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**The long sleep-over: the lived experience of teenagers, parents and
staff in an adolescent psychiatric unit.**

David John Ward
B.SocWk., B.A., M.Couns.(UNE), MPhil.

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Abstract

Adolescents are in a particular life cycle stage that involves numerous psychosocial changes. When this stage of life is compounded by serious mental health difficulties, the effects can have significant repercussions for both teenager and family. For some adolescents, an extended inpatient stay is necessary in order to address these difficulties. This research investigates the subjective experience of adolescents, their parents and staff who live, work and have a child in such a facility; the Barrett Adolescent Centre (BAC) located in Brisbane Australia. The qualitative study was completed by the sole social work practitioner who was employed at the Unit for over eight years. The Unit was a long stay residential facility and provided the opportunity to collect data over an extended period of time. The research therefore emerges from an insider, practitioner-researcher context. The primary research question focused on how the collective experiences of adolescent consumers, parents and staff can inform mental health practice in adolescent residential settings.

A review of the literature suggests that there is a strong tendency to incorporate concepts from the adult mental health literature into adolescent mental health practice. The notion of recovery is an example, which is heavily influenced by conceptualisations of adult experience. Consequently, the aim of the present research was to better understand the participants holistically, but also in the appropriate developmental context; incorporating the social, emotional and experiential domains that form the lived experience of inpatient life. Broadly speaking, the key areas of interest included how the notion of recovery was experienced by the adolescents, the experiences of the parents during their child's inpatient stay, and the experiences of the staff while helping the adolescents.

The research emphasises and values subjectivity as well as the interpretation of significant personal experience. Subsequently, the study is located within an interpretative phenomenological analysis frame. It is also informed by critical realism that posits that mental illness is an objectively real phenomenon, though experienced uniquely by each individual affected by it. Semi-structured interviews formed the basis of the data, involving the three population groups of adolescent inpatients, their parents and staff. A total of 13 adolescents, 10 staff and 8 parents were interviewed. Single interviews were utilised for all participant groups as well as a small focus group of the three primary staff professions; that of Allied Health, Nursing and Education. The use of photography was also utilised with the adolescents in order to explore various facets of the therapeutic milieu from their perspective. The adolescents were also offered successive interviews over a number of

months to enrich the picture of inpatient life. Elements such as family, education, consumer-staff relations as well as the recovery process were investigated.

Hermeneutical thematic analysis uncovered rich experiences unique to each participant group, as well as common experiential domains for all. The results also demonstrated a complex interplay of relationships between the adolescents, parents and staff. The use of photography in particular, created powerful imagery that helped capture these complex and often hard-to-articulate experiences. Results highlight the crucial role relationships play for adolescent recovery, as well as the necessity of incorporating a developmentally-informed framework. The concept of ambiguous loss was a most notable experience for the parents, while the narratives of the staff brought to light concepts such as the 'BAC personality'; the professional who is able to embrace workplace pain while remaining hopeful for a better future.

Drawing on the above data revealed a range of elements crucial to adolescent mental health recovery such as the importance of fit between adolescent and hospital environment, a supportive management that contains the anxieties of staff while valuing a developmentally-informed practice, and an open collaboration between parents and staff. The study reinforces the importance of a developmental lens in understanding the requirements of adolescents with mental health problems and the supportive needs of parents during their child's recovery. Adolescent mental health recovery can be conceptualised as a developmental reconstruction, expressed through the 5 principal themes uncovered in the study. The importance of a reflexive stance for practice is also emphasised. The study contributes to the knowledge base of clinicians and researchers who work with adolescents in mental health settings at individual, family and organisational levels. It also contributes to the body of insider/practitioner research by detailing the vicissitudes of conducting research in one's own organisation.

Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

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Publications during candidature

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Adolescent mental health, inpatient, practitioner, staff, parents, phenomenology

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CHAPTER 1 INTRODUCTION

Despite being almost ten years ago, I clearly recall the first day at my new job at the *Barrett Adolescent Centre* (BAC). I recall seeing a number of sad-looking adolescents sitting around the common room, saying little verbally, though telling much by their despairing affect. A common response to my greeting some of the teenagers was a strong sense of, “Oh, another one...” It seemed they were used to people coming and going and saw me as another candidate for inclusion for that list. Later on that same day, I helped out the nursing staff by restraining an adolescent girl who had to be forcefully given a nasal gastric tube to halt her plummeting weight loss. While the tube insertion was successful, I still recall her loud, demanding screams declaring her right to die should she wish...

I recall many staff conversations about how someone had the day off (mainly the nurses) due to yet another physical assault the day before. I remember the frustration of several staff after yet another serious self-harm incident that required medical hospitalisation, and that the teen should now be discharged since, “We’ve done all we can do”...

I also recall many parents sitting in my office in tears, explaining how close they were to burnout in looking after their child 24/7 to prevent another suicide attempt. Others recounted how for the first time in two years, they could finally spend some quality time with their other children; siblings of the unwell teen who had been temporarily put in a holding pattern until things settled with their brother or sister. Sometimes they had to wait a long time...

The above is the background to a study that examines the subjective experience of adolescents, their parents and staff who live, work or have a child in a psychiatric inpatient facility. Adolescence can sometimes be a tumultuous period, and coupled with mental illness, the experience can be deeply painful and confusing. Over time, I came to appreciate that the pain and confusion are not limited to the teenagers. Not only were these and other experiences manifesting in the parents as well, but they were also exhibited by the staff. This became both a personal and a clinical interest; personally, as I too, have a developmental history and needed to be aware of its present-day impact and clinically, as I could see the analogous interpersonal processes occurring between adolescent, parent and staff. I also saw firsthand how a developmental trajectory can be thwarted by mental illness and how important it is to regain some of that lost developmental ground. I became fascinated then, by the

intertwining of experiences in a sometimes much-pressured environment. How these experiences could enrich my social work practice in residential care became the research problem I wanted to explore. What follows is an introduction to the research that explores this problem.

This chapter first of all outlines the primary and secondary research questions for the study. The following sections then locate the organisational context for the research, as well as locating myself as practitioner-researcher. This section explains how clinical practice has influenced the development and focus of the research. The contribution that the study will make to current knowledge, at both clinical and theoretical levels is then presented. Also, given the nature of the study, certain terms are used throughout the thesis and are therefore clarified briefly. Finally, an outline of the thesis is presented, detailing the contents of each chapter including a concise précis of results.

Primary and secondary research questions

The introduction above explained that the interest in this research developed out of ‘coal face’ practice over many years. It emerged from numerous observations of the three participant groups and questioned how these collective experiences can guide practice and build upon existing theory. Given that the study emerges from such a practitioner-researcher frame, the primary research question is:

‘How can the collective experiences of adolescents, parents and staff in a psychiatric inpatient setting inform mental health practice in residential care?’

Behind the above question is a guiding theme asking ‘*What is this kind of experience like?*’ (van Manen 1997, p.9). What is the inpatient experience like? What specific facets drawn from the experiences the adolescents, parents and staff create such an experience? By asking such questions it will be possible to develop a deeper experiential analysis of:

- How is the notion of ‘recovery’ experienced by adolescents and how does it relate to the wider literature?
- What meaning is given by the adolescents about their relationships with staff?
- What are the parents’ experiences of having a child in the Unit?
- What commonalities of experience do patients, staff and parents have?

The primary and secondary questions will have both practical and theoretical implications and the findings will be an innovative contribution to the literature.

Locating the study

The BAC opened twenty-six years ago as part of a larger facility, *The Park - Centre for Mental Health* (which was formerly known as *Wolston Park*). The larger facility originally opened in 1865 for adult patients with serious psychiatric disability and was funded by Queensland (Australia) State Health. The Unit admitted adolescents from anywhere in the State of Queensland and had the capacity for 15 inpatients and 5-7 day patients for adolescents 13 to 18 years of age. These ages varied slightly depending on the individual adolescent and presenting concerns. Length of stay varied depending on referral need. For example, an adolescent may stay for 2-4 weeks for diagnostic clarification, or be offered an 'open' admission whereby the teenager could stay up to 3 years if their condition warranted it as judged by a multidisciplinary team. The adolescents often experienced significant language deficits and long-term school refusal. Consequently, Education Queensland ran a modified school program Monday to Friday where the adolescents attended classes that were catered for teenagers with mental health issues. School subjects were very similar to other schools, though it was interspersed with a variety of therapeutic programs such as individual, family and adventure-based therapies.

It is important to note that the present research was situated in a special set of circumstances. Throughout the study there was considerable anxiety about the possibility of the Unit relocating to another part of Brisbane, or the potential for the Centre to shut completely. Despite architectural plans being drawn up for a new facility, it was difficult to obtain permanent nursing staff for a Unit with an uncertain future. This lack of employee stability detracted from the general stability of the milieu and few concrete answers were given from upper management. With the change of State Government in Queensland, many potential building projects were cancelled, including the proposed new adolescent inpatient facility. This only elevated the anxiety levels for adolescents, parents and staff. Despite numerous meetings with various individuals from Queensland Health management, little assurance could be given as to the future of the unit. It was not until August 2013 that the decision was officially made to close the BAC, with the doors closing permanently in February 2014. To date, some adolescents who are clinically well enough attend a school program attached to a public school. Others outside the Brisbane area were discharged back into community mental health clinics or non-government agencies. There was tremendous anxiety particularly for the parents and staff by this decision, as some adolescents were admitted to the BAC in the first place due to the community clinics being unable to contain such high risk for self-harm or

suicidality. Nonetheless, the unit was deemed unnecessary and subsequently shut. It is also important to note that much of the research was carried out whilst employed at the Unit, until ceasing employment there in January 2013. However, during the analysis and major writing up phases of the research, I was not employed at the BAC. While greatly disappointed at the closure, the emotional distance proved to be useful when it came to analysing the data.

BAC adolescents came from a mix of family backgrounds including sole parent, blended family and nuclear family constellations. Ethnically, all participants in this study were of white, Anglo-Saxon background though this is not always the case, with some indigenous adolescents occasionally being inpatients. Clinically, the adolescents are diverse. However, chronic social anxiety, depression, self-harm, eating disorders and significant histories of abuse or neglect were the most common. Other factors such as poor family attachment or family conflict were also very frequent. While the socio-economic profile varies, the adolescent sample in this study is representative of the clinical presentations at the BAC.

The Centre itself was staffed by a full allied health team consisting of two psychologists, two occupational therapists, one speech pathologist, nurses, a psychiatric registrar and Unit Director (Psychiatrist). I remained the only social worker. The day patients who lived locally in the Brisbane area, returned home each afternoon after school. Some adolescents returned home on the weekends had they been well enough and lived close enough to do so. Other adolescents remained at the centre, though the staff tried their best to take them out on the weekends for outings suitable for this age bracket. This research investigated the experiences of teenagers who spent the majority of time as inpatients. This decision was made because these teenagers were the most immersed in the inpatient environment.

Locating the researcher

As the above paragraphs reveal, the use of the personal pronoun 'I' is utilised throughout the thesis. This reflects the insider position of the study with my subjectivity, internalised views and biases needing to be explicit. As the thesis reveals, I have endeavoured to be as transparent as possible about my pre-existing knowledge of the phenomenon under study and have incorporated this into the research process as opposed to somehow separating it from the research journey. A lesson learnt by being employed at the BAC is that one cannot disregard the issues of culture, gender or other internalised facets of one's life. Rather, the goal should be an increasing awareness and appropriate utilisation of one's self to more fully appreciate the standpoint of another.

My professional background has largely focused on individual and family therapy. Subsequently, I have continued to show a professional interest in the lives and narratives of individuals and families when life is often at its hardest. Also, much of my career has been involved in a child and adolescent mental health environment. For eight years this was at the BAC. Being a long-stay residential facility, there was a unique opportunity to develop relationships with the adolescents over an extended period of time. This allowed me to view firsthand the many difficulties and breakthroughs for those who experienced enduring and complex mental health problems. Given such clinical difficulty, there were often many intense, despairing and frustrating experiences. Conversely, there were many other occasions of fun and lightheartedness. I can recall many adolescents explaining how sometimes the more care-free activities at the BAC were the most emotionally healing. It seemed that often the most memorable times for them were amusements typical for their developmental niche.

What I particularly noticed over the years was the commonality of experiences. In my role I often felt like the ‘meat in the sandwich’; a member of a large multidisciplinary team helping the adolescents, as well as providing the bulk of any family work with the parents. Being the family therapist at the Unit, meant sometimes I found myself acting as a mediator or translator between the three groups. *Subsequently, I often noticed things from three vantage points; viewing the same event but hearing it from different angles.* This insider study then, originates from the perspective of a practitioner-researcher, with this facet being revisited throughout the study.

While I found myself interpreting events from the three primary groups, I was also endeavouring to examine my own internal processes and external behaviours. Chapter 5 specifically focuses on this aspect of the research. Here I outline what preconceptions I was consciously aware of about the work at the Unit and how I focused on increasing my awareness of such for the purposes of this study. Chapter 5 echoes previous experiences at the centre where, to my mind, there was sometimes very poor reflexivity on the part of some adolescents, parents or staff. This prompted me to explore my own responses and my own part in the ‘BAC story’. As well as reflexivity being important to my past clinical work, it was now equally important to incorporate such a stance to my research; a stance of ‘intersubjective reflection’ (Finlay & Gough, 2003, p. 8).

Accordingly, the above elements have been strongly influential in the incorporation of a phenomenological methodology. Over many years it was observed that there was a ‘layering’ of external, imposed narratives that seemed to cloud the original, unique meaning of personal experience. By the time the adolescents were admitted to the unit, various narrative residues clung

to both adolescent and parent. Despite the multidimensional, complex nature of their stories, various organisational and bio-medical discourses continually attempted to ‘make what is not definite, definite’ (Dahlberg & Dahlberg, 1992). The persistent and adhesive-like residue of various diagnostic labels was a case in point. This research then, represents a practitioner seeking to understand afresh the inpatient experience via three groups of people linked by adolescent mental health recovery. First person adult accounts of mental illness are increasingly common in the literature (e.g. Andresen et al., 2011; Basset & Stickley, 2010; LeCroy & Holschuh, 2012; Melbourne, 2010). However, as the literature review will shortly explain, adolescent accounts are far less common. To appreciate and understand their personal experiences acknowledges their place as unique individuals in what usually are adult-directed and adult-centred systems. Also, this study does not focus on a specific disorder. Subsequently, there is less chance of restricting what data may surface; allowing the adolescents to interpret their experience of inpatient life as freely as possible.

The qualitative, practitioner-researcher methodology not only creates an opportunity for the exploration of the areas of greatest concern to the adolescent, but it also contributes to the knowledge base of both clinicians and researchers. At a time when the notion of evidence-based practice is making a substantial impact on research policy, this project aims toward ‘practice-based evidence’ where professional expertise is valued and utilised (Staller, 2006). Some have documented as the limitations of the evidence-based model such as the privileging of randomised control studies, the de-emphasis on human behaviour theory and little value given to practice wisdom (Adams et al., 2009). The present exploratory study provides an opportunity where evidence is collated during and not just after practice, thereby honouring practitioner wisdom (Rolfe, 1999). This is discussed further in Chapter 3.

Contribution to knowledge

As well as contributing to the knowledge base of practitioner research generally, the study contributes to the literature in other ways. Firstly, there is little Australian research focusing on the descriptive, lived experience of adolescents in inpatient care. While the academic and therapeutic communities overseas have documented various facets of this phenomenon (e.g. Bettmann & Jaspersen, 2009; Hayes et al., 2011; Moses, 2011a), it appears that Australia has yet to offer any robust qualitative research. This is significant as some Australian surveys suggest that up to one quarter of adolescents may experience mental health difficulties, while only less than 1 in 3 may attempt at getting help (Sawyer et al., 2007; Zubrick et al., 2000). This study will therefore be a significant addition to the literature from an Australian context.

Secondly, the study also incorporates the experiences of the parents with a child at the BAC. A review of the literature reveals that the majority of extant research focuses on the experiences of parents whose adult child has a mental illness (e.g. Ozgul, 2004). There is considerably less written about the experiences of parents of younger children or teenagers; particularly surrounding the issues of ambiguous loss or caregiver strain. From a staff perspective, more has been written about working with adults with mental illness as opposed to adolescents (e.g. Thomas et al., 2002).

Finally, this study will contribute at a theoretical level to the extant research. As the literature review will demonstrate, much of the mental health recovery literature focuses on adult mental health and which then tends to narrowly focus on psychological disorders such as schizophrenia or bipolar. This exacerbates the poor linkage between recovery theory and adolescent mental health. Closely related is the equally poor linkage between recovery theory and developmental theory. Possibly because of the disproportionate focus on adult recovery, there is a significant gap in the literature that links mental health recovery as pertaining to adolescents and developmental theory. This study will therefore contribute to a stronger relationship between recovery theory and adolescent mental health, as well as recovery theory and developmental theory. The present research is also significant in its merging of three primary narratives; not just exploring individual journeys, but also investigating the parallel experiences of the three groups as a collective; the inpatient experience. This has implications for clinical practice with adolescents not only in psychiatric hospital settings, but also for other residential domains. It will subsequently have practice implications for the support of parents and staff.

Definition of terms

The area of mental health has many terms that remain controversial. The term ‘consumer’ for example, is embraced by some individuals and groups, while refused by others. Given the study is in the context of a Queensland Health (i.e. government) facility, the term consumer was commonly used at the BAC. Consequently, this thesis will continue to use the term and define consumer as:

‘A person who is accessing or has previously accessed a mental health service...Within a child and youth mental health context, both the parents and the child or young person may be described as consumers’ (CCFPF, 2010, p. 9).

The term ‘mental illness’ can also evoke a range of different opinions and feelings. Given that the BAC was informed by State and National Mental Health Policy, this research will also accept that same definition:

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of diseases (ICD) (NMHP, 2008, p. 30).

The term 'patient' is also sometimes used in the thesis. This was a term commonly utilised at the BAC, primarily by the medical staff. It is used regularly in the nursing literature which has been heavily drawn upon for this research. Consequently, the term may be occasionally used in this study. Given the term 'patient' means 'one who is suffering', its etymology reflects a painful reality.

Finally, it must be remembered that the notions of mental illness, disorder and psychopathology are all widely challenged concepts (see Maddux & Winstead, 2012) and while space does not permit further discussion specifically, this aspect is readily acknowledged.

Overview of the thesis

The thesis consists of 8 chapters. Following this introduction, the Literature Review in Chapter 2 introduces the topic of adolescent mental health and outlines some mental health conditions commonly experienced by adolescents. The following section then explores adolescent developmental theory and highlights some of the distinctives of this life-cycle period as well how these separate adolescents from their adult counterparts. The next section outlines the literature surrounding the experiences of teenagers with mental illness, followed by a discussion on the notion of recovery as it pertains to adolescence. Of note is the lack of theoretical integration between recovery theory and adolescence, as well as developmental theory and recovery theory. The literature on the parents' experiences of having a child with a mental illness is then surveyed, followed by an overview of the different forms of residential care. The adolescent, parent and staff experiences of residential care are then examined respectively. Finally, there is a brief review showing the lack of research combining these three perspectives. The chapter closes by summarising the results of the literature review.

Chapter 3 follows by detailing the Conceptual Framework for the study. It firstly locates the concept of adolescence for the research, and then explains the underlying theoretical presuppositions of the study. The research is premised on the belief that mental illness is objectively 'real' and reflects a reality beyond the description. However, the meaning-making experiences of

this reality are unique to each individual. The role of hermeneutic phenomenology is then explained and its applicability to answering the research question. An explanation of the practitioner-researcher frame is then offered, including the important role of reflexivity in the study.

The study's Methodology is outlined in Chapter 4. Here the interpretative phenomenological frame is clarified further as well as methods and analysis. Given the insider-practitioner position, the issues of validity and bias are also examined. Important ethical considerations of the study are then explained. The research was conducted at my place of employment, with minors who experience significant mental health difficulties. Consequently, there were numerous processes in place to ensure a transparent and ethical study.

Chapter 5 is also designed to elevate the transparency of the study, detailing the analysis trail for the research. The challenges experienced while collecting the data are described as well as an explanation of the role of the research diary. In this chapter I also document what I as the researcher knew of the phenomenon before the data collection was initiated. How this knowledge was drawn upon during the course of the research is then explained.

Chapters 6 and 7 represent the individual and collective experiences of the participants respectively. The purpose of Chapter 6 is to give as fully as possible, a clear picture of the sub-themes from each participant sub-group. Copious extracts are purposefully employed to give the reader adequate background to the thematic coding structure that is depicted at the beginning of the chapter. Chapter 7 represents a synthesis and analysis of the 5 principal themes that form the basis in responding to the research question. With the chapters separated, the point is also made for the equal valuing of individual and collective experience.

Chapter 8 discusses the theoretical and practical contributions of the research to the field. It highlights the importance of adolescent mental health recovery being seen as a developmental reconstruction and how the 5 principal themes can act as a template for practitioners working in adolescent residential care. Further implications for reflexive mental health practice are put forward. Limitations of the present research are then acknowledged. Critical reflections on the progression of the data as well as the progression of myself as a researcher are also presented. The chapter closes with potential directions for future research.

CHAPTER 2 LITERATURE REVIEW

Introduction

This chapter reviews the literature that focuses on the primary domains relevant to the study; drawing upon research from a number of areas including social work, psychology, nursing and mental health. The first section gives a brief overview of adolescent mental health generally and is followed by an exploration of adolescent developmental theory. Three key developmental theories and four primary areas of adolescent life are elaborated. Following on is an overview of what the literature reveals about the adolescent experience of mental illness. The important notion of recovery as it pertains to adolescence is then examined, along with some comparisons to concepts drawn from adult recovery. The literature that examines the experiences of the parents who have an adolescent child as an inpatient is then surveyed. Of importance will be the experiential burden of caring for an unwell teenager with mental illness. Following this is a select review of the literature that explores the concept of the milieu and the various forms of residential care. The final area investigates the experiences of those who work in such an environment. The summary will show that by collating these bodies of knowledge, gaps in the extant literature are revealed. Two key examples include the application of recovery theory to adolescents and the sparse literature that combines an adolescent/parent/staff perspective on inpatient residential care.

Backdrop: adolescent mental health

The literature suggests that there is significant global neglect of epidemiological data, research and intervention into child and adolescent mental health (Belfer, 2008; Remschmidt et al., 2007). This is particularly concerning given that up to 20% of children and adolescents worldwide may be suffering a mental disorder and that as high as 50% of all adult mental disorders have their onset in adolescence (Belfer, 2008, p. 226). These figures are not dissimilar to Australia, where mental health problems account for almost 50% of the burden of disease among young people (AIHW, 2011).

A well-known Australian survey of mental health and well-being incorporated data from 1490 adolescents aged 13-17 years (Sawyer et al., 2007). The parent reports suggested that 13% of adolescents were experiencing a mental disorder, while 19% of the adolescent reports suggest mental health issues. However, only 31% of the parent and 20% of adolescent sample revealed they had attended any professional service within six months of the survey to address the concerns. This is problematic in light of other research that suggests adolescents who have such problems also

have issues that are multifaceted in both diagnosis and family disturbance (Tonge et al., 2008). Equally concerning is the trend for mental health problems to develop at an increasingly earlier developmental stage (Zubrick et al., 2000).

The above figures point to adolescent mental health research being a worthy area of study; particularly so when we recall the World Health Organisation's recommendations for Mental Health Reform (NMHP, 2007). It argues that Australia has a "paucity of services" for young people with mental disorders and that research is low by international standards (p.480). This Australian 2007 report which contains the latest figures (due to be updated at the end of 2014), also documents the common diagnoses in adolescent (16-24yrs) mental health:

- The most commonly reported disorders were anxiety disorders (15%), substance use disorders (13%) and affective disorders (6%).
- While this pattern held true for females (22%, 10% and 8% respectively), among males substance use disorders were more prevalent than anxiety disorders (16% compared with 9% respectively).
- The prevalence of affective disorders was considerably lower among males than females (4% and 8% respectively).
- The most prevalent types of anxiety disorders were post-traumatic stress disorder and social phobia, accounting for 50% and 35% of anxiety disorders, respectively.
- Females were more likely than males to have experienced mental disorders (30% and 23% respectively).
- Around 17% of young people with a mental disorder had a severe level of impairment, 35% a moderate level and 48% a mild impairment. (NMHP, 2007)

The above figures are consistent with other Australian samples such as the managed mental health problems of 12-24 year olds by General Practitioners (AIHW, 2011). The most prevalent presentations in 2008-2009 were depression, anxiety, drug abuse, sleep disturbance and acute stress reactions (p.27).

