in order to move forward and get on with life.

> *Supporting Daniel in understanding what was going on for him ... letting him know as much about the illness as possible. Being really sensitive to how that would feel for him, you know, adjusting to having had that experience and how he would make sense of that for himself ... that he would be able to work through some of those things.*

Adolescents are people: refers to the way nurses try to see the adolescent as an individual with personal qualities, as well as someone with particular problems, in order to get to know them well within their personal context.

> *It's important to get to know the adolescent and get to know what they're like and get used to their mannerisms and idiosyncrasies ... It's very important to take them as you get them and to get to know the adolescent very well. See them in different situations, taking part in different activities ... taking them on a one to one situation, talking to them, getting feedback from them and seeing how they feel about a certain situation or particular thing, and get a feeling for what they like and don't like.*

Nurses are people: refers to the way nurses use their personal qualities to assist adolescents to see and relate to them as a person. Such qualities relax barriers between the adolescent and nurse and

include the ability to have fun and be silly, a sense of humour, open mindedness and flexibility.

> *I don't want to come down and be this manager of their person, I want to encourage ... in order to do that I want that to be genuine. I'm not just a figure like a teacher ... I want that to be brought across in a sense where [they feel] "well that's that person, that's that nurse I'm talking to."*

Getting on with life refers to the nurse's ability to help adolescents to look beyond the past, to understand and deal with the present and to plan for the future in order to move on.

> *It's a really important age to have nurturing and positive direction. Really [you have to] get them out of those difficult times or experiences they had before ... they never forget ... but they can get on, move on.*

The unit was not clinical: refers to the familiarity and comfort of a nonmedical, nonhospital environment where adolescents experience feelings of homeliness and freedom.

> *The adolescent unit was very different to any other type of environment I'd worked in ... a much more nonmedical setting ... it had nice landscaped gardens and a pool, a music room with bean bags ... a lovely tennis court and the oval at the back. It wasn't a clinical, hospital setting.*

Building the nurse-adolescent relationship: refers to the nurse's preparedness to be available for the adolescent, and to their ability to use relational skills to gain the adolescent's confidence and trust as a means of beginning the relationship between them. In turn, this allows the relationship to obtain a deeper therapeutic level.

> *They're responding, it's a deepening of the process of the conversation ... they just hang out with you a lot more, they may not say anything but you notice that they want your presence ... If we say "lets get down to the core of things" it may be too exposing or too raw, too quick, so we have to go through the process ... not to go too fast because that may not be appropriate for the kid and where they're at and what's going on for them in their life.*

Providing mutuality: refers to the way nurses share appropriate

personal information with adolescents in order to demonstrate understanding and foster feelings of unity between them.

> *Things that I felt were common and might help us to identify with each other, or be useful in them feeling that I understood where they were at, if they were similar things [I would share them] ... there can be a lot of areas for blurring or that I don't think are appropriate ... you might only learn from experience, by finding out "oh gee that didn't feel okay" or "I don't think, in hindsight, that was an appropriate thing for me to disclose."*

Identifying behaviours: refers to the nurse's ability to use activities of daily living, including school participation, as information through which to assess the adolescent, and identify or make sense of problematic behaviour, in order to plan appropriate care.

> *Does a psychotic episode always happen to evade something, or at times of stress, or does the psychotic episode occur over a broader range of experiences, is there a pattern ... [like] whenever parents are visiting or whenever they have to go to school. You've got to read the behaviour in the context of what else is happening ... over a period of time you pick up unconscious, nonverbal sorts of things [like] kid's eyes change or they tremor a bit more.*

Building confidence and self esteem: refers to the nurse's ability to provide opportunities for the adolescent to be successful and to praise and support adolescents in order that they experience feelings of achievement and enhanced well being.

> *He just couldn't settle in class so there were a lot of times I was sitting next to him and he wanted me to do some of the work with him ... and [I did] a bit with him and in the process I continued to give him positive feedback, I'd say "you're actually smarter than I!" and all those things ... to build up his self esteem. I had to get something that he can grasp and do well and get like 90% or 100% right to make him feel good ... so that he feels he can achieve.*

Seeing and responding to what's underneath: refers to the nurse's ability to look beyond external behaviours in order to understand the underlying cause of those behaviours or the deeper message the adolescent is attempting to communicate. In doing this the nurse

strives to identify the antecedents of behaviour and to work with them.

> *I remember Jonothan ... his arrogance, his smart arsed smartness ... sometimes it's hard not to respond to that. With experience you gradually learn not to respond to that overt stuff and see what's going on underneath ... not responding to the [behaviour but] going underneath and tapping into that ... it's not having that reactionary response that escalates that behaviour ... trying different strategies to engage them in what's really going on for them.*

Monitoring behaviour: refers to the way the nurse observes and monitors behaviour in order to make sense of the adolescent's problems, to foresee and intervene in escalating or self harming behaviour and make judgments about change. Through such actions the nurse provides a safe, secure and predictable environment.

> *The nurse has got to foresee the impending escalation of the behaviour and it can be unsafe for the kid to continue their behaviour ... when an adolescent is increasingly verbal, gets flushed in the face, starts invading other people's personal space, with yelling included, starts reaching out to hit, hurt or grab another adolescent [behaviour is escalating] ... Others become very quiet and withdrawn and lots of times that results in self harming behaviour or taking it out on physical objects.*

Nurses are flexible: refers to the nurse's ability to provide adolescents with a sense of freedom within the environment through a flexible approach to the routines of daily living, and to their ability to maintain a fluid perspective of each adolescent within their context.

> *You have to have a lot of flexibility in looking at the individual situation ... sometimes it could appear that you're not consistent overall, [to] someone looking at it from the outside ... [you have] to see the adolescent in their context and where they're at, at what point they're at in their admission.*

Relating to adolescents: refers to the nurse's ability to find common interests through which to build connections and engage with the adolescent, and to their capacity to accept and find enjoyment in

the ways adolescents relate to them.

> *There are a lot of mannerisms adolescents use and sometimes I might use them myself ... it connects you with them and they're not seeing you as an older out of tune person, you get in tune with them and they can see "oh he's not that much different he's just older." I try and keep up with the things they're into ... the characters they associate with ... that's common ground to have.*

Nurses persevere: refers to the nurse's ability to accept and endure rejecting, challenging and disturbed behaviour so the adolescent comes to believe the nurse understands and will be there for them .

> *Others just wouldn't want to engage with you at all [it's like] "oh you're just the same as everyone else", so you'd just ride it out until they could see you weren't gonna get cranky and you were gonna be there for them.*

Being neutral: refers to the nurse's ability to transcend feelings of hurt or anger in order to respond with neutrality to challenging behaviour, and to their capacity to accept and sustain such personal attacks in order to remain engaged with the adolescent. In doing this nurses provide a safe, accepting and supportive environment.

> *You have to be able to [be neutral] ... not to bite because you'd be biting every five seconds, you have to develop a certain strength within yourself to be able to stay neutral ... The ability to be able to manage your own feelings in response to them being triggered by the kid's behaviour requires a tremendous amount [of effort] ... to override or transcend your own feelings to actually see what's going on with the other person in the situation.*

Nurses are seen as family: refers to the nurse's ability to develop close, communal relationships through which adolescents experience the nurse as a sibling, parent or family member.

> *Sometimes it's a bit of a parent role, sometimes they might look on you as being in a big brother or sister role. What a normal parent does with their 15 year old I try and bring areas of that into my work ... interacting in much the same way as parents would interact with their adolescent.*

Nurses are role models: refers to the nurse's ability to provide

adolescents with examples of new ways of thinking, feeling and behaving in order to assist them to develop different and positive representations of adulthood.

> *It was a new experience, they could take away a new inner representation of the world ... the whole amalgam of personalities working with a common philosophy of respect and caring for these kids would enable them to take in and internalise, at some level, the idea that there was a different way of being.*

Expanding nursing practice knowledge: refers to the way nurses develop and expand their knowledge through experiences in the workplace which include orientation, inservice, group discussion and the observation of peers.

> *Boys with real behavioural difficulties, I learned so much from watching Erin stand up to their bad behaviour and just clearly setting limits in spite of the rage that would come back, and that was something that when I first went there I found very hard to do ... to stand up [to them], to clearly say "this is not acceptable."*

Devalued nursing practice knowledge: refers to the way nurses fail to appreciate the value of their work in comparison to that of their colleagues, and to the continual frustration and difficulty nurses experience with colleagues who devalue nursing knowledge.

> *From the nursing point of view sometimes it's very frustrating when the medical side is not prepared to listen ... [with] changes of registrar or clinician it seems to take a long time for them to believe that we need to agree with a certain contract with the kids ... or [that] things we've been doing [are] workable for the unit and the kids.*

A cohesive, consistent and cooperative environment: refers to an environment where therapeutic work with adolescents is supported by a shared philosophy of care, a unified and consistent approach to practice, a cooperative manner of dealing with differences and the valuing and use of individual skills.

> *In an adolescent setting you can't be alone, a one off, you've got to work as part of a team, be able to communicate and get on with other team members and deal with things that arise ... differences,*

inconsistencies, all that stuff, to be able to discuss those things is really important.

The ethics of practice: refers to the personal maturity required for moral engagement in practice, and to the dilemmas nurses confront in trying to provide just, equitable and moral care for adolescents when they are unable to influence the decisions doctors make. Such dilemmas leave nurses feeling angry, sad and depleted.

[I remember] feeling very angry that Belinda was sent away to a psychiatric hospital because we didn't have enough of an ability to hold her in the environment and I felt very strongly that we did and that she got sent away when she shouldn't have ... [The doctor] said "send her up to the psychiatric hospital" ... and [I] struggled with this whole issue of "is it because she's a girl?"

Nurses are friends: refers to the nurse's ability to assist adolescents to feel befriended so they experience comfort, companionship and relief while receiving an opportunity to learn how to establish and maintain adult and peer group friendships. Nurses do this by spending time with adolescents and by doing things together.

A lot of them have trouble developing friendships ... they lack the ability to establish friendships with peers let alone adults. If they can achieve some sort of friendship with a nurse that can help them work with their peer relationships.

In the following table, the 21 sub-elements of practice knowledge identified in four nurse's texts are presented.

Table 8.4: Sub-Elements Identified in Four Nurse's Texts

The therapeutic use of self	The nursing peer group is supportive	Expanding the knowledge of self
The adolescent peer group is supportive	Establishing boundaries	Failing to establish boundaries
It's more than a job	Implementing restraint	Nurses provide and take opportunities
Testing nurses	Interpreting communication	Having fun
An open, accepting and supportive environment	Nurses are advocates	The problem of labelling

Supporting parents	Working in partnership	The pressure is taken off
Nurses use humour	Nurses are there	Providing attention

The therapeutic use of self: refers to the nurse's ability to use healthy aspects of their self to engage therapeutically with adolescents in order to foster personal reintegration. The self encompasses all the nurse is and can become.

> *The person that the nurse is and becomes ... I think automatically that process must carry along to the adolescents. It's not the techniques or model that a person particularly has that actually does the work between client and nurse it is the relationship that can be developed ... being who you are and focusing that for a therapeutic end.*

The nursing peer group is supportive: refers to the way nurses make themselves available to one another in order to discuss and review practice and to provide moral support, practical assistance and relief. In doing this they create a caring, sustaining milieu.

> *Harriet spoke with me about that [incident], about my feelings, she was very good like that ... everyone looked out for everyone else ... sometimes [it meant] removing yourself from the situation and getting someone else to take over, which is time out for the staff.*

Expanding the knowledge of self: refers to the nurse's ability to continually review their relationship with, and responses to adolescents, in order to separate their own unresolved issues from those resulting from present encounters with the adolescents. In working through unresolved issues the nurse develops a deeper level of self knowledge which, in turn, allows more insightful practice.

> *It was losses or sadness I was identifying [with] and I was suddenly aware of that with something that came up with an adolescent who was depressed ... just being aware that I was affected was enough ... that person touched something that was unresolved in me and I'd need to be aware that that was going on, observe my own responses when I'd be dealing with that person*

to monitor that.

The adolescent peer group is supportive: refers to the way nurses encourage adolescents to support each other and to the awareness nurses have of the importance of the peer group in providing a sense of belonging, affiliation, understanding and acceptance.

> *They themselves provide support for one another ... sometimes the teenagers feel they get more of a sense of understanding and acceptance by the other kids ... they can hang out with the other kids much easier than with the adults. There are those odd occasions where kids find other kids difficult to hang out with ... but that's not often. The peer group is very important.*

Establishing boundaries: refers to the understanding nurses have of a physical and psychic space, surrounding the adolescent and themself, into which neither should trespass inappropriately because to do so would be violating. Boundaries provide a safe, stable and respectful relationship through which nurses maintain a balanced perspective.

> *I hope I never overstepped that kind of boundary ... if anything I probably would have set the boundaries too far back. I think it was a boundary question because this kid's boundaries, we later [found], had been violated ... you can invade not only their physical space but their minds as well by asking too many questions and not waiting for them to be able to talk.*

Failing to establish boundaries: refers to the nurse's inability to remain engaged with the adolescent without being overwhelmed by the adolescent's emotions or experience, and to their inability to prevent unresolved events from their own childhood or adolescence from unbalancing their perspective and interfering with therapeutic work.

> *I think there were times when adolescents who were depressed triggered some things in me ... not being able to recognise that would stand in the way of the relationship. I wouldn't be as effective a nurse with that adolescent where I identified too much [with them] ... that triggered some feelings that I myself had experienced as an adolescent, being depressed, [and] may be I hadn't worked through those.*

It's more than a job: refers to the way nurses continue to wonder about adolescents long after termination of their relationship, and to think about them with affection, tenderness, enthusiasm and warmth so they remain as someone special in the nurse's memory.

> *This rather beautiful, well dressed young woman came up to me and said "hello Origma" ... it's Justine." ... I asked her looking back on the unit whether she thought it had done any good and she said "no, not really" but I don't believe her because otherwise why would she come up and make contact with me, I simply wouldn't have recognised her ... I think we actually love those kids in our own way. I still think of some of them with deep affection and wonder how they're going.*

Implementing restraint: refers to the way nurses physically hold an out of control adolescent to prevent them from destroying property or from hurting themselves or others. Nurses only restrain when all other strategies have failed to contain escalating behaviour, prefer not to restrain in front of other adolescents, use a time out room whenever possible and use a modified form of restraint for those adolescents who have been sexually abused.

> *Warnings are given to give the adolescent time to try and manage his behaviour ... if that doesn't happen usually you get a verbal outburst and physical aggression. They may need to be restrained until they calm down [especially] in a situation where they're not in control ... restraint is only done when all other methods of calming the adolescent have failed and the adolescent cannot grasp the results of their behaviour ... they may be going to hurt someone.*

Nurses provide and take opportunities: refers to the nurse's ability to make themself available to create opportunities for therapeutic work in ways that are acceptable to adolescents, and to take such opportunities when they arise through shared activities of living.

> *We were jumping on the trampoline and [I] start asking about "how's mum?" ... those things start getting [discussed] ... they're relaxed and [it's a] free environment to talk about their problems. When particular incidents happen it's a good time to talk to them because it's more effective, you can use that incident to work on the issues ... take the chance to work it through with them.*

Testing nurses: refers to the nurse's ability to respond in a neutral and accepting way to behaviours that challenge authority, expectations and discipline, and to endure such testing in order that adolescents come to believe the nurse is strong, capable and trustworthy and will remain engaged with them despite continual testing.

> *Adolescents can say all the right things or wrong things ... pushing your buttons and making you want to explode and that's the test they're giving you to see if you're going to be able to cope with them at their worst time. If you can cope ... they'll make it even worse [to see] that you're going to be there next time and you're not going to run away, you're not going to slam the door in their face and say "I can't deal with this."*

Interpreting communication: refers to the nurse's ability to interpret verbal, behavioural and symbolic communication in order to create understanding and meaning for themself, the adolescent and others. Such understanding allows therapeutic work to begin or progress.

> *With Kara [it] was that she didn't value herself as a person and therefore it didn't matter what happened to her ... a lot of risk taking behaviours, eating mushrooms then going to hospital and being lavaged ... getting alcohol from the shop ... running away. There was a lot of emotion there that she couldn't put into words.*

Having fun: refers to the way nurses participate in activities with adolescents in order to create a lighthearted atmosphere where adolescents experience freedom, warmth and laughter.

> *Some of them have disruptive lives and disruptive families, humour's not introduced in their family life much and [so] I encourage fun times .. lots of games, lots of playing ... any game that we can instigate where laughter is brought into it, and it usually brings out a sense of warmth ... I think it's good, it helps them, they need a good laugh.*

An open, accepting and supportive environment: refers to a positive, nonpunitive, explorative, facilitative and nurturing milieu where adolescents feel free to be themselves, to express themselves and to act out their distress, and where nurses feel supported in their

work with adolescents.

> *If the nurses aren't providing that supportive environment where the kids can be themselves, where they feel they can express themselves and have an opportunity to be themselves and act out [it won't work] ... it's the attitude and behaviour of the nurses and what sort of atmosphere they create that's the most important element of setting the milieu ... that provides the blanket or place where the adolescent can act out or do whatever.*

Nurses are advocates: refers to the nurse's ability to support and defend the adolescent, to speak out or act on their behalf, and to attempt to provide others with an understanding of the adolescent's position or perspective. Such action allows the nurse to fulfil an ethical obligation to the adolescent despite the hostility, resistance and prejudice they encounter from colleagues and peers.

> *Justine was most unattractive, disliked by many of the staff and pejoratively labelled but I think she wrestled her way through quite a profound depression ... I remember defending her against other members of the staff, it was an effort at times to get her to shower ... she had this dank smell about her ... There's a temptation to, rather than empathise with an adolescent's depression and difficulty in caring for themselves, to attack them or feel embarrassed ... I felt that was the case with some of the staff, that she was naughty rather than depressed.*

The problem of labelling: refers to the nurse's ability to resist the use of negative labels which result in preconceived expectations and prevent nurses from relating effectively to adolescents who are viewed as different or difficult.

> *There's a tendency to expect or not expect a certain level, say for example [with] a psychotic adolescent because of what was going on, you know, their emotions and feelings at that particular time ... I've seen each individual adolescent can be quite different even if there's a [similar] picture there of psychosis or whatever you label young people with. I tend to steer clear of labelling ... to look at them as an individual or how I see them and their abilities, whether it's creative, academic, sport or anything else.*

Supporting parents: refers to the nurse's ability to establish an effective working relationship with the adolescent's parents in order to engage them in their adolescent's care while offering hope, encouragement, assistance and information. In supporting parents this way nurses relieve anxiety and blame and provide comfort.

> *It's important to have the parent's input and feedback and expressions of their difficulties. Parents need help managing so you need to support the parents and help with their ... anxieties about how they're going to manage the adolescent at home. Parents are very important [but] sometimes parents need as much work as the adolescents do ... they need a lot of support.*

Working in partnership: refers to the nurse's ability to unite with adolescents, parents and other health professionals in a supportive and cooperative way in order to deal with the problems the adolescent is experiencing. The nurse-adolescent partnership is characterised by attempts to empower adolescent autonomy and by a sense of working closely together.

> *It's important that they know that you're not going to fix them, they're going to be responsible and it is this joint thing of working together ... we will work on things and work together in helping you work through the problems you've come to the unit with ... the doing of that would be the important thing, they would know that was happening, experience it happening ... May be when they come in they feel it will be you doing it and may be that's okay initially ... but as the admission proceeds, that partnership with them [changes], taking their responsibility for their part will become more and more ... when they leave they will be a responsible individual in their own right.*

The pressure is taken off: refers to the nurse's ability to allow the adolescent to feel unpressured in developing their relationship and to maintain control over issues such as disclosure of information. It requires patience, acceptance and judgment.

> *When I first met Martyne she just sat there on her bed and wouldn't even raise her eyes up to me ... may be a week later she'd look up and say "hello", so it was just gradual. Don't push them too hard because they've got enough pressure on them ... be very patient with kids until they're ready to talk and tell you about themselves ... let them go at their own pace.*

Nurses use humour: refers to the way nurses laugh at themselves and with adolescents, and use humour to defuse tension, anxiety and seriousness. The use of humour creates a lighthearted atmosphere conducive to playfulness and fun.

> *In your everyday interactions with adolescents I find you can make life really quite funny at times for them ... One evening we were going for a long walk ... and one of the adolescents, she was in very bad form that evening, and I said "okay, come on then lets go, we're going for a walk, lovely fresh air." [I] was trying to encourage them out and she was moaning and [said] "oh, I don't want to go and I've got a pain in my neck" and I said "well, you won't be walking on your neck will you!" She had a laugh from that.*

Nurses are there: refers to the way the nurse's presence and preparedness to be there for and with adolescents, engenders feelings of togetherness, provides comfort and companionship, and opportunities for therapeutic engagement through discussion and activities.

> *Amanda is very quiet, she hardly speaks at all, she has withdrawn into a fairly mute state and I find, as difficult as it is, I spend time with her ... just being with her, talking to her even though she was not responding ... Despite the worthlessness she was feeling, the sense of isolation, the confusion about herself and what was happening to her someone was still there talking to her ... they just need you to be there.*

Providing attention: refers to the nurse's ability to be interested in the adolescent and to provide them with attention in order that they experience that attention as nurturing and as a reflection of their worthiness.

> *It was a bit more attention that he needed, someone to talk to him, spend time with him and just listen to what he had to say ... it gives a sense of identity and self worth.*

In the following table, the seven sub-elements of practice knowledge identified in five nurses's texts are presented.

Table 8.5: Sub-Elements Identified in Five Nurse's Texts

Being understanding	Being accepting	Providing individualised care
Providing containment	Providing equality	Nurses encourage independence and responsibility
Providing safety and security		

Being understanding: refers to the nurse's ability to empathise with difficulties the adolescent is experiencing, both developmentally and through their emotional disturbance, in an accepting, nonjudgmental way so the adolescent feels understood.

> *Knowing there's someone there to understand when they're going through the rough times and someone they can share what they're going through and who won't be too judgmental about their responses and behaviour ... being there for them and trying to understand.*

Being accepting: refers to the nurse's ability to inherently value the adolescent as a person, understand their perspective, pace the process of engagement through the adolescent's responses and allow the adolescent to be themself. In turn, the adolescent experiences the nurse as approachable, available and nonjudgmental.

> *[It's] the adolescent feeling somebody cares about them and accepts them and likes them, regardless of their problems, for what they are. I think they can see you then for being a very kind of human person and approachable. They can say what they feel to you and they don't feel put off some way in approaching you, or expressing how they feel, or what they are, or how they feel about you.*

Providing individualised care: refers to the way nurses seek to develop an individual and contextual understanding of the adolescent in order to pay attention to their particular needs and maximise their work together.

> *Martin had a sense of humour and he was much more out going than Mitchell ... if I used the same sense of*

> *humour with Mitchell as I did with Martin it would've destroyed the whole relationship. You've got to get to know the kid, just look at the kid first and ... think about how they would react if I said this, if I said that.*

Providing containment: refers to the nurse's ability to deal with escalating feelings and behaviour in a calm, neutral, reassuring and supportive way, to provide anger reduction strategies and to take control for adolescents when they are unable to be in control themselves. In doing this the nurse provides a safe, predictable environment and the adolescent experiences a reduction in anxiety and tension and an increased sense of control and well being.

> *When they don't have that [feeling of control] internalised in themselves then somebody on the outside needs to provide that for them, so they feel safe and secure ... they're unable to call it forth in that situation because of what they're going through at that moment. If the combination of adolescents that are together are really egging each other on ... [then] giving them time out or removing them, taking them to another activity or doing something else, could avoid that [escalation].*

Providing equality: refers to the way nurses strive to develop a nonauthoritarian and nonhierarchical relationship with adolescents in order to foster feelings of trust, respect, connectedness and comfort while removing barriers which constrain communication, sharing and therapeutic engagement.

> *Some health workers put themselves above the client but we're grass roots people, the nurses, and if we had the attitude ..."you're not my equal" I don't think we'd get very far ... [equality allows] spontaneity, trust, respect ... It's important that you're not putting yourself above kids, let them know that everybody is equal ... I think they relate better to you.*

Nurses encourage independence and responsibility: refers to the way nurses encourage adolescents to develop increasing levels of emotional, behavioural and ideational autonomy. They do this by replacing the nurse-adolescent relationship with adolescent-peer relationships, by providing adolescents with freedom and opportunities for practice and skills building, and by demonstrating trust in the adolescent's ability to become independent and

responsible. In turn, adolescents develop confidence in their developing skills and their progression toward adulthood.

> *We worked in a general way of having adolescents, once they were ready to, take responsibility for their behaviour and in learning to be with other people ... to eventually becoming independent people ... at the beginning you might be observing, in the middle there might be more intervention and towards the end you would hope the adolescent would have internalised or learnt ways of managing to control that [problem] themselves.*

Providing safety and security: refers to the way nurses try to create a predictable, stable, harmonious, moral and caring environment. They do this by being calm and consistent, by varying levels of supervision according to need and by containing exploitative or acting out behaviours. Such an environment provides a sanctuary for adolescents and opportunities for therapeutic work.

> *The basis would be one to one care, Sarah would be provided with that level of supervision and contact with someone when she was really distressed, there would be someone there to help her through those times. And, the physically safe environment, not let her have access to anything dangerous. I guess being in a unit that overall she knew cared about her and had her best interests at heart.*

In the following table, the three sub-elements of practice knowledge identified in six nurse's texts are presented.

Table 8.6: Sub-elements identified in six nurse's texts

Setting limits	Developing trust	It gets you down

Setting limits: refers to the nurse's ability to create a predictable, stable, safe, moral and consistent environment by communicating expectations and directions clearly, by assisting adolescents to recognise, accept and learn contextually acceptable ways of behaving and by intervening before behaviour escalates out of control.

> *Limit setting refers to curtailing behaviour to what's appropriate ... putting limits on what an adolescent can do or get away with before it becomes unacceptable. The behaviour is addressed, the adolescent is asked if*

> *they realise what they're doing, the consequences of what they're doing [and] what is acceptable within that particular setting ... it's all right to jump and scream in the swimming pool but you can't do that at a restaurant.*

Developing trust: refers to the nurse's ability to spend time with the adolescent and work slowly toward developing a comfortable, mutual relationship through which the adolescent feels free to share their difficulties and distress. Adolescents demonstrate their trust in nurses by spending time, and sharing information, with them.

> *Even though you may be talking about a dog or a bike it's not the content that's important but the process to see that there's trust going on ... it's meaningful in the sense of allowing a process to develop or deepen. There's times when I know chit chat is useful because the kids need to warm up to you and you need to warm up to them ... to get to know one another.*

It gets you down: refers to the frustration, sadness, disappointment and exasperation nurses experience in their work with adolescents, colleagues and peers. Such emotions result from their perceived inability to work effectively with the adolescent, from the strain of dealing with acting out behaviour, from their perceptions of poor prognosis with major emotional disorders and from experiences of being devalued or having to defend their nursing care to colleagues and peers.

> *When a kid is dirty and a little bit smelly and a little bit lank, how do you explain this? ... Isn't it your job as a psychiatric nurse to see they wash themselves? I tried basically to be educative about what feelings might be underneath and even now I have a sense of "God, do I have to say this again!"*

In the following table, the sub-element of practice knowledge identified in seven nurse's texts is presented.

Table 8.7: The Sub-Element Identified in Seven Nurse's Texts

Nurses try to create change		

Nurses try to create change: refers to the nurse's ability to engage with adolescents and develop strategies to help them rework the

past, deal with the present and focus on working toward change. Nurses use day to day interactions and encounters between the adolescent and peers, teachers, nurses and others to facilitate this process.

> *It's in the interactions with the other kids that the 'pathology' or behaviour comes up to work with ... it can [also] be with authority figures like the principal ... [but, for example] when they try to care for each other and support each other and they overload each other you can point out "is this perhaps what you also do within your family?" or "is this a role that's familiar to you in other parts of your life?"*

As the foregoing work demonstrates the sub-elements of practice knowledge were noted with varying frequency. For instance, "therapeutic touch" was identified in one nurse's text, "establishing boundaries" in four and "nurses try to create change" in seven. This does not mean no other occurrences of those sub-elements are in the text. Interpretation is influenced by preunderstandings and as interpretive decisions are made about multiple meanings and the significance of those meanings, interpretive certainty is not possible. Other interpreters would find different sub-elements and different frequencies of their occurrence. Moreover, some nurses spoke about adolescents with specific disorders, for example, Lai discussed experiences with psychotic adolescents whereas Brandon discussed experiences with conduct disordered adolescents. It may be therefore that different practice knowledge is required in the care of those two groups of adolescents. If Lai and Brandon were asked specifically about the adolescents they did not discuss, they too may have mentioned sub-elements of practice knowledge which were not identified in the information they provided. In this way, the sub-elements identified in the study could be used in future research to explore the practice knowledge of adolescent mental health nursing more fully. For instance, while I identified

"establishing boundaries" in four nurse's texts, my foreknowledge of practice suggests all adolescent mental health nurses would understand and use this concept in their practice. Thus, research focused on expanding this particular sub-element would produce a greater understanding of its use in practice.

Following definition of the sub-elements, I proceeded to the second level of interpretation where I developed and defined the elements. This work is presented in the following section.

8.03 Level Two Interpretation: the Elements of Practice Knowledge

At the second level of interpretation I grouped the sub-elements with shared meanings into elements of practice knowledge. From the 80 sub-elements of practice knowledge I developed and defined four elements of practice knowledge. In the following section, I present the four elements and the sub-elements of which they are composed, after which, I present their definitions.

In the following table, the 19 sub-elements of the element "engaging in therapeutic relationships" are presented.

Table 8.8 Engaging in Therapeutic Relationships

Providing mutuality	Nurses are there	The nurses are not there
Relating to adolescents	Experiencing attachment	Developing trust
Nurses are people	Nurses are seen as family	Adolescents are people
Building the nurse-adolescent relationship	Establishing boundaries	Failing to establish boundaries
Providing equality	The pressure is taken off	Nurses discipline through relationships
Working in partnerships	Mismatched adolescent/primary nurse relationships	Supporting parents
Facilitating termination and separation		

Engaging in therapeutic relationships: refers to the nurse's ability to develop, engage in and terminate the therapeutic nurse-adolescent relationship in ways that enhance mutuality, trust, familiarity and partnership.

The following table lists the 20 sub-elements of which the element "providing a therapeutic milieu" is composed.

Table 8.9: Providing a Therapeutic Milieu

The stress of admission	Providing adolescents with their own space	The unit was not clinical
Having fun	Nurses use humour	The adolescent peer group is supportive
The nursing peer group is supportive	Being neutral	Striving for consistency
Setting limits	Failing to set limits	Monitoring behaviour
An open, accepting and supportive environment	A secure, accessible and unconstrained environment	A cohesive, consistent/cooperative environment
Providing safety and security	Failing to provide safety and security	An unethical environment
An uncooperative, inconsistent/noncohesive environment	Inappropriate admission to adult or child units	

Providing a therapeutic milieu: refers to the nurse's ability to participate in developing an environment which is experienced by the adolescent as homelike, accepting, unconstrained, safe, stable, lighthearted and enabling.

In the following table, the 10 sub-elements of the element "guiding the potential for change" are presented.

Table 8.10: Guiding the Potential for Change

Nurses encourage independence and responsibility	The adolescent developmental stage	Being supportive
Getting on with life	Working through issues in groups	Nurses try to create change

Highlighting difference and change	The therapeutic use of self	Nurses are role models
The distress od therapy		

Guiding the potential for change: refers to the nurse's ability to facilitate the adolescent's capacity toward personal, interpersonal and social wellness by fostering development, assisting the adolescent to understand their experience and focusing on forward movement.

The following table lists the 31 sub-elements of which the element "facilitating positive outcomes" is composed.

Table 8.11: Facilitating Positive Outcomes

It's more than a job	Nurses are friends	Being understanding
Seeing and responding to what's underneath	Providing individualised care	Nurses are flexible
Being tolerant	Being honest	Nurses persevere
Providing containment	Nurses provide and take opportunities	Therapeutic touch
Identifying behaviours	Interpreting communication	Being accepting
Nurses take time and make time	Providing attention	Failing to provide attention
Building confidence and self esteem	Demonstrating concern	Testing nurses
Implementing restraint	Nurses are advocates	The problem of labelling
The ethics of practice	Expanding nursing practice knowledge	Devalued nursing practice knowledge
Expanding the knowledge of self	Intuition	Failing to respond appropriately
It gets you down		

Facilitating positive outcomes: refers to the nurse's ability to intervene therapeutically through positive, informed, moral and engaged practice, and through their capacity to endure and deal with challenging behaviours in order to contain the adolescent's distress and foster the adolescent's self worth and belief in themself.

Following development and definition of the elements of practice knowledge, I proceeded to the third level of interpretation where I examined all my previous work in order to obtain an understanding of the meta-element of practice knowledge.

8.04 Level Three Interpretation: the Meta-Element of Practice Knowledge - Fostering a Functional Self

At the third level of interpretation, I reviewed my definitions of the elements and sub-elements of practice knowledge in order to develop the meta-element of practice knowledge. In doing this, I focused on a broad conceptualisation rather than on specifics. For example, when I identified and defined the 80 sub-elements of practice knowledge I focused on textual particulars in order to provide concise understandings of practice through explicit definitions. On the other hand, when I developed and defined the four elements of practice knowledge I attempted to synthesise the overall meanings of the sub-elements within each element. In this way, I moved toward an interpretive summary rather than looking at precise examples. When developing the meta-element of practice knowledge, I continued the move away from the specific in order to take account of practice in the broadest sense. In this regard, the meta-element "fostering a functional self" describes, in a wholistic way, what occurs in adolescent mental health nursing when the sub-elements and elements are applied to practice. Thus, while aspects of the sub-elements and elements are integrated into the meta-element they are not as explicit.

Fostering a functional self: refers to the way nurses break through the barriers restraining change and assist adolescents to develop more functional ways of thinking, feeling and acting in personal, interpersonal and social contexts and through which, in turn, adolescents experience reintegration and wellness. Nurses do this by working against the background of an enabling milieu, through the therapeutic relationships they engage in with adolescents and through their capacity for therapeutic intervention.

8.05 Conclusion

Although the practice knowledge of nursing on residential adolescent mental health units was represented through its parts, the sub-elements, elements and meta-element, it should be considered as a whole. For example, an understanding of the "what" and "how" of practice is represented in the sub-elements. On the other hand, the elements provide an understanding of "why" nurses apply the sub-elements to practice and the meta-element describes the "aim" and "outcomes" of practice through application of the sub-elements and elements to practice. Thus, the most complete understanding of adolescent mental health nursing practice knowledge is achieved when the sub-elements, elements and meta-element are considered in relation to one another.

In the last two chapters, I presented the research findings developed from the information provided by the young people and the nurses. In the following chapter, entitled "Adolescent Mental Health Nursing Practice Knowledge - New Horizons", I discuss the research findings in relation to their implications for adolescent mental health nursing.

Chapter Nine

9 The Practice Knowledge of Adolescent Mental Health Nursing: New Horizons

9.01 Introduction

In this chapter, I argue that the study findings represent new horizons from which to understand the practice knowledge of nursing on residential adolescent mental health units. I use horizon to imply all that can be seen from a particular vantage point as a result of being prefigured by determinate traditions (Gadamer, 1979). These traditions include those of the researcher and research participants, as well as nursing in general, and adolescent mental health nursing in particular. They are the traditions of living, of nursing and of being nursed. The new horizons of adolescent mental health nursing practice knowledge, allow understanding of the way nurses break through the barriers restraining change in order to assist adolescents to develop more functional ways of thinking, feeling and acting in personal, interpersonal and social contexts, and through which adolescents experience reintegration and wellness. In bringing new horizons of knowledge into being, the study findings highlight the significance of therapeutic relationships, an enabling milieu and the positive outcomes and change achieved through therapeutic intervention.

Through explication of the sub-elements, elements and meta-element the study findings reveal the practice knowledge of nursing on residential adolescent mental health units. The sub-elements represent the what and how as well as the therapeutic effects of practice, the elements represent the why of practice, and the meta-element represents the aim and outcomes of practice through application of the sub-elements and elements to practice. In the

first instance, I discuss the way: (1) engaging in therapeutic relationships, (2) providing a therapeutic milieu, (3) guiding the potential for change, and (4) facilitating positive outcomes reveal the how, what and why of adolescent mental health nursing. I also integrate findings and theoretical positions from the nursing and mental health nursing literature into this discussion. Prior to doing this, I note the difficulties encountered in attempts to compare the findings of interpretive studies.

9.02 Interpretive Difference and Research Findings

Interpretive difference is the hallmark of qualitative research and nowhere is this more obvious than in the decisions interpreters make regarding the naming of meanings. As a result, what appears to be differences in study findings may be differences in the focus of studies or in the traditions and preunderstandings of interpreters. I demonstrate differences in the naming of meanings by using examples from the present study findings and Weissman and Appleton's (1995) study. For instance, "a couple of them they are always with the kids. [They are] always in the groups and always being there, just like a regular staff member ..." While Weissman and Appleton used this excerpt as an example under the theme "friendship", I singled out similar excerpts and named them "the nurses were there." Also, "they talk to you and get to know you ... they believe I'm a person, that I'm myself, not just everybody else." Again, Weissman and Appleton did not individually identify such examples but included them under the theme "friendship" whereas I picked out similar examples and named them "adolescents are people." Thus, where Weissman and Appleton developed the one theme "friendship", I developed the three sub-elements "nurses are friends", "the nurses were there" and "adolescents are people."

I am not suggesting Weissman and Appleton (1995) should have

differentiated their excerpts nor that they would have chosen the names I did, rather I am suggesting that comparisons between the findings of qualitative studies is difficult. Had Weissman and Appleton used sub-themes, as well as themes, the additional analysis may have produced more similarities between their study and the present study. On the other hand, it may not. Gadamer (1979) reminds us that we understand and interpret in the light of our preunderstandings which are themselves constantly changing. Thus, while we aim at a faithful understanding of what a text says, what the text says will be different in the light of those preunderstandings and the different questions we learn to ask. This does not mean our interpretations are arbitrary nor distortive but rather they are incomplete, fluid and partial. In this way, traditions and changing preunderstandings produce similarity and difference in qualitative studies and, with regard to practice knowledge, a representation that is always in the process of change.

The Elements

9.03 Engaging in Therapeutic Relationships

The nurses and adolescents characterised the relationship that developed between them as engaged, relational, mutual and familial. They spent time together and experienced a sense of equality, give and take and companionship. Because nurses worked slowly toward developing trust and did not pressure adolescents to engage with them or disclose information, they built a working alliance with the adolescents. Nurses understood that adolescents would engage with them when they felt ready. Adolescents experienced this lack of pressure as a relief and took the opportunity to relax, have fun and get on with other aspects of their lives. Through the experience of sharing their lives with nurses on a day to day basis, adolescents came to see the nurses as people, family and friends. The nurses

encouraged this, understanding that it would assist adolescents to relate to them and aid them in their attempts to foster change. In perceiving the significance of the relationships they built with adolescents, nurses understood the need to prepare adolescents for the loss of those relationships. Despite such preparation, many adolescents experienced the loss of their relationships with nurses with deep sadness (see Chapter 7, p. 156; Chapter 8, p. 190).

The contribution this finding makes to the practice knowledge of adolescent mental health nursing is to illuminate the nature of the nurse-adolescent relationship. The sub-elements do this by pointing out "what" happens between the nurse and adolescent, "how" it happens, and the "therapeutic effects" resulting from the "application" of the sub-elements to practice. I use the sub-elements "experiencing mutuality" and "nurses are there" to delineate these concepts. Adolescents and nurses experience mutuality (what they do) by sharing of themselves, being together and providing companionship for each other (how they do it) (see Chapter 7, p. 148; Chapter 8, p. 173). When "nurses are there" they come to understand adolescents, are on hand to encourage and affirm them, and available to comfort and assist when needed (application). Adolescents experience the nurse's presence as comforting, an expression of genuine concern and interest, an opportunity for shared involvement and a way of removing barriers (therapeutic effects) (see Chapter 7, p. 148; Chapter 8, p. 184).

On the other hand, the element of practice knowledge points to the purpose behind what the nurse does or the "why" of practice. In this regard, nurses participate in therapeutic relationships with adolescents in order to provide the agency through which the shared, intersubjective transactions of nursing can be engaged in and experienced within the milieu (see Chapter 8, p. 190).

The nurse-client relationship is a common aspect of nursing research and theorising in general (see Lowenberg, 1994; May, 1991; Morse, 1991b; Ramos, 1992; Rawnsley, 1994), and of mental health nursing in particular (see Armstrong & Kelly, 1995; Forchuk, 1995; Lacey, 1993; Olsen, 1996; Peplau, 1994; Walsh, 1994; West and Sieloff Evans, 1992). Thus, it is understandable that this study and the following studies in long term, acute care, mental health, medical, surgical and oncology nursing, all present the relationship between the nurse and client as significant in some way. To begin, I demonstrate this point by reviewing two studies in adult mental health nursing. In the first study, Nehls (1994) found clients experienced familial attachments and friendship in their relationships with nurses in the same way the present study found adolescents experienced familial attachments and friendship with nurses (see Chapter 7, pp. 141, 147, 148), while in the second study, Heifner (1993) found nurses portrayed their relationship with clients as reciprocal and interactional in the same way findings from the present study portrayed the nurse-adolescent relationship as mutual and interactional (see Chapter 8, pp. 173, 181, 184, 188). In the following discussion, I review findings from the present study in relation to findings from studies in oncology, long term, medical, surgical and acute care nursing.

Trygstad (1986) conducted research with oncology nurses and found they became the client's professional friend in a relationship characterised by reciprocity, trust, genuine interest and humour. Similarly, findings from the present study suggest nurses became the adolescent's friend in a relationship characterised by mutuality, trust, attention and humour (see Chapter 8, pp. 173, 177, 184, 188). Astrom, Norberg, Hallberg and Jansson (1993), in their study with nurses working in long term, medical and surgical settings,

noted the importance of the nurse-patient relationship and how nurses were committed to clients and made themselves available in order to try to understand and to share and exchange experiences. Findings from the present study also noted the importance of the nurse-adolescent relationship and how nurses were committed to the adolescents and spent time with them in order to try to understand and to share and exchange experiences (see Chapter 8, pp. 167, 173, 175, 184, 185, 190). Finally, Tippl's (1995) research involved nurses working with chronically ill adolescents in acute care settings. Her findings suggested nurses formed significant relationships with adolescents founded on friendship, reciprocity, involvement, presence and choice. Similarly, findings from the present study suggested nurses formed significant therapeutic relationships with adolescents founded on friendship, mutuality, involvement and presence (see Chapter 8, pp. 173, 175, 177, 181, 184, 190). Even so, similarities in research findings does not mean sameness and such similarities may prove, on further investigation, to be superficial. I use Tippl's study to make this point.

The nurses in Tippl's (1995) study formed significant relationships with adolescents by being present yet the milieu of their presence, both personally and environmentally, would be different to that of an adolescent mental health unit. For example, in acute care settings relationships are established and enacted in the technological and clinical environment of laboratory results, diagnostic procedures and a variety of tasks associated with the client's physical illness. In adolescent mental health settings the same relationships take place in a homelike, nonhospital environment where nurses jump on trampolines, go to school, play snooker, have water fights and share meals with the adolescents (see Chapter 7, pp. 146, 147, 152, 153; Appendix G, pp. 345, 351,

355, 358). As the adolescent James said, it was like living with the nurses (see Appendix G, pp. 345-346). Thus, while the findings from Tippl's and the present study both emphasised relationships between adolescents and nurses, more focused research is required in order to say anything beyond the superficial about the nature of those relationships since their development occurred within such different contexts and settings.

In reviewing the findings of studies conducted in adolescent and adult mental health nursing as well as long term, medical, surgical, acute care and oncology nursing, the centrality of the nurse-client relationship to nursing is noted. Rawnsley (1994, p. 185) refers to the nurse-client relationship as a "distinguishing characteristic of the discipline" of nursing. However, as findings from the present study suggest, one characteristic of the nurse-client relationship in mental health nursing is the therapeutic nature of it, that is, its orientation goes beyond the notion of interpersonal processes to include change (see Hinds, 1988; Wilson & Hobbs, 1995; Yurkovich, 1989). Moreover, change is not the same as healing or caring; two notions linked to therapeutic nurse-client relationships by McMahon (1991) and Pearson (1991), and by the authors in Pearson's (1988) and McMahon and Pearson's (1991) books on therapeutic and primary nursing. In this regard, change is not characterised by repair, restoration or mending but by movement, a shift or transformation. Its orientation and outcomes are somewhat the same yet somewhat different to healing. Nevertheless, outside Robinson's (1996) public health nursing research, there appears to be little research linking the notion of change to the therapeutic nurse-client relationship. In this regard, the present study: (1) supports claims within the mental health nursing literature that the nurse-client relationship provides the agency through which nurses

guide and foster the client's potential for change, (2) provides research findings noting the association between change and the therapeutic nurse-client relationship, and (3) expands the breadth and depth of understandings on the therapeutic relationship by unifying a number of aspects of nursing knowledge (see Chapter 7, pp. 156-157; Chapter 8, pp. 190-191). To this point, my review of the nursing literature has noted the way findings from the present study align with or illuminate already developed theoretical or research positions. However, in the following discussion I present: (1) "experiencing equality/providing equality", and (2) "the pressure is taken off"; two aspects of "engaging in therapeutic relationships" which do not appear to be in the nursing literature.

For the nurses and adolescents in the present study, equality was fundamental to the nature of the therapeutic relationship they developed. Equality was represented as providing the basis for a nonauthoritarian and nonhierarchical relationship. It allowed the development of trust, respect, connectedness and comfort by removing barriers to communication, sharing and therapeutic engagement (see Chapter 7, p. 154; Chapter 8, p. 186). While discussion on the nature of the nurse-client relationship is available in the mental health nursing literature (see Bonnivier, 1996; Forchuk, 1995; Heifner, 1993; Peplau, 1962, 1969, 1988a; Wilson & Hobbs, 1995), the notion of equality has not been a part of this discussion. On the other hand, Lowenberg (1994) does mention status differential and egalitarianism but in the context of collaboration, advocacy and empowerment rather than as a way of fostering therapeutic relationships and engagement. Thus, the knowledge that equality is integral to the nurse-adolescent relationship provides a new horizon from which to conceptualise the nature of therapeutic relationships. This finding highlights how

equality is necessary in order for therapeutic relationships to provide the foundation through which nurses and clients can work toward change. In highlighting its significance to the nurse-adolescent relationship, equality illuminates that relationship from a particular perspective. In the same way, "the pressure is taken off" also opens up possibilities.

"The pressure is taken off" should not be confused with patience as it characterises not only the nurse's ability to go at the pace of the client in developing the nurse-client relationship, but also the ability to give clients control over the processes of relationship building and disclosure (see Chapter 7, p. 149; Chapter 8, p. 183). Thus, "the pressure is taken off" says as much about perseverance as it does about a capacity to share power and control. This finding focuses attention onto the nurse-adolescent relationship from a different perspective. For example, while equality focused on one part of the structure or form of the nurse-adolescent relationship, "the pressure is taken off" focuses on one of its processes. However, the knowledge that this finding provides throws it into conflict with systemic constraints related to predetermined lengths of stay formulated through diagnostic related groups and casemix funding. In this regard, research into the processes of the nurse-client relationship, such as "the pressure is taken off", could provide useful information through which nurses could engage in economically driven health care debates.

In the preceding discussion, I reviewed the findings on "engaging in therapeutic relationships" in relation to present positions in nursing, and in relation to knowledge provided through the study findings. In the following section, I examine the findings on "providing a therapeutic milieu" in relation to mental health nursing theory on adolescent unit milieus.

9.04 Providing a Therapeutic Milieu

The nurses and adolescents perceived and valued the complex and intricate web of influence that characterised the milieu. The adolescents spoke of the physical and metaphysical environment as an open, accepting, homelike and flexible place where they found protection, companionship, safety and caring. It was a harmonious, unpressured and lighthearted atmosphere in which they were involved and had fun and yet could simultaneously find solitude, privacy and silence. Nurses strove to keep the milieu homelike, stable, flexible, neutral, cohesive and consistent and to provide the adolescents with a sense of freedom, belonging, support, safety and acceptance. The nurses and adolescents understood the need for such a milieu and saw the shelter, respite, healing and transformation that it allowed. Moreover, some adolescents and nurses experienced other milieus that were not enabling and those milieus stood in stark contrast to adolescent unit milieus (see Chapter 7, p. 157; Chapter 8, p. 191).

The contribution this finding makes to the practice knowledge of adolescent mental health nursing is to illustrate the nature and function of the milieu; what it is, how it is maintained and its therapeutic effects. For example, adolescents experience the milieu as safe and secure (what it is) because nurses provide structure through routines, deal with challenging behaviours with neutrality and set limits (how it is maintained) (see Chapter 7, pp. 140, 148, 149; Chapter 8, pp. 144, 175, 186, 187). The therapeutic effects experienced by the adolescents through the application of the sub-elements to practice is demonstrated, for example, by the sub-element "the pressure is taken off." Nurses take the pressure off by being open to and accepting of the pace at which adolescents need to proceed. They are also patient and take the focus off the

adolescent's problems by engaging them in enjoyable activities in a lighthearted atmosphere (application) (see Chapter 7, pp. 147, 149; Chapter 8, p. 181, 183). Adolescents experience activities, the nurse's patience and acceptance, and the lighthearted, unhurried atmosphere as relief from the pressures they previously felt. Pressure and tension are replaced by feelings of ease and relaxation (therapeutic effects) (see Appendix G, pp. 345, 349). Thus, nurses participate in establishing and maintaining a therapeutic milieu in order to provide the ground and background against which the shared, intersubjective transactions of nursing can be enacted and experienced. Through the enabling environment that nurses create, they are able to work toward guiding adolescents in the direction of change (see Chapter 8, p. 191).

While the milieu is a traditional concept about which mental health nurses write (see Burnard, 1990; Butterworth, 1991; Creedy & Crowe, 1996; Hogarth, 1985; Le Curyer, 1992; Mulvihill, 1989; Tuck & Keels, 1992; Walker, 1994b), research on this aspect of mental health nursing is lacking. On the other hand, in recent nursing articles on child (Delaney, 1992) adolescent (Creedy & Crowe, 1996) and adult milieus (Tuck & Keels, 1992), the authors used Gunderson's (1978) theory of the therapeutic milieu to inform their discussion. This use of borrowed theory is problematic in mental health nursing since there appears to be: (1) no research on the therapeutic milieu, (2) an excessive reliance on borrowed theory, (3) a lack of testing and evaluation of borrowed theory, and (4) a need for theory generating practice based research (Austin, Gallop, Harris & Spencer, 1996; Barker, 1990; Butterworth, 1987; Deans, Lea & Geyer, 1997; Hoffman & Bertus, 1992; Koldjeski, 1990; Lacey, 1993; McBride, 1986; Thomas & Wilt, 1989). Moreover, as the following discussion of Creedy and Crowe's (1996)

article suggests, research into nursing practice provides openings through which to expand present theoretical understanding.

Creedy and Crowe (1996) adapted and applied Gunderson's (1978) five processes of containment, support, structure, involvement and validation to their discussion on the development of a therapeutic adolescent milieu. Many aspects of their discussion are noted in the findings from the present study including notions of safety, security, neutrality, flexibility, consistency, acceptance, support, cohesion, stability, monitoring behaviour and limit setting (see Chapter 8, pp. 169, 171, 173, 174, 175, 187). On the other hand, aspects missing from Creedy and Crowe's discussion, and other discussions on the therapeutic milieu (see Delaney, 1992; Tuck & Keels, 1992; Walker, 1994b), but noted in the present findings include the:

(1) use of humour and the therapeutic effects of having fun,

(2) centrality of both the adolescent and nursing peer group,

(3) importance of a homelike environment and of adolescents having their own space, and

(4) need for an open, accessible and unconstrained environment (see Appendix G, p. 345; Chapter 7, pp. 146, 149; Chapter 8, pp. 164, 168, 178, 179, 184).

In this regard, findings from the present study reveal that the adolescent milieu is somewhat more than, and somewhat different to, Creedy and Crowe's (1996) conceptualisation. Moreover, while the use of humour and having fun is presented as a nursing intervention (Hunt, 1993), a means of facilitating interaction (Dunn, 1993), an avenue through which to provide client care (Harries, 1995) or a tool for relationship building (Davison & O'Brien, 1997), its use in constructing a therapeutic milieu appears new. Thus, the present findings provide a new horizon of the therapeutic milieu in

general and the adolescent milieu in particular. The therapeutic adolescent milieu is characterised by lightheartedness, laughter and fun, and by an open, unpressured, accessible and homelike environment where adolescents have opportunities for solitude and silence, and where nurses and adolescents receive support from their peer group (see Chapter 7, p. 157; Chapter 8, p. 191). In bringing this perspective of an adolescent milieu into view, the study findings provide an opening for the development of a research based theory of the therapeutic adolescent milieu.

In the foregoing discussion, I examined the findings on "providing a therapeutic milieu" in relation to mental health nursing theory on the adolescent milieu, and in relation to knowledge provided through the present findings. In the following section, I discuss the findings on "guiding the potential for change" in relation to the mental health nursing literature in this area.

9.05 Guiding the Potential for Change

The nurse-adolescent relationship is oriented toward therapeutic change. Both the nurses and adolescents understood this and formed an alliance through which to achieve that end. On the other hand, nurses also worked toward fostering developmental milestones with the focus on independence and responsibility. In this way, the orientation toward change was both functional and developmental. Nurses encouraged, supported, assisted and highlighted attempts at change. The adolescents experienced the nurses assistance as helping them to: believe in their capacity to change, make sense of things, develop feelings of mastery over events occurring in their life, deal with the past, live in the present and plan for the future. Nurses employed a variety of strategies to foster change including using themselves to model personal integration and wellness. Adolescents understood the need for

change and experienced those changes, and the influence of the nurses, as significant in their lives (see Chapter 7, p. 157; Chapter 8, pp. 191-192).

The contribution this finding makes to the practice knowledge of adolescent mental health nursing is to clarify the way nurses work toward assisting adolescents to change and move on in their lives. For example, nurses assist adolescents to develop personal and behavioural autonomy (what they do) by encouraging adolescents to care for themselves, by being flexible about routines and chores, by negotiating rather than imposing consequences, and by providing opportunities through which adolescents can learn and practice relevant skills and behaviours (how they do it) (see Chapter 7, p. 140; Chapter 8, p. 186). The therapeutic effects experienced through application of the sub-elements to practice is illustrated, for example, by the sub-element "being supportive." In being supportive nurses try to assist adolescents to understand their experiences and are sensitive to what those experiences might mean. They spend time with adolescents doing things together and try to help adolescents to deal with or resolve their difficulties. Whenever necessary, nurses teach and inform adolescents about health related issues and help parents, friends and peers to understand and appreciate what adolescents are experiencing (application) (see Appendix H, p. 375). In turn, adolescents feel understood, relieved and as though they are no longer alone and overwhelmed by their difficulties. They experience hope and are once again able to look forward (therapeutic effects) (see Chapter 7, pp. 144, 149, 150, 155). Accordingly, nurses guide the adolescents potential for change in order to foster personal, interpersonal, familial and societal reintegration and wellness. Nurses do this by harnessing and focusing the shared, intersubjective transactions of

nursing in the direction of change and by facilitating positive outcomes (see Chapter 7, p. 157; Chapter 8, pp. 191-192).