When one speaks of the types of mental health disorders adolescents may experience, it is also important to note that the disorders often appear during specific developmental times. For example, Costello et al. (2011) explored the longitudinal and cross-sectional papers published in the past 15 years exploring childhood to early adulthood. Apart from their report that 1 in 5 adolescents had a psychiatric disorder, what was noteworthy was how the disorders were related to specific

developmental periods. They found that from childhood to adolescence there was an increase in rates of depression, panic disorder, agoraphobia, and substance use disorders. However, from adolescence to early adulthood there was an increased risk for panic disorder, agoraphobia, and substance use. They found that with age comes a decrease in separation anxiety disorders, ADHD and other phobias. Noteworthy also is the impact of intervention on the prevalence of adolescent psychological disorders and the importance of addressing the difficulties as early as possible.

This was demonstrated in one Australian study by Patton et al. (2014) who recruited a stratified, random sample of adolescents in Victoria ($n = 1943$). They assessed for common mental disorders at five points in adolescence and three in young adulthood and how these might persist from adolescence to adulthood. They confirmed that depression and anxiety were common during adolescence (29% for boys and 54% of girls). They also discovered that almost 60% of their participants who had an episode during adolescence also reported another episode as a young adult. However, these researchers also reported that for adolescents who had only one episode of less than 6 months duration, just over half had no further mental health disorders as a young adult. By the participants' late 20's, the prevalence of the disorders had noticeably decreased or did not have any further episodes at all as a young adult. They suggested that interventions that might shorten the adolescent episodes could have positive effects later in adult life. Indeed, both the studies above are consistent with other research that suggests mental health difficulties in adolescence increase the risk of adult mental health disorders, (Clark et al., 2007; Fergusson et al., 2007) and adults who have a mental disorder often experienced their first episode in adolescence (Costello et al., 2011; Newman et al., 1996).

Finally, the literature also documents other co-morbid conditions often connected to depression or anxiety that can be experienced by adolescents. Self-harm is a key example, as discussed in Stallard et al.'s (2013) UK study of the prevalence of self-harm in 12-16 year old adolescents ($n = 3964$). These researchers suggest that self-harm can be already established by 12/13 years of age; common with 1 in 4 reporting self-harming thoughts and 1 in 6 engaging in self-harming behaviour. However, of those who self-harmed, less than 1 in 5 (18%) had sought help. Likewise, Moran et al.'s (2012) Australian study revealed depression and anxiety were noticeably associated with self-harm in young adulthood (14-19yrs). Their participant sample ($n = 1802$) reported 8% of the adolescents experienced self-harm (girls 10%, boys 6%), utilising cutting and burning as the most common methods. The above two studies are just two examples in the literature that consistently demonstrate an association between adolescent self-harm and depression and anxiety (de Kloet et al., 2011; Fergusson et al., 2000; Jacobson & Gould, 2007).

Adolescent development

There are many adolescent developmental theories, each with strengths and weaknesses (Gavazzi, 2011). Those discussed below have been chosen for their ability to highlight specific facets of adolescent development that are pertinent to this research. They also complement each other with their divergent emphases; the Piagetian model explores the specific area of adolescent cognitive development; Erikson's stage-based model offers a wider view into adolescence as a crucial stage, being built on previous developmental epochs and finally, developmental contextualism expands further to focus more acutely on the adolescent-environment fit. Each is briefly outlined below, followed by four key developmental domains that are also relevant to the present research.

Firstly, Jean Piaget's (1896-1980) cognitive-developmental theory has something to offer in the understanding of the adolescents' experiences. The last stage of his four-period model is the *formal operations period* that is initiated around 11 years of age and follows through to adulthood. While he did subdivide this stage into smaller stages involving further disequilibrium and restructuring (Muuss, 1996), for the purposes of this research it is sufficient to note that during adolescence reasoning becomes more abstract with a more sophisticated mastery of formal operations. He proposed that during this formal operations period young people could now start to grasp more abstract and idealistic concepts that were previously beyond the reach of younger children. For instance, they are now able to use hypothetic-deductive reasoning; beginning with a general theory of possibilities leading them to deduce specific hypotheses to test a situation. They start to conceptualise justice, liberty and love and dream of a better world (Crain, 2000). With this comes a fresh ego-centric thinking that believes they can truly change anything they want.

Examples of this adolescent egocentrism include three common 'fables' (Burns, 2008). The *personal fable* is belief that the personal adolescents' experiences are unique. Because of this belief, adolescents often think that no one could truly understand their thoughts, feelings, or experiences. The *imaginary audience* consists of adolescents' beliefs that everyone else is as interested in their appearance and behaviour as much as they are. Due to this egocentric mindset, the adolescent can often feel very self-conscious and engage in behaviours to fit in with their peers. Finally, the *invincibility fable* consists of adolescents' belief that there are few if any consequences with risky or dangerous behaviour. With this belief, adolescents could engage in unprotected sex (thinking they will never become pregnant), or drink driving (thinking they will never get caught or have an accident).

Erikson (1963) posited a trajectory of psychosocial crises that occurred at eight points during the life cycle and that required of the individual specific intra- and inter-personal tasks in order to successfully resolve the crises. Piaget emphasised thinking processes in his theory, while Erikson focused on the development of the Ego, with a particular interest in identity; most probably emerging from his own search for identity during his formative years (Miller, 2010). He also based his approach on the organismic epigenetic principal; that development occurs sequentially from simple structures to complex ones whereby each season of development has its opportunity eventually creating a new entity. Each stage then, is crucial for the development of the one that follows (Palombo et al., 2009, p. 198). However, regardless of whether the stage has been ‘met’, biological and social forces will nonetheless bring on the following stage (Crain, 2000, p. 290). Still, it is believed that a favourable outcome with one stage lends itself to an easier journey for the next one.

Of the eight stages Erikson put forward, it is the fifth, *identity vs. role confusion* that has particular reference to adolescence. While it could be said that the identity substrate of an adult has been largely set, paralleling most aspects of teenage development, the adolescent ego is a work in progress. For the most part it has its genesis now, ‘because it is the first time that all of the necessary ingredients exist for its construction’ (Marcia, 2002, p. 202). For that reason, Erikson’s theory has a number of insights that could prove useful for researching the experiences of adolescent inpatients.

Finally, Erikson believed that should one not achieve a coherent identity synthesis, then a fragmented, confusion of identity occurs (Schwartz et al., 2013). This incomplete sense of identity has been conceptualised in the literature in various ways as have other neo-Erikson approaches to adolescent identity (Schwartz et al., 2011). However, Marcia’s work (Kroger & Marcia, 2011; Marcia, 1966) will be surveyed for its contribution to the present research. Drawing on Erikson’s work, Marcia proposed that *exploration* (initially *crisis* by Erikson) and *commitment* were the key elements that define identity. Exploration entailed the sifting of potential identity alternatives, whereas commitment referred to the choosing of one or more of these alternatives to hold fast to. Marcia also crossed these two dimensions to create four possible identity scenarios:

1. *Achievement*: a set of commitments after a period of exploration leading to balanced thinking and mature interpersonal relationships. These adolescents despite the obstacles of life, can persevere with the choices they have made while remaining flexible.

2. *Moratorium*: active exploration, but with few commitments resulting in openness and curiosity but with some remaining anxiety or depression. These adolescents do attempt to form an identity, but are torn. Generally they find identity achievement.
3. *Foreclosure*: a set of commitments enacted prematurely with little exploration. Adolescents in this category, rather than forming their own identity, are ‘conferred’ one by others. While they can seem well-adjusted, should they stray from the imparted identity (e.g. from parents or peers) they may well experience self, peer or family rejection.
4. *Diffusion*: an absence of commitments and a lack of interest in any exploration resulting in low self-esteem and poor self-direction. Here the adolescent struggles to make any definite commitments or constantly looks externally to define themselves. At worst, they feel empty and lost. (Schwartz et al., 2011, p. 98).

Finally, identity formation generally occurs over a period of years and when mental health problems or significant stressors arise, they may well divert the identity-formation pathway (Hernandez et al., 2006; Wiley & Berman, 2013). Indeed, there is evidence to suggest that psychopathology and identity distress can affect each other in a reciprocal fashion (Wiley & Berman, 2013, p. 1303). Given that the adolescent identity formation process typically takes more than just a few months, this might have implications for the length of inpatient treatment. While this aspect is discussed later in the thesis, at this point it can be noted that the literature suggests that residential care can indeed be helpful for adolescents (Bettmann & Jaspersen, 2009). However, for some adolescents, it is maintaining the therapeutic benefits post-admission that often remains the challenge as Schwartz et al. (2011) explained in their review of interventions for adolescent identity development:

Although immediate intervention gains were apparent, these gains were not well maintained over time. From these studies, it seems that identity exploration and consolidation requires time and readiness for development to proceed, and short-term intervention efforts (e.g., sessions over the course of several weeks or months) have, in general, not been particularly effective in facilitating long-term identity development (p.48).

Given that mental disorders can be understood as a biographical disruption (Bury, 1982) and that identity formation is generally a prolonged process, there is merit in the suggestions of more

longitudinal research into adolescent identity processes as well as further exploration of the utility of Erikson and Neo-Erikson approaches (Schwartz, 2005).

The third and final theoretical framework that will guide the present research is developmental contextualism (Sorell, 2005). ‘Developmental contextualism focuses on the interaction between the growing, that is, the continuously changing individual, and the ecological context within which that person lives’ (Muuss, 1996, p. 339). In contrast to Piaget or Erikson which are stage-based epigenetic theories, developmental contextualism does not focus on epigenesis but rather on how contextual factors determine developmental progression (Muuss, 1996, p. 356). However, Kroger (2004) argues that despite Erikson basing his formulation of development on epigenetic principles, he was still one of the earliest proponents of developmental contextualism; examining how biological processes and psychological needs interacted with the social context to create change. The goal of contextualism is not so much to add to already established knowledge of such variables as family, peers or organisations, but ‘to elevate the interaction patterns and the bipolar direction of these influences to the analysis of development’ (Muuss, 1996, p. 342). For example, Muuss (1996) explains that there are essentially three primary domains of adolescent-contextual influences that are commonly researched:

1. The domain that investigates how characteristics, attributes or physical features of the adolescent influences others. In other words, the adolescent \rightarrow social context.
2. The domain that investigates how the characteristics of the setting influence the adolescent. That is, the social context \rightarrow the adolescent.
3. The third domain is the specific contribution of developmental contextualism that investigates the continuous, bidirectional interactions of both spheres; individual attributes \leftrightarrow contextual features (Muuss, 1996, p. 348).

It is the latter that has reference to this present research that acknowledges a number of bi-directional processes between adolescent, parent and staff. To date, the literature has tended to focus on the first two domains such as the impact of psychiatric hospitalisation on the adolescent (Lopez, 2000; Thibeault et al., 2010), the impact of the adolescent’s difficulties on their parents (Faust & Scior, 2008; Knock et al., 2011) or the impact of working with this population on staff (Dean et al., 2010; van Kessel et al., 2012). Little literature could be found that could be said to investigate the third domain in the context of adolescent inpatient units.

Another key element of developmental contextualism is the notion of goodness-of-fit (Gutman & Eccles, 2007; Roesner, 2005). This concept investigates the match between an individual's temperament, values, beliefs and skills and the corresponding characteristics of significant others such as parents, teachers, siblings or friends. At this level of analysis, the developmental outcome does not simply depend on individual characteristics, nor on the impact from the immediate environment; it is the 'congruence or match between individual and context' (Muuss, 1996, p. 352). The goodness-of-fit model posits that the outcomes of any interactions are dependent on this match between individual and the social context.

For example, the adolescents in this study are closely connected to the systems of family and the inpatient facility. While there has been some research into the stage-environment fit of adolescents and their families of origin (e.g. Gutman & Eccles, 2007), no literature could be located exploring stage-environment fit in relation to adolescent inpatient units. There is much room here for further research that could investigate the interactional nature between the adolescents' temperaments, skills or mental health difficulties with parent and staff characteristics as well as the familial and organisational cultures. Developmental contextualism then, would be another useful model to research such areas offering '...a greater understanding of the individual in the multiple contexts in which he or she lives' (Muuss, 1996, p. 340).

As well as developmental theories, there are specific domains of adolescent life that are important to consider. To elaborate on the full number and range of developmental spheres in adolescence is beyond this study. However, below are four examples that separate adolescents from the adult population; highlighting an important premise in this study, that research investigating adolescent phenomena requires an 'adolescent-centred view' (Rich & Ginsburg, 1999, p. 377).

Adolescents and family

The family environment of the adolescent has been regarded by some as the most influential facet during adolescence and consequently the most researched (Collins & Laursen, 2004; Steinberg, 2000). While it is readily acknowledged that families can experience tremendous stress when their adult child develops a serious mental illness (Shpigner et al., 2013), there are important differences with the immediate family of the adolescent, such as their general dependence on the family of origin and ongoing attachment development. Adolescence by its very nature, is a time of preparation and eventual launching of the young person into the wider community (McGoldrick et al., 2011) and these years are an important time to give appropriate launching messages to the adolescent (Ward, 2009). Consequently, the meaning parents give to any mental health issues their

child is experiencing could have an impact on the treatment their son or daughter is receiving (Moses, 2011c). To put it another way, due to the lifecycle stage the adolescents are presently in, their families can wield significant influence in the understanding and containment of, as well as the eventual passage through, the experience of mental illness.

Adolescents and peers

Secondly, the influence of peers during adolescent development can be most impactful. Peer relationships during adolescence incorporate individuals, groups, same-sex and opposite sex relationships and can be constructive or destructive for the developmental journey (Smetana et al., 2006). The notion of adolescent identity is inextricably bound with the influence of peers; ‘The peer group, the clique, and the gang, even the lover, aid the individual in the search for a personal identity since they provide both a role model and very personal social feedback’ (Muuss, 1996, p. 52). Essentially, peers will remain one of the strongest influences of teenage life, powerfully shaping adolescents’ well-being and development (Santrock, 2003).

Adolescents and education

Closely connected to the above domain is the area of the adolescent’s education. This is particularly important given the amount of time spent in this environment as Eccles and Roser (2011) point out:

Adolescents spend more time in school than any other setting except their bed. It is the place where they are exposed to their culture’s font of knowledge, hang out with their friends, engage in extracurricular activities that can shape their identities, and prepare for their future. Consequently, experiences at school influence every aspect of development during adolescence, ranging from the breadth and depth of their intellectual capital to their psychological well-being to the nature of peer influences on their development (p.225).

The school environment then, provides a key domain for the identity formation process, which will subsequently have implications for other aspects of their social, psychological and intellectual development. As the BAC has its own school with the adolescents expected to attend, it will be a useful area to help understand the inpatient experience.

Adolescents and physiological change

Fourthly, the adolescent is experiencing tremendous and unprecedented physiological change (Sisk & Foster, 2004). These changes begin with the onset of puberty; the initiation of a range of physical

processes such as growth spurts, sexual maturation and body image concern that influence and coincide with other psycho-social phenomena (Santrock, 2003). Some research suggests that these physiological changes create a ‘developmentally thin ice’ where the adolescent-in-transition is far more vulnerable to seek out potentially damaging experiences due to the structural and chemical reorganisation of the brain (Spear, 2000). Other research suggests that early pubertal timing may be associated with an increase in mental health difficulties (Kaltiala-Heino et al., 2003) and that puberty can be a critical time for specific issues such as eating disorders (Klump, 2013). As Piaget’s theory above recalls, there are also important cognitive shifts during adolescence. Whilst these physical and cognitive changes occur, it also tends to be during a time of change in the family system when parents or caregivers react to their own lifecycle stage (McGoldrick et al., 2011). Consequently, there is a uniqueness of development with the converging of these multiple physical, cognitive and social domains.

The above four areas represent a sample of the developmental domains that converge to create a period of bio-psycho-social flux for the adolescent. There are many other theories of adolescence, with other complex and debated facets such as educational issues and wider socio-economic variables (Santrock, 2003). As this research will be utilising an interpretative lens to understand the lived experience, the above will provide useful maps from which to make sense of the adolescents’ narratives.

Adolescents and the experience of mental illness

The literature has consistently documented the lived experience of mental illness from the perspectives of adults in recovery (e.g. Andresen et al., 2011; Basset & Stickley, 2010; LeCroy & Holschuh, 2012; Melbourne, 2010). A review of the literature however, indicates there is less research offering first person accounts from adolescents who are also in recovery from mental illness. This does appear to be changing, with an increase in researching the adolescent experience; possibly with a growing recognition of firsthand adolescent accounts of their illness. This body of research primarily consists of investigations into the subjective experiences of specific mental disorders, though there are also broader explorations. Leavey’s study (2005) is one example. This qualitative study of 7 males and 6 females aged 15-24, constructed themes from the initial onset of mental illness to the latter stages of stabilisation. It was noted that of the four themes of emergence, loss, adaption, and recovery, the theme of loss was considerably broad; including loss of identity, independence, academic functioning, friends and family status. The social reintegration was the most helpful recovery aspect for these youth. What was also noteworthy in this sample was the fact that 7 of the 13 young people had multiple diagnoses, with one male experiencing 8 diagnoses in 10

years. This may be concerning, given diagnoses could be construed as a form of negating an individual's personhood or potentially detrimental for the identity of a young person (Jacobs, 2014).

Other research in the literature has investigated a range of mental illnesses commonly experienced by adolescents such as Woodgate' (2006) phenomenological study of adolescent depression. An important finding of the study ($n = 14$) was that despite the depression being under control, there was a persistent fear of it returning in the future. The researcher suggests that strengths-based work with adolescents should never be underestimated and is important to cement the gains made. Woodgate's research is consistent with Meadus' (2007) grounded theory study of 9 adolescents experiencing depression. The core category in their study, 'coping through connections', was the strongest theme from early diagnosis to treatment and beyond. It involved a range of significant others being stable and informative points of reference throughout the journey, which was rarely linear. The relational connections made during the illness helped buffer the back and forth process of a depressive episode. The literature then, suggests that the experience of depression during adolescence is strongly mediated by the quality of the immediate relationships.

This point was a core finding of Leone et al.'s (2013) phenomenological study into adolescent anxiety. In this research ($n = 8$) the environments of school and home were key domains that directly affected the experience of anxiety. The participant accounts showed that their everyday anxiety was directly influenced by bullying and social isolation in the school environment and conflict or unsupportive parents in the home environment. Conversely, those relationships that were seen to be supportive, particularly those with fewer demands, were able to dilute the constant anxiety that permeated much of life. The researchers suggest further studies are needed to integrate the body, mind and environmental domains of adolescents experiencing anxiety.

One mental health disorder that acutely affects body and mind is anorexia nervosa; a mental illness that most commonly emerges during adolescence (Striegel-Moore & Bulik, 2007). Given that this serious condition usually emerges during the teenage years, it was concerning that this present review of the literature revealed there was a significant gap in first-hand adolescent accounts of eating disorders. There is considerable research investigating the adolescent experience of treatment (e.g. Halvorsen & Heyerdahl, 2007; Offord et al., 2006; Westwood & Kendal, 2012) but little research exploring adolescents' perceptions of having the illness in the first place. Equally surprisingly was Bezance and Holliday's review (2013) of qualitative studies on the treatment and recovery from anorexia, where they discovered that the majority of studies failed to relate their

findings to the literature on adolescent life cycle theory. They subsequently warn that this may have an impact on how adolescents experience treatment and recovery.

This was also suggested in Koruth et al.'s (2012) grounded theory study. These researchers interviewed 8 adolescents aged between 13 and 17 years about their early experiences of anorexia. The study was useful in its reminder of the necessity to incorporate a developmental lens for adolescent research. The study's first key finding revealed that the adolescents experienced overwhelming emotions at the onset of the eating disorder, particularly the feelings of frustration and loneliness. However, the second key finding was how the participants described an inability to express these emotions vocally and subsequently resorted to non-verbal methods of communicating their distress such as risk taking, self-harm or destroying their belongings. The third primary finding was a greatly impaired capacity to interact with people due to these overwhelming emotions and the incapacity to express them. This would sometimes exacerbate power struggles and complete an anorexia maintenance cycle. The researchers urge clinicians to be developmentally aware in their dealings with adolescents with eating disorders, and to be mindful of the powerful mix of strong emotions, poor expressive skills and emerging identity development.

The importance of the developmental context was also noted in Gallichan and Curle's (2008) study into adolescent experiences of attention-deficit hyperactivity disorder (ADHD). Also using a grounded theory methodology, 12 adolescents were interviewed about their experiences of the condition. Two important findings were noted that again revealed the importance of developmental issues. Firstly, the condition had significant impact on the adolescents' capacity to relate to others. They felt different to their peers and the environment generally; 'like square pegs trying to fit round holes'(Gallichan & Curle, 2008, p. 356). This had considerable impact on their self-esteem and subsequently their sense of identity. Secondly, should the environment of the adolescent be perceived to be coercive or rigid, not making any allowances for the adolescent, interventions designed to help were rejected and with a corollary reduced emotional well-being. However, should the environment be flexible and understanding, rather than increase social isolation and poor self-image, stress would reduce while self-esteem increased. This would create a virtuous cycle whereby positive external changes occurred (e.g. in schooling) and positive internal change occurred (e.g. greater sense of competence and self-worth). In other words, when the environment of the adolescent was more adaptable to the needs of the adolescent in question, the negative experience of ADHD diminished. The researchers close the study by highlighting the finding that the challenges of such a condition are not necessarily created by the young person themselves, but by the mismatch of adolescent need and environmental set-up.

Less commonly researched areas include the adolescent experience of psychotropic medication (Floersch et al., 2009). In this mixed methods study, 20 adolescents aged 12-17 years were recruited to explore their personal meaning of taking medication for their mental health disorders (primarily mood disorders). A key finding was revealing the extent to which adolescents were deeply influenced by a range of interpersonal and socio-cultural pressures when it came to taking medication. In particular, these researchers suggest that not only is the adolescent medicated, by implication, the family becomes symbolically medicated because the meanings generated implicate the entire family. This is consistent with other literature that suggests medication during the teenage years can either help or hinder the therapeutic alliance with both adolescent and the wider family system (Chubinsky & Rappaport, 2006).

There are many other mental health conditions experienced in adolescence though perceived as more controversial, such as bipolar disorder. While some estimates suggest 1-3% of young people experience the illness, diagnosis remains difficult and any delays in its treatment can effect poorer outcomes (Birmaher, 2013). Essentially, when considering the experience of adolescent mental illness, one must recall that few mental health conditions occur in isolation. For example, in Finland (Hintikka et al., 2009), eighty 13-18year olds were drawn from a larger community sample ($n = 4205$) investigating mental disorders in adolescents who self-harm. Of this smaller sample, (79% of which were girls) major depressive disorder, anxiety disorders, and eating disorders were the most common mental health difficulties among the adolescents. This was in addition to the self-harm.

Other complications such as residual trauma can also have lasting effects should it not be addressed adequately and earlier enough (Ford et al., 2013). In summary, the experience of mental illness for adolescents is usually a complicated, multi-faceted phenomenon. It occurs at a time when developmental forces are at the forefront, coupled with the persuasive influences of family and peer. What the literature says about how the adolescents' experience recovery from such mental illness is discussed below.

Adolescents and the notion of Recovery

The notion of recovery is a core component in the mental health literature (Carpenter, 2002; Davidson & Roe, 2007; Leamy et al., 2011), but one that is rarely applied in the context of adolescent mental health. Paradoxically, the concept of 'recovery' is a somewhat vague term with no consensual meaning, although it has been continually used for a number of years. Some authors argue that use of the term invites risk; discouraging individuals from seeking professional help or generating unrealistic expectations about an objective state (Meehan et al., 2008). Others seek to

operationalise the concept. For example, Noordsy et al. (2002) suggest a definition that includes components of hope, personal responsibility and moving beyond illness with a range of scales to measure these three broad concepts. One of the difficulties within the recovery literature as Davidson et al. (2005) have explained, is the varied way the term recovery is used. These researchers suggest it can be used in at least four different ways:

- *Recovery seen as a return to a normal condition* (Taken from the idea of healing from a physical injury and the person has been restored to varying degrees).
- *Recovery paralleling traumatic recovery* (Often used by victims of interpersonal trauma, whereby the trauma is integrated, again to varying degrees; incorporating it into one's life so that its impact decreases with time).
- *Recovery paralleling addiction abstinence* (Whereby the person is no longer using substances and while abstinent, is 'in recovery' though ever remaining vigilant for possible relapse).
- *Recovery from mental illness* (Where there is increasing control over any psychiatric condition and reclaiming of one's life) (Davidson et al., 2005, pp. 481, 482).