The use of the therapeutic nurse-client relationship to focus on change is not new in mental health nursing (see Bonnivier, 1996; Hinds, 1988; Riddle, 1994; Weissman & Appleton, 1995; Yurkovich, 1989). Also, that this focus will include a developmental approach is well understood in adolescent mental health nursing (see Hogarth, 1991; Peterson, Gray & Weinstein, 1994; Redston-Iselin, 1987; Riesch & Forsyth, 1992). Some understanding of how nurses guide the client's potential for change and what processes are involved in achieving this aim are present in the literature. They include aspects of role modelling, providing support, forming an alliance, working in partnership, working through issues in groups, facilitating adolescent development, the therapeutic use of self, becoming hopeful, problem solving, limit setting, discipline and consequences (see Bonnivier, 1996; Byrne & Sebastian, 1994; Byrne et al, 1994; Heifner, 1993; Hinds, 1988; Hogarth, 1991; Riddle, 1994; Wilson & Hobbs, 1995), all of which are supported by findings from the present study (see Chapter 8, pp. 150, 164, 169, 170, 171, 176, 178, 181, 183, 187).

Nevertheless, while the notion of change is often mentioned by authors it is rarely the focus of their discussion. In this regard, Riddle (1994) is the exception although she uses borrowed theory to discuss the potential for change through group work. Thus, the present findings on guiding the potential for change are significant in several ways. First, they support and extend present theoretical understandings in the literature, and second, they provide a foundation of research based findings for theory development in mental health nursing.

With regard to guiding the potential for change, four aspects of

importance in the findings yet receiving little or no attention in the literature were: (1) getting on with life, (2) nurses try to create change, (3) highlighting difference and change, and (4) the distress of therapy. The first three aspects deal directly with assisting adolescents to construct a different perception of themselves by reworking the past, dealing with the present and working toward the future through change (see Chapter 7, pp. 142, 151, 153; Chapter 8, pp. 163, 169, 172, 188). The notion of reworking the self through change is prominent in the meta-element "fostering a functional self" and is explored in later discussion on this issue. The fourth aspect, the distress of therapy, is a concerning finding from the study. It demonstrates how, for the adolescents involved, formal therapy did not guide or foster the potential for change but rather appeared to act as a force restraining change (see Appendix G, pp. 354-355). This is significant as it suggests approaches to formal therapy with adolescents could benefit from evaluation and modification. It may be, considering the success of nursing and milieu therapy suggested in the overall findings, for example, that nurses could fill this therapy role with supervision from suitably trained nurses and other health clinicians.

In the preceding discussion, I reviewed the findings on "guiding the potential for change" in relation to theoretical positions in the mental health nursing literature, and in relation to knowledge provided through the present findings. In the following section, I discuss the findings on "facilitating positive outcomes" in relation to theory development in this area.

9.06 Facilitating Positives Outcomes

The work nurses did centred around distress, turmoil and challenging behaviours. In order to make a positive impact nurses needed, on the one hand, to deal with emotions and behaviours

while, on the other hand, to try to acknowledge, understand and work with the young person experiencing distress. Nurses did not accept superficial understandings of distress and turmoil but strove to interpret the adolescent's communication, and to look beneath the obvious, in order to respond to deeper and more complex meanings and struggles. This striving to understand deeper meanings was exemplified in the nurse's understanding of adolescent testing and acting out. Nurses responded to such behaviours by trying to understand but also by appreciating the need to intervene, contain and restrain escalation. In attempting to obtain positive outcomes in their work nurses avoided the use of negative labels and advocated for adolescents in often difficult circumstances. At times, nurses experienced their work as disappointing, frustrating, sad and draining but their commitment to, affection for, and enjoyment of the adolescents was tangible.

Adolescents experienced the nurse's efforts to come to know, to understand and to work with them as demonstrations of interest, attention, care, fondness and concern. They perceived the nurses as being committed to and enjoying their work and they understood that nurses made time to be with them and took opportunities to help them. More than anything else the adolescents remembered the friendship and acceptance they received from the nurses and the equality they experienced in relationships with them. Through this friendship, acceptance and equality the adolescents came to accept and value themselves, to learn how to be friends, to trust, and to begin working toward change. Such friendship was a haven that provided adolescents with shelter, respite and companionship. The adolescents remembered the nurses, valued their experiences with them and saw them as significant in their lives.

In their practice nurses worked hard not only to understand and

foster change in the adolescents but also in themselves. The nurses struggled with unresolved issues in their lives, understanding as they did, how significant their own personal integration and wellness was in responding to, and dealing therapeutically with, the challenges of adolescent turmoil and distress. Nurses tried hard to understand themselves in their relationships with adolescents and sought to take account of and monitor their self within the therapeutic relationship. This aspect of their work, embodies the wisdom of practice (see Chapter 7, p. 158; Chapter 8, p. 192).

The contribution this finding makes to the practice knowledge of adolescent mental health nursing is to portray the way nurses make a positive impact on the distress and difficulties the adolescent is experiencing. For example, nurses assist adolescents to feel valued and accepted (what they do) by being nonjudgmental, open, patient and inclusive, and by encouraging adolescents to express their thoughts and feelings without blaming, judging or belittling (how they do it) (see Chapter 7, p. 139, 150, 154). On the other hand, the sub-element "the nurses persevered" illustrates the therapeutic effects from the application of the sub-elements to practice. Nurses persevered so adolescents would come to believe in their continuing commitment. Adolescents challenged this commitment by testing nurses and acting out their distress and turmoil. In persevering, nurses accepted challenging, rejecting and disturbed behaviours while continuing to encourage and support adolescents (application). As a result, adolescents came to believe that nurses understood and would be there for them (therapeutic effects) (see Chapter 7, p. 144, 147, 150). Thus, nurses facilitated positive outcomes in order to optimise the shared, intersubjective transactions of nursing, and the adolescent's efforts and movement

toward change (see Chapter 7, p. 158; Chapter 8, p. 192).

The term facilitating positive outcomes does not appear in the mental health nursing literature and while other terms suggest similar meanings, for example, health care outcomes (Hinds, 1988), facilitative affiliation (Rogers, 1996), well being (Weissman & Appleton, 1995) and recovery (Wilson & Hobbs, 1995), they were not as expansive as facilitating positive outcomes nor did they focus on the same aspects of knowledge. For example, Hind's study links nurses' caring behaviours and hopefulness to positive health care outcomes, whereas Roger's theoretically relates presence, assessment, individualised intervention, trust, nurturance and advocacy to enhanced healing. Weissman and Appleton's findings link acceptance, friendship, comfort and security to well being, while Wilson and Hobbs theorise that a therapeutic partnership founded on alliance, accompaniment, agreement, action and accessibility will enhance recovery. On the other hand, "facilitating positive outcomes" unites more than 30 individual aspects of practice knowledge (see Chapter 7, p. 157; Chapter 8, p. 192) and points to the way nurses: (1) intervene therapeutically through positive, informed, moral and engaged practice, and (2) endure and deal with challenging behaviours in order to contain distress and foster the adolescent's self worth and belief in themself. Here again, a link is established between therapeutic intervention, change and the development of a functional self. Moreover, one of the hallmarks of facilitating positive outcomes is to highlight how nurses as well as adolescents work toward change and a more functional self (see Appendix H, pp. 389-390). In this finding resides the centrality of "fostering a functional self"; it is a task always partial and incomplete and in which individuals engage throughout their lives. In the following section, I further explore

the meta-element of practice knowledge.

The Meta-Element

9.07 Fostering a Functional Self

The notion of fostering a functional self is not encountered in the nursing literature. I am not suggesting the terms functional and self are not used in mental health nursing as self is a commonly used term (see Birckhead, 1989; Greene & Ugarriza, 1995; Peplau, 1988a, 1988b; Pilette, Berck & Achber, 1995; Rogers, 1996; Scott, 1993), rather I am suggesting the terms functional and self have not been combined to denote a specific concept nor as a notion relating to the outcomes of practice through the use of practice knowledge. For me, fostering a functional self was reflected in the way nurses strove to assist adolescents to change the thoughts, feelings or behaviours that resulted in dysfunction within themselves, their relationships with others, or social systems. Thus, a functional self is one with the capacity to live in harmony with self and other. I do not mean to suggest that self and other is a duality for they are together with one another. This relational quality of a functional self is in keeping with hermeneutic understandings that we come into being in relationship to and with the other. Our understandings of self are developed through shared and embodied linguistic, historic, cultural and sociopolitical situatedness. Such understandings, in the way of all understanding, are intersubjectively given and received. In the same way, what it means to be functional within any particular tradition is similarly determined. If this were not so, all behaviours would be acceptable and appropriate within any context. Accordingly, adolescents and nurses, through their situatedness in shared traditions, understand the changes required in order to foster a functional self or, at the very least, can negotiate some understanding. In turn, this

understanding is the hope toward which the therapeutic relationship, therapeutic milieu, positive outcomes and change are focused.

What each adolescent or nurse hopes for in fostering a functional self is the same and different. All hope for some form of resolution and healing, for change and enhanced well being, for improved relationships and the ability to move on in their lives but what is required in order to achieve these things will vary. The young people's and nurse's stories give witness to this. For instance, Jane experienced a psychotic episode resulting in withdrawal, paranoia, fear and hallucinations. Her suspicion, withdrawal and fearfulness meant trusting relationships were difficult to form (see Appendix F, pp. 314-322). In order to develop a functional self these things needed to change in the direction of positive outcomes. On the other hand, James had a depressive disorder and was withdrawn, discouraged, unmotivated and unhappy; he had difficulty relating to adults and peers, a confused sense of identity, low self esteem and feelings of isolation (see Chapter 6, p. 105). Thus, the change required for James to develop a functional self was different to that required by Jane. For example, even though both young people experienced difficulties relating to self and other, the reasons behind those difficulties were different. Nurses too spoke of the need for changes to the self.

When nursing a depressed adolescent, Maggie became aware of unresolved feelings of loss and sadness within herself and of the need to work toward understanding and changing that aspect of herself (see Chapter 8, pp. 178-179). Merlin referred to such experiences as the nurse's dramas from their own adolescence being replayed in their work with young people and he stressed the need for nurses to work through such "incompletions" (see

Appendix H, p. 389). Thus, a functional self is not given but is accrued when dysfunction or awareness deliver an opportunity for further change and development. As the nurses in the study demonstrated, such opportunities are lifelong.

In their work with emotionally disturbed adolescents, nurses use dysfunction as the opportunity through which to work toward forward movement and positive change. In order to facilitate forward movement nurses have to break through the barriers restraining change. How nurses help adolescents to grow through and beyond their dysfunction is amplified in many of the study findings. For instance, nurses assist adolescents to develop a different and positive perception of the self. This is critical, as a negative perception of the self is disabling while a positive perception is enabling. When nurses take time to be with adolescents and provide attention, concern and acceptance adolescents perceive themselves as worthy and worthwhile. In helping adolescents to feel normal, become hopeful, get on with life, feel accepted and in trying to create change, nurses allow adolescents to perceive themselves differently (see Chapter 7, p. 139, 142, 144, 146, 147, 148, 150, 152, 153, 154; Chapter 8, p. 165, 167, 172, 173, 180, 181, 184, 185). Even so, perception is selective so nurses foster the most enabling perception by highlighting the changes that adolescents make (see Chapter 8, p. 169). Gradually, a different perception evolves and within this different perception resides the adolescents belief in themself and in their capacity for change. When the self perceives itself as able, change becomes possible. Change however always occurs in relation to the other and in this respect too the findings are illuminating.

In remembering Lee's (adolescent) disabling experiences with Tricia (nurse) and her enabling experiences with Robyn (nurse), it

seems the potential for change, wellness and the development of a functional self resides in the quality of the people around the adolescent (see Chapter 7, pp. 137-138). When the environment is open, accepting, protective, lighthearted and caring it enables and supports change (see Chapter 7, p. 138, 142, 147). In the same way, the nurse's capacity to work in partnership with the adolescent, to be there for them and to provide containment and endure testing, also supports the adolescent's movement toward change (see Chapter 8, p. 175, 183, 184, 186). When the nurses and environment enable, support and nurture change the threats to self are removed and the barriers which constrain interaction with others are broken. This is essential, as a functional self only develops in relationship with enabling others, and through this relationship with others the functional self learns to live an involved, responsible and cooperative life.

Nurses assist adolescents to learn how to live an involved, responsible and cooperative life by modelling such behaviours. Through their friendships, attachments, mutuality and familial relationships with nurses, and peers, adolescents learn about companionship, togetherness, intimacy and respect. In turn, the obligations and responsibilities of such relationships become clearer (see Chapter 7, p. 141, 147, 148, 150, 154) and the adolescents, learning the value of such experiences, take them into their own life (see Appendix G, p. 350, 351, 356, 357, 358, 365). In this way, the outcomes of fostering a functional self are indeed significant. Moreover, when nurses engage with adolescents to positively influence dysfunction toward function, the benefits extend beyond the individual to others and to society. This is because the self always lives in relation to the other.

9.08 Summation

The practice knowledge of adolescent mental health nursing was conceptualised through Gadamer's (1979) hermeneutic of tradition and represented as knowledge developed through shared and embodied language, culture, history and sociopolitical experience. In this study new horizons of intersubjective knowledge were explicated through the researcher's, nurse's and young people's traditions of living and nursing, or being nursed, on residential adolescent mental health units.

The sub-elements and elements provide new horizons of adolescent mental health nursing practice knowledge by identifying then uniting individual aspects of knowledge into a larger entity. Some of these aspects were already known, either theoretically or through research findings, many were not. In discovering new aspects of knowledge and uniting them with known aspects of knowledge, the study expanded understandings of therapeutic nurse-adolescent relationships and the therapeutic adolescent milieu while developing and focusing attention onto guiding the potential for change and facilitating positive outcomes. In all instances, the study findings united the elements in novel ways providing a new perspective from which to view the practice of nursing on residential adolescent mental health units. This occurred because research in adolescent mental health nursing is extremely limited and because the present study's focus was broad rather than specific. Thus, the study did not focus on hope or support or the milieu but on nursing, or being nursed, and in this way provided a broad base of findings representing new horizons of the practice knowledge of adolescent mental health nursing. At the pinnacle of these findings was the completely new notion that adolescent mental health nurses work toward fostering the

adolescent's functional self.

What a functional self is like is difficult to say. Nevertheless, the study findings allow several things to be said about this notion. A functional self is more:

(1) acceptable, different to and better than the old self. It will be perceived more positively;

(2) competent, able and confident than the old self. It will be more optimistic;

(3) whole, integrated and complete than the old self. It will be more together;

(4) knowing, aware and understanding than the old self. It will have more wisdom; and

(5) strong, stable and resilient than the old self. It will have more courage.

Through all of this, a functional self comes to believe in itself, to look favourably toward the future and to live more ably in relation to the self and other.

In the final chapter entitled "Conclusion", I address the research question and present some closing remarks on adolescent mental health nursing research, education and practice.

Chapter Ten

10 Conclusion

In this chapter, I review the research findings in relation to the question which guided the research and relate the study findings to adolescent mental health nursing education, research and practice.

10.01 What the Findings Reveal

Through this hermeneutic study I sought to explicate the practice knowledge of nursing on residential adolescent mental health units. Seven nurses and seven young people shared their experiences of nursing, or of being nursed, on such units. In this way, practice knowledge was explicated through interpretation of the actual experiences of the nurses and young people. I chose hermeneutics to guide the research as it provided the opportunity to pursue an epistemological inquiry using an intersubjective approach. Throughout the study I sought answers to the question:

> What do nurse's and adolescent's stories, arising from experiences of nursing or being nursed on residential adolescent mental health units, reveal about the knowledge informing practice within that context?

The nurse's and adolescent's stories reveal *the way nurses break through the barriers restraining change in order to assist adolescents to develop a functional self. Nurses do this by working against the background of an enabling milieu, through the therapeutic relationships they engage in with adolescents and through their capacity for therapeutic intervention.* Explication of the sub-elements, elements and meta-element reveals the practice knowledge of nursing on residential adolescent mental health units. The sub-elements represent the what and how as well as the therapeutic effects of practice, the elements represent the why of

practice, and the meta-element represents the aim and outcomes of practice through application of the sub-elements and elements to practice. Because the sub-elements and elements point to the way nurses do such things, the findings provide knowledge for use in research, education and practice. In the following discussion, I address recommendations arising from the research findings.

10.02 Recommendations for Future Research

The generation of theory from practice remains a central issue in adolescent mental health nursing. This is because a paucity of published nursing practice research has resulted in excessive reliance on borrowed theory and because adolescent mental health nurses have failed to test and evaluate the use of borrowed theory in practice. One of the strengths of the present study is the way the findings identified theory-in-practice thereby providing fertile ground for further theorising and research. Such research could include, for example, investigation of the:

* unique qualities of the nurse-adolescent relationship,
* therapeutic outcomes of equality,
* benefits to nursing milieus of humour and having fun,
* role of friendship in reconceptualising the nurse-client relationship,
* health care outcomes from the use of nurses as therapists,
* way nurses in different specialties use the nurse-client relationship to orient the client toward change,
* investigation of generic and unique aspects of nursing practice knowledge, such as, the nurse-client relationship, the use of humour, or being accepting, and
* exploration of the concept "fostering a functional self."

In order for knowledge to be used, tested and evaluated in contexts beyond its development, it must first be identified through

research. The explication of practice knowledge represented by the study findings provides the first step in this process. Moreover, because the sub-elements and elements point to the way nurses and adolescents work together, the findings provide a useful guide for practice. This is not only important for adolescent mental health nurses as more than two thirds of emotionally disturbed adolescents were discharged from general hospitals, paediatric units and adult psychiatric units thereby highlighting the need for comprehensively prepared undergraduate nurses with a significant mental health nursing component in their curricula, and for comprehensively prepared graduate mental health nurses with a significant adolescent mental health nursing component in their curricula. In this regard, the study findings could be used to educate nurses in different settings to understand and work therapeutically with emotionally disturbed adolescents. This is possible because the sub-elements and elements identify the what, how and why of practice as well as the therapeutic outcomes from the use of practice knowledge. Thus, the findings reveal, to a greater or lesser extent, the way nurses and adolescents work together to create the positive outcomes and change required in order to foster a functional self.

10.03 Limitations of the study

The study has the following limitations:

(1) it took a broad perspective rather than a narrow one and in doing this some of the clarity and detail of focused research was lost;

(2) the contextual, shared and intersubjective nature of the knowledge developed means that extrapolation of the research findings to other contexts may be difficult; and

(3) the hermeneutic nature of the research resulted in one interpretive understanding of the text. Other researchers would produce other readings and emphasis.

10.04 Strengths of the study

The study has the following strengths:

(1) it explicates, for the first time, a broad understanding of the practice knowledge of nursing on residential adolescent mental health units;

(2) the development of sub-elements, elements and a meta-element makes the findings useful in guiding practice, supporting education and providing a basis for further research;

(3) practice knowledge was explicated from the shared, intersubjective experiences transacted between adolescents and nurses thereby grounding the findings in the actuality of adolescent mental health nursing practice; and

(4) the hermeneutic nature of the research acknowledges and values the partial, incomplete, dynamic and changing nature of all knowledge thereby situating practice knowledge within an evolutionary perspective.

10.05 Summation

Because I conceptualised practice knowledge hermeneutically, its shared and intersubjective nature was always at the fore. Practice knowledge was founded on the experiences transacted between nurses and adolescents and as such is not a precise, cold, hard and detached form of knowledge. This is an enriching aspect of practice knowledge since it allows portrayal of the skill, finesse and wisdom of adolescent mental health nursing as well as the beauty, tenderness and hope of shared human encounter, as noted in Jane's comments about the nurse James:

> *You're trusting each other with each other's secrets and with your dreams and what you hope to obtain in the future and so, you know, you're trusting nurses with very fragile things, but you also know those things are safe with them because they're strong to look after you. [Its] like an equal basis, you talk about where you hope to be and also where he hopes to be and, you know, it's an exchange.*

In the mutuality, trust, safety and equality of such therapeutic

relationships the agency is established through which the nurse fosters the adolescent's functional self. In doing this, the nurse begins a cycle of transforming dysfunction which extends beyond them and the adolescent to touch all those others with whom the adolescent will relate. The significance of such work is enormous and its discovery through this study is unique.

Chapter Eleven

References

Allen, D. (1985). Nursing research and social control: Alternative models of science that emphasise understanding and emancipation. Image: The Journal of Nursing Scholarship, 17 (2), 58-64.

Allen, M., & Jensen, L. (1990). Hermeneutical inquiry: Meaning and scope. Western Journal of Nursing Research, 12 (2), 241-253.

Altheide, D., & Johnson, J. (1992). Tacit knowledge: The bounds of experience. Studies in Symbolic Interaction, 13, 51-57.

American Psychological Association. (1995). Publication manual (4th ed.). Washington: American Psychological Association.

Appleton, C. (1993). The art of nursing: The experience of patients and nurses. Journal of Advanced Nursing, 18, 892-899.

Armstrong, J. (1987). Psychiatric treatment programs for adolescents. Canadian Journal of Psychiatric Nursing, 28 (2), 4-6.

Armstrong, M., & Kelly, A. (1995). More than the sum of their parts: Martha Rogers and Hildegard Peplau. Archives of Psychiatric Nursing, 9 (1), 40-44.

Ast, F. (1990). Hermeneutics (D. Van Vranken, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 39-56). Albany: State University of New York Press.

Astrom, G., Norberg, A., Hallberg, I., & Jansson, L. (1993). Experienced and skilled nurses' narratives of situations where caring action made a difference to the patient. Scholarly Inquiry for Nursing Practice: An International Journal, 7 (3), 183-193.

Austin, W., Gallop, R., Harris, D., & Spencer, E. (1996). A 'domains of practice' approach to the standards of psychiatric and mental health nursing. Journal of Psychiatric and Mental Health

Nursing, 3, 111-115.

Australian Bureau of Statistics. (1991). Census. Canberra: Australian Government Publishing Service.

Australian Bureau of Statistics. (1992). Hospital inpatient separations by principal condition treated, Queensland 1992. Canberra: Australian Government Publishing Service.

Australian Bureau of Statistics. (1995). Causes of death: Australia, 1991-1994. Canberra: Australian Government Publishing Service.

Australian and New Zealand College of Mental Health Nurses. (1996). Constitution: Revised 1996. Sydney: ANZCMHN.

Barker, P. (1990). The philosophy of psychiatric nursing. Nursing Standard, 5 (12), 28-33.

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. California: Addison-Wesley.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science. Advances in Nursing Science, 8 (1), 1-14.

Benner, P. (1991). The role of experience, narrative and community in skilled ethical comportment. Advances in Nursing Science, 14 (2), 1-21.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring and ethics in health and illness (pp. 99-125). London: Sage.

Benner, P., & Tanner, C. (1987). Clinical judgment: How expert nurses use intuition. American Journal of Nursing, 87, 23-31.

Benner, P., Tanner, C., & Chelsa, C. (1992). From beginner to expert: Gaining a differentiated clinical world in critical care

nursing. Advances in Nursing Science, 14 (3), 13-28.

Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. California: Addison-Wesley.

Bennett, D. (1984). Adolescent health in Australia. Glebe: Australian Medical Association.

Bernstein, R. (1983). Beyond objectivism and relativism: Science, hermeneutics and praxis. Philadelphia: University of Pennsylvania Press.

Biggs, J., & Telfer, R. (1987). The process of learning. Sydney: Prentice Hall.

Birckhead, L. (1989). Psychiatric/mental health nursing: The therapeutic use of self. Philadelphia: Lippincott.

Bonnivier, J. (1996). Management of self-destructive behaviours in open inpatient setting. Journal of Psychosocial Nursing, 34 (2), 38-42.

Brown, L. (1986). The experience of care: Patient perspectives. Topics in Clinical Nursing, 8 (2), 56-62.

Buker, E. (1990). Feminist social theory and hermeneutics: An empowering dialectic? Social Epistemology, 4 (1), 23-39.

Burnard, P. (1990). Staying in balance: Humanistic psychology and psychiatric nursing. Community Psychiatric Nursing Journal, 10 (1), 17-19.

Burns, K. (1982). Adolescent adjustment reactions. In J. Haber., A. Leach., S. Schudy., & B. Flynn Sideleau (Eds.), Comprehensive psychiatric nursing (pp. 1035-1071). New York: McGraw Hill.

Bush, C. (1992). Child and adolescent mental health: Building a base for research and practice. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (4), 5-6.

Butterworth, C. (1987). Psychiatric nursing: Fumbling in the vacuum or grasping at opportunity? Mental Health Nursing, 1, 7.

Butterworth, T. (1991). Generating research in mental health nursing. International Journal of Nursing Studies, 28 (3), 237-246.

Byrne, C., & Sebastian, L. (1994). The defining characteristics of support: Results of a research project. Journal of Psychosocial Nursing, 32 (6), 33-38.

Byrne, C. M., Woodside, H., Landeen, J., Kirkpatrick, H., Bernado, A., & Pawlick, J. (1994). The importance of relationships in fostering hope. Journal of Psychosocial Nursing, 32 (9), 31-34.

Caputo, J. (1987). Radical hermeneutics: Repetition, deconstruction, and the hermeneutic project. Bloomington: Indiana University Press.

Carper, B. (1978). Fundamental patterns of knowing in nursing. In L. Nicoll (Ed.), (1992), Perspectives on nursing theory (2nd ed.). (pp. 216-224). New York: Lippincott.

Carroll, L. (1988). Alice in wonderland. Newmarket: Brimax.

Carter, E. (1986). Psychiatric nursing: 1986. Journal of Psychosocial Nursing, 24 (6), 26-30.

Chinn, P., & Wheeler, C. (1985). Feminism and nursing. Nursing Outlook, 33, 74-77.

Commonwealth Department of Human Services and Health. (1995a). National mental health report, 1994. Canberra: Australian Government Publishing Service.

Commonwealth Department of Human Services and Health. (1995b). Mental disorders: Prevention and human services research. Canberra: Australian Government Publishing Service.

Creedy, D., & Crowe, M. (1996). Establishing a therapeutic

milieu with adolescents. Australian and New Zealand Journal of Mental Health Nursing, 5 (2), 84-89.

Crowe, M. (1997). An analysis of the sociopolitical context of mental health nursing practice. Australian and New Zealand Journal of Mental Health Nursing, 6 (2), 59-65.

Cushing, A. (1994). Historical and epistemological perspectives on research and nursing. Journal of Advanced Nursing, 20 (3), 406-411.

Davis, A. (1992). Suicidal behaviour among adolescents: Its nature and prevention. In R. Kosky., H. Salimi Eshkevari., & G. Kneebone (Eds.), Breaking out: Challenges in adolescent mental health in Australia (pp. 89-103). Canberra: Australian Government Publishing Service.

Davis, B. (1986). A review of recent research in psychiatric nursing. In J. Brooking (Ed.), Psychiatric nursing research (pp. 3-19). London: John Wiley.

Davis, A., & Kosky, R. (1991). Attempted suicide in Adelaide and Perth: Changing rates for males and females, 1971-1987. Medical Journal of Australia, 154, 666-670.

Davison, M., & O'Brien, D. (1997). Humour in midwifery. Modern Midwife, 7 (4), 11-14.

Deans, C., Lea, D., & Geyer, R. (1997). Nursing research 'down under.' Journal of Psychosocial Nursing, 35 (2), 25-31.

Deetz, S. (1978). Conceptualising human understanding: Gadamer's hermeneutics and American communication studies. Communication Quarterly, 26 (2), 12-23.

Delaney, K. (1992). Nursing in child psychiatric milieus: What nurses do. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (1), 10-14.

Di Censo, J. (1990). Hermeneutics and the disclosure of truth: A study in the work of Heidegger, Gadamer and Ricoeur. Charlottesville: University of Virginia.

Diekelmann, N. (1992). Learning-as-testing: A Heideggerian hermeneutic analysis of the lived experiences of students and teachers in nursing. Advances in Nursing Science, 14 (3), 72-83.

Dilthey, W. (1990). The rise of hermeneutics (F. Jameson, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 101-114). Albany: State University of New York Press.

Doering, L. (1992). Power and knowledge in nursing: A feminist poststructuralist view. Advances in nursing science, 14 (2), 24-33.

Dowie. J., & Elstein, A. (1984). Professional judgment: A reader in clinical decision making. Cambridge: Cambridge University Press.

Drew, N. (1989). The interviewer's experience as data in phenomenological research. Western Journal of Nursing Research, 11 (4), 431-439.

Drew, N. (1993). Reenactment interviewing: A methodology for phenomenological research. Image: Journal of Nursing Scholarship, 25 (4), 345-351.

Dreyfus, H., & Dreyfus, S. (1986). Mind over machine: The power of human intuition and expertise in the era of the computer. New York: The Free Press.

Dunlop, M. (1994). Is a science of caring possible? In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring and ethics in health and illness (pp. 27-42). London: Sage.

Dunn, B. (1993). Use of therapeutic humour by psychiatric nurses. British Journal of Nursing, 2 (9), 468-473.

Eco, U. (1990). The limits of interpretation. Bloomington: Indiana University Press.

Egan, B. (1988). Adolescent psychiatry: Coming of age. Nursing Standard, 9 (3), 24.

Egan, E., & Beckstrand, J. (1979). 'Personal knowledge' versus 'self knowledge.' Advances in Nursing Science, 1, 7-9.

Ermarth, M. (1981). The transformation of hermeneutics: 19th century ancients and 20th century moderns. Monist, 64 (2), 175-194.

Evans, A. (1995). Philosophy of nursing: Future directions. Australian and New Zealand Journal of Mental Health Nursing, 4 (1), 14-21.

Fanker, S. (1996). Biological psychiatry and mental health nursing. Australian and New Zealand Journal of Mental Health Nursing, 5 (4), 180-190.

Farrell, G., & Carr, J. (1996). Who cares for the mentally ill? Theory and practice hours with a 'mental illness' focus in nursing curricula in Australian universities. Australian and New Zealand Journal of Mental Health Nursing, 5 (2), 77-83.

Farrell, G., & Grichting, W. (1997). Social science at the crossroads: What direction for mental health nurses? Australian and New Zealand Journal of Mental Health Nursing, 6 (1), 19-29.

Field, P., & Morse, J. (1985). Methods of data collection. In P. Field & J. Morse. Nursing research: The application of qualitative approaches (pp. 65-89). Maryland: Aspen.

Finke, L., & de Leon Siantz, M. (1993). National workshop: Implementation of practice with severely mentally and emotionally disturbed children and adolescents. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 6 (1), 31-32.

Fishel, A. (1990). A community based program for emotionally disturbed children and youth. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 3 (4), 128-133.

Forchuk, C. (1995). Uniqueness within the nurse-client relationship. Archives of Psychiatric Nursing, 9 (1), 34-39.

Ford, J., & Reutter, L. (1990). Ethical dilemmas associated with small samples. Journal of Advanced Nursing, 15 (2), 187-191.

Forester, J. (1980). Listening: The social policy of everyday life (critical theory and hermeneutics in practice). Social Praxis, 7 (3-4), 219-232.

Fox, D. (1976). Fundamentals of research in nursing. New York: Appleton-Century-Crofts.

Gadamer, H-G. (1975). Hermeneutics and social science. Cultural Hermeneutics, 2 (4), 307-316.

Gadamer, H-G. (1979). Truth and method (2nd ed.). London: Sheed and Ward.

Gadamer, H-G. (1987). The problem of historical consciousness. In P. Rabinow & W. Sullivan (Eds.), Interpretive social science: A second look (pp. 82-140). Berkeley: University of California Press.

Gadamer, H-G. (1989). Truth and method (2nd Rev. ed.). (J. Weinsheimer and D. G. Marshall, Trans.). New York: Crossroad.

Gadamer, H-G. (1990). The universality of the hermeneutical problem (D. Linge, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 147-158). Albany: State University of New York Press.

Gilbert, G. (1980). Being interviewed: A role analysis. Social Science Information, 19 (2), 227-236.

Gilbert, C. (1992). Association of Child Psychiatric Nursing

president responds to Pothier's commentary. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (4), 50-51.

Gilchrist, V. (1992). Key informant interviews. In W. Miller & B. Crabtree (Eds.), Doing qualitative research (pp. 70-89). Newbury Park: Sage.

Gombrich, E. (1969). The evidence of images. In C. Singleton (Ed.), Interpretation: Theory and practice (pp. 35-104). Baltimore: Hopkins.

Gordon, R. (1980). Interviewing: Strategy, techniques and tactics. Illinois: Dorsey.

Gortner, S. (1993). Nursing syntax revisited: A critique of philosophies said to influence nursing theories. International Journal of Nursing Studies, 30 (6), 477-488.

Greene, H., & Ugarriza, D. (1995). Borderline personality disorder: History, theory and nursing intervention. Journal of Psychosocial Nursing, 33 (12), 26-30.

Griffin-Francell, C. (1993). Advocating for seriously emotionally disturbed children and their families: An overview. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 6 (1), 33-37.

Guba E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Communication and Technology Journal, 29 (2), 75-91.

Guba, E., & Lincoln, Y. (1981). Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches. San Francisco: Jossey-Bass.

Guba, E., & Lincoln, Y. (1982). Epistemological and methodological bases of naturalistic inquiry. Journal of Educational Communication and Technology, 30 (4), 233-252.

Gullickson, C. (1993). My death nearing its future: A Heideggerian hermeneutic analysis of the lived experience of persons with chronic illness. Journal of Advanced Nursing, 18, 1386-1392.

Gunderson, J. (1978). Defining the therapeutic processes in psychiatric milieus. Psychiatry, 41, 327-335.

Hall, J., & Stevens, P. (1991). Rigor in feminist research. Advances in Nursing Science, 13 (3), 16-29.

Harries, G. (1995). Use of humour in patient care. British Journal of Nursing, 4 (17), 984-986.

Heidegger, M. (1962). Being and time (E. Robinson and J. Macquarrie, Trans.). New York: Harper and Row.

Heidegger, M. (1990). Being and time (sections 31-34). (E. Robinson and J. Macquarrie, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 116-144). Albany: State University of New York Press.

Heifner, C. (1993). Positive connectedness in the psychiatric nurse-patient relationship. Archives of Psychiatric Nursing, 7 (1), 11-15.

Hekman, S. (1986). Hermeneutics and the sociology of knowledge. Indiana: University of Notre Dame Press.

Higgs, J., & Titchen, A. (1995). Propositional, professional and personal knowledge in clinical reasoning. In J. Higgs & M. Jones (Eds.), Clinical reasoning in the health professions (pp. 129-146). Oxford: Butterworth Heinemann.

Hinds, P. (1988). The relationship of nurses' caring behaviours with hopefulness and health care outcomes in adolescents. Archives of Psychiatric Nursing, 2 (1), 21-29.

Hirsch, E. D. (1967). Validity in interpretation. New Haven: Yale University Press.

Hirsch, E. D. (1976). The aims of interpretation. Chicago: University of Chicago Press.

Hoffman, A., & Bertus, P. (1992). Theory and practice: Bridging scientists' and practitioners' roles. Archives of Psychiatric Nursing, 6 (1), 2-9.

Hogarth, C. (1985). Providing a therapeutic milieu on an inpatient adolescent unit. Ohio Nurses Review, 60 (4), 7.

Hogarth, C. (1991). Adolescent psychiatric nursing. St. Lois: Mosby.

Holden, R. (1986). Christos: A case study from a sociological perspective. Journal of the Australian Congress of Mental Health Nurses, June, 35-41.

Honey, M. (1987). The interview as text: Hermeneutics considered as a model for analysing the clinically informed research interview. Human Development, 30, 69-82.

Howard, R. (1982). Three faces of hermeneutics: An introduction to current theories of understanding. Berkeley: University of California Press.

Human Rights and Equal Opportunity Commission. (1993). National inquiry into human rights of people with mental illness (Vols. 1 & 2). Canberra: Australian Government Publishing Service.

Hunt, A. (1993). Humour as a nursing intervention. Cancer Nursing, 16 (1), 34-39.

Jackson, B. (1986). Legal and ethical issues. In G. LoBiondo-Wood & J. Haber. Nursing research: Critical appraisal and utilisation (pp. 29-43). St. Lois: Mosby.

Jacobs-Kramer, M., & Chinn, P. (1988). Perspectives on knowing: A model of nursing knowledge. Scholarly Inquiry for Nursing Practice: An International Journal, 2, 129-139.

Jaffe, E. (1991). Working with troubled teens. RN, February, 58-62.

Johnson, M. (1987). The body in the mind: The bodily basis of meaning, imagination and reason. Chicago: University of Chicago Press.

Johnson, M. (1989). Embodied knowledge. Curriculum Inquiry, 19 (4), 361-77.

Jones, S., & Jones, P. (1989). A statistical evaluation of the psychiatric nursing research literature. In I. Abraham., D. Nadzam., & J. Fitzpatrick (Eds.), Statistics and quantitative methods in nursing: Issues and strategies for research and education (pp. 96-117). Philadelphia: Saunders.

Kidd, P., & Morrison, E. (1988). The progression of knowledge in nursing: A search for meaning. Image: Journal of Nursing Scholarship, 20 (4), 222-224.

Killeen, M. (1990). Challenges and choices in child and adolescent mental health-psychiatric nursing. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 3 (4), 113-119.

Koch, T. (1993). Toward fourth generation evaluation: Listening to the voices of older patients. A hermeneutic inquiry. Unpublished doctoral dissertation, Manchester University, England.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. Journal of Advanced Nursing, 19, 976-986.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. Journal of Advanced Nursing, 21 (5), 827-836.

Koldjeski, D. (1990). Psychiatric and mental heath nursing: Content of the specialty. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 3 (3), 103-105.

Kondora, L. (1993). A Heideggerian hermeneutical analysis of survivors of incest. Image: Journal of Nursing Scholarship, 25 (1), 11-15.

Kosky, R. (1992). Adolescents in custody: A disciplining or a disabling experience? In R. Kosky., H. Salimi Eshkevari., & G. Kneebone (Eds.), Breaking out: Challenges in adolescent mental health in Australia (pp. 121-137). Canberra: Australian Government Publishing Service.

Krupinski, J., Baikie, A., Stoller, A., Graves, J., O'Day, D., & Polke, P. (1967). Community mental health survey of Heyfield, Victoria. Medical Journal of Australia, 1, 1204-1211.

Kuhn, T. (1962). The structure of scientific revolutions. Chicago: University of Chicago Press.

Kunes-Connell, M. (1987). Adolescence. In J. Norris., M. Kunes-Connell., S. Stockard., P. Ehrhart., & G. Renschler Newton (Eds.), Mental health-psychiatric nursing: A continuum of care (pp. 347-366). New York: John Wiley and Sons.

Kvale, S. (1983). The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. Journal of Phenomenological Psychology, 14 (2), 171- 195.

Lacey, D. (1993). Discovering theory from psychiatric nursing practice. British Journal of Nursing, 2 (15), 763-766.

Lather, P. (1986). Research as praxis. Harvard Educational Review, 56 (3), 257-277.

Le Curyer, E. (1992). Milieu therapy for short stay units: A transformed practice theory. Archives of Psychiatric Nursing, 7 (2), 108-116.

Leonard, V. (1989). A Heideggerian phenomenological perspective on the concept of the person. Advances in Nursing Science, 11 (4), 40-55.

Leslie, S. (1974). Psychiatric disorders in the young adolescents of an industrial town. British Journal of Psychiatry, 125, 113-124.

Liaschenko, J. (1989). Changing paradigms within psychiatry: Implications for nursing research. Archives of Psychiatric Nursing, 3 (3), 153-158.

Lincoln, Y., & Guba, E. (1985). Establishing trustworthiness. In Y. Lincoln & E. Guba. Naturalistic inquiry (pp. 289-331). Newbury Park: Sage.

Livo, N., & Rietz, S. (1986). Storytelling: Process and practice. Colorado: Libraries Unlimited.

Lowenberg, J. (1993). Interpretive research methodology: Broadening the dialogue. Advances in Nursing Science, 16 (2), 57-69.

Lowenberg, J. (1994). The nurse-patient relationship reconsidered: An expanded research agenda. Scholarly Inquiry for Nursing Practice: An International Journal, 8 (2), 167-184.

Lowery, B. (1992). Psychiatric nursing in the 1990's and beyond. Journal of Psychosocial Nursing, 30 (1), 7-13.

MacLaughlan, G., & Reid, I. (1994). Framing and interpretation. Melbourne: Melbourne University Press.

Macquarie University. (1991). The Macquarie dictionary (2nd Rev. ed.). Sydney: The Macquarie Library.

Mascord, P. (1990). Can mental health nurses utilise research? Australian Journal of Mental Health Nurses, 1 (2), 25-28.

Mason, T., & Mercer, D. (1996). Forensic psychiatric nursing: Visions of social control. Australian and New Zealand Journal of Mental Health Nursing, 5 (4), 153-162.

May, C. (1991). Affective neutrality and involvement in nurse-patient relationships: Perceptions of appropriate behaviour among nurses in acute medical and surgical wards. Journal of Advanced Nursing, 16, 552-558.

McBride, A. (1986). Theory and research: Present issues and future perspectives of psychosocial nursing. Journal of Psychosocial Nursing, 24 (9), 27-32.

McBride, A. (1992). Nurses develop a plan for research on child and adolescent mental disorders. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (1), 41-43.

McCrone, S. (1996). The impact of the evolution of biological psychiatry on psychiatric nursing. Journal of Psychosocial Nursing, 34 (1), 38-46.

McMahon, R. (1991). Therapeutic nursing: Theory, issues and practice. In R. McMahon & A. Pearson (Eds.), Nursing as therapy (pp. 1-25). London: Chapman and Hall.

McMahon, R., & Pearson, A. (Eds.), (1991). Nursing as therapy. London: Chapman and Hall.

Merwin, E., & Mauck, A. (1995). Psychiatric nursing outcome research: The state of the science. Archives of Psychiatric Nursing, 9 (6), 311-331.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). Indepth interviewing: Researching people. Melbourne: Longman Cheshire.

Mintz, R. (1989). Mental health counselling of adolescence. In L. Birckhead (Ed.), Psychiatric-mental health nursing: The therapeutic use of self (pp. 511-532). Philadelphia: Lippincott.

Mischler, E. (1979). Meaning in context: Is there any other kind? Harvard Educational Review, 49 (1), 1-19.

Mischler, E. (1986a). Research interviewing: Context and narrative. Massachusetts: Harvard University Press.

Mischler, E. (1986b). The joint construction of meaning. In E. Mischler. Research interviewing: Context and narrative (pp. 52-65). Massachusetts: Harvard University Press.

Moch, S. (1990). Personal knowing: Evolving research and practice. Scholarly Inquiry for Nursing Practice: An International Journal, 4 (2), 155-165.

Morse, J. (1991a). Qualitative nursing research: A contemporary dialogue. Newbury Park: Sage.

Morse, J. (1991b). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, 455-468.

Morse, J., & Carter, B. (1995). Strategies for enduring and the suffering of loss: Modes of comfort used by a resilient survivor. Holistic Nursing Practice, 9 (3), 38-52.

Mulvihill, D. (1989). Therapeutic relationships in milieu therapy. Canadian Journal of Psychiatric Nursing, 30 (1), 21-22.

National Health and Medical Research Council. (1983). Community health care for adolescents. Canberra: Australian Government Publishing Service.

Nehls, N. (1994). Brief hospital treatment plans: Innovations in practice and research. Issues in Mental Health Nursing, 15 (1), 1-11.

New South Wales Department of Health. (1991). Leading the way: A framework for NSW mental health services, 1991-2001. Sydney: State Health Publications.

Niemela, K., Poster, E., & Moreau, D. (1992). The attending nurse: A new role for the advanced clinician. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (3), 5-12.

Nurse Education Review Secretariat (1994). Nursing education in Australian universities: Report of the national review of nurse education in the higher education sector, 1994 and beyond. Canberra: Australian Government Publishing Service.

Oiler, C. (1982). The phenomenological approach in nursing research. Nursing Research, 31 (3), 178-181.

Oiler-Boyd, C. (1993). Toward a nursing practice research method. Advances in Nursing Science, 16 (2), 9-25.

Olsen, T. (1996). Fundamental and special: The dilemma of psychiatric-mental health nursing. Archives of Psychiatric Nursing, 10 (1), 3-10.

Ormiston, G., & Schrift A. (Eds.), (1990). The hermeneutic tradition from Ast to Ricoeur. Albany: State University of New York Press.

Packer, M., & Addison, R. (1989a). Introduction. In M. Packer & R. Addison (Eds.), Entering the circle: Hermeneutic investigation in psychology (pp. 13-36). Albany: State University of New York Press.

Packer, M., & Addison, R. (1989b). Evaluating an interpretive account. In M. Packer & R. Addison (Eds.), Entering the circle: Hermeneutic investigation in psychology (pp. 275-292). Albany: State University of New York Press.

Palmer, R. (1969). Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger and Gadamer. Illinois: Northwestern University Press.

Pearson, A. (Ed.), (1988). Primary nursing. Nursing in the Burford and Oxford nursing development units. London: Croom Helm.

Pearson, A. (1991). Taking up the challenge: The future for therapeutic nursing. In R. McMahon & A. Pearson (Eds.), Nursing as therapy (pp. 192-210). London: Chapman and Hall.

Peplau, H. (1962). Interpersonal techniques: The crux of psychiatric nursing. American Journal of Nursing, 62 (6), 50-54.

Peplau, H. (1969). Professional closeness. Nursing Forum, 8 (4), 342-360.

Peplau, H. (1988a). Interpersonal relations in nursing. London: Macmillan.

Peplau, H. (1988b). The art and science of nursing: Similarities, differences and relations. Nursing Science Quarterly, 1 (1), 8-15.

Peplau, H. (1994). Psychiatric mental health nursing: Challenge and change. Journal of Psychiatric and Mental Health Nursing, 1, 3-7.

Peterson, E., Gray, K., & Weinstein, S. (1994). A look at adolescent treatment in a time of change. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 7 (2), 5-15.

Pilette, P., Berck, C., & Achber, L. (1995). Therapeutic management of helping boundaries. Journal of Psychosocial Nursing, 33 (1), 40-47.

Plager, K. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring and ethics in health and illness (pp. 65-127). London: Sage.

Platt, J. (1981). On interviewing one's peers. British Journal of Sociology, 32 (1), 75-91.

Polanyi, M. (1958). Personal knowledge: Towards a post-critical philosophy. London: Routledge and Kegan Paul.

Polanyi, M. (1983). The tacit dimension. Gloucester: Peter Smith.

Pond, V. (1988). The angry adolescent: Treatment versus containment practices. Journal of Psychosocial Nursing and Mental Health Services, 26 (12), 15-17.

Pothier, P. (1992). Twenty years: A great beginning. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (4), 41-49.

Puskar, K., & D'Antonio, I. (1993). Tots and teens: Similarities in behaviour and interventions for paediatric and psychiatric nurses. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 6 (2),18-28.

Puskar, K., & Wargoe, K. (1992). Difficulties with teens: Can nursing consultation help? Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (3), 34-41.

Ramos, M. (1989). Some ethical implications of qualitative research. Research in Nursing and Health, 12, 57-63.

Ramos, M. (1992). The nurse-patient relationship: Theme and variations. Journal of Advanced Nursing, 17, 496-506.

Rasmussen, D. (1971). Mythic-symbolic language and philosophical anthropology: A constructive interpretation of the thought of Paul Ricoeur. The Hague: Martin Nijhoff.

Rather, M. (1992). "Nursing as a way of thinking" - Heideggerian hermeneutical analysis of the lived experience of the returning RN. Research in Nursing and Health, 15, 47-55.

Rawnsley, M. (1994). Response to "the nurse-patient relationship reconsidered: An expanded research agenda." Scholarly Inquiry for Nursing Practice: An International Journal, 8 (2), 185-190.

Redston-Iselin, A. (1987). Adolescent psychiatric nursing. In G. Stuart & S. Sundeen (Eds.), Principles and practice of psychiatric nursing (pp. 897-925). St. Lois: Mosby.

Reed, P. (1987). Constructing a conceptual framework for psychosocial nursing. Journal of Psychosocial Nursing, 25 (2), 24-28.

Reed, P. (1996). Transforming practice knowledge into nursing knowledge: A revisionist analysis of Peplau. Image: Journal of Nursing Scholarship, 28 (1), 29-33.

Reeder, F. (1988). Hermeneutics. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 193-238). New York: National League for Nursing Press.

Rew, L. (1991). Intuition in psychiatric-mental health nursing. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 4 (3), 110-115.

Rew, L., & Shirejian, P. (1993). Sexually abused adolescent: Conceptualisation of sexual trauma and nursing interventions. Journal of Psychosocial Nursing and Mental Health Services, 31 (12), 29-33.

Ricoeur, P. (1971a). The model of the text: Meaningful action considered as a text. Social Research, 38, 529-562.

Ricoeur, P. (1973a). The hermeneutical function of distanciation. (D. Pellauer, Trans.). Philosophy Today, 17 (2-4), 129-141.

Ricoeur, P. (1973b). The task of hermeneutics. (D. Pellauer, Trans.). Philosophy Today, 17 (2-4), 112-128.

Ricoeur, P. (1973c). Ethics and culture: Habermas and Gadamer in dialogue. (D. Pellauer, Trans.). Philosophy Today, 17 (2-4), 153-165.

Ricoeur, P. (1973d). From existentialism to the philosophy of language. (D. Pellauer, Trans.). Philosophy Today, 17 (2-4), 88-96.

Ricoeur, P. (1974a). Paul Ricoeur: The conflict of interpretations: Essays in hermeneutics. D. Ihde (Ed.), (K. McLaughlin, Trans.). Evanston: Northwestern University Press.

Ricoeur, P. (1974b). Existence and hermeneutics. In Paul Ricoeur: The conflict of interpretations: Essays in hermeneutics. D. Ihde (Ed.), (K. McLaughlin, Trans.). (pp. 3-24). Evanston: Northwestern University Press.

Ricoeur, P. (1974c). The problem of double meaning. In Paul Ricoeur: The conflict of interpretations: Essays in hermeneutics. D. Ihde (Ed.). (K. McLaughlin, Trans.). (pp. 62-78). Evanston: Northwestern University Press.

Ricoeur, P. (1974d). Metaphor and the main problem of hermeneutics. New Literary History, 6 (1), 95-110.

Ricoeur, P. (1976a). Interpretation theory: Discourse and the surplus of meaning. Texas: Texas Christian University Press.

Ricoeur, P. (1976b). History and hermeneutics. (D. Pellauer, Trans.). Journal of Philosophy, 73 (19), 683-695.

Ricoeur, P. (1981a). Paul Ricoeur: Hermeneutics and the human sciences: Essays on language, action and interpretation. J. B. Thompson (Ed. and Trans.), Cambridge: Cambridge University Press.

Ricoeur, P. (1981b). Appropriation. In Paul Ricoeur: Hermeneutics and the human sciences: Essays on language, action and interpretation. J. B. Thompson (Ed. and Trans.), (pp. 182-193). Cambridge: Cambridge University Press.

Ricoeur, P. (1983). On interpretation. (K. McLaughlin, Trans.). In A. Montefiore (Ed.), Philosophy in France today (pp. 175-197). Cambridge: Cambridge University Press.

Riddle, C. (1994). Development of an adolescent inpatient sexual abuse group: Application of Lewin's model of change. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 7 (1), 17-24.

Riesch, S., & Forsyth, D. (1992). Preparing to parent the adolescent: A theoretical overview. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 5 (1), 32-40.

Robinson, C. (1996). The health care relationship revisited. Journal of Family Nursing, 2 (2), 152-173.

Robinson, K. (1992). The politics of knowledge. In K. Robinson & B. Vaughan (Eds.), Knowledge for nursing practice (pp. 201-212). London: Butterworth Heinemann.

Rogers, S. (1996). Facilitative affiliation: Nurse-client interactions that enhance healing. Issues in Mental Health Nursing, 17 (3), 171-184.

Roy, C. (1995). Developing nursing knowledge: Practice issues raised from four philosophical perspectives. Nursing Science Quarterly, 8 (2), 79-85.

Rutter, M., Graham, P., Chadwick, O., & Yule, W. (1976). Adolescent turmoil: Fact or fiction? Journal of Child Psychology and Psychiatry, 17, 35-56.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. Image: Journal of Nursing Scholarship, 23 (3), 161-165.

Sandelowski, M. (1995a). Triangles and crystals: On the geometry of qualitative research. Research in Nursing and Health, 18 (6), 569-574.

Sandelowski, M. (1995b). Aesthetics in qualitative research. Image: Journal of Nursing Scholarship, 27 (3), 205-209.

Sawyer, M., Meldrum, D., Tonge, B., & Clark, J. (1992). Mental health and young people: Report to the national youth affairs research scheme. Hobart: University of Tasmania.

Scahill, L. (1991). Nursing diagnosis versus goal oriented treatment planning in inpatient child psychiatry. Image: Journal of Nursing Scholarship, 23 (2), 95-98.

Scahill, L., Walker, R., Lechner, S., & Tynan, K. (1993). Inpatient treatment of obsessive compulsive disorder in childhood: A case study. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 6 (3), 5-14.

Schleiermacher. F. (1990a). The aphorisms on hermeneutics from 1805 and 1809/10 (R. Haas and J. Wojcik, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 57- 84). Albany: State University of New York Press.

Schleiermacher. F. (1990b). The hermeneutics: Outline of the 1819 lectures (J. Wojcik and R. Haas, Trans.). In G. Ormiston & A. Schrift (Eds.), The hermeneutic tradition from Ast to Ricoeur (pp. 87-100). Albany: State University of New York Press.

Schraeder, B., & Fischer, D. (1987). Using intuitive knowledge in the neonatal intensive care nursery. Holistic Nursing Practice, 1 (3), 45-51.

Schultz, P., & Meleis, A. (1988). Nursing epistemology: Traditions, insights, questions. Image: Journal of Nursing Scholarship, 20 (4), 217-221.

Schumacher, K., & Gortner, S. (1992). (Mis)conceptions and reconceptions about traditional science. Advances in Nursing Science, 14 (4), 1-11.

Schutz, S. (1994). Exploring the benefits of a subjective approach in qualitative nursing research. Journal of Advanced Nursing, 20 (3), 412-417.

Scott, A. (1993). A beginning theory of personal space boundaries. Perspectives of Psychiatric Care, 29 (2), 12-21.

Shklar, J. (1986). Squaring the hermeneutic circle. Social Research, 53 (3), 449-473.

Smith, J. (1984). The problem of criteria for judging interpretive inquiry. Educational Evaluation and Policy Analysis, 6 (4), 379-391.

Smith, L. (1992a). Ethical issues in interviewing. Journal of Advanced Nursing, 17 (1), 98-103.

Smith, M. (1992b). Is all knowing personal knowing? Nursing Science Quarterly, 5 (1), 2-3.

Sorrell, J., & Redmond, G. (1995). Interviews in qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing, 21 (6), 1117-1122.

Stevenson, C. (1996). Taking the pith out of reality: A reflexive methodology for psychiatric nursing research. Journal of Psychiatric and Mental Health Nursing, 3, 103-110.

Sweeney, N. (1994). A concept analysis of personal knowledge: Application to nursing education. Journal of Advanced Nursing, 20 (5), 917-924.

Taylor. B. (1991). The phenomenon of ordinariness in nursing. Unpublished doctoral dissertation, Deakin University, Australia.

Taylor, C. (1971). Interpretation and the sciences of man [sic]. Review of Metaphysics, 25, 3-51.

Tippl, H. (1995). Significant relationships: Nurses caring for adolescents with cystic fibrosis. Contemporary Nurse, 4 (3), 123-128.

Thomas, S., & Wilt, D. (1986). Mental health nursing clinical specialisation: Extinction or adaptation? Issues in Mental Health Nursing, 8, 1-13.

Thompson, J. B. (1985a). Critical hermeneutics: A study in the thought of Paul Ricoeur and Jurgen Habermas. Cambridge: Cambridge University Press.

Thompson, J. B. (1985b). Paul Ricoeur and hermeneutic phenomenology. In Critical hermeneutics: A study in the thought of Paul Ricoeur and Jurgen Habermas (J. B. Thompson, Trans.). (pp. 36-70). Cambridge: Cambridge University Press.

Thompson, J. L. (1985). Practical discourse in nursing: Going beyond empiricism and historicism. Advances in Nursing Science, 7 (4), 59-71.

Thompson, J. L. (1987). Critical scholarship: The critique of domination in nursing. Advances in Nursing Science, 10 (1), 27-38.

Thompson, J. L. (1990). Hermeneutic inquiry. In L. Moody (Ed.), Advancing nursing science through research (Vol. 2). (pp. 223-280). Newbury Park: Sage.

Trygstad, L. (1986). Professional friends: the inclusion of the personal into the professional. Cancer Nursing, 9 (6), 326-332.

Tuck, I., & Keels, M. (1992). Milieu therapy: A review of development of this concept and its implications for psychiatric nursing. Issues in Mental Health Nursing, 13, 51-58.

van Manen, M. (1990) Researching lived experience: Human science for an action sensitive pedagogy. New York: State University of New York Press.

Vaughan, B. (1992). The nature of nursing knowledge. In K. Robinson & B. Vaughan (Eds.), Knowledge for nursing practice (pp. 3-31). London: Butterworth Heinemann.

Walker, K. (1994a). Research with/in nursing: 'Troubling' the field. Contemporary Nurse, 3 (4), 162-168.

Walker, M. (1994b). Principles of a therapeutic milieu: An overview. Perspectives in Psychiatric Care, 30 (3), 5-8.

Walker, R. (Ed.), (1985). Applied qualitative research. London: Gower.

Walsh, K. (1994). Ontology and the nurse-patient relationship in psychiatric nursing. Australian and New Zealand Journal of Mental Health Nursing, 3 (4), 113-118.

Walters, A. (1992). The phenomenon of caring in an intensive care unit. Unpublished doctoral dissertation, Deakin University, Australia.

Walters, A. (1994). An interpretative study of the clinical practice of critical care nurses. Contemporary Nurse, 3 (1), 21-25.

Walters, A. (1995). The phenomenological movement: Implications for nursing research. Journal of Advanced Nursing, 22 (4), 791-799.

Waters, B., Molony, H., & Vandenberg, D. (1992). Impaired adolescents: Can we offer them something better? In R. Kosky., H. Salimi Eshkevari., & G. Kneebone (Eds.), Breaking out: Challenges in adolescent mental health in Australia (pp. 139-153). Canberra: Australian Government Publishing Service.

Watson, J. (1995). Postmodernism and knowledge development in nursing. Nursing Science Quarterly, 8 (2), 60-64.

Weinberger, A., Sandiford, E., & Rodine, D. (1988). The psychiatric nurse in a community based child and youth services setting. Canadian Journal of Psychiatric Nursing, 29 (1), 14-16.

Weissman, J., & Appleton, C. (1995). The therapeutic aspects of

acceptance. Journal of Child and Adolescent Psychiatric and Mental Health Nursing, 31 (1), 19-23.

West, P., & Sieloff Evans, C. (1992). The specialty of child and adolescent psychiatric nursing. In P. West & C. Sieloff Evans (Eds.), Psychiatric and mental health nursing with children and adolescents (pp. 1-16). Maryland: Aspen.

Wilde, V. (1992). Controversial hypotheses on the relationship between researcher and informant in qualitative research. Journal of Advanced Nursing, 17 (2), 234-242.

Wilson, J., & Hobbs, H. (1995). Therapeutic partnership: A model for clinical practice. Journal of Psychosocial Nursing, 33 (2), 27-30.

Wolfer, J. (1993). Aspects of 'reality' and ways of knowing in nursing: In search of an integrating paradigm. Image: Journal of Nursing Scholarship, 25 (2), 141-146.

Yardley, T. (Ed.), (1996). The directory of higher education courses: 1997. North Sydney: New Hobsons Press.

Yurkovich, E. (1989). Patient and nurse roles in the therapeutic community. Perspectives in Psychiatric Care, 25 (3-4), 18-22.

EXPLICATING PRACTICE KNOWLEDGE: A HERMENEUTIC INQUIRY INTO ADOLESCENT MENTAL HEALTH NURSING

Rene Geanellos RPN, RGN, Adolescent Mental Health Certificate, DNE, BHSc(Nurs), MNurs.

A Thesis Submitted in Total Fulfilment of
the Requirements of the Degree of
Doctor of Philosophy
(Vol 2)

School of Nursing and Human Movement
Faculty of Health Sciences
(Mackillop Campus)

Australian Catholic University
Office of Research
412 Mt Alexander Road,
Ascot Vale, Victoria 3032
AUSTRALIA
27th August 1997

Appendix A: Interpreter Forestructures

Statement Seven: the nurse demonstrates neutrality when faced with aggression, abuse, anxiety and sexualised behaviour.

Interpretation: these are expressions of out of control feelings and/or behaviours on the part of adolescents. This may relate to the present moment or to the adolescent's life in general. Adolescents may use such behaviours to test the nurse's response to them. Adolescents may not have learnt to deal with internal or external conflicts in any other way.

Forestructures: the nurse assists adolescents to take control by being in control herself. Her ability to respond neutrally to such challenges creates a safe, secure and nonabusive environment. A foundation of trust is laid through the manner in which the nurse manages out of control behaviour. She assists adolescents to learn more effective personal, interpersonal and social skills.

Statement Eight: the nurse engenders hope.

Interpretation: adolescents develop hope, for the present and for the future, when the nurse highlights their strength, courage and resilience in dealing with their difficulties. The ability to deal with personal, interpersonal and social difficulties provide an adolescent with an avenue through which they can believe in themself and have hope in the person they can become. Hope allows adolescents to believe life can change for the better and is therefore worth living.

Forestructures: the nurse works with adolescents to facilitate change. She does this by helping adolescents to confront and deal with their difficulties and concerns. She assists adolescents to confront the past, live in the present, believe in the (their) future and plan for that future.

Statement Nine: the nurse fosters equality and shares power.

Interpretation: adolescents feel a sense of control when they have power to influence their relationships with nurses, the environment and decision making processes. Through their effective use of power adolescents learn reciprocity in human relationships and how to become responsible for themselves. Nurses give up their position of authority but not their role as the adult in the relationship. Equality and power sharing allows the development of a therapeutic partnership between the adolescent and nurse.

Forestructures: sharing power and control means a preparedness on the part of the nurse to allow adolescents to make mistakes and to learn from them. It acknowledges that adolescents are in transition to adulthood and need to develop a sense of personal mastery. Nonhierarchical relationships allow the greatest opportunity for equality and power sharing. In such relationships nurses are

partners rather than adult authority figures.

Statement Ten: the nurse resists challenges and has a high level of tolerance for testing behaviour.

Interpretation: challenging authority figures is a part of the adolescent developmental stage. Adolescents may test the nurse for a variety of reasons including to see: (a) how far they can push the limits, (b) that there are limits operating, (c) what sort of response they will get, (d) whether the nurse will behave differently to abusive adults in their life, (e) if the nurse is personally strong enough to handle their challenging, testing, out of control behaviours, and (f) whether the nurse is prepared to accept them despite such behaviours.

Forestructures: adolescent behaviours have a purpose and provide nurses with information through which to understand and make sense of the adolescent's thoughts, actions and feelings. Adolescents need adults to be in control when they themselves are, or feel, out of control. The complex nature of the adolescent's behaviour requires careful reflection and interpretation. Such behaviours may be the only way the adolescent can communicate with the nurse.

Statement Eleven: the nurse highlights small, significant gains.

Interpretation: difficulties that adolescents experience create feelings of powerlessness, hopelessness and despair; a feeling that their life may never change for the better. Adolescent's feel overwhelmed by the nature of their difficulties and their inability to see how they can resolve them. By highlighting the adolescent's ability to enact change and participate in modifying thoughts, feelings and/or behaviours, the nurse helps adolescents to focus on small goals through which they can experience feelings of mastery, accomplishment and success.

Forestructures: through persistent negative feedback and feelings of failure, adolescents tend not to notice or acknowledge successful experiences. The nurse assists adolescents to become aware of their successes and an increasing ability to influence what happens in their life. She appreciates a small gain is significant when the adolescent's personal, interpersonal, familial and social relationships have been chaotic for some time.

Statement Twelve: contact is maintained with the adolescent while it is needed.

Interpretation: adolescents develop significant therapeutic relationships with nurses and an attachment to the unit (milieu). At times, these are the most important relationships adolescents have as, prior to admission, their emotional disturbance resulted in decreasing friendships and fewer positive relationships with others. Adolescents come to see nurses as their friend and nurses fill this role while there is an absence of others to do so. Through such relationships adolescents come to experience well being and a

renewed sense of connectedness to others and to society.

Forestructures: understanding the significance she presently has in the adolescent's life, the nurse terminates the therapeutic relationship slowly. The unit continues to be available to the adolescent while they reduce their attachment to it and gradually replace it with other experiences, places and relationships.

Statement Thirteen: the nurse demonstrates respect and assists the adolescent to respect themself, others and property.

Interpretation: the intrinsic valuing of each individual is important in developing interpersonal and social reciprocity. Through her respectful behaviour toward adolescents, the nurse demonstrates that the adolescent too is worthy of respect. In coming to respect themselves adolescents give up guilt and blame and learn to forgive themselves for perceived failings and failure.

Forestructures: nurses intervene when disrespectful behaviour is demonstrated. In attempting to assist adolescents to develop empathy for others nurses use their self, colleagues, peers and the adolescent group. They harness the positive attributes of the milieu and use their therapeutic relationships with certain adolescents to assist other adolescents to change. Communication, negotiation, warnings and consequences form the foundation of discipline with adolescents. Such discipline is managed with neutrality, flexibility, consistency, forethought and concern.

Statement Fourteen: the nurse is warm, affectionate and welcoming.

Interpretation: personal, interpersonal and familial difficulties leave adolescents vulnerable and needy. They often lack affection and warmth in their lives. Sometimes, the cost of warmth and affection has been disturbing, abusive and destructive relationships. Adolescents find themselves on the margin; ostracised, feeling different and inevitably blaming themselves. Such adolescents feel alienated, unwanted and as though they don't belong.

Forestructures: through her welcoming approach and her warm, affectionate relationship with adolescents, the nurse fosters feelings of inclusiveness and belonging. She appreciates the adolescents are outside their normal orbit of familiar people and places. Her personal milieu creates opportunities for adolescents to risk reaching out to her.

Statement Fifteen: the nurse is nonjudgmental.

Interpretation: through personal, interpersonal, familial and societal difficulties, adolescents experience the intolerance of others to both their behaviours and to themselves. A cycle of negativity, hostility and defensiveness comes into being. Because adolescents are unsuccessful in, or unable to change this cycle of dynamics, a deep resentment and estrangement occurs.

Forestructures: the nurse's forbearing, broad minded and progressive approach and response to the adolescent's behaviours thoughts and feelings, allows the adolescent to feel less alienated and more hopeful. The nurse's ability to tolerate and manage immature, bizarre, testing, ambiguous and contradictory behaviours affirms the adolescent's trust in the nurse's capacity to assist forward movement. The adolescent's hostile and defensive energy is freed up for use in the process of change.

Statement Sixteen: the nurse has a sense of fun and a sense of humour.

Interpretation: the adolescent's inner and outer world is often bleak so laughter and joyfulness become superficial or nonexistent. Adolescents focus on how difficult and "stuffed up" life has become and see no way out of their present dilemmas. A high level of chronic miserableness develops; the adolescent acts-in or acts-out these feelings.

Forestructures: the nurse's ability to share a joke, laugh at her self and laugh with others, provides an atmosphere of lightness and acts as a tension release. Her capacity for enjoyment, participation, laughter and sharing produces an environment where adolescents feel free to participate, experiment and be unlike their previous selves. Adolescents reexperience having fun and being happy.

Statement Seventeen: the nurse is a willing participant in activities.

Interpretation: the capacity to participate, to engage in normal risk taking activities and to be adventurous, is blocked or misdirected in the adolescents. They need to learn, or relearn, how to participate, how to act and interact appropriately, and how to establish and maintain friendships and/or relationships.

Forestructures: adolescents are provided with opportunities to have fun, learn new things and practice relevant skills when nurses willingly participate in meaningful activities and interactions with them. Engagement in activities with adolescents provides nurses with opportunities to work therapeutically with them. The adolescents feel worthy, and life feels worthwhile, when the nurse demonstrates her preparedness to be with them and do things with them. Adolescents find hope and meaning in doing, and being able to do, what other adolescents do.

Statement Eighteen: the nurse has a positive attitude.

Interpretation: adolescents have often lost hope, trust and the capacity for effective interpersonal, familial and social relationships. These losses relate to their beliefs about themselves, the world in general and the (their) future.

Forestructures: through the therapeutic relationship the nurse becomes a significant influence in the life of the adolescent. This means she has power to use in one way or another. In displaying a

confident, optimistic, constructive, affirming attitude the nurse assists the adolescent to engage with her in hoping for, believing in and creating change, in the present and for the future. What the nurse believes and how she behaves are fundamentally transparent.

Statement Nineteen: the nurse demonstrates compassion, consideration and tenderness.

Interpretation: because of their abusive, chaotic and unhappy backgrounds, adolescents have lost their trust in adults and in the world in general. Such backgrounds often preclude experiences of tenderness, consideration and compassion. In lacking such experiences, or in being unable to recall them, adolescents come to believe they are not worthy of them. More often than not they neither know how to give nor to receive such expressions replacing them with abusiveness, aggression, despair or anxiety. The adolescent's emotional pain and confusion is often expressed in the same way.

Forestructures: nurses appreciate that adolescents are needy and vulnerable despite their behaviour. They understand acting-out and acting-in behaviour has both purpose and meaning and they do not take it personally. Nurses learn to interpret verbal and nonverbal communication and use such insights to assist adolescents to better understand themselves and their needs. They work with tenderness and compassion toward jointly healing the pain and suffering that adolescents are experiencing. Such experience teaches adolescents they are worthy, and worthwhile, and allows them to reach out to others in the same way.

Statement Twenty: the nurse believes in adolescents.

Interpretation: working with adolescents is difficult. They are challenging adult authority figures, struggling for independence from adults (symbolically represented by their parents), developing a sense of self and their place in the world of the future, and demanding more say in decisions about their lives. The experience of emotional disturbance at this time adds another dimension to the adolescent's struggles.

Forestructures: the nurse is aware of the doubt, vulnerability and uneasiness the adolescent experiences. She appreciates the magnitude of their task and assists them by believing in their capacity to overcome their difficulties, achieve developmental tasks and build a future for themselves and others. She guides adolescents in looking toward and planning for the future rather than focusing on the past. As a result of her belief in them, the nurse creates an opportunity through which adolescents come to believe in themselves and to have hope for the (their) future.

Appendix B: Interpreter Preunderstandings

Story Three: Anthony

This is a story about happiness, confidence and self worth and how the activities nurses engage in with adolescents provide opportunities for such things to happen. The story concerns a 16 year old called Anthony who was thought to be developing an obsessive compulsive disorder. He was a quiet, somewhat uncertain and anxious adolescent who tended not to be popular with his peers. He was also intelligent, had a lively sense of humour and related well with adults; a long time later I discovered he had a lovely smile which literally lit up his whole face. I was drawn to what I sensed was a feeling of aloneness in him and in conversation I found him to be a sensitive, concerned and aware young man. He had been living on the unit for a while when we chanced upon a game of tennis together, from that point on we formed a pair and played a lot of doubles. He never discussed his problems with me as our relationship centred around doing things together. This included basketball, snooker and sitting around the swimming pool talking but it mostly involved tennis. We developed a warm, positive relationship and I used touch a lot with him; I would walk him to school with my arm around his neck or shoulders and a feeling of camaraderie grew up between us. In this way, the relationship flourished on activities and the scene was set for it continuing at the end of school camp. It was winter and we were to stay in the snow country. The organisation of such camps was amazing but the nurse in charge of the camping program had become quite expert at managing consent, information letters, car and bus bookings, finances, linen, games and camping requirements. Whatever he couldn't do he would obtain assistance with. Provisions were organised by Sally who worked in the kitchen; she never let us run out of anything and always seemed to know what the kids liked, she was just wonderful and there was very little she wouldn't do for the kids, who in turn, really loved her. Other staff filled cars with petrol, picked up the bus or spoke with parents, attended to administrative liaison tasks and letters and so it went. Staff included teachers, nurses and doctors. Such camps became the heart of the adolescent unit program and provided the opportunity for intense therapeutic work. Needless to say, both adolescents and staff were exhausted by weeks end. Camp attendance was strictly by choice and those who went found them hard work at times but they generally loved them. Anthony and I didn't have anything to do with each other on the trip down as I was driving one of the cars and a group of girls chose to come with me, but the next day we teamed up for tobogganing and I discovered what a boost in self esteem can do. After a few goes down the slope behind me Anthony was confident enough to go in front but this was only the beginning! Soon after he decided we should try such manoeuvres as going down on our stomachs piled on top of each other, then it was going down backwards and I was the one being hesitant; whatever he saw someone else do we had to try too. I can't count the number of times we fell off (although we became quite expert in the end), or

found the thin patches of snow at the bottom of the slope and ended up in water, but nothing stopped us from having fun for 4 hours straight. The same nurse who organised the camps took lots of photos, as mementos for the adolescents and staff, and when they were developed Anthony and I were seen in full flight with exuberant, smiling faces as we careered down the slope. I still have these photos and they look so joyful they always make me smile. That night a group of us walked after dinner and Anthony and I were talking together, the happiness of the day was still with him and he told me how changed he felt after one term on the program. I asked him to tell me about his old self and new self and how they were different. He said the biggest change was in his sense of happiness, confidence and self esteem and that all this put together allowed him to relate to his peers and others in a more comfortable way. He felt somehow equal to others now and noticed the adolescents were willing to spend time with him and treated him differently, they seemed to value him and his company more. This was very different to the unsure and uncomfortable person he had been when he felt he wasn't worth much and saw this reflected in the fact that his peers seemed to agree with his assessment of himself. He told me he couldn't believe all the things he'd done because previously he'd been too frightened of making himself obvious or making a fool of himself to do the things other people did. At this point he said "just think, with you it was tennis and now tobogganing, I wonder what'll be next?" I asked him what was left that he felt he'd like to try but found difficult to contemplate. Quick as a flash he said "dancing." Just as quickly I answered "that's easy to organise, a party and some music, would you like to give it a go?" In the dark I couldn't see his face but in a smiling voice he said "yes, if you'll be my partner." My reply was "you're on." Anthony spent a lot more time with his peers and other staff so I didn't speak with him until the party the following night. In the meantime a couple of staff and adolescents went shopping for party food, balloons and streamers. Naturally with so many adolescents there was no shortage of music. The kids made a special effort with clothes and make up and prepared everything for the party; they loved the idea and Anthony was a hero for suggesting it. The music selection was given over to several different adolescents throughout the night and was well received by both kids and staff. Anthony and I had our eyes on each other so when the music started we headed straight for the dance floor. It only took a few dances and he was ready to dance with someone else, it was a good example of how confident, happy kids find the strength to move beyond their families, or us. He really enjoyed the party and told me he found it hard to believe he had achieved so much at this camp alone. Throughout the remainder of the camp we spent time together and cemented the friendship which began months before. Two weeks after we returned from camp the school term ended and Anthony was discharged from the program; he would ring and come to see us from time to time but he lived many hours from the unit and was also busy with his life and school. He seemed to maintain his sense of well being and made sure he found me to say hello whenever he was visiting. We often joked about our tennis, tobogganing and dancing and still had a warm fondness for each other. When I think

about this story I'm reminded of the way nurses use day to day activities to establish and maintain therapeutic relationships with adolescents. These activities allow you to provide opportunities for fun, enjoyment and success and as a result to foster the adolescent's self esteem and confidence. Anthony really enjoyed activities, he seemed to forget his problems while he was engaged in them and gained so much from being involved with others in normal day to day activities. The other thing I learnt from Anthony was that therapeutic relationships take many forms and this was quite a significant learning experience for me. Previously I thought it was necessary to have involved yourself in talking with the adolescent about their problems and pain before you could develop a therapeutic relationship which allowed you to work positively together. Anthony taught me that wasn't true. He and I had never spoken about his problems or why he joined the program, he never shared such thoughts and feelings with me, at least not verbally, but we spent a lot of time doing things together. Our relationship was warm and affectionate because I felt this was what he needed; it created opportunities for him to try new and different things and it allowed him to feel valued, accepted and worthy. People looking from the outside would probably see it as an easy going relationship based on having fun together, and while it was these things, it was also a deeply therapeutic relationship through which Anthony was able to experience change and well being. I suppose I look on therapeutic relationships differently now, they're not always what they seem.

Preunderstandings Developed from Story Three

I believe:

* the activities nurses engage in with adolescents provide avenues through which they can experience happiness, success, confidence and enhanced self esteem;

* the nurse closely observes the adolescent and modifies her approach to them in response to her understanding of their needs;

* a nurse can have a therapeutic relationship with an adolescent that does not involve talking about the reasons the adolescent was admitted to the program;

* activities provide a vehicle for therapeutic engagement;

* affection and touch are part of my relationship with adolescents unless unacceptable to the adolescent or inappropriate to the context;

* major activities on an adolescent unit, like a camping program, require a team approach and cooperative effort;

* activities with adolescents can be great fun and mementos from such experiences are cherished;

* highlighting difference is an effective way of getting an adolescent

to notice the gains they have made;

* when an adolescent trusts a nurse they share their doubts, feelings and fears. Such a relationship is a therapeutic partnership through which the adolescent can take risks, take up challenges and change;

* a confident and happy adolescent has the strength to move beyond their therapeutic relationship with the nurse. Equally as important is the nurse's ability to separate from the adolescent and foster their individuation. This mimics the parenting of an adolescent;

* through their therapeutic relationship adolescents and nurses maintain feelings of fondness and attachment to each other long after the adolescent's discharge;

* adolescents forget their problems while engaged in activities. This psychic respite leads the adolescent to hope for improvement. Successful experiences allow the adolescent to feel valued, accepted and worthy;

* the relationship between an adolescent and nurse is unlike other professional relationships. It is easy going, friendly, affectionate, activity based and founded on activities that resemble those that would normally occur at home.

Story Four: David and Sam

I chose this story because I believe it helped me to learn about working with adolescents. Although it was about something I already believed was important the experience made it tangible and helped me to remember it's significance. I was working on the weekend and there were only two adolescents on the unit, David and Sam. There were two units on the same site and because of the low numbers of kids staying over the weekend we usually amalgamated the units, this meant there was a nurse from our unit and one from the other unit. However, during the weekend the staff and adolescents from the adolescent unit spent their time on that unit. Liaison between the staff allowed the organisation of meal breaks, medication and management issues. I was with the two adolescents in the craft room, both were around 15 years old. I'm not sure what we were doing but I think it included painting and wood work. We had been there for a little while and were content to stay. Essentially, the boys were talking together and from time to time I would join in. Their conversation centred around the usual adolescent things like families, music, school and what was going on in the peer group, the latter being the most frequent topic of conversation. The chatter was liberally sprinkled with swear words like fuck, prick and dick head. I don't find this type of language offensive and feel it's an inherent part of adolescent development, it's a way of kids being different to adults and expressing themselves in ways which is individual to their peer and age group. I know it can be used offensively and hurtfully, or disrespectfully, but this

wasn't the way these kids were using it so I didn't intervene to modify their language. I would only do this if someone else was present who found it unacceptable or if it was inappropriate in the context, like if young children were about or we were in a restaurant. I think young people need to learn consideration for others in this way. Sometime in the afternoon the nurse from the other unit came to speak with me and I was struck by the change in the behaviour of the kids. They spoke with her making polite conversation, even their bearing had changed, they were somehow more upright, focused, attentive and alert. "Hello Sandra", they said, "how are you going with those monsters?" There was a few minutes of chatter, of exchanging jokes and laughter but not one swear word passed their lips. I noticed this and was quite fascinated by the change that came over them. Sandra soon left and things returned instantly to normal, almost as though the atmosphere changed completely. I said to the kids "what's going on, how come you were so different when Sandra was here?", they replied "what do you mean different, what did we do?" "Well", I said, "you didn't use one swear word, you were polite and almost like you were standing to attention." "Oh", said David, "Sandra's a lady you can't use words like that when she's around." "Yeah" said Sam "she's an adult." This was confusing so I said "I don't understand, I'm a lady and adult too you know!", they both looked at me somewhat perplexed then David said "no you're not, you're Rene", Sam added "what David means is you're our friend, we don't think of you like them." "That's right" said David "it's different with you, we can be ourselves." Although I was amused by what had happened I was also touched by what they said. I asked them to tell me what sort of things allowed them to be themselves and they said not being hassled about how they looked, what they said or swearing or anything like that, they said when people accepted them they could be themselves and feel comfortable. It was difficult for them to say exactly what they meant but after some discussion they decided it was all to do with accepting kids, and where they're at, because if nurses accepted kids then they didn't have to worry, they could be themselves. They said they couldn't make it any clearer for me but I thanked them and told them they'd made it very clear. I never forgot this interaction, it taught me how important the relationship is between the nurse and young person and how this relationship is founded on acceptance, tolerance and flexibility. Really, whatever power the nurse has to influence the adolescent arises out of their relationship. I came to appreciate how important each nurse's personality and working style is because it's this that adolescents pick up on and relate to. This is like the individual nurse's milieu while all the nurses create the unit milieu. The person of the nurse is so important to the therapeutic relationship as who you are is the foundation of everything you're able to do in relationships with others. But you can't pretend to be someone you're not, especially with adolescents, they have a fine, intuitive awareness of the unauthentic.

Preunderstandings Developed from Story Four

I believe:

* nurses learn about working with adolescents through experiences of practice. Such experiences make learning tangible and memorable;

* certain behaviours are integral to adolescent development because they signal differences between them and adults, for example, the use of particular words, specific ways of speaking or dressing and swearing;

* it is appropriate to intervene to modify the adolescent's behaviour in order to assist them to consider others and to act in contextually appropriate ways;

* relationships with adolescents are founded on tolerance, flexibility, acceptance, honesty and personal integrity. Any power or influence I have as a nurse arises through this relationship;

* the personality and working style of the nurse is significant because it is this that adolescents pick up on and relate to. These aspects of myself I see as my individual milieu. My milieu combines with all other individual ones to create a part of the unit milieu;

* the person of the nurse is of utmost importance because who I am is the foundation of everything I am able to do in relationships with others.

Story Five: Ned

I remember this incident because I used a strategy that I very seldom use; in fact I think it's the kind of strategy you would draw on very rarely and would need to be very sure of yourself in using. It has to be done with complete neutrality if it's going to be successful. The story is about a 14 year old called Ned who had a mixed attention deficit and conduct disorder. He was unpredictable, quick to anger, difficult to engage for long, apt to act out his emotions and abusive. He was also given to smiling a lot, loved to be active, was affectionate, and at times was insightful and sensitive. The incident took place one afternoon when all the staff were arriving for a case review meeting. Ned was especially unsettled that day and had been in and out of school because of his disruptive behaviour and inability to stay on task. There was something troubling Ned but he had not been able to talk about it and so his emotions were building. It was 1:30 pm and the adolescents were back in school. The nurses came in breathing a sigh of relief that Ned was off their hands and they were hoping he would be contained in school. However, no sooner were we in the meeting room than he came into sight. The nurses looked at each other and seemed genuinely too depleted to deal with him so they chose to ignore him, but there was no way we could ignore him walking around outside the room. As I watched Ned I was struck by his behaviour and the responses of the staff; he paced and stalked around the area as though he were planning an attack and the staff in the room responded by acting as though they felt they we being set upon, I think they felt they were under some kind of psychic assault. I hadn't been dealing with Ned that day so probably had more energy than them but I felt their feelings and

noted the impact it had on Ned. He was working himself up for an outburst; he walked fast, was agitated, restless, called out and berated people to himself. His actions were fast and furious and his face increasingly contorted by frustration, anger and impending rage. He started punching out at the surroundings and his aggression was escalating. I felt he would soon be completely out of control and that containment was essential or it would end up with Ned being restrained. Restraint was rarely used as we worked hard to help adolescents to learn to control themselves; if we did restrain we used holding but never any other form. Most often we encouraged kids to go off and cool down then come back and talk about their worries but I felt Ned was beyond hearing or responding to requests. I got up quite suddenly and went outside coming face to face with Ned. He was caught by surprise, not expecting to see me, and I shouted at him very, very loudly "what do you think you're doing?" I was not angry but I was trying to obtain the position of authority. I wanted him to feel that I was the one who was in control of what was going to happen, that I had the upper hand. I shouted again "you can't threaten and intimidate people here, we treat people with respect and we expect it back." He looked as though he'd come down a bit so I went on in a slightly lower tone "take yourself off the unit and go for a walk to calm down, we can't help you when you're like this, first you'll have to help yourself." At this point he snorted, looked down and muttered something but with a lot less force and in a much less angry voice. I responded in a normal voice. "Ned we know something's worrying you and when you come back we'll be here to help you sort it out, you know you can tell us anything you need to, we'll listen to whatever you have to say, so come back when you're ready to talk." While I said this I was pointing to the door leading off the unit so my message was very clear but I also didn't think he was ready to talk, that he was calm enough to do so. Ned half smiled and went as requested. The more controlled and less angry way in which he was behaving suggested he was no longer out of control. I didn't feel it would be unsafe for him to take a walk and cool down. As he left I wondered if he'd had to get to this point before he could go any further. When I walked into the staff room people cheered and were very relieved (this must be how parents feel) but also surprised at my intervention. I didn't shout. I felt it only replicated the negative adult or parental relationships many adolescents had experienced, that of anger, aggression and abuse. I'd intervene early to manage escalating behaviour, or to assist adolescents to regain control, but shouting and ranting were not in my repertoire. I hadn't planned the intervention but my quick and decisive response, and my up front "I'm in charge here so don't give me any nonsense" approach, was a strong message. My purpose was clearly in my face and in my demeanour and I think he read that message. I moderated my approach in response to his responses; I kept pace with his mood. I have only used this strategy a few times. You and the adolescent need to know each other well, there must be an inherent trust and understanding between you. The adolescent must never feel that you might lose control and attack them. You have to be sure there's no anger in you otherwise it would be easy to lose control. You must

be completely neutral. If a kid pushes your buttons then don't try this with them. On the day it worked out well. Ned came back an hour or so later and spoke with his therapist. We discovered his father had disciplined him very harshly and he had welts and bruises on his back and legs from a beating with a belt. When the staff heard about Ned's black and blue legs and back they were shocked, mildly outraged toward the father and very sympathetic and understanding toward Ned. I was called in by Ned's therapist to witness the bruising from Ned's belting and, as a result, I was also present at a later meeting between the therapist and Ned's father. It was a long interview but two things stand out. First, assumptions are counter productive and second, change can be small yet significant. People assumed Ned's father, Mr D, beat Ned in anger and was cruel and uncaring but none of these things were true. Mr D told us the story of life with his own father who was a violent, cruel and vindictive man. Mr D had been repeatedly beaten by his alcoholic father for minor misdemeanours or simply because he was there; he saw no love from his father and swore he would never treat his own children that way. Mr D said he never disciplined his children in anger so he did not lose control and behave violently, in fact he only disciplined them physically when they deserved it. Mr D said "I love my children and discipline them because I want them to grow into good people who can contribute to society, I don't do things the way my father did, with anger." Ned confirmed this but he said he told us about the beatings because he'd learnt from us that there was another way to discipline adolescents. We were able to help Ned's parents learn more appropriate strategies for parenting adolescents and they benefited greatly from joining the parent support group. Ned remained an extremely challenging adolescent to parent and to nurse. From Mr D I discovered the danger of assumptions and especially that such assumptions may carry judgment and blame. I also came to appreciate how people can make significant changes as a result of their life experiences. For example, Mr D chose his mode of parenting because he wanted to be different from his father. Moreover, people themselves have this capacity for change, it doesn't need to come from the interventions of health professionals. I was more thoughtful and hopeful in the face of this incident.

Preunderstandings Developed from Story Five

I believe:

* interventions require a high level of understanding of the self and the adolescent if they are to be effective. Neutrality is essential when dealing with out of control behaviours;

* working with adolescents can be emotionally and physically draining thereby leaving you too depleted to deal effectively with challenging behaviours. In such circumstances it is important that the team allows you to take a break from the adolescent concerned;

* it is necessary to notice escalating behaviours, to interpret those behaviours, and then to act or not act on them according to your assessment of the adolescent's ability to regain control without

intervention. Timely intervention can prevent escalating behaviour from becoming out of control behaviour;

* working with adolescents requires the nurse assists them to take control rather than imposing control. Allowing adolescents time out from distressing situations is a useful strategy in helping them to regain control. Restraint, physically holding an adolescent, is a last resort for managing out of control behaviour;

* following time out the nurse should reassure and speak with the adolescent about their concerns. Adolescents need to know they can discuss anything with you and that together, and with the help of the team, you will try to resolve their concerns;

* respect should be expected and fostered between nurses and adolescents;

* aggressive or abusive responses from the nurse are inappropriate. Such negative behaviours replicate those to which adolescents have been exposed. An adolescent should never fear you might lose control and attack them, psychically or physically;

* verbal and nonverbal communication should be congruent and consistent so the adolescent does not receive mixed messages;

* to work therapeutically you must acknowledge your own areas of unresolved conflict in order that you can work on resolving them;

* assumptions are counter productive because they can lead to inappropriate judgment and blame;

* parents and nurses can make a significant contribution to each others knowledge and understanding;

* people themselves have the capacity to make significant changes as a result of their experiences of living and not only through the intervention of health professionals;

* being nursed on an adolescent unit can assist adolescents to learn developmentally appropriate ways of parenting;

* the nurse observes the adolescent in a variety of situations and interactions thereby gaining an increasing understanding of their concerns, difficulties and nature. She strives to develop a balanced view of them.

Story Six: Martyne

I like this story because it reinforced my thoughts about testing behaviour in adolescents. At age 15 Martyne's parents found her adolescent rebellion beyond their ability to manage. She came from a wealthy upper class family and chose to become "a goth" in order to assert her individuality and separate from her family. Her hair was died black and kept long and straight. She wore long medieval skirts and dresses and very heavy, accentuated eye make up. She

was intelligent, articulate, well read and attractive. She also had a delightful sense of humour, smiled a lot and was a sensitive and compassionate young woman. She shared the following information with me about two years after she was discharged from the unit by which time she was 18 years old. During the time Martyne was on the program we developed a positive and warm relationship and she called me one day to see if we could have lunch. I readily agreed because I enjoyed her company and had not seen her for a while. After lunch we went for a walk and she began talking about what kind of nurses make good workers with adolescents. She mentioned a few things but what I remember most concerned me. With a half smile Martyne said "we used to try all sorts of things to get you going but you never lost your temper, you would just smile and listen or you would tell us what you thought or accept whatever we said." She went on saying "at one stage we tried to come up with all sorts of shocking things to say but nothing seemed to worry you, you took everything in your stride." I asked her what she thought of my behaviour and she replied it was what adolescents needed. When I asked her why, she said adolescents like to test adults and shock them but they trusted adults who didn't abuse them or lose their cool. I thought there was a lot more to this type of adolescent behaviour and decided to explore it with her. After talking about challenging behaviours for a while I asked Martyne why is was adolescents felt they could trust a nurse who they couldn't shock or get to lose control. She said it was because they could say or do anything to this nurse and she wouldn't abuse or reject them and she'd be the sort of person who'd be able to help if they needed it. I asked Martyne why adolescents needed to test nurses in this way but she said she'd never really thought about it. I remember saying something like "give it a go and see what you came up with." Her answer went something like this, "may be it's to see how far we can push you, to see if you really care about us or if you're going to hurt us like other adults have done. We were really unsure and confused but we wanted to be accepted by adults too, it's crazy though the way we went about getting what we wanted." This story shows what we can learn from adolescents if we're prepared to listen. I learnt a lot about the seemingly paradoxical behaviour of adolescents who although needing acceptance and assistance from adults may behave in ways that are likely to achieve the exact opposite. I think it says a lot about the need to interpret behaviours so you can go beyond the superficial to the deeper message beneath. The story is also about how adolescents test adults to gauge their responses and determine their trustworthiness, I think it shows that behaviours which nurses tend to label as 'naughty, childish, silly or testing' have a very real purpose. I suppose it's a bit like a test, if you pass you're able to go to another level in your relationship with the adolescent but if you fail you may not get another chance. For me this testing is important for another reason since it provides the nurse with the opportunity to restore the adolescent's faith in adults, I think this is the real significance of what Martyne had to say. Later, I worried a good deal about this and thought about the power nurses had in their seemingly mundane interactions with adolescents. The way I saw it, the implications of such interactions went beyond the

restoration of an adolescent's faith in adults to influencing their belief that adulthood was actually something worth aiming for; it meant they could believe in their own future.

Preunderstandings Developed from Story Six

I believe:

* the relationship between an adolescent and nurse can be quite significant, founded on mutual liking and last for sometime after the adolescent's discharge. Following discharge the adolescent may visit, phone or meet with nurses who were important to them;

* listening to adolescents and exploring issues with them can assist you to learn a great deal which is of significance to your work;

* the testing behaviours of adolescents are complex, paradoxical and purposeful. Through such behaviours they may ascertain your trustworthiness and see how you respond to them. They may wish to see whether you will set limits and boundaries and learn where those limits and boundaries will be. Such behaviours may also be a way of engaging the nurse, of gaining her attention, or making the first approach in establishing a relationship;

* interpretive communication allows the nurse to go beyond the superficial to the deeper and more complex meanings beneath;

* adolescents use challenging behaviours to test you. If I behave in ways that are frightening, confusing or condescending the adolescent may not give me another chance to form a relationship with them;

* my work with adolescents provides me with an opportunity to restore their faith and belief in adults and adulthood;

* through their day to day interactions with adolescents nurses have a great deal of power to influence their hopes for the future;

* the nurse is a keen observer of the nature of the adolescent.

Story Seven: Martin and Luke

This story concerns two adolescents but I'm dealing with them together because the action I want to talk about relates to them both. Luke was 17 and joined the program for respite from a chaotic home life. He was a quiet, self contained and popular young man who enjoyed and excelled in sports and activities. We had an easy going relationship and shared some special experiences at a camp which deepened that relationship. Our relationship was founded on activities and doing things together. Some little time after Luke was discharged he returned to see his doctor. I was walking down a corridor when I heard my name called and stopped. I turned to see someone standing near the doctor's door but with the sunlight behind them I couldn't tell who was calling my name and waving. I walked toward the person and realised it was Luke. I said something like "hello, I couldn't see you with the light behind

you, it's great to see you." At the same time as I was talking and walking toward him he threw his arms open in that unmistakable gesture that welcomes an embrace. I was folded in and returned his embrace and he said "how about a game of ping pong?" I said "sure" and we went off to enjoy a hard fought game because although I was hopeless at snooker I was pretty good at ping pong. I was reminded as we walked to the activities block how significant such activities were in my relationships with adolescents and how much these activities mimicked what adolescents usually do with their friends and may be rarely do with adults or parents.

The other young man I want to speak about is Martin who was 17 when he left the program but 18 at the time of this story. He came from a violent background of physical abuse and a beating from his father resulted in the loss of hearing in one ear. Various foster homes had not met his emotional needs and the trauma of his early life proved difficult to resolve. He was quiet and serious, tended to be a loner and was shy in social situations. He also had a good sense of humour, a lovely smile and a gentle nature and by consensus we all thought he needed a great deal of loving affection. During his time on the unit he went through his middle adolescent growth spurt and grew 15 cms taller and 10 kgs heavier but despite being a very big adolescent he retained that tenderness and gentleness that so many of us valued. He too was returning to see his doctor. One day I was sitting at the desk and looked up to see this young giant at the door dressed in black motorbike clothing and holding a black helmet. Somewhat incongruously with this image was his gesture. His arms were thrown widely open welcoming me into his embrace. I remember how touched I was to receive this show of affection and tenderness from him because, while it was something I expected from Luke, it was an unexpected gesture from Martin. I commented on his size and said something like "it's really lovely to see you." He smiled shyly and we spoke for a few minutes about what was happening in his life before his doctor arrived. I remember closing the door and crying. I felt how much he trusted me to risk reaching out that way and I experienced a real sense of hope for him. Again I'm reminded of the power existing in your relationship with adolescents; the power you have to join with them to change things. In the beginning, Martin's sense of self was so fragile after the experiences in his life and his vulnerability so obvious to those who cared to look. Sometimes it's hard to look because confronting such pain, uncertainty and sadness never leaves you untouched; it brings you close to your own sadness and anger at the terrible injustices of the world. It needs experiences like the ones I had with Luke and Martin so you can keep looking with a sense of hope. The experience with Martin reminds me that when adolescents first join the program they often feel bewildered, frightened and unsure of what to expect in a strange environment full of strangers. They are unequal to everyone but especially the adults in the environment; they're uncertain what we expect of them and how they'll resolve the burdens they bring with them. They often lack self esteem and hope, feeling quite rightly that the world is a hostile and dangerously painful place. Their abusive and hurtful experiences with adults make them resentful, suspicious and

cautious so trust is a long time coming and affection is something some of them have rarely received let alone given. I think this is why I was so touched and pleased when Luke and Martin were able to give of themselves by reaching out in that affectionate way. They now had something to give and felt a sense of confidence in risking the gesture of offering themselves. I know they couldn't have done that before because they themselves had received so little affection and had no reservoir from which to give; in a way they were quite empty inside. I suppose this demonstrates how healing allows you to give to others and sets in motion cycles of giving and receiving; it's about developing the capacity for reciprocity in relationships. It reminds me that while the relationship you and the adolescent build together is born of a professional need it is also very unlike adult therapeutic relationships. This occurs for different reasons but includes the fact that you spend so much time with the young person. You engage in activities they usually engage in with friends; you hang out with them talking and just being together and you share of yourself as they share with you. You do homework together, walk them to school as a friend or sibling would do and share ice cream, music, outings and dinner when school is done. All this leads to the relationship taking on the attributes of a friendship and as the adolescent grows and changes a feeling of equality enters the relationship which seems to obtain another level. In the end the adolescent and nurse both give and receive; the traditional hierarchical, objective, professional relationship is a long way from this. The relationship is certainly professional and bounded by limits but it mimics friendship and anyone spending time on an adolescent unit would note the friendliness which characterises the relationship between the adolescent and nurse. This is even more evident later when young people continue to visit and engage you more than ever on equal footing.

Preunderstandings Developed from Story Seven

I believe:

* relationships with adolescents are easy going and founded on sharing experiences and doing activities together. Such engagement in activities with adolescents mimics what they usually do with friends and less often do with adults;

* a strong bond of reciprocal affection develops in the therapeutic relationship between the adolescent and nurse and endures beyond the adolescent's discharge. This is significant because it: (1) indicates the adolescent has the capacity to sustain an interpersonal relationship; (2) suggests the adolescent can give of themself having been nurtured and, as a result, received something from which to give; and (3) points to a process of healing resulting in an increased sense of self esteem and confidence from which they can reach out to others;

* the nurse is a keen observer of the nature of the adolescent and plans her responses according to those observations;

* a shared milieu leads to the valuing and fostering of particular

attributes and behaviours in adolescents, for example, tenderness;

* adolescents often behave unexpectedly and vacillate in their move toward adulthood;

* a welcoming, encouraging and secure environment is required for adolescents at admission, throughout admission and after discharge;

* an adolescent who trusts a nurse will reach out and risk themself in that relationship. This places me in a powerful position to join with the adolescent to work on change;

* the pain an adolescent brings to their relationship with the nurse never leaves you untouched. It awakens feelings of sadness and anger in you because of the injustices the adolescent has experienced. When an adolescent successfully works through their pain it gives the nurse hope and sustains her;

* the adolescent's painful, negative and abusive experiences with adults makes them hostile, suspicious, resentful and cautious of nurses. This means trust takes a long time to develop and often remains tentative and fragile;

* equality and the sharing of power are important in my work with adolescents because this assists in reducing the distance between myself and them;

* adolescents find predictability, limits and boundaries helpful because they are often uncertain, confused and anxious;

* the relationship between an adolescent and nurse is founded on activities such as those normally taking place at home and with friends. It has the attributes of a friendship and a feeling of equality. It is divorced from the notion of a traditional hierarchical, objective, professional relationship. The relationship is professional and bounded by limits but mimics friendship and is characterised by friendliness.

EXPLICATING PRACTICE KNOWLEDGE: A HERMENEUTIC INQUIRY INTO ADOLESCENT MENTAL HEALTH NURSING

Rene Geanellos RPN, RGN, Adolescent Mental Health Certificate, DNE, BHSc(Nurs), MNurs.

A Thesis Submitted in Total Fulfilment of
the Requirements of the Degree of
Doctor of Philosophy
(Vol 2)

School of Nursing and Human Movement
Faculty of Health Sciences
(Mackillop Campus)

Australian Catholic University
Office of Research
412 Mt Alexander Road,
Ascot Vale, Victoria 3032
AUSTRALIA
27th August 1997

Appendix A: Interpreter Forestructures

Statement Seven: the nurse demonstrates neutrality when faced with aggression, abuse, anxiety and sexualised behaviour.

Interpretation: these are expressions of out of control feelings and/or behaviours on the part of adolescents. This may relate to the present moment or to the adolescent's life in general. Adolescents may use such behaviours to test the nurse's response to them. Adolescents may not have learnt to deal with internal or external conflicts in any other way.

Forestructures: the nurse assists adolescents to take control by being in control herself. Her ability to respond neutrally to such challenges creates a safe, secure and nonabusive environment. A foundation of trust is laid through the manner in which the nurse manages out of control behaviour. She assists adolescents to learn more effective personal, interpersonal and social skills.

Statement Eight: the nurse engenders hope.

Interpretation: adolescents develop hope, for the present and for the future, when the nurse highlights their strength, courage and resilience in dealing with their difficulties. The ability to deal with personal, interpersonal and social difficulties provide an adolescent with an avenue through which they can believe in themself and have hope in the person they can become. Hope allows adolescents to believe life can change for the better and is therefore worth living.

Forestructures: the nurse works with adolescents to facilitate change. She does this by helping adolescents to confront and deal with their difficulties and concerns. She assists adolescents to confront the past, live in the present, believe in the (their) future and plan for that future.

Statement Nine: the nurse fosters equality and shares power.

Interpretation: adolescents feel a sense of control when they have power to influence their relationships with nurses, the environment and decision making processes. Through their effective use of power adolescents learn reciprocity in human relationships and how to become responsible for themselves. Nurses give up their position of authority but not their role as the adult in the relationship. Equality and power sharing allows the development of a therapeutic partnership between the adolescent and nurse.

Forestructures: sharing power and control means a preparedness on the part of the nurse to allow adolescents to make mistakes and to learn from them. It acknowledges that adolescents are in transition to adulthood and need to develop a sense of personal mastery. Nonhierarchical relationships allow the greatest opportunity for equality and power sharing. In such relationships nurses are

partners rather than adult authority figures.

Statement Ten: the nurse resists challenges and has a high level of tolerance for testing behaviour.

Interpretation: challenging authority figures is a part of the adolescent developmental stage. Adolescents may test the nurse for a variety of reasons including to see: (a) how far they can push the limits, (b) that there are limits operating, (c) what sort of response they will get, (d) whether the nurse will behave differently to abusive adults in their life, (e) if the nurse is personally strong enough to handle their challenging, testing, out of control behaviours, and (f) whether the nurse is prepared to accept them despite such behaviours.

Forestructures: adolescent behaviours have a purpose and provide nurses with information through which to understand and make sense of the adolescent's thoughts, actions and feelings. Adolescents need adults to be in control when they themselves are, or feel, out of control. The complex nature of the adolescent's behaviour requires careful reflection and interpretation. Such behaviours may be the only way the adolescent can communicate with the nurse.

Statement Eleven: the nurse highlights small, significant gains.

Interpretation: difficulties that adolescents experience create feelings of powerlessness, hopelessness and despair; a feeling that their life may never change for the better. Adolescent's feel overwhelmed by the nature of their difficulties and their inability to see how they can resolve them. By highlighting the adolescent's ability to enact change and participate in modifying thoughts, feelings and/or behaviours, the nurse helps adolescents to focus on small goals through which they can experience feelings of mastery, accomplishment and success.

Forestructures: through persistent negative feedback and feelings of failure, adolescents tend not to notice or acknowledge successful experiences. The nurse assists adolescents to become aware of their successes and an increasing ability to influence what happens in their life. She appreciates a small gain is significant when the adolescent's personal, interpersonal, familial and social relationships have been chaotic for some time.

Statement Twelve: contact is maintained with the adolescent while it is needed.

Interpretation: adolescents develop significant therapeutic relationships with nurses and an attachment to the unit (milieu). At times, these are the most important relationships adolescents have as, prior to admission, their emotional disturbance resulted in decreasing friendships and fewer positive relationships with others. Adolescents come to see nurses as their friend and nurses fill this role while there is an absence of others to do so. Through such relationships adolescents come to experience well being and a

renewed sense of connectedness to others and to society.

Forestructures: understanding the significance she presently has in the adolescent's life, the nurse terminates the therapeutic relationship slowly. The unit continues to be available to the adolescent while they reduce their attachment to it and gradually replace it with other experiences, places and relationships.

Statement Thirteen: the nurse demonstrates respect and assists the adolescent to respect themself, others and property.

Interpretation: the intrinsic valuing of each individual is important in developing interpersonal and social reciprocity. Through her respectful behaviour toward adolescents, the nurse demonstrates that the adolescent too is worthy of respect. In coming to respect themselves adolescents give up guilt and blame and learn to forgive themselves for perceived failings and failure.

Forestructures: nurses intervene when disrespectful behaviour is demonstrated. In attempting to assist adolescents to develop empathy for others nurses use their self, colleagues, peers and the adolescent group. They harness the positive attributes of the milieu and use their therapeutic relationships with certain adolescents to assist other adolescents to change. Communication, negotiation, warnings and consequences form the foundation of discipline with adolescents. Such discipline is managed with neutrality, flexibility, consistency, forethought and concern.

Statement Fourteen: the nurse is warm, affectionate and welcoming.

Interpretation: personal, interpersonal and familial difficulties leave adolescents vulnerable and needy. They often lack affection and warmth in their lives. Sometimes, the cost of warmth and affection has been disturbing, abusive and destructive relationships. Adolescents find themselves on the margin; ostracised, feeling different and inevitably blaming themselves. Such adolescents feel alienated, unwanted and as though they don't belong.

Forestructures: through her welcoming approach and her warm, affectionate relationship with adolescents, the nurse fosters feelings of inclusiveness and belonging. She appreciates the adolescents are outside their normal orbit of familiar people and places. Her personal milieu creates opportunities for adolescents to risk reaching out to her.

Statement Fifteen: the nurse is nonjudgmental.

Interpretation: through personal, interpersonal, familial and societal difficulties, adolescents experience the intolerance of others to both their behaviours and to themselves. A cycle of negativity, hostility and defensiveness comes into being. Because adolescents are unsuccessful in, or unable to change this cycle of dynamics, a deep resentment and estrangement occurs.

Forestructures: the nurse's forbearing, broad minded and progressive approach and response to the adolescent's behaviours thoughts and feelings, allows the adolescent to feel less alienated and more hopeful. The nurse's ability to tolerate and manage immature, bizarre, testing, ambiguous and contradictory behaviours affirms the adolescent's trust in the nurse's capacity to assist forward movement. The adolescent's hostile and defensive energy is freed up for use in the process of change.

Statement Sixteen: the nurse has a sense of fun and a sense of humour.

Interpretation: the adolescent's inner and outer world is often bleak so laughter and joyfulness become superficial or nonexistent. Adolescents focus on how difficult and "stuffed up" life has become and see no way out of their present dilemmas. A high level of chronic miserableness develops; the adolescent acts-in or acts-out these feelings.

Forestructures: the nurse's ability to share a joke, laugh at her self and laugh with others, provides an atmosphere of lightness and acts as a tension release. Her capacity for enjoyment, participation, laughter and sharing produces an environment where adolescents feel free to participate, experiment and be unlike their previous selves. Adolescents reexperience having fun and being happy.

Statement Seventeen: the nurse is a willing participant in activities.

Interpretation: the capacity to participate, to engage in normal risk taking activities and to be adventurous, is blocked or misdirected in the adolescents. They need to learn, or relearn, how to participate, how to act and interact appropriately, and how to establish and maintain friendships and/or relationships.

Forestructures: adolescents are provided with opportunities to have fun, learn new things and practice relevant skills when nurses willingly participate in meaningful activities and interactions with them. Engagement in activities with adolescents provides nurses with opportunities to work therapeutically with them. The adolescents feel worthy, and life feels worthwhile, when the nurse demonstrates her preparedness to be with them and do things with them. Adolescents find hope and meaning in doing, and being able to do, what other adolescents do.

Statement Eighteen: the nurse has a positive attitude.

Interpretation: adolescents have often lost hope, trust and the capacity for effective interpersonal, familial and social relationships. These losses relate to their beliefs about themselves, the world in general and the (their) future.

Forestructures: through the therapeutic relationship the nurse becomes a significant influence in the life of the adolescent. This means she has power to use in one way or another. In displaying a

confident, optimistic, constructive, affirming attitude the nurse assists the adolescent to engage with her in hoping for, believing in and creating change, in the present and for the future. What the nurse believes and how she behaves are fundamentally transparent.

Statement Nineteen: the nurse demonstrates compassion, consideration and tenderness.

Interpretation: because of their abusive, chaotic and unhappy backgrounds, adolescents have lost their trust in adults and in the world in general. Such backgrounds often preclude experiences of tenderness, consideration and compassion. In lacking such experiences, or in being unable to recall them, adolescents come to believe they are not worthy of them. More often than not they neither know how to give nor to receive such expressions replacing them with abusiveness, aggression, despair or anxiety. The adolescent's emotional pain and confusion is often expressed in the same way.

Forestructures: nurses appreciate that adolescents are needy and vulnerable despite their behaviour. They understand acting-out and acting-in behaviour has both purpose and meaning and they do not take it personally. Nurses learn to interpret verbal and nonverbal communication and use such insights to assist adolescents to better understand themselves and their needs. They work with tenderness and compassion toward jointly healing the pain and suffering that adolescents are experiencing. Such experience teaches adolescents they are worthy, and worthwhile, and allows them to reach out to others in the same way.

Statement Twenty: the nurse believes in adolescents.

Interpretation: working with adolescents is difficult. They are challenging adult authority figures, struggling for independence from adults (symbolically represented by their parents), developing a sense of self and their place in the world of the future, and demanding more say in decisions about their lives. The experience of emotional disturbance at this time adds another dimension to the adolescent's struggles.

Forestructures: the nurse is aware of the doubt, vulnerability and uneasiness the adolescent experiences. She appreciates the magnitude of their task and assists them by believing in their capacity to overcome their difficulties, achieve developmental tasks and build a future for themselves and others. She guides adolescents in looking toward and planning for the future rather than focusing on the past. As a result of her belief in them, the nurse creates an opportunity through which adolescents come to believe in themselves and to have hope for the (their) future.