In addition to the above, Davidson and Roe (2007) suggest there is the 'recovering from' and a 'recovering in' mental illness. The former defined as 'the amelioration of symptoms and other deficits...allowing the person to resume personal, social, and vocational activities within what is considered a normal range' (p.461). The latter being '...only one aspect of an otherwise whole person...the process of living one's life, pursuing one's personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse' (pp.462, 464). These researchers do acknowledge however, that these concepts remain rather fluid; with both being able to co-exist in the same individual. It also needs to be recognised that despite such lengthy explorations of recovery as a concept in the mental health literature, it does not necessarily translate into corresponding reformed services (Ramon et al., 2007).

What is significant for the present research is the absence of literature that specifically links the concept of recovery with adolescence. When the literature does link these two areas, it invariably focuses on recovery from specific disorders such as depression (Woodgate, 2006) or more commonly, physical illnesses such as cancer (Grinyer, 2007). However, the taken-for-granted meaning and general principals of recovery are poorly linked with adolescence as a distinct lifecycle stage.

Typical of this gap in the literature are texts such as *Recovery In Mental Illness* (Ralph & Corrigan, 2005), *Psychological Recovery; beyond mental illness* (Andresen et al., 2011) or *The Social Worker's Guide to Child and Adolescent Mental Health* (Walker, 2011). While acknowledging the usefulness of such texts for broad recovery principals or the value of qualitative research in recovery, it is noteworthy that these volumes fail to include any information about how this well-used concept in the mental health literature can inform work with the adolescent population. This gap in the literature is most pronounced. Even when the literature explores recovery from a qualitative framework, it does so with adult populations, and with a significant proportion exploring only schizophrenia or psychosis (e.g. Borg & Davidson, 2008; Bradshaw et al., 2008; Davidson et al., 2005; Noordsy et al., 2002). It is argued that this gap in the literature is significant as it increases the propensity for adolescent difficulties to be addressed via conceptualisations that are primarily generated from adult data (Weisz & Hawley, 2002).

Adolescents experiencing physical or mental illnesses have the same developmental needs as their healthy counterparts but risk developmental rupture due to poor health, physical changes or scholastic difficulties (Taylor et al., 2008). However, far less attention has been drawn to mental health issues with the extant literature leaning heavily towards medical conditions. For example, there has been qualitative research into the lived experience of adolescents with serious cardiac conditions (Zeigler & Nelms, 2009) and the experience of adolescents coming to terms with asthma (Kintner, 1997). No doubt there are common useful parallels with research such as this, particularly the investigation of the lived experience of illness and the meaning ascribed to such experience. For example, in Zeigler and Nelm's (2009) study, 14 adolescents had the opportunity to explain firsthand the various difficulties they experienced as a result of having a cardiac condition. What stood out in this study was the contextual impact for the adolescents, with social exclusion, the impact on one's social network and trying to rediscover what is now 'normal', all pointing to the social domain as highly important in their physical and emotional recovery. Nonetheless, there is insufficiency in the literature that explores the use of recovery specifically with teenagers and specifically around mental health issues.

There are of course, potential parallels between adult and adolescent populations in terms of common recovery themes. Each population requires empathic and validating relationships, as well as hope for a better future during the recovery journey. Having a degree of control over one's life and the opportunity to make informed choices are also universal facets of recovery. For example, while Leamy et al. (2011) in their systematic review of recovery deny a rigid definition of the

concept, they offer a useful and comprehensive narrative synthesis of the concept with five key processes:

1. *Connectedness* (peer support, relationships, community support)
2. *Hope and optimism about the future* (belief in possibility of recovery, positive aspirations)
3. *Identity* (rebuilding/redefining positive sense of identity, overcoming stigma)
4. *Meaning in life* (meaning of mental illness experiences, spirituality, quality of life rebuilding life)
5. *Empowerment* (personal responsibility, control over life, focusing upon strengths)

These five processes could be equally applied to both adult and adolescent populations; each individual regardless of age, would to varying degrees, incorporate most or all of the above in their recovery journey.

On the other hand, there are differences that must be taken into consideration. For example, as noted above, the family of an adult loved one experiencing mental health problems can play an important role in the recovery process. However, there are developmental processes within the family with adolescents that stand out. Both attachment and individuation processes are occurring during the teenage years, as well as identity formation. Consequently, it is argued that this is a qualitative difference that separates the adult and adolescent populations. In Table 1 on the following page I have compared and contrasted four domains common to all teenagers with that of adults in relation to recovery. They do share common recovery themes which are also acknowledged:

Table 1. Common and contrasting recovery themes

Adult	Primary common recovery themes (Leamy et al. 2011)	Adolescent
<p><i>Role of family</i> The adult’s family can play an important role in encouraging their loved ones to overcome the impact of mental illness and stigma (Rose et al., 2002).</p>	<p>Connection with others</p>	<p><i>Role of family</i> A crucial influence for the recovery journey, with attachment and individuation processes ongoing (Collins & Laursen, 2004).</p>
<p><i>Peers</i> The recovery process for adults can be enhanced by supportive peers (Topor, et al. 2009).</p>	<p>Hope for the future</p>	<p><i>Peers</i> Peers exert tremendous pressure on the developmental trajectory with peer contagion a strong factor in adolescent difficulties (Dishion & Tipsord, 2011).</p>
<p><i>Identity development</i> Adults redefine their identity and start viewing their mental illness as only one aspect of themselves. They also recover from societal stigma associated with this (Davidson et al., 2005; Leamy et al., 2011)</p>	<p>Developing & maintaining Identity</p>	<p><i>Identity development</i> Identity development is a core work in progress, influenced by peers and various systems such as education (Kroger, 2003). Building on earlier years, this period will be foundational for adult identity.</p>
<p><i>Physiological change</i> Apart from typical ageing processes, physical development has been completed.</p>	<p>Empowerment & control over one’s life</p>	<p><i>Physiological change</i> Profound physiological change that could have significant implications for later life (Sisk and Foster 2004, Spear 2000).</p>

Taken from Ward (2014, p. 88)

Finally, it is important to document that there is a noticeable absence of research specifically linking recovery theory and developmental theory. Both separate bodies of knowledge are vast in the literature, though the specific linkage between the two is very weak. The literature does contain much about developmental psychopathology as a discipline (Wadsworth, 2005), that investigates ‘the understanding of causal processes, appreciation of the role of developmental mechanisms, and consideration of continuities and discontinuities between normality and psychopathology’ (Rutter & Sroufe, 2000, p. 265). This body of research can be a useful framework in understanding how pathology can affect developmental pathways, including adolescence (Cicchetti & Rogosch, 2002). However, while this literature can certainly help elucidate both developmental psychopathology and normal functioning, it still falls short of specifically incorporating recovery theory and developmental theory. The explicit linkage between recovery theory and developmental theory – particularly with reference to adolescence – could not be located whilst completing this review. The only exception is Vogel-Scibilia et al.’s (2009) theoretical piece that incorporates Erikson’s eight stages of human development and a corresponding eight phases of mental health recovery. It is an

interesting and potentially useful synthesis and given its rarity in the literature, the shortened form is quoted below:

Table 2. Comparison of human development and recovery stages

Developmental stages of recovery	Erikson's stages of human development
Stage 1 Trust versus doubt	Trust versus mistrust
Stage 2 Hope versus shame	Autonomy versus shame/self-doubt
Stage 3 Empowerment versus guilt	Initiative versus guilt
Stage 4 Action versus inaction	Industry versus inferiority
Stage 5 New self versus sick self	Identity versus identity diffusion
Stage 6 Intimacy versus isolation	Intimacy versus isolation
Stage 7 Purpose versus passivity	Generativity versus stagnation
Stage 8 Integrity versus despair	Integrity versus despair

Taken from Vogel-Scibilia et al. (2009, p. 406)

These authors do acknowledge that human development tends to be linear, as opposed to recovery journeys that rarely are (Mancini, 2007). Secondly, one needs to be cautious in constructing 'stages' of recovery given its amorphous nature. Also, this paper utilises the experiences of adults in its construction of the stages. Still, their suggestion of developmental stages of recovery is a starting point for the transposing of lifecycle theory and recovery theory for their mutual benefit. I would also suggest that most of the developmental themes in this table could still be loosely applied to adolescents (e.g. all adolescents must still trust, confront passivity and re-discover a new self).

The parent's experience of their child's mental illness

The literature consistently demonstrates that caring for a child or adolescent with psychiatric difficulties affects almost all aspects of life (Angold et al., 1998; Harden, 2005; Oruche et al., 2012). The issue of stigma as related to mental disorders is also well known in the literature (Hinshaw & Stier, 2008; Moses, 2010a), though parents in particular often blame themselves for their child's mental illness due to perceived deficits in their parenting (Crowe et al., 2011). Moreover, parents often gauge their success as parents, and are judged by others via the successes, failures or character of their children (Harden, 2005). In the mental health context when factors such as not being heard by medical professionals or being excluded from their child's care are

experienced, a ‘de-skilling’ of the parents can also be created thereby adding to caregiver stress (Harden, 2005, p. 211).

In the literature, the terms caregiver *stress*, *distress*, *burden* or *strain* historically have had divergent though similar meanings over the years, having been researched with both quantitative and qualitative methodologies (Schulze & Rössler, 2005). Despite such definitional variance, there has been a steady increase in the number of studies describing the burden of care upon families with a relative who is mentally unwell (e.g. Baronet, 1999; Oruche et al., 2012; Schulze & Rössler, 2005). For the purposes of this research, caregiver burden refers to ‘the demands, responsibilities, difficulties, and negative psychic consequences of caring for relatives with special needs’ (Brannan et al., 1997, p. 212). According to Brannan and Heflinger (2001), such caregiver burden or strain can be conceived as having both objective and subjective domains. The objective domain involves those observable negative occurrences that are a result of the child’s problems such as disrupted family relationships or financial strain, whereas the subjective facets revolve around the caregiver’s feelings toward those areas such as anger, guilt or worry. In other words, objective burden can be conceptualised as the observable impact whereas the subjective burden is the extent to which the caregivers interpret their caregiving as stressful.

For example, in families experiencing mental health difficulties, there can be many confusing experiences and conflicting emotions such as anger or resentment, and subsequent guilt for the anger (Jones, 2004). For other families, ‘external’ facets stand out as being particularly stressful such as found in Yantzi et al.’s study (2001) where there was a marked increase in strained family relationships with the need to travel long distances (>80km) to see their unwell child. Another study by Vaughan et al. (2013) demonstrated that difficulties in multiple areas and not just more clinical symptoms would display the most caregiver strain. Their quantitative study ($n = 177$) was consistent with prior research that showed the severity of child symptoms was related to greater caregiver strain and stress; particularly if the child was demonstrating both internalising and externalising behaviours. Consequently, the best possible outcomes would need to involve care and respite to both child and caregiver, thereby limiting the mutual stress. As well as the child’s clinical symptoms, parents and family members could also confront a range of other stressful experiences such as relationship problems, financial hardship emotional exhaustion or isolation (Bouma & Schweitzer, 1990; Johnston & Mash, 2001; Yatchmenoff et al., 1998).

What is noticeable in the literature review of caregiver burden is the disproportionate number of studies that investigate the burden of caregivers looking after adult children (e.g. Ghosh &

Greenberg, 2009; Möller-Leimkühler & Wiesheu, 2012; Papastavrou et al., 2010), compared to studies that explore caregiver burden of children or adolescents with mental health problems. In a rare study of caregiver burden of carers with adolescents who experience schizophrenia, Knock et al. (2011) point out that ‘Despite the recent increase in research exploring caregiver burdens for adults with schizophrenia, virtually no studies of caregivers of children and adolescents with schizophrenia exist’ (p.350). It must be acknowledged that schizophrenia in adolescents is uncommon and subsequently, such a study is equally uncommon in the literature. Nonetheless, a lack of investigation into the notion of recovery as applied to young people remains, with the vast majority of research exploring recovery within the context of severe adult mental health disorders. In spite of this, there are a number of studies that can develop and guide this research into the experience of parents caring for adolescents with psychiatric problems.

One such recent qualitative study conducted in-depth interviews with 14 Australian caregivers who had a teenager involved with mental health services (Richardson et al., 2013). Primary themes identified were the initial discovery of the illness, complex grief, waning support, caregiving challenges and the call for assistance. A core theme in the parent narratives was the strong sense of loss and grief that was often ambiguous and non-finite.

Focus groups with 20 caregivers of children 2-17 years in Oruche et al.’s (2012) study revealed similar experiences of anxiety, exhaustion and the stress of meeting other family responsibilities. This American-based parent sample found a range of barriers to obtaining sufficient help for their children and was critical of the health care providers. Conversely, other overseas caregiver populations such as in Turkey (Tas et al., 2010) report high levels of service satisfaction. The divergence in service satisfaction would be influenced by a large number of socio-economic and personal variables. However, as identified in the previous section, the literature strongly points to relational factors being the core features of service satisfaction.

An area closely related to the above domain of caregiver strain is the experiences of ambiguous loss and disenfranchised grief. Compared to the research base exploring caregiver strain, there have been fewer studies specifically researching the parents’ experiences of loss and grief (Richardson et al., 2013). Ambiguous loss, as the name suggests, is a difficult-to-define experience due to its amorphous nature. Boss (2006) defines ambiguous loss as a situation of unclear loss in which it is not known if a loved one is dead or alive, absent or present (p.12). It can be a form of ‘good-bye without leaving’, or a sense of ‘leaving without goodbye’ (Boss, 2009, p. 40). In other words, a loved one can be physically absent, yet psychologically present or psychologically absent but

physically present (though sometimes both). It is “inherently traumatic because the inability to resolve the situation causes pain, confusion, shock, distress and often immobilisation” (Boss, 2006, p. 4). Boss and Couden (2002) argue that it is the ambiguity of the situation that creates any blockages to healing:

Our premise is that the most stressful losses are those that are ambiguous. When people are unable to obtain clarity about the status of a family member, they are often immobilized: decisions are put on hold; roles remain unclear; relationship boundaries are confusing; celebrations and rituals are cancelled (p.1352).

The above reflects the experience of parents or other caregivers of adolescents with mental health difficulties. While the teenager may be physically present at home, psychologically they may not be. Conversely, the teen may be physically absent while in hospital, but psychologically available to the parents. Such situations make it difficult for the family to accommodate family life and potentially restrict any adaptive grieving process (Jones, 2004; Ozgul, 2004). Having a child with a mental illness almost always involves multiple and varied losses. Missed opportunities, an uncertain future, the loss of the ‘real child’ and complex grief reactions have all been documented with Australian families (Richardson et al., 2013). Not only are the varied losses ambiguous, each family member can experience the loss and grief differently, possibly leading to further family conflict (Young, 2004). Furthermore, having a child live away from home exacerbates the experiences of grief and loss not only during the inpatient stay, but prior to it. Farley (1984) points out that there is a distinct mourning process that adolescents and families experience both before and during an inpatient stay. He suggests a temporary detachment occurs between the adolescent and his/her family, and new attachments to staff are formed. Furthermore, he proposes that how the adolescents and their families navigate such a process can have important repercussions for treatment progress.

In comparison to the loss experienced by parents of younger children or adolescents, the literature has disproportionately focused on the grief or loss experiences of parents of adult children who have a mental illness (e.g. Godress et al., 2005; Jones, 2004). There is however, an emerging body of literature that does focus on younger populations, though not directly investigating mental illness. These studies can still reveal parallel emotional experiences such as Marion’s (2007) mixed methods study of mothers who had a child with autism. In this study, over half the parents experienced a notable sense of ambiguous loss. The caregiver’s lack of clarity with diagnosis, day to day variability in functioning and the (physically) deceptive appearance of health all parallel the experience of parents who care for a child with mental illness. Important to briefly note also, is the

phenomenon of enrichment or gains made while caring for a child with a mental illness; with some research pointing to latent strengths being discovered and meaning created in the midst of such stress (Doornbos, 1996; Yatchmenoff et al., 1998). To recap, a review of extant research reveals that historically the majority of studies investigating the loss experience for carers tend to utilise the experiences of those who care for adult children as opposed to the adolescent experience.

The corollary experience to ambiguous loss and one that is equally rare in the adolescent recovery literature, is the notion of disenfranchised grief (Doka, 2002). Disenfranchised grief has been defined as when an individual incurs a personal loss that is not openly acknowledged, socially sanctioned, or publicly mourned (Doka, 2009). The literature has consistently shown that while those individuals and families who have experienced mental illness also encounter significant stigma, the parents in particular tend to be blamed for their child's illness (Hinshaw & Stier, 2008; Moses, 2010a, 2010b). Consequently, when their child becomes unwell, there is less opportunity for any resultant losses to be acknowledged and consequently grieved. Indeed, despite the parents' best efforts at helping their child, being involved in their treatment and offering continued emotional support, the suffering they see their adolescent experience may still continue for a longer time than they had hoped, leading to deep grief (Penzo & Harvey, 2008).

To summarise, there is a significant gap in the literature that investigates the relationship between grief, loss and mental illness in families of adolescents, with current knowledge being largely based on adult consumers and the aging parents (Richardson et al., 2013). The areas of non-finite loss and disenfranchised grief are topics that are notably lacking in the child and adolescent mental health literature. As Young (2004) argues, a medicalised environment could have repercussions for those experiencing such latent pain:

The preoccupation with categorising and diagnosing mental illness has led to an emphasis on the tangible and objective, and a corresponding de-emphasis of the subjective, emotional, spiritual and symbolic. Because there is no medication for it, a medically dominated system may not actively look for grief, nor recognise it in its more subtle or disguised forms. Grief counselling may not seem a pressing task compared to addressing suicidality and overt symptoms, and therefore its relevance can easily be lost in a busy work environment (p.191).

Overview of residential care

The term ‘residential care’ is a broad one, incorporating a range of out-of-home situations for children and adolescents for a variety of reasons, though usually for prior involvement in protective services. However, it is also used for services that have a more therapeutic purpose or a combination of both. The term ‘milieu’ is a related term, usually reserved for those situations that are strongly therapeutic in orientation. It continues to be regularly used in the literature and hospital-based systems of care and was regularly used by the staff participants in this study. Consequently, a brief overview is in order.

The concept of ‘milieu’ or therapeutic community has its genesis in the literature in the 1940’s, particularly with children with impoverished backgrounds to offer a ‘corrective experience’ or to rehabilitate military persons (Tuck & Keels, 1992). Goffman’s famous study (1961) was one of the first explorations of inpatient life in ‘total institutions’ and while the sociological study has been steadily critiqued over the years (Weinstein, 1994) it remains one of the most discussed five decades later. More recently, the oft-quoted primary essentials of milieu therapy incorporates characteristics from Gunderson’s seminal paper (Gunderson, 1978): emotional and physical containment, support, structure, constructive involvement with the environment, and validation. The concept of the milieu and related ‘milieu therapy’ has been a controversial one, with varied opinions as to not only its effectiveness, but its very nature (Delaney, 1997).

Similar to the literature on recovery, much of the research investigates the concept of the milieu in terms of adult inpatient units (e.g. Thibeault et al., 2010; Thomas et al., 2002) or when it does explore a therapeutic milieu specifically with adolescents, it uses the five primary concepts drawn from Gunderson’s (1978) adult milieu practices (e.g. Creedy & Crowe, 1996; Crouch, 1998; Lawson, 1998). Again similar to the recovery literature, these concepts are certainly valid and necessary for adolescents in inpatient care. However, developmental considerations are still weak, leaving assessment and intervention informed by adult models of practice.

More recently, terms such as *healing communities* and *optimal healing environments* have been suggested to better exemplify the various therapeutic processes of inpatient life (Mahoney et al., 2009). However, conceptualising ‘residential care’ remains difficult given the international varieties of such care, coupled with matching these with the Australian context.

On the following page, I have taken the summary from McLean et al. (2011) that describes the various forms of out-of-home care that are utilised internationally. It summarises the most common forms of residential care for children and adolescents, with the levels of intrusiveness and complexity of treatment increasing with each level. A discussion then follows. The table, which is rather extensive, is included in the literature review for two primary reasons. First, ‘residential care’ is a very broad term, and one which has various meanings both nationally and internationally. Consequently, there needs to be some clarification about where the BAC sits on the continuum of care in order to appropriately locate this present study. Secondly, as the discussion following the table highlights, there is much in common across the types of out-of-home care arrangements. This has both practical and theoretical implications for this study’s contribution. It is therefore envisaged that this research will not only benefit those connected to hospital-based inpatient units, but also other forms of adolescent residential care.

Table 3. Diversity of out-of-home residential care

Taken from McLean et al. (2011, pp. 4-5)

Receiving homes

This is a form of home-based care provided by families who will take children on short notice for limited periods of time while long-term alternatives are organised. Although not commonly used in Australia, these can be considered to be analogous to emergency foster placements.

Kinship care

Kinship care is the provision of home-based care for children by adults who have a kinship bond with the child. This form of care is considered the most appropriate for children for whom it is important to maintain family and broader cultural connections; for this reason it is the first choice for Indigenous children in Australia.

Conventional foster care

This refers to the provision of home-based care by unrelated non-kin adults, and is a commonly used option for children who are removed from their homes due to abuse or neglect.

Treatment foster care (specialised or therapeutic foster care)

This is home-based care provided by foster carers who are recruited and trained to care for children in a therapeutic, trauma-informed way. These caregivers are typically reimbursed at a higher rate than conventional foster carers, in recognition of the complex needs of the children that they care for. It is well utilised in North America, where it may be employed for children with special needs or juvenile offenders.

Family group care

This is similar to treatment foster care; however, the foster parents are also supported by workers on a shift basis. The home may be owned by the service provider, with the foster parents “living in”. These homes may be larger than specialised or treatment foster homes, and may or may not exist in a cluster in close proximity to each other. This model of care does not appear to be widely used in Australia.

Congregate care (staffed group care or residential care)

Congregate care is provided in community-based residential homes, in which workers provide direct care of children on a rostered or shift-work basis. In Australia, these models have not typically received input or support from multidisciplinary teams or consultants, and do not necessarily provide a therapeutic or treatment aspect to children by design.

Therapeutic residential care

This intensive care placement for young people in statutory care within a residential setting aims to address the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences, informed by a sound understanding of trauma, attachment, and developmental needs. This option is “time-limited”; that is, efforts will be made to address critical issues and behaviours first before the young person is transitioned into a foster care placement.

Residential treatment care

Residential treatment care involves managing a fully staffed group home or a large campus under a common clinical supervisory structure, which may include day treatment programs or “on-site classrooms”, and a multidisciplinary clinical support unit. These are not exclusive to young people in out-of-home care, and are generally of a time-limited nature. The residential treatment model may have a well-articulated theoretical framework—typically focusing on either mental health or educational/ training needs—using a therapeutic milieu or specific (cognitive/social) skills training, and may involve biological families in treatment.

Psychiatric hospital (secure treatment unit care)

These institutions contain all of the main ingredients of a residential treatment centre, but with the additional capacity to medicate or certify/secure a young person if they are considered a danger to themselves or others. They are not provided exclusively to children in out-of-home care and generally provide short-term care for children with acute needs.

Secure care/correctional facility

These are locked facilities to which young people are sent by court order, typically but not always as a consequence of criminal misconduct, which are not exclusive to children in out-of-home care and do not generally provide therapeutic input. In the Australian out-of-home care sector, this option can be enacted for children when the Children’s Court deems that there are serious concerns for the safety and wellbeing of the child on a protective order (used in some jurisdictions).

The above table has 2 important themes that need clarification. Firstly, in terms of underlying therapeutic practice, the various models of care have much in common such as addressing trauma, building resiliency and the use of therapeutic relationships. Note the Australian definition of therapeutic residential care as outlined by the National Therapeutic Residential Care Working Group:

Therapeutic Residential Care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs. (McLean et al., 2011, p. 2)

These researchers go on to explain that the above definition ‘...has been developed to allow for various interpretations, according to the needs and scope of therapeutic residential care in different jurisdictions (p.2). In other words, regardless of whether one is exploring foster care, residential treatment care or more complex psychiatric facilities, there is much in common with regards to therapeutic goals, methods and ultimately, a recovery-based ethos. Elements such as the use of medication, restraint and specialist medical staff do separate the specialist facilities from the others. Nonetheless, the literature consistently points out that the most healing aspects of a residential facility revolve around the therapeutic nature of staff-client relationships such as the physical and emotional availability of staff (Soenen et al., 2013), open communication, trust and fun (Rabley et al., 2014) and consistent emotional connection along with preparing the adolescents for discharge (Soldevila et al., 2013).