Appendix B: Interpreter Preunderstandings

Story Three: Anthony

This is a story about happiness, confidence and self worth and how the activities nurses engage in with adolescents provide opportunities for such things to happen. The story concerns a 16 year old called Anthony who was thought to be developing an obsessive compulsive disorder. He was a quiet, somewhat uncertain and anxious adolescent who tended not to be popular with his peers. He was also intelligent, had a lively sense of humour and related well with adults; a long time later I discovered he had a lovely smile which literally lit up his whole face. I was drawn to what I sensed was a feeling of aloneness in him and in conversation I found him to be a sensitive, concerned and aware young man. He had been living on the unit for a while when we chanced upon a game of tennis together, from that point on we formed a pair and played a lot of doubles. He never discussed his problems with me as our relationship centred around doing things together. This included basketball, snooker and sitting around the swimming pool talking but it mostly involved tennis. We developed a warm, positive relationship and I used touch a lot with him; I would walk him to school with my arm around his neck or shoulders and a feeling of camaraderie grew up between us. In this way, the relationship flourished on activities and the scene was set for it continuing at the end of school camp. It was winter and we were to stay in the snow country. The organisation of such camps was amazing but the nurse in charge of the camping program had become quite expert at managing consent, information letters, car and bus bookings, finances, linen, games and camping requirements. Whatever he couldn't do he would obtain assistance with. Provisions were organised by Sally who worked in the kitchen; she never let us run out of anything and always seemed to know what the kids liked, she was just wonderful and there was very little she wouldn't do for the kids, who in turn, really loved her. Other staff filled cars with petrol, picked up the bus or spoke with parents, attended to administrative liaison tasks and letters and so it went. Staff included teachers, nurses and doctors. Such camps became the heart of the adolescent unit program and provided the opportunity for intense therapeutic work. Needless to say, both adolescents and staff were exhausted by weeks end. Camp attendance was strictly by choice and those who went found them hard work at times but they generally loved them. Anthony and I didn't have anything to do with each other on the trip down as I was driving one of the cars and a group of girls chose to come with me, but the next day we teamed up for tobogganing and I discovered what a boost in self esteem can do. After a few goes down the slope behind me Anthony was confident enough to go in front but this was only the beginning! Soon after he decided we should try such manoeuvres as going down on our stomachs piled on top of each other, then it was going down backwards and I was the one being hesitant; whatever he saw someone else do we had to try too. I can't count the number of times we fell off (although we became quite expert in the end), or

found the thin patches of snow at the bottom of the slope and ended up in water, but nothing stopped us from having fun for 4 hours straight. The same nurse who organised the camps took lots of photos, as mementos for the adolescents and staff, and when they were developed Anthony and I were seen in full flight with exuberant, smiling faces as we careered down the slope. I still have these photos and they look so joyful they always make me smile. That night a group of us walked after dinner and Anthony and I were talking together, the happiness of the day was still with him and he told me how changed he felt after one term on the program. I asked him to tell me about his old self and new self and how they were different. He said the biggest change was in his sense of happiness, confidence and self esteem and that all this put together allowed him to relate to his peers and others in a more comfortable way. He felt somehow equal to others now and noticed the adolescents were willing to spend time with him and treated him differently, they seemed to value him and his company more. This was very different to the unsure and uncomfortable person he had been when he felt he wasn't worth much and saw this reflected in the fact that his peers seemed to agree with his assessment of himself. He told me he couldn't believe all the things he'd done because previously he'd been too frightened of making himself obvious or making a fool of himself to do the things other people did. At this point he said "just think, with you it was tennis and now tobogganing, I wonder what'll be next?" I asked him what was left that he felt he'd like to try but found difficult to contemplate. Quick as a flash he said "dancing." Just as quickly I answered "that's easy to organise, a party and some music, would you like to give it a go?" In the dark I couldn't see his face but in a smiling voice he said "yes, if you'll be my partner." My reply was "you're on." Anthony spent a lot more time with his peers and other staff so I didn't speak with him until the party the following night. In the meantime a couple of staff and adolescents went shopping for party food, balloons and streamers. Naturally with so many adolescents there was no shortage of music. The kids made a special effort with clothes and make up and prepared everything for the party; they loved the idea and Anthony was a hero for suggesting it. The music selection was given over to several different adolescents throughout the night and was well received by both kids and staff. Anthony and I had our eyes on each other so when the music started we headed straight for the dance floor. It only took a few dances and he was ready to dance with someone else, it was a good example of how confident, happy kids find the strength to move beyond their families, or us. He really enjoyed the party and told me he found it hard to believe he had achieved so much at this camp alone. Throughout the remainder of the camp we spent time together and cemented the friendship which began months before. Two weeks after we returned from camp the school term ended and Anthony was discharged from the program; he would ring and come to see us from time to time but he lived many hours from the unit and was also busy with his life and school. He seemed to maintain his sense of well being and made sure he found me to say hello whenever he was visiting. We often joked about our tennis, tobogganing and dancing and still had a warm fondness for each other. When I think

about this story I'm reminded of the way nurses use day to day activities to establish and maintain therapeutic relationships with adolescents. These activities allow you to provide opportunities for fun, enjoyment and success and as a result to foster the adolescent's self esteem and confidence. Anthony really enjoyed activities, he seemed to forget his problems while he was engaged in them and gained so much from being involved with others in normal day to day activities. The other thing I learnt from Anthony was that therapeutic relationships take many forms and this was quite a significant learning experience for me. Previously I thought it was necessary to have involved yourself in talking with the adolescent about their problems and pain before you could develop a therapeutic relationship which allowed you to work positively together. Anthony taught me that wasn't true. He and I had never spoken about his problems or why he joined the program, he never shared such thoughts and feelings with me, at least not verbally, but we spent a lot of time doing things together. Our relationship was warm and affectionate because I felt this was what he needed; it created opportunities for him to try new and different things and it allowed him to feel valued, accepted and worthy. People looking from the outside would probably see it as an easy going relationship based on having fun together, and while it was these things, it was also a deeply therapeutic relationship through which Anthony was able to experience change and well being. I suppose I look on therapeutic relationships differently now, they're not always what they seem.

Preunderstandings Developed from Story Three

I believe:

* the activities nurses engage in with adolescents provide avenues through which they can experience happiness, success, confidence and enhanced self esteem;

* the nurse closely observes the adolescent and modifies her approach to them in response to her understanding of their needs;

* a nurse can have a therapeutic relationship with an adolescent that does not involve talking about the reasons the adolescent was admitted to the program;

* activities provide a vehicle for therapeutic engagement;

* affection and touch are part of my relationship with adolescents unless unacceptable to the adolescent or inappropriate to the context;

* major activities on an adolescent unit, like a camping program, require a team approach and cooperative effort;

* activities with adolescents can be great fun and mementos from such experiences are cherished;

* highlighting difference is an effective way of getting an adolescent

to notice the gains they have made;

* when an adolescent trusts a nurse they share their doubts, feelings and fears. Such a relationship is a therapeutic partnership through which the adolescent can take risks, take up challenges and change;

* a confident and happy adolescent has the strength to move beyond their therapeutic relationship with the nurse. Equally as important is the nurse's ability to separate from the adolescent and foster their individuation. This mimics the parenting of an adolescent;

* through their therapeutic relationship adolescents and nurses maintain feelings of fondness and attachment to each other long after the adolescent's discharge;

* adolescents forget their problems while engaged in activities. This psychic respite leads the adolescent to hope for improvement. Successful experiences allow the adolescent to feel valued, accepted and worthy;

* the relationship between an adolescent and nurse is unlike other professional relationships. It is easy going, friendly, affectionate, activity based and founded on activities that resemble those that would normally occur at home.

Story Four: David and Sam

I chose this story because I believe it helped me to learn about working with adolescents. Although it was about something I already believed was important the experience made it tangible and helped me to remember it's significance. I was working on the weekend and there were only two adolescents on the unit, David and Sam. There were two units on the same site and because of the low numbers of kids staying over the weekend we usually amalgamated the units, this meant there was a nurse from our unit and one from the other unit. However, during the weekend the staff and adolescents from the adolescent unit spent their time on that unit. Liaison between the staff allowed the organisation of meal breaks, medication and management issues. I was with the two adolescents in the craft room, both were around 15 years old. I'm not sure what we were doing but I think it included painting and wood work. We had been there for a little while and were content to stay. Essentially, the boys were talking together and from time to time I would join in. Their conversation centred around the usual adolescent things like families, music, school and what was going on in the peer group, the latter being the most frequent topic of conversation. The chatter was liberally sprinkled with swear words like fuck, prick and dick head. I don't find this type of language offensive and feel it's an inherent part of adolescent development, it's a way of kids being different to adults and expressing themselves in ways which is individual to their peer and age group. I know it can be used offensively and hurtfully, or disrespectfully, but this

wasn't the way these kids were using it so I didn't intervene to modify their language. I would only do this if someone else was present who found it unacceptable or if it was inappropriate in the context, like if young children were about or we were in a restaurant. I think young people need to learn consideration for others in this way. Sometime in the afternoon the nurse from the other unit came to speak with me and I was struck by the change in the behaviour of the kids. They spoke with her making polite conversation, even their bearing had changed, they were somehow more upright, focused, attentive and alert. "Hello Sandra", they said, "how are you going with those monsters?" There was a few minutes of chatter, of exchanging jokes and laughter but not one swear word passed their lips. I noticed this and was quite fascinated by the change that came over them. Sandra soon left and things returned instantly to normal, almost as though the atmosphere changed completely. I said to the kids "what's going on, how come you were so different when Sandra was here?", they replied "what do you mean different, what did we do?" "Well", I said, "you didn't use one swear word, you were polite and almost like you were standing to attention." "Oh", said David, "Sandra's a lady you can't use words like that when she's around." "Yeah" said Sam "she's an adult." This was confusing so I said "I don't understand, I'm a lady and adult too you know!", they both looked at me somewhat perplexed then David said "no you're not, you're Rene", Sam added "what David means is you're our friend, we don't think of you like them." "That's right" said David "it's different with you, we can be ourselves." Although I was amused by what had happened I was also touched by what they said. I asked them to tell me what sort of things allowed them to be themselves and they said not being hassled about how they looked, what they said or swearing or anything like that, they said when people accepted them they could be themselves and feel comfortable. It was difficult for them to say exactly what they meant but after some discussion they decided it was all to do with accepting kids, and where they're at, because if nurses accepted kids then they didn't have to worry, they could be themselves. They said they couldn't make it any clearer for me but I thanked them and told them they'd made it very clear. I never forgot this interaction, it taught me how important the relationship is between the nurse and young person and how this relationship is founded on acceptance, tolerance and flexibility. Really, whatever power the nurse has to influence the adolescent arises out of their relationship. I came to appreciate how important each nurse's personality and working style is because it's this that adolescents pick up on and relate to. This is like the individual nurse's milieu while all the nurses create the unit milieu. The person of the nurse is so important to the therapeutic relationship as who you are is the foundation of everything you're able to do in relationships with others. But you can't pretend to be someone you're not, especially with adolescents, they have a fine, intuitive awareness of the unauthentic.

Preunderstandings Developed from Story Four

I believe:

* nurses learn about working with adolescents through experiences of practice. Such experiences make learning tangible and memorable;

* certain behaviours are integral to adolescent development because they signal differences between them and adults, for example, the use of particular words, specific ways of speaking or dressing and swearing;

* it is appropriate to intervene to modify the adolescent's behaviour in order to assist them to consider others and to act in contextually appropriate ways;

* relationships with adolescents are founded on tolerance, flexibility, acceptance, honesty and personal integrity. Any power or influence I have as a nurse arises through this relationship;

* the personality and working style of the nurse is significant because it is this that adolescents pick up on and relate to. These aspects of myself I see as my individual milieu. My milieu combines with all other individual ones to create a part of the unit milieu;

* the person of the nurse is of utmost importance because who I am is the foundation of everything I am able to do in relationships with others.

Story Five: Ned

I remember this incident because I used a strategy that I very seldom use; in fact I think it's the kind of strategy you would draw on very rarely and would need to be very sure of yourself in using. It has to be done with complete neutrality if it's going to be successful. The story is about a 14 year old called Ned who had a mixed attention deficit and conduct disorder. He was unpredictable, quick to anger, difficult to engage for long, apt to act out his emotions and abusive. He was also given to smiling a lot, loved to be active, was affectionate, and at times was insightful and sensitive. The incident took place one afternoon when all the staff were arriving for a case review meeting. Ned was especially unsettled that day and had been in and out of school because of his disruptive behaviour and inability to stay on task. There was something troubling Ned but he had not been able to talk about it and so his emotions were building. It was 1:30 pm and the adolescents were back in school. The nurses came in breathing a sigh of relief that Ned was off their hands and they were hoping he would be contained in school. However, no sooner were we in the meeting room than he came into sight. The nurses looked at each other and seemed genuinely too depleted to deal with him so they chose to ignore him, but there was no way we could ignore him walking around outside the room. As I watched Ned I was struck by his behaviour and the responses of the staff; he paced and stalked around the area as though he were planning an attack and the staff in the room responded by acting as though they felt they we being set upon, I think they felt they were under some kind of psychic assault. I hadn't been dealing with Ned that day so probably had more energy than them but I felt their feelings and

noted the impact it had on Ned. He was working himself up for an outburst; he walked fast, was agitated, restless, called out and berated people to himself. His actions were fast and furious and his face increasingly contorted by frustration, anger and impending rage. He started punching out at the surroundings and his aggression was escalating. I felt he would soon be completely out of control and that containment was essential or it would end up with Ned being restrained. Restraint was rarely used as we worked hard to help adolescents to learn to control themselves; if we did restrain we used holding but never any other form. Most often we encouraged kids to go off and cool down then come back and talk about their worries but I felt Ned was beyond hearing or responding to requests. I got up quite suddenly and went outside coming face to face with Ned. He was caught by surprise, not expecting to see me, and I shouted at him very, very loudly "what do you think you're doing?" I was not angry but I was trying to obtain the position of authority. I wanted him to feel that I was the one who was in control of what was going to happen, that I had the upper hand. I shouted again "you can't threaten and intimidate people here, we treat people with respect and we expect it back." He looked as though he'd come down a bit so I went on in a slightly lower tone "take yourself off the unit and go for a walk to calm down, we can't help you when you're like this, first you'll have to help yourself." At this point he snorted, looked down and muttered something but with a lot less force and in a much less angry voice. I responded in a normal voice. "Ned we know something's worrying you and when you come back we'll be here to help you sort it out, you know you can tell us anything you need to, we'll listen to whatever you have to say, so come back when you're ready to talk." While I said this I was pointing to the door leading off the unit so my message was very clear but I also didn't think he was ready to talk, that he was calm enough to do so. Ned half smiled and went as requested. The more controlled and less angry way in which he was behaving suggested he was no longer out of control. I didn't feel it would be unsafe for him to take a walk and cool down. As he left I wondered if he'd had to get to this point before he could go any further. When I walked into the staff room people cheered and were very relieved (this must be how parents feel) but also surprised at my intervention. I didn't shout. I felt it only replicated the negative adult or parental relationships many adolescents had experienced, that of anger, aggression and abuse. I'd intervene early to manage escalating behaviour, or to assist adolescents to regain control, but shouting and ranting were not in my repertoire. I hadn't planned the intervention but my quick and decisive response, and my up front "I'm in charge here so don't give me any nonsense" approach, was a strong message. My purpose was clearly in my face and in my demeanour and I think he read that message. I moderated my approach in response to his responses; I kept pace with his mood. I have only used this strategy a few times. You and the adolescent need to know each other well, there must be an inherent trust and understanding between you. The adolescent must never feel that you might lose control and attack them. You have to be sure there's no anger in you otherwise it would be easy to lose control. You must

be completely neutral. If a kid pushes your buttons then don't try this with them. On the day it worked out well. Ned came back an hour or so later and spoke with his therapist. We discovered his father had disciplined him very harshly and he had welts and bruises on his back and legs from a beating with a belt. When the staff heard about Ned's black and blue legs and back they were shocked, mildly outraged toward the father and very sympathetic and understanding toward Ned. I was called in by Ned's therapist to witness the bruising from Ned's belting and, as a result, I was also present at a later meeting between the therapist and Ned's father. It was a long interview but two things stand out. First, assumptions are counter productive and second, change can be small yet significant. People assumed Ned's father, Mr D, beat Ned in anger and was cruel and uncaring but none of these things were true. Mr D told us the story of life with his own father who was a violent, cruel and vindictive man. Mr D had been repeatedly beaten by his alcoholic father for minor misdemeanours or simply because he was there; he saw no love from his father and swore he would never treat his own children that way. Mr D said he never disciplined his children in anger so he did not lose control and behave violently, in fact he only disciplined them physically when they deserved it. Mr D said "I love my children and discipline them because I want them to grow into good people who can contribute to society, I don't do things the way my father did, with anger." Ned confirmed this but he said he told us about the beatings because he'd learnt from us that there was another way to discipline adolescents. We were able to help Ned's parents learn more appropriate strategies for parenting adolescents and they benefited greatly from joining the parent support group. Ned remained an extremely challenging adolescent to parent and to nurse. From Mr D I discovered the danger of assumptions and especially that such assumptions may carry judgment and blame. I also came to appreciate how people can make significant changes as a result of their life experiences. For example, Mr D chose his mode of parenting because he wanted to be different from his father. Moreover, people themselves have this capacity for change, it doesn't need to come from the interventions of health professionals. I was more thoughtful and hopeful in the face of this incident.

Preunderstandings Developed from Story Five

I believe:

* interventions require a high level of understanding of the self and the adolescent if they are to be effective. Neutrality is essential when dealing with out of control behaviours;

* working with adolescents can be emotionally and physically draining thereby leaving you too depleted to deal effectively with challenging behaviours. In such circumstances it is important that the team allows you to take a break from the adolescent concerned;

* it is necessary to notice escalating behaviours, to interpret those behaviours, and then to act or not act on them according to your assessment of the adolescent's ability to regain control without

intervention. Timely intervention can prevent escalating behaviour from becoming out of control behaviour;

* working with adolescents requires the nurse assists them to take control rather than imposing control. Allowing adolescents time out from distressing situations is a useful strategy in helping them to regain control. Restraint, physically holding an adolescent, is a last resort for managing out of control behaviour;

* following time out the nurse should reassure and speak with the adolescent about their concerns. Adolescents need to know they can discuss anything with you and that together, and with the help of the team, you will try to resolve their concerns;

* respect should be expected and fostered between nurses and adolescents;

* aggressive or abusive responses from the nurse are inappropriate. Such negative behaviours replicate those to which adolescents have been exposed. An adolescent should never fear you might lose control and attack them, psychically or physically;

* verbal and nonverbal communication should be congruent and consistent so the adolescent does not receive mixed messages;

* to work therapeutically you must acknowledge your own areas of unresolved conflict in order that you can work on resolving them;

* assumptions are counter productive because they can lead to inappropriate judgment and blame;

* parents and nurses can make a significant contribution to each others knowledge and understanding;

* people themselves have the capacity to make significant changes as a result of their experiences of living and not only through the intervention of health professionals;

* being nursed on an adolescent unit can assist adolescents to learn developmentally appropriate ways of parenting;

* the nurse observes the adolescent in a variety of situations and interactions thereby gaining an increasing understanding of their concerns, difficulties and nature. She strives to develop a balanced view of them.

Story Six: Martyne

I like this story because it reinforced my thoughts about testing behaviour in adolescents. At age 15 Martyne's parents found her adolescent rebellion beyond their ability to manage. She came from a wealthy upper class family and chose to become "a goth" in order to assert her individuality and separate from her family. Her hair was died black and kept long and straight. She wore long medieval skirts and dresses and very heavy, accentuated eye make up. She

was intelligent, articulate, well read and attractive. She also had a delightful sense of humour, smiled a lot and was a sensitive and compassionate young woman. She shared the following information with me about two years after she was discharged from the unit by which time she was 18 years old. During the time Martyne was on the program we developed a positive and warm relationship and she called me one day to see if we could have lunch. I readily agreed because I enjoyed her company and had not seen her for a while. After lunch we went for a walk and she began talking about what kind of nurses make good workers with adolescents. She mentioned a few things but what I remember most concerned me. With a half smile Martyne said "we used to try all sorts of things to get you going but you never lost your temper, you would just smile and listen or you would tell us what you thought or accept whatever we said." She went on saying "at one stage we tried to come up with all sorts of shocking things to say but nothing seemed to worry you, you took everything in your stride." I asked her what she thought of my behaviour and she replied it was what adolescents needed. When I asked her why, she said adolescents like to test adults and shock them but they trusted adults who didn't abuse them or lose their cool. I thought there was a lot more to this type of adolescent behaviour and decided to explore it with her. After talking about challenging behaviours for a while I asked Martyne why is was adolescents felt they could trust a nurse who they couldn't shock or get to lose control. She said it was because they could say or do anything to this nurse and she wouldn't abuse or reject them and she'd be the sort of person who'd be able to help if they needed it. I asked Martyne why adolescents needed to test nurses in this way but she said she'd never really thought about it. I remember saying something like "give it a go and see what you came up with." Her answer went something like this, "may be it's to see how far we can push you, to see if you really care about us or if you're going to hurt us like other adults have done. We were really unsure and confused but we wanted to be accepted by adults too, it's crazy though the way we went about getting what we wanted." This story shows what we can learn from adolescents if we're prepared to listen. I learnt a lot about the seemingly paradoxical behaviour of adolescents who although needing acceptance and assistance from adults may behave in ways that are likely to achieve the exact opposite. I think it says a lot about the need to interpret behaviours so you can go beyond the superficial to the deeper message beneath. The story is also about how adolescents test adults to gauge their responses and determine their trustworthiness, I think it shows that behaviours which nurses tend to label as 'naughty, childish, silly or testing' have a very real purpose. I suppose it's a bit like a test, if you pass you're able to go to another level in your relationship with the adolescent but if you fail you may not get another chance. For me this testing is important for another reason since it provides the nurse with the opportunity to restore the adolescent's faith in adults, I think this is the real significance of what Martyne had to say. Later, I worried a good deal about this and thought about the power nurses had in their seemingly mundane interactions with adolescents. The way I saw it, the implications of such interactions went beyond the

restoration of an adolescent's faith in adults to influencing their belief that adulthood was actually something worth aiming for; it meant they could believe in their own future.

Preunderstandings Developed from Story Six

I believe:

* the relationship between an adolescent and nurse can be quite significant, founded on mutual liking and last for sometime after the adolescent's discharge. Following discharge the adolescent may visit, phone or meet with nurses who were important to them;

* listening to adolescents and exploring issues with them can assist you to learn a great deal which is of significance to your work;

* the testing behaviours of adolescents are complex, paradoxical and purposeful. Through such behaviours they may ascertain your trustworthiness and see how you respond to them. They may wish to see whether you will set limits and boundaries and learn where those limits and boundaries will be. Such behaviours may also be a way of engaging the nurse, of gaining her attention, or making the first approach in establishing a relationship;

* interpretive communication allows the nurse to go beyond the superficial to the deeper and more complex meanings beneath;

* adolescents use challenging behaviours to test you. If I behave in ways that are frightening, confusing or condescending the adolescent may not give me another chance to form a relationship with them;

* my work with adolescents provides me with an opportunity to restore their faith and belief in adults and adulthood;

* through their day to day interactions with adolescents nurses have a great deal of power to influence their hopes for the future;

* the nurse is a keen observer of the nature of the adolescent.

Story Seven: Martin and Luke

This story concerns two adolescents but I'm dealing with them together because the action I want to talk about relates to them both. Luke was 17 and joined the program for respite from a chaotic home life. He was a quiet, self contained and popular young man who enjoyed and excelled in sports and activities. We had an easy going relationship and shared some special experiences at a camp which deepened that relationship. Our relationship was founded on activities and doing things together. Some little time after Luke was discharged he returned to see his doctor. I was walking down a corridor when I heard my name called and stopped. I turned to see someone standing near the doctor's door but with the sunlight behind them I couldn't tell who was calling my name and waving. I walked toward the person and realised it was Luke. I said something like "hello, I couldn't see you with the light behind

you, it's great to see you." At the same time as I was talking and walking toward him he threw his arms open in that unmistakable gesture that welcomes an embrace. I was folded in and returned his embrace and he said "how about a game of ping pong?" I said "sure" and we went off to enjoy a hard fought game because although I was hopeless at snooker I was pretty good at ping pong. I was reminded as we walked to the activities block how significant such activities were in my relationships with adolescents and how much these activities mimicked what adolescents usually do with their friends and may be rarely do with adults or parents.

The other young man I want to speak about is Martin who was 17 when he left the program but 18 at the time of this story. He came from a violent background of physical abuse and a beating from his father resulted in the loss of hearing in one ear. Various foster homes had not met his emotional needs and the trauma of his early life proved difficult to resolve. He was quiet and serious, tended to be a loner and was shy in social situations. He also had a good sense of humour, a lovely smile and a gentle nature and by consensus we all thought he needed a great deal of loving affection. During his time on the unit he went through his middle adolescent growth spurt and grew 15 cms taller and 10 kgs heavier but despite being a very big adolescent he retained that tenderness and gentleness that so many of us valued. He too was returning to see his doctor. One day I was sitting at the desk and looked up to see this young giant at the door dressed in black motorbike clothing and holding a black helmet. Somewhat incongruously with this image was his gesture. His arms were thrown widely open welcoming me into his embrace. I remember how touched I was to receive this show of affection and tenderness from him because, while it was something I expected from Luke, it was an unexpected gesture from Martin. I commented on his size and said something like "it's really lovely to see you." He smiled shyly and we spoke for a few minutes about what was happening in his life before his doctor arrived. I remember closing the door and crying. I felt how much he trusted me to risk reaching out that way and I experienced a real sense of hope for him. Again I'm reminded of the power existing in your relationship with adolescents; the power you have to join with them to change things. In the beginning, Martin's sense of self was so fragile after the experiences in his life and his vulnerability so obvious to those who cared to look. Sometimes it's hard to look because confronting such pain, uncertainty and sadness never leaves you untouched; it brings you close to your own sadness and anger at the terrible injustices of the world. It needs experiences like the ones I had with Luke and Martin so you can keep looking with a sense of hope. The experience with Martin reminds me that when adolescents first join the program they often feel bewildered, frightened and unsure of what to expect in a strange environment full of strangers. They are unequal to everyone but especially the adults in the environment; they're uncertain what we expect of them and how they'll resolve the burdens they bring with them. They often lack self esteem and hope, feeling quite rightly that the world is a hostile and dangerously painful place. Their abusive and hurtful experiences with adults make them resentful, suspicious and

cautious so trust is a long time coming and affection is something some of them have rarely received let alone given. I think this is why I was so touched and pleased when Luke and Martin were able to give of themselves by reaching out in that affectionate way. They now had something to give and felt a sense of confidence in risking the gesture of offering themselves. I know they couldn't have done that before because they themselves had received so little affection and had no reservoir from which to give; in a way they were quite empty inside. I suppose this demonstrates how healing allows you to give to others and sets in motion cycles of giving and receiving; it's about developing the capacity for reciprocity in relationships. It reminds me that while the relationship you and the adolescent build together is born of a professional need it is also very unlike adult therapeutic relationships. This occurs for different reasons but includes the fact that you spend so much time with the young person. You engage in activities they usually engage in with friends; you hang out with them talking and just being together and you share of yourself as they share with you. You do homework together, walk them to school as a friend or sibling would do and share ice cream, music, outings and dinner when school is done. All this leads to the relationship taking on the attributes of a friendship and as the adolescent grows and changes a feeling of equality enters the relationship which seems to obtain another level. In the end the adolescent and nurse both give and receive; the traditional hierarchical, objective, professional relationship is a long way from this. The relationship is certainly professional and bounded by limits but it mimics friendship and anyone spending time on an adolescent unit would note the friendliness which characterises the relationship between the adolescent and nurse. This is even more evident later when young people continue to visit and engage you more than ever on equal footing.

Preunderstandings Developed from Story Seven

I believe:

* relationships with adolescents are easy going and founded on sharing experiences and doing activities together. Such engagement in activities with adolescents mimics what they usually do with friends and less often do with adults;

* a strong bond of reciprocal affection develops in the therapeutic relationship between the adolescent and nurse and endures beyond the adolescent's discharge. This is significant because it: (1) indicates the adolescent has the capacity to sustain an interpersonal relationship; (2) suggests the adolescent can give of themself having been nurtured and, as a result, received something from which to give; and (3) points to a process of healing resulting in an increased sense of self esteem and confidence from which they can reach out to others;

* the nurse is a keen observer of the nature of the adolescent and plans her responses according to those observations;

* a shared milieu leads to the valuing and fostering of particular

attributes and behaviours in adolescents, for example, tenderness;

* adolescents often behave unexpectedly and vacillate in their move toward adulthood;

* a welcoming, encouraging and secure environment is required for adolescents at admission, throughout admission and after discharge;

* an adolescent who trusts a nurse will reach out and risk themself in that relationship. This places me in a powerful position to join with the adolescent to work on change;

* the pain an adolescent brings to their relationship with the nurse never leaves you untouched. It awakens feelings of sadness and anger in you because of the injustices the adolescent has experienced. When an adolescent successfully works through their pain it gives the nurse hope and sustains her;

* the adolescent's painful, negative and abusive experiences with adults makes them hostile, suspicious, resentful and cautious of nurses. This means trust takes a long time to develop and often remains tentative and fragile;

* equality and the sharing of power are important in my work with adolescents because this assists in reducing the distance between myself and them;

* adolescents find predictability, limits and boundaries helpful because they are often uncertain, confused and anxious;

* the relationship between an adolescent and nurse is founded on activities such as those normally taking place at home and with friends. It has the attributes of a friendship and a feeling of equality. It is divorced from the notion of a traditional hierarchical, objective, professional relationship. The relationship is professional and bounded by limits but mimics friendship and is characterised by friendliness.

Appendix C: An Example of a Research Interview

In the interviews (I am in plain brackets), Elizabeth is outside the brackets, clarifying words are in [square] brackets and events, such as, {pauses} are in fancy brackets. Information identifying participants, places, times or others has been removed or altered.

Elizabeth's Interviews

The Transcript of Elizabeth's First Interview

(To begin with I'd like to thank you very much Elizabeth for being involved in the research. The other thing is I am taping the interview and if you want to mention people's names that's okay because when I transcribe the interview I'll take that information out so there's no problem with confidentiality). Okay. (And, if at any time you want to terminate the interview just to let me know and we'll finish at that point). Okay. (Perhaps we can start by taking you back to when you first went to the unit, if you can tell me a little bit about what you remember from when you first went there, any feelings or thoughts you had). The first time I went there was for the interview and I hated it and I was crying and I just didn't want to be there and then a week later I was put in there and I just remember feeling a little miserable and hating it and not giving anything a go, [I] didn't want to eat, didn't want to do anything and I don't remember when it stopped [but] one day I realised how much fun I was having there and it was really good, but yeah, I hated it at first [I] didn't want to go at all, I thought it was like a psychiatric hospital (right). I didn't think I needed to be there (mmhh) but I learned heaps from being there, you don't realise until you've gone, until you've left there what you've learnt and then you wish you were back there (right). I didn't want to leave in the end. (That was a big change wasn't it?). Yeah, I just wanted to stay and it was like "no Elizabeth you have to leave one day", I didn't like the idea of that. (Can you think of the sort of things that worried you about going there?) I just didn't like the idea of living in another institution (right) like I'd lived in them plenty of times before and all different types (mm) and I thought it was going to be like that. I didn't like the idea of new people and I thought that everyone would think I was sick cause I was there, but I remember Marcia (mm) explained to me, you know, something about when you've got a back ache you go to a chiropractor, when you've got problems with your eyes you go to an optometrist and I was there because, you know, I needed help in other ways but the way she said it to me she made me feel heaps better about it, but I always felt like I didn't belong, it was a mistake that I was there (mmhh), they were going to realise that I didn't need to be there. (You mean it was a place for mad people or something like that?) Yeah, I didn't think it would have anything to offer me. (You said you went from not wanting to go there and being very angry to not wanting to leave when it came time to leave) Yep, I didn't want to leave in the end. (What sort of things happened in the middle to get that change?) The people I met, you know, I've got quite a few of them I'm still friends with but I just had heaps of fun like it ended up being a good release, I had a lot of anger, like

before I went there I was a really angry person and I was angry a lot of the time I was there but I got to release it in positive ways (mmhh). I remember doing anger therapy, we painted some bottle and every time I went into the room I could undo the lid and take my anger out (uhu) and then they put the lid back on and I was meant to not be angry, like I could still be angry but I wasn't allowed to have tantrums. (You kept it in the bottle) [I] kept it in the bottle. We got a 4 litre orange juice bottle and I painted it black and I used to kick it and do all things like that but only when the bottle was open and I wasn't allowed to open it I think it was either Beth or Antoinette who used to open it. (So where did you keep this bottle?) They kept it in the staff room somewhere or something like that, just little things like that I remember. There was all different things they used to do with us like the dolls, we had the dolls, {pause} like role reversal, (mm?) it was quite interesting and just drawing. (What was that about the dolls?) The dolls, I would pretend I was my family and I would be me and the dolls would be my parents and I would do the talking for the dolls but they would tell me things, and then I would be my mum and the doll would be me and just swapping roles. (What were you hoping to do with that?) I thought it was quite strange at first, I even thought the bottle thing was strange, the idea was to get out how I felt and show how the situation was and then how I would have liked to have handled it (ah), like how I would liked my mum to talk to me instead or how I would have liked to have been treated (right), and so I would be my mother talking to me (mm) that was quite interesting. A lot of stuff I did with drawing therapy and but I liked it because it was one on one like you had your special workers that were assigned (yes) and they always had time for you. (Nurses and what the nurses did with you was an important thing). Mm, I can't remember how it happened, when I think back I remember hating it when I first went there, like I can remember my first day really clearly, I hated it, and [later] I just remember having so much fun with all the different workers. Also, I don't know if they did it with everyone but I went to their house and was involved in their lives like I went to Adrian's house, Beth's house, I went somewhere with Tricia, like they took us to their homes (mm), yeah it was pretty good. When I first went there for the interview [assessment] I thought it would be really clinical (yes), I can't remember if some of them were social workers or what, or what they were, like if they were psychiatric nurses or what I don't know but they all just dressed normally and we all called them by their names and they were all really really nice (mmhh). Of course I remember fighting with them every now and then, you know, usually because I didn't like authority that was the only thing but they were never never rude or anything like that, never nasty, extremely nice a lot of them, I should have been a lot nicer to them a lot of the time like [instead of] pushing them to the limits. (What do you think that was all about testing people to their limits?) Testing boundaries seeing how far [we could go] also I'd been in so many institutions (mmhh) when I was young and I kind of knew what it was all about, you know, how far you could push people and I decided anyway, I did it. I lived in other institutions after I left the unit and I was told I either was too institutionalised

or I just liked mucking up the system (mm) I think it was a bit of both. I don't know, [I] was very angry and just took it out on them but they responded pretty well all the time, like I was never abused, like yelled at or anything, they always had a really good approach, always some good way to handle it, like time out, I didn't like the time out at first, I hated that, you know, like when I was told to take off somewhere by myself, oh I didn't like that but, I don't know, it all made sense in the end and I kind of got used to the programs and the routines that they had. The time out and having to write things too, I remember writing at night, having to write things down about how I felt and it was good attention wise, you were never short of attention, you know, there was always someone there to give their full attention to you (right). It's like I can't remember or think of a time when I ever felt rejected or whatever and I felt rejected when I went there but I soon lost that feeling (mm), except when they were kicking me out, telling me I have to move on, [then] I felt really rejected again. (How long were you on the unit?) I don't know, it was something like 9 months. (Oh a long time). I was there for a long time because I could not go home at all, they knew that from the day I was there so they tried different options, [they] tried to get me to live with my aunt and so on weekends I was going home with her and that didn't work out I was not happy at all (mm) and then they found Autumn Lodge and I was fostered, that was all very [much] in a hurry like I think it was coming towards holidays and so they had to hurry things along. (So it's hard to leave somewhere after you've settled in and felt comfortable). I became very attached to the people and the routines, everything like that (yeah). At first it was so hard to get up at the same time every morning and do the routine things like the meetings and things and then you kind of get so used to it (mm), having all your food cooked for you, you knew what you were eating [it was] just different yeah, quiet time at night, outings. (What was good about the routine then?) Just that we did have some kind of routine, you knew what you were doing, like when you get up in the morning you know what you have to do, you'd get up and you have to go to breakfast but it was also like [with] a lot of it you were quite independent at the same time (mm), you know, they were always there telling us what to do or whatever but we kind of knew, they got us up in the morning and then we'd do the routine of going and having a shower if we wanted to, you know, we weren't made to but they would've preferred if we did, [then] going to breakfast and the meeting or whatever (mm). At first it was always I suppose being told what to do but in the end I knew and I could tell other kids (yeah), you know, this is what we do, it became habit. (It's sort of a predictable environment?) Yeah that was good. (You said there were lots of things you had to do and there was a routine but also you were independent, tell me a bit about how people encouraged you to be independent). Well, like I was shown where the washing machine was and you did your washing when you wanted to (right), you know, they wanted you to do it but you did it at your own [choosing] at what ever time you wanted to and you did it all yourself, just the showering and looking after our rooms, you were told when to get up but they just knocked on the door and woke us

up then it was up to us to get ourselves to breakfast and to look after our clothes and to do our homework. I remember they always offered us help if we wanted it, like if we wanted help it was there, but they would let you be independent, let you do things on your own (right). Well I suppose they didn't want to everyday say "it's 6 o'clock it's quiet time" (yeah) or "do your homework or do your washing" or whatever [you'd] just do it yourself. You kind of liked doing your washing in the end cause it could be a time out [and] it could get you out of other things like "I've got to do my washing now." (People encouraged you to be responsible for yourself). Responsible yep (and that was a good feeling) yeah, that was a very good feeling. Like if you didn't get to dinner, like when I was first there I used to get chased around but in the end if you didn't turn up for dinner you didn't turn up, you know, they weren't happy that you weren't there they didn't say "oh that's fine run off and do what you want" but the thing is if you weren't there for dinner you weren't there for dinner, they'd always want to know where you were but it was up to you to get yourself there (yeah) while it was on, so a few times I missed out. You didn't have to do any washing up or anything like that, there was a few things I really liked like having all your food cooked for you and you didn't have to wash up later which was a different experience cause most places I lived in you had to do the washing up and drying up. (Sounds like a good balance there). Yep, the last few months were just great, I just really, really didn't want to leave, I liked it so much, you just get so used to it all as well. (How did people prepare you for leaving?) Well I think from day one they wanted me to be with my family if I could, you know, so they were always saying to me that in a certain period of time I would go for weekends at my aunts and then we tried that for quite a while and that was just a bad, bad experience (mmhh) so the next thing it was coming towards [holidays]. I think they really thought that it might work out with my aunt so they [hadn't considered other options], not that they didn't expect that it wouldn't work but they like weren't prepared when it didn't work, so they had to think pretty quick, and fostering [became an option, but] the fostering just came on so quick. I remember being told that I was going to be fostered through and outside agency, Autumn Lodge, and the next thing I know I met the workers and the second meeting they'd found me somewhere and I just did not want to go, you know, I just did not want to go. I remember being really upset but I also knew I couldn't stay there forever but I didn't like the idea of going from there straight into a foster family (mm) so I made it very hard for myself, but I was very, very sad. (Do you think it was because it was too quick, it didn't give you enough time to adjust?) I don't think, no matter how long it took I probably would have been unhappy (right), I don't know [really] but I know that, I do think it was a bit quick but that wasn't anyone's fault, it was just that other things fell through and they had to do something as quick as they could (mm). I don't think you could stay there over holidays, you know, I think you could but they didn't really like it, not that they didn't want you there, I don't think, it was just better for you to be somewhere else cause everyone, [like] a lot of the other kids were going home or going somewhere (yeah) and it wouldn't be much fun

living there by yourself. (What do you think it was about the unit and nursing staff that you got so attached to them, what was it that you were able to form such a positive attachment to the people and the place?) I don't know, cause they just understood (uhu), I never felt, like no one didn't understand me and all the kids that were there I related to nearly everyone of them and after being there for a while I didn't feel that we were strange or that we were sickos or anything like that, (ah) I just felt like everyone [else], quite normal. And the workers it was like, sometimes I felt like I was up in day care (laughs - yes?) Well that was the way we were acting, like doing stupid things keeping them on their toes (uhu) but, I don't know, I just felt that I fitted in, I fitted right in there (It was good being in amongst a bunch of kids and nurses who understood how you were [feeling], or with the kids [because] they were experiencing the same thing you were). Yeah, and the nurses they weren't like what you think, like when I think of nurses I always think of wearing uniforms and being fairly routine [but] they were just like {pause} normal people, they dressed normally, we would call them all by their first name and [they were] just more like your friend a lot of the time (uhu). I got quite fond of quite a few of them and they never acted like nurses [or] what you think a nurse would be. (Tell me a little bit about what kind of things you did with the nurses, like you said it was sort of like having a friend, so what sort of things did you do together that helped you feel that you were friendly with them?) Well with different ones [it was] different things, like I remember with Angelica it was always going to do craft, she got me into things, like she wanted me to come and make some things and I enjoyed it more and I used to talk to her more and like then you ended up talking about things you didn't plan to, like I didn't want to talk about anything (yeah) but, I don't know, just good approaches like the crafts with Angelica. With Antoinette it was always cooking, she used to take us for cooking and like just start conversations and you kind of like [open up] and if you really like cooking you would go towards Antoinette because you had a choice of things you could do, you could either go to craft or cooking (uhu). There was usually two different things you could chose from so it had a lot to do with what their approach (yeah) was, like some would get on the trampoline with you and do things like that, Beth always came on the trampoline with me, so did Simon, so did Edward (uhu), or like you'd go play pool with them, all different things and they used to always want to do fun things it wasn't like you had to ask them, they were always there ready to do fun things, (uhu) [like] go for a drive or go bowling, getting you to do things [like] go on the trampoline, go for a swim, watch TV or a video. (There were lots of activities). Yeah. (When you were talking then about Antoinette, you'd just start a conversation and then you might start talking about something completely different, do you mean when you first start talking to people it's on the surface and superficial stuff and then). Yeah, and then you go further and you talk about more and more as you go on, like I remember for the first while I was there I didn't want to talk to them about anything not even like what time is it or what do you like eating, you know, I didn't want no part of that (mm) but then it's just one thing leads to another. As much as I was, as angry as I

was I didn't have much trouble expressing myself, you know, like I didn't want to express myself through anger, I didn't, but then they had such a good approach. I just had a totally different idea, like my expectations of the place were totally different to what they were (right), I expected it to be really horrible and really clinical and it just wasn't, it wasn't clinical not at all. (What was it like if it wasn't clinical, if it wasn't like a hospital and the nurses were more like friends than nurses, how would you describe the environment?) It was just like a big day care kind of thing, I don't know, it just felt so normal, sometimes it was like a living situation (mm) more like a refuge, it just didn't feel [clinical] like it wasn't real hospital or real clinical (mm), it was just homely. (Was it more homelike?) Kind of homelike the atmosphere was. I remember we were allowed to go there at night and make snacks all the time. We had our own little kitchen on the unit (mm) for like actavite or you could make tea or coffee something like that. But in other ways like the activities we used to do and just the way we used to hang out it wasn't like it was an institution (mm). {pause} (When you were talking about Antoinette and how the relationship you have with people deepens and gets to another level, I'm wondering what it is you look for or what it is you found in nurses like Antoinette that allowed you to feel you could trust them and talk to them about more deep issues?) I think that's why we did quite naughty things to see what limit you could push them to and see how they'd respond to you, well I know that's how I did it, like I pushed a lot of them and did some really stupid things for no reason at all apart from just wanting to see their reaction and I think that's how I judged them (mmhh), on how they responded to the stupid things I did, you know, how they handled certain situations. Like if I did something really stupid and they were to get angry with me I probably would stay away from them but I remember some of them had really good approaches, like Antoinette, you know, after locking her in there [in the cooking room] she didn't yell at me and tell me off, you know, it was "you shouldn't do that Elizabeth" and she asked me why I did it, and I can remember all the time after they asked me what made me feel like doing those things, I didn't know, like there was nothing that made me do it it was just to get a reaction to see how they would react to me (mmhh), just to test them, they knew my behaviour quite well. (You were talking about Antoinette and locking her in can you tell me that story and what happened). I remember doing cooking I think we were cooking cakes (mm) something like that. I just decided that I didn't want to be part of it for a while then somehow Antoinette got me in there and [then] I ran off and locked her in and they were in the kitchen going "let us out Elizabeth, let us out" and I'm just bouncing on the trampoline laughing, that's what I remember like with the key [going] "ha, ha, ha, ha, ha." But it wasn't being malicious or anything, like I wasn't angry or pissed off or anything, I was just doing it cause I could do it I guess (mm), I don't know, like I just did it. I didn't leave them there for very long but I don't know how I got talked into letting them out (mm) cause I don't think there was any phone in there so they couldn't ring [anyone for help]. I let them out and I don't remember getting into too much trouble, like I was told I shouldn't be doing things like

that but I didn't get grounded or I didn't get things taken away from me (mm), it was just asking me why I felt the need to do that. (Do you think Antoinette understood you were testing her to see what her response might be?) Yeah, well of course she wasn't happy about the situation, about being locked in there with me with the key but she reacted really well to it like I think she just knew, you know, may be I was frustrated or something like that but she seemed to understand that I was angry or just acting up or whatever, she didn't yell at me, she didn't scream or tell me I was stupid (mm), she just had a really good approach to it because I would have been angry if like someone had locked me in there I would have been like "get me out of here!" Like I would have been very angry but next day she was still cool she was still talking to me. (Was it those kinds of experiences that taught you you could test her and she'd still be okay with you and care about you and talk with you and all that?) Yeah. {pause} (You were telling me you got on really well with Simon have you got any stories you can tell me about him?) I remember with Simon him trying to get us to stay in our rooms for quiet time and he was really trusting, he wouldn't come and check on us so much he used to give us the benefit of the doubt, like we'd go "yeah, we'll stay in our rooms." And he always knew when something was up, he wouldn't come and check on us but he used to catch us out (right) cause the others kept an eagle eye on the bedroom doors, cause we used to stay in our rooms in quiet time, I think may be at first we'd stay together in the one room and then it ended up being that we weren't allowed to talk to each other we had to stay in our room, then we ended up sneaking out even more. I just remember sneaking out and Simon catching us outside and he was always "ho, ho, ho, come back inside guys", you know, it was always such a quiet voice and just a really good approach. Like no worker was really aggressive but he was just really happy, happy go lucky, like [he'd say] "come on guys." He acted like one of us sometimes, he got right into things like trampolining and playing around, but quiet time was good, I always used to look forward to him being on. (Why was that, what did you really like about him?) He was just a soft person (uhu) like really nice not aggressive, you know, he's an assertive person but he had such a soft voice when he spoke and a really good approach, you know, no better with me than anyone else but it was just that he was so soft (mm). He used to have a really good approach to things and he was funny he could laugh, he used to laugh a lot, I remember him laughing, he was always laughing. (He had a good sense of humour and he was sort of gentle). Yeah, I think it was the way he looked as well, he didn't look domineering, like I really liked Adrian [but] Adrian was really big, he was tall and big whereas to me Simon, he was like Patrick, Patrick had a really quiet voice he used to always talk really softly (mm). See, I really like Adrian but what I remember about Adrian is him being big and he had like quite a strong deep voice (mm), it didn't make me like him any less or anything but yeah some people had like really soft voices (It appealed to you that gentle softness). Yeah. (It's interesting cause you described Edward in the same way didn't you as soft and sensitive). He was one of my favourites he was, he used to get hell, he was always picked on and he used to say "come on guys you don't

have to be like that." You could have lots of fun with him, he was always really good to me and I used to be able to push him quite a bit, he used to let me get away with a lot. (Can you think of any experiences you can tell me about?) Just the one about the camp, that's what I think of now, where he carried me, (mm) and like no one else got carried and I know he was really tired but he was so nice that he piggy backed me all this way over rocks and through the water and like no one else, I'm sure other people were as tired. I don't remember if I hurt myself, I don't think I did, I think I just wanted him to piggy back me [because] I just couldn't be bothered walking. I was fine for the rest of the camp so I didn't hurt myself and he did, he carried me and it was hard, you know, it was hard for him but he did it, he was always like that, he put himself out. Everyone liked him, no one disliked him that I remember but he used to get picked on quite a bit but he was still really nice. {pause} I think I used to taunt him sometimes just for fun. (Like teasing him?) Teasing him yeah, he used to get teased a bit but he used to take it pretty well like [he'd say] "come on guys you don't have to be like this." (He had a sense of humour as well). Yeah, I think he had a good sense of humour. (Do you think that's a good quality for a nurse in that sort of setting to have?) Yeah I think so, well if you're working with us or working with the kids that were there when I was there you would have needed a good sense of humour, like that thing about locking Antoinette in [the kitchenette], she could look on the funny side of it like it was quite funny. She could have got all worked up and reported me straight away or given me some severe punishment so I wouldn't do it again but, you know, I don't remember her laughing thinking "oh ho, I thought this was really funny" but she just handled it really well cause we were always playing jokes on the staff (mm) and like hiding and running around. I think it was mainly for the attention and we always got it, if we wanted to get chased we got chased, like if we took off we knew damn well they'd be running after us. (Do you think it was to see if people cared about you?) Oh sure yeah, like it was natural for you to get attached to some workers rather than to others like usually singling one out (mmhh), I think overall when I look back Beth was the one that I was attached to most and after I left I still had a lot to do with her (mmhh). Even the staff [got attached to kids] not that they had their favourites, like I don't remember any favouritism, but they did have the kids they were most attached to. (Was the primary nurse?) Yeah, that was the way with me but I could see with others their primary worker wasn't their favourite (right) but it wasn't a thing like "oh, I don't like you you're not my favourite" but it's just natural that you get on better with some people than you do with others and they had to work shift they couldn't be there all the time but I noticed I was better behaved when some staff were on than others. (Tell me about that). Well you just knew the ones you could get away with things [with], like some of the night staff you wouldn't think twice about doing the wrong thing cause like they were going, there'd be some you couldn't do things to where others you found it quite easy to laugh and hide and give them a hard time while they were on shift. (Who do you mean by the night staff, like the nurses on night duty). Mm. (So how were they different?) I don't know, it

was just some of them you knew boundaries, you knew how far you could push them and some of them you wouldn't even really bother, you just wouldn't do it, you'd just feel sorry. Adrian was fine and he had a family but Edward didn't. Edward, he wasn't married then (yeah) and I remember when he was getting married it was a big thing cause he was taking off more time. I don't know how long he'd known his girl friend or fiancee but gradually he wouldn't be working [as much] cause some of them worked so often, I remember Edward was always there, he would always be there for a long time, [it seemed as though] he was always on duty (mmhh). Whereas others, you know, Beth had a family and she wasn't there as often cause she had a family of her own. (It's interesting that you know so much about the nurses, there was this reciprocal relationship between you, they knew a lot about you and you knew about them). Well that's the way you get things out of them, I remember like to get things out of us [you'd say] "you tell me something I'll tell you something" (uhu), that's pretty fair, like you don't want it to be just a one way thing, you've got to feel like you can relate to them in some way, well I know that if I was in their position I would want to relate to the adolescent. They probably couldn't relate in every way, I can't remember the things that we related [shared] in but if I felt some [particular] way some of them would tell me a little story about something they'd done, you know, if you ended up being rejected or whatever (mm) [they'd tell you how] they were rejected too and it's quite normal and it didn't seem like by the book. (A lot of sharing and may be equality in the relationship). Yeah, well I think back now and I can't remember a lot but I remember knowing quite a lot about them, like their personal lives and things they liked and it was good (mm) it wasn't just like I did all the talking, they talked as well. (That helps to take away the gap or the distance?) Mm, well you don't want it to be like an [interview] like "how are you feeling today?" and you answer all these questions and all they do is ask questions (yeah), it was more like conversation, you could tell them how you feel in a conversation instead of being asked questions (mm), or games, like I ended up playing a lot of games and I liked that, you know, I liked playing the games everything was like woven into it, even like I said about the cooking and the craft and things like that they had different ways, good techniques, and I didn't always realise it at the time but after leaving and looking back, in retrospect, you can see things a lot clearer. (It was a good way to establish the relationship and be able to work with the kids doing all these activities). Well, the kids aren't there because they've been having such a great time so you've got to have a really good approach. {interruption} Yeah, I can't remember if I ever felt they dealt with me in a bad or wrong way [but] I remember in the end them getting quite strict with me and not being able to go on outings and things and having to write apologies, you know, write why we did what we'd done and why we were sorry and things like that and I quite enjoyed them. Yeah, the reasons why you should be allowed to stay and stuff like that I liked things like that, it got me ready for when I went back to school, cause when I was at school I was always writing things like that and I was quite experienced it in it then by the time I left the unit

(Explaining yourself?) Explaining myself yeah, it made me think, and you had to say something about yourself on a Monday. I don't think it was every meeting but you had to say something about yourself [at the Monday meeting] (mm), what you'd done on the weekend and things like that, (oh yeah) and that was so scary at first and in the end you get to really like all of it, you get to like it and it's like [when someone else is speaking] "be quiet you're saying too much." {interruption} (I've turned the tape over and you were telling me how things got {interruption}, you were telling me how they got stricter with you and there was more discipline, how did that come about?) I think the first few times they thought it was like I was acting up and testing things and they would let me get away with a bit because I was new and just settling in and things like that but as they worked out why I was doing the things I was doing, plus we had a better relationship, so they could tell me [to do things] and discipline me more. In the beginning if they'd have tried to discipline me the way they did in the end I probably would have taken off or reacted in a different way but because I had grown quite used to them and it was in a way kind of like a family, you know, you see them all the time and we had such a good relationship [so] they could discipline me (mm) in that way, and even though I hated it I could handle it a lot better. Plus I needed it, you know, like I used to do such stupid, stupid things, and for no reason, so when it came time to like writing out "why did I do what I did" I didn't know half the time. But all the punishments that I got it was never really that bad, it was pretty fair. I think I behaved in the end, behaved more, until I realised I was going, they were kicking me out, I had to move on (mm). I felt really rejected then, I just did not want to go, not at all. (That's really interesting about how it was only because you'd established a relationship with the nurses that they could discipline you and you were prepared to take that discipline and not rebel against it). Well that's the way I remember it because at first I got away with a little bit more, like their approach to things were different but as time went by and I did things they could really discipline me, you know, like and they knew that I trusted them and that I wasn't being persecuted (mm) by them cause in the beginning I didn't want to be there, I was angry about being there, I didn't like anyone, I didn't trust anyone but in the end it was different. And a lot of time I knew I deserved what I got anyway, like I knew when I was getting grounded or getting privileges taken away from me that I really did deserve it, you know, and also in the end I could talk back more so I got trouble. {both laugh} (When you had that discipline, or consequences or loss of privilege did the nurses talk to you about that and explain what was going on or?) Yeah, whenever I was given punishment it was always fully explained to me why and I was always given options and that was quite a different experience, someone saying to me "you can either have this this or this", like I might have loss of privileges or I might want to do something [else], I might want to do this to make up for it [in another way] or whatever (right). It was hard to choose, like you think sometimes that you'd find it easier to choose your punishment but it was quite a different approach (mm) I never had that approach before in any other situation I'd never been told, you

know, like you've done this wrong you can either have this, this or this, it's usually you get told and [so] that was a different experience being told to choose. (What do you think that was all about giving you an option and a choice?) I think a lot of it was being fair, how do you explain it, like did I think that the punishment fitted the crime like what I'd done (mm), so I was given the option, like they would tell me a few things that they thought should happen and then if I disagreed [we'd negotiate] cause they would never have made me do anything I didn't want to do, like they can obviously take privileges away from you but in myself some punishments weren't always real punishments. (You could negotiate with the nurses about what the consequences of your behaviour would be). Yeah and I can't explain it in words, may be I should write about that. (Do you think it was like trying to teach you how to take control?) Well yeah, I probably didn't rebel as much when I was given a choice about things whereas if I was told, like I remember that time [with Marcia] I don't know what I'd done but Marcia said to me, I must have done something bad, cause she said to me "you can't go on the outing", you know, like oohh I was so angry but that was different cause she wasn't dealing with me every day (mm), she was just the person I would go and see for a few hours here and there and so she would say to me you're not going here or there. But with other staff it would be like "do you think it's fair that you should go there?" or "may be you should write about it, how you feel" or may be they'd just give you some advice a lot of the time (mm). The worst punishment I ever got was being sent away for 2 weeks (mm) {pause} but it's hard to explain about that. (Mm, quite a different experience, sounds like they had lots of different strategies) Yeah, different strategies and I just didn't rebel quite as much, not that they treated every child, well they did treat everyone a bit different but you were the same as well, but what worked for one kid wouldn't work for another (mmhh). We weren't all treated exactly the same (yeah) which was good cause some kids didn't need as much discipline as others, like they could get heaps more freedom, you know, you worked for a bit more freedom here and there but some really needed to be disciplined and they didn't have choices, they were like [told] "you're doing this", (mm) where others didn't need that which I thought was good because it showed that they paid attention because they'd know not to treat everyone the same and what worked for one wouldn't work for all the others. (They treated each adolescent like an individual). Like an individual yeah, I guess that's the purpose of having a worker assigned to you (mmhh) like I had Beth and Antoinette they were my main carers. {pause} (So it sounds like the nurses involved you a lot in the decisions about what you did and what you didn't do). Yeah, they talked with me not always to me which I found like in the school [situation], like when you go to school and things like that (mmhh) it's the teacher talks to you not with you [but the nurses] they were always like talking with me not at me. {interruption} (You were telling me about how the nurses didn't talk down to you or at you but they were with you). Well like it was weird for me because I'd come from a hospital before I went to the unit, I'd been in hospital for 2 weeks/3 weeks, something like that, may be longer, I'd been living in an actual

hospital in a ward (right) and when they told me I was going to the unit and they tried to explain it was like "oh no!", and I knew I could be there for an indefinite amount of time, I was like "nup" like I made my mind up that I hated it before I went. But you know that's fairly normal, like (mm) I don't feel bad about it now when I look back, and like I didn't have to jump in there and like it straight away, it was quite normal to [feel like I did], I didn't know anyone, it was like somewhere I'd lived before where I was going to live for quite a while and I had no choice in the matter. I don't think it took me that long to fit in, to feel like I fitted in but the thing about it being part of a hospital was the part I really hated. (You said you'd been in a hospital for 3 weeks before you went to the unit). Yeah. (So there were nurses there who). They were totally different and my expectations were different. (How were the nurses different in the general hospital as opposed to the ones on the unit?) Well looking back now I know they weren't trained in that way, like to look after me in the way the [nurses on the unit did], they didn't specialise (oh yes) but I being only young as well expected it [the unit] to be like it was when I was in for 3 weeks in a hospital ward, I wasn't in with nurses [trained to help me] like I was in a children's ward (I see) but I wasn't with [specialised nurses] I was with just normal everyday nurses who work in hospitals. (How were they different?) Well they didn't know how to handle me, they just went about their job and it just wasn't a happy experience for me, they weren't mean or anything but it just wasn't a happy experience and I expected when I went to the unit, being part of a hospital and having nurses looking after me, I thought that it would be the same, (uhu) so I went into it thinking "it's going to be bad" from the start (mm) and it just wasn't like that. I was surprised to see they wore normal clothing and we could call them by their names. (And they did fun things with you). Yeah, joined in doing lots of things. {pause} (Have you got any stories you'd like to tell me about anybody?) I can't really think clearly at the moment. {both laugh} (Can you think of a really positive experience that you had with one of the nurses that stayed in your mind, something really good that happened?) I'm trying to think, I remember when I went to dinner at Beth's house it was just like a really normal experience and I wasn't used to it, you know, like she took a lot of [interest in me] (mm) and I went to the house for dinner and I was involved with a lot of the things she did. I remember going there and it was just excellent, like she was a worker from the unit but she took me to her house and cooked me dinner and I hung out with her kids. Simon, I remember being on on weekends and letting us get really cool videos, you know, we'd just sit there and watch videos. {long pause} But there were heaps of good experiences like every now and then when I talk with Nathan we laugh about things that we'd done. I remember, I'd been with Roland, Roland and I had stolen the keys to the unit car and we were driving around, like we were really stupid, we were reversing the car and driving it really fast and slamming on the brakes and being idiots and Angelica came out screaming cause it was quiet time, that's right, it was quiet time and we snuck out and we'd stolen the keys and we didn't drive far out of the grounds but Angelica came out and she's like "what are you doing?" and started

screaming at us and [she said] "you're done it this time Elizabeth, you're in big trouble now." I'd done something really stupid, I'd stolen the keys to the car and Angelica started screaming when she saw us, like freaking out because she probably thought we were going to smash the car and kill ourselves. {laughs} See, when we used to take off it wasn't because we hated being there or whatever, it was just something funny to do, that's why we did it, not because we hated the staff that were on and we wanted to seriously run away because if we wanted to seriously run away we could have done it but it was like "lets get the staff to chase us we're bored" (mm). We must have had quite a lot of freedom to get a chance to do the bolt [and all these other things]. (Like you said different staff would give you different levels of freedom). Some of them they must have been hawk eyes like every movement [was] like "where are you going?", I think Angelica was one like that, she never really was out of sight for a moment, that's why she came looking for us and found us (yes) but some of them [the kids] were very trustworthy and wouldn't take advantage of it (uhu). That's why it made it hard sometimes when we had to write why we're sorry and why we think we should be there, when the reasons for doing it weren't because we were upset or angry (mm) it was because we were bored. Oh I'm sure there were times when I was upset and that's why I took off but I remember quite a few times just doing it because we could, for the fun of it, giving them a hard time and making them work hard. (Sounds like on the whole they knew how to handle it). Yeah, I remember being in trouble so often but I also remember getting so many good things, like I can remember them letting Nathan, one of the other kids and I go jogging (mmhh), I'm sure that they weren't there, like they'd let us go off by ourselves. We used to do it in the morning, get up and go for a jog. (It felt good to be trusted). Yeah, we'd just get out there on our own and go running around {pause} but yeah we had some good experiences. (Tell me, did you have any experiences that weren't so good). I remember I had a weird situation with one of the boys Kieran (yeah). He was in the room next to me and he came in and said something, he came in and told me that he loved me or something, and Kieran was quite a weird one and he was a very morbid person and I just went "oh yeah, I love you too Kieran" and he started screaming at me going "you're lieing you don't" and just went berserk and tore all the pictures of his wall (mm) and did all these things and I remember the staff coming in [saying] "what did you do to him Elizabeth, what have you done?" and it's like "I haven't done anything" (yeah) I didn't know that I shouldn't have said "I love you" I should have said this or that or "I love you back" or whatever, I remember like it was my fault and I know now and I knew back then that it wasn't my fault. I thought what I said was the right thing but I'd made him lose the plot (mm) and he was outside my window banging and he took off all night and they were worried about him. I just felt like they [blamed me] I was in trouble, you know, may be I wasn't in trouble may be they were just really worried about Kieran and trying to work out the reason why he was like that or whatever (mm) but I remember being really upset. {interruption} (Did you feel you were blamed). Yeah, I don't remember the whole situation but I remember that I felt bad, not

that I was made to feel bad but I did feel pretty bad, like I was to blame for it all. I had a few situations like with Kieran, they were really big things like locking ourselves in the room with the stereo and the bean bags (yes), locking ourselves in there and staff couldn't get in (mm). There was about five of us and we put all the bean bags up against the door and sat on them. I think Simon was on that night cause I can remember him knocking on the door going "come on guys let us [in], come out don't do this." (He always said it in a very casual sort of way). Yeah, he was always really cool, I don't know some of them could yell at you or raise their voice but he was, "oh come on guys." {interruption} (Maybe I can ask you if you can speak in a general sense about what you think is important for nurses working with young people, how they should be or what they should know or just generally). That's hard {long pause}, well they should be understanding like it's hard to explain, the kind of people they'd have to be, you'd have to be a pretty versatile person (Like flexible?) flexible yeah, very flexible because like everyone's different but, you know, like handling adolescents that are, you know, like with me, I was a quite depressed adolescent and just knowing that. Like when they got abused, I know they got abused a lot of the time, they've got to learn not to take it personally (mmhh) but I know it's really hard, you know, people say things they don't mean but it would be hard to be in a job where that might happen to you often, like don't take things personally and don't let it get you down, you have to have a good self esteem I guess (uhu). Being able to relate to people because, you know, it took me quite a while to understand that the nurses had a life outside, that just never occurred to me that they had lives. You have to share some of yourself with kids because I know for a fact that I always wanted to relate, not that I wanted to hear that they were messed up or as sad as I was just to hear that they had been sad or that a similar situation had happened to them, (mm) I think that's really important. I don't think they should lie or just make up stories to always relate, just show that they're human (yeah) as well, and it's normal for everyone to have difficult periods in life but it doesn't make you any less of a person (mm). I think being flexible that's really important. {interruption} (You mentioned relating skills and not taking things personally and being flexible, I think that's where we turned the cassette off). Being flexible and I'm just trying to, {pause} I can't think of anything. (Okay, we'll leave it at that point). I can't get over Megan. (That's stuck in the middle now) I just find it hard to believe what you said about Megan and being married with kids!

<u>The Edited Transcript with Comments and Questions</u>: Sent to Elizabeth in Preparation for the Second Interview

(Perhaps we can start by taking you back to when you first went to the unit, if you can tell me a little bit about what you remember from when you first went there, any feelings or thoughts you had). The first time I went there was for the interview and I hated it and I was crying and I just didn't want to be there, and then a week later I was put in there and I remember feeling a little miserable and hating it and not giving anything a go, [I] didn't want to eat, didn't

want to do anything and I don't remember when it stopped, just one day I realised how much fun I was having and it was really good, but I hated it at first, [I] didn't want to go at all, I thought it was like a psychiatric hospital (right), I didn't think I needed to be there (mmhh) but I learned heaps from being there **Can you give me some examples?** you don't realise until you've gone until you've left there what you've learnt and then you wish you were back there (right). I didn't want to leave in the end. (That was a big change wasn't it?) Yeah, I wanted to stay and it was like "no Elizabeth you have to leave one day", I didn't like the idea of that. (Can you think of the things that worried you about going there?) I just didn't like the idea of living in another institution (right) I'd lived in them plenty of times before, and all different types, and I thought it was going to be like that. I didn't like the idea of new people and I thought that everyone would think I was sick because I was there, but I remember Marcia (mm) explained to me, you know, something about when you've got a back ache you go to a chiropractor, when you've got problems with your eyes you go to an optometrist and I was there because I needed help in other ways, the way she said it to me she made me feel heaps better about it, but [in the beginning] I felt I didn't belong it was a mistake that I was there (mm) [and] they were going to realise I didn't need to be there. (You mean it was a place for mad people or something like that?) Yeah, I didn't think it had anything to offer me. (You said you went from not wanting to go there to not wanting to leave). Yep, I didn't want to leave in the end. (What things happened to get that change?) The people I met, I've got quite a few of them I'm still friends with but I just had heaps of fun, it ended up being a good release, I had a lot of anger before I went there I was a really angry person and I was angry a lot of the time I was there but I got to release it in positive ways (mmhh). I remember doing anger therapy, we painted some bottle and every time I went into the room I could undo the lid and take my anger out (uhu) and then they'd put the lid back on and I was meant to not be angry, I could still be angry but I wasn't allowed to have tantrums. (You kept it in the bottle). I kept it in the bottle, we got a 4 litre orange juice bottle and I painted it black and I used to kick it and do all things like that but only when the bottle was open and I wasn't allowed to open it, I think it was either Beth or Antoinette who used to open it. (Where did you keep this bottle?) They kept it in the staff room somewhere. I remember there was all different things they used to do with us like the dolls, we had the dolls {pause} like role reversal (mm?), it was quite interesting and drawing. (What was that about the dolls?) I would be me and the dolls would be my parents and I would do the talking for the dolls but they would tell me things and then I would be my mum and the doll would be me and just swapping roles. (What were you hoping to do with that?) I thought it was quite strange at first, I even thought the bottle thing was strange, the idea was to get out how I felt and show how the situation was and then how I would have liked [my mum] to have handled it (ah), like how I would have liked my mum to talk to me instead or how I would have liked to have been treated (right), and so I would be my mother talking to me (mm) that was quite interesting. A lot of stuff I did with drawing therapy but I liked

it because it was one on one you had your special workers that were assigned (yes) and they always had time for you. (Nurses and what nurses did with you was important). I remember hating it when I first went there, I can remember my first day really clearly, I hated it and [later] I remember having so much fun with all the different workers. When I first went for the interview I thought it would be really clinical (yes) but they all dressed normally and we called them by their names and they were all really, really nice (mmhh). Of course, I remember fighting with them every now and then, it was usually because I didn't like authority, that was the only thing but they were never, never rude or anything like that, never nasty [they were] extremely nice a lot of them, I should have been a lot nicer to them [instead of] pushing them to the limits. (What do you think that was about testing people to their limits?) Testing boundaries, seeing how far [you could go] also I'd been in so many institutions (mmhh) when I was young and I kind of knew what it was all about, you know, how far you could push people. I was very angry and took it out on them but they responded pretty well all the time, I was never abused, like yelled at or anything, they always had a really good approach always some good way to handle it like time out, I didn't like time out at first, I hated that, like when I was told to take off somewhere by myself I didn't like that but it all made sense in the end and I got used to the programs and routines. And it was good attention wise you were never short of attention there was always someone there to give their full attention to you **Why is this important ?** (right), I can't remember or think of a time when I ever felt rejected, and I felt rejected when I went there but I soon [lost] that feeling (mm), except when they were kicking me out, telling me I have to move on [then] I felt really rejected again. (How long were you on there?) Something like 9 months. (A long time). I was there a long time because I couldn't go home at all, they knew that from the day I was there so they tried different options, [they] tried to get me to live with my aunt and so on weekends I was going home with her (right) and that didn't work out, I was not happy at all (mm), and then they found Autumn Lodger and I was fostered, that was all very [much] in a hurry, I think it was coming towards holidays and they had to hurry things along. (It's hard to leave somewhere after you've settled in and felt comfortable). I became very attached to the people and the routines (yeah), at first it was so hard to get up at the same time every morning and do the routine things like the meetings and then you get so used to it (mm), having all your food cooked for you, quiet time at night, outings. (What was good about the routine?) Just that we did have some kind of routine, you knew what you were doing. When you get up in the morning you know what you have to do, you'd get up and you go to breakfast but it was also like [for] a lot of it you were quite independent at the same time (mm), they were always there telling us what to do but we kind of knew, they got us up in the morning and then we'd do the routine of going and having a shower if we wanted, we weren't made to but they preferred if we did, going to breakfast and the meeting or whatever (mm). At first it was always being told what to do but in the end I knew and I could tell other kids (yeah) this is what we do, it became habit. (A predictable environment) Yeah that was good.

What's good about such an environment ? (Tell me how people encouraged you to be independent). Well I was shown where the washing machine was and you did your washing when you wanted to (right), they wanted you to do it but you did it at your own [choosing], at whatever time you wanted to and you did it all yourself, [also] showering and looking after our rooms. You were told when to get up but they just knocked on the door and woke us up then it was up to us to get ourselves to breakfast and to look after our clothes and to do our homework, I remember they always offered us help if we wanted it, if we wanted help it was there, but they would let you be independent let you do things on your own (right). I suppose they didn't want to everyday say "it's 6 o'clock it's quiet time" (yeah) or "do your homework or do your washing", you'd just do it yourself. (People encouraged you to be responsible for yourself). Responsible yep (and that was a good feeling). Yeah, that was a very good feeling. Like when I was first there I used to get chased around but in the end if you didn't turn up for dinner you didn't turn up, they weren't happy you weren't there they didn't say "oh that's fine run off and do what you want" but the thing is if you weren't there for dinner you weren't there for dinner, they'd always want to know where you were but it was up to you to get yourself there (yeah) while it was on, a few times I missed out. There was a few things I really liked like having your food cooked for you and you didn't have to wash up later which was a different experience cause most places I lived in you had to do the washing up and drying up. (Sounds like a good balance). Yep. The last few months was just great I really, really didn't want to leave I just liked it so much, you get so used to it as well. (How did people prepare you for leaving?) I think from day one they wanted me to be with my family if I could so they were always saying to me that in a certain period of time I would go for weekends at my aunts (mm) and then we tried that for quite a while and that was just a bad, bad experience (mmhh) so the next thing it was coming towards [holidays], I think they thought it might work out with my aunt so they [hadn't planned other options], not that they didn't expect it wouldn't work but they weren't prepared when it didn't so they had to think pretty quick and fostering [came to mind], the fostering came on so quickly. I remember being told I was going to be fostered through an outside agency [and] the next thing I know I met the workers and the second meeting they'd found me somewhere and I was just [not wanting to go], like did not want to go, I just did not want to go. I remember being really upset but I also knew I couldn't stay there forever but I just didn't like the idea of going from there straight into a foster family (mm) so I made it very hard for myself, but I was very, very sad. (Do you think it was too quick, it didn't give you time to adjust?) No matter how long it took I probably would have been unhappy (right) I know that, I do think it was a bit quick but that wasn't anyone's fault, it was that other things fell through and they had to do something as quick as they could (mm) cause I don't think you could stay there over holidays. I think you could but they didn't really like it, not that they didn't want you there, it was better for you to be somewhere else cause a lot of the kids were going home or going somewhere (yeah) and it wouldn't be much fun living

there by yourself. (What was it that allowed you to form such a positive attachment to the people and the place?) Cause they understood, (uhu) I never felt people didn't understand me and all the kids, I related to nearly everyone of them and after being there for a while I didn't feel we were strange or we were sickos or anything like that (ah). I just felt like everyone [else] quite normal, and the workers, sometimes I felt like I was in day care. (yes?) Well that was the way we were acting, doing stupid things, keeping them on their toes (uhu), I just felt I fitted in, I fitted right in there. (It was good being amongst nurses who understood or kids who were experiencing the same thing you were). Yeah, and the nurses weren't like what you think, when I think of nurses I always think of wearing uniforms and being fairly routine [but] they were just like {pause} normal people, they dressed normally, we would call them by their first name and just more like your friend **Can you tell me what this friendship was like and why it was important?** a lot of the time (uhu), I got quite fond of quite a few of them (yeah) and they just never acted like nurses [or] what you think a nurse would be. (Tell me what kind of things you did with nurses that helped you feel you were friendly with them). Well, with different ones [it was] different things (uh), I remember with Angelica it was always going to do craft, she got me into things, she wanted me to come and make things and I like enjoyed it more and more and I used to talk to her more and then you ended up talking about things you didn't plan to, like I didn't want to talk about anything (yeah) but [they had] good approaches [to get us talking]. With Antoinette it was always cooking she used to take us for cooking and just start conversations and you kind of [open up] and if you really like cooking you would go towards Antoinette because you had a choice of things you could do (uhu), there was usually two different things you could choose from so it had a lot to do with what their approach was [as to who you might go with]. Some would get on the trampoline with you and do things like that, Beth came on the trampoline with me, so did Simon, so did Edward (uhu), or you'd go play pool with them and they used to want to do fun things, it wasn't like you had to ask them they were always there ready to do fun things (uhu), [like] go for a drive or go bowling, getting you to do things [like] go on the trampoline, go for a swim, watch TV or a video. (Lots of activities). Yeah. (You were talking about how you'd start a conversation and then you might start talking about something completely different, do you mean when you first start talking to people it's on the surface and then). Yeah, and then you go further and you talk about more and more as you go on. I remember for the first while I was there I didn't want to talk to them about anything, not even what time is it or what do you like eating, I didn't want no part of that (mm) but then it's just one thing leads to another. As angry as I was I didn't have much trouble expressing myself, like I didn't want to express myself through anger, I didn't, but then they just had such a good approach. I had a totally different idea, like my expectations of the place were totally different to what they were (right), I expected it to be really horrible and really clinical and it wasn't clinical not at all. (If it wasn't clinical, if it wasn't like a hospital and the nurses were more like friends, how

would you describe the environment?) It was just like a big day care kind of thing, it felt so normal it was like a living situation (mm), it wasn't real hospital or real clinical (mm), it was just homely. (More homelike?) Kind of homelike the atmosphere was. **What was good about this?** (You were talking about how the relationship you have with people deepens and gets to another level, I'm wondering what you found in nurses like Antoinette that allowed you to trust them and talk to them about more deep issues?) I think that's why we did quite naughty things, to see what limit you could push them to and how they'd respond to you, that's how I did it, I pushed a lot of them and did some really stupid things for no reason at all apart from wanting to see their reaction and I think that's how I judged them (mmhh). I'd see how they responded to the stupid things I did, how they handled certain situations, if I did something really stupid and they were to get angry with me I probably would stay away from them but I remember some of them had really good approaches, like Antoinette, after locking her in [the kitchenette], she didn't yell at me and tell me off, it was "you shouldn't do that Elizabeth" and she asked me why I did it. I can remember all the time they asked me what made me feel like doing those things, I didn't know, there was nothing that made me do it, it was just to get a reaction, to see how they would react to me (mmhh), just to test them. (You were talking about Antoinette and locking her in can you tell me that story?) I remember doing cooking, I think we were cooking cakes, (mm) something like that, I decided I didn't want to be part of it for a while then somehow she got me in there and I ran off and locked her in, and they were in the kitchen going "let us out Elizabeth, let us out" and I'm just bouncing on the trampoline laughing with the key [going] "ha, ha, ha." But it wasn't being malicious, I wasn't angry or pissed off, I was just doing it cause I could do it I guess (mm), I just did it. I didn't leave them there for very long, I got talked into letting them out (mm) cause I don't think there was any phone in there so they couldn't ring, I let them out and I don't remember getting into too much trouble, I was told I shouldn't be doing things like that but I didn't get grounded or get things taken me away from me (mm), it was just asking me why I felt the need to do that. (Do you think Antoinette understood you were testing her to see her response?) Well of course she wasn't happy about the situation, about being locked in there with me with the key, but she reacted really well to it, I think she just knew. May be I was frustrated or something like that but she seemed to understand that I was angry or just acting up, she didn't yell at me, she didn't scream or tell me I was stupid (mm), she just had a really good approach to it. I would have been angry if someone had locked me in there I would have been like "get me out of here!" I would have been very angry but [not her] next day she was still cool, (yeah) she was still talking to me. (Was it those kinds of experiences that taught you that you could test her and she would still be okay with you?) Yeah {pause} (You were telling me you got on well with Simon, have you any stories you can tell about him?) I remember him trying to get us to stay in our rooms for quiet time and he was really trusting, he wouldn't come and check on us so much he used to give us the benefit of the doubt, we'd go "yeah we'll stay in our rooms"

with the kids that were there when I was there you would have needed a good sense of humour, like that thing about locking Antoinette in [the kitchenette], like she could look on the funny side of it, it was quite funny, she could have got all worked up and reported me straight away or given me some severe punishment so I wouldn't do it again but, [well] I don't remember her laughing thinking "oh ho I thought this was really funny" but she just handled it really well. We were always playing jokes on the staff (mm) and hiding and running around, I think it was mainly for the attention and we always got it, if we wanted to get chased we got chased, like if we took off we knew damn well they'd be running after us. (Do you think it was to see if people cared?) Oh sure, it was natural for you to get attached to some workers rather than to others, like usually singling one out (mmhh), I think overall when I look back Beth was the one I was attached to most and even the staff [got attached to kids], not that they had their favourites, I don't remember any favouritism, but they did have the kids they were most attached to. (Do you think that was the primary nurse?) That was the way with me but I could see with others their primary worker wasn't their favourite (right) but it wasn't like "oh I don't like you you're not my favourite" but it's just natural that you get on better with some people than you do with others, and they had to work shift, they couldn't be there all the time but I noticed I was better behaved when some staff were on than others. (Tell me about that). Well you knew the ones you could get away with things [with] like some of the night staff you wouldn't think twice about doing the wrong thing, there'd be some you couldn't do things to where others you found it quite easy to laugh and hide and give them a hard time while they were on shift (Who do you mean by the night staff, the nurses on night duty?) Mm. (How were they different?) Some of them you knew boundaries, you knew how far you could push them and some of them you wouldn't even bother you wouldn't do it **Why not, and how would the nurses react who you wouldn't push?** Adrian was fine and he had a family but Edward didn't. Edward, he wasn't married then (yeah) and I remember when he was getting married it was a big thing cause he was taking off more time. I don't know how long he'd known his girl friend or fiancee but gradually he wouldn't be working [as much] cause some of them worked so often, I remember Edward was always there, he would always be there for a long time, [it seemed as though] he was always on duty (mmhh). Whereas others, you know, Beth had a family and she wasn't there as often cause she had a family of her own. (It's interesting that you know so much about the nurses, there was this reciprocal relationship between you, they knew a lot about you and you knew about them). Well that's the way you get things out of them, I remember like to get things out of us [you'd say] "you tell me something I'll tell you something" (uhu), that's pretty fair, like you don't want it to be just a one way thing, you've got to feel like you can relate to them in some way, well I know that if I was in their position I would want to relate to the adolescent. They probably couldn't relate in every way, I can't remember the things that we related [shared] in but if I felt some [particular] way some of them would tell me a little story about something they'd done, you know,

if you ended up being rejected or whatever (mm) [they'd tell you how] they were rejected too and it's quite normal and it didn't seem like by the book. (A lot of sharing and may be equality in the relationship). Yeah, well I think back now and I can't remember a lot but I remember knowing quite a lot about them, like their personal lives and things they liked and it was good, (mm) it wasn't like I did all the talking, they talked as well (that helps to take away the distance). Mm well you don't want it to be like an [interview] like "how are you feeling today?" and you answer all these questions and all they do is ask questions, (yes) it was more like conversation, you could tell them how you feel in a conversation instead of being asked questions (mm), or games, I ended up playing a lot of games and I liked that, I liked playing the games, everything was like woven into it, even the cooking and craft and things like that, you know, they had different ways, good techniques and I didn't always realise it at the time but after leaving and looking back, in retrospect you can see things a lot clearer. (It was a good way to establish the relationship and work with the kids doing all these activities). Well the kids aren't there because they've been having such a great time so you've got to have a really good approach. {interruption} I can't remember if I ever felt they dealt with me in a bad or wrong way I just remember in the end them getting quite strict with me and not being able to go on outings and things like that and having to write apologies, [like] write why we did what we'd done and why we were sorry and things like that. And you had to say something about yourself on Monday, I don't think it was every meeting but you had to say something about yourself (mm), what you'd done on the weekend and things like that (yeah) and that was so scary at first and in the end you get to really like it, and it's like [when someone else was talking you'd think] "be quiet you're saying too much." (I've turned the tape over and you were telling me how things got). {interruption} (You were telling me how they got stricter with you and there was more discipline, how did that come about?) I think the first few times they probably thought it was like I was acting up and testing things and they would let me get away with a bit because I was new and just settling in and things, but as they worked out why I was doing the things I was doing [they disciplined me more]. Plus we had a better relationship so they could like tell me [to do things] and discipline me more. In the beginning if they'd have tried to discipline me the way they did in the end I probably would have taken off or reacted in a different way but because I had grown quite used to them and it was in a way like a family, you know, you see them all the time and we had such a good relationship they could discipline me in that way (mm), and even though I hated it I could handle it a lot better and plus I needed it, like I used to do such stupid, stupid things and for no reason, so when it came time to like writing out "why did I do what I did?" I didn't know half the time. But all the punishments that I got it was never really that bad, it was pretty fair. I think I behaved in the end, behaved more until I realised I was going, they were kicking me out, I had to move on, (mm) I felt really rejected then I just did not want to go, not at all **What would have helped you at this time?** (That's really interesting about how it was only because

you'd established a relationship with the nurses that they could discipline you). That's the way I remember it because at first I got away with a little bit more, like their approach to things was different but as time went by and I did things they could really discipline me and they knew I trusted them and that I wasn't being persecuted (mm) by them. In the beginning I didn't want to be there, I was angry about being there, I didn't like anyone, I didn't trust anyone but in the end it was different and a lot of time I knew I deserved what I got anyway, I knew when I was getting grounded or getting privileges taken away from me that I really did deserve it. (Did the nurses talk about that and explain what was going on?) Whenever I was given punishment it was always fully explained to me why and I was always given options and that was quite a different experience, someone saying to me "you can either have this, this or this", like I might have loss of privileges or I might want to do something [else], I might want to do this to make up for it (right), it was hard to choose, you think you'd find it easier to choose your punishment but it was quite a different approach. (mmhh) I never had that approach before in any other situation, I'd never been told "you've done this wrong you can either have this, this or this", it's usually like you get told and that was a different experience being told to choose. (What do you think that was all about giving you an option?) I think a lot of it was being fair, like did I think the punishment fitted the crime, what I'd done (mm), so I was given the option, they would tell me a few things they thought should happen and then if I disagreed [we'd negotiate] cause they would never have made me do anything I didn't want to do, they can obviously take privileges away from you but in myself some punishments weren't always real punishments. (You could negotiate with the nurses about what the consequences of your behaviour would be) I don't know how to explain it in words, may be I should write about that. (Do you think it was like trying to teach you how to take control). Well yeah, I probably didn't rebel as much when I was given a choice about things. I remember that time Marcia said to me, I must have done something bad cause she said to me "you can't come on the outing", like oohh I was so angry, but that was different cause she wasn't dealing with me every day, she was the person I would go and see for a few hours here and there (mm) and so she would say to me you're not going here or there but with other staff it would be "do you think it's fair that you should go there?" or "may be you should write about it, how you feel", or they'd just give you some advice a lot of the time, {pause} but it's hard to explain about that (Sounds like they had lots of different strategies). Yeah different strategies and I didn't rebel quite as much, I think it was different for [other kids], not that they treated every child [differently] well they did treat everyone a bit different but you were the same as well but what worked for one kid wouldn't work for another, (mmhh) we weren't all treated exactly the same (yeah) which was good cause some kids didn't need as much discipline as others, like they could get more freedom. You worked for a bit more freedom here and there but some really needed to be disciplined and they didn't have choices, they were [told] "you're doing this" (mm) where others didn't need that, which I thought was good cause it showed they

paid attention because they'd know not to treat everyone the same and what worked for one wouldn't work for all the others (Like an individual). Like an individual yeah, I guess that's the purpose of having a worker assigned to you (mm) {pause}. (It sounds like the nurses involved you a lot in the decisions about what you did and what you didn't do). Yeah, they talked with me not to me which I found [different], like when you go to school and things like that (mmhh) the teacher talks to you not with you [but the nurses] they were always talking with me not at me. {interruption} (You were telling me about how the nurses didn't talk down to you). Well it was weird for me because I'd come from a hospital before I went to the unit (right), I'd been in hospital for 2 weeks/3 weeks something like that, I'd been living in an actual hospital ward (right) and when they told me I was going to the unit and they tried to explain it was like "oh no!" and I knew I could be there for an indefinite amount of time, I was like "nup" I made my mind up that I hated it before I went, but that's fairly normal (mm) I don't feel bad about it now when I look back (mm) and I didn't have to jump in there and like it straight away, it was quite normal to [feel like I did], I didn't know anyone and I had no choice in the matter. I don't think it took me long to fit in, to feel like I fitted in but the thing about it being part of a hospital was the part I really hated. (You said you'd been in a hospital before you went to the unit and so there were nurses there who) They were totally different and my expectations were different. (How were the nurses different in the general hospital?) They weren't trained in that way, to look after me in the way the [unit nurses did] they didn't specialise (oh yes) but I being only young expected it [the unit] to be like it was when I was in a hospital ward, you know, I wasn't in with nurses [who could help me], I was in a children's ward (I see) but I wasn't with [specialised nurses], I was with just normal everyday nurses like work in hospitals. (How were they different?) Well they didn't know how to handle me, they just went about their job and it wasn't a happy experience for me, they weren't mean or anything but it just wasn't a happy experience and I expected when I went to the unit, being part of a hospital and having nurses looking after me, I thought it would be the same, (uhu) so I went into it thinking "it's going to be bad" (mm) and it wasn't like that. I was surprised to see they wore normal clothing and we could call them by their names. (And did fun things with you). Yeah joined in doing lots of things. {pause} (Can you think of a really positive experience that stayed in your mind?) I went to dinner at Beth's house, I remember it being like a really normal experience and I wasn't used to it, you know, she took a lot of [interest in me] (mmhh) and I went to the house for dinner and I was involved with a lot of the things she did. I remember going there and it was excellent, like she was a worker but she took me to her house and cooked me dinner and I hung out with her kids and it was just [great]. I remember Simon being on on weekends and letting us get really cool videos, we'd just sit there and watch videos. {long pause} But there were heaps of good experiences, like every now and then when I talk with Nathan we laugh about things that we'd done. I remember, I'd been with Roland, Roland and I had stolen the keys to the unit car and we were driving around, like we

were really stupid, we were reversing the car and driving it really fast and slamming on the brakes and being idiots and Angelica came out screaming cause it was quiet time, that's right, it was quiet time and we snuck out and we'd stolen the keys and we didn't drive far out of the grounds but Angelica came out and she's like "what are you doing?" and started screaming at us and [she said] "you know you're done it this time Elizabeth, you're in big trouble now." I'd done something really stupid, I'd stolen the keys to the car and Angelica started screaming when she saw us like freaking out because she probably thought we were going to smash the car and kill ourselves. {laughs} See, when we used to take off it wasn't because we hated being there it was just something funny to do, that's why we did it, not because we hated the staff that were on and we wanted to seriously run away cause if we wanted to seriously run away we could have done it but it was like "lets get the staff to chase us we're bored." We must have had quite a lot of freedom to get a chance to do the bolt, I'm sure there were some of them they must have been hawk eyes like every movement [was] "where are you going?" Angelica was like that, she never really was out of sight for a moment, that's why she came looking for us and found us (yeah) but some of them [the kids] were very trustworthy and wouldn't take advantage of it (uhu). That's why it made it hard when we had to write why we're sorry and why we think we should be there, when the reasons for doing it weren't because we were upset or angry (mm) it was because we were bored. I'm sure there were times when I was upset and that's why I took off but I remember quite a few times just doing it because we could, for the fun of it, giving them a hard time and making them work hard. (It sounds like they knew how to handle it). Yeah, I remember being in trouble so often but I also remember getting so many good things. I can remember them letting Nathan and I go jogging (mmhh), I'm sure they weren't there, like they'd let us go off by ourselves, we used to do it in the morning, get up and go for a jog. (It felt good to be trusted). Yeah, we'd just get out there on our own and go running around, {pause} (mm) we had some good experiences. (Did you have any experiences that weren't so good?) I remember I had a weird situation with one of the boys Kieran (yeah). He was in the room next to me and he came in and said something, he came in and told me that he loved me or something, and Kieran was quite a weird one and he was a very morbid person and I just went "oh yeah, I love you too Kieran" and he started screaming at me going "you're lieing you don't" and just went berserk and tore all the pictures of his wall (mm) and did all these things and I remember the staff coming in [saying] "what did you do to him Elizabeth, what have you done?" and it's like "I haven't done anything." (yeah) I didn't know that I shouldn't have said "I love you" I should have said this or that or "I love you back" or whatever, I remember like it was my fault and I know now and I knew back then that it wasn't my fault. I thought what I said was the right thing but I'd made him lose the plot (mm) and he was outside my window banging and he took off all night and they were worried about him. I just felt like they [blamed me] I was in trouble, you know, may be I wasn't in trouble may be they were just really worried about Kieran and trying to work out the reason

why he was like that or whatever (mm) but I remember being really upset. {interruption} (Did you feel you were blamed?) Yeah, I don't remember the whole situation but I remember that I felt bad, not that I was made to feel bad, but I did feel pretty bad like I was to blame for it all. **How do you think the nurses should have handled this?** I had a few situations like with Kieran like they were really big things like locking ourselves in the room with the stereo and the bean bags (yes), locking ourselves in there and staff couldn't get in (mm). There was about five of us and we put all the bean bags up against the door and sat on them. I think Simon was on that night cause I can remember him knocking on the door going "come on guys let us [in], come out don't do this." (He always said it in a very casual sort of way). Yeah, he was always really cool, I don't know some of them could yell at you or raise their voice but he was "oh come on guys." {interruption} (Maybe I can ask you if you can speak in a general sense about what you think is important for nurses working with young people, how they should be or what they should know or just generally). That's hard {long pause}, well they should be understanding, like it's hard to explain, the kind of people they'd have to be, you'd have to be a pretty versatile person (Like flexible?) flexible yeah, very flexible because like everyone's different but, you know, like handling adolescents that are, you know, like with me, I was a quite depressed adolescent and just knowing that. Like when they got abused, I know they got abused a lot of the time, they've got to learn not to take it personally (mmhh) but I know it's really hard, you know, people say things they don't mean but it would be hard to be in a job where that might happen to you often, like don't take things personally and don't let it get you down, you have to have a good self esteem I guess (uhu). Being able to relate to people because, you know, it took me quite a while to understand that the nurses had a life outside, that just never occurred to me that they had lives. You have to share some of yourself with kids because I know for a fact that I always wanted to relate, not that I wanted to hear that they were messed up or as sad as I was just to hear that they had been sad or that a similar situation had happened to them (mm) I think that's really important. I don't think they should lie or just make up stories to always relate, just show that they're human (yeah) as well, and it's normal for everyone to have difficult periods in life but it doesn't make you any less of a person (mm). I think being flexible that's really important. {interruption} (You mentioned relating skills and not taking things personally and being flexible, I think that's where we turned the cassette off). Being flexible and I'm just trying to, {pause} I can't think of anything. (Okay, we'll leave it at that).

Often throughout the interview you said the nurses had 'a really good approach' to testing, abusive or challenging behaviour. **Can you explain in more detail what this approach was like?**

The Transcript of Elizabeth's Second Interview

(What we'll do is go through the questions page by page, on the first page you were talking about what you learnt when you were on the unit and you said "I learned heaps being there" and I was wondering

if you could give me some examples of the sorts of things you learnt). Well I learned how to get along with other people, to live with other people my own age and to be responsible for myself like [be] self sufficient, things like taking time out and different approaches to things, like with anger, a different approach to dealing with feelings and getting along [with people], getting social skills (oh yeah). I always thought I was a pretty sociable person but when you're living with lots of people your own age [well] I had to learn a few other things. (Right, so when you say you learned to live with people you mean cooperatively, considering other people and things like that?) Yeah, and when they were feeling bad how to handle that, like leave them alone or talk to them, things like that (uhu). Different people were different, after living with them so closely you learned patterns about them, they learned patterns with me but it was different living with all those people my age. (Sounds like it taught you to be observant and sensitive). Mm, because I'd always lived with younger children or with my brothers and sisters, and there it was completely different, it was actually better, I really enjoyed living with all those people my own age, we had lots of fun, we had fights as well but it always worked out. (Learning about relationships). And timetables as well! {laughs} About going to bed at the right times and having a bit of consistency in life (a routine), I didn't like that at first, I don't think I ever really liked it, like that's one thing you appreciate after you leave, like set times to go to bed and dinner being at the same time, you have to work things out, like this is when you can play and this is when you can go do craft and this is when you can go do this and that and it took a lot of getting used to but it was good. {interruption} (You were talking about routine and in the first interview you said routine became like a habit and a predictable environment and that was really good having a predictable environment). It makes you feel a lot safer, like you know what to expect and you know when everything's going to happen and it was just different to what my life was like before that [where] I didn't know when anything was happening. It was hard to adjust to at first but it was very safe to know what's going on, when things are going to happen and who's going to be there. You always knew which staff would be on, about group meetings, you knew all that and it was good. (You mean in your previous life there hadn't been that predictability in the environment?) Not at all, no structure, no knowing what was going to happen, who was going to be there, when things were happening but there [on the unit] I knew who would be there, where I could find them, what was going on, what my plans were for the next day and what was expected of me. (Yes, so do you think that made you feel less anxious, when you talk about safety is that what you?) That's what I mean, I think you feel unsafe when you don't know what's happening, when you don't know where you stand, what's happening [next], what to expect but there I always knew what to expect, I knew that I'd always have dinner, I knew I'd always be going to bed at this time whether I liked it or not but I knew, I knew who was going to be there, where to find people. Also, I knew I could have some fun at certain times and I had a choice, it was just things like that, it was just good, the whole thing had a good structure. It's sort of a discipline as well

because I didn't have any of that either, like even back then being 14 I did know discipline was a good thing, like self discipline, like the rest time and going to school, things like that. [At home] I never had any structure or discipline, I'd just do whatever my mum told me to do, stay home, go to school, I never knew what was happening in the next hour. There, [on the unit], I knew every second week what we'd be eating {both laugh}, I knew we'd always get the same flavoured ice cream and that was fine. (Sounds like it was consistent). Yeah, I don't like it being real rigid but it was fairly flexible, I kind of got used to those routines. (Mm, so from what you're saying it's important to have the routines and the consistency but it's also important to have a bit of flexibility). Oh for sure, you don't want to seem like you're in gaol or something or really rigid, it was pretty flexible, like we had to do our laundry every day but it's not like "you have to do it at 8 o'clock" it's like "you have to do the laundry today but when it fits in with you." (mm) I like things like that because if you don't have routine like that you don't know where you're going or what's happening. {pause} (Okay, the next question is on page two, we've actually answered question three about the predictable environment so we'll go from two to four. You were talking about the nurses and your relationships and you said you were never short of attention, you said there was always someone there to give you attention and I was wondering why that was important). Because it makes you feel important like you're not going to be forgotten, like there was always someone who came on shift and they were there for you and they'd chase you around to know how you felt, you know, having you're little talks together, it was good, you felt kind of important because they were there to find out how you feel and they were interested. I know it was their job and they were paid to do it but I don't think it's a job you'd do if you didn't enjoy it, it's not the type of job you'd do to pass the time and make some money, you've got to be in to it to do it and they certainly were. I used to look forward to it, having certain workers chase me around and wanting to know how I feel and time out and taking me for an ice cream or something and just [being] interested in how I was going, it was a big deal to them like finding out what I was up to, what I felt, what I wanted. (That made you feel important, like you were worth being interested in). Yeah! oh for sure, taking a big interest in you, not just forgotten about. I always felt like I was forgotten about in my life so when I was there it used to bug me a bit, at first they wanted to talk to you all the time and in the end you got to really like it, you still might play little games where you made them chase you to find out but I always wanted to talk. I'm just trying to think of certain nurses and how it was different with some of the nurses, you know, to other nurses (mm). The one thing I did like was when I realised they had lives and they'd tell you about their lives and when they felt bad and I really liked that, they were very human, acted human, as though they were human but like they had problems too (mm). I remember lots of them telling me things that weren't so great for them, especially when you're feeling really sorry for yourself (yes), they'd say "well everyone has bad things happen to them and things that they don't like" and they'd tell you some, it was good. (It sounds like the sharing that took place

between the nurse and you made it a more equal relationship). Mm, sure like yeah, it didn't make you feel like you had a problem and no one else feels that way it's like, "well a lot of people feel that way" even they had felt that way and they'd come to work and they'd be a little bit depressed but they didn't take it out on us but they showed that they were very human and they felt things too (mm), that was good, I liked hearing about their experiences. (How do you think that helped you, the fact that they were prepared to share things with you and talk about their own experiences as adolescents or problems in their lives, how do you think that was able to help you?) It just makes you feel a bit normal because if someone else feels the way you feel or has felt the way you feel then I feel it mustn't be really abnormal, you know, if someone else relates to you [and your experience] (mm). I always feel good if someone else has related to an experience or a feeling [I've had], I don't feel so bad, like I'm not the only one. (Not the only one, yeah). No, it's good and it's also good as in role models, you know, like I can't remember which ones but I remember being told by [one of the nurses] that they were a real brat when they were young and look where they are now, and some were running away from homes and having bad family problems and they're still where they are today. Your life doesn't stop because you have problems like that, you can keep growing (mm) and use it to your advantage to help someone else out from your experiences. Well that's what a good experience is, you learn something from it (mmhh). {interruption} (One thing that came to mind when you were saying the nurses had had problems in their life when they were younger and you said, "well look at where they are now", so do you think that when nurses share that sort of experience it gives you hope that you can overcome your problems?) Yeah for sure, well when you know someone else has been through the same and they've succeeded in changing that or getting somewhere it's not an excuse to stay the way you are, you can still get on with life no matter how bad your problems are (yeah), you know, other people can do it. (Do you think it's important for nurse to help young people to see their future and to plan for their future?) Well give them some hope, everyone needs a little bit of hope, of course, you don't have really negative people working as nurses because it's not going to happen if they're always negative but give them [the kids] some hope, you don't want them to reinvent their lives and say they came from a perfect family, we never had problems or this and that but you also don't want them to lie. You want to hear it's normal for everyone to have problems and you're not an outcast or a bad person or whatever and [that] it happens to everyone, you know, everyone goes through sad things and sad parts of their life, young or old, and I think people should be told that more. (Mm, more honesty). More honesty because when you're in that situation you feel like it's a no win situation, it feels like it's never going to end, it's never going to change. (You were talking about the need for honesty when nurses were talking about their lives, do you think the unit encouraged kids and staff to share things honestly?) Well the policies must have been pretty good because we were allowed to go to the staff members houses, I went to quite a few of their houses and met their kids and they were from all

different walks of life, and it was good. A lot of the things they'd told me obviously they were true, you got to see for yourself, and a lot of them had young children and they might not have gotten a lot of sleep and they're come in the next day and we've given them hell and and they've got to go back to those kids. I don't know if I really did think they had no life apart from working [there], they did have a life apart from us, it's like you know that's true but it's good to see it for yourself. (mm) {pause} (Anything more you'd like to say about that?) {Shakes head, no} (Okay, the next question you were talking about your relationships with the nurses and they were more like a friend than a nurse, could tell me how they were your friend and why that was important). Well it wasn't just based around [problems], when they were there they weren't always focused on problems, they were focused on having a good time as well (mmhh) and getting through the day. We'd have fun, we'd go for bike rides and different staff members had different hobbies, Angelica would do crafts and she was really good at that, that was something she did out of [work] that she did at home (mm) and so when she was there we would go and do craft and it wasn't like we're going in for a therapy session or we're going in there to have a big talk, we're just going in there to have some fun (yeah), and if you want to talk you talk otherwise you talk about the weather or whatever. Other ones liked bike riding or going for a swim, or going for a jog. (So it was a bit like a friendship because you did things together) Yeah, especially with your buddies, I don't know what you called them, you had your set people who used to look after you and do your reports (oh yes), you'd have time out with them and you'd go find something to do, it wasn't like you sit behind a desk and they'd ask you questions, you have conversations, they don't say "are you happy?" and you say "yes", it wasn't like that. {interruption} (Would you describe the relationship you developed with those nurses as a close relationship, was there closeness in it?) Some more than others, certain ones you grow really attached to, well your sharing things, you've got to work at getting that closeness by telling them certain things and them respecting you by either not telling anyone else or whatever, like building up a trust, but with certain ones you could talk about certain things, you know, I was lucky because there were certain ones I could talk about anything with. {interruption} (In the first interview you were talking about the way the unit was set up and how it was homely, you said it was a homelike atmosphere which was good, and I was wondering what you thought was good about the fact that the unit was set up to be homely). Well, there was single rooms which were all the same, no one had better quality than anyone else, in the single rooms we all had set things but we could do them up the way we wanted, you could have posters and all that and you could have a single room or there was a room where there were about 5 beds in it. For a while there I didn't want my own room I wanted to share it, like we'd all share together for a while, but I went back to having my own room and it was really good. You had your own bedroom, it was your own space, you could go in there and slam your door and, you know, like [it was] 'keep out' kind of thing, it was your own private space. There were rules like you couldn't be in the boys room with the door closed, which

was fair enough, not just because you would do things but if anything does happen they were protecting themselves (mm). We had a video room and a little kitchen that we cooked pop corn in and made drinks and we had bathrooms and showers which were cool, they weren't like institutional style where they didn't have doors but they had locks and that and we had a bath. (So it was important that you were able to have your own space and privacy). Mm, and that part was separate to everything else it wasn't like you had everyone trampling through there, it was ours, the inpatients, it was your own space and we painted pictures and we put pictures on the wall (yeah). We had fun, we had the telephone in there, it was good, we had bean bags everywhere. Simon used to be in charge of getting us videos (yes) because he used to work a lot on weekends. (Do you think that homely environment made it feel more comfortable?) Yeah, but it was also very safe because I remember, was it every hour they'd shine the torch in the rooms to check we were there, (You mean in the night?) in the night and they had that little station thing in the middle [of the sleeping area] where the staff would sit (yeah), which was good because you knew they were always not far away. But we used to get past them, you know, there was a bit of fun that used to go on running around. (But it made you feel safe having someone there all the time). The doors were closed at night so no one could get in, like sneak in and [harm you], because that was a big deal, we had a few close encounters with people, you know, it was pretty sad people's parents coming and harassing them but they couldn't get in, but it wasn't like a gaol. (You felt it was something to keep you safe rather than to keep you in). Yeah to keep you safe, sometimes you felt "oh it's to keep us in" but it was more so [to keep you safe], you knew it was to keep you safe (mm) and it was a good thing that it was that way sometimes, like it was as good as it could be. I was happy, you had a good sized room, like [in] my room I had a bean bag in there and people could come into my room. I don't remember always having people say "pick everything up", like I know your room had to be clean but I don't remember to what extent, I don't think we were hassled on a daily basis to hurry up and clean your room and have it like this and have it like that (right), you were pretty free to have it the way you wanted to (uhu). {interruption} (The next question was when you were talking about one of the male nurses and you said he acted like us and I was wondering why you thought it was a good thing for nurses to do the kinds of things that adolescents did?) It builds trust with them as well, like a friendship because it's all about relating, it just shows that life is fun and even when you're older things aren't always that serious and just the way you're treated it takes your mind off things, like if they're participating in and doing the same things it's just good, it just makes you feel normal. (When you say it takes your mind off things you mean like your worries and stuff like that?) Yeah, it takes the focus off things, like there's fun to be had and everyone can have it and not everything is so serious all the time (uhu), everyone's got time to have fun and muck around (It sort of lightens the atmosphere or?) Like when you're that young and in that situation you have a lot more respect for someone if they're on your level and do the same things as you, like you don't want to feel

inferior or have people being superior to you, if they have fun, like get into pillow fights or stuff like that (mm) it's all fun, they're on your level, it's good, you know, you don't want to tell your fears and secrets to someone who's all prim and proper and won't do anything that you'll do, like won't have fun or won't break free or anything like that. (You think it helps to create that equality). It creates a good atmosphere as well and yeah being equal, being more equal, you don't feel very equal when you're there, well like you're different, kids your age are doing different things like living at home with their parents. {interruption} (At this point you were talking about Edward and you said he always put himself out and I was wondering why you thought that was a nice quality to have in a nurse?) Well it was really good because it's not something I would have done {laughs} but the incident was where he piggy backed me a long way, it must have been quite uncomfortable and it wasn't really necessary, I hadn't hurt any bones but he just piggy backed me and he nearly hurt himself, he nearly fell down a hole, but he still carried me and that's pretty [nice], you know, he was thinking about me, like it was a good time for me. It wouldn't have been much fun for him, it was hard enough walking through the bush without an extra few kilos on your back (mm) and I thought that was [really nice], like it's not something that's written in the rules, you have to piggy back kids when they demand it {laughing}, so I though it was pretty cool. But I knew I could get away with that with him, it's not like I could ask Angelica or Simon {laughs}, for different reasons, but it was cool. (It's like putting you first?) I remember he was like full on worried that I was okay and that I continue. (Anything more you'd like to say about that?) Not that I can think of. (All right, the next question you were talking about different nurses and boundaries and you were saying you knew how far you could push nurses and some of the nurses you wouldn't bother to do that with, I was wondering how the nurses reacted who you knew you couldn't push, what stopped you from doing that?) I think it's just little games you do all along, you do certain things and you see how they react (yes) and certain nurses just wouldn't take it, the outcome wouldn't be what you'd want to put up with so you don't push that person, but with others they had different boundaries and you could push them just that bit further and they were may be a bit more lighthearted or a bit thicker skinned (mm). Like some of them were quite sensitive and you wouldn't want to be too mean whereas others you could be mean and it wouldn't hurt them, they wouldn't take it personally but others, you know, would take things personally because they had feelings just like [us]. You could just work it out but like I know sometimes you would say things that would really hurt them but others you could say that thing to them and it wouldn't bother them. {interruption} (Well, the next question you were talking about leaving and how difficult it was for you and you felt they were kicking you out and felt rejected and I was wondering if there was anything that could have been done at that time to make it easier for you). Well it could have been a more gradual process, like it wasn't just, like one day you're out of here, see you later pack your bags and go but I felt that it was done too quickly. When you grow rather attached to something you just can't

[let go quickly] I think it all happened in a matter of a few days, you know, may be the planning went on for a while like they were all planning but I just wasn't let in on the idea, I was told when it was all finalised. I don't remember being told "this is what's going to happen", like I remember talking about what I wanted and what the best thing for me was. I know at the time I didn't cooperate very well but I just remember being told "you're going to foster parents" and this is their aim and this is how it is. I just wasn't happy about that (mm), also it made it hard because I didn't want to go and it was something new and I was used to being there and now I was going somewhere else where I had to get used to someone else, but also you know things are going to change, you know you're not going to stay there forever, you know it's inevitable that things are going to change but when the time comes it's quite a rude shock. But, I think I should have been told and may be visited them more, like I was told about them went for dinner and then moved in with them. (Mm, strangers). Like that's not how it goes and of course it's a whole new situation, it's not the same situation I've lived in for the last 9 months, I don't think I was very well prepared, like you don't get to set boundaries and learn things over dinner, you learn them by trial and error and there was more error {laughs} than anything else, so much went wrong, I don't think I was ready for it. (Were you still able to keep in touch with the nurses you had strong relationships with?) Yep, I remember I went to dinner at Beth's once and she took me out for dinner with one of the other kids and her husband and kids, and I'd go back there [to the unit] every now and then. (So you were able to withdraw from the relationships over a period of time). Well I carried on seeing the therapist until 5 years later. My original therapist, Marcia, I remember her telling me she was going away and I wasn't happy about that but that was being a bit selfish and I was [upset], I wasn't very nice about it. But it was all right, I'd go back there [to the unit] and see people but one of the most important things was I kept in touch with a lot of the kids which was good because I just carried on with them, hung out with them. (You were able to continue your association with the unit in that way). Yeah, and we'd all come back and visit Sally in the kitchen, she was popular, she was extremely popular (Why do you think she was popular?) Because she used to always give us ice creams and let us raid the pantry (It was just food you reckon?) Oh no, she was really cool as well, like you could really talk to her but if we wanted ice creams she was like "yep, you can have ice creams here it is" and if you want to go in the [pantry] and have a look what's in there, and she would get you extra things and she was really good to talk to. And, you know, she wasn't an old witch, like in most places the kitchen hands are [awful], it's run with an iron fist it's like "get out of my kitchen I'm washing the floor", if she was washing the floor you could sit on the fridge and talk to her or, you know, nothing was too much of a problem for her, if you were hungry she was there to get you something to eat, she wasn't rigid with her schedule. {pause} (A lot through our first interview you were talking about nurses having a really good approach to the kinds of problems adolescents have and I was wondering if you could tell me a little more about what that approach was like or why you

thought it was a good approach or anything about it). Oh well in certain situations, like when we'd absconded Antoinette and Beth drove around looking for us and when we were found it wasn't like, I know they weren't allowed to hit you, like slap you, but it was like she was asking us why we did it, she told us they were worried about us and they were freaking out that something had happened to us and why were we doing it. They didn't just yell at us "look what you've done, all night we've been looking for you" they wanted to find out why we had run away. (Like what was worrying you?) What was worrying us. The only thing is, if I remember [right], it wasn't anything worrying us, we were just being little shits. There were times when we did run away when we were unhappy but a lot of the time we did it because we could do it and they'd say "what was wrong?", trying to get to the bottom of it but they didn't threaten us or say "you're grounded" it was left [and dealt with in the group]. We always knew, come the morning, you would hear about it in the meeting and it was up on the board, it was quite funny at times. You just weren't freaked out, they just had a really good way of dealing with it, it wasn't like they'd find you and say "you're grounded, get to your room and all privileges taken away", it was like "we'll find out why they ran away" and if there was a good reason it was worked out, you weren't always grounded, but if you did it because you were just doing it to be an idiot or waste time or whatever then, you know, they dealt with it but you were never made to feel like you were bad. (You're saying they didn't over react). You could see their concern was for real, like I still remember them driving around at night [saying] like "where were you all, we were so worried" and like staying back, they stayed back and still drove around in the cars looking for us in all the places they thought we'd be, you know, like that was a time when there wasn't any reason just because we felt like it. (So their approach was also one of concern, always one of concern) Yeah concern, plus it wasn't like deal out the punishment and then ask, it was heaps concerned about what was going on. {pause} They also had families to get back to and other things to do but they stayed back if things were happening [and] if we couldn't be found it wasn't like "oh well it's 6 o'clock in the morning my shift ended at 6 it's your problem now" (mm), with big things like that they stayed back and it was good, a lot of good staff there, they put up with us for a long time. {pause} (Anything else about that, anything else you'd like to say at all because we've actually come to the end of the questions). Nothing that I can think of at the moment. (Okay, thanks).