The second point has to do with the range of emotional and behavioural problems exhibited by the young people; that they are noticeably consistent despite the various forms of residential care. For instance, in his review of residential care in Australia, Bath (2009) reports that despite a decline since the 1960’s in the use of residential care services across Australia, there are signs ‘...of an emerging awareness of the need for residential programmes with a treatment or therapeutic focus’ (p.28). This is due to the increasing complexity of presentations and the subsequent need for residential care that has a strong therapeutic focus. He documents that the following are regularly addressed in residential care services in Australia:

- Trauma/abuse-related symptomatology
- Neuro-developmental problems

- Mental Illness/disorders
- Chronic school problems including learning difficulties
- Difficulties with family relationships with greatly increased risk of ending up in the justice system

The length of stay for such residential care in Australia varies anywhere from 6 – 18 months (Ainsworth & Hansen, 2008). Given the resource-intensive nature of addressing such needs, McLean et al. (2011) indicate that residential treatment care and therapeutic residential care are being increasingly suggested for residential placement of Australian children (p.5). There has also been increasing recognition of the need for specialised therapeutic models for children with complex emotional and behavioural needs (p.4) and the calls for secure therapeutic facilities in Queensland are increasing (Bowe et al., 2012). In other words, the Australian context appears to be moving toward a greater acknowledgement of the need for residential services for its younger population; services that can address not just transitory statutory cases, but complex clinical presentations that require specialised input over a period of time.

The literature then, reveals that regardless of whether the residential service is statutory, foster care-based or mental health in origin, the presenting clinical issues and subsequent underpinning principals are very consistent. Not only do residential care services have common therapeutic processes, the problematic behaviours and subsequent developmental needs of the young people are equally similar.

The adolescent experience of residential care

Given that the adolescents in this study live for a considerable time at the BAC, the concept of the milieu as discussed above is important. While research into adolescent milieu populations has been occurring over many years, it tends to do so with a quantitative methodology, such as Rederstorff's (2003) exploration between ego development, symptoms and gender. Utilising Loevinger's theory (Loevinger & Blasi, 1976), this study ($n = 305$) did not find any statistical significance between aggressive, depressive or conformist behaviours in relation to ego development during adolescence. The relationship between self-efficacy and adjustment was investigated in Schwartz' (2002) study. This quantitative study ($n = 70$) confirmed higher levels of self-efficacy during adolescent hospitalisation was associated with fewer depressive symptoms, but with minimal support for global functioning. Other researchers such as Radcliffe (2005) investigated the relationship between therapeutic alliance and stages of change for adolescent inpatients ($n = 16$). She concluded that

adolescents who are not self-referred take longer to build a therapeutic rapport and interestingly, that a good therapeutic alliance does not necessarily determine therapeutic outcome.

When other studies incorporate a qualitative lens, again the focus tends to be restricted to one type of phenomenon such as Crouch and Wright's (2004) investigation into self-harm in an adolescent unit. Six adolescents were interviewed as to their reasons for self-harm. Contagion effects were documented as a result of the self-harm, with the researcher also finding important themes such as self-harming for 'attention' versus a 'genuine self-harmer'. These researchers suggest that the study points to group work as a method to address this. While that study incorporated the same methodology and population that this research does, the maximum stay for the adolescents in Crouch and Wright's study was 16 weeks. No study could be located that explored adolescents' experiences of inpatient life over an extended timeframe of more than three or four months.

An exception is Painter's UK-based qualitative study (Painter, 2008) that explored the experiences of 10 adolescents in psychiatric care. This Doctorate study utilised a grounded theory methodology to understand the experience of hospitalisation from the adolescents' perspective. This study did involve teenagers who had mental health issues and is therefore a useful contribution. The researcher presents some useful depictions of inpatient life from an adolescent's perspective such as how one accommodates aggression on the unit, the feelings of restriction or disconnection and the negotiation of new relationships. However, the admission length varied from four weeks to three years, and the inpatient stays included adolescents previously admitted to facilities such as prison and adult wards. The author also fails to mention in her analysis any implications of the large time gap of four weeks to three years with the participants. This may create significant variation in the formation of staff relationships, the influence of social contagion, and the impact on identity formation.

Some adolescent studies have sought to have a wider analysis, researching the general experience of inpatient treatment (e.g. Offord et al., 2006). However, this small phenomenological study ($n = 7$) was retrospective (2-5yrs) and focused on one disorder (anorexia). Still, the findings offered some useful insight into adolescent experiences of treatment for the condition, such as the disconnection from 'normality' and how developmental needs were sometimes not met during their stay. Staff relations were found to be important, with authoritarian approaches compounding the adolescents' feelings of worthlessness or sense of isolation. Other studies have also investigated inpatient life from a phenomenological frame, but again, from an adult's perspective (Thomas et al., 2002).

Still, there have been studies that are useful starting points that can guide this research. For example, in her master's thesis of interior design, Tapak (2012) interviewed adolescents in her attempts to understand what considerations needed to be incorporated into inpatient mental health environments. The bedroom held particular significance for the teenagers, as was the opportunity to decorate the room as an expression of their personalities. These were also linked with choice and privacy; all typical developmental areas of concern for teenagers. Her central finding was that should the inpatient environment be carefully considered with developmental factors in mind, there is much opportunity to reduce stress levels.

More useful research is found in Geanellos' work (Geanellos, 1997; Geanellos, 2000). As with other researchers exploring adolescents in inpatient care, she too includes the five primary domains of the milieu as originally explicated by Gunderson (1978). However, in contrast to some research, she acknowledges the importance of the developmental domain for adolescent inpatient work. One of her qualitative studies explored what an adolescent milieu entails, with seven adolescents and seven nurses as participants (Geanellos, 2000). Given the scarcity of such research, the results of her study are noteworthy:

...the therapeutic adolescent milieu is characterised by lightheartedness, laughter and fun, and by an open unpressured, accessible and homelike environment where the adolescents have opportunities for involvement, companionship, solitude and silence and where nurses provide protection, safety, stability, consistency and attention. The milieu is experienced as a place of respite and shelter; there is a sense of freedom, familiarity, belonging, support and acceptance (Geanellos, 2000, p. 646).

In summary, research has tended to focus on adolescent inpatients with a quantitative framework. Alternatively it has utilised a qualitative lens, but often for adult populations. A sample of the viewed research is found in Appendix A. It contains examples of theses and articles that have investigated adolescents in inpatient settings as well as a select review on the concept of recovery. Both sections highlight the lack of research into the topic under discussion.

The parent experience of residential care

The earlier section revealed some of the stressors that parents experience as they care for their child with a mental illness. The literature also points to a range of stressors that continue while their teenager resides in a residential facility. When their adolescent son or daughter enters a therapeutic facility, many parents are already in a state of crisis (Scharer, 2002), and while their child remains

in psychiatric care, maintaining family unity as well as other responsibilities are common stressors; particularly if travel distance is involved in order to see their child (Suiter & Heflinger, 2011). The parent-facility relationship can therefore be crucial to achieve the best possible outcomes for the adolescent consumer, as well as limiting as much as possible a range of stressors associated with such a difficult situation.

To date, there have been a number of studies – predominately survey-based – investigating such a relationship through exploring parents' perceptions of the treatment process. What complicates interpreting these studies are the different types of services provided, or how clinical outcome and consumer satisfaction are differentiated (Joseph et al., 1999). For example, in one Australian study ($n = 94$) the researchers discovered an inverse relationship between higher satisfaction and improved situation (Martin et al., 2002). Part of a consumer satisfaction and outcomes project study, it utilised both quantitative and qualitative components over a 2 year period exploring the relationship between therapeutic change and client satisfaction of services. These researchers discovered that change and satisfaction are not necessarily linked and are often inaccurately conflated. However, elements of a caring relationship, feeling supported and strengthened as parents, all pointed to helpful therapist qualities. They suggest that there are many organisational and interpersonal variables that influence satisfaction such as gaining specific strategies, fostering resilience, service availability and being offered new perspectives (Martin et al., 2002, p. 86).

The research consistently highlights that empathic and emotionally containing relationships are the core feature of consumer satisfaction. Interestingly in one large Australian study ($n = 1278$) of parental satisfaction with adolescent outpatient treatment (Joseph et al., 1999), satisfaction (defined by a scale incorporating aspects such as recommending the service to others, ability to meet needs etc) increased with length of treatment. These researchers suggest that the extended inpatient time allowed a quality relationship to develop between parents and clinicians.

Another Australian study (Geraghty et al., 2011) utilised a retrospective content analysis of consumer records ($n = 50$). Typically, there was a mixture of positive and negative experiences reported. Noteworthy in this study was the investigation into the perceived helpfulness of consumer consultants; parents who have had past personal experiences of having a child in psychiatric care. Responses were uniformly positive, documenting the parents' appreciation for being able to debrief with non-clinical people as well as practical help such as the offer of food when visiting their child. Once again, that study supports research emphasising the important and necessary role of validating, emotionally containing, yet practical parent-staff relations (Scharer, 2002). These studies

are also consistent with research that investigates the experiences of parents who have children in medical wards (Diaz-Caneja et al., 2005); highlighting the consistent theme that compassionate staff-parent communications and the involvement of parents in their child's treatment are foundational practices.

The staff experience of residential care

As the above review demonstrated, the notion of residential care is broad, containing both common elements and specific differences. For the sake of brevity, the literature that explores residential care in this section primarily refers to that which is reflective of the BAC, involving a multidisciplinary team and a strong biomedical framework.

The literature suggests that one of the first challenges in working in such an environment lies with the issue of worker identity, particularly for social workers. It is not uncommon for those working in multidisciplinary teams to sometimes struggle to maintain a professional identity and to maintain one's specific professional focus and ideals. For example, in a survey of Canadian mental health social workers ($n = 339$) O'Brian and Calderwood (2010) found that mental health social workers in Ontario 'profess to do a little bit of everything' (p.331); in line with international trends such as in the UK (Nathan & Webber, 2010) and Australia (Shankar et al., 2009). Interestingly, the Canadian study also revealed that the social workers in their sample felt there was an equal measure of advocacy and psychotherapy; in contrast to some who might struggle to be both clinically relevant and critical (Renouf & Bland, 2005). This is particularly noticeable in the mental health arena, where medical or biological discourses enjoy a principal standing.

Probst (2012) explored the sometimes difficult navigation of professional life in mental health settings in her interviews with 30 mental health social workers. Speaking from the American context where social work practice is heavily therapeutically focussed, her results showed that some social workers walk a fine professional line; traversing issues such as diagnosis and labelling as well as the difficulty of negotiating the differences in professional values, status and power. Her later study (Probst, 2013) of mental health social workers explored the interplay between diagnostic and person-in-environment perspectives in the professionals' work. These workers saw the two domains of advocacy and therapy as a two-sided coin and felt these facets could complement each other. This stance is not uncommon for social workers in mental health settings, despite it often being a matter of 'walking the tightrope' (p.184).

There are other facets that are related to mental health workers generally, who are employed in residential care. Firstly, Farragher and Bloom (2011) point out that staff, to varying degrees, who work in residential care may have their own personal history of trauma or loss and that it would be naive to think that it could not interfere with one's work – particularly in a clinical setting with hurting young people:

This does not suggest that these social service workers are ill equipped to do their jobs, but it might suggest that they could be prone to having reactions to stress not unlike the clients that they serve. Add to this the reality that the work in residential care and virtually all social service settings is routinely stressful, and it is not always clear who is triggering whom when we unpack incidents. Making the assumption that the clients are the most volatile ingredient in these situations is often wishful thinking (Farragher and Bloom 2011, p.66).

Parallel process – a phenomenon where patterns of behaviour originating in one setting are repeated in another – can occur in any human service organisation whether it be residential care or one that deals with difficulties such as separation and divorce (e.g. Lego & Pawlicki, 1993; Webb, 2011). Particularly with adolescent inpatient units which usually address such problems as serious self-harm, suicidality or other significant emotional disturbance, there is the potential for all staff to absorb the despair and emotional pain of the inpatients. This psychic pain has been well documented, such the impact of aggressive young people on staff (Dean et al., 2010). This Australian study ($n = 47$) used a brief structured interview with clinical and non-clinical staff with 84% experiencing aggressive behaviour from patients, with nursing staff primarily the targets. Interestingly, one-third of participants reported the levels of aggression to be either acceptable or dependent upon the context. This is despite many participants reporting post-incident difficulties such as being emotionally drained, impaired sleep or concentration and anxiety about attending work. The researchers suggested that the developmental context may grant a leniency toward the adolescents who were in the midst of receiving help.

However, the literature also points to such treatment by clients as increasing the chances of vicarious traumatisation of staff (Bell et al., 2003), leading to difficulties in staff retention (Conner et al., 2003). Given the context of residential care and the possibility of unresolved pasts impacting the professional's work, Anglin (2002) contends that reasonable steps must be taken towards self-awareness and self-development to dilute such psycho-emotional pain. Furthermore, I suggest that this necessitates significant reflexivity on the professional's part to reduce unhelpful responses in

their work. On the other hand, this is not to diminish the responsibility of the organisation in supporting its staff. Bloom and Farragher (2010) posit that organisations in their complex mix of cultural, political and personal fields, have a capacity to both inflict and experience strain and injury. Like the individuals they are trying to help, organisations sometimes require ‘healing’ of workplace culture before beneficial change can occur.

Secondly, the above residual difficulties that the mental health professional may experience are closely related to the tasks one takes with the young people; particularly that of parenting tasks and roles. The literature explains that much of what adolescents find helpful during residential treatment involves typical family-oriented processes such as the emotional and physical availability of adults, clear boundaries and time to self (Creedy & Crowe, 1996; Soenen et al., 2013). Just as a hospital or home act as holding environments, so too can staff offer interpersonal and intrapsychic holding (Applegate & Bonovitz, 1995). In other words, the work of the mental health worker, regardless of profession, is essentially relational (Shattell et al., 2006; Shattell et al., 2007; Sudbery, 2002).

Staff are also given the responsibility for various parental tasks which occur in an attachment-based environment and which underscores, as developmental contextualism would suggest, the importance of goodness-of-fit. This was highlighted in Rabley et al.’s (2014) survey of 14 adolescents in residential care that investigated staff-adolescent relationships from an attachment perspective. Not surprisingly, there was a mixture of secure and insecure styles. These authors also explained how some adolescents would attach to some staff and not others, or re-enact unresolved relational issues from their pasts with staff. They suggested that understanding the young people’s background and matching the young person with the appropriate staff member may encourage a firmer relationship and a subsequently more resilient emotional base. Again, this suggests that a relational reflexivity for the mental health professional would benefit both adolescent and worker.

One phenomenon; three standpoints

An examination of the literature revealed that research has documented the experiences of adolescents in residential care, the experiences of the parents in their dealings with service providers as well as the caregiver experience of parenting an unwell child. There is also material on the experiences of staff working in this area. However, the final gap in the literature that this review uncovered is the merging of these three perspectives. It is rare to find such a study that integrates or compares three standpoints on adolescent inpatient (or residential) care. As noted on page 38, while Geanellos (2000) did not interview parents, she did interview 7 adolescent inpatients and 7 nursing staff in her attempts to understand the key elements of an adolescent milieu. This small

hermeneutical study is one of the few that interviewed more than one group and sought to explore commonalities and differences of experience within an adolescent milieu. A study investigating adolescent inpatient or residential care from the combined standpoints of teen, parent and staff would therefore be an innovative contribution. However, in the absence of such a tri-partite investigation in the area of mental health, related studies might prove useful in providing overall themes that could inform work in mental health. For instance, potential parallels such as the role of relationships, the experience of services and what is found to be helpful generally, might expand conceptualisations in the mental health domain.

For example, Byczkowski et al. (2010) state in their study of parent and adolescent experiences of medical outpatient care, providing sound healthcare – and I would include mental health care – involves a balancing of parental and adolescent needs. Their study revealed there was general agreement between the parents and teens. However, they did not always view confidentiality the same way. Confidentiality is most important for both physical and mental health domains and clarification could benefit the relationship between consumers and service providers.

Interestingly, more has been written exploring divergent perspectives in the substance abuse treatment literature. For instance, in Gogel et al.'s (2011) study of 87 adolescents, parents, and staff from three residential substance abuse treatment agencies, the adolescents and staff noted the importance of parental involvement. However, the parents themselves did not credit their own involvement. These authors point to the wider substance abuse literature and recount that parents play a crucial role in adolescent substance abuse recovery. Consequently, the study shows how essential it is for parents to understand how central they are in the child's recovery. I would highlight that it is equally important for parents with an adolescent with mental health difficulties to be involved and to appreciate their important role.

There were consumer discrepancies in Acri et al.'s (2012) study, again in adolescent substance abuse treatment. Although there was wide consensus about what the adolescents needed post-discharge, two-thirds of the staff believed the adolescents required out-patient treatment after the residential stay, whereas the adolescents preferred a program such as Alcoholics Anonymous. This is another important facet that has parallels with mental health recovery; after discharge from inpatient treatment, what follow-up is best? A lack of agreement may well undermine gains made while in residential care.

Finally, in their study of adolescent, parent and staff perspectives also on substance abuse treatment, Wisdom and Gogel (2010) showed that more than a third of staff could not provide clear criteria for the goals of treatment, a third of the adolescents felt they did not need treatment and around half of the parents could not indicate from their perspective when their child's treatment should finish. This has important repercussions for issues such as the definition of recovery and how to know when it has been sufficiently gained to cease treatment. This information presents a cautionary note for the mental health realm, where as discussed, there is much debate as to recovery definition and how one gauges recovery.

The above areas of treatment goals, the definition and gauging of recovery, and the role of caregivers are all core features of sound therapeutic practice. Significant disagreement over such fundamental areas between adolescent, parent and staff may well weaken previously successful interventions or discourage those involved. Conversely, when there is a greater awareness and integration of the perceptions of all three standpoints, a much greater chance of success affords itself.

Summary: navigating the inpatient experience

The above review of the literature has surveyed several areas pertinent to this present research. It has explored areas relevant to adolescents, parents and staff; all with the common goal of adolescent mental health recovery. A number of themes emerged from this review:

The adolescent is in the midst of a critical lifecycle stage incorporating the physical, psychological and social domains.

The review above highlighted that the adolescent is a work in progress; simultaneously experiencing several developmental processes and transitions. Consequently, many adult concepts may not fit the adolescent experience. Indeed, one of the National Standards for Mental Health Services states that support services should be '...wherever possible, specialised in regard to a person's age and stage of development' (Standard 11.4.3, MHCA, 2005).

Theories of adolescent development therefore locate this research in a specific developmental time. Piaget recalls that the adolescents' thinking is changing; requiring the adults in the immediate context to broaden their interactions and expectations. The adolescents are now thinking about spheres of life that they could not previously and subsequently look to peers and adults for answers. Erikson suggested that these interactions will act as a developmental mirror for the emerging ego and sense of identity. The developmental journey will continue with a particular focus on

discovering what “I” looks like and its place in the world. How this emerging sense of self surfaces and interacts with the social context – the stage-environment fit – is therefore most important. Developmental contextualism indicates that if individual characteristics and the social demands of the context are incompatible, there will be poor social relationships and/or hampered development.

While the literature has explored a range of areas pertinent to adolescent mental health and with varying methodologies, theoretical gaps remain.

Much of the literature exploring the notion of recovery does so from an adult perspective, and one which often explores psychosis, schizophrenia or bipolar disorder. Adolescents also experience recovery and yet the concept has yet to be adequately applied to the teenage population. Parallel concepts between adult and adolescent recovery principals were outlined, along with specific areas that were qualitatively different with adolescents. The milieu plays an important role in this study, and how this concept is expressed in the various models of residential care was outlined. It was shown that despite divergent complexity within the various residential models, certain underlying processes such as the importance of relationship, emotional and physical containment as well as incorporating a developmental framework into the milieu were all foundational.

Subsequently, the lack of connection between developmental theory and recovery theory was most noticeable. Possibly because the recovery literature has focused heavily on adult populations, it might be expected that developmental theory has subsequently yet to be adequately linked with recovery. While some bodies of knowledge run parallel with this topic (i.e. developmental psychopathology), a valuable opportunity remains for the investigation into how developmental theory can enhance recovery theory and vice versa for the benefit of adolescent mental health.

The review highlighted underlying parallels between the various forms of residential care as well as the problems experienced by the young people with mental illness.

Despite the variegated nature of residential care (with the possible exception of secure forensic services), all incorporate common therapeutic principals. Each to varying degrees acknowledge the importance of sound therapeutic relationships and safe, nurturing environments with the aim of healthy independent living. Each residential service houses young people with a range of psychological, emotional and behavioural difficulties. These difficulties, like the residential services that address them, obviously lie on a continuum. It is argued however, that despite the differences, both the clinical presentations and the broader therapeutic processes are very similar. In other words, irrespective of service delivery, they have much in common.

Whilst research could be located exploring the experiences of parents of adolescents with mental illness, it has only emerged relatively recently.

As outlined above, research could be located that investigated the experiences of parents in this context. However, it is only in the last fifteen years that focused work has explored what it is like for a parent to have a young person with a mental illness. Considerably more has been written about the experiences of parents who have an adult child with mental health difficulties. Far less has been written about those who have younger children or adolescents. The review also pointed out a number of developmental differences between adolescents and adults that have a direct bearing on recovery.

The literature suggests that more needs to be investigated into working in such environments and the roles that staff take on.

The literature reveals that working in such an environment can generate multiple emotional responses. Psychodynamic processes, vicarious trauma and the elastic notion of parenting tasks for staff, all emerged in the literature exploring working in an inpatient milieu. If we accept the notion of a developmental goodness-of-fit for adolescent residential care, then by definition, this includes the important role staff have in the adolescents' care. Again, there were commonalities within the diverse forms of residential care, highlighting that the results of this study need not be limited to psychiatric inpatient units.

Research that synthesises the lived experience of the three primary participant groups is lacking.

A significant gap remains in the literature that simultaneously explores the lived experience of adolescents with mental illness, the experiences of their parents, as well as the professionals who aim to address those illnesses. Very few studies could be located that investigated the one phenomenon of inpatient life from three different participant groups. It is suggested that by investigating the whole and not solely isolated aspects, a more complete and holistic picture can be created; which in turn, could strengthen the particular knowledge bases of the three groups.

In summary, this literature review has revealed a number of related themes linked to adolescent mental health recovery in the context of residential care. The present research is an opportunity to contribute to the literature by exploring the phenomenon of inpatient life from three standpoints. By doing so, other fields such as adolescent recovery, staff-parent-adolescent relations and the mental health worker's sphere of influence will become clearer. Also, given the parallels with other residential care services, the underlying processes uncovered in this present research could also

inform other models of care. The following chapter presents the conceptual framework that will help capture such diverse experiences.

CHAPTER 3 CONCEPTUAL FRAMEWORK

Introduction

Norlyk and Harder (2010) point out that ‘Philosophical differences have methodological implications for empirical research’ (p.428). In keeping with this truism, this chapter outlines the conceptual framework from which to investigate the areas covered by the literature review. It is also written in order to explain more fully what undergirds the methodology in Chapter 4. The chapter accepts Jabareen’s (2009) definition of conceptual framework as “‘a network”, or “a plane,” of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena....possessing ontological, epistemological, and methodological assumptions’ (p.51). It is structured in 5 sections. The first briefly locates adolescence as a concept and explains its position within the thesis. The second section outlines the broad philosophical base of critical realism followed by an outline of some of the basic tenets of hermeneutical phenomenology. The chapter suggests that hermeneutical phenomenology contains essentials that provide a useful mindset for practitioners investigating lived experience. A more focussed and practical discussion of phenomenology is included in Chapter 4. Sections 2 and 3 are then brought together within the framework of practitioner research. It is argued that the broad tenets of critical realism and hermeneutic phenomenology can be configured in a pragmatic fashion that shapes and guides a practitioner-researcher study such as this. The final section assembles the previous discussions and a representation of the conceptual framework is offered.