Appendix D: The Nurse's Information Package

Rene Geanellos
Lot A Fine Road
SILTOWN 7690 NSW
3rd December 1995

Dear _____

Thank you for agreeing to consider participation in this study concerning Adolescent Mental Health Nursing. Included with this letter is the information I prepared for research participants. The information relates to the **six steps** outlined on page one of the Information Letter/Consent Form and includes:

- The Information Letter/Consent Form: provides an overview of the research, outlines your involvement in that research and includes a consent form for you to sign if you agree to participate in the study.
- The Demographic Data Questionnaire: relates to step 1.
- The Interview Information Sheet: relates to steps 2 and 5.
- The Information on the Written Story and the Feedback: relates to steps 3 and 6.
- The Skills, Attributes and Knowledge Survey: relates to step 4.

I hope the information gives you an understanding of what you will be asked to do. I realise there is a lot to read but it is important for you to understand what we will be doing so that you can give informed consent. The information should also provide some understanding of the different aspects of the research.

I will be in touch, in several weeks, to discuss your involvement in the research and any concerns you may have about it. I would also welcome any feedback you care to offer. If you want to speak with me beforehand you can phone me at home on (067) 5980-657 and **thank you** for giving this research your consideration.

With Kind Regards

ALL THE INFORMATION CONTAINED IN THIS PACKAGE HAS BEEN PREPARED FOR POTENTIAL RESEARCH PARTICIPANTS WHO ARE IDENTIFIED AS REGISTERED NURSES WITHIN THE STUDY

INFORMATION LETTER AND CONSENT FORM FOR POTENTIAL RESEARCH PARTICIPANTS (Registered Nurses)

PROJECT TITLE: Storytelling: exploring knowledge and practice issues related to nursing on residential adolescent mental health units

NAME OF RESEARCHER: Rene Geanellos

NAME OF PARTICIPANT: _____

I am conducting research as a part of my studies at the Australian Catholic University. The research is inquiring into nursing on residential adolescent mental health units and has been approved by the Research Ethics Committee. During the research I will be talking with nurses who have this type of nursing experience and with young people who, as adolescents, were nursed in this type of setting. If you agree to be involved in the study you will be asked to complete the following six steps:

(1) **demographic data questionnaire** for example, name, age, qualifications;
(2) **in depth interview**, talking about nursing adolescents;
(3) **written story** of an experience nursing an adolescent;
(4) **skills, attributes/knowledge survey**;
(5) **possible second interview** of approximately 1/2 an hour;
(6) **feedback** about my interpretations of the stories you give me.

These Six Research Steps Are Explained In More Detail Below:
Step (1) This form will take 15 minutes to complete at the first interview.
Steps (2), (3) & (4) The first interview may take one to two hours and we will discuss your experiences of nursing on an adolescent unit. This will be done in an informal way as if we were talking together. I will audiotape the interview to ensure I recall your stories correctly. The written story and the knowledge/skills survey will also require about one hour of your time. We will discuss these two steps at the interview. You will have several weeks to complete this work before I contact you to arrange its collection.
Step (5) A second interview may be required if I need to talk more with you.
Step (6) Your feedback will give me the opportunity to understand and tell your stories as accurately as possible.

* These steps could require 4 to 5 hours of your time over several months *

Although you will choose the experiences we talk about you may have strong feelings about those events. If you feel upset you can stop the interview. This is your right. We will not go on unless you want to and if you feel you would like to talk with someone about how you are feeling, I will have a list of names and telephone numbers of people you can contact.

The information you give me will be looked at by myself and my supervisors. **However, I will be the only person who knows your identity and which work is yours.** When all the work is finished I will write the research into a thesis for my degree. It will also be written into articles for

publication in journals and papers for presentation at conferences. Even so, your identity will only be known to me and I am bound by strict rules of confidentiality. **In order to preserve your identity you will choose a false name as a code**. Also, all the research information will be stored in a locked filing cabinet.

You may not obtain any personal benefit from this research, however, your involvement may help in the discovery of knowledge that could inform mental health nursing practice. It is important for you to realise you have control over your involvement in the study. Therefore, you are free to withdraw from the research at any time without giving a reason.

Any questions regarding the project titled: Storytelling: exploring knowledge and practice issues related to nursing on residential adolescent mental health units

Can be directed to the Chief Researcher: Rene Geanellos

At her home on telephone number: (067) 5980-657

If there are questions I have been unable to answer to your satisfaction, or if you take part in the study then have some complaint about the way you were treated, please write to the Research Ethics Committee who will investigate your complaint and write to you with the results of their investigation. You can contact the committee at the following address and telephone number:

The Chair, Research Ethics Committee
Australian Catholic University
NSW Division 179 Albert Road
STRATHFIELD NSW 2135
Telephone: (02) 739-2100

CONSENT FORM (Participants Copy)

You are asked to sign a consent form in which you agree to participate in the activities outlined in this letter. Please read the consent form carefully and if you agree to participate in this study, sign the form in the space provided.

I, the participant, have read and understood the information in this letter and any questions I have asked have been answered to my satisfaction.

I agree to participate in this activity realising that I can withdraw at any time without reason.

I agree that research data provided by me and collected for this study, may be published or provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT _____

SIGNATURE _____ DATE _____

NAME OF RESEARCHER _____

SIGNATURE _____ DATE _____

TITLE OF STUDY Storytelling: exploring knowledge and practice issues related to nursing on residential adolescent mental health units.

CONSENT FORM (Researchers Copy)

You are asked to sign a consent form in which you agree to take part in the activities outlined in this letter. Please read the consent form carefully and if you agree to take part in this study, sign the form in the space provided.

I, the participant, have read and understood the information in this letter and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity realising that I can withdraw at any time without reason.

I agree that research data provided by me and collected for this study, may be published or provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT _____

SIGNATURE _____ DATE _____

NAME OF RESEARCHER _____

SIGNATURE _____ DATE _____

TITLE OF STUDY Storytelling: exploring knowledge and practice issues related to nursing on residential adolescent mental health unit.

DEMOGRAPHIC DATA QUESTIONNAIRE

Please complete this form and give it to me before we begin the interview. I will check it with you at that time. If you have any questions about the form, or the information being collected, please ask me about it.

(1) NAME _____

(2) ADDRESS _____

(2) DATE OF BIRTH _____ (3) GENDER M ___ F ___

(4) QUALIFICATIONS (please write in full) _____

_____

_____

(5) TRAINING COURSES (please write in full) _____

_____

_____

(6) YEARS OF NURSING EXPERIENCE:
(a) In Total: Full Time _____ Part Time _____

(b) In Mental Health Nursing: Full Time _____ Part Time _____

(7) YEARS OF NURSING EXPERIENCE WITH ADOLESCENTS IN MENTAL HEALTH SETTINGS:
(a) On A Residential Unit: Full Time _____ Part Time _____

(b) In Other Settings (e.g. Community) Full Time _____ Part Time _____

(8) COUNTRY OF BIRTH _____

(9) ETHNIC BACKGROUND _____

Thank you for completing this questionnaire, I appreciate your assistance.

INTERVIEW INFORMATION SHEET

I am looking forward very much to hearing your stories. At the interview I will ask you to tell me stories regarding your experiences with adolescents on an adolescent mental health unit. As we go along, I will ask questions so that I can obtain as much information as possible. This will also help me to understand your stories. So that you have some idea what we will talk about I have included a few examples of statements I may use during the interview. Our conversation will only relate to your experiences on residential adolescent mental health units and I will only ask about interactions and interventions between yourself and adolescents. For example, during the interview I might say:

> "We often remember experiences that stand out in someway. I'd like to hear about an experience you remember as outstanding."
>
> "I'm interested in hearing about an experience that you think was important in helping you learn how to work with adolescents."
>
> "I'd like to hear about an experience that you think reflects some essential aspect of working with adolescents."
>
> "Tell me about an experience where you think your involvement made a real difference to what happened."

Even though the interview will be fairly long there may be issues I don't discuss with you because, at the time, I didn't realise they were important. Unfortunately, I won't know what I've missed until I listen to the audiotape. If I do miss something important I will ask for a second interview. The second interview will give me a chance to explore the issues I missed in the first one.

Although the interview will be recorded, the tape recorder will be in a position that allows you to turn it off. I think it is important for you to have control of the interview. I would like you to think of the interview as something we are doing together rather than something I am asking you to do. I hope this information is helpful. If there is anything you would like to discuss with me please phone me at home on (067) 5980-657. My Thanks, Rene.

INFORMATION ON THE WRITTEN STORY AND FEEDBACK

(1) The Written Story

Please write a story of an experience you had nursing on a residential adolescent mental health unit. The experience you choose to relate is entirely up to you. Generally, we tend to remember events that went well for ourselves and the clients, or we remember events that did not go as we expected or wished but from which we learnt a great deal about ourselves or nursing clients in that type of setting. Write down everything you remember about the experience; what happened, what was said or done and how you felt about it. Say what was important about the experience and why you remember it. Don't worry about how long or short the story is, just write about what happened in as much detail as you can.

Your story is important because from stories like yours we will learn about what nurses working with adolescents do and what is important for adolescents when they are being nursed. If you have difficulty deciding what to write about, the statements from the interview information sheet may give you some ideas.

(2) Feedback

By telling your stories you are making an important contribution to our understanding about nursing adolescents. My job will be to look at the spoken and written stories and interpret them. When I do this I will look for common points in the stories. When I have completed the interpretations I will give you a copy so you can provide me with feedback about them. Reading my interpretations will give you the chance to discuss differences between your understanding of the stories and mine. This should also allow me to represent the information I receive from you as accurately as possible. At times we may need to negotiate meaning but this is to be expected. Following your feedback I will go back to the stories and try to improve my understanding of them before writing the thesis. At this point you will have completed everything you agreed to do as a research participant, however, should you wish to remain interested in the study I would welcome your interest very much.

SKILLS, ATTRIBUTES AND KNOWLEDGE SURVEY

Please list 15 skills, attributes or knowledge that you think are essential for nurses working on residential adolescent mental health units. This may include such things as maintaining sexual neutrality. The items will not be ranked so write them in any order.

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

(7) _____

(8) _____

(9) _____

(10) _____

(11) _____

(12) _____

(13) _____

(14) _____

(15) _____

Thank you again for all your help.

Appendix E: Storytelling Guidelines

GUIDELINES FOR TALKING AND WRITING ABOUT STORIES

Because of questions asked by some research participants I have produced more specific guidelines on storytelling. I did this to aid understanding about the type of information being sought in the study. I hope they prove useful and thank you to the people whose questions helped me to understand the problems they were having.

If you have already written your story you may wish to reconsider it in the light of these guidelines. If you are happy with what you have done that's fine too. I would be delighted to receive as many stories as you care to send as they are wonderful sources of information.

The research is progressing smoothly and I'm learning 'heaps.' Once again, thank you for your part in making this possible.

In thinking, writing or talking about the particular experience/s around which your story/stories centre, you may like to consider the following points:

* What was the context of the incident you are describing in your story? (where did it happen, what time of day or night, who was around).

* Provide as detailed a description of events as possible (what was said or done by you or others, how did it turn out in the end, what other things/changes occurred as a result of what happened).

* Why was this experience important to you?

* Why do you remember it? Why does it stand out amongst so many experiences?

* Has the experience influenced your present ideas, behaviour or understanding?

* What were your thoughts/feelings/concerns at the time of the incident?

* Was there something particularly demanding, special or unique about the experience-incident?

* What is your understanding of this event from your past? What does it mean to you now? What have you learnt from it?

Appendix F: Examples of Identifying the Sub-Elements of Practice Knowledge

Introduction

The information received from seven young people and seven nurses provided the text for interpretation. With regard to the thesis length, I am unable to present the sub-elements of practice knowledge identified from each participant's text. Thus, in order to provide an understanding of the process I engaged in to identify the sub-elements, I document the sub-elements from the adolescent Jane's and the nurse Merlin's information. Prior to documenting Jane's and Merlin's sub-elements, I use several stories to represent wholistically some of the experiences they spoke about.

It is not possible to document every example where a sub-element of practice knowledge occurs within a text therefore only one example of each sub-element is provided. Occasionally, when a range of examples of a sub-element occurs within a text, several examples are used to represent the breadth of that sub-element.

Jane Doe

> *"You always felt comfortable and safe with him knowing that he's a friend ... my friend, helping hand, he was always there to lean on if you needed."*

Jane was admitted to an adolescent mental health unit when she was an early adolescent. She spent five months on that unit. At the time of admission Jane was experiencing a psychotic episode. Her behaviour included withdrawal, paranoia, fear and hallucinations. Jane's psychosis was precipitated by the continual emotional abuse she experienced from a teacher. Her suspicion, withdrawal and fearfulness meant trusting relationships were difficult to form. At the completion of data collection Jane wrote*"[when I was on the unit] it was the first time I had trusted since my breakdown and also the first time I had been betrayed since my breakdown."* The two stories which follow exemplify Jane's comments and demonstrate the significance trust had for her at that time in her life.

Jane's Stories

With James, Jane found friendship, acceptance, equality and honesty. He gave her power and control and was not domineering.

Through the enactment of their relationship Jane learnt to trust.

> *I made friends eventually with the male nurse James. He came across as like one of us, just hung out with us and he was never judgmental or looked down on us, he was just like drifting along with us. So, you could talk to him about anything and he was always honest and straight to the point which was good because you knew where you stood with him and so you were in [no doubt], [I] never doubted, never had anything to doubt.*
>
> *With James not pushing, and giving me control, I could see he was a genuine person and [he] was there offering his friendship and not asking for anything in return. So there was no threat, and for once I could be a friend and have someone be a friend to me instead of feeling that there was always a price to be paid. You always felt comfortable and safe with him knowing that he's a friend ... my friend, [my] helping hand, he was always there to lean on if you needed but it was never like "I'm here to help you so tell me all your problems" ... he was never pushy, he would suggest things and leave it up to you.*
>
> *He's not very outspoken, if he had something to say he'd say it but he won't just talk for the hell of talking. But he was never quiet in a way that made you feel uncomfortable, there was a balance, and he wasn't the sort of bloke that was over masculine, you know, like you've got to be tough. [It's like] you don't have to put on a false front to try and feel better about yourself ... he was sort of very natural.*

The trust Jane found through her relationship with James, and other nurses, was tested by a single incident with Pat. Jane felt betrayed and experienced it as a breach of trust. She has not forgotten it.

> *Pat took us over there [the kitchenette] and was giving us a lecture on nutrition, but to get us there ... or to make us stay longer ... she said that we could go swimming in the pool that night ... and she would supervise us in the pool so that was the deal. After the lecture ... we went to the unit to get our costumes to go swimming and somebody mentioned to her about getting a towel and she said "what for?" and the comment was "we're going swimming you said we could" and she said "no, it's too late now you can't."*
>
> *So, it's sort of we're there because people betrayed us and here we have someone who we're supposed to trust*

who just bribed us with an out and out lie ... I was very annoyed with her. We said to her "you promised and that was the deal" and she said "no, no, it's too late now you can't" ... If she had spoken to us and said I'm sorry but I can't let you go swimming but we'll do it this time or make up another time for it" but she just denied it all and said "forget it."

She's there wanting to help young people and I think one of the main reasons we are there is because we have been betrayed, and she totally ignores that and then turns on us. You're supposed to be in a safe place and then you find one of the nurses is just like the world out there that you were done in by, you think, "is this all there is?" It was very disappointing ... you don't just drop your end of the deal and forget about it because we certainly don't forget.

The Sub-Elements of Practice Knowledge

In the section that follows, the sub-elements of practice knowledge are depicted using excerpts from Jane's information.

Admission during the school holidays proved difficult for Jane.

The stress of admission

Everyone was on holidays so I was there by myself for two weeks which wasn't very comforting. I went to therapy and was told I couldn't go home and had to stay so it was pretty traumatic. Suddenly I was in a place unfamiliar and no one there virtually which was pretty scary.

When the other adolescents returned from holidays it was different.

The peer group is supportive

There were a few that were fairly quiet and seemed on their own the same as I ... you tend to home in on them and make friends with them so you felt you weren't the odd one out or you didn't feel alone. There was someone there who you could talk to around your own age and who's been through something similar so you have that bond.

Unfortunately, Jane could not relate to the nurses allocated to work with her.

Mismatched adolescent and primary nurse relationships

I was allocated two nurses, Tania and Sylvia, I don't know whether it was because of being paranoid or not getting along with them [but] I preferred not to have anything to do with them. I made friends eventually

> *with the male nurse James. They were both feminine women and I felt uncomfortable with them ... all my life my closest friends were blokes so I got along with blokes more than I do with females, so it was uncomfortable for me to talk with them.*

Jane eventually developed a trusting relationship with James.

Developing trust

> *With being paranoid and fearful of people I [was wary] though I noticed that everyone got on well with James so I thought "well if anyone's to trust it would be him." So, I hung around with a few blokes who hung around with James and just observed what was happening ... It was a positive experience, it was good at that stage that you could trust.*

When James felt Jane was ready he tried to engage her in change.

Nurses try to create change

> *One day he turned around and he pointed out that it made it hard to include me in a conversation when I was walking behind him, he said it was like I was excluding myself and he didn't want that, he wanted me to be part of the group but it was up to me. He simply quoted, "do not walk in front of me I will not follow, do not walk behind me I will not lead, walk beside me and be my friend" and he left it at that. So, over the next few weeks I summed up the courage to start to walk beside him and became a part of the group and I eventually felt comfortable, like I belonged.*

Example two:

> *One of the nurses came in ... he just started a casual conversation, asked how I'd been going and how I was going with my schoolwork and how the family was ... then he asked me to describe my family. They were easy to describe but when it came to my mother I described what she did, [so] he asked me to describe what she was like ... I realised I didn't know my mother. He said "next week I'll ask what she's like." The following week when I caught up with him he asked "so, who is your mother?" and I said "you'd never believe it!" I'm still learning what she's like.*

For Jane, it was important that James offered inclusion but did not insist on participation.

Nurses provide and take opportunities

> *He never insisted that I had to participate or be a part of [anything] or had to walk beside him, I was never pushed, it was just [that] I was given the opportunity*

> *and it was up to me. He was always there to lean on if you needed but it was never like "I'm here to help you so tell me all your problems", it was never [like that] it was always up to you, he gave you the opportunity and left it up to you.*

This meant that control was 'placed in Jane's hands.'

Feeling in control

> *The control was placed in my hands. Most of us are there because someone has taken control and abused that and we're paying for it ... to feel that you have some control in your life is utmost important ... with James not pushing and giving me control I [could] see he was a genuine person. He would give you the feel that you've got the reins, that you're in control ... he encouraged you ... he guided you, he never drove you ... and he watched over you.*

James was interested in Jane and put her first.

Having attention

> *He would let you tell your story ... you could bounce ideas off him, he was never [dominating], you felt that you were the important one, that this was your life and you had to do something about it that was positive.*

There was also equality in their relationship.

Experiencing equality

> *He was more like one of us ... it was never a different set of rules for him than for us ... watching how James worked with the adolescents you saw that he never put himself above us ... He came across like one of us, just hung out with us and he was never judgmental or looked down on us, he was just like drifting along with us, so you could talk to him about anything.*

The acceptance Jane experienced with James made a difference.

Being accepted

> *With the bad experience that I had I was always made to feel that it was my fault ... the feeling I got out of that was that I had to try and be someone else or do something else to be accepted. But when I met James it just didn't matter, you'd be yourself and he accepted you as yourself ... you belonged ... you're accepted as yourself ... I think being accepted is the main thing.*

Jane's difficulties, at the time, were distressing and frightening but the nurses understood Jane's strategies for coping with her

distress.

Receiving understanding

> *What I was dealing with was very frightening and it had driven me to the edge, and hiding [in cupboards] was all I could do, I felt that was the only thing I could do to feel secure ... no matter how strange it must sound, it was the only positive thing I could do to deal with what was happening. They didn't say "what are you doing in there get out", it was never like that, it was just "oh, there you are, we're going to the kitchen to get some ice cream would you like to come?" It was never made a big issue of so you felt comfortable in there for the time you needed to be there.*

Nevertheless, while the nurses accepted Jane's need to feel secure by hiding, they 'never gave up' encouraging her to join them.

The nurses persevered

> *Even when I was hiding [in cupboards] the nurses would come and find me and ask if I'd want to join them, and in the beginning I always refused but they never gave up, and they always gave me the opportunity if I wanted to join them ... The fact that they didn't push me or drag me out of there meant I didn't feel threatened. It was very important, they always made me feel they wanted me to be part of the group but when I was ready not "you're going to be part of it now!"*

Eventually, Jane came to trust the nurses and feel safe.

Feeling safe and secure

> *When I started feeling safer with certain nurses ... with James and some of the others, I felt that I could spend time with them and still feel some safeness. As I felt more secure with the nurses and kids I spent less time in cupboards and more time with them, it sort of just transferred ... I had some kind of security the whole time really and if I was dragged out [of hiding] it would be like being dragged out naked, like you'd have nothing.*

The renewed experience of trust was beneficial for Jane.

Developing trust

> *It was a positive experience, it was good at that stage that you could trust, whereas your other experiences were all negative, it was very positive.*

However, trust was tentative, so when a nurse broke her promise Jane felt betrayed. Pat agreed to let the adolescents go night

swimming if they went to her talk on nutrition.

Experiencing the loss of trust

> *After the lecture about food nutrition we went to the unit to get our costumes to go swimming ... she said "no, it's too late now you can't go", we were all pretty pissed off about that. We're there because people betrayed us and here we have someone who we're supposed to trust who bribed us with an out and out lie. We said to her "you promised and that was the deal" and she said "no, no, it's too late now you can't, another time." Well, there's not gonna be another time, you're not gonna trust her again are you?*

The example of Pat is in stark contrast to the integrity which characterised Jane's relationship with James.

Nurses are people

> *He was always honest and straight to the point which was good because you knew where you stood with him and so you were in [no doubt], [I] never doubted, never had anything to doubt ... He showed concern about each of us so after a while you spend a bit more time with your mates and him seeing how it all kind of works. You yearn for friendship and company and he has a gentle way which makes it easy for you to talk with him and just to be with.*

Because of the strong attachment which developed between Jane and James she looked upon him as a friend.

Nurses are friends

> *James was a genuine person and was there offering his friendship and not asking for anything in return. So there was no threat, and for once I could be a friend and have someone be a friend to me instead of feeling that there was always a price to be paid ... You always felt comfortable and safe with him knowing that he's a friend ... my friend, [my] helping hand, he was always there to lean on.*
>
> *It's a very firm friendship, it's not just the kind of friendship like [where you say] "oh, we'll go to the movies together, oh, yeah, yeah" and that sort of thing, you're trusting each other with each others secrets and with your dreams and what you hope to obtain in the future, you're trusting them with very fragile things.*

Thus, mutual sharing was a feature of the relationship between Jane and James.

Experiencing mutuality

> *Like an equal basis, you talk about where you hope to be and also where he hopes to be and, you know, it's an exchange.*

On the other hand, therapy was a difficult experience.

The distress of therapy

> *You spend a lot of time with psychiatrists diving into the black holes of your life ... I think after getting out of therapy you feel like "this is my life, you know, what the hell is there to look forward to?" ... with therapy dealing with your past it sort of forgets to offer encouragement sometimes, and that there is life after [this], you know, it forgets that ... to provide hope.*

Nursing therapy, enacted through engaged daily living, was different to formal therapy, it was both positive and forward looking.

Getting on with life

> *Nurses don't ask you to dig up your past ... if you want to talk about it they let you bring it up, and usually if something's worrying you they ask what's on your mind, but if you don't want to talk about it you don't have to, not like therapy ... therapy makes you feel pretty rotten.*
>
> *Therapy's going backwards through your life, it's sort of the psychiatrist dealt with before [your admission] and the nurse deals with life after [it], so it keeps everything in perspective instead of "oh my God, look at my life it's not worth shit." I think it's very important to keep looking forward, to work on that.*
>
> *The nurses focused on the positive side, you know, what you're hoping for, what you're aiming at and how you're going to go about it. It's not just you as the victim or you as the bad bugger, it's like you have another side not just the victim ... it's your hopes, your dreams, what you're doing on the weekend, it's getting on with life.*

When Jane discussed concerns with nurses, activities often provided the forum.

The pressure was taken off

> *Often it was just activities like bike riding, tennis, ping pong, playing the piano [or] pool, it was an activity you did and you were thinking about doing that activity and then often you'd find yourself talking about different things in your life, some good, some bad but it was always done in a light atmosphere.*

And, because Jane's relationships with nurses were positive she thought of them as family.

Nurses are seen as family

> *Like family, you would protect them like family and look after each other, look out for each other like family. It's a very firm friendship ... you feel very protective of each other like in a family.*

Merlin Dunn

> *"You don't know what picture you're building half the time ... the threads are being given to you by the kids and you just weave them accordingly."*

Merlin is a Registered Psychiatric Nurse. He has also completed courses in counselling, psychodrama and training. He has 11 years of nursing experience having worked nine of those years as a mental health nurse. Merlin has worked for five years on two residential adolescent mental health units. All his nursing experience was gained in Australia. Merlin's stories emphasise the sociopolitical dimension of his work. The first story notes the impact of time limited admissions resulting from economic theories of health care delivery, the second deals with the politics of difference between the nurse and doctor, and the third with the influence of the self of the nurse on nursing care and the unit milieu.

Merlin's Stories

The story of Samantha describes how Merlin systematises his care to accommodate the constraints of the health care service. It notes the problems of time limited admissions for adolescents like Samantha who may receive only minimal care during allotted times.

> *We have a kid for one school term [but] I knew Samantha would need a 6 month period ... I had question marks about whether to form a rapport with her because by the time I form a rapport she'll be in and out ... [I] work out time frames [by] 2 weeks I need to start building rapport, 4 weeks ... looking at family, 6 weeks ... looking at school integration ... 8 weeks look at the discharge plan, you've got a timetable in your mind given this one term thing.*
>
> *It's not necessarily an effective way of working but it comes down to the dollar and how many kids you can get through in the shortest period of time and numbers and dollars and stuff like that. So, rather than leave a kid up in the air at the end of term I at least try and*

form some sort of closure and do whatever minimal work I feel I can do.

For safety, for the kid, I've also got to gauge "how much can we deal with?", I don't want to open a Pandora's box ... and process those emotions that are coming up only to know that half way through that process they're going to be discharged ... I've got to work out how much I can allow to come up ... given our time frame and given the kid.

When Merlin's nursing knowledge is devalued he advocates for his client through her parents. In role training the parents, for their meeting with the doctor, he empowers them as health consumers.

This ECT thing came up when there actually was progress beginning to occur ... ECT was recommended because of the doctor's frustration and not feeling like they're getting anywhere and it was too premature ... we needed months before we came to that sort of decision ... I said to the doctor I'm not keen about this ... and they said "well too bad basically we're going to do it anyway."

I said to the family "... this is what they're recommending [and] this is my appraisal of the situation" and the family was horrified and there's no way in the world they were going to allow it to happen but they were scared ... if the doctor said "we can't do anything the only thing we can recommend is ECT" and the family goes "no ..." then the doctor might go "well sorry, we can't do anything, so out."

I did some role plays with the parents and prepared them for how to handle the doctor ... I'd already set the scenario up before the real scenario had occurred so they would know how to respond to the doctor ... I just gave them lots of different options to handle the doctor, so they went in and they were very strong ... and that was fine. [But] ... you feel like the psychiatrists have no idea what to do with the kids and you advocate as a nursing staff member that change is occurring and they go " ... we've met with the kid for 5 minutes and we don't think that the kid's changing" so it becomes your word against their word.

In the following story, Merlin highlights the impact of the self of the nurse on the care they provide. He notes how the nurses' collective milieus intermingle to produce a facilitating or blocking unit milieu.

When we have an inadequacy within ourselves [we] don't know how to deal with the kid ... [so] the kid doesn't have the possibility of enacting something different and repeats the same behaviours ... [When this happens] we say " there's no hope for them because they're doing what they did within the family ..." But really it's due to the lack of resources or skills within the nurse themself to be able to ... work with that part of themself so they know how to work with that part of the kid ... the kid ultimately comes off thinking they are bad or inadequate or ugly or awful and it reinforces the low self image they have ... and that they're the one that's wrong.

In an environment that's not emotionally honest we have communication which is fairly defensive, it doesn't explore the deeper parts of yourself ... that may be the problem lies within your own style [or] ... repertoire because then people will think you're an inadequate or unskilled person as opposed to, you're a very skilled professional but it's a very challenging and demanding area and we're always learning and growing ... we need to be very honest and own our own stuff ... to do that we need to acknowledge it, work through it and find alternative ways of working.

The Sub-Elements of Practice Knowledge

In the section that follows, the sub-elements of practice knowledge are depicted using excerpts from Merlin's information.

Intuition

I find I work very intuitively ... it doesn't require a lot of my conscious, thinking abilities to know how to respond in a moment cause I've had to do it so many different times ... if someone asks me why did I do something I have to sit down and think about it [but] I can get in touch with the rationale quite easily.

Building the nurse-adolescent relationship

They're responding, it's a deepening of the process of the conversation ... they just hang out with you a lot more, they may not say anything but you notice that they want your presence ... If we say "lets get down to the core of things" it may be too exposing or too raw, too quick, so we have to go through the process ... not to go too fast because that may not be appropriate for the kid and where they're at and what's going on for them in their life.

Setting limits

Limits provide safety, they provide boundaries so that kids know what to expect ... [if] we let them do

whatever they want the teenagers may escalate each other ... and begin to feel unsafe because of their own behaviours building up to a point where it gets out of control ... [Also] you've put a limit on it before it gets to the point where they've regretted they've done something ... It provides safety for other kids because they know when those kids do those behaviours that someone will put a limit to it ... it brings the environment [back] to some sort of safe, predictable, constant, consistent state.

Providing equality

Not to put yourself always as the dominant [one] or as the priority or as the number one, you're the number two really and by listening to them it unfolds ... [Equality is] sometimes a bit hard because they don't know how to deal with power ... [but] that just becomes more experience to work with.

Working in partnership

It becomes a joint thing ... work with them cooperatively yet with firm limits and boundaries, guiding their energies rather then trying to extinguish or control ... you need to be able to go with them and enter their world and let them play out some things ... Be of service to them, help them understand what's going on then let them tell you how far they can go and how far they can't go.

Mismatched adolescent and primary nurse relationships

I usually get articulate kids, I don't work as well with kids that can't articulate ... Joshua related to the macho sort of image and I'm discussion and talking [oriented] and a gentle approach, he needed to link up to models he could relate to ... You're aware that the kid can't relate to you and you're finding it very hard to relate to this kid because of different conditions, backgrounds and understandings.

Developing trust

Even though you may be talking about a dog or a bike it's not the content that's important but the process to see that there's trust going on ... it's meaningful in the sense of allowing a process to develop or deepen. There's times when I know chit chat is useful because the kids need to warm up to you and you need to warm up to them ... to get to know one another.

Being accepting

We went through many different phases from not wanting to talk, that was her beginning stance ... she was pretty strong in it and rightly so because her experiences had lead her to that and that was fine. In time she began to make gradual interactions that went from one word to ... a paragraph ... that was fine, let the natural process occur.

Nurses provide and take opportunities

Aaron would be on the trampoline and I'd lead in with "look mate it looks like you're really upset about something ... is there something I can do to support you?" ... [he says] "no fuck off, piss off, leave me alone" but there's a response and you just kind of bounce off the response, whatever it is that they give you.

Being neutral

You have to be able to [be neutral] ... not to bite because you'd be biting every five seconds, you have to develop a certain strength within yourself to be able to stay neutral ... The ability to be able to manage your own feelings in response to them being triggered by the kid's behaviour requires a tremendous amount [of effort] ... to override or transcend your own feelings to actually see what's going on with the other person in the situation.

Being honest

You've got to engage them in conversation that's interesting [but] ... when I've had 500 conversations about this band and that band and I hate them all, it's just being real and saying to them "you want to talk to me about this rock band and I'll be open to that but I can't get into it" ... the kids suss out what nurses are good for what.

Nurses persevere

I suppose through my perseverance when she did want to talk to somebody she actually said "can I talk to you?" but it was [only ever] problem solving stuff.

Nurses are there

It's only through the constant encouragement and being there. Spending time with them lets them know that what they think and feel is of value ... you understand it and that it's their reality and it's okay [like] "it might not always be working out for you but at least we

understand it ... we can still be with you."

Nurses are flexible

[Flexibility is essential] because you're working with different kids, with different temperaments, with different developmental stages, with different capabilities, with different experiences, with different family structures and [because] what they make behaviour mean is according to their world not ours.

Providing individualised care

For instance, someone drinking ... if that family has an alcoholic in it and that's the way they cope and that's what's encouraged within the family [our aim is] helping to develop other ways of coping ... In another kid it could be experimenting ... The same behaviour needs to be interpreted in different ways depending on the kid ... The sense you make of it is dependent on the context.

Seeing and responding to what's underneath

When she came in she was just self effacing ... a tablet drops on the ground and it's like "oh don't waste the tablet", you know, I'm not worthy of a clean tablet, this really incredible self devaluing ... she would say "I don't want to waste your time" [so] I'm trying to relate to Maree that she is of value to spend time with and she is important and [how] 'I don't want to waste your time' keeps everything bottled in.

Being supportive

Being supportive takes many forms, it can be being on an outing, playing a game of basketball, sitting down with them while they're listening to some music and listening to it with them ... it can come sometimes in challenging a kid so that they don't keep on repeating behaviours that alienate them from everyone else ... challenging them as in "I notice when you're in those situations that this is the behaviour that can get you into trouble."

The adolescent peer group is supportive

They themselves provide support for one another ... sometimes the teenagers feel they get more of a sense of understanding and acceptance by the other kids ... they can hang out with the other kids much easier than with the adults. There are those odd occasions where kids find other kids difficult to hang out with ... but that's not often. The peer group is very important.

Identifying behaviours

> *Does a psychotic episode always happen to evade something, or at times of stress, or does the psychotic episode occur over a broader range of experiences, is there a pattern ... [like] whenever parents are visiting or whenever they have to go to school. You've got to read the behaviour in the context of what else is happening ... over a period of time you pick up unconscious, nonverbal sorts of things [like] kid's eyes change or they tremor a bit more.*

Monitoring behaviour

> *She was a very fluctuating, moody sort of kid ... One day she could say "I'm fine, everything's rosy" and the next day burn a hole in her jumper and the next day have a razor blade cut across her wrists and the next day be under hospitalisation ... very unpredictable, so I had to monitor, at least for safety, the process that they're going through. There may be a reduction in intensity [overall] ... less frequency of the same behaviour ... less intensity of the same behaviour, they may not be so up and down, the range narrows, instead of going so high and so down it's medium high and medium down.*

The problem of labelling

> *I got allocated [to] Lauren and the ... first information I was given was that this kid had a borderline personality [he said] "here, you can read up on borderline personalities" ... which wasn't a really useful handover for me and I said "well lets take it as it comes" ... because I don't use labels.*

Example two:

> *Sometimes it was very difficult to tell when Sally was having a psychotic episode and when ... [she was] having a temper tantrum ... Staff got tired of the temper tantrums and so they put down whenever she doesn't get her own way she'll throw a temper tantrum and it became quite difficult because there were times when she was genuinely having a psychotic episode ... as the primary nurse working with the kid you often [knew].*

Failing to provide safety and security

> *He often framed her behaviour as manipulative [so] it became a safety issue ... when she felt unsafe, like she was hearing voices or needed reassurance or needed to make contact or connect up with someone, this nurse wasn't available to her and kind of [closed off] ... If a kid says "I'm feeling unsafe" you have a real responsibility to*

provide them with safety.

Nurses are advocates

You walk into the staff meeting to talk about a kid which most staff don't like and think is a pain in the bum [they] think she's manipulative ... and just wanting to get her own way, and having to try and advocate ... people would just role their eyes. It's very hard to [advocate] sometimes when you've got a whole culture that works against that.

Example two:

I said "do you feel like things are changing, do you just feel there's a sense of change?" Michelle said "yes I do but I can't articulate it", I said "okay so there's change but you can't articulate it, so they're basing [their evaluation] of you on the external words you're saying and they're not really getting a sense of what's going on for you as a person" ... So, I can tell them that, I can advocate for you on that one.

Example three:

The only thing I can do is think further than the one term admission ... I can refer them to someone else who I know will be very good with them. I referred Kara to another person ... and Kara, out of trusting me, went and saw that person [for] long term psychotherapy.

Being understanding

It can be like a clue to something else that we need to work with but often we don't try and find the meaning of the behaviour we just get thinking [in a] very judgmental or critical [way] ... We had a kid who had marijuana and jigged school and everyone said "oh he should be suspended or kicked out" as opposed to "well may be he's done a great deal of work and he's finding it a bit difficult at the moment."

Interpreting communication

With Kara [it] was that she didn't value herself as a person, and therefore it didn't matter what happened to her ... a lot of risk taking behaviours, eating mushrooms then going to hospital and being lavaged ... getting alcohol from the shop ... running away. There was a lot of emotion there that she couldn't put into words.

Nurses try to create change

> *It's in the interactions with the other kids that the 'pathology' or behaviour comes up to work with ... it can [also] be with authority figures like the principal ... [but, for example] when they try to care for each other and support each other and they overload each other you can point out "is this perhaps what you also do within your family?" or "is this a role that's familiar to you in other parts of your life?"*

Example two:

> *They do behaviours that alienate them from other people, testing behaviours, unusual behaviours, weird behaviours, inappropriate behaviours ... On the one hand it can be a bridge for them to communicate but it highlights a lack of social ability ... sooner or later you need to start working with that ... you're going to take them beyond what they already know but you also need to have developed the relationship.*

Example three:

> *Some behaviours ... they're part of a developmental path ... If you've got a whole lot of boys that are swearing it's a very natural stage of development. I'm not trying to extinguish the behaviour I'm trying to give them distinctions about where they can do the behaviour and where it's not quite suitable.*

Supporting parents

> *The family was horrified but they were scared of how to deal with the doctor because if the doctor said "we can't do anything, the only thing we can recommend is ECT" and the family goes "no, we do not want you to do ECT" then the doctor might go "well sorry, we can't do anything so out" ... I basically did some role plays with them and prepared them for how to handle the doctor ... I'd already set the scenario up before ... so they would know how to respond to the doctor ... they were very strong and they handled the doctor and that was fine.*

The distress of therapy

> *The doctor doesn't relate to Michelle very well because they only see each other for five minutes a week ... what sort of relationship can the doctor build with the kid in five minutes, and that five minutes is usually of an interrogative nature ... the whole focus is medical and it's all around whether the medication's working or not ... Michelle said "I find it really hard to talk to her."*

Devalued nursing practice knowledge

> *The thing is, you feel like the psychiatrists have no idea what to do with the kids and you advocate as a nursing staff member that change is occurring and they go "rhubarb rhubarb, we've met with the kid for five minutes and we don't think that the kid's changing" so it becomes your word against their word.*

The nurses are not there

> *The kids will hang out with each other and the nurses will hang out in the office and look like they're busy making phone calls, doing paperwork ... putting programs together that look good on paper. It begins to polarise the kids [away] from the nurses.*

An uncooperative, inconsistent and noncohesive environment

> *I work in this environment much more in isolation .... Often when you work alone no one else knows what's going on and so when it comes to major decisions other members of the multidisciplinary team [make] decisions ... based on very poor information ... so it actually interferes with the case. There were some kids I had a relationship with but I didn't know what I was doing with them, I didn't know what direction I was going ... in this culture that's seen as being incompetent, weak or unskilled.*

Example two:

> *In the absence of leadership we have nursing staff who rival for the leadership but that depends on the different styles [like] autocratic ones ... laissez faire ones ... and more assertive ones ... It becomes draining on your energy to say "okay, so what's the culture for today?" It's tiring enough working with the kids sometimes let alone with the staff and the dynamics ... it can be quite terrible.*

An unethical environment

> *There's never a question of the efficiency or the productiveness of the process that's going on but more a rationalisation or an excuse ... There's no accountability within the system. You're not really working with the best thing that works for the kid, you're working with the best thing that works in keeping the status quo so that people's pride and personalities and status is maintained.*

Example two:

> *Rather than [say] the team doesn't have the wherewithal to be able to deal with this and adjust to this and be flexible and intervene [we blame the kid] ... we say they're unworkable ... The unit does not tolerate [acting out] behaviour, it does not tolerate the regression. You can predict the environment's habitual response to a kid's behaviour even though you yourself know it's not the most useful response.*

An open, accepting and supportive environment

> *The culture there allowed people to grow and explore and experiment so that was passed down to the kids ... it was a very dynamic environment ... therapists would let you know what happened in the family meeting and you could marry that with the unit and the school whereas here [that doesn't happen] even the communication within the team was cohesive, much more open, dynamic, much more explorative, [you might say] "... any other ideas about this?" and it's like here's another five or six different ideas.*

Expanding the knowledge of self

> *You have to have developed personally within your own adulthood, to have worked through incompletions within your own life ... you can use the feelings that come up for your own development as a human being ... You need to own your own feelings, discriminate between what is your stuff and what is the teenagers, that takes a certain amount of courage, awareness and some inner character development ... Sometimes they take you into your own stuff, they plug you into your own stuff.*

Example two:

> *When you work with teenagers you replay your own dramas ... your own adolescence ... where I feel socially awkward in talking with teenagers I could say "they make me feel uncomfortable" or [I could say] "when I was an adolescent I felt very awkward talking to other adolescents" ... they bring me back into contact with a stage of development which I myself was incomplete on ... It retriggers or brings up those old feelings.*

The therapeutic use of self

> *It's almost like using yourself as a therapeutic tool and it means that you actually take in your strengths, your resources, your abilities, your talents ... but at the same time where do your own weaknesses, deficits, inadequacies, fears and concerns also impair that tool*

in building or working within the milieu and with the teenager ... Your tolerance level, your style, your approach, your way of being available for the kids ... your ability to be able to facilitate someone else's development or just get stuck in your own defences, [its all you].

Failing to establish boundaries

You get a sense within yourself that you're beginning to be controlled by the illness, it's kind of weird to put into words ... you build a rapport and you get [to feel what she feels] and you don't know where to go, you feel almost as powerless as the kid.

It gets you down

It's not my strength, nontalking options, because I've been well versed in kids who are fairly insightful and articulate ... when you have a kid that requires options that you yourself are not well versed with it brings up the frustration within you.

Working through issues in groups

They had a big group meeting with the kids ... if someone did something last night we'd debrief it with the kids in the morning so every kid's not wondering "what the hell's going on" and got their own interpretation, you can talk about it [and] work through it and everyone has a general understanding of what's going on.

Appendix G: A Summary of the Young People's Sub-Elements of Practice Knowledge

Sub-Elements Identified in One Adolescent's Text

Experiencing a lack of containment

> *Tricia would come up and see me at the punching bag, [I was] trying to take my frustration out that way. She would turn up ... and she would see that I was angry ... and show her feelings. She used to always show that she was scared of me and that used to get me the most ... it's not a nice feeling to have, for fear to be in somebody's eyes when you're looking at them ... I felt like hurting myself.*
>
> *I started to over react ... I knew Tricia couldn't deal with it, she didn't really know how to talk to me, she was all right when I did have a problem and I wasn't uptight but as soon as I was really uptight she showed that she wasn't in control ... I smoked a lot more and I didn't sleep very much and I didn't go to school and I think I got more violent, definitely.*

A helpful and caring environment

> *Even though the residents were predominantly male the atmosphere was predominantly female ... that effects you ... the masculine's like "this is something hard you have to go through and you'll get over it" [whereas] the feminine thing is "this is something hard you have to go through, I'll help you as much as I can" ... so many kids are coming from such violence and then having something ... almost so opposite to that is good, just to get the balance ... there wasn't the power aspect, that went and the more caring one came through.*

A protective environment

> *You've entered into the unit with some sort of wound and straight away you're protected from outside influences ... and intimidation just because you're with nurses who don't do that ... It was protection from harm, healing requires that ... I mean you can't heal without protection.*

Being pressured

> *Sandra would come into my room ... and [say] "what's bothering you?" and really push me to talk, it would be "why don't you tell me?" ... She really pushed me to know what was going on in my life ... the more you push somebody to talk the more they're gonna close up.*

Katherine might've come and said "what's up today?" but if I didn't want her to [know] that was fine. With Sandra ... if I said I didn't want to talk about it, it was "but why won't you talk to me, why can't you talk to me?" If you said to Katherine "I don't want to talk about it she'd just say "okay, well when you're ready come and talk." Most of the time, five minutes later, I would go and talk to her

Feeling blamed

[Kieran] started screaming at me ... and went berserk and tore all the pictures off his wall. I remember the nurses coming in [saying] "what did you do to him Elizabeth, what have you done?" and it's like "I haven't done anything!" ... I just felt like the nurses [blamed] me ... I remember being really upset ... like I was to blame for it all.

Having your own space

You had your own bedroom, it was your own space, you could go in there and slam your door and [it meant] keep out kind of thing, it was your own private space ... it wasn't like you had everyone trampling through there, it was ours, the inpatients. It was your own space ... we painted pictures and we put pictures on the wall.

Experiencing concern

You could see their concern was for real, like I still remember them [saying] "where were you all? we were so worried" and like staying back ... they also had families to get back to and other things to do but they stayed back ... it wasn't like "oh, it's 6 o'clock in the morning and my shift ended at 6 it's your problem now" ... they stayed back and it was good.

Receiving individualised care

Well they did treat you different but the same as well ... we weren't all treated exactly the same ... it showed that they paid attention because they'd know not to treat everyone the same and what worked for one wouldn't work for others. Like an individual.

Nurses are flexible

I don't like it being too rigid but it was fairly flexible ... you don't want to seem like you're in gaol or something really rigid, like it was pretty flexible. Like we had to do our laundry every day but it's not like "you have to do it at 8 o'clock", it's like, "you have to do the laundry today but when it fits in with you." I like things like that.

Nurses encourage independence and responsibility

You did your washing ... the showering and looking after our own rooms ... it was up to us to get ourselves to breakfast, to look after our clothes and do our homework. I remember the nurses always offered us help if we wanted it, like if we wanted help it was there but they would let you be independent, let you do things on your own. I learnt how to get along with other people, to live with other people my own age and to be responsible for myself, like self sufficient ... dealing with feelings ... getting social skills, [and helping people] when they were feeling bad, like how to handle that.

Nurses negotiate consequences

Whenever I was given punishment it was always fully explained to me why and I was always given options, and that was quite a different experience, someone saying to me "you can either have this, this or this", like I might have a loss of privileges or I might want to do something [else]. It was hard to choose ... I think a lot of it was being fair ... like did I think the punishment fitted the crime, like what I'd done, so I was given options.

Nurses discipline through relationships

In the beginning, if they'd have tried to discipline me in the way they did in the end I probably would have taken off or reacted in a different way, but because I had grown quite used to them ... and we had such a good relationship, they could discipline me ... and even though I hated it I could handle it a lot better. Like their approach to things was different in the beginning but as time went by and I did things they could discipline me.

Experiencing attachment

I got quite fond of quite a few of them ... I became very attached to some of the nurses ... when I look back Beth was the one I was attached to most ... after I left I still had a lot to do with her.

Sub-Elements Identified in Two Adolescent's Texts

Working through issues in groups

I remember being in the bean bag room ... and talking, they were pretty good sessions ... it was good, comfortable, we used to relate ... sometimes it got a bit awkward when someone was really angry or upset ... most of the time it was fine. We had sessions in the mornings ... they were great because if we had a

problem with anyone we were associating with, in the school or in the lunch hour or within the groups, we could bring that to a head and generally the problem is solved.

Working through issues in groups

The first day I was there we had one [a group] in the afternoon and there were kids there talking about their fathers abusing them or whatever ... my dad always told me "nobody believes you and you get locked up in homes when you tell people that", and like, there's people sitting there talking about it and it was an everyday thing, just about every kid there I think would've been abused in some way.

An open and accepting environment

I found there was a lot of honesty, a lot of kids were very open about the problems they had which is something I found surprising cause you leave yourself vulnerable when you start opening up too much, being honest. If I'd been in a situation where no one else was being honest and open about what was going on in their lives it would have been basically impossible for me to do that.

It was a pretty open and accepting environment, you didn't have to put on a front, you could be yourself. You could sit down with a nurse and talk about how you felt about things ... it was just a natural thing to do ... when you step into a situation like that ... it's easy to become that way yourself ... it was the environment set up by the nurses I guess and that's the feelings that were going around.

An open and accepting environment

A boy was talking about how he had been raped and that's exactly what was happening to me and I was like "this guys talking about it, nobody's going off at him for telling, how can he talk about that in front of people?" ... I'd never been around people that had talked about it, it was always a hush hush thing at my house and I was just spun out that people were talking about it ... it was just really unusual for me.

Experiencing a lack of concern

They took me to the casualty department and fixed my wrist up then the doctor came and said I had to go to this psychiatric hospital and the nurse just left me ... she just left me there ... She could've been nicer and understanding to me, she could've explained what was

going to happen ... If she'd been nicer and explained to me ... [I'd have known] somebody cared and I wasn't just being chucked in there, cause that's how I felt, I felt they were putting me in there to get rid of me so they didn't have to bother with me.

Experiencing a lack of concern

I woke up one night after I had a nightmare and Sarah was looking in the door at me when I woke up and she said ... "go back to sleep now you'll be all right" and closed the door on me. I got up and she said "I said you'd be all right, go back in your room and go back to sleep" like I was a two year old ... She should have knocked on my door then asked if I wanted a coffee or something, like "are you okay, do you want a coffee?" ... and sat next to me on the bed and talked to me. If I said "I'm tired" ... that's all right but if I wanted to talk she was sitting there and she was ready.

Making sense of things

Robyn sort of settles you down, doesn't let the feelings get in the way. She made me think more than act, not like "how do you feel?" but just "tell me what's going on and then I'll see if I can sort it out" and sort of like "well, is it this?", "why are you feeling like this?" or "does this happen because of that?", more than saying "tell me how you feel."

Making sense of things

Because we were able to interact with nurses we had a lot more input, we were hearing things from other sources, apart from what was just going on in our mind, so it made it a lot easier to find solutions to problems.

Getting on with life

Therapy's going backwards through your life, it's sort of the psychiatrist dealt with before [your admission] and the nurse deals with life after so it keeps everything in perspective instead of "oh my God, look at my life it's not worth shit." I think it's very important to keep looking forward, to work on that.

The nurses focused on the positive side, you know, what you're hoping for, what you're aiming at and how you're going to go about it. It's not just you as the victim or you as the bad bugger, it's like you have another side not just the victim ... it's your hopes, your dreams, what you're doing on the weekend, it's getting on with life.

Getting on with life

I remember a couple of times the nurses saying "it's hard, it's a hard time" but ... it wasn't like my life went on hold while I got better, my life was sort of happening.

The people and the place

It was just a terrific [place], just a blessing I reckon, like just to have nurses like that, so warm and so gentle and understanding ... and the unit in particular cause it was a lot sort of like a home, [I was] fortunate that there was a place like that to go to ... having the space to move around, not too may restrictions [and] having people to talk to whenever you wanted.

The people and the place

It was the whole place, it was big and open, there was nothing around it ... it was airy, it was a comfortable place ... there were fields at the back [and] you'd lie down on the hill ... it was peaceful all the time ...The nurses were with it, that was the thing, they were there, the two were together. It was grass and space and people who were quite prepared to talk to you whenever you wanted ... it's a great atmosphere for healing.

Experiencing the loss of trust

You're lead to believe you're friends with that nurse and if that turns out to be false it's a little harder to trust other people's motives when they start to befriend you. You start to doubt all the relationships you have ... which is one of the problems I had when I went to the unit ... you've given a part of yourself and felt that was worth something then the nurse doesn't even let you know they're going away, they don't finalise the friendship ... you can almost compare it to somebody dieing, if a friend dies you've never really had the chance to say goodbye have you?

Experiencing the loss of trust

After the lecture about food nutrition we went to the unit to get our costumes to go swimming ... she said "no, it's too late now you can't go", we were all pretty pissed off about that. We're there because people betrayed us and here we have someone who we're supposed to trust who bribed us with an out and out lie. We said to her "you promised and that was the deal" and she said "no, no, it's too late now you can't, another time." Well, there's not gonna be another time, you're

not gonna trust her again are you?

Specialist nurses

I wasn't in with [specialist] nurses ... I was with normal, everyday nurses who work in hospitals, they didn't know how to handle me, they just went about their job and it wasn't a happy experience ... when they told me I was going to the unit and they tried to explain, it was like "oh, no!" ... being part of a hospital and having nurses looking after me I thought it would be the same so I went into it thinking "it's going to be bad from the start" and it just wasn't like that.

Specialist nurses

These are nurses ... dealing with patients in all sorts of pain ... The unit was the special education of nursing. You couldn't have standard nurses going there.

Nurses take time and make time

In the night time Robyn was there and she'd spend time with me, like had a bit of a chat and that so I was in a better mood before I went to sleep ... I just went straight to sleep sort of thing. She took the time to look around and I was awake, well I was pretending to be asleep but she knew I was awake, but basically she took the time to spend with me.

Nurses take time and make time

Whatever the nurses were doing ... they could come back to later and didn't mind doing that ... and they sort of let you know that. Like if someone's doing a report or something like that and I came up it was usually put the report down and "what do you want to do?" That was really good, having someone who was prepared to put aside work to talk to me, that's a boost to your self confidence at least.

Testing nurses

We did quite naughty things to see what limit you could push them to and see how they responded ... I think that's how I judged them, on how they responded to the stupid things I did, how they handled certain situations ... if I did something stupid and they were to get angry with me I would stay away from them ... it was just to get a reaction, to see how they would react to me, just to test them.

Testing nurses

At first I usually give them a really hard time, swear my head of or whatever and it's to see how much they'll take ... you test their limits ... [I tested limits] to see how much this person's going to put up with, like whether they will stick around, like you push the limits. Someone might be able to handle one overdose or handle you telling them off [only] once and [so] then you think "well, they're not going to stick around if something worse happens."

Working in partnership

I remember coming the first time as an inpatient, it was pretty scary leaving my family ... my father came with me the first week ... he stayed in with me, stayed for the week, [he] slept somewhere else on the unit and then my mum did until I settled in and then after a while it was just me.

Working in partnership

It wasn't that the kids were to be conquered it was the problems of the kids that were to be conquered, but the problems were to be conquered by everyone ... you weren't there struggling to keep your head above water, you had a couple of nurses beside you who were pushing you up as well.

Mismatched adolescent and primary nurse relationships

I was allocated two nurses, Tania and Sylvia, I don't know whether it was because of being paranoid or not getting along with them [but] I preferred not to have anything to do with them. I made friends eventually with the male nurse James. They were both feminine women and I felt uncomfortable with them ... all my life my closest friends were blokes so I got along with blokes more than I do with females, so it was uncomfortable for me to talk with them.

Mismatched adolescent and primary nurse relationships

Tricia tried to fill the gap but she was a feelings person so that made me more uptight than anything else ... and then she got uptight because I was uptight so it didn't really work.

Feeling in control

The control was placed in my hands. Most of us are there because someone has taken control and abused that and we're paying for it ... to feel that you have

some control in your life is utmost important ... with James not pushing and giving me control I [could] see he was a genuine person. He would give you the feel that you've got the reins, that you're in control ... he encouraged you ... he guided you, he never drove you ... and he watched over you.