Locating ‘adolescence’

‘Adolescence is as much a social phenomenon as a psychological one. As societies change over time, so does the conceptualisation of adolescence’ (Claudio, 1998, p. 2). The underlying premise for the present research is that adolescence is indeed both, with an age spread as wide as 8 to 21 years (Pratt, 2005) though The World Health Organisation define it as between 10 and 19 years (WHO, 2001). Mead’s well-known but controversial *Coming of Age in Samoa* (Mead, 1928) was one of the first anthropological studies on adolescence, though preceded by Hall’s *Adolescence* (Hall, 1905) which continues to be influential (Kett, 2003). Both demonstrate that concepts such as adolescence and identity have changed much over the generations depending on the social, cultural and political contexts of the time (Baumeister, 1987). Consequently, the way adolescence has been studied has also changed. Psychoanalytic formulations, object relations, systems theory, and feminism, to name a few have all influenced the field of adolescent research (Dubas et al., 2003).

Adolescence in this present study is equally mindful of other research; areas such as the enormous physiological changes during this period (Sisk & Foster, 2004) and the proliferation of research of recent years into adolescent brain development (Casey et al., 2011). The present research's conceptual foundation and subsequent methodology are founded on the premise that adolescence is influenced by many biopsychosocial forces. As such, contemporary debates may be a moot argument as Sercombe and Paus (2010) provocatively put it:

...the nature nurture debate is obsolete. Neither genes nor experience determine behaviour. Both do, in a complex dance which includes the person's own brain as a structure. It makes no more sense to talk about which is determining behaviour than it does to talk about whether it is Torvill or Dean¹ who is doing the dancing, or to talk about a coin only having one side. Neither variable is independent (p.29).

In other words, this study pre-supposes adolescence to be an active, reciprocal process that while clearly displaying a range of unique distinctives, is a lifecycle stage that is 'mobile'. The term adolescence itself is derived from the Latin *adolescere*, which means 'to grow' or 'to develop towards maturity' (Feixa, 2011, p. 1635). The investigation into the inpatient experience presumes that much of the phenomenon under investigation is often in a state of flux. This is especially true for the adolescent participants who are emerging toward adulthood; '*Youth is not separate from adulthood. It is the becoming of adulthood*' (Sercombe & Paus, 2010, p. 35 emphasis original).

A critical realist base

The philosophical base from which to initiate this research has two primary elements, both of which have been influenced through practitioner experience. Having worked in mental health for some years, I suggest there are valuable aspects of the 'medical model' such as prediction, causality and the reality of pathology. However, I would also suggest that aspects of a more constructivist way of thinking with its emphasis on meaning and role of language are equally useful. These two conflate whereby a realist ontology and constructivist epistemology marry to produce a critical realist hermeneutic (Scollon, 2003). That is, in terms of this research, mental illness is both 'real' and at the same time a social construct. In other words, various psychiatric labels describe, but do not constitute the illness (Williams, 2003, p. 52). While a more purist constructivist methodology might value participant perceptions for their own merit, perceptions within a realist framework can be 'studied because they provide a window on to a reality beyond those perceptions' (Healy & Perry,

¹ The ice skating couple who received a perfect score at the 1984 winter Olympics.

2000, p. 120). This is not incompatible with phenomenology that is explored shortly. Giorgi (1994) explains:

The phenomenological approach admits to a reality independent of consciousness but claims that knowledge of such reality can only come through consciousness of it, so it is better to study the reality claims made by persons through their consciousness of it...The researcher's phenomenological task, then, is not to specify in advance what reality is like but to describe the nature of reality as taken up and posited by the research participants (p.203).

While there has been a steady increase in interest in this methodology, including within the social work literature (Houston, 2010), realism itself has no unified position and confusion remains in making sense of the various schools (Mantysaari, 2005). For the purposes of this study, certain facets of critical realism provide conceptualisations that will be useful in making sense of the phenomena researched. The first is the notion of a stratified reality. For the critical realist, rather than one single, positivistic global view, or conversely, a constructivist 'multiple realities' position, reality is layered. The *empirical* consists of events directly experienced, the *actual* consisting of events whether they are experienced or not, and thirdly, the *causal*, that which involves the unseen, often multiple mechanisms that generate the events. The latter is important in critical realism as while this level of reality may not be directly discerned, it is real because the *effects* can be. An analogy would be metal shavings visibly moving due to invisible magnetic forces. This stratified reality encompasses multiple domains of social life such as the domains of the person, culture and social settings (Houston, 2010).

This is particularly useful for this study that equally values the biological, psychological and social domains of the participants. For example, some adolescent females at the BAC experience anorexia nervosa. This condition clearly has biological components and an entrenched mindset while at the same time involving a 'social body' that is positioned in a particular time and culture with equally real (causal) effects. Anorexia is not merely the product of an impaired body, nor only the result of an oppressive society. It represents "...an emergent property, one involving the interplay of physiological impairment, structural enablements/constraints and socio-cultural elaboration over time" (Williams, 1999, p. 813). Critical realism therefore encourages a wide range of methods to answer research questions such as the honouring of quantitative approaches while acknowledging the fallibility of knowledge (Williams, 2003, p. 60). It equally values qualitative research and the evidence it

produces, despite some regarding qualitative research as demonstrating poor reliability compared to more positivist thinking (Gray et al., 2009, pp. 11,12).

The ‘critical’ in critical realism has various meanings (Danermark et al., 1997, p. 200) pertinent to this study. For example, it critiques any attempt to elevate individual or social explanations at the expense of another; recognising and valuing multiple standpoints from which to make sense of a phenomenon. For instance, the notion of ‘risk’ is often discussed in the context of adolescent inpatient units including the BAC. A critical realist position would claim that ‘risk’ can have demonstrable and measurable effects while at the same time be culturally defined (Houston, 2001a, p. 853). Consequently, a both/and position as opposed to an either/or dichotomy remains a core feature of this research where multiple, subjective and sometimes contradictory narratives are examined. The present research also recognises that science has limits, is critical of pure empiricism and acknowledges the social domain that contains a range of unseen, yet real, mechanisms. Houston (2001a, p. 854) asks the question how are we to identify these mechanisms if they are unseen? He replies by referring to Bhaskar’s (1978) work from which critical realism principally derives and one which is again relevant to this study. The answer is to apply multiple relevant theories to formulate hypotheses about any causal mechanisms that may be in place, whether they be in the interpersonal level (i.e. attachment theory) or at a meso or macro level (i.e. socio/political theory). Should the theories conflict, as they often do, Houston argues that a stance of ‘professional reflexivity’ should encourage the social worker to examine and reflect on the particular spheres of professional life in the matter at hand. The important idea of reflexivity is discussed shortly in the practitioner-researcher section of the present chapter.

In summary, core features of critical realism offer a useful philosophical foundation from which to build a methodological framework. It embraces multiple perspectives while not succumbing to any extremes of positivism or constructivism. It suggests a stratified reality that has benefits for understanding in the social and behavioural sciences, thereby encouraging critical engagement and reflection at both the personal and political level. Essentially it advocates what Wakefield (1995) terms a “humble realism” (p.14). This qualitative study is located within the same methodological family where:

“..there is indeed a reality, that there are objective truths about that reality, and that there are better and worse arguments in support of claims about that reality,

combined with the views that the truth is exceptionally complex, multifaceted, and difficult to know...” (p.14)

Hermeneutic phenomenology

This research explores the subjective experiences of specific populations in a specific time and place. It aims to examine and understand personal meaning. Of the methodologies that seek to understand lived experience, phenomenology is appropriate at a number of levels. Firstly, it fits with the aforementioned philosophical base of realism in that it acknowledges an external, mind-independent reality², but seeks out multiple subjectivities in order to make sense of it. However, this does not advocate a naive realist position that discounts or minimises language or context. Paralleling critical realism, hermeneutic phenomenology suggests that what is real is *not* dependent on us, while the meaning of that reality *is*.

Secondly, as the following section discusses, the role and use of the researcher’s own subjective processes and subsequent reflexivity are important. This is explained more specifically in Chapter 5 where I outline explicitly my pre-understandings of the research topic. As a practitioner investigating my immediate sphere of practice, the capacity for reflexivity is crucial. Such emphasis on reflexivity is a strong component of hermeneutical phenomenology.

Thirdly, as the above section on critical realism outlined, reality is stratified, where one endeavours to simultaneously investigate the personal and environmental. For the purposes of this research, *personal* is defined as that which pertains to the individual; their unique cognitive, affective and experiential domains as well as their interpretative, sense-making processes. *Environmental* includes all the external spheres of influence that are significant to the individual at a given point in time. For example, the adolescent domain includes peers, family, staff relationships and the physical environment of the BAC Unit. This research sees these two domains as inextricably linked at all times at different levels. Consequently each facet is a layer of stratified reality that deserves to be explored. This study then, will analyse through lived experience how the personal and environmental impact each other and how this knowledge can be used for mental health practice. The semi-structured interviews reflected this by asking specific questions about particular areas, but with sufficient freedom for the participants to expand as they wished. This required a strong interpretive component that this branch of phenomenology utilises.

² Some branches of phenomenology would disagree. However, there is wide variation as to the ‘official’ ontological position of phenomenology. The above position is in keeping with Smith’s Interpretative Phenomenological Analysis (Smith et al 2009) that this study utilises and which is discussed in the next chapter.

There are a range of phenomenological approaches that have been used over the last one hundred years, each with its own presuppositions, worldview and methods (Dowling, 2004). Despite the variants, phenomenology has a number of common elements. The following are taken from Langdridge (2007, p. 9):

1. A focus on human experience as a topic in its own right.
2. A concern with meaning and the way in which meaning arises in experience.
3. A focus on description and relationships.
4. A recognition of the role of the researcher in the co-construction of the study as well as the context in which it is constructed (historical, cultural and personal)

Two schools of phenomenology, the descriptive and interpretative (or 'hermeneutical'), tend to be utilised the most in qualitative research and are often contrasted with each other (Cohen & Omery, 1994; Hein & Austin, 2001). As the names suggest, the descriptive school seeks out rich descriptions of experience and utilises bracketing as a core feature of the research process. For this school, the separation of one's preconceptions about a phenomenon is important, whereas less weight is placed on this facet in the interpretive school. For hermeneutic researchers, the making explicit of presuppositions is important, however they "...cannot bracket and place aside implicit assumptions and perspectives that are embedded in their own biology and history; rather, they need to acknowledge them and make them explicit" (Hein & Austin, 2001, p. 9). In terms of the practitioner-researcher, Fox, Martin and Green (2007) agree; 'The goal is not the elimination of subjectivity but the understanding of it in order to understand how it has affected the research' (p. 187). This is important given that two core features of practitioner-researcher projects involve the practitioner taking the primary role in design and delivery of the project, and which usually concentrates on the professional's own practice (Mitchell et al., 2010). Other grounds for incorporating the interpretive phenomenology school are:

It departs from previous research that has tended to focus on causality or prediction and instead seeks to appreciate and interpret the subjective experience.

The aim of this research is to better understand the experience of living, working, and having a child in a long-stay adolescent inpatient unit. As the literature review suggested, there is an under-representation of the subjective interpretation of the inpatient experience from multiple perspectives. Phenomenology was initially an attempt to reclaim a focus on the internal experience when empiricism monopolised the behavioural and social sciences. This methodology was

originally conceived and later developed to help understand phenomena by articulating internal experiences such as this.

A phenomenologically-based study allows the participants' stories to be heard without being constricted by pre-determined categories.

There have been a range of useful studies that have explored the experience of specific conditions or diagnoses such as anorexia (Offord, Turner & Cooper 2006), or depression (Woodgate (2006). Conversely, this present study will attempt to be open to new phenomena rather than be limited by pre-determined schemes of interpretation (Kvale, 2009). This allows a more mutual process of meaning-making, resulting in a joint effort between researcher and participants. The study is therefore not concerned about the factual nature of the adolescent narratives, but rather the experiential data that illuminates a phenomenon – the inpatient experience. The interpretations of the staff also contribute to our understanding of the phenomenon, but from a contrasting perspective as does the parents. By utilising adolescent, staff and parent narratives, it is argued a more holistic representation of inpatient life is constructed.

The broad concepts of interpretivist phenomenology offer the opportunity for a clearer picture of the adolescent clinically.

I suggest that by allowing the participants – and the adolescents in particular – to voice that which is most concerning to them, creates the potential to fine-tune the treatment process. For example, most of the adolescents at some point experience significant depressive episodes. However, the meaning given to that experience varies considerably. One adolescent with depression may be in the midst of peer difficulties, another affected negatively by family conflict, or another may be experiencing a typical lifecycle transition. Possessing a richer picture of their personal and organisational experience may enhance clinical work by tailoring therapeutic intervention more appropriately (Miller & Duncan, 2000). This is in keeping with the literature where the elucidation of internal experience has been historically foundational to the helping professions (Hansen, 2005). Furthermore, some qualitative studies support the idea that the best way to create a working therapeutic relationship is for the therapist to persevere in grasping the internal world of clients (Myers, 2000). My past clinical experience agrees; helping an adolescent articulate that which has been inarticulate, was often the catalyst to move past areas of continued difficulty and on toward growth. I suggest that using the above methodology will complement a practitioner-researcher base thereby further developing theory from practice (Jarvis, 1999).

Interpretative phenomenology is a methodology that is consistent with the practitioner-researcher framework.

Interpretative phenomenology and related hermeneutics also share parallels with social work practice, such as the search for meaning and the valuing of multiple perspectives (White, 1997). However, I do acknowledge White's cautionary note that 'competing perspectives must take account of the *consequences* of a particular interpretation' (1997, p. 747). The sometimes overzealous practice of diagnostic labelling within the medical model is an example. To help counter-act this, she suggests that reflexivity act as a self-monitoring mechanism for social workers. By doing so, a greater awareness of any dominant professional constructions that influence practice is produced. Such reflexivity is well established in the phenomenological perspective with its emphasis on self-awareness through the elucidation of researcher pre-understandings. These are discussed in detail in Chapter 5, while the notion of reflexivity is a recurrent theme throughout the study.

The practitioner-researcher frame

This section details some basic tenets of practitioner research. Given that '...there is no sacrosanct way of conducting practitioner research' (Dadds 2006, quoted in Fox et al., 2007, p. 81) and the range of methodological choices, there needs to be clarity about what this research is *not*. That is, while the methodology has overlap with some well-known approaches, clarification is in order to highlight the project's distinctiveness.

Firstly, while the study shares parallels with action research, it is not derived purely from that framework. Action research itself has a "...bewildering array of activities and methods" (Brannick & Coghlan, 2005, p. 13). It does share some overlap, such as having an objectivist ontology, subjectivist epistemology and with the researcher purposefully close to the data. It also is open to all types of data collection, collected in real time, with the researcher experiencing a close relationship to the participants in the study. Conversely, while this study examines the organisational context, structural change within the organisation is not the primary aim, though it is envisaged that the data will produce a foundation from which to consider processes that need to be re-examined. Secondly, action and research are important phases that occur simultaneously in the action research cycle (Brannick & Coghlan, 2005). The present study could not instigate such processes due to time constraints though at a later date, these phases may be applicable depending on the organisational context at the time.

Third, this research is not a self-ethnographic study despite such parallels as enjoying ‘natural access’ to the research setting and drawing attention to one’s own culture (Alvesson, 2003, pp. 174, 175). Culture, while an aspect contained in this study, is not the focus; the *experiences* of organisational culture are. Differences also emerge in data collection. Ethnographic interviewing is aimed at describing the cultural knowledge of the informant while in contrast, phenomenological interviewing is concerned with uncovering knowledge related to specific phenomena, particularly the participants’ daily lived experience (Sorrell & Redmond, 1995, p. 1118).

It is accurate to say however, that his study is clearly an insider research piece. I define such research by borrowing from Brannick and Coghlan (2007) who suggest it is,

“...research by complete members of organisational systems and communities in and on their own organisations, in contrast to organisational research that is conducted by researchers who temporarily join the organisation for the purposes and duration of the research’ (p.59).

Much has been written over the years about the pros and cons of ‘insider research’ (Mercer, 2007). On the one hand, discovering patterns of meaning may be lost because the phenomenon under study may be too familiar, while on the other, it could be argued that this very familiarity and trust allows the researcher to collect in-depth data (Lipson, 1984). Bias and role confusion are also regular criticisms of practitioner research and insider research generally (Fox et al., 2007; Smyth & Holian, 2008). The important issues of bias and role identity during the research process are explained more fully in the next chapter. However, at this point I need to underscore the position that,

There is really no such thing as pure objective observation of much human behaviour in real work situations, regardless of whether the research is conducted by either external researchers or researchers from within. All observation is theory or value laden, and dependent on past experience of the observer (Smyth & Holian, 2008, p. 37).

These authors continue by suggesting that external researchers usually do not develop the same level of explicitness as insider researchers do in terms of their interactions with participants (p.37). In contrast, this study has endeavoured to be as transparent as possible regarding origins of the research, ethical processes and organisational relationships.

Practitioner research generally has as its focus the worker's own practice, and typically utilises colleagues and/or service clients for data while often focusing on service delivery or other organisational/practice-based issues (Mitchell et al., 2010, p. 9). The present study correlates closely with one review of social work practitioner research where qualitative studies were most common; with interviews and focus groups the methods of choice for the majority of studies (Mitchell et al., 2010, p. 16). This present research also has a strong "pragmatic" influence, where:

The emphasis is upon identifying useful evidence that realistically can be gathered and applied by social workers needing to make informed judgements in particular practice contexts (Gray et al., 2009, p. 60).

Another guiding theme for this research that threads through most of the study is that of reflexivity. Typically for qualitative research in general, the researcher is seen to be the key 'instrument' in the research process. Finlay's (2003) description of reflexivity fits well with the principals of this research:

Reflexivity is thus the process of continually reflecting upon our interpretations of both our experiences and the phenomenon being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes (Finlay, 2003, p. 108).

The idea of reflecting on the relationship between the researcher and the researched is well documented in the practitioner-researcher literature (Arber, 2006; Fox et al., 2007, p. 186) as well as the phenomenological literature (Drew, 1989). This research project had its origins in day to day practice; a practice that valued the importance of relationship between staff and patients. Without such emotional connection, attempting to address the mental health concerns of the adolescents would end in failure; not surprising given the emphasis that teenagers place on their adult and peer relationships. Consequently, a yet to be hoped for goal for this research is 'empathetic validity' (Dadds, 2008). That is,

'...the potential of the research in its processes and outcomes to transform the emotional disposition of people toward each other, such that more positive feelings are created between them in the form of greater empathy. Related to the growth of empathy is the enhancement of interpersonal understanding and compassion' (p.280).

As a practitioner with 8 years experience at the BAC, I can verify (as my colleagues would) that empathy and interpersonal understanding are crucial features of the overall treatment process within the Unit. Dadds (2008) acknowledges that ‘practitioner research is not a panacea for generating ‘right’ relationships’ (p.288), but laments the fact that human empathy does not rate very high in any quality criteria for research.

Indeed, whilst during the study I chose to leave behind the ‘therapeutic self’ in order to focus on the ‘researcher self’, it was still hoped that the ‘relational base’ was maintained. The phenomenological psychologist Jonathan Smith explains:

...when I read a transcript from a patient with a chronic health condition, I am trying to make sense of the words used but I am also trying to make sense of the person who has said the words... Therefore, the participant, like me, is a unique individual worthy of an idiographic, holistic analysis. At the same time however, here is the possibility of bridging the divide between selves because we are all at the same time part of a larger whole, a collectivity that allows the possibility of mutual understanding (Smith, 2007, p. 5)

In other words, my practitioner background that has led me to initiate this research has been inherently relational and this value will continue to be incorporated.

Finally, the conceptual framework for this research also needs to locate itself with reference to the wider literature on evidence-based practice and practice-based research. The very terms are meaning-laden and with significant controversy (Epstein, 2009; Gray et al., 2013) and for the purposes of this study, there needs to be some definitional clarity. The following is to only briefly explain where this particular study is on the methodological continuum. I acknowledge that other authors have given both similar and contrasting definitions for the concepts below.

Evidence-Based Practice (EBP) has generally been regarded as,

‘...the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare or care of individuals, service-users, clients and/or carers’ (Plath, 2006, p. 58).

Research-Based Practice (RBP) has been defined as,

‘...the use of research-based concepts, theories, designs and data-gathering instruments to structure practice so that hypotheses concerning cause-effect relationships between social work interventions and outcomes may be rigorously tested’ (Peake & Epstein, 2004, p. 31).

Practice-Based Research (PBR) has been defined as,

‘...the use of research-inspired principals, designs and information-gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice’ (Peake & Epstein, 2004, p. 31).

More recently, Epstein (2009) who has written extensively on this topic, has advocated a less dichotomous, more pluralistic model that seeks to integrate various aspects of the above with a much broader conceptualisation of ‘evidence’. Given that this research grew out of direct social work practice, I would also agree with his suggestion to substitute ‘...the word “informed” for “based” because it implies that practice knowledge and intervention decisions might be *enriched* by prior research but not *limited* to it’ (p.224 emphasis original).

Nonetheless, it is the latter definition that most closely resembles this research. This study grew out of observing the interactions between adolescents, parents and staff and how all three navigated inpatient life from different, but closely interconnected positions. Over the course of several years, it seemed a number of ‘invisible hands’ were at work; unseen yet keenly felt at a number of personal and organisational levels. In other words, I was observing what critical realism would term *tendencies*; actions influenced, but not necessarily determined by, a range of complex but unseen psychological and social mechanisms (Houston, 2005). As it will be clarified in the next chapter, the research is interested in utilising individual voices to make sense of the larger phenomenon of inpatient life. This brings into play individual experience, organisational elements and the interactional processes of the two.

This of course lends itself to the question of what is the best path to take when attempting to understand such a complex environment? Given the significance of relationships at the BAC, it seemed important to place the narratives at the centre of the research process, and from there, to make sense of these in the context of the wider literature. In other words, while the conceptual framework is informed by a range of theories as outlined in the literature review, personal meaning was intended to be the foremost guiding theme; hence a qualitative, phenomenological frame that

was generated from practitioner experience. This method of knowledge production has been depicted by Geanellos and Wilson (2006):

Figure 1: Contrasting knowledge production

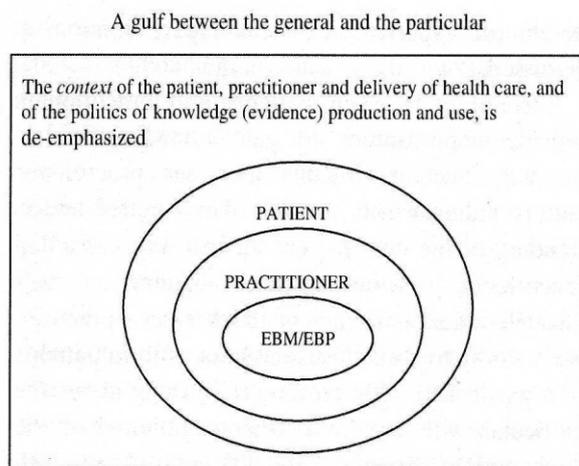


Figure 1 The relationship between evidence-based practice (EBP), practitioner, patient and context in the pro EBP discourses. EBM, evidence-based medicine.

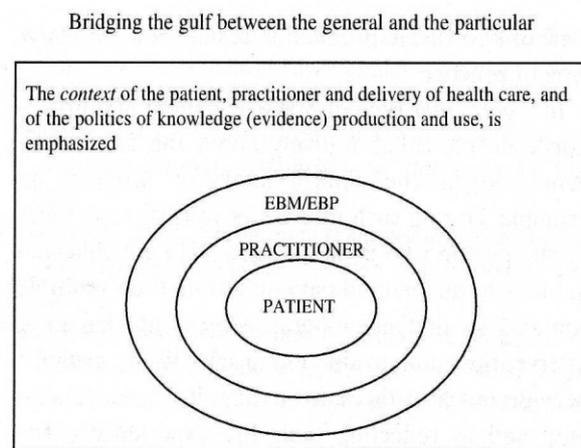


Figure 2 (Inter)relationships between evidence-based practice (EBP), practitioner, patient & context in contra EBP discourses. EBM, evidence-based medicine.

Taken from Geanellos & Wilson 2006. p.303

These nurse researchers suggest that the EBM/EBP position (figure 1) tends to locate the patient on the outer where the recipient is given what is regarded as ‘best practice’ as described in the current literature. They argue that the context of the patient is given less importance (or seen as further symptomatology), while the process largely remains task-oriented. The practitioner is seen as almost an extension of the literature; a mere conduit through which the latest health care ‘evidence’ is delivered. The notion of best practice assumes a hierarchy of evidence that can be ranked, that while valid to a point, there is the strong tendency to favour randomised trials and large scale quantitative studies (Staller, 2006).