Feeling in control

No one ever forced them down my throat with their fingers, I had to take them myself, the nurses can only convince me ... they were saying "take the tablets", so I never got them forced down me which was good cause then you'd feel the trust would go wouldn't it?" I eventually took them ... but I think if they'd forced them down me that could have been a stuff up.

Being neutral

I remember fighting with them every now and then, you know, usually because I didn't like authority, that was the only thing but they were never, never rude or anything like that, never nasty ... [I] was very angry and just took it out on them but they responded pretty well all the time, I was never abused, like yelled at or anything, they always had a really good approach, always some good way to handle it.

Being neutral

You come along and you're really angry and you've been making other people angry ... all of a sudden you come to Simon who no matter what you do seems to just say "well okay, you're angry but it's not going to make me angry."

Sub-Elements Identified in Three Adolescent's Texts

Inappropriate admission to adult or child units

[At the psychiatric hospital] the black in my eyes was as large as the colouring ... they [the male patients] started giving me speed and marijuana trying to get me to do things I didn't want to do [like] the guys.

[At the psychiatric unit] they expected me to relax to this stupid music and when I wouldn't, I was just sitting there, because I couldn't relax they put me in my room ... they were all really bitchy ... I nicked a butter knife once ... I didn't take my medication I kept that as well ... they seemed to dare you to do something like that.

Inappropriate admission to adult or child units

Once I got there it was 50 times worse than what I

expected. It was just crazy people, about 100 crazy people shoved into a big room. The whole time I was there I just sat in the corner, I didn't talk to anybody, I wouldn't even talk to the staff at the psychiatric hospital.

Inappropriate admission to adult or child units

I was in a children's ward ... they didn't know how to handle me, they just went about their job and it wasn't a happy experience for me. I'd been in hospital for two [or] three weeks ... I expected when I went to the unit, being part of a hospital and having nurses looking after me, I thought it would be the same, so I went into it thinking "it's going to be bad from the start" and it just wasn't like that.

Having attention

You were never short of attention, there was always someone there to give their full attention to you. I used to look forward to it ... [you're] not forgotten about. They were there for you ... it was good, you felt kind of important because they were there to find out how you feel and they were interested.

Having attention

I started to feel better about myself in that I had confidence that if someone wanted to talk to me then I could talk to them ... I was worthy to listen to, if I wanted to talk I was quite confident that someone would listen.

Having attention

He would let you tell your story ... you could bounce ideas off him, he was never [dominating], you felt that you were the important one, that this was your life and you had to do something about it that was positive.

The unit was homelike

Like my expectations of the place were totally different ... I expected it to be really horrible and really clinical and it just wasn't, it wasn't clinical, not at all ... it just felt so normal ... like it wasn't real hospital or real clinical, it was just homely. Kind of homelike the atmosphere was.

The unit was homelike

It wasn't so much a hospital set up, it was quite comforting I suppose in a way, it looked a bit homey to

go into ... the environment being a homey set up with a pool and everything ... right away you related to your family home or something similar ... in a sense it's comforting like that ... the best thing was just that home environment, that home sort of set up.

The unit was homelike

It was a place, well the only place I could go to feel comfortable and to feel I didn't have to be anyone else other than myself, so it was home.

Feeling normal

It was good because they gave you time to cool down and knew that it was something you had to do. If you went off like that in a psychiatric hospital they'd give you a needle to put you to sleep for a few hours, whereas [on the unit] they knew you had to get it out of you. They let you do what you had to do, oh it's hard to explain, they let you be angry, they let you cry, they let you do whatever without putting a psychiatric illness to it ... they knew that it was normal.

Feeling normal

After being there for a while I didn't feel that we were strange or that we were sickos or anything like that, I just felt like everyone [else], quite normal. I remember the nurses telling me things that weren't so great for them ... they'd say "well everyone has bad things happen to them and things that they don't like", and they'd tell you some ... you want to hear that it's normal for everyone to have problems and that you're not an outcast or a bad person or whatever and [that] it happens to everyone.

Feeling normal

I liked those swimming carnivals and things like that ... I like running around a lot, I love sport ... I suppose it makes you feel like you're doing the kid thing too, like I felt a bit separate cause I wasn't going to school and all my mates were ... some of those things made me feel I'm getting into it too ... feeling normal too and that feeling [that] I've started to enjoy sports again, like I didn't earlier when I was feeling shitty.

Having fun

Beth always came on the trampoline with me, so did Simon, so did Edward ... they used to always want to do fun things, it wasn't like you had to ask them, they were always there ready to do fun things. It wasn't just based

around [problems], when they were there they weren't always just focused on problems ... it was like we'd have fun, we'd go for bike rides ... it wasn't like we're going in for a therapy session, or we're going in there to have a big talk, we're just going to have some fun.

Having fun

Everything was "why aren't you doing so well at school?" or "why aren't you behaving the way my son should behave?" ... [but] Joe still had a fair bit of the kid in him, he was still able to muck around and didn't have to take things seriously all the time, which was good, it's nonthreatening ... How much trouble can you get into having fun?

Having fun

It was fun, there was always something happening, there was never any angst amongst people.

Nurses are seen as family

It was more like having a big brother or big sister having the nurses around.

Nurses are seen as family

I had grown quite used to them and it was in a way kind of like a family, you know, you see them all the time and we had such a good relationship.

Nurses are seen as family

Like family, you would protect them like family and look after each other, look out for each other like family ... you feel very protective of each other like in a family.

The nurses persevered

I used to tell Katherine where to go plenty of times but she just kept being there for me, I think I told her to "fuck off" about two million times and she was still there, like she didn't get sick of me ... no matter what, she kept being there for me ... [and] like Erin stuck around through all my shit, I knew she'd always be there no matter what.

The nurses persevered

Even when I was hiding [in cupboards] the nurses would come and find me and ask if I'd want to join them, and in the beginning I always refused but they never gave up, and they always gave me the opportunity

if I wanted to join them ... The fact that they didn't push me or drag me out of there meant I didn't feel threatened. It was very important, they always made me feel they wanted me to be part of the group but when I was ready.

The nurses persevered

It was probably over a week before [I let her do that], Robyn like came in and I said "no, go away" sort of thing, so it was about a week before she came in and we talked and that for a long time, she did that a fair bit.

Experiencing mutuality

Like an equal basis, you talk about where you hope to be and also where he hopes to be and, you know, it's an exchange.

Experiencing mutuality

They were able to say how they'd feel about a certain situation even if it meant saying they would feel unhappy or threatened with a situation, something which you may think would perhaps even be a little bit humiliating ... they're sort of exposing who they really are ... its got to be a two way thing. You describe a certain situation or the way you feel about something and the nurse can relate how they would feel in that situation ... When a nurse gives a bit of advice on something it's a bit easier to accept if you understand that they've been through problems themselves so it doesn't just sound like a bunch of talk.

Experiencing mutuality

They'd tell you about their lives and when they'd felt bad and I really liked that, they were very human, acted human ... I remember lots of them telling me things that weren't so great for them, especially when you're feeling really sorry for yourself, they'd say "well everyone has bad things happen to them and things that they don't like" and they'd tell you some, it was good.

The nurses were there

The more the nurses were with us, on a day to day basis, the more we felt they were in a similar situation to what we were and that it was okay to talk to them. We probably formed better relationships with them just for the fact that we were together so often, it made it that much more comfortable.

We were still able to joke around and take an interest in

the same types of things. We'd go and hire a video and sit down and watch it with the nurses cause everybody would be interested. It was more like we were living with the nurses rather than them just working there and us residing there, it took away the them and us.

The nurses were there

The nurses were just there and ready for you rather than telling you what to do ... it's as much a human spirit more than anything ... you can be taught a lot of things but if you get a genuine concern for someone [that matters] too, I mean as much as there's techniques, that's the most helpful you can be.

The nurses were there

Robyn seemed to be there when I needed her ... [with] Tricia I had to go look for her ... I don't think Robyn spent anymore time [with me] but she just seemed to be there when I [needed her]. I told Robyn and I told Tricia that the main time I was upset was before I went to bed and after [therapy] sessions and Robyn seemed to be there at those times ... A lot of times Tricia was busy talking to somebody else or doing paper work or going to a meeting or something like that and that would make me build up more ... With Robyn when I had something to say she was there, if I just wanted to walk around she was there ... she just seemed to be there at the right times and say the right things and be able to work it out the right way.

Feeling safe and secure

It makes you feel a lot safer, you know what to expect ... it was different to what my life was like before that [where] I didn't know when anything was happening. It was hard to adjust at first but it was very safe to know what's going on, when things are going to happen and who's going to be there. Going to bed at the right time and having a bit of consistency in life ... like set times to go to bed and dinner ... I knew what was going on, what my plans were for the next day and what was expected of me.

Feeling safe and secure

When I started feeling safer with certain nurses ... with James and some of the others, I felt I could spend time with them and still feel some safeness. As I felt more secure with the nurses and kids I spent less time in cupboards and more time with them, it sort of just transferred ... I had some kind of security the whole time really and if I was dragged out [of hiding] it would

be like being dragged out naked, like you'd have nothing.

Feeling safe and secure

When I was on the unit I felt safe, like he [my dad] couldn't get to me, I was safe and nobody could hurt me there and that's exactly how the unit felt. He told me that it happened everywhere and so I figured no one was going to stop him if it was such a normal thing. On the unit they knew that it was wrong and it's the first place I've ever been where they knew that kind of thing was wrong ... just being safe and all that stuff it means heaps.

Experiencing containment

You come along and you're really angry and you've been making other people angry ... all of a sudden you come to Simon who no matter what you do seems to say "well okay, you're angry but it's not going to make me angry." Rather than anger being met with anger it can be met with ... "you have a problem because of a reason ... we'll try and work out what that reason is and resolve it." It showed me an alternative ... it's something you can work to.

Experiencing containment

After the meetings with [my therapist] Richard ... like [I talked] about actual events and what they did and everything so of course that's going to upset me ... But when I talked to Robyn it was all right in an hour or two, I was all right and I was calmed down and there was nothing wrong. What Robyn would do [was], we used to walk around really slowly and talk and she used to say "you don't have to rush it, you can just talk slowly and we'll walk slowly and just keep talking and when you want to stop we'll stop and if you want to keep walking we'll keep walking."

Experiencing containment

[I] was very angry and took it out on them but they responded pretty well all the time, like they never abused, like yelled or anything, they always had a good approach, always some good way to handle it ... I remember doing anger therapy, we painted a bottle and every time I went into the room I could undo the lid and let my anger out ... We got a four litre orange juice bottle and I painted it black and I used to kick it and do all things like that but only when the bottle was open.

Sub-Elements Identified in Four Adolescent's Texts

The pressure was taken off

> *Sometimes it just seems hopeless and the more you're sitting there thinking about your problem the bigger the problem seems to get. If 100% of your energy is focused on the problem, it's a big problem, but if you can just hang around with the nurses and the kids and just be yourself and not have all the pressures of society on you, all of a sudden the problem seems smaller.*
>
> *The more intense the whole situation is, the more you're feeling pressured to try and discuss your problems and find solutions ... the less effective it is ... wait until the kids are ready to talk, don't try to bring it on or force it out ... It's best to wait for the kids to make the first move really, wait till they're ready to talk.*

The pressure was taken off

> *They were very patient ... there was no hurry, may be no hurry to get better ... I didn't need a quick fix ... the nurses just went along and were open to what you had to do or what you had to say or what you were going through, [I] didn't feel rushed or pressured.*

The pressure was taken off

> *It was very different. At the psychiatric hospital everybody was looking at every move to see whether it's normal or not, like if you say something wrong they think you're suicidal ... but on the [adolescent] unit they didn't sit there and analyse you, like it was just different. The nurses got in and did what everybody else did and they talked about the things we did, they were a lot easier to talk to like that.*

The pressure was taken off

> *Often it was just activities like bike riding, tennis, ping pong, playing the piano [or] pool, it was an activity you did and you were thinking about doing that activity and then often you'd find yourself talking about different things in your life, some good, some bad but it was always done in a light atmosphere.*

The peer group is supportive

> *Probably the best therapy ever was just casual conversation with the kids, whether it be one on one or sometimes just a group of three or four kids talking about what was happening, that was some of the best therapy on the unit.*

The peer group is supportive

There were a few that were fairly quiet and seemed on their own the same as I ... you tend to home in on them and make friends with them so you felt you weren't the odd one out or you didn't feel alone. There was someone there who you could talk to around your own age and who's been through something similar so you have that bond.

The peer group is supportive

Well the other kids, I thought they'd be really horrible to me but they were really nice and accepted me and didn't sort of look at me strangely, or they were exactly like me that's probably more like it.

The peer group is supportive

All of the kids were from similar backgrounds in certain aspects ... in being oppressed by something and rebelling against that or just coping with it or not coping with it. Coming to a place where there were so many others with the same experiences you felt you weren't really alienated.

Nurses are role models

If I ever have a daughter I'm gonna be like that [like Toni]. I was refusing to go to school one day because I had women's problems and Toni came in to see why I didn't want to go to school and I got around to telling her why. She talked to me like my mother never had ... It was strange for her to come in and say it in a caring way and natural way ... that was the first time I'd ... [had] that woman kind of thing. It was really different for me to have somebody talk about that kind of stuff ... it was good.

Nurses are role models

You tend to look at the nurses and model your behaviour a little bit on them, so it not only helps you form other friendships later on but it almost helps you to operate in the adult world. It's a bit of a transition cause as well as missing out on a lot of socialisation with your peers before going to the unit, you miss out on a certain amount of that development that's required to be able to exist in an adult world as an adult.

Nurses are role models

It's also good as in role models ... I remember being told by a nurse that they were a real brat when they were

young, and look where they are now ... some were running away from home and having bad family problems and they're still where they are today. Your life doesn't stop because you have problems like that, you can keep growing and use it to your advantage ... that's what a good experience is, you learn something from it.

Nurses are role models

I've just been given such a strong masculine thing straight along and all of a sudden there was this other thing that I'd never felt or experienced before, that men aren't all [the same], don't all have to be super strong [they] don't have to be like that. That was an opening. I was around 14 or 15 ... it was a good experience at the right time.

Receiving understanding

You got a feeling that may be the nurses didn't know or understand exactly what was happening but they did too ... and just a real willingness to want to and I mean there's an understanding in trying to understand, there's almost an understanding in that ... just patience and a willingness to understand I found the most comforting.

Receiving understanding

I don't think I realised how good I had it on the unit until I left ... how good it was and how understanding nurses were. Katherine would give me time to calm down ... She'd give me time to do what I had to do whether it's swear or punch a wall and then she'd talk to me once that was over. She didn't go off at me about losing my temper ... with her it's something that's happened, it wasn't a big deal.

Receiving understanding

What I was dealing with was very frightening and it had driven me to the edge and hiding was all I could do, I felt that was the only thing I could do to feel secure ... no matter how strange it must sound it was the only positive thing I could do to deal with what was happening. They didn't say "what are you doing in there get out", it was never like that, it was just "oh, there you are, we're going to the kitchen to get some ice cream would you like to come?" It was never made a big issue of so you felt comfortable in [hiding] there for the time you needed to.

Receiving understanding

I think Antoinette just knew ... she seemed to understand that I was angry or acting up or whatever, she didn't yell at me, didn't scream or tell me I was stupid ... the nurses just understood, I never felt like no one understood me.

Becoming hopeful

There's short term happiness when you're having a good time ... Then you've got that longer term happiness where even though you might have a bad day you're still basically happy. If you've been a long period of time without either of those happinesses you lose hope but if you can [be happy] even if it's just an hour where you forget about things ... you think "well may be if I can keep stringing all these happy times together I'll end up happy."

Becoming hopeful

When you know someone else has been through the same and they've succeeded in changing or getting somewhere it's not an excuse to stay the way you are, you can still get on with life no matter how bad your problems are ... [it gives you] hope, everyone needs a little bit of hope.

Becoming hopeful

You had kids who you knew were going through the same things as you or you knew had gone through the same things, you could see success ... this person's been through more than you and they've come out so you think "well if they can do it why the hell can't I?"

Becoming hopeful

I had faith in the nurses and the place I was at, I think I did deep down, apart from all the anxiety ... I was so lucky that that place was available ... it gave me hope.

It's more than a job

The nurses on the adolescent unit seemed to enjoy their work or choose their work and the ones on the adult unit were there just to get their money.

It's more than a job

They could well have been nurses ... in a hospital treating other people in a completely different environment, they didn't have to do the youth work

they were doing ... they were there because they chose to be ... They gave their time towards [youth work], I mean, they could well have been working somewhere else, they gave sacrifices.

It's more than a job

You didn't feel like they were clocking on or clocking off or seeing you for 50 minutes, you didn't get that feeling like their shift had finished.

It's more than a job

I know it was their job and they were paid to do it but I don't think it's a job you'd do if you didn't enjoy it, it's not the type of job you'd do to pass the time or make some money, you've got to be in to it to do it, and they certainly were.

Experiencing loss through termination and separation

I didn't want to leave in the end, I just wanted to stay, and it was like "no Elizabeth you have to leave one day", I didn't like the idea of that ... I just really, really didn't want to leave, I liked it so much, I just did not want to go ... I made it very hard for myself but I was very, very sad. It could have been a more gradual process I felt that it was done too quickly, when you grow rather attached to something you just can't [let go quickly]. You're not going to stay there forever, it's inevitable that things are going to change but when the time comes it's quite a rude shock.

Experiencing loss through termination and separation

That was the hardest thing, when it came time to leave, cause at the time I honestly didn't think I was going to make it once I left ... To a certain extent I felt a bit deserted, like intellectually I knew why I couldn't stay but emotionally it was just hard to deal with. It's not just one friendship that you're ending it's relationships with ... the kids and the nurses and you've got the change of physical environment as well. It's almost like your life as you knew it is ending and you're starting from scratch again ... it's very traumatic making such a sudden change.

I don't think I had enough time to say goodbye to nurses the way I wanted to say goodbye ... not that you're never going to see them again but it's obviously going to be an end to the relationship as it was on a day to day basis ... you lose a lot you know. It's important to make it a gradual process ... it's like going back out into the cold again and starting from scratch ... it was

important for me to be able to go back and see the nurses again ... I rang a couple of times ... we had a couple of dinners ... that's the sort of thing that's necessary.

Experiencing loss through termination and separation

Everybody was nice to me and I made friends and I loved it there, I didn't want to go home ... all teenagers should go there for their teenage years.

Experiencing loss through termination and separation

As far as I can remember Robyn was the main person I got along with ... I can remember crying when we had a party for her leaving ... that left quite a gap ... I was really down when I went there and Robyn brought me back up to half way and then I went below the bottom line within two weeks [after she left].

Sub-Elements Identified in Five Adolescent's Texts

The distress of therapy

I don't think the fact that it's called therapy necessarily means you're finding it therapeutic ... I don't think it was beneficial at all ... It's very confrontational, you almost feel like you're going in there for a fight ... it's as though it's forced on you. I found that I wasn't comfortable speaking with the therapist ... so it was never really going to work ... It's not something you look forward to and then coming away from it you feel really depressed ... it wasn't positive, it was all very negative.

The distress of therapy

I'd talk to [my therapist] Richard. He used to make me talk and talk and I didn't like talking so I used to get angry and upset with him ... I don't know what Richard was trying to do but the way he talked to me was really sarcastic ... that was the main reason I was so uptight ... I didn't really like him from the start.

The distress of therapy

You spend a lot of time with psychiatrists diving into the black holes of your life ... I think after getting out of therapy you feel like "this is my life, what the hell is there to look forward to?" ... with therapy dealing with your past it forgets to offer encouragement sometimes and that there is life after [this], it forgets that ... to provide hope.

The distress of therapy

I talked to the therapist but he wasn't very understanding ... He really tried to get it out of me, he'd say, "if you tell us what's happening at home we won't make you go home." There was no way I was telling him but I wish that I had told somebody ... there were nurses I trusted that I could have told.

The distress of therapy

I remember being a bit scared sometimes, I went through periods of really hating [my therapist] David, really avoiding him. I don't think I got that with many of the nurses ... cause there's a difference between a psychiatrist than the nurses, I'd only see him [occasionally].

Relating to nurses

Simon ... had a van and that was the attraction. I've always loved vans, that was something I could talk to him about ... I remember meeting Simon when he drove up to the unit and got out of his van and then I realised he was one of the nurses, from then on I was pretty happy to talk to Simon.

Relating to nurses

Some people you talk to, you want to open up more to than others ... just the warmth ... you can feel like a concern or a warmth and a bit of that caring thing ... I remember Erin had a smile, like she had a good laugh, that's sort of warm too ... it's just Erin's disposition [and] I think you can see when someone's with you and concerned for you ... being with you.

Relating to nurses

I used to get on pretty well with Joe ... we were just able to relate pretty well. At the time I came to the unit I hadn't really been able to do anything to express myself, I hadn't been able to express ideas to anybody or relate experiences to anybody, everything was still inside. To be able to relate was really great, it was worth something. It was just sitting out in the sun having a chat [or] watching the kids in the pool.

Relating to nurses

You don't want it to be a one way thing, you've got to feel like you can relate to them in some way ... I remember knowing quite a bit about their personal lives and things they liked and it was good, it wasn't like I

did all the talking, they talked as well ... like a conversation.

Relating to nurses

If they're talking in ... nurse language they talk like they're above you but if they're talking like you they're just like one of you, and you can relate to them, you can accept them ... so you can talk to them about stuff.

Developing trust

It just gradually happens that you trust them. At first I wouldn't have told Katherine anything but over time I sort of trusted her and realised she wasn't gonna go away ... it happens over time that trust thing and all that sort of stuff.

Developing trust

You don't have to start dealing with important issues [straight away], you're working into it ... If you can start of with something trivial and unimportant, until you get your feet wet and feel more comfortable with that nurse, I think it really helps. The best thing is just be there when the kids are ready ... be available ... the kids will be able to trust you ... That's why I was more likely to speak to one of the nurses than I was to one of the therapists ... you don't know them, you have no reason to trust them.

Developing trust

The nurses knew I trusted them and that I wasn't being persecuted by them. In the beginning I didn't want to be there, I was angry about being there, I didn't like anyone, I didn't trust anyone but in the end it was different.

Developing trust

With being paranoid and fearful of people I [was wary] though I noticed that everyone got on well with James so I thought "well if anyone's to trust it would be him." So, I hung around with a few blokes who hung around with James and just observed what was happening. It was a positive experience, it was good at that stage that you could trust, whereas your other experiences were all negative, it was very positive.

Developing trust

I suppose you're distant in a way from a lot of people who you're with or who are helping you ... it took a while for me to trust, to trust the nurses ... I realised

they'd always be prepared to listen ... [they were] prepared to help. I suppose when you realise that people are really prepared to help, are really prepared to, then you can trust them.

Sub-Elements Identified in Six Adolescent's Texts

Nurses try to create change

Once I didn't talk for a while or for a couple of days ... Sue got me to write in these different coloured paints [and] she wrote beautiful in different colours ... she said "oh, what does that say?" and I said "beautiful" [and] that was the first time I spoke in a couple of days. I remember she didn't make a big fuss about it ... It's weird though, not speaking, like you think "oh you idiot you're not mute, you can talk."

At the start it was like "okay, fix me up, tell me the thing that's going to make me feel better" ... then I started to realise, just through the nurses listening and [their] willingness to talk it through patiently, I thought "may be they don't have the answers and may be this is going to take a bit of time" ... I've always looked back on this period of my life, as ugly as it was, as one of the most golden moments, in a way, as far as how I feel I've developed.

Nurses try to create change

There was all different things they would do with us like the dolls ... I would be me and the dolls would be my parents ... the idea was to get out how I felt and show how the situation was and then how I would have liked to have handled it, like how I would like my mum to talk to me instead [of how she did] or how I would have liked to have been treated, and so I would be my mother talking to me.

Nurses try to create change

One day he turned around and he pointed out that it made it hard to include me in a conversation when I was walking behind him, he said it was like I was excluding myself and he didn't want that, he wanted me to be part of the group but it was up to me. He simply quoted, "do not walk in front of me I will not follow, do not walk behind me I will not lead, walk beside me and be my friend" and he left it at that. So, over the next few weeks I summed up the courage to start to walk beside him and became a part of the group and I eventually felt comfortable, like I belonged.

One of the nurses came in ... he just started a casual conversation ... then he asked me to describe my family

... when it came to my mother I described what she did [so] he asked me to describe what she was like ... I realised I didn't know my mother. He said "next week I'll ask what she's like." The following week when I caught up with him he asked me "so, who is your mother?" and I said "you'd never believe it!" I'm still learning what my mother's like.

Nurses try to create change

The nurse always had a certain amount of power in that they could say "right, I'm not going to work with that kid" ... [but] if some kid was particularly aggressive ... I mean mentally as well as physically, it was [like] "fair enough, you have some sort of problem lets deal with it" rather than "you get out of here until you deal with it" [it was] let's both go ... and work out what your problem is."

It gave me a start in some aspects that if I hadn't gone there I wouldn't have got ... [it was] very important, it did change me, it obviously happened at the right time and with the right people. I wanted to finish school when I turned 15 but once I turned 15 I thought "oh well I'll get my school certificate" ... the unit taught me to have goals.

Nurses try to create change

I learnt to be strong ... when I went there I started to get strong again. When I came back from the unit I started to fight back ... started saying things to him [my dad] like "you can't do that to me." I'd never said that before and just little things like [that]. They probably didn't mean much to him but they meant a lot to me. If I didn't go to the unit I don't think I would've told anybody [about my abuse]. I got a lot stronger when I was there and when I came back I was ready to tell somebody.

Nurses try to create change

A lot of kids were in the same situation I was where before they came to the unit they'd stopped socialising, they'd basically withdrawn into themselves [and] didn't have a lot of friends. Suddenly being in an environment where there were nurses around you felt you could trust, because they were in the same situation as you were, they weren't an outsider looking in on your problems, they were there with you, because of that situation you were more likely to be able to talk and start learning to socialise again and develop those skills again.

Nurses provide and take opportunities

I remember with Harriet it was craft, she got me into things ... I used to talk to her and like then you ended up talking about things you didn't plan to. With Antoinette it was always cooking, she used to take us for cooking and like just start conversations and you kind of like [open up].

Nurses provide and take opportunities

Robyn was by herself most of the time and she looked approachable ... she like looked up and she was all there and she smiled at me ... it's just the look ... not "what are you doing out of your room, get back" like some of the other nurses did.

The first camp we went to was only a couple of weeks after I went there ... I had the nightmare and I punched somebody ... I took a runner as soon as I woke up properly and Robyn went and sat in front of the fireplace and that's where I ended up. When I walked into the room she looked around like invitingly not like "you bitch, get fucked" and so I went and sat next to her and we made coffee and that and we were talking.

Nurses provide and take opportunities

He never insisted that I had to participate or be a part of [anything] or had to walk beside him, I was never pushed, it was just [that] I was given the opportunity and it was up to me. He was always there to lean on if you needed but it was never like "I'm here to help you so tell me all your problems", it was never [like that] it was always up to you, he gave you the opportunity and left it up to you.

Nurses provide and take opportunities

We were only just sitting down watching tele and we just started talking. I wasn't pushed to talk about anything which is how psychiatrists treat you, they sit you in a room for an hour and you have to talk. I wasn't made to talk about anything, it just happened, that was really different.

Nurses provide and take opportunities

You'd come in and you were having a bad day and before the day was out someone would notice and come up and say "look I can see something's biting at you, can you tell me what it is?", if not, "can you tell someone else that I can get?" ... I mean I'd turn up and be really quite angry ... but the next day you'd get over it because you've

had a chat to a nurse and you've resolved at least part of it ... just the fact that you've brought it out into the open is the biggest step toward resolving it.

Nurses provide and take opportunities

Sometimes it would be a general conversation that you would have, just the fact that you were able to interact with someone, whilst you weren't really trying to achieve something, was very positive, just the fact that you found someone you could talk to.

The stress of admission

I remember dad driving me there and looking through the maps, I remember looking through maps and thinking "oh, what's he doing, I'm getting carted off to this hospital thing, no way, get out of it!"

The stress of admission

Once I got used to it it was good but for the first few weeks it was pretty stressful ... it was a totally new environment and all the kids with their different problems and [nurses] telling me what was going on and what I could do and what I couldn't do [and] getting used to the people there.

The stress of admission

When the doctors told me had to go there I thought it was just another psychiatric hospital. Then I went for the interview and everybody was nice but I thought that was a front they put on to everybody and they were really horrible. It was about a week before I went back there to live and at first I didn't talk to anybody cause I didn't know anybody and I didn't really want to know anybody.

The stress of admission

When I first went to the unit no one had really informed me of why I was there or what the place was about so I had no real expectations. I turned up and gradually figured it out for myself. I felt fortunate that I was in a place where I was going to be able to resolve the problems I had and ... bad that I'd gotten to the point where I was in a place where there were kids with such bad problems.

The stress of admission

The first time I went there was for the interview and I hated it and I was crying and I didn't want to be there

... I remember feeling a little miserable and hating it and not giving anything a go, [I] didn't want to eat, didn't want to do anything ... I can remember my first day really clearly, I hated it. I thought it was like a psychiatric hospital ... that everyone would think I was sick cause I was there.

The stress of admission

Everyone was on holidays so I was there by myself for two weeks which wasn't very comforting. I went to therapy and was told I couldn't go home and had to stay so it was pretty traumatic. Suddenly, I was in a place unfamiliar and no one there virtually which was pretty scary.

Nurses are people

He was always honest and straight to the point which was good because you knew where you stood with him and so you were in [no doubt]. [I] never doubted, never had anything to doubt ... he showed concern about each of us. After a while you spend a bit more time with your mates and him seeing how it all kind of works. You yearn for friendship and company and he has a gentle way which makes it easy for you to talk with him and just to be with.

Nurses are people

The nurses on the unit were just like one of the kids, they jumped on the trampoline with the kids, they talked like the kids, they were just like one of the kids and that's why they were easy to get along with. They were a lot younger, I'm sure when they went home they weren't young in the head but on the unit they were just like teenagers.

Nurses are people

There were a couple of nurses I was able to talk to and [who] I got on very well with. If you can't get on with a nurse on a basic level, if you can't hold a conversation with them, or muck around and have a bit of fun with them first, you're not really going to be able to interact with them when it comes to solving some of the deeper issues.

Nurses are people

[Simon] got right into things like trampolining and playing around ... he was just a soft person, like really nice not aggressive, he's an assertive person, he was so soft. He used to have a really good approach to things

and he was funny, he could laugh, he used to laugh a lot. [Edward] was one of my favourites ... you could have lots of fun with him, he was always really good to me ... He was so nice, he put himself out ... I think he had a good sense of humour.

Nurses are people

Most of the nurses were nice people that you could talk to pretty much whenever you wanted ... The nurses were always pretty peaceful, they didn't have any hang ups at work, it was like they were always happy. They put across the feeling that they were quite happy doing what they were doing and if you wanted to do whatever with them, that was fine, they were happy to go along with that.

Nurses are people

I don't remember they ever wore uniforms or anything like that which was terrific ... it makes it open, I felt more comfortable to talk to the nurses because it wasn't that authority thing or set up ... it just takes away that barrier.

Sub-Elements Identified in Seven Adolescent's Texts

Being accepted

The nurses were beautiful, like very unjudgmental ... I remember most of the nurses being just wonderful, very open, very patient ... I remember sitting on the bed once and I was talking and crying and Jeff had his arm around me ... he was saying "what's up?" and I said something like "... I'm scared if I become gay or if I'm gay" and he was saying "there's nothing wrong with that or that's all right."

Being accepted

You can tell when you say the wrong thing but with Robyn I never really said the wrong thing, she always accepted it as what I was saying and how I was feeling or [as] what the real problem was.

Being accepted

I could be what I wanted to be, I didn't have to conform to someone else ... I could be me. The nurses were just so accepting ... if you wanted to talk to someone they were there. Sometimes you couldn't relate to anyone and ... it was "okay, we'll treat you with feather gloves for a few days until you can talk to someone" ... [they'd] say "when you decide to divulge then we're ready to accept."

Being accepted

With the bad experience I had I was always made to feel it was my fault ... the feeling I got out of that was that I had to try and be someone else or do something else to be accepted. But when I met James it just didn't matter, you'd be yourself and he accepted you as yourself ... you belonged ... you're accepted as yourself ... I think being accepted is the main thing.

Being accepted

Erin never put me down or anything even if I did something stupid like slit my wrist ... she'd just accept that and help me, like help me with it rather than tell me off about it ... other ones would say "oh that was really stupid" and really put you down ... no matter what they think, if they think you're a stupid little bitch well fair enough, as long as they can still accept you.

Being accepted

[They] were not judgmental, you were who you were and they accepted you as you were. The only thing nurses would find unacceptable at times were behavioural things, violence and foul language ... Nurses were accepting of the faults and problems ... It's easy to feel bad about not liking your parents, to feel bad when you don't get on with other kids ... but if nurses are accepting of those problems you learn to accept them in yourself.

Being accepted

I can't remember or think of a time when I ever felt rejected or whatever and I felt rejected when I went there but I soon lost that feeling ... I just felt that I fitted in, I fitted right in there.

Experiencing equality

When you're young and in that situation you have a lot more respect for someone if they're on your level and do the same things as you, like you don't want to feel inferior or have nurses being superior to you ... you don't want to tell your fears and secrets to someone [like that]. It creates a good atmosphere being equal ... They talked with me not always to me ... like when you go to school and things like that the teacher talks to you, not with you, [but the nurses] they were always talking with me not at me.

Experiencing equality

He was more like one of us ... it was never a different set of rules for him than for us ... watching how James worked with the adolescents you saw that he never put himself above us ... He came across like one of us, just hung out with us and he was never judgmental or looked down on us, he was just like drifting along with us, so you could talk to him about anything.

Experiencing equality

Nurses or whatever look down on you and treat you like you're below them but on the unit they didn't do that, they were like one of us, you'd hear them swear now and then and they'd talk about whatever we were talking about. I'd never had that before from nurses ... If they're acting like they're above you and not on the same level, not as an equal, you're going to tell them to get lost, you're not going to trust them, not going to talk to them about everything.

Experiencing equality

An important part was treating the kids as an equal. You didn't feel it was the kids versus the grown ups ... you felt like you were making a transition in society, you were moving up to a point where you were gonna be treated as a mature human being [though] not necessarily an adult. You were treated as though you had a right to exist and to believe what you wanted to believe and that your opinions counted ... Just the way they made you feel, you felt closer to being an equal.

The more you feel you're on the same level as the nurse the easier it is to talk [to them]. That's another reason why I found it hard to talk to the therapist ... you didn't feel you were talking to them as an equal. Perhaps the fact that you didn't see them all the time, they must have felt themselves to be somehow superior [because] they didn't have to hang around with us kids.

Experiencing equality

Robyn, was an adult and she was treating me like an equal. To be a friend you have to be treated as an equal. It's like [between] a teacher and a student there's no equality ... whereas when you're friends or equals you're swapping and changing. I tell her something and she tells me something ... it has to be equal to say what you're really feeling ... not have any inhibitions of "what's she going to think?"

Experiencing equality

Having [experienced] the equality I think that's the big learn, that's pretty much how I would describe how it changed me, I discovered equality and found out that I liked it ... there was no hierarchy at all.

Experiencing equality

All the nurses that were on the unit and going out and playing footy with us were probably more [on our level] and the ones that went on excursions you'd see more on the level ... that felt more equal than it was say between me and David [my therapist].

Nurses are friends

You feel like you're friends with that nurse, you're doing the sort of thing friends would normally do together. It helps by taking the pressure off thinking "oh gees, I don't have any friends, I can't socialise", you're not constantly nervous around everybody, you feel like you've been set free. It's a friendship on a different level, it's not the kind of friendship the nurses would have with people their own age outside of the job ... but just being able to relate to somebody or to think of them as a friend and be accepted as a friend, meant something, it was valuable.

[It's like] if you're capable of making a friend you must be okay, you must be a likable person that's capable of being liked by people and making friends, you figure if you can make one friend [in a nurse] you can make more, it makes you feel like you're getting somewhere ... you're being accepted ... you've got genuine acceptance there.

Nurses are friends

The nurses weren't like what you think, like when I think of nurses I always think of them wearing uniforms and being fairly routine [but] they were just like normal people, they dressed normally, we would call them all by their first name and they were more like your friend ... they were really, really nice ... they just never acted like nurses [or] what you think a nurse would be.

Nurses are friends

James was a genuine person and was there offering his friendship and not asking for anything in return so there was no threat. For once I could be a friend and have someone be a friend to me instead of feeling there was always a price to be paid ... You always felt

comfortable and safe with him knowing that he's a friend ... my friend, [my] helping hand, he was always there to lean on.

It's a very firm friendship, it's not just the kind of friendship like [where you say] "oh, we'll go to the movies together, oh, yeah, yeah" and that sort of thing, you're trusting each other with each others secrets and with your dreams and what you hope to obtain in the future, you're trusting nurses with very fragile things.

Nurses are friends

Kids that have been abused ... get abused and treated like shit ... they need somebody who is going to be their friend because they want to be their friend not because they want something off them. It helps you, it makes you think "I can have a friend" ... it's nice to know someone's going to stick around because they want to, because they like you.

Nurses are friends

Robyn ... was more like a person than a nurse, she was more like a friend that was there when you needed her, more than a nurse that had to do this because they were paid to do it ... I didn't have to make her be my friend, she was my friend anyway. Erin was my friend ... I didn't tell her every little bit of my problems [but] she seemed to take an interest in what I had to say and it wasn't like I was trapping her into talking to me ... Erin was there, I didn't have to go chasing her.

Nurses are friends

Nurses were friends for six months or whatever ... they had lives other than that, they're not just there to be your friends but they also knew you have a life other than ... to be a patient ... there was an acceptance that there's more to life than [the here and now].

Nurses are friends

It took me a little while for me to say "oh, you're friends and helpers", not just a teacher to tell me what to do ... that was nice, knowing it was not a student [and] teacher thing ... helpers and friends ... nurses probably adopted that position so that they could talk to you on your level.

Appendix H: A Summary of the Nurse's Sub-Elements of Practice Knowledge

Sub-Elements Identified in One Nurse's Text

Failing to provide safety and security

> *He often framed her behaviour as manipulative [so] it became a safety issue ... when she felt unsafe, like she was hearing voices or needed reassurance or needed to make contact or connect up with someone, this nurse wasn't available to her and kind of [closed off] ... If a kid says "I'm feeling unsafe" you have a real responsibility to provide them with safety.*

Failing to respond appropriately

> *We were trying to get Geoffrey to take some medication and I remember him saying something to me like "look at her she's laughing at me, she's got a smirk on her face" and I actually did because I thought it was humorous ... [I learnt] just keep your expression blank ... because Geoffrey was quite suspicious and paranoid at times.*

The distress of therapy

> *The doctor doesn't relate to Michelle very well because they only see each other for five minutes a week ... what sort of relationship can the doctor build with the kid in five minutes, and that five minutes is usually of an interrogative nature ... the whole focus is medical and it's all around whether the medication's working or not ... Michelle said "I find it really hard to talk to her."*

Failing to provide attention

> *Some of the quiet adolescents are missed, they can go for days without having any attention ... and that does not help them, they just withdraw even more [like] "no one cares so they're not talking to me." All the kids need attention, the quiet kid needs the nurse to go and sit down and say "how are you feeling today?" and see where that leads them.*

Providing time out

> *Give adolescents some space, they need space like any of us, whether it's time away listening to music, writing some letters, reading [or] painting. They need some space of their own ... Maybe they're feeling a little bit tense within the group and, you know, you get to know*

when they need some time out on their own.

Failing to set limits

There's some kids who you're fearful are going to act out so you let things ... you could have stopped things getting to that point. [You think] ... I should have intervened earlier, this has gone on too long ... rather than letting them escalate each other and hype each other up you could've, with some other intervention, have stopped things getting to that point.

Nurses discipline through relationships

Discipline always works better ... [if] it comes from the relationship you have. It gives you more power to intervene or more right to intervene ... it always works better for someone who has cared for that adolescent ... You know the adolescent and what's going on for them and where they're at and what their own resources are internally and how much they need [help]. [Also] the work and trust you put in facilitates intervention when limits have to be set, there's that trust built up between you.

When someone comes in initially and is quite disturbed, conduct disordered, you would tolerate more disturbance because they haven't learnt anything yet or been exposed to what we would be expecting is the norm, we haven't discussed [that] with them ... that relationship and feedback and all that hasn't been there. If they were there a few weeks you probably ... set more limits with them.

Being tolerant

With kids like that if they did something ... were really disruptive, destructive or really abusive to other people, you know, in their language or carrying on ... you allow a certain amount and have a tolerance for what is normal ... but there would be a certain point where that would be as far as you think is appropriate that they go.

Experiencing attachment

It so happened that I was one of the few nurses that stayed on full time during that [holiday] time so during that eight or nine weeks she and I formed a very strong attachment to each other and I still remember her with great affection.

Therapeutic touch

He was really edgy one night and I said "come on

Martin sit down and I'll massage your head." He sat in front of me and I massaged his head and he was going "oh that's really good, it's made me feel good" ... it was relaxing and neutral ... it was them being touched in a positive sort of way which made them feel good ... A lot of the kids wouldn've had many cuddles ... someone giving them a rub on the head or a pat on the back, just those little contacts.

Demonstrating concern

Sarah came up and said "are we going to go out tonight?" and I said "well yeah it's Tuesday, we'll have to sit down and talk about where we're going" and then something happened and we couldn't go out ... She told Alison I had really disappointed her because I had promised her we'd go somewhere and we didn't ... [Later] I approached Sarah and said "I'm really sorry about the other night, I should've come and explained why we couldn't go out", and after I explained she was much better.

The nurses are not there

The kids will hang out with each other and the nurses will hang out in the office and look like they're busy making phone calls, doing paperwork ... putting programs together that look good on paper. It begins to polarise the kids [away] from the nurses.

An unethical environment

There's never a question of the efficiency or the productiveness of the process that's going on but more a rationalisation or an excuse ... There's no accountability within the system. You're not really working with the best thing that works for the kid, you're working with the best thing that works in keeping the status quo so that people's pride and personalities and status is maintained.

Rather than [say] the team doesn't have the wherewithal to be able to deal with this and adjust to this and be flexible and intervene [we blame the kid] ... we say they're unworkable ... The unit does not tolerate [acting out] behaviour, it does not tolerate the regression. You can predict the environment's habitual response to a kid's behaviour even though you yourself know it's not the most useful response.

An uncooperative, inconsistent and noncohesive environment

I work in this environment much more in isolation .... Often when you work alone no one else knows what's

going on and so when it comes to major decisions other members of the multidisciplinary team [make] decisions ... based on very poor information ... so it actually interferes with the case. There were some kids I had a relationship with but I didn't know what I was doing with them, I didn't know what direction I was going ... in this culture that's seen as being incompetent, weak or unskilled.

In the absence of leadership we have nursing staff who rival for the leadership but that depends on the different styles [like] autocratic ones ... laissez faire ones ... and more assertive ones ... It becomes draining on your energy to say "okay, so what's the culture for today?" It's tiring enough working with the kids sometimes let alone with the staff and the dynamics ... it can be quite terrible.

Sub-Elements Identified in Two Nurse's Texts

The stress of admission

It's pretty scary going somewhere when you're an adolescent ... but even more so going to an adolescent unit, [the idea] that you're a disturbed adolescent.

The stress of admission

The first couple of weeks is a settling in period in a residential unit ... they may be very lonely, be upset being away from home, possibly for the first time, getting used to all the routines, getting used to the staff and how different nurses react in different situations.

Being honest

You've got to engage them in conversation that's interesting [but] ... when I've had 500 conversations about this band and that band and I hate them all, it's just being real and saying to them "you want to talk to me about this rock band and I'll be open to that but I can't get into it" ... the kids suss out what nurses are good for what.

Being honest

Be quite honest with them be open with them, sometimes they might ask you awkward or difficult questions but be as honest as possible ... and if something's not possible then obviously to say so because they will understand, I think they know when things are difficult for you as well.

Nurses take time and make time

He used to talk all the time with me and I'd always make sure I had 15-20 minutes up my sleeve to go and sit in his room and talk to him ... I think you've got to [make time] when you're working with adolescents.

Nurses take time and make time

It's very important to give the adolescent time ... to give them time and make them feel at ease, if there's anything they want to say to you, if there's any concerns they have, then allow them time and space to come to you.

Intuition

I find I work very intuitively ... it doesn't require a lot of my conscious, thinking abilities to know how to respond in a moment cause I've had to do it so many different times ... if someone asks me why did I do something I have to sit down and think about it [but] I can get in touch with the rationale quite easily.

Intuition

It's something that I actually feel more than think out, there's a point at which my own inner resonance almost impels an action and I don't think I can describe it ... something in me reacts at that time ... I suppose that's why intuition and the ability to be empathic to other people's feelings is important.

Inappropriate admission to adult or child units

I felt that to put an adolescent into an adult institution rather than to special her with people that she knew well ... was not helpful for her. I had experience taking kids up there and it was an awful atmosphere, it wasn't suitable for youngsters and I felt we had a responsibility not to put them in an adult, chronic, psychiatric system.

The message was this is what you're going to become and we can't cope with you, your turmoil is too big for us and I think that's a huge message to give anybody. This whole unit can't help you ... there just weren't the facilities around [for acutely disturbed kids] so maybe the other side is you give what you can.

Inappropriate admission to adult or child units

Hospitals like that were for disturbed adults ... that environment would be totally detrimental for Sarah, you

know, how would she cope with that and ... I mean she'd established a relationship with the unit ... it's like being chucked into somewhere else that you would have no connection [to] and built up something with ... I and other staff had developed a relationship, a connection and attachment with her [the psychiatric hospital] was that big, anonymous institution where you're just one of a mass.

[Also, the message is] that we've failed and rejected her and that her containment was beyond us ... that she was crazy and we weren't able to manage her, that she was beyond our care, and may be that she was beyond our care reinforces she was crazy.

A secure, accessible and unconstrained environment

More or less any adolescent going to a new place has got to feel a bit secure and have the security there but on the other hand have the freedom to move around and do things that they want to do.

A secure, accessible and unconstrained environment

I think the adolescents felt the place was very accessible ... they had that feeling of belonging, that sense of space belonging to them ... they felt free in their environment, free access to things. Once they got to know the unit they felt very comfortable in the environment.

Facilitating termination and separation

We also had an [ex] student's group, we slowly separate in that way ... it's a way of reassuring the adolescents that they're not completely separate from the unit once they're discharged, it's a way of weaning off rather than suddenly cutting off ... In a way it's to let them know we still have contact ... but it's also time for them to be independent a bit and have their life outside.

Ideally we should prepare for discharge from when they come but then in reality it's not that easy ... we have to have time to know who this person is and where this person comes from ... the preparation of the termination is more or less from half way.

Facilitating termination and separation

I told Mitchell I'd get him something special so he'd remember his time on the unit ... I bought him that Adrian Mole book and gave it to him on his last day but before that I'd been saying to him "well Mitchell you're going home in a couple of weeks" ... [After discharge]

he rang up a couple of times.

Striving for consistency

Consistency is always difficult where you have a lot of nurses or different nurses managing [behaviours] ... tolerance to certain behaviours [varies] ... there would need to be certain things that would be consistent [like] violence where there would be a real stand taken but some other less damaging behaviours there'd be a more variable response in how you'd manage those.

Striving for consistency

[With behaviour programs] they test whether you're carrying out the appropriate results ... if they can get away with it they will. If they can still go out and still have the odd [problem] behaviour they will. So, what we have to do is be consistent, each nurse has to do that.

Highlighting difference and change

You'll be encouraging, giving positive feedback [about] how they were getting on with the other adolescents, how they were able to participate and their level of achievement in what they were doing ... if that was something new they weren't able to do before ... [highlighting] changes where kids have moved on from behaviours or how they related to other adolescents [you might say] "Jonothan, last week when you came here it was really difficult for you ... it's great this week you and Tony are playing well together and planning the next game, that's a real difference to what happened last week and it's great." Highlighting where they've come from initially will add more weight to positive feedback.

Highlighting difference and change

We had feedback from the teachers and she was getting higher marks and she started making friends at school so those are the positive things we consistently tell her ... the way she relates to her peers in the unit and school because at one stage she lost her confidence ... going back to jazz ballet, losing weight, we keep reinforcing how it takes a lot of determination to do it.

The adolescent developmental stage

There's a very definite maturity that happens with adolescents ... you can see the physical maturity, then the emotional maturity, then the mental-cognitive maturity. It makes a big difference and that makes me aware of what I'm dealing with because that helps me to help the adolescent in their behaviour. I've got that

situation now where I've got 17 year olds in with 12 year old ... the 17 year old will see the 12 year old as very silly and immature ... it reminds me again "oh, he's only 12 years old!" ... so my interventions have to be streamlined to the age appropriateness of that kid.

The adolescent developmental stage

Most kids rebel ... [but] Martyne's rebellion was just to the extreme, she picked something that her parents could not cope with, [her being a gothic]. I think it serves to say "look mum and dad here I am, I am getting older and this is my way of saying I want to be independent and [so] relax your controls on me ... I'm my own person."

Working through issues in groups

They had a big group meeting with the kids ... if someone did something last night we'd debrief it with the kids in the morning so every kid's not wondering "what the hell's going on" and got their own interpretation, you can talk about it [and] work through it and everyone has a general understanding of what's going on.

Working through issues in groups

We use moral responsibility or moral dilemma groups. Some of them have not been exposed to moral judgment, they don't know how to behave in certain settings ... we try and pick issues that deal with situations at home [like] if they know their brother's lied should they dob them in. We try and keep it simple then incorporate it into ... where they're at.

Mismatched adolescent and primary nurse relationships

He'd chosen me, he hadn't chosen his [primary] nurse, although I became his primary nurse ... As the weeks went by he started to open up a bit more and then developed relationships with other staff members as well.

Mismatched adolescent and primary nurse relationships

I usually get articulate kids, I don't work as well with kids that can't articulate ... Joshua related to the macho sort of image and I'm discussion and talking [oriented] and a gentle approach, he needed to link up to models he could relate to ... You're aware that the kid can't relate to you and you're finding it very hard to relate to this kid because of different conditions, backgrounds and understandings.

Sub-Elements Identified in Three Nurse's Texts

Being supportive

> *Supporting Daniel in understanding what was going on for him ... letting him know as much about the illness as possible. Being really sensitive to how that would feel for him, you know, adjusting to having had that experience and how he would make sense of that for himself ... that he would be able to work through some of those things.*
>
> *Adolescents could get stuck and find it difficult to move on and face the future and yet if they can work through that with support it doesn't necessarily have to be a detrimental experience, if it's managed well and the person gets the support ... they can move on from that ... it depends how it's dealt with and the support [they get].*

Being supportive

> *Being supportive takes many forms, it can be being on an outing, playing a game of basketball, sitting down with them while they're listening to some music and listening to it with them ... it can come sometimes in challenging a kid so that they don't keep on repeating behaviours that alienate them from everyone else ... challenging them as in "I notice when you're in those situations that this is the behaviour that can get you into trouble."*

Being supportive

> *[In depression] the other thing is psycho-education, with the kid, family and peers ... people have no knowledge of this disorder so help them understand the situation ... the kid himself doesn't know what's going on so he needs people surrounding him to support and understand him.*

Adolescents are people

> *It's important to get to know the adolescent and get to know what they're like and get used to their mannerisms and idiosyncrasies ... It's very important to take them as you get them and to get to know the adolescent very well. See them in different situations, taking part in different activities ... taking them on a one to one situation, talking to them, getting feedback from them and seeing how they feel about a certain situation or particular thing, and get a feeling for what they like and don't like.*

Adolescents are people

[To know] who that person is and be able to get a picture of what's going on for them, what pain they're in, what's going on in their world and has caused them to be at that point, you know, to have to be admitted to the unit ... get some idea of the problems and the context.

Adolescents are people

We were encouraged to look at the adolescent not just as a naughty, conduct disordered kid or a depressed kid but to look at every part of their well being ... there was a more wholistic approach and little bits of pathology, so called, weren't taken out and tried to be dealt with on their own.

Nurses are people

I don't want to come down and be this manager of their person, I want to encourage ... in order to do that I want that to be genuine. I'm not just a figure like a teacher ... I want that to be brought across in a sense where [they feel] "well that's that person, that's that nurse I'm talking to."

Nurses are people

If you can laugh with the young people and they can see you're human, you know, we can all act very silly at times and I think young people can appreciate ones sense of humour ... they would appreciate you for your sense of humour as well as your sense of fun and your ability to be kind of silly as it were.

Nurses are people

That lets them know we're human and we can see the funny side of life ... I've got a good sense of humour ... so you're not this rigid, cut and dry, black and white, this is the rules you don't bend the rules [person].

Getting on with life

Talk to them and see what are their plans or their hopes for the future and what they would like to get out of their placement, how they would like to feel, you know, towards [the time when they're] leaving the unit, what they would like to get out of school and out of their young life.

Getting on with life

It's a really important age to have nurturing and positive direction. Really [you have to] get them out of those difficult times or experiences they had before ... they never forget ... but they can get on, move on.

Getting on with life

We got them interested in things to broaden their outlook on the world ... There's a whole world out there, life isn't this single tunnel, there's all these different paths, if you want to be a mountain climber you can do that ... start with the first step.

The whole environment of the unit helps them to look at their life and see the other kids are working through things, so they start thinking about working through their lot.

The unit was not clinical

A unit should have lots of posters on the walls because kids [normally] have them on their walls. I encourage that ... that expression of themselves ... I'd rather see that than bare walls.

The unit was not clinical

The adolescent unit was very different to any other type of environment I'd worked in ... a much more nonmedical setting ... it had nice landscaped gardens and a pool, a music room with bean bags ... a lovely tennis court and the oval at the back. It wasn't a clinical, hospital setting.

The unit was not clinical

It can't be just like staying in a ward or an institution ... I felt really it's like a holiday home .... it's easier to create a therapeutic environment rather than in an institution [where] they would probably feel very restricted and locked in ... the unit was just so free for them.

Building the nurse-adolescent relationship

The beginnings of helping an adolescent would be working on forming that relationship, using the interpersonal skills and knowledge you have of people [in] establishing that relationship. Spending time with the person, doing one to one activities, setting up things like to establish that relationship.

Building the nurse-adolescent relationship

They're responding, it's a deepening of the process of the conversation ... they just hang out with you a lot more, they may not say anything but you notice that they want your presence ... If we say "lets get down to the core of things" it may be too exposing or too raw, too quick, so we have to go through the process ... not to go too fast because that may not be appropriate for the kid and where they're at and what's going on for them in their life.

Building the nurse-adolescent relationship

He wouldn't let people get very close to him at all but he saw how relaxed [Martin was] and what enjoyment he was getting from the [head massage] and he said to me "can you do my head too" and I said "yeah, that's okay" ... every third day or something he would come and say "can you massage my head so I feel better?" [I'd say] "yeah, okay that's fine." So, he was getting relaxed and I was gaining his confidence and he was trusting me.

Providing mutuality

Things that I felt were common and might help us to identify with each other, or be useful in them feeling that I understood where they were at, if they were similar things [I would share them] ... there can be a lot of areas for blurring or that I don't think are appropriate ... you might only learn from experience, by finding out "oh gee that didn't feel okay" or "I don't think, in hindsight, that was an appropriate thing for me to disclose."

Providing mutuality

Having walks with kids around the oval or sitting on the hill talking about things ... my experiences in life is something I like to share and adolescents are usually hungry for knowledge, hungry for understanding.

Providing mutuality

Show the warmth and interest in them you're not [there] only to get the information ... there's a bit of sharing.

Identifying behaviours

Activities [are a] platform to provide focused interaction and valuable information on the adolescent's ability, skill, concentration, level of cooperation [and]

interaction with peers and adults.