In contrast, the second model in the above figure depicts a vantage point where patient knowledge and experience are valued and therefore central to their care. The practitioner is informed of the prevailing literature, but it is screened through a critical, reflexive process. The practice wisdom of the practitioner is therefore valued. Evidence becomes more contextual and which demands an interpretative, process-oriented approach. Clinical experience at the BAC suggests that there are often no clear-cut answers to multi-problem adolescents and their families. Rather, ‘clinical intuition’ is more often the guide than manualised procedures. This is not to disparage more

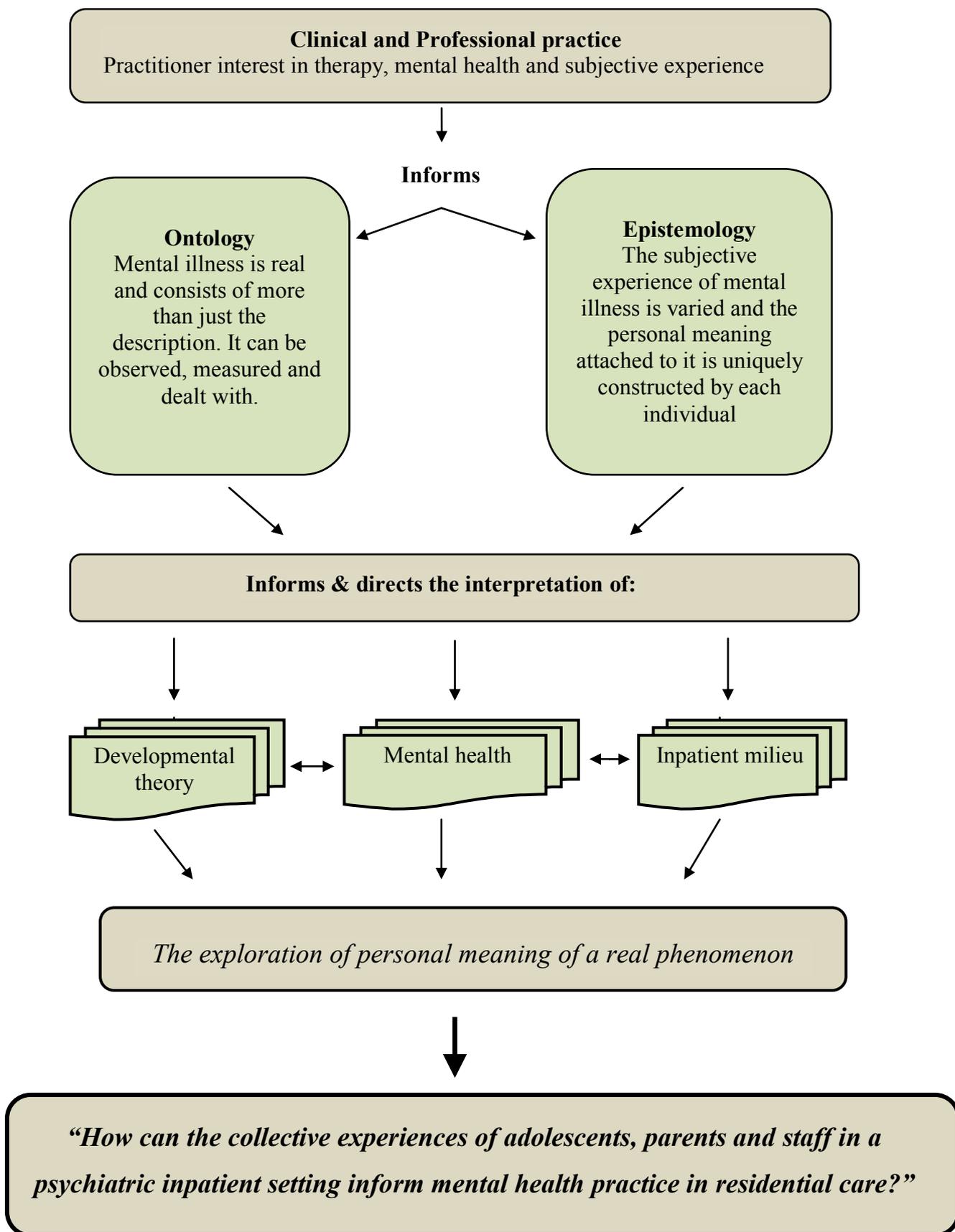
positivistic approaches. Controlled trials abound in mental health and have contributed to a sound empirical base to inform a range of clinicians. However, as Houston (2005) argues, it is when other approaches are scoffed at due to being unscientific and therefore of poor value, that such one-sidedness greatly diminishes the potential to help.

Summary

Jabareen (2009) in his discussion of qualitative conceptual frameworks, states that two core features of conceptual frameworks include 'not merely a collection of concepts, but rather, a construct in which each concept plays an integral role'. Neither does it provide a '...causal/analytical setting, but rather, an interpretative approach to social reality' (p.51). The interpretative approach for this research is informed by a range of concepts and experiences that include professional practice, theories of mental illness, recovery and developmental theory. It is also girded by a desire to appreciate and learn from the personal narratives of those who have had significant experience – positive and negative – within the mental health realm. In contrast to solely focusing on causal mechanisms, these bodies of knowledge form a complimentary, interpretative approach to understanding personal experience.

As the foregoing sections explained, this has influenced my conceptual framework. It is a framework that maintains a belief in real phenomena without assuming a perfect view into the phenomena. It is also a framework that is guided by the practice-based research principals of being naturalistic, heuristic, reflective and inductive (Peake & Epstein, 2004, p. 31). In one review of (descriptive) phenomenological studies, the authors (Norlyk & Harder, 2010, p. 427) discovered that many researchers did not articulate the particular approach that guided the study, nor made explicit the philosophical assumptions on which the studies were based. Conversely, this chapter has made the philosophical assumptions that undergird the study explicit; thereby offering a more secure conceptual footing for the methodology that follows in the next chapter. This chapter will close with a representation of the conceptual framework on the following page.

Figure 2: Conceptual Framework



CHAPTER 4 METHODOLOGY

Introduction

The previous chapter outlined the conceptual framework of the study, detailing the ontological and epistemological assumptions of the research. This chapter explains more specifically the methodology; what Crotty (1998) defines as ‘the strategy, plan of action, process or design lying behind the choice and use of particular methods’ (p.3). It presents the strategy to respond to the research question ‘*How can the collective experiences of adolescents, parents and staff in a psychiatric inpatient setting inform mental health practice?*’ The chapter is presented in six sections.

The first section introduces Interpretative Phenomenological Analysis (IPA); the phenomenological base from which to make sense of the inpatient experience. Phenomenology is a broad and complicated framework and this section is written to clarify my ‘mindset’ during the attempts to grasp the personal meaning of others. The following sections then introduce methods, sampling, recruitment and analysis. All three areas are consistent with a qualitative, phenomenological approach and are explained accordingly. Researching one’s practice or own organisation has a range of potentials and pitfalls, most notably those of validity and bias. Consequently, these two final and interrelated areas are also explained in detail at the end of the chapter, as are ethical considerations. The summary concludes by highlighting the cohesiveness of conceptualisation and methodology, where my epistemological and ontological premises are made explicit in the methods, analysis and overall approach.

Interpretative Phenomenological Analysis (IPA)

Previously the conceptual framework explained that the focus of the study concerns the personal, subjective meanings given by adolescents, their parents and staff in a hospital environment; that these collective experiences then converge to permit an investigation into the phenomenon of the inpatient experience. In turn, this information will provide a useful platform from which to guide mental health practice. As Bland et al., (2009) contend: ‘...attention to the lived experience of mental illness should always be the starting point for professional practice’ (p.20). In this regard it was argued that the broad tenets of hermeneutical phenomenology provide a structure and mindset that can guide the research process. This section now focuses more specifically to explain IPA; a branch of hermeneutical research that has its genesis in the United Kingdom, but now has been

utilised across the globe to understand personal meaning in a variety of settings. I have chosen this methodology for two primary reasons.

Firstly as I explained in the Introduction, a primary desire – borne out of practitioner experience – was to explore personal meaning; unclouded by diagnoses and the layering of external organisational narratives.³ The BAC was a tertiary mental health unit and by the time the adolescents were admitted, a strong ‘narrative residue’ clung to the teenagers and their carers. This in turn influenced the perceptions of staff which then appeared to create yet another layering of narrative about the presenting issues and individual identity. The outcome of this process seemed to be a calcification of pathology leading to a rigidity of viewpoint; ‘making what is not definite, definite’. Subsequently, a hermeneutical, phenomenological stance was chosen; one that resisted the pre-existing inertia to add yet another layer, and in contrast make pre-understandings explicit and processes transparent.

Secondly, a core feature of phenomenology is to ‘go back to the things themselves’ and, echoing Bland et al. (2009) again, to have the raw personal experiences and associated meanings as the basis from which to do this. However, as Giorgi (2000, p. 11) noted, ‘The amorphousness of phenomenology is both a boon and a bane’. Consequently, a methodology that contains analytical breadth but methodological depth was required. IPA was therefore chosen to offer not a rigid method, but a ‘stance’ for qualitative data analysis (Larkin et al., 2006, p. 104). IPA was also chosen as it is consistent with the epistemological position of my research question (Smith et al., 2009, p. 46).

Created by health psychologist Jonathan Smith (Smith et al., 2009), IPA has both a ‘short and long history’ (p.4). That is, Smith initiated his ideas in the mid-nineties, though the philosophical frameworks that informed his methodology are longstanding and drawn from phenomenological writers such as Husserl, Heidegger, Gadamer and hermeneutics generally. Typically for phenomenology, IPA has a number of facets that separate it from, and correspond with, other life-world research. Firstly, IPA is ‘...concerned with human lived experience, and posits that experience can be understood via an examination of the meanings which people impress upon it’ (Smith et al., 2009, p. 34). It is therefore founded and built upon the work of such individuals as Heidegger, Merleau-Ponty and Sartre. IPA is particularly interested in experiences that have special significance, hence the number of studies completed on illness and other existential issues. This fits

³ No doubt I too, had internalised some of these narratives. However, being conscious of this fact, Chapter 5 was subsequently written (in part) to elevate my awareness of these taken-for-granted meanings.

well with this research that explores an experience that is often painful, confusing and which occurs in a sensitive lifecycle stage. To comprehend the experience of others also requires interpretation, which is the second feature of IPA. The ‘hermeneutic circle’ is a foundational theme in interpretative phenomenology in general and IPA in particular (Smith, 2007) whereby the part/whole and participant/researcher domains are interrelated, circular and in constant cognitive motion. This methodological reflexivity sits well with the previous discussions about the role of reflexivity for the practitioner, and the process of mutuality. As Smith et al., (2009) explain:

Thus IPA requires a combination of phenomenological and hermeneutic insights. It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognises that this inevitably becomes an interpretative endeavour for both participant and researcher. Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen (p.37).

Thirdly, IPA is concerned with the particular. Influenced by ideography, IPA is not primarily focused on making claims that are generalisable to large populations, though at the theoretical level, findings can be generalised at a more abstract position. I suggest that the strong value placed on detailed individual experience can open the way for linkages with the wider literature as will be shown later in the thesis. This facet is also linked with the previously mentioned concerns about imposed external narratives. By taking the time to complete a holistic, personal narrative, the message is given that the individual is unique and valued, while at the same time acknowledging he/she is part of a larger whole.

The above features undergird the research process while addressing the two primary aims of IPA. The first being to understand the world of the participants by focusing on their experiences, and secondly, to develop an interpretative analysis that is located in the wider social, theoretical and cultural context (Larkin et al., 2006). This is demonstrated in this research through Chapters 6 and 7 that explore experience and the interpretation of that experience, respectively. The first aim for a study utilising IPA is that of investigating peoples’ experiences or their experiences of a particular phenomenon (Smith et al., 2009, p. 46). In a previous IPA review, Brocki and Weardon (2006) noted that most had been carried out in the field of health exploring the experience of such areas as chronic pain, eating disorders or various diseases. Paralleling this research, most of the studies used a semi-structured format, with an open-ended and semi-directive style. Sample size varied from one to thirty, non-random and purposefully designed to shed light on a specific phenomenon. In a more recent review, Smith (2011) noted that the largest area of study within the IPA corpus (over a

quarter) had been the illness experience though the breadth of topics was steadily increasing. Of the two primary aims of IPA, the first involves a detailed thematic analysis of individual cases followed by investigating patterns across cases. This is pertinent to the present research where I will investigate how a number of individuals make sense of their experience and then explore convergences and contrasts. Indeed as Smith (2011) states, ‘This nuanced capturing of similarity and difference, convergence and divergence is the hallmark of good IPA work’ (Smith, 2011b, p. 24).

The second aim has a more speculative slant that seeks to understand what it means for the individual; a ‘double hermeneutic’ where one tries to make sense of an individual’s sense-making and transform that into a phenomenological document crystallising the experiential essence. This research however is not seeking some metaphysical essence where some phenomenological writers try to ‘capture’ and revere ‘the’ experience (such as the philosopher Husserl). Van Manen’s comments encapsulate the goal of this research:

By essence we do not mean some kind of mysterious entity or discovery, nor some ultimate core or residue of meaning. Rather, the term “essence” may be understood as a linguistic construction, a description of a phenomenon. A good description that constitutes the essence of something is constructed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way (van Manen, 1997, p. 39).

The above is central for this research; to steer away from pre-existing pre-understandings (though never totally escaping them) and see the narratives of adolescents, parents and staff in a new, previously unseen way. Such an inductive stance is a core feature of IPA.

Methods

Given that the goal of this research is to better understand human lived experience, it is appropriate that the method chosen to accomplish this be able to collate multiple meanings of a sufficiently information-rich nature. This is important when one recalls the multiple and simultaneous developmental processes that adolescents experience. First-person reports are often used in this regard (Polkinghorne, 2005), and in this study allowed the adolescents to ‘...give voice to their own interpretations and thoughts rather than rely solely on our adult interpretations of their lives’ (Eder & Fingerson, 2001, p. 181). However, as Moyle (2002) suggests, people with illnesses such as depression or other mental health problems may struggle to reflect on their experience or to

communicate their experience to the interviewer. The interview schedule was therefore in a simple, semi-structured format. Prompts were often used to help the adolescent participants tell their story. The interview schedule is found in Appendix B.

At the outset, further explanation is required as to my rationale for the interviewing of three groups of participants. The original research topic was the experiences of the adolescents. It was felt that given they were the most powerless during a very difficult time, their experiences needed to be focused on. Then as various themes emerged from the interviews, it was decided that single interviews for the staff could be used to supplement the adolescent narratives. It was later decided that this picture could develop further if the respective professions could be interviewed once more as a small ($n = 3$) focus group. This was due to some themes developing in relation to the research question that emerged during those individual adolescent and staff interviews. For example, it seemed the male and female adolescents may have processed certain stressful events differently while at the unit. Subsequently, it was decided to follow potential fresh themes that emerged in the individual interviews further via the staff focus groups. While reflecting on this data, it became apparent that despite the parents not living on the actual premises, they too had genuine encounters with the inpatient experience. Consequently, it was decided to include parental narratives to continue to develop the data even further. As the study progressed, a fuller, far richer picture developed – via individual descriptions – of the inpatient experience. Further details on the process of recruitment provided in Chapter 5.

With regard to the addition of focus groups, there are potential criticisms of adding such a method to phenomenological interviews (Bradbury-Jones et al., 2009). Personal sensitivities to subject matter, reactions by peers in the group, and pre-existing relationships all may influence what is and what is not said. However, I agree with Palmer et al. (2010) that a small group experience often provides an added dimension that otherwise could not emerge and generate rich information. Smith (2004) suggests that to help address the above concerns, the researcher be mindful of group process and to analyse both for ‘...group patterns and dynamics and subsequently for idiographic accounts’ (p.50). The focus groups were also purposefully small which tends to encourage individual expression (Bradbury-Jones et al., 2009).

I would also argue that because there are many and varied methodological challenges in interviewing adolescents as research participants (Bassett et al., 2008), the inclusion of focus group perspectives do not detract from the adolescent narratives, but rather provide a valid secondary platform from which to view and make sense of the inpatient experience. They also can help

illuminate a phenomenon and encourage theoretical generalisations. Insights can then be cautiously projected onto similar contexts such as other adolescent inpatient units (Sim, 1998, p. 350).

It was initially expected that there would be three to four interviews for each adolescent participant, approximately three months apart over the course of a year. The rationale for multiple interviews over a period of twelve months was twofold. Firstly, it would help to better capture the notions of time and change in the adolescents' experiences as well as offering a more complete picture of how personal, social and organisational structures are interconnected (Neale & Flowerdew, 2003). Secondly, there would be greater depth and breadth in the participant narratives generally as opposed to a singular 'snapshot' of their experience. The question as to whether this study is longitudinal is open to debate. Saldaa (2003) in his review of what constitutes 'longitudinal', reluctantly admits that 'it depends, because time and thus change are contextual' (p.5), though he recommends that for educational settings at least, nine months should be the minimum. I suggest that this research does fall into that category, albeit at the lower end of the longitudinal spectrum.

The interviews were audio taped as opposed to being videotaped to help the interview process be less intrusive and they occurred in a room which is not usually utilised for any therapy so as to reinforce the research-nature of the interviews. The tapes were transcribed by myself as well as a paid transcriber. The completed transcripts were thoroughly checked against the tapes, acknowledging that sound transcribing enhances the rigor of a study (Poland, 1995). Each participant was informed at the beginning of the study that they could have a copy of their own transcript after it was 'cleaned' of any personal information related to other adolescents or staff. They were also informed that while they were able to withdraw at any stage of the project, all written and photographic (see next paragraph) interview material could still be incorporated into the research.

The first interview of the adolescents oriented them to the research-nature of the study and helped establish rapport. It also created a material base for the subsequent interview. For the remaining interviews, a digital camera was given to them for half a day. During this time, they were encouraged to take photos that were personally meaningful for them and that would help them describe their inpatient experience. In the words of Guillemin & Drew (2010) they were given explicit permission to 'photograph the good, the bad and the ugly of their lives' (p.180). These photos were then used as a tool during the second and subsequent interviews as a springboard to further explore their experiences. Photo elicitation has been used for many years in qualitative research, particularly in ethnography (Harper, 2002) or with populations that find talking difficult,

such as those with disabilities (Aldridge, 2007). The use of photographs allowed the adolescents to take more control during the interviews, and enabled them to share their experiences more spontaneously (Hagedorn, 1994).

The methodological benefits of photo use extend further. As described shortly, practitioner researchers must be mindful of, and where possible address, taken-for-granted meanings in a familiar environment. In her discussion of various myths of insider and outsider research, Mannay (2010) suggested that one of the ways researchers working in familiar territory could enhance objectivity was to utilise 'techniques of defamiliarisation' (p.95). That is, techniques such as art and photography can open up experience and 'make the familiar strange' for both researcher and participant, thereby enriching the data. Dahlberg et al. (2008) insightfully state that '...the things that we are closest to are the things that are most hidden from us. What we are immersed in we assume exists in the way we experience it' (p.34). The use of photographs created an opportunity for a much richer understanding of the adolescents' own experiences than what otherwise would have occurred by simple interview. The photos themselves were of varying quality. However, they provided a medium that created significant and deeply meaningful conversations about their inpatient experience. This is consistent with Drew, Duncan and Sawyer's study (2010) that explored the experience of adolescents with chronic health problems, where the images of the photos were a means to gather richer verbal data rather than the photos themselves being the priority.

I do acknowledge that the photographs were more than a simple collaboration between myself and the adolescent participants. For example, in their research exploring identity in the military, Jenkins, Woodward & Winter (2008) argue that given the reciprocal and reflexive nature of using photographs to enrich data, one cannot help initiate analysis. In other words, data collection and analysis are not so easily separated as one might initially assume. Likewise in this present study, both the adolescents and myself participated in a reflexive process that created collaborative meaning as they made sense of their photographs.

During the remaining interviews, the participants reflected back on the photos, explored what aspects of their experience was important to them, what had changed, or remained the same. Each of the adolescents were informed that due to confidentiality, all photographs of any individual must remain with the researcher. Some adolescents chose to keep photos of inanimate objects. The use of photography was common within the Unit, with photographs and videos often taken of both staff and patients (with their consent). However, no identifying material left the premises. In some circumstances such as the School's newsletter, the faces of the adolescents are disfigured to prevent

identification. Subsequently, the guidelines for the use of photography for this study were in keeping with the Unit generally. The final interview then gave the adolescents an opportunity to discuss anything further and bring a sense of closure to the study.

The length of the interviews was open. By doing so, the participants were given an opportunity to share what was most personally significant as well as determining for themselves when their storying was complete. While the above was the starting point for data collection, I agree with Richards (2005) who believes '...completion of a project happens when the question is answered...' (p.19). Likewise, the quality and quantity of the data was closely monitored during the study to ensure sufficient material had been collected.

Given the practitioner-researcher frame, my own experience of the adolescent inpatient stay has been incorporated in the form of a reflective diary/log (Drew, 1989; Ortlipp, 2008). A reflective log aided in recording significant events in between interviews, guided ongoing analysis and helped formulate the next research phase (Altrichter & Holly, 2005). Indeed, as I discuss in Chapter 5, it was the reflective diary that helped me to decide to include parents in the study and withdraw an adolescent participant. It also acted as an audit trail to explain decisions made along the research process. It is therefore not data in the strict sense of the term. However, it became a most valuable reflective tool to help me analyse the data and reflect on my own personal processes during the research. As Tenni, Smyth and Boucher (2003) suggest 'The willingness to see, confront and discover oneself in one's practice and to learn from this is at the core of this work and central to the creation of good data' (p.6). The relationship between the research diary and my phenomenological pre-conceptions are elaborated in Chapter 5.

Sampling

In terms of sampling for qualitative research, a number of factors need to be considered such as scope of the study, nature of the topic and potential quality of data (Morse, 2000a). Research with a phenomenological base such as this tends to utilise small, purposeful samples (Creswell, 2007). Practitioner-researcher projects also tend to be smaller in scale (Mitchell et al., 2010). Subsequently, a purposeful sample size of ten to twelve adolescents was initially thought to be sufficient to provide the primary data. All adolescent inpatients admitted to the Unit were approached for inclusion into the study, with 8 adolescents declining participation (see table p.75). The adolescent sample was also representative of the inpatients of the Unit; typical in their presentation, both demographically (white Anglo-Saxon background) and clinically.

Recruitment of adolescents

The recruitment of the adolescents had a range of significant ethical and pragmatic considerations. Firstly, the researcher/participant power differential and capacity to consent are acutely important ethical themes for research with young people (Duncan et al., 2009), particularly with this study given it was also my place of employment. To address this, a range of processes were put in place. At the outset, the study was clearly outlined in written and verbal form to all staff and any concerns discussed. Secondly, the adolescent's vulnerability and capacity to be involved in the study were reviewed in the weekly case conference meeting comprised of regular Barrett clinical staff (including the Consultant Psychiatrist and Nurse Unit Manager). The staff were well aware of current functioning and subsequent potential risks for the adolescents by being involved in such a study. Making sound ethical and clinically-informed decisions regarding the adolescents was the core business of the multidisciplinary team. It was reinforced to the staff that adolescents who lacked reasonable cognitive or emotional stability must be excluded. For example, while very rare, adolescents who experienced significant intellectual impairment were not to be approached. However, no such adolescent was a patient during the data collection phase of this study.

Admittedly, 'emotional stability' is an elastic term. However, given the very nature of the project, there will always be a certain degree of emotional variability with the adolescent participants. While these and other conditions do fluctuate, input from the multidisciplinary team reduced potential risks. By having a team input, there was greater transparency regarding recruitment as well as utilising the team's clinical wisdom in screening potential participants. Given that some adolescents may be discharged before the data collection period ceased, and all recruited at different stages, each adolescent who was admitted as an inpatient was approached to be involved to help ensure adequate numbers. This was also to ensure that the characteristics of the adolescents for the study were typical and representative of inpatients of the Unit generally.

In recognition of power issues in qualitative research (Nunokoosing, 2005), I did not directly approach the adolescents so as to minimise any perceived coercion and to reinforce the research nature of the project. The adolescent's case manager (a nurse) approached the potential participant and informed them of the study and gave them the information sheet. In this way, the adolescent was approached by someone they knew. Initially it was thought best to have a third party external to the Unit approach the adolescents. However, Queensland Health Ethics committee deemed it more beneficial for the potential participants if they were approached by someone they were familiar with. The Ethics committee reasoned that because the adolescents had regular contact with their contact nurse, it would be the least intrusive or coercive method.

The issue of literacy was also previously discussed with the case managers in terms of the adolescents' capacity to understand any written materials such as the information sheet. Case managers who felt their adolescent may have difficulty with literacy gave extra attention to making sure the adolescent understood any possible involvement. The adolescents were then asked to consider involvement over the next 2-3 days, after which they were again approached by their case manager regarding possible participation. It was emphasised to the adolescents that participation was also contingent upon parental consent which was an ethical condition from the two Ethics committees (Queensland Health and University of Queensland). While the adolescent considered participation, the parents were informed of the study by the case manager and information sheets given. The parents also had 2-3 days to consider the study, after which time they were again contacted by the case manager. So as to not allow reimbursement to affect participation, it was explained that there would be no immediate incentive or reimbursement. However, once all interviews were finished, a gift voucher of \$50 was given to all participants regardless of number of interviews completed. This included the three who were withdrawn and others who were discharged before the data collection finished. Paying for research participation is common, including research with adolescents (Borzekowski et al., 2003; Fry et al., 2005). The funding for these vouchers came from the researcher's study budget at the University.

Recruitment of staff

The procedure for staff was more easily managed. After obtaining ethical clearance from both Queensland Health and The University, a letter was written to the staff informing them of the opportunity for staff interviews. This was followed up several days later in which the researcher approached potential participants. The Ethics Committees saw no concerns about approaching the staff directly for involvement in the study. All were given 2-3 days to consider their participation. Two individuals declined, stating the lack of time for such interviews (both were part-time). The staff interviewed in the individual sessions were also utilised for the focus groups. All were interviewed in a spare office.

Recruitment of parents

In terms of parents, again after obtaining ethical clearance, eight parents were chosen to be approached. The key criterion for such selection was their availability – primarily decided by geographical location. As the BAC is a State-wide service, along with the desire for the interviews to be consistent in their approach (i.e. face to face), it was decided to ask those who were within a three hour driving distance from the Unit. All parents who were approached were most happy to be involved. Three were interviewed in their homes; five were interviewed at the Unit. As part of

Queensland Health policy on home visits, a social work student accompanied me for the home interviews. Again, the location for the interviews was decided by the parents themselves and allowed them to fit the interviews in amongst other commitments. I also acknowledge Herzog's (2005) point that interview location can be embedded with personal meaning for the parent participants. The figures below depict the recruitment process, after which is a table showing the study's sample.

Figure 3: Recruitment of staff

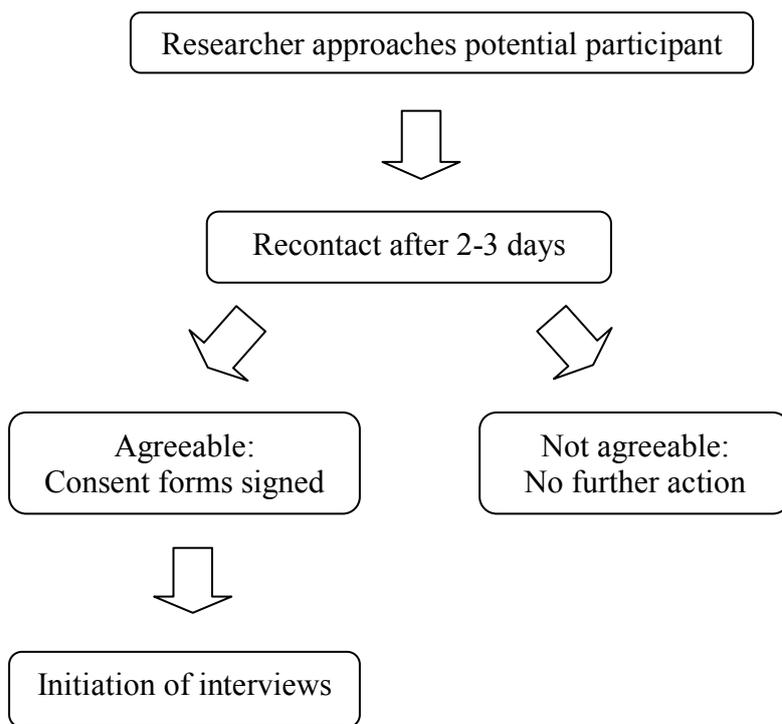


Figure 4: Adolescent and parent recruitment process

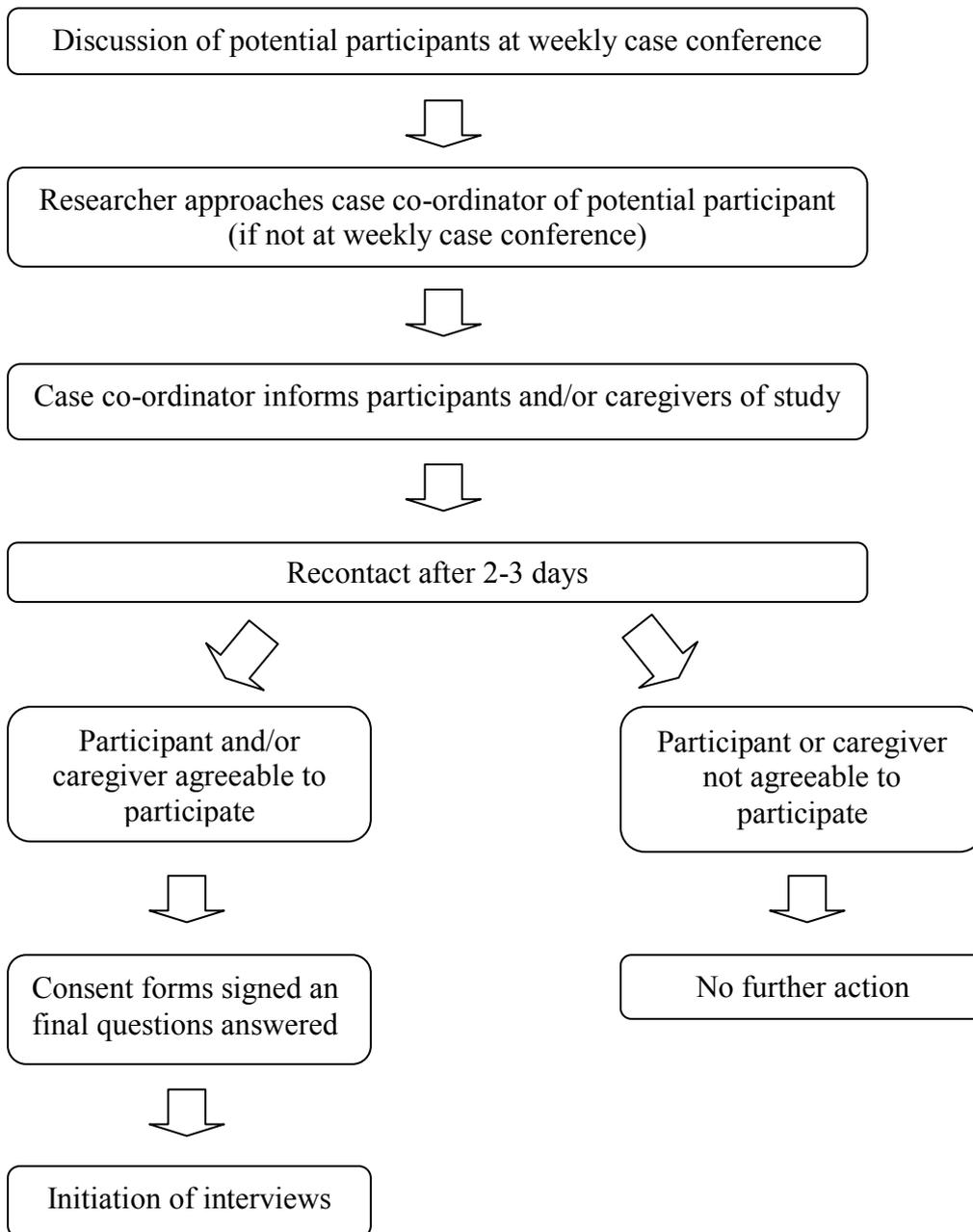


Table 4: Study sample

Adolescent sample		Parent sample		Staff sample		
Males interviewed	6	Males	1	Males	4	
Females interviewed	7	Females	7	Females	6	
Average age	16yrs 2mths			Individual interviews	10	
Involuntary treatment				(involving 3 individuals from the 3 professions of allied health, education & nursing)		
Males	3				Focus groups	3
Females	4					
Number of 1 st interviews	13					
Number of 2 nd Interviews	7					
Number of 3 rd Interviews	3					
Adolescents refusing participation	8					
Adolescents withdrawn (self)	2					
Adolescents withdrawn (researcher)	1					
Interviews	23		8		13	
TOTAL INTERVIEWS:				44		

Some aspects of the table need explanation. Firstly, none of the adolescents who refused participation gave any explanation as to why. Mindful of any perceived coercion, their decision not to be involved was respected without question. Secondly, an advantage of being an insider researcher was the knowledge that almost all adolescents were very anxious upon being admitted to the Unit. Consequently each adolescent was given some weeks to settle into the Unit before being approached for prospective involvement. Thirdly, it will be noticed that over time there was a marked decrease in adolescent interviews. This was unfortunate as it was originally hoped that the experience of care over time would be captured; hence the repeated interviews. While this was partly due to participants leaving the Unit, there was a distinct ‘interview fatigue’ with them. That is, there was reluctance on behalf of some of the adolescents to have another interview, despite explaining clearly at the outset what the procedure would be for the study. This varied from participant to participant; some did not want to complete a second interview, others did not want to complete a third. Again, their decision was respected, despite not giving clear reasons why. This

was, however, not unusual behaviour for the adolescents in the Unit where sustained mental effort was sometimes difficult to procure.

There was also some variation in the ‘richness’ of the adolescent narratives, primarily due to the variability in emotional and social functioning, especially with their individual language skills. Some had significant language deficits. For others, their emotional stability varied and there were several occasions where the teenagers did not want to be interviewed at that given moment, but were happy to later on. I suggest that an advantage of being an on-site, insider researcher was this ability to put things on hold and then to return later, as well as having a very clear, day to day, clinical picture of the adolescents. This was most useful in getting sufficient data which was particularly important given eight adolescents refused participation.

It will be noticed that the table does not give any specific diagnoses of the adolescents. This is because for many of them, their ‘official’ diagnoses fluctuated or remained unclear for some time. Importantly however, the clinical profile of the adolescent sample remained representative of the wider BAC adolescent patients. For example, nearly all adolescent inpatients of the Unit experienced significant anxiety and depression leading to chronic school refusal. Language impairment was common as well as a range of psycho-social skill deficits. Their ability to see an extensive or concentrated task completed tended to be much less than their non-hospitalised peers. This was demonstrated throughout their inpatient stay in such matters as their schooling and other scheduled activities in the Unit. This had to be taken into consideration for this research, where the interview schedule was simple but directive. Topics were pre-arranged for the interviews, though the adolescents were encouraged to discuss what was important to them. The interviews were often short – on average around 20 minutes. This was a reflection of their attention span generally and gives an idea of why educational lessons at the school were 30 minutes in length.

Table 5 on page 78 summarizes the spread of interviews for the participants. The average length of stay for the adolescent participants was 21 months. Kerry, who remained at the Unit for 4 years, was an exception due to serious eating issues and was interviewed just before discharge. This pushed the length of stay longer. Should the 4 year stay be removed, the average stay was 19 months. In my experience, 16 to 20 months was the average range for adolescent patients at the Unit. Interviews were originally set at 3 months apart, though it was dependent on the adolescent’s emotional well-being at the time. Secondly, only the parents were offered a choice for the location for the interview. As explained in the Methodology, the primary criterion for parent inclusion – apart from having a child in the Unit – was based on location; being within a 3 hour driving

distance from the BAC. Three parents took up the offer of the interview being in the family home, with the researcher being accompanied by a social work student for safety reasons. Doctors were not included in the focus groups as there were insufficient numbers as well as the potential unbalancing of the professional background represented in the 3 groups. Also, in line with the interpretative phenomenological lens, the focus groups needed to remain small so as to not lose the individual voices. Finally, while there was the desire to have an even gender mix, some professions at the Unit had a high proportion of one gender such as Allied Health where I was the only male in a team of six. Table 5 is on the following page:

Table 5: Interviews by participant sample

Staff	Gender	Individual interview	Profession-specific focus group	
Allied Health (1)	Female	✓	✓	
Allied Health (2)	Female	✓	✓	
Allied Health (3)	Female	✓	✓	
Nurse (1)	Male	✓	✓	
Nurse (2)	Female	✓	✓	
Nurse (3)	Male	✓	✓	
Teacher (1)	Female	✓	✓	
Teacher (2)	Male	✓	✓	
Teacher (3)	Female	✓	✓	
Psychiatrist	Male	✓	✘	
Adolescents				
Adolescents	1st interview	2nd Interview	3rd Interview	Total length of stay
Tracey (15yrs)	✓	✓	✓	2yrs 3mths
Meg (16yrs)	✓	✓	✓	2yrs 2mths
Samantha (16yrs)	✓	✓	✓	1yr
Todd (15yrs)	✓	✓		10mths
Ashley (14yrs)	✓	✓		1yr 7mths
Peta (16yrs)	✓	✓		2yrs 3mths
Matt (15yrs)	✓	✓		2yrs 6mths
Rick (16yrs)	✓			1yr 6mths
Ken (15yrs)	✓			1yr 5mths
Andy (15yrs)	✓			1yr
Kerry (20yrs)	✓			4yrs
Louise (16yrs)	✓			2yrs 4mths
Michael (16yrs)	✓			9mths
Parents				
Parents	Location of Parent interview			
Jasmine	BAC			
Susan	BAC			
Luke	Home (Brisbane Southside)			
Alex	Home (Sunshine Coast)			
Anne	BAC			
Cindy	Home (Brisbane Northside)			
Patricia	BAC			
Lana	BAC			

Analysis

Essentially, my analytic aims for this study are taken from Richards (2005). They are:

1. Responding to the research question
2. The production of analysis, not just description
3. The contribution of innovative theory or explanation giving rise to usable knowledge for practitioners

The data analysis itself consisted of the examination and comparison of participant transcripts as well as the analysis of categories compiled from the transcripts (Morse, 1994). Other domains of analysis that have been incorporated into the research include the words of the participants, the constructed coding, broader theoretical concepts, and also any memos or diary entries written by myself (Peters & Wester, 2007). With each purposeful act of interpretation there is a higher level of abstraction; a cyclical process between examining raw text and theoretical abstraction. Richards (1998, p. 324) describes this as an ‘in-out process’ whereby both familiarity (enabling a micro appreciation of the data) and distance (enabling abstraction) are used. The interviews in this study have likewise been transcribed to allow thematic analysis and as the methodology explained, an interpretive phenomenological analysis was used to guide this process. I acknowledge my own purposeful activity during the interviews and analysis, and any data will be the product of being ‘co-authored by interviewer and interviewee’ (Kvale, 2009, p. 54). NVivo 10 software was used to aid with coding speed and organisation of the data. Broadly, it involved:

1. Cumulative coding – when patterns of meaning are generated within a transcript.
2. Integrative coding – when patterns of meaning are generated across a set of transcripts.
3. The use of existing theoretical concepts to assist in the development of those themes (Larkin et al., 2006). The latter is particularly notable for Chapter 7, where the literature was consulted to aid the understanding of the inpatient experience.

Braun and Clark (2006, p. 96) also have a number of suggestions that I have incorporated into this process. Firstly, the transcripts were checked against each other for accuracy, the coding process was thorough and inclusive and was not generated from just a few examples, the data has been interpreted, rather than just paraphrased, and my analysis and data matched each other. My language and concepts are also consistent with my epistemological and ontological positions. Finally, I acknowledge my own purposeful activity in the emergence of any themes. The last point is important given that the research used a semi-structured interview schedule and so while the

study was essentially inductive, it contained deductive elements. I was also mindful of Gilbert's (2002) caution regarding the coding trap whereby one gets 'sucked in to coding' (p.219); meaning the temptation to code endlessly at the expense of a wider, and therefore more complete, picture of the data. Her suggestions in addressing this pitfall have been useful for this research and include working alternatively with computer and paper transcripts, writing memos and maintaining a focus on the research question. While one could argue for an external coder to help increase validity, I would suggest that my experience as a practitioner at the Unit gave me an insider perspective; with a subsequent organisational insight that others would lack. Secondly, given that I was no longer a practitioner at the Unit during the analysis/coding stage, there was some 'distance' to help the analysis. I suggest that the data collection while a practitioner *at* the Unit, and analysis *apart* from the Unit was a helpful combination.

As previously described, an interpretative perspective is a core feature of IPA. The analytic process used for this study followed typical IPA protocol (Smith et al., 2009; Smith et al., 1999):

1. The individual transcript was read a number of times so as to become "...as intimate as possible" (Smith et al., 1999, p. 220) with the reading. Significant themes were noted. Other words were noted down to help capture the meaning of the narrative. There was a close, line by line analysis of the experiential claims, concerns and understandings of the participants.
2. A preliminary list of themes was constructed. There was a repeated checking of the primary material, mindful of commonality and divergence.
3. There was a 'dialogue' between myself as researcher, data and prior knowledge. (In addition to this, I would add an awareness of my own pre-understandings)
4. The development of a structure or gestalt that helped illustrate the relationships between the themes (as found in Chapter 6).
5. The use of supervision and reflexivity to help develop plausibility and coherence.
6. A table of master themes was produced. These themes were compared and contrasted to each participant's transcript. Finally, there was a development of a narrative; evidenced by detailed commentary on the extracts and often supported by some form of visual diagram (as found in chapter 7).

Smith highlights that it not merely the number of times a theme appears in the transcripts:

The themes are not selected purely on the basis of their presence within the data. Other factors including the richness of the particular passages which highlight the themes, and how the theme helps illuminate other aspects of the account, are also taken into account (Smith et al., 1999, p. 226).

Braun and Clarke (2006) who also utilise IPA agree; it is ‘...whether it captures something important in relation to the overall research question’ (p.82). IPA is therefore a thematic analysis, grounded in the phenomenological tradition and where interpretation is a key process. Smith (2003) terms it, ‘an interpretative relationship with the transcript’ (p.64). During this analysis, there is no search for any ‘ultimate essence’ of inpatient life, as I would suggest that the experience of this phenomenon changes for a variety of individual and organisational reasons. There is however, the search for themes that allow an understanding of the experience as van Manen (1997) explains:

Phenomenological themes may be understood as the structures of experience. So when we analyse a phenomenon, we are trying to determine what the themes are, the experiential structures that make up that experience (p.79).

Again following the basic precepts of interpretative phenomenology, it is argued that the most helpful way to understand a phenomenon is through individual experience. As the lived experiences of adolescents in the BAC is a multi-faceted phenomenon, it therefore requires ‘multifaceted individual experiences’ of a sufficient nature to interpret and understand the phenomenon. The issue of the relationship between the individual experience and the phenomena being investigated is a controversial one in phenomenology, being complicated and unsettled. IPA, as previously explained, tends to be idiographic in nature, yet almost always incorporates multiple perspectives in the data analysis. While a strong ‘descriptive’ phenomenologist, Giorgi’s (2006) comments below nonetheless describe the analytical focus for this research:

The individual understood as a general human subject can help determine general features of experiential phenomena, and then later, in applications, one can see how individual variations compare with the general features of the phenomenon (Giorgi, 2006, p. 318).

In other words, this research is indeed interested in the individual experiences of all participants; adolescents, parents and staff. Each narrative is unique; both from the vantage points of patient, parent and staff, but also as unique individuals with a distinctive interpretation of experience. However, the multiple positions and experiences are a means to an end. They will converge and allow me to focus on a wider phenomenon – the inpatient experience. In other words, this study acknowledges that the only way one can look at the phenomenon of the inpatient experience, is by means of the individuals' narratives that constitute that experience.

Giorgi (2006) then continues to appropriately warn of any loose application of the phenomenological method giving rise to unhelpful methodological slurring. On this point, it is interesting to note the passionate and sometimes disparaging debate between international experts including Giorgi and Smith on the nature of phenomenological analysis and research (Giorgi, 2010; Smith, 2010a) demonstrating the significant variation of the application of this methodology.

Another debate within this methodology is the analysis of focus groups. Tomkins and Eatough (2010) recall the idiographic nature of IPA and warn against losing the individual voice in such a “multiple hermeneutic” (p.255). I would argue though that such a ‘whole vs. part’ dichotomy is not warranted. The personal meaning-making experience is really unretractable from the phenomenon that created the meaning in the first place. Secondly, I agree with other IPA researchers that “Hermeneutic phenomenology can accommodate such work [i.e. focus groups] because the defining quality of being-in-the world, its central concept, is *relatedness*” (Palmer et al., 2010, p. 102). The three primary participant groups – staff, parents and adolescents – are deeply connected at a number of levels. I would therefore reiterate that because both individual and group processes are ever present in inpatient units, both domains must be utilised to understand the phenomenon under study.

While mindful of the above debates, the analysis in this study is still filtered through the aforementioned critical realist frame. The use of multiple viewpoints on a single phenomenon seeks to understand a complex, ‘stratified reality’. Though ultimately only partially and imperfectly understood, all participant accounts, whether they be found in a group or within an individual, are ‘not just narratives, but windows onto real events, real people, real lives and real emotions’ (Robinson & Smith, 2010, p. 174). More importantly, the analysis of these multiple interviews will be guided by the research question. It will remain the ‘filter’ through which the data is sifted; mindful of how these narratives and experiences of the inpatient experience could guide the practitioner.

The issues of validity and bias

The literature contains many and varied definitions of validity and subsequent methods to enhance validity and decrease bias (Onweugbuzie & Leech, 2007). Maxwell (2005) defines validity as '...the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account' (p. 106). He describes two primary 'threats' to validity that are pertinent to this study; researcher bias and reactivity. He describes them as the researcher selecting data that fits the researcher's pre-existing theory or preconceptions, and inappropriate levels of influence by the researcher, respectively. He argued that while it is impossible to eliminate the actual influence of the researcher, there is the need 'to understand it and use it productively' (p.109). Below I have outlined my steps to address the threats to validity and reduce undue bias for this study. I purposely use the term 'undue' as I agree with Mantzoukas' (2005) argument that for the qualitative paradigm, it is necessary to *include* my biases in the research and incorporate them in to the research process. Examples will be given in Chapter 5 where I outline in more detail the decision-making process of the study, as well as my pre-understandings of the phenomenon.

Intensive, long-term involvement

I suggest that conducting the research at my employment has allowed me to understand a variety of organisational and clinical processes that an outside researcher may not appreciate. The adolescents were aware that this is my project, and so that familiar link to their stay at Barrett was maintained. Clinical experience at the Unit has shown that it can take months for some adolescents to have sufficient trust in a staff member before the recovery process can truly begin. I would argue that being an insider-researcher was the only viable method to address the research question. Secondly, conducting the interviews over a period of approximately fourteen months was necessary to ensure sufficient breadth and depth of data.

Respondent validation

The issue of respondent validation is a controversial one. Maxwell (2005) argues that it is crucial to address any researcher/participant misunderstanding. Seale (1999) suggests that there are 'levels of strength' with respondent validation. I hold the position that a mild version of validation is acceptable via the exploration of any emerging themes with the participants. This was accomplished for the adolescents by having more than one interview and incorporating themes from a previous interview. This was also utilised with the staff where it was decided to include focus groups after the individual interviews to follow up themes of interest. This has not 'ensured' validity, but has been part of a larger attempt to elevate the rigour of the study as Angen (2000) posits:

Thus validity does not need to be about attaining positivist objective truth, it lies more in a subjective, human estimation of what it means to have done something well, having made an effort that is worthy of trust and written up convincingly (p. 392).