Identifying behaviours

We can observe the adolescent, I'll use the classroom setting, sometimes the nurse will be in there just watching a group of adolescents and observing how many times a kid gets off his chair, how many times he is distracted, how many times he annoys other adolescents and before you know you have a pattern.

Identifying behaviours

Does a psychotic episode always happen to evade something, or at times of stress, or does the psychotic episode occur over a broader range of experiences, is there a pattern ... [like] whenever parents are visiting or whenever they have to go to school. You've got to read the behaviour in the context of what else is happening ... over a period of time you pick up unconscious, nonverbal sorts of things [like] kid's eyes change or they tremor a bit more.

Building confidence and self esteem

He just couldn't settle in class so there were a lot of times I was sitting next to him and he wanted me to do some of the work with him ... and [I did] a bit with him and in the process I continued to give him positive feedback, I'd say "you're actually smarter than I!" and all those things ... to build up his self esteem. I had to get something that he can grasp and do well and get like 90% or 100% right to make him feel good ... so that he feels he can achieve.

Building confidence and self esteem

[It begins with] one to one activities with them and giving them praise but not over the top, just giving them enough praise to know that they are worthwhile ... You encourage them and build up their self esteem ... when you're out doing activities, without them knowing, without it being a structured time.

Building confidence and self esteem

Activities [provide] an opportunity to build on self esteem, gain new skills [and] a sense of achievement ... every sort of thing was used doing individual or group activities.

Seeing and responding to what's underneath

I remember Jonothan ... his arrogance, his smart arsed

smartness ... sometimes it's hard not to respond to that. With experience you gradually learn not to respond to that overt stuff and see what's going on underneath ... not responding to the [behaviour but] going underneath and taping into that ... it's not having that reactionary response that escalates that behaviour ... trying different strategies to engage them in what's really going on for them.

Seeing and responding to what's underneath

Underneath that rage there is actually terror and the feeling is of fragmenting inside, of falling apart ... and I thought it seemed so important that she be held together and have that experience that she could be held together ... I remember making this decision to try to contain the feelings [by restraining her].

Seeing and responding to what's underneath

When she came in she was just self effacing ... a tablet drops on the ground and it's like "oh don't waste the tablet", you know, I'm not worthy of a clean tablet, this really incredible self devaluing ... she would say "I don't want to waste your time" [so] I'm trying to relate to Maree that she is of value to spend time with and she is important and [how] 'I don't want to waste your time' keeps everything bottled in.

Monitoring behaviour

Say they were participating in an activity, how was that getting out of control, say they were doing painting and they started splashing on the walls ... on the floor ... I mean just the behaviours, observing what they were doing in the activity, how they were concentrating ... how they were relating to each other and the staff, were they in a cooperative frame of mind, were they beginning to get aggro, beginning to be hostile or building up [like] tone of voice, you know, swearing [and] their nonverbal behaviour.

Monitoring behaviour

The nurse has got to foresee the impending escalation of the behaviour and it can be unsafe for the kid to continue their behaviour ... when an adolescent is increasingly verbal, gets flushed in the face, starts invading other people's personal space, with yelling included, starts reaching out to hit, hurt or grab another adolescent [behaviour is escalating] ... Others become very quiet and withdrawn and lots of times that results in self harming behaviour or taking it out on physical objects.

Monitoring behaviour

She was a very fluctuating, moody sort of kid ... One day she could say "I'm fine, everything's rosy" and the next day burn a hole in her jumper and the next day have a razor blade cut across her wrists and the next day be under hospitalisation ... very unpredictable, so I had to monitor, at least for safety, the process that they're going through. There may be a reduction in intensity [overall] ... less frequency of the same behaviour ... less intensity of the same behaviour, they may not be so up and down, the range narrows, instead of going so high and so down it's medium high and medium down.

Nurses are flexible

There's routine but on the other hand they are allowed to do things they like to do within the routine ... a lot of adolescents come from a home that has no routines so in the unit you create this routine [but] give them options ... rather [than] telling them ... it's more democratic.

Nurses are flexible

[Flexibility is essential] because you're working with different kids, with different temperaments, with different developmental stages, with different capabilities, with different experiences, with different family structures and [because] what they make behaviour mean is according to their world not ours.

Nurses are flexible

You have to have a lot of flexibility in looking at the individual situation ... sometimes it could appear that you're not consistent overall, [to] someone looking at it from the outside ... [you have] to see the adolescent in their context and where they're at, at what point they're at in their admission.

Relating to adolescents

There are a lot of mannerisms adolescents use and sometimes I might use them myself ... it connects you with them and they're not seeing you as an older out of tune person, you get in tune with them and they can see "oh he's not that much different he's just older." I try and keep up with the things they're into ... the characters they associate with ... that's common ground to have.

Relating to adolescents

This happened at a camp. A kangaroo came close to me

and I had some bread so I couldn't stop feeding the kangaroo [so] since then they call me 'skippy' ... and that's [how at] the time that group of kids related to me, whenever I walk in they call me 'skippy', it's just [a] really nice, warm, welcoming thing. One time I curled my hair [so] they started calling me 'curly' ... every time I walked in [they'd say] "hello curly!" and I accept that because I feel that's a friendly gesture and everyone laughed.

Relating to adolescents

I'd ask her about her music and things that adolescents like and that I knew she'd respond to. I remember talking with Martyne about the gothics in London ... if you know something about what they're into they'll look at you in a different light ... not the same as mum and dad ... and the teachers.

Nurses persevere

Sometimes you might have six or seven separate experiences of your buttons being pushed before some disclosure. They want to find someone who they can trust ... your ability to sustain what they give out [is critical].

Nurses persevere

I suppose through my perseverance when she did want to talk to somebody she actually said "can I talk to you?" but it was [only ever] problem solving stuff.

Nurses persevere

Others just wouldn't want to engage with you at all [it's like] "oh you're just the same as everyone else", so you'd just ride it out until they could see you weren't gonna get cranky and you were gonna be there for them.

Being neutral

We have to be neutral about how we deal with our emotions and the emotions of the adolescent, you can't take things to heart, you can't hold grudges, you just have to be fairly neutral and accepting of what the adolescent needs in that situation ... it's important to realise the anger is going to be directed towards you and you have to be able to deal with that anger ... most times it's not a personal attack, it's an attack on life, the world, everything around them.

Being neutral

You have to be able to [be neutral] ... not to bite because you'd be biting every five seconds, you have to develop a certain strength within yourself to be able to stay neutral ... The ability to be able to manage your own feelings in response to them being triggered by the kid's behaviour requires a tremendous amount [of effort] ... to override or transcend your own feelings to actually see what's going on with the other person in the situation.

Being neutral

Keep your cool and maintain your sense of humour .... Working with adolescents taught me a lot about keeping my cool ... they're still very vulnerable and finding their own way in the world ... you can't do that [you can't shout].

Nurses are like family

Sometimes it's a bit of a parent role, sometimes they might look on you as being in a big brother or sister role. What a normal parent does with their 15 year old I try and bring areas of that into my work ... interacting in much the same way as parents would interact with their adolescent.

Nurses are like family

I felt it was just like a family because the staff I worked with really were caring. Sometimes it's a mother figure or a sister figure [that you are] ... more or less like a family.

Nurses are like family

We had lots of uninterrupted time and a lot of that time was just spent doing the basic, ordinary things that we do in a parental relationship, a loving, parental relationship with an adolescent. [Also], many of the kids hadn't experienced family holidays or a wide range of activities and it was providing something these kids, most of them, had missed out on.

Nurses are role models

Sam used me as someone to look up to ... he took up a trade like I did and definitely wanted me to know how he had achieved something and I think that developed out of the relationship I had with him. [Also] a lot of them turn around and say "I want to be a nurse" ... I've got 13 year olds talking about when they grow up they want to help kids ... they see what you're doing as a

good thing. You become a sort of a figure head in their life and ... they can use that to guide them a bit.

Nurses are role models

It was a new experience, they could take away a new inner representation of the world ... the whole amalgam of personalities working with a common philosophy of respect and caring for these kids would enable them to take in and internalise, at some level, the idea that there was a different way of being.

Nurses are role models

[They learnt] that not all adults were unreasonable that adults could be spoken to and reasoned with and we would listen to them whereas ... a lot of their parents wouldn't listen because they were at their wits end with the kids.

Expanding nursing practice knowledge

We had a big meeting because they were talking about whether kids should be restrained ... in the end we agreed when there is a need we have to. We had inservice, two or three sessions looking at tapes and role plays ... some help and demonstrations, I think it was good.

Expanding nursing practice knowledge

Boys with real behavioural difficulties, I learned so much from watching Erin stand up to their bad behaviour and just clearly setting limits in spite of the rage that would come back, and that was something that when I first went there I found very hard to do ... to stand up [to them], to clearly say "this is not acceptable." I felt quite intimidated by the knowledge people seemed to have ... I do remember having a months supernumerary status and being so relieved that that was available, that I could sit and observe what other nurses did.

Expanding nursing practice knowledge

I didn't know any of the signs and symptoms of sexual abuse when I started there, I was just raw, completely raw ... We had that very good lecture ... she had done a lot of work with sexually abused kids, she just let us know this, this and this so it was very helpful for a lot of us.

Devalued nursing practice knowledge

I undervalued enormously ... what nurses did compared

to what therapists did and I fell into that trap. I had a sense that therapy was something special and esoteric. Now I see therapy as a much broader range of behaviour ... everything's therapy from the moment that you step onto the unit but at the time I still had a fairly rigid distinction in my mind about what was real therapy and what wasn't.

Devalued nursing practice knowledge

From the nursing point of view sometimes it's very frustrating when the medical side is not prepared to listen ... [with] changes of registrar or clinician it seems to take a long time for them to believe that we need to agree with a certain contract with the kids ... or [that] things we've been doing [are] workable for the unit and the kids.

Devalued nursing practice knowledge

The thing is, you feel like the psychiatrists have no idea what to do with the kids and you advocate as a nursing staff member that change is occurring and they go "rhubarb rhubarb, we've met with the kid for five minutes and we don't think that the kid's changing" so it becomes your word against their word.

A cohesive, consistent and cooperative environment

In an adolescent setting you can't be alone, a one off, you've got to work as part of a team, be able to communicate and get on with other team members and deal with things that arise ... differences, inconsistencies, all that stuff, to be able to discuss those things is really important.

A cohesive, consistent and cooperative environment

You have to have a team of staff accepting adolescents and have the same working attitude otherwise the kids will feel very confused. If the team is cohesive and consistent automatically the adolescents will settle ... The consistency of approach to the kid among the staff [is important]. You have to let them know we work as a multidisciplinary team, whatever they tell us the staff from the team are aware [of] but also it stays within the team ... not allow splitting among the team [members].

A cohesive, consistent and cooperative environment

Using the skills of the personnel on the unit [is important]. We have a mixed staff group ... they have a lot of varied experience and I think bringing that together and making it work for the positive aspects of

the unit is very important.

Nurses are friends

A lot of them have trouble developing friendships ... they lack the ability to establish friendships with peers let alone adults. If they can achieve some sort of friendship with a nurse that can help them work with their peer relationships. That friendship, I like it to be where they can talk to me about what they're not feeling good about, apart from what they're feeling good about ... if they're feeling a bit lost or upset or depressed about issues, that's why the friendship needs to be there, for them to be able to ventilate the feelings that they have.

Nurses are friends

It's not easy ... working out where that professional relationship is, like is it the same as being a friend? Drawing the lines and having clear lines on what is a healthy, working, trusting relationship with the adolescent but still maintaining some sort of clinical objectivity ... I sometimes think "well what is the difference between being a friend and this therapeutic relationship?"

Nurses are friends

They just come and put their hands on my shoulder like friends ... the nurse is more or less a friend, that type of relationship.

The ethics of practice

If you start developing a friendship, which I think is healthy, you have to make sure you don't include ... influencing adolescents into exacerbating bad behaviour. A certain level of maturity must be exhibited by the nurse.

The ethics of practice

At one stage we suggested the mother refer him to another program but Adam refused. I can understand it, he doesn't want to be rejected again in another place, this is [like] one failure to another failure ... I just feel [we were] really unfair to this kid.

The ethics of practice

[I remember] feeling very angry that Belinda was sent away to a psychiatric hospital because we didn't have enough of an ability to hold her in the environment and

I felt very strongly that we did and that she got sent away when she shouldn't have ... [The doctor] said "send her up to the psychiatric hospital" ... and [I] struggled with this whole issue of "is it because she's a girl?"

Example two:

Here we were saying continuity and consistency is so important and every January and July the kids would lose their [registrar] therapist if they [kids] were staying on ... That was crazy stuff ... a real use [by] the establishment of the kids ... it's just wrong.

Sub-Elements Identified in Four Nurse's Texts

The therapeutic use of self

Who you are as a person is what you will bring to mental health nursing, that will just come out ... who you are will come through in what happens ... a good sound clinical knowledge of adolescence and the disorders is important but it's who you are [that's significant] because that will be the basis of the relationship and what comes out of that, so the more you know about yourself ... I'd see as really valuable to nurses who would work in adolescent settings.

The therapeutic use of self

The person that the nurse is and becomes ... I think automatically that process must carry along to the adolescents. It's not the techniques or model that a person particularly has that actually does the work between client and nurse it is the relationship that can be developed ... being who you are and focusing that for a therapeutic end.

Example two:

It had to be something in you that was stable enough [so they could] latch onto it every time they saw you even though different things might be happening. Just walking into a room my presence would have an effect on what was going on and another nurse would walk into the room and they would have a different effect. I'm talking about an ordinary, average day on the unit ... that amazing power of the presence.

The therapeutic use of self

It's almost like using yourself as a therapeutic tool and it means that you actually take in your strengths, your resources, your abilities, your talents ... but at the same time where do your own weaknesses, deficits, inadequacies, fears and concerns also impair that tool

in building or working within the milieu and with the teenager ... Your tolerance level, your style, your approach, your way of being available for the kids ... your ability to be able to facilitate someone else's development or just get stuck in your own defences [its all you].

The therapeutic use of self

I get feedback from adolescents that I to them am an individual ... I reflect that back on them and say " ... I'm not afraid to say what I think, this is something you'll start developing yourself, you can try it now and see if it works, and you'll be surprised [that] there are other adolescents out there who feel exactly how you feel [and] like the same things you like but haven't spoken about it because it's not the so called latest thing that they're into."

The nursing peer group is supportive

We need to sit down and think about what has been happening ... I find [the kids] quiet time is the time to have feedback and sharing amongst the staff ... I have to keep thinking what is best for them and what works and what doesn't and then have continuous feedback and review on my own work.

The nursing peer group is supportive

I remember one day [the nurse] Charlotte was so frustrated with [the therapist] Andrew over this whole business of limit setting and she came to me ... we talked about the broken record technique. We went to Andrew the next day ... I was just there to give her moral support not to actually take part in it.

The nursing peer group is supportive

If the nurse is having difficulty with a particular adolescent it's helpful to ask another nurse to take over ... there are adolescents we clash with, that's just reality ... it's very important to ask somebody else to take over, to get support from your colleagues, and that's good for the young person as well ... not to hesitate in asking for help or time out from a situation.

The nursing peer group is supportive

Harriet spoke with me about that [incident], about my feelings, she was very good like that ... everyone looked out for everyone else ... sometimes [it meant] removing yourself from the situation and getting someone else to take over, which is time out for the staff.

Expanding the knowledge of self

You start from what you've got and you learn over time to separate what's yours from what's theirs, and I think that's something that you have to keep doing all the time in the therapeutic relationship, what belongs to me, what belongs to them and where is it meeting in this encounter.

Example two:

Working on the unit allowed me to develop a trust in myself. I became more able to stand up for my point of view so it was a huge learning experience for me ... you can make mistakes but if you can acknowledge them and work with them they actually can be growth producing.

Expanding the knowledge of self

It taught me a lot about myself, to be more patient, to pull my head in about myself, I was a bit full of myself ... it made me grow up, mature a bit, to think of my behaviour, how that would effect them ... [not] talking, talking, talking [but] listen to what they've got to say.

Example two:

Sometimes you've got to work on yourself to get that therapeutic relationship going, so you think ..."right, I'm not getting through to so and so, what do I need to change about myself?" [You] look at yourself a little bit and change.

Expanding the knowledge of self

You have to have developed personally within your own adulthood, to have worked through incompletions within your own life ... you can use the feelings that come up for your own development as a human being ... You need to own your own feelings, discriminate between what is your stuff and what is the teenagers, that takes a certain amount of courage, awareness and some inner character development ... Sometimes they take you into your own stuff, they plug you into your own stuff.

When you work with teenagers you replay your own dramas ... your own adolescence ... where I feel socially awkward in talking with teenagers I could say "they make me feel uncomfortable" or [I could say] "when I was an adolescent I felt very awkward talking to other adolescents" ... they bring me back into contact with a stage of development which I myself was incomplete on

... It retriggers or brings up those old feelings.

Expanding the knowledge of self

It was losses or sadness I was identifying [with] and I was suddenly aware of that with something that came up with an adolescent who was depressed ... just being aware that I was affected was enough ... that person touched something that was unresolved in me and I'd need to be aware that that was going on, observe my own responses when I'd be dealing with that person to monitor that.

The adolescent peer group is supportive

One particular camp we had a couple of depressed kids ... some music had been brought, heavy metal stuff, and we talked to the kids about may be they could refrain from playing it because it made the kids who were feeling down feel worse ... the kids did basically refrain from doing it.

The adolescent peer group is supportive

[When a kids depressed] explain to the other adolescents where he's at and how to approach him because the others also wonder what's happened to him, so encourage peer support.

The adolescent peer group is supportive

They themselves provide support for one another ... sometimes the teenagers feel they get more of a sense of understanding and acceptance by the other kids ... they can hang out with the other kids much easier than with the adults. There are those odd occasions where kids find other kids difficult to hang out with ... but that's not often. The peer group is very important.

The adolescent peer group is supportive

They need a sense of belonging and they feel like they don't belong to their families anymore because they're becoming adults, so people their own age are very, very important to them.

Establishing boundaries

I know there were particular times with adolescents where you would feel yourself identifying too much ... it's really important to be able to discuss those and deal with them ... being able to step back from it and see it rather than just be in it. I've been there and in it with a lot of adolescents ... [you need] to step back and see

what's going on ... in the relationship between you two.

Establishing boundaries

I hope I never overstepped that kind of boundary ... if anything I probably would have set the boundaries too far back rather than too close. I think it was a boundary question because this kid's boundaries, we later [found], had been violated ... you can invade not only their physical space but their minds as well by asking too many questions and not waiting for them to be able to talk.

Establishing boundaries

[You] start building the closeness ... but I know my boundaries, like taping my head or my shoulder I accept this as friendly but I wouldn't [allow] anything further or [them] invading my privacy so I already set the boundaries.

Establishing boundaries

You've gotta be very careful and put the boundaries down first [like] "okay I'm just gonna massage your head and that's all I'm gonna do" because a lot of kids had been sexually abused and they could have seen it as "my God this is gonna happen all over again."

It's more than a job

I often wonder what they're doing as time goes by, where he or she is, what they've done with their lives. If ever there's been a situation where I've come across an adolescent I've worked with ... it's a great sense of achievement and enjoyment to see them, there's common ground ... a good feeling about it.

It's more than a job

I met him in a shopping centre. He came and said "hi" ... patted my shoulder and all those [things] ... he's the one that called me 'curly' ... I know I was special to him because he bought me perfume ... I had to get him a soccer ball because he loved soccer.

It's more than a job

This rather beautiful, well dressed young woman came up to me and said "hello Origma" ... it's Justine." ... I asked her looking back on the unit whether she thought it had done any good and she said "no, not really" but I don't believe her because otherwise why would she come up and make contact with me, I simply wouldn't have recognised her ... I think we actually love

those kids in our own way. I still think of some of them with deep affection and wonder how they're going.

It's more than a job

Dear Mitchell who I had a soft spot for. I often wonder about Mitchell, what happened to him and where he is ... The day Mitchell left I gave him that little book to read and a cuddle and when he cuddled me it was a warm sort of cuddle.

Implementing restraint

David was really acting out and he was starting to throw things around his room and we restrained him ... his therapist came and spoke to us and said "well it's query whether he's been sexually abused" and like that was information she hadn't passed on ... if we would've known that we wouldn't have restrained him that way ... we probably would've tried to sit him on his bed and hold his hands ... because a lot of time when kids are being sexually abused they have been restrained.

Implementing restraint

There were times when Greg was really destructive and he attacked other kids and we had to restrain him ... he was scratched here and there because he was so destructive we just had to restrain him where he was.

Implementing restraint

For some reason Theresa got into an absolutely furious rage and started to destroy her room. She had a tennis racket in her hand and she started lashing out at me ... I actually held her and it must have taken about 15 minutes for her to calm down ... She swore, she spat, she kicked, she yelled and she was a strong, chunky young woman ... and even though I'm pretty big it took every bit of effort I had.

Example two:

It was knowing how to hold Sam, how to walk with him, it was building on a previous relationship ... he knew about me, about the limit setting, so there's a combination of physical, mental, emotional background [and] context ... for us it was part of a job.

Implementing restraint

Warnings are given to give the adolescent time to try and manage his behaviour ... if that doesn't happen usually you get a verbal outburst and physical aggression.

They may need to be restrained until they calm down [especially] in a situation where they're not in control ... restraint is only done when all other methods of calming the adolescent have failed and the adolescent cannot grasp the results of their behaviour ... they may be going to hurt someone.

Nurses provide and take opportunities

I accidentally spilled some of the feed I was using, I needed to flush Melissa's tube out and it went all over the place, some splashed on her and some splashed on me and she just burst out laughing and she basically had no expression on her face for weeks ... so I deliberately stepped on a balloon that was in her room and it burst and she laughed more.

Example two:

[David was] hurling abuse at me and then he would hang around me and be there ... I could see there was an opportunity there to grab and take and get David to ventilate like "what are you actually feeling?" He had been home and had a bad time at home the night before and was able to start talking about that, that gave me a clearer picture of what was happening and I could address that.

Nurse provide and take opportunities

We were jumping on the trampoline and [I] start asking about "how's mum?" ... those things start getting [discussed] ... they're relaxed and [it's a] free environment to talk about their problems. When particular incidents happen it's a good time to talk to them because it's more effective, you can use that incident to work on the issues ... take the chance to work it through with them.

Nurses provide and take opportunities

Aaron would be on the trampoline and I'd lead in with "look mate it looks like you're really upset about something ... is there something I can do to support you?" ... [he says] "no fuck off, piss off, leave me alone" but there's a response and you just kind of bounce off the response, whatever it is that they give you.

Nurses provide and take opportunities

[Change] may or may not happen and that's one of the things as a nurse that you have to be open to, that you can provide and offer and influence but the ultimate choice is the kids.

Testing nurses

Adolescents can say all the right things or wrong things ... pushing your buttons and making you want to explode and that's the test they're giving you to see if you're going to be able to cope with them at their worst time. If you can cope ... they'll make it even worse [to see] that you're going to be there next time and you're not going to run away, you're not going to slam the door in their face and say "I can't deal with this."

Testing nurses

They resent authority anyway and of course we were authority figures. They would test us to the limit to see what they could get away with and see what controls we would put on them ... They test you to see if you're gonna explode, to see what they can get away with, to see what sort of person you are.

Testing nurses

They have to test the nurses, how much the nurses can accept them, so they push the limits and see whether we will push them away ... that's the way they test whether they can trust this nurse or not.

Testing nurses

They do want to see how far they can push you, when you're gonna draw the line and say "this is it."

Interpreting communication

The kids were acting out not because they were naughty, horrible, nasty, little kids but because something had happened to them and this was the only way they could let us know something was wrong ... unfortunately that involved a lot of aggression at times and verbal abuse ... Acting out was one way of getting assistance.

Example two:

You would go up and say hello and it would depend how they responded to you then ... and their body language, if their hands were clasped, if they were facing the window or they actually turned around and faced you when you came into their room, just things like that.

Interpreting communication

With Kara [it] was that she didn't value herself as a person, and therefore it didn't matter what happened

to her ... a lot of risk taking behaviours, eating mushrooms then going to hospital and being lavaged ... getting alcohol from the shop ... running away. There was a lot of emotion there that she couldn't put into words.

Interpreting communication

It's about fear, the boy who kicked the registrar knew that she was frightened and so his own violence, anxiety, whatever it was, escalated into out of control behaviour ... Laura was the same ... she had a space and if you violated that space, in words or physically, she would lash out, which again was fear [like] stay away don't overwhelm me.

Interpreting communication

Sometimes they're very poor at expressing themselves so you have to listen carefully to what they're saying ... A lot of them are saying things that have double messages ... be open and receptive ... when they say something and the penny drops you can get a foot in the door about an issue that needs to be dealt with or spoken about.

Failing to establish boundaries

You get a sense within yourself that you're beginning to be controlled by the illness, it's kind of weird to put into words ... you build a rapport and you get [to feel what she feels] and you don't know where to go, you feel almost as powerless as the kid.

Failing to establish boundaries

Michael's family background was more or less like my family background when I was young ... I have to admit I gave a lot of attention to him wanting him to really do well ... after he was discharged it really came up to a conscious level. There were times inside I felt I have some funny feelings [it] was probably that certain moments my own childhood things came up ... got in the way of my work.

Failing to establish boundaries

I think there were times when adolescents who were depressed triggered some things in me ... not being able to recognise that would stand in the way of the relationship. I wouldn't be as effective a nurse with that adolescent where I identified too much [with them] ... that triggered some feelings that I myself had experienced as an adolescent, being depressed,

[and] may be I hadn't worked through those.

Failing to establish boundaries

Becoming too over familiar with the adolescent [means] the nurse can get caught up in the adolescent's behaviour and become another adolescent ... this brings up moral issues, it brings up trust and boundaries.

Having fun

Some of them have disruptive lives and disruptive families, humour's not introduced in their family life much and [so] I encourage fun times .. lots of games, lots of playing ... any game that we can instigate where laughter is brought into it, and it usually brings out a sense of warmth ... I think it's good, it helps them, they need a good laugh.

Having fun

Just have fun with them and let them feel free. I couldn't swim much [and] ... a few [kids] tried to get me to the deep end and when they put me in that situation I was screaming but another group of kids tried to rescue me ... that sort of fun, it's nice, have fun. At the time I worked with [the kids] the nurses were fun people to work with.

Having fun

A lot of the activity facilities like the swimming pool, the tennis court and the activities area were really valuable areas where kids derived a lot of fun.

Having fun

I remember I had a great deal of physical energy and how much I enjoyed the games, races, bicycle riding, footy ... and the camps. I used to have an enormous sense that we were giving these kids something so important.

An open, accepting and supportive environment

If the nurses aren't providing that supportive environment where the kids can be themselves, where they feel they can express themselves and have an opportunity to be themselves and act out [it won't work] ... it's the attitude and behaviour of the nurses and what sort of atmosphere they create that's the most important element of setting the milieu ... that provides the blanket or place where the adolescent can act out

or do whatever.

An open, accepting and supportive environment

If the staff weren't comfortable with each other and in working together that becomes reflected in disintegration and violence [in the kids] ... It was remarkable how little violence there was and I think that was because there was such a positive atmosphere towards them and it wasn't punitive, it wasn't attacking ... and because the staff had a positive milieu they could provide it for the kids.

An open, accepting and supportive environment

The culture there allowed people to grow and explore and experiment so that was passed down to the kids ... it was a very dynamic environment ... therapists would let you know what happened in the family meeting and you could marry that with the unit and the school whereas here [that doesn't happen] even the communication within the team was cohesive, much more open, dynamic, much more explorative, [you might say] "... any other ideas about this?" and it's like here's another five or six different ideas.

An open, accepting and supportive environment

They had to have a secure environment and people supporting them to move on, that's very important. Loving care and nurturing are the basic essential things for them ... once their self esteem is affected their confidence to continue is also affected.

Nurses are advocates

You walk into the staff meeting to talk about a kid which most staff don't like and think is a pain in the bum [they] think she's manipulative ... and just wanting to get her own way, and having to try and advocate ... people would just role their eyes. It's very hard to [advocate] sometimes when you've got a whole culture that works against that.

Example two:

I said "do you feel like things are changing, do you just feel there's a sense of change?" Michelle said "yes I do but I can't articulate it", I said "okay so there's change but you can't articulate it, so they're basing [their evaluation] of you on the external words you're saying and they're not really getting a sense of what's going on for you as a person" ... So, I can tell them that, I can advocate for you on that one.

Example three:

> *The only thing I can do is think further than the one term admission ... I can refer them to someone else who I know will be very good with them. I referred Kara to another person ... and Kara, out of trusting me, went and saw that person [for] long term psychotherapy.*

Nurses are advocates

> *People didn't want to have Adam because he's too disturbed but his therapist and myself ... wanted him to stay a bit longer because we just started the work. It was very hard ... the director insisted this kids got to be out, other clinicians were also not happy to have him [there] ... With that pressure in the system we couldn't do much ... in the end if we push enough that's all we can do.*

Nurse are advocates

> *Justine was most unattractive, disliked by many of the staff and pejoratively labelled but I think she wrestled her way through quite a profound depression ... I remember defending her against other members of the staff, it was an effort at times to get her to shower ... she had this dank smell about her ... There's a temptation to, rather than empathise with an adolescent's depression and difficulty in caring for themselves, to attack them or feel embarrassed ... I felt that was the case with some of the staff, that she was naughty rather than depressed.*

Nurses are advocates

> *It's no harm to give [your opinion] if you feel there's a change or a need to change, for example, medication, if you feel that something else will benefit the adolescent it's very important to say that.*

The problem of labelling

> *There's a tendency to expect or not expect a certain level, say for example [with] a psychotic adolescent because of what was going on, you know, their emotions and feelings at that particular time ... I've seen each individual adolescent can be quite different even if there's a [similar] picture there of psychosis or whatever you label young people with. I tend to steer clear of labelling ... to look at them as an individual or how I see them and their abilities, whether it's creative, academic, sport or anything else.*

The problem of labelling

> *In the medical paradigm it's often easy for nurses to focus in a pejorative way on the things that are not working well for the kid and forget about the huge part that can be healthy and should be promoted ... a lot of them didn't have that, in their environments they were labelled the bad one, noisy one, chaotic one [or] the delinquent.*

The problem of labelling

> *I got allocated [to] Lauren and the ... first information I was given was that this kid had a borderline personality [he said] "here, you can read up on borderline personalities" ... which wasn't a really useful handover for me and I said "well lets take it as it comes" ... because I don't use labels.*

Example two:

> *Sometimes it was very difficult to tell when Sally was having a psychotic episode and when ... [she was] having a temper tantrum ... Staff got tired of the temper tantrums and so they put down whenever she doesn't get her own way she'll throw a temper tantrum and it became quite difficult because there were times when she was genuinely having a psychotic episode ... as the primary nurse working with the kid you often [knew].*

The problem of labelling

> *I remember one boy, Jonothan ... it was really interesting that I had seen the other side of him as he progressed through his admission, in my mind I had thought "well nothing will change Jonothan." So, it was something in my head but then it was nice to see that disproved.*

Supporting parents

> *It's important to have the parent's input and feedback and expressions of their difficulties. Parents need help managing so you need to support the parents and help with their ... anxieties about how they're going to manage the adolescent at home. Parents are very important [but] sometimes parents need as much work as the adolescents do ... they need a lot of support.*

Supporting parents

> *We deal with quite a lot of parents and obviously individual parents would have a different level of contact [but] you're there as a source of support for the*

parents because sometimes they can feel quite lost with the adolescent or with the problems the adolescent is having.

Supporting parents

The family was horrified but they were scared of how to deal with the doctor because if the doctor said "we can't do anything, the only thing we can recommend is ECT" and the family goes "no, we do not want you to do ECT" then the doctor might go "well sorry, we can't do anything so out" ... I basically did some role plays with them and prepared them for how to handle the doctor ... I'd already set the scenario up before ... so they would know how to respond to the doctor ... they were very strong and they handled the doctor and that was fine.

Supporting parents

Apart from working with the kid you work with the parents or the family members at the same time ... explain to them ... it's hard for them to see their kid like that.

Working in partnership

I believe it's always favourable to have the adolescent know what's happening because I believe it's not right for them to feel we're doing something but they don't know what it is ... I believe they should be involved in [developing] their own management strategies.

Working in partnership

Working along with the medical staff ... [monitoring] how the medication effects the adolescent, and the importance of cooperating with the parents and talking to them and getting feedback and getting their thoughts and how they feel about the medication and various aspects of care.

Example two:

A lot of the young people go home on the weekend so it's very important to have feedback on how they are at home, how the parents see their improvement or if the parents see there's any change ... link up with the parents of each individual.

Working in partnership

It's important that they know that you're not going to fix them, they're going to be responsible and it is this joint thing of working together ... we will work on

things and work together in helping you work through the problems you've come to the unit with ... the doing of that would be the important thing, they would know that was happening, experience it happening ... May be when they come in they feel it will be you doing it and may be that's okay initially ... but as the admission proceeds, that partnership with them [changes], taking their responsibility for their part will become more and more ... when they leave they will be a responsible individual in their own right.

Working in partnership

It becomes a joint thing ... work with them cooperatively yet with firm limits and boundaries, guiding their energies rather then trying to extinguish or control ... you need to be able to go with them and enter their world and let them play out some things ... Be of service to them, help them understand what's going on then let them tell you how far they can go and how far they can't go.

The pressure is taken off

When I first met Martyne she just sat there on her bed and wouldn't even raise her eyes up to me ... may be a week later she'd look up and say "hello", so it was just a gradual getting to know you. Don't push them too hard because they've got enough pressure on them ... be very patient with kids until they're ready to talk and tell you about themselves ... let them go at their own pace.

The pressure is taken off

They've got the feeling that you're prepared to listen to them and are nonjudgmental ... you have to give them space as well like if they only want to disclose to a certain extent, we just allow that and not push too far.

The pressure is taken off

He had a really well developed delusional system which he managed to keep under wraps for such a long time ... I was amazed that anybody could have all of this stuff inside them and that it hadn't come out ... and people were able to sit and wait until he could talk about it.

The pressure is taken off

This is a huge aspect of our care and it's very important from the point of view of the adolescent enjoying themselves. A lot of these young people have come from situations which were quite difficult ... Most of them enjoy activities because ... they take their minds off a lot

of their problems and it's a very relaxing time as well.

Nurses use humour

In your everyday interactions with adolescents I find you can make life really quite funny at times for them ... One evening we were going for a long walk ... and one of the adolescents, she was in very bad form that evening, and I said "okay, come on then lets go, we're going for a walk, lovely fresh air." [I] was trying to encourage them out and she was moaning and [said] "oh, I don't want to go and I've got a pain in my neck" and I said "well, you won't be walking on your neck will you!" She had a laugh from that.

Nurses use humour

I've got a bit of a bizarre sense of humour, a good sense of humour ... the kids picked up on that and I think that's important when you work with adolescents, to have a sense of humour and to muck around with them.

Nurses use humour

He was asking did I think he was a nice enough guy for a girl to like ... because he was going through that gawky growth spurt and the oily face and pimples but a lot of reassurance, and humour was added to it, and he was able to see the humorous side to his serious emotional state.

Nurses use humour

Still be in touch with the naughty child in yourself that can laugh cheekily at things ... having a sense of humour is just so important, the ability to laugh at yourself and laugh with the kids at themselves.

Nurses are there

Amanda is very quiet, she hardly speaks at all, she has withdrawn into a fairly mute state and I find, as difficult as it is, I spend time with her ... just being with her, talking to her even though she was not responding ... Despite the worthlessness she was feeling, the sense of isolation, the confusion about herself and what was happening to her someone was still there talking to he ... they just need you to be there.

Nurses are there

The activities which take place give the adolescent a very positive experience ... they're very enjoyable and very positive ... It's really about getting out of the unit

and going out together as a group and getting involved in all these activities and getting the adolescent to join in.

Nurses are there

It's only through the constant encouragement and being there. Spending time with them lets them know that what they think and feel is of value ... you understand it and that it's their reality and it's okay [like] "it might not always be working out for you but at least we understand it ... we can still be with you."

Nurses are there

Treating the kids fairly, listening to them, making time for them, not locking yourself away in the office and ignoring them, just actually putting time into them [is what counts].

Providing attention

It was a bit more attention that he needed, someone to talk to him, spend time with him and just listen to what he had to say ... it gives a sense of identity and self worth.

Providing attention

When a kid is depressed it's harder, when they don't want to eat and don't want to do anything but at that stage being with them and continuing to offer them things is already nurturing for them ... encourage the family to come more often as well ... we need constantly to approach the kid.

Providing attention

I try and encourage what they have done and what their interests are and let them know I'm interested in that. A lot of adolescents like music, I have an interest in music so I use that to share and enjoy ... I have music programs at work and I interact with the kids that way.

Example two:

I take the adolescent aside and ask them what they felt during that experience of a temper tantrum ... what they would like to have happen to them without that temper tantrum and surprisingly lots of them want attention but don't know how to get it appropriately. ... [So], I draw attention to the simple things that are being done, I draw attention to that and they're being noticed for something they're not used to being noticed

for.

Providing attention

Listen to the adolescent and like hearing what they say and come down to their level and enjoy being with them and they, in turn, can see that you're interested and obviously that somebody cares because one of the reasons that a lot of them would have been there is that nobody would have listened to what they felt or what was going on in their lives.

Sub-Elements Identified in Five Nurse's Texts

Being understanding

It can be like a clue to something else that we need to work with but often we don't try and find the meaning of the behaviour we just get thinking [in a] very judgmental or critical [way] ... We had a kid who had marijuana and jigged school and everyone said "oh he should be suspended or kicked out" as opposed to "well may be he's done a great deal of work and he's finding it a bit difficult at the moment."

Being understanding

To be able to reflect on your own adolescence and trying to remember how you felt at that particular time, which was quite traumatic and quite difficult at times with parents and older people [is helpful], and I suppose trying to have a sense of empathy with the young people.

Being understanding

Knowing there's someone there to understand when they're going through the rough times and someone they can share what they're going through and who won't be too judgmental about their responses and behaviour ... being there for them and trying to understand.

Being understanding

There was a part of me as an adolescent who had also experienced abuse that was very like Theresa ... I think I did identify with her in some ways and may be she sensed that, there was a part of me that was very comfortable with her or understood perhaps.

Being understanding

The kids are still coming to terms with their emotions and trying to control them and learn about them ...

Quite often we'd be up in the craft room and one of the kids would say something to the other kid and they'd flare up straight away and just be off, they'd walk out.

Being accepting

Adolescence is a very trying time for normal kids ... so with kids that are emotionally disturbed you've got to accept that when they lose their temper it's going to be a bit worse than normal [it's] trying to teach them ... It's okay to be angry but there's better ways to express it.

Being accepting

We went through many different phases from not wanting to talk, that was her beginning stance ... she was pretty strong in it and rightly so because her experiences had lead her to that and that was fine. In time she began to make gradual interactions that went from one word to ... a paragraph ... that was fine, let the natural process occur.

Being accepting

Sometimes you feel really fed up and wish the person were not there ... but when you learn to accept the person your thinking will be different, we accept them and then they gradually change. If [I] as the primary nurse am not there, and there are others there, then how much they accept this kid can make the difference.

Being accepting

She was very closed in those weeks and I was happy to talk or not talk ... if she didn't want to talk we'd go for a drive in the car or to the movies or go and have a hamburger, and if she wanted to talk we'd talk, so I guess it was pacing to her speed.

Being accepting

[It's] the adolescent feeling somebody cares about them and accepts them and likes them, regardless of their problems, for what they are. I think they can see you then for being a very kind of human person and approachable. They can say what they feel to you and they don't feel put off some way in approaching you, or expressing how they feel, or what they are, or how they feel about you.

Providing individualised care

It would be great to have an across the board program

but it doesn't work because each kid's an individual [even though] at times there are some adolescents who have that same range of behaviours that need the same type of management or checking strategies ... programs have to be looked at differently and individualised.

Providing individualised care

It depends on the adolescent, some are not comfortable on their own, some feel they have to be within the group but some of our adolescents like to be on their own ... Morgan spends quite a lot of time on her own writing ... this is very therapeutic ... while we encourage her to spend time with the group talking and doing activities we feel it's been very helpful for her [to be alone as well].

Providing individualised care

Martin had a sense of humour and he was much more out going than Mitchell ... if I used the same sense of humour with Mitchell as I did with Martin it would've destroyed the whole relationship. You've got to get to know the kid, just look at the kid first and ... think about how they would react if I said this, if I said that.

Providing individualised care

For instance, someone drinking ... if that family has an alcoholic in it and that's the way they cope and that's what's encouraged within the family [our aim is] helping to develop other ways of coping ... In another kid it could be experimenting ... The same behaviour needs to be interpreted in different ways depending on the kid ... The sense you make of it is dependent on the context.

Providing individualised care

It's a learning process ... we learn how much we can push the adolescents, not push [but] expect them to achieve, what's their limitations because they all come from different backgrounds so we can't expect them all [to] behave the same or achieve to the same level.

Providing containment

The adolescent is [learning] controlling their own behaviour ... If the adolescent can't be asked to take control and manage his own behaviour then the nurse will take charge and let the adolescent know they are taking control. They're given warnings ... they may be asked to remove themselves and if they can't do that ... you just remove them, take them somewhere where it's

quieter. That should be done in a nurturing way not an aggressive, challenging or a negatively challenging way ... so the adolescent feels safe.

Example two:

Sometimes if the behaviour continues to escalate we offer them a room where they can sit and calm down. They might have a time limit set on that, five minutes [or] 10 minutes, whatever's appropriate for the behaviour, situation or problem with that adolescent.

Providing containment

A calm approach and honesty [is needed] when dealing with issues with adolescents. Susie's 13 ... the unit policy is no smoking until 15. I remember talking to her about this issue, she was quite angry, all she wanted was a cigarette. I pointed out the problems with smoking long term ... health problems, financial [costs] ... [I was] being quiet, just continuing in the same kind of monotone ... and being very calm with her and she was getting really, really angry and eventually stormed out of the area and went off to her room ... the approach was very calm and reassuring at the same time ... she returned later and apologised.

Providing containment

When they don't have that [feeling of control] internalised in themselves then somebody on the outside needs to provide that for them, so they feel safe and secure ... they're unable to call it forth in that situation because of what they're going through at that moment. If the combination of adolescents that are together are really egging each other on ... [then] giving them time out or removing them, taking them to another activity or doing something else, could avoid that [escalation].

Providing containment

With Greg I would not have dared to have touched him ... The only thing that I could think of to do that might contain the situation and prevent him attacking me physically was to literally ground myself ... I had to project somehow or other a calm sense of "I am in control and this is my expectation of you" but that it couldn't be done verbally, that it was a nonverbal thing, and it worked.

Providing containment

It was mainly with boys, getting them to kick a ball

against the wall really hard ... one of them I got to punch a pillow so they wouldn't hurt themselves or anybody else, and when they settled down talk to them about it to see if they could work out better ways.

Providing equality

Some health workers put themselves above the client but we're grass roots people, the nurses, and if we had the attitude ..."you're not my equal" I don't think we'd get very far ... [equality allows] spontaneity, trust, respect ... It's important that you're not putting yourself above kids, let them know that everybody is equal ... I think they relate better to you.

Providing equality

Not to put yourself always as the dominant [one] or as the priority or as the number one, you're the number two really and by listening to them it unfolds ... [Equality is] sometimes a bit hard because they don't know how to deal with power ... [but] that just becomes more experience to work with.

Providing equality

Be on the same level with them because I don't believe in hierarchy ... the friends that treat me equally I tell them what's happening to me ... with the adolescents I do the same, come down to a similar level then they know you are ready to accept them and they feel more comfortable.

Providing equality

I try not to use big words and say something to impress myself over and above them, I try and work at their level so the connections are there ... I don't want to be authoritarian.

Providing equality

The nature of [working with] adolescents very much is that, you know, being able to get down to their level and participate at their level ... the nature of activities you do together ... it's a fairly intimate, very intimate sort of relationship.

Nurses encourage independence and responsibility

We worked in a general way of having adolescents, once they were ready to, take responsibility for their behaviour and in learning to be with other people ... to eventually becoming independent people ... at the

beginning you might be observing, in the middle there might be more intervention and towards the end you would hope the adolescent would have internalised or learnt ways of managing to control that [problem] themselves.

Example two:

[It's] allowing the adolescent more space and times with their peers and less time with their primary nurse ... facilitating developing skills ... allowing them time away from the unit so they get more confidence that they're able and capable of being an independent adolescent and can manage 'out there' when they leave.

Nurses encourage independence and responsibility

We get the kids to go through certain role playing techniques and get them to assess themselves in certain situations and ask them how they feel [and] how they might prevent a situation. We try and do this on a regular basis so when their behaviour is needing management they have learnt ways of being responsible for it.

Nurses encourage independence and responsibility

[Exstudent groups] is a way of learning social skills. Nurses act as facilitators to organise them to meet then hopefully they learn these skills and eventually they [make] contact themselves and form their own group ... then bring this skill to future situations.

Nurses encourage independence and responsibility

That was fundamentally how I worked ... just highlighting the emerging adult behaviours and empathising with how hard it was to give up the others. You saw [it] resonating with those altered ego states of adult/young person, that forward thrust and then catapulting back into the regressed [behaviour].

Nurses encourage independence and responsibility

We thought it appropriate that they have free time while they were out to let them know we were trusting them and we weren't keeping an eye on them 100% of the time ... [We'd say] "you are changing, you're not a child anymore but you're not an adult and you have to learn to live in an adult's world, may be your parents haven't been the best role models but this is your chance to learn other ways."

Sub-Elements Identified in Six Nurse's Texts

Providing safety and security

> *He often framed her behaviour as manipulative [so] it became a safety issue ... when she felt unsafe, like she was hearing voices or needed reassurance or needed to make contact or connect up with someone, this nurse wasn't available to her and kind of [closed off] ... If a kid says "I'm feeling unsafe" you have a real responsibility to provide them with safety.*

Providing safety and security

> *Paul told me, because I was in charge of the shift,"I think David's got something in his room" and I said "well we've got to search it, we've got to make sure that it's safe." [So] Paul and I went back into his room and we searched it and we found that he had razor blades ... hidden in the light switch, so he was obviously thinking of harming himself and he'd put [them there] for future use.*

Providing safety and security

> *Joshua got neuroleptic syndrome [and] had to be admitted to hospital ... we took turns to stay with him ... he was so confused he didn't know where he was. For him security is people he is familiar with, he kept grabbing my hand [and] looked at me ... every time I had to go back to the unit, he just didn't want me to go, he grabbed me so hard.*

Example two:

> *We have rules and regulations ... so people know what the expectations are with each other, how far they can go, they wouldn't go too far and hurt each others feelings. The nurses really play an important role if things happen like that ... [they] control it and put it back to a more harmonious atmosphere.*

Providing safety and security

> *Most of them [experienced me] as reasonably consistent and calm, there would be a sense of containment or safety ... I would notice if something was happening and not allow it to continue ... kids felt very safe ... [like] Laura wouldn't lash out at me because she didn't sense that I was frightened and again I think she sensed that I could contain whatever she might do.*

Providing safety and security

> *The basis would be one to one care, Sarah would be*

provided with that level of supervision and contact with someone when she was really distressed, there would be someone there to help her through those times. And, the physically safe environment, not let her have access to anything dangerous. I guess being in a unit that overall she knew cared about her and had her best interests at heart.

Providing safety and security

Anthony was venting lots of anger towards me but when the situation came back in control [and] he calmed down he then approached me ... he just wanted to be around me and I could see that he felt, through me dealing with that situation, he felt safe.

Example two:

You can look at it as being a sphere, at the outer sphere the more freedom you get [while] in the centre of the sphere more safety is needed ... more direct care. At a certain level they're not able to be in a classroom, they're not able to be regarded as being safe to themselves or others ... they may need one to one care.

Setting limits

Limits provide safety, they provide boundaries so that kids know what to expect ... [if] we let them do whatever they want the teenagers may escalate each other ... and begin to feel unsafe because of their own behaviours building up to a point where it gets out of control ... [Also] you've put a limit on it before it gets to the point where they've regretted they've done something ... It provides safety for other kids because they know when those kids do those behaviours that someone will put a limit to it ... it brings the environment [back] to some sort of safe, predictable, constant, consistent state.

Setting limits

Every time before we went out on outings we would get them together then we would say "okay this is the expected behaviour, if you disrupt the outing in anyway it will be dealt with when we get back to the unit" ... It was all set out before we went ... at home a lot of them didn't have limits and consequences.

Setting limits

They need direction and some restriction otherwise they just don't know when to stop ... if we give them consistent limits they can follow expectations ... then

they feel safe. [Like] tell them straight, make it very clear to them ... when we have activity time I let them muck around and enjoy themselves but once it's over and they need to settle down in their room for quiet time I mean it and there's no testing.

Setting limits

There's always [the temptation] ... with those difficult kids, you can also ignore the behaviour and pretend it didn't happen, like throwing things out of the bus ... you go through this whole thing of "oh do we have to stop the bus and make them get out and pick it up, is it worth it?" but by not doing it you're actually colluding with it.

Setting limits

Dealing with that [abusive] behaviour, what would be the consequences ... removing them for some time, having a break or going to their room for a while to think about their behaviour, letting them calm down and then discussing the issue ... why it wasn't acceptable ... so they can learn what is appropriate behaviour and what isn't.

Setting limits

Limit setting refers to curtailing behaviour to what's appropriate ... putting limits on what an adolescent can do or get away with before it becomes unacceptable. The behaviour is addressed, the adolescent is asked if they realise what they're doing, the consequences of what they're doing [and] what is acceptable within that particular setting ... it's all right to jump and scream in the swimming pool but you can't do that at a restaurant.

Developing trust

That trusting, building up that trust, consolidating it, getting to a point where the adolescent feels comfortable in disclosing things ... having that nurse get a feel for what's really going on with them and what are the things which make them click and where their distress lies and what they perceive that to be ... Adolescents would initiate coming to you ... would seek you out in times of distress, that would obviously be someone they trusted and be able to work through their particular distress at that time with.

Developing trust

Even though you may be talking about a dog or a bike it's not the content that's important but the process to

see that there's trust going on ... it's meaningful in the sense of allowing a process to develop or deepen. There's times when I know chit chat is useful because the kids need to warm up to you and you need to warm up to them ... to get to know one another.

Developing trust

They have to feel comfortable and trust you before they can tell you things in depth ... [there's] changes in their response to me. When they're new to the unit they're guarded but when they start approaching me I can start some work ... they will come and sit down next to you ... they want to share something with you or just be with you.

Developing trust

I've noticed it's like a pattern they go through where it takes them a while to establish [trust] ... after a while the trust starts coming in.

Developing trust

She trusted me, even though she hated me at that moment there was nevertheless that trust, that she could allow herself to scream and yell and carry on and then give it up and be okay after that.

Developing trust

I was cleaning up and Mitchell said "oh I'll stay with you and help" and I thought "this is odd for a boy who used to ride motor bikes" and he just started talking about home and how he wasn't getting along with his mum ... and I thought "well he's obviously trusted me for some reason" ... he wanted to ventilate and gauge my reaction ... see if he could trust me a bit more.

It gets you down

It's not my strength, nontalking options, because I've been well versed in kids who are fairly insightful and articulate ... when you have a kid that requires options that you yourself are not well versed with it brings up the frustration within you.

It gets you down

By the end of the year his explosive temper was exactly the same ... some kids you can't really change, may be they're not ready for it or they're not old enough to understand that they need to change or what effect their anger and aggression has on other people.

It gets you down

Once you have one or two [conduct disordered kids] then every day you go into battle, there were times when I felt "God, do I really want to be there?" ... they change slowly.

Example two:

He's a young boy, he used to be very clever ... he has suffered a lot. I really feel sadness for him [like] "what's for him for the rest of his life?"... and seeing the family "what can I tell them?" The prognosis is so poor when he starts so young and is so psychotic.

It gets you down

Daniel had a psychotic illness ... I remember I was really sad, I found that really hard to deal with ... observing his family and the difficulties, the distress with seeing their son being so disturbed ... that sense of loss.

It gets you down

You work in the midst of social [and] emotional problems, it can get you down from time to time unless you take a break away from it and see outside it and beyond it ... Sometimes adolescents would be quite angry, things would be thrown at you and you'd be feeling "why all the energy put in for this situation?"

It gets you down

After the rest of the staff had come back [from holidays] Theresa had been assigned to a particular therapist, Liz, and I remember feeling really discounted and put to one side ... I had a supposed change over period whereby the emphasis on the relationship with me would be gradually eased into the relationship with Liz but that didn't happen.

Example two:

When a kid is dirty and a little bit smelly and a little bit lank, how do you explain this? ... Isn't it your job as a psychiatric nurse to see they wash themselves? I tried basically to be educative about what feelings might be underneath and even now I have a sense of "God, do I have to say this again!"

Sub-Elements Identified in Seven Nurse's Texts

Nurses try to create change

It's in the interactions with the other kids that the

'pathology' or behaviour comes up to work with ... it can [also] be with authority figures like the principal ... [but, for example] when they try to care for each other and support each other and they overload each other you can point out "is this perhaps what you also do within your family?" or "is this a role that's familiar to you in other parts of your life?"

Example two:

There are occasions when the peer group is destructive because it teaches kids behaviours that aren't going to be useful to them. You can relate that back to [them as] the need for belonging, for acceptance, the deep yearning to fit in and [you can] talk about those kind of issues ... [like] "sometimes we do things to get approval and a belonging with other people but we put ourselves [at risk] when we do that."

Example three:

They do behaviours that alienate them from other people, testing behaviours, unusual behaviours, weird behaviours, inappropriate behaviours ... On the one hand it can be a bridge for them to communicate but it highlights a lack of social ability ... sooner or later you need to start working with that ... you're going to take them beyond what they already know but you also need to have developed the relationship.

Example four:

Some behaviours ... they're part of a developmental path ... If you've got a whole lot of boys that are swearing it's a very natural stage of development. I'm not trying to extinguish the behaviour I'm trying to give them distinctions about where they can do the behaviour and where it's not quite suitable.

Nurses try to create change

Going along with feeding in whatever the information would be and ... looking to see what were the triggers, the stressful events that might have lead up to and contributed to that event, looking at how you could impact on those things, and help Daniel cope with those, helping him identify those things for himself.

Nurses try to create change

Some kids are not in the right place at the right time so we have a form ... we tick off a form [and] that gives you something concrete so you can say "how often are you in the right place at the right time?" ... at the end of

the day or week you can say "you've earned yourself enough ticks to go on any outing with the school." It's self regulating, a lot of them become aware of what they need to do ... in some sense it's a reward but it's self regulating because they know what they have to do.

Nurses try to create change

I remember Jerry, he was quite unmotivated and it was difficult sometimes to motivate him ... working with him it was trying to find his likes ... and then it was trying to motivate him through his likes, in a way rewarding him for a task achieved by giving him one of his favourite treats.

Nurses try to create change

Suddenly Adam stopped struggling with us, he just lay down, we were cuddling him and his tears came ... he started talking about his original father's anniversary, death anniversary coming up. We got the mother's permission to take him to the father's graveyard ... he bought a bundle of flowers and put it on there, since then his relationship changed with Samuel and me ... we can sit down and talk and he would ask for us to help him.

[Also] we started some behavioural program for Adam and [a] reward system. If he's able to sit in a classroom for 50 minutes without disturbing the others he earns certain points and then once he has earned [enough] points he can have 15 minutes with a nurse doing things he wants to do.

Nurses try to create change

I did a series of groups on gender roles ... [with] girls basically saying "well he can hit you if you provoke him" ... this was the role that so many of them saw but there were a couple of times ... [with] one or two of the girls, I could see that they'd taken on board something different about themselves and the way that they were.

Nurses try to create change

Some of the time you had to do one to one ... but generally it was milieu based, activity based so that nurses as the role models could teach the kids how to interact properly and sort out their differences.