Reflexivity

Arber (2006) defines reflexivity as ‘the capacity to reflect upon one’s actions and values during the research, when producing data and writing accounts, and to view the beliefs we hold in the same way that we view the beliefs of others’ (p.147). One method she suggests that has been adopted here is the keeping of a journal. This has acted as a reflective diary as well as providing an audit trail for the research process. Such a position is common within practitioner research (Fox et al., 2007, p. 186). The diary was also used to record significant events at BAC in-between interviews. This helped the participants and I recall and reflect together on important incidents. However, to ensure a more rigorous and transparent research process, a further, more purposeful step was added. My pre-understandings of the phenomenon as a practitioner were made explicit through the listing and subsequent explanation of my professional experiences of the topic – before the data collection was initiated. This was a crucial facet to the research process, given that the project occurred in my workplace. My pre-understandings are disclosed and explained fully in Chapter 5. Finally, Whitemore et al. (2001) have distilled a number of useful validity themes into primary and secondary criteria. These have also acted as more broad guides for this study. They are found in Appendix C.

'Structural transparency'

By this I mean a number of processes at the organisation level to reduce researcher bias. These include the recruitment of participants at the outset being a team decision, the reinforcement of the therapist/researcher distinction and the use of third parties to approach potential participants (i.e., case managers). As a practitioner piece, the research was fortunate to have a range of staff to draw upon to be involved in the recruitment and monitoring of the study. The Unit itself is, by nature, a very containing environment; infrastructure that would have been very useful in the unlikely event of the adolescents being upset during the interviews.

'Moderate' Triangulation

The issue of triangulation in qualitative research has been discussed and debated extensively over the years (Moran-Ellis et al., 2006). While traditionally the concept refers to the use of two or more methods to help more accurately measure a phenomenon, for this study the notion was a useful concept to enable qualitative data analysis to be more rich (Perlesz & Lindsay, 2003). For example,

interviews and focus groups were used as well as photography to encourage a deeper understanding of the adolescents' experiences. The adolescents themselves, while in many aspects are similar, nonetheless have varied backgrounds and conditions that offer a mosaic of experiences to investigate. It was also longitudinal; again to help develop a richer comprehension as opposed to a 'snapshot' view. Both approaches are often used to provide a 'thicker description' of lived experiences when articulation is difficult (Kirkevold & Bergland, 2007). Data sources were also widened, to include staff – from three different professions – as well as parents. This is consistent with IPA that is open to a variety of data sources if it means creating as rich an account as possible (Smith et al., 2009).

'Bridling' as opposed to 'Bracketing'

As an interpretivist study, this project investigated meaning behind descriptions (Lopez & Willis, 2004). IPA, as an interpretive school, therefore makes use of pre-existing theory to guide research questions, data analysis or any other phase of the research process. Consequently the phenomenological notion of bracketing did not carry the same weight in this study as it does for the descriptive paradigm. Bracketing itself has evolved over many years and continues to be debated as to the types and subsequent engagement (Gearing, 2004). However, the attempt to hold preconceptions in abeyance before the phenomenon is fully made sense of, remains its core feature. The interpretivist tradition however, sees prior knowledge as valuable in the pursuit of understanding; the researcher does not – indeed cannot – put aside assumptions that are grounded in our biology or culture (Hein & Austin, 2001, p. 9). Rather than bracketing, this present research has pursued what Dahlberg et al (2008) have coined 'bridling'. This concept encapsulates previous components of bracketing such as the restraint of one's personal beliefs and theories, but also includes the mindful, purposeful slowing down of premature interpretations; 'not making what is indefinite, definite' (p.130). It also contains within it, a mindset that is very similar to the therapeutic mindset of a practitioner, where one is mindful of not creating premature decisions:

While "bracketing" is directed backwards, putting all energy into fighting pre-understanding and keeping it in check "back there", "bridling" has a more positive tone to it as it aims to direct the energy into the open and respectful attitude that allows the phenomenon to present itself (Dahlberg et al., 2008, p. 130) .

In other words, throughout this research, I have sought to be open as possible about my pre-existing knowledge and experiences of the phenomenon, and in particular, strived to be curious afresh; to expect to find new experiential data that will help illuminate a complex phenomenon.

Final thoughts on bias

A recurring critique of practitioner research or insider research in general, is that they lend themselves disproportionately to bias. As Hammersley and Gomm (1997) point out however, the notion of bias itself is ambiguous and often ill-defined and I would suggest it has epistemological and ontological assumptions that are not totally applicable to this study. For example, there have been no attempts to strip subjectivity or hide assumptions in the hope of reaching some state of methodological neutrality. Nor if it were possible, to then procure ‘untainted data’. This study has been inextricably bound within professional practice and the subjectivity of both participant and researcher. Indeed, as is often portrayed, the researcher can be quite accurately described as ‘the instrument’ of the research. Nevertheless, throughout this study there has been the explicit detailing of my role as a practitioner and the attempts to be transparent about pre-existing knowledge as well as processes put in place to address undue influence in the recruitment and monitoring of the study.

Finally, I agree with many of Morse’s (2010) arguments that a background in health could be crucial for some qualitative health research. She cites advantages such as the ability to perceive signs of participant fatigue, the ability to recognise appropriate research questions and an intimate knowledge of organisational processes. In contrast, I cannot concur with writers such as Haggman-Laitila (1999) who strive to “overcome” the researcher’s views. While this researcher rightly points out that there can be helpful processes in place to enhance the overall quality of phenomenological research such as this, I would argue that attempts to “overcome” one’s socio-cultural and psychological predispositions are *not* helpful. As previously described, to do so would be to put all energy into fighting pre-understanding and keeping it in check ‘back there’ (Dahlberg et al., 2008).

Ethical considerations

There are a range of ethical issues attached to this study, most notably the involvement of minors with mental health difficulties, in an intense care-based environment, and where the researcher is also an employee of the organisation. While there are parallels with their adult counterparts, young people are in a very different developmental stage that brings with it a range of unique methodological and consequently, ethical risks (Kirk, 2007). The recruitment process was previously explained under sampling. Below are other ethical areas considered for this research.

Dual Researcher-Practitioner relationship

During the data collection phase I was a staff member of the Unit and consequently was known to the participants. This presented a valuable opportunity to initiate practitioner research. However, it was stressed continually throughout the data collection to all participants and staff that the study

was independent from all therapy, schooling or other therapeutic programs. See Appendix D for the photocopied letter send to the Nurse Care Coordinators explaining this, as well as the information and consent forms in Appendix E, reinforcing the researcher/therapist distinction. All interviews were taken at a place apart from the researcher's office (where therapy usually occurs) to reinforce the therapist/researcher distinction during the data collection phase. During the interviews themselves, I was aware of the necessity for a different mindset; being cognisant of the differences between my past clinical interviewing and research interviewing. Awareness of power issues, mixed messages and language as well as on-going evaluation of interview processes were all areas I was mindful of during the interviews (Hunt et al., 2011). To enhance my self awareness of these influences, purposeful efforts were carried out before, and during the research process. Chapter 5 details these efforts by outlining the challenges of the study, as well as presenting what I knew of the phenomenon before the data collection commenced and how this information was subsequently utilised during the analysis stage.

Research within one's place of employment is not uncommon and often produces rich data if organised efficiently and ethically (Arber, 2006; Coy, 2006; Hewitt, 2007). None of the participants in this study received therapy from myself during the data collection. One of the advantages of a large multidisciplinary team is the potential to allocate roles as needed. In this case, the psychologists were responsible for individual therapy, while the psychiatric registrar was responsible for family work. I was however, involved in supportive roles within the organisation (e.g. a supportive role in group programs such as camping and helping with Centrelink issues). It is worthwhile noting that the Queensland Health Ethics committee accepted the above conditions for the study, and were satisfied that my relationship to the participants posed no harm to those involved.

Monitoring of the study

Given that it was the case manager (a nurse) with whom the adolescent was most familiar and the one who initially approached the young people regarding participation, it was decided that this individual regularly review with the adolescent any emerging concerns during the data collection phase. The mental health status of some adolescents can fluctuate. Consequently, it might not have been in the best interests of the adolescent to continue with the study at a particular point in time due to elevated emotional disturbance. While it was not necessary, the case manager in liaison with Barrett's clinical staff could have suggested that the adolescent temporarily or permanently withdraw from the study. Typically, the case manager sees the adolescent almost daily and so there was ample opportunity to discuss any difficulties. Had the case manager not been available due to

shift work, there was always a contact nurse at the Unit. A distinct advantage of this study was that the interviews were held within the safe and containing environment of the treatment Unit. Also, few clinical decisions are generally made by a sole individual at the BAC. This policy continued within this study, thereby ensuring a more holistic and safe assessment of any emerging concerns. Had matters been raised, they would have been reported to the researcher or, if in the opinion of the case manager that was not appropriate, directly to the Queensland Health Ethics committee. A short bi-monthly verbal report was given to the team regarding study progress to allow questions from the team and to discuss any emerging concerns regarding adolescent involvement in the study. There were also meetings with University supervisors to monitor progress of the study. Had any adolescent required any post-study support, they again had access to their case manager or their individual therapist at the Unit. Once again, the benefit of such a study was the availability of organisational and human resources to draw upon should the need arise. Fortunately that was not the case.

Recruitment of parents and staff

Unlike the adolescents, there were few concerns in approaching the parents and staff. There was the potential for parents to become distressed while sharing, though this did not eventuate. Indeed, the parents reported that their interview experiences were very positive. All were keen to share their story and most offered more help for the study should it be required. Had there been difficulties for the parents, the case manager was available to speak to (whom they have had regular contact) and concerns directed to the Unit Manager or Ethics Committee. The Ethics committees raised no concerns regarding the recruitment of either parent or staff.

Confidentiality

Throughout the project, paper transcripts of the interviews were used and were kept in a locked filing cabinet in the researcher's office at BAC. The transcripts were also stored on a computer USB that was also locked. All respondents were given pseudonyms. In terms of confidentiality during the interviews, it was stressed to the adolescents that typical organisational policies would remain in force. That is, during the interviews had the issue of harm to self or others been disclosed, appropriate action would have been taken. It was also explained to the participants and their caregivers that it was the adolescents' choice to reveal any of the content of their interviews to parents or peers. A basic summary of the research findings was offered to all participants should they so wish. Any and all identifying information has been altered.

Throughout the study I have attempted to move beyond ethical integrity at a technical level; I have strived for what Guillemin and Gillam (2004, 2006) term ‘ethical mindfulness’. That is, there are situations that are not ‘typical’ or ‘classical’ ethical conundrums, but rather, moments in the research process that call more for a moral response that is needed in the moment. One such moment is described in Chapter 5 (see p.93) where I decided to end an interview and shortly thereafter terminate the adolescent’s participation in the study.

All research has strengths and weaknesses and this study is no exception. Giorgi’s (2010) critique of IPA identifies IPA as lacking scientific status because, among other reasons,

“A critical other needs to know exactly how the research was conducted not only to evaluate the adequacy of method employed, but also so that he or she can check the original researchers’ results or even replicate the study if so desired” (pp. 6,7).

I agree with Giorgi that an individual external to the study should know how the findings were produced, and in a transparent way. Indeed, this is the goal of Chapter 5 where I purposefully detail the *process* of the research; complimenting this methodological section that details the *how*. However, one of the reasons for multiple interviews was to try and capture the ‘movement’ of experience. That is, I have doubts that another researcher could recreate the results in this study thereby ‘confirming’ its’ validity or reliability. While the debate continues regarding the criteria for good qualitative research, replicability is rarely one of them.

Another critique that Giorgi makes of IPA is that it lacks “principals”, “instructions” or “constraints” for the method (p.10). This is a common and longstanding critique of phenomenology, that it does not have a clear ‘recipe’ for research (Dukes 1984). Noteworthy however, is that Giorgi in his critique of IPA (published in 2010) has only two IPA research articles from the wider IPA literature, which by 2010 was substantial. It is equally unfortunate that his critique came *after* Smith’s primary textbook on IPA which was published in 2009. This text has detailed suggestions for IPA studies. I concur with Smith (Smith, 2010b) that methodological structures are but one aspect of the research process:

“Doing good IPA requires the development of some complex skills – interviewing, analysis, interpretation, writing, and researchers at different states will have different degrees of fluency and adeptness at these skills. It is the degree of proficiency in these

skills which will influence the quality of the research carried out more than the conscientious following of procedures” (p.188)

The final critique is that the paradigm is limited to those participants who can articulate their experience with reasonable clarity (Willing, 2001). I reiterate that for this study, processes were put in place to ensure the participants – particularly the adolescent participants – had structures in place to help them articulate their experiences such as a semi-directive interview schedule and the visual aid of photography.

Summary

Carter and Little (2007, p. 1316) suggest that ‘epistemology becomes visible’ through one’s methodology and methods. I would add that one’s ontology also surfaces in a study’s methodology and this chapter has endeavoured to ‘increase the visibility’ of the various components in the research. As a practitioner-researcher, I have sought to understand a phenomenon by interpreting the experiences of participants through their narratives of that phenomenon. The conceptual framework, methodology and methods have a qualitative, phenomenological base from which to investigate those experiences. The distinctive themes of this phenomenon will then be able to guide and inform mental health practitioners who work in such an environment.

I do acknowledge that the experiences of the participants will always be more complex, intricate and rich than what can be articulated. This is especially true for these adolescent participants who sometimes struggle with language. However, I have strived to see my conceptual framework, methodology and methods both connected and consistent in order to best respond to the primary research question. The following chapter presents a brief account of some of the background efforts at accomplishing this.

CHAPTER 5 THE ANALYTIC TRAIL

Introduction

This chapter explains various processes that led to the creation of the data that follows in Chapters 6 and 7. It supplements the methodology by giving further detail about processes before and during the data collection. The first section explores the challenges in conducting a practitioner study, while the second explains the usefulness of the researcher's diary and its place in the research. This is followed by a brief chronology of events in terms of data sampling. Given the study is an insider piece, it is necessary to be explicit about what was known about the phenomenon *before* data collection started. Consequently, the final section clarifies my pre-understandings of the phenomenon and their role in the research process. It is offered as another way to demonstrate the transparency and credibility of the research.

Challenges while conducting the study

There were a range of challenges in conducting the study; not uncommon for practitioner work in general, but also in adolescent research in particular. Firstly, the BAC Unit was a small facility, with the capacity for only 15 inpatients and 5 day patients. Given the chronic nature of the adolescents' difficulties, there was a slow turnover of patients. Consequently, any drop out or refusal to participate was noticeable. Table 4 on page 75 showed that a total of 8 adolescents refused participation. Obviously their decision was respected, but had implications for generating sufficient numbers for the research. Two adolescents asked to cease involvement, one after the first interview and the other after the second interview. While frustrating, such a dropout rate and refusal to participate are not uncommon in adolescent research (Bassett et al., 2008). Only 7 of the 50 potential participants decided to be involved in Offord et al.'s (2006) qualitative study of adolescents with anorexia; emphasising the complications in studying adolescents and mental health simultaneously.

Two other related challenges were experienced during the data collection phase. The adolescents were obviously patients because of longstanding mental health difficulties. Their mental status could fluctuate sometimes on a daily basis and despite being willing to be involved in the study, there were times where an interview had to be put on hold due to the adolescents' poor functioning. Secondly, the adolescents were expected to have therapeutic and educational input from a large team. This sometimes required the interviews to be rescheduled. Both of these elements of inpatient

work slowed the collection of data considerably. The most significant challenge to the study was to gain sufficient data of a reasonable quality. The sample size and resultant interview numbers were large for a phenomenological study generally and very large for one utilising Interpretative Phenomenological Analysis. However, the high number of interviews was due to two factors.

Firstly, part of the study involved the researcher interviewing colleagues. The challenges of interviewing peers or colleagues are well known, such as interviewees wanting to project a positive identity (Coar & Sim, 2006) and the potential consequences of any *faux pas*; realising that one has to continue a working relationship with the participants after the research is finished (Platt, 1981). I was mindful that the interviews were not professionally or politically neutral and were not simply ‘collected’ but actively co-authored (Kvale, 2009). Consequently, both individual and small focus groups were utilised in order to help counteract any drawbacks and to draw out sufficient ‘gems’ among the rubble (Smith, 2011a). Interestingly, in a review of the IPA core textbook it was suggested that the originators of the methodology may be too restrictive in the ‘official’ sample number that makes up an IPA study and that larger samples should not be automatically dismissed (Clarke, 2010).

Secondly, the adolescents in the study experienced a range of mental health difficulties often coupled with language deficits; hence the use of photography to help tell their stories. All the adolescent interviews were less than 30 minutes and most were under 20 minutes; again reflective of their ability to concentrate on the matter at hand. Some of the interviews were extremely ‘thin’ in their descriptions of inpatient life. This is not unusual for research interviews with adolescents who may struggle with a range of cognitive, developmental or interpersonal difficulties (Mack et al., 2009). Below is an extract from one of the adolescent participants showing the paucity of some of the interview material:

DW: *Okay, all right. Matt, how would you describe yourself as a person?*

Matt: *I don't know.*

DW: *You're not sure?*

Matt: *No.*

DW: *What kind of person are you?*

Matt: *[Laughs] Ask other people.*

DW: *What do you think they would say about you?*

Matt: *I don't know.*

DW: *All right. Your friends here at Barrett; what would they say?*

Matt: [Yawns] *I don't know.*

DW: *If I were to ask them, "What do you think of Matt?", what do you think they'd say?*

Matt: *They're all teenagers; they're not going to give a really good answer.*

DW: *Yeah?*

Matt: *Just like me.*

(Matt 15yrs; 1st interview)

Some of the photographs and narratives by the adolescents were also less than helpful:



DW: A tyre and a...

Meg: A tree.

DW: Tell me a little about that.

Meg: Yeah. Not quite so...[long pause]

DW: Deep?

Meg: Yeah. Well I don't know. I was interested in the shapes again but it's not particularly – just probably...I don't know...

DW: Sure. Do you recall what was going through your mind at the time?

Meg: It's not really that...[long pause]

DW: That's okay.

Meg: Yeah. It's not that...

DW: Significant?

Meg: ...significant really. Yeah.

(Meg 16yrs; 2nd interview)

The above two extracts demonstrate that sometimes the material from the adolescent participants was not as helpful as anticipated. However, this may be a reflection of where the teenagers were in their recovery journey as well as developmentally. Once again, frustration with poor responses and weak participation are common researcher experiences with adolescent research (Bassett et al., 2008). Despite material such as the above, by increasing the number of interviews sufficient material was collated to respond to the research question:

'The principle is that the weaker the data source, the greater the number of data sources needed to elicit the experience. The less appropriate and less targeted these data, the greater the amount of data is required to reach data adequacy' (Morse, 2000b, p. 544).

The role of the researcher's reflective diary

Throughout the data collection and much of the study, a reflective diary was kept in order to record significant events in the Unit during the research. While a researcher's experience can be used as data in its own right (Drew, 1989), for the purposes of this study, the diary was used for other reasons. It assisted in the understanding of the participants' standpoint and helped navigate decision making during the project. It also acted as a prompt for any unhelpful intrusion from my own pre-understandings of the topic. An example can be seen in the reflective diary extract on page 154 of Chapter 7 where it confirmed for me that the methodology was appropriate. It was also helpful with two other incidents during the data collection. The first, repeated below, shows how the diary was valuable *emotionally* as I had to make a difficult ethical decision to cease participation from a willing adolescent. I found the process of writing my thoughts to be therapeutic. The second extract below helped me *conceptually*; deciding to include parents in the study after some deliberation:

Week ending 27/5/11

Just attempted to interview J. She really struggled to answer my questions, despite me clarifying them and taking my time. I really felt for her. My guess is that the ECT has taken its toll on her memory and possibly the medication is affecting her too. After five minutes I wanted to terminate the interview, but I know that she feels she is doing much better (which she is). Consequently I was torn. I made the snap decision to ask a few questions, but leave the majority of them out. She was none the wiser. I feel almost guilty, but it *was* taken to the team this week and all agreed that she has been far more stable and functional of late. She said herself that the voices and hallucinations have stopped. I didn't want to say to her that I didn't think she should continue. I don't think there will be a second interview. She had such a flat affect, with real difficulty remembering. No harm done and I did consult with the Team. I think I feel ethically to stop. Although she was not distressed in any way at all, it pained me to see her struggle to answer my questions, though they were very basic. Rather than run the risk of reinforcing to her, her deficits, I'll cease her involvement. It won't bother her as she will forget the interview I'm sure :(We'll see after I come back from LSL in 2 months.

Week ending 23/12/11

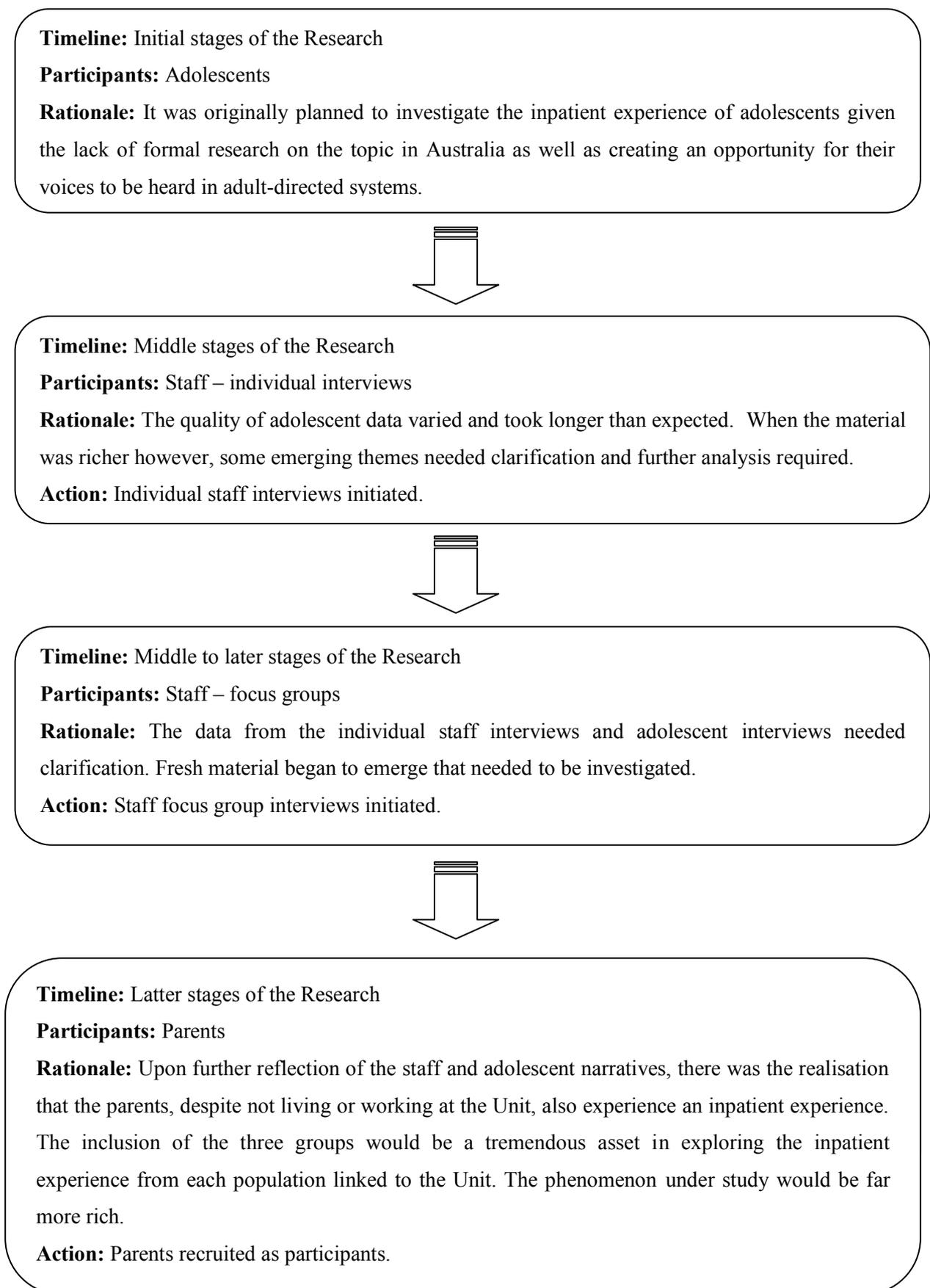
I guess a part of me originally thought the parents were *not* part of the inpatient experience, unlike the staff and of course, the kids. But then it dawned on me that they *do* have an inpatient experience. If it was matter of a distant relative, the experience might be so far removed from their own experience, that it could offer little by way of

understanding the phenomenon. But I realised that if one of my own children were in the Unit, by the fact that they are literally a part of me, in a sense I am there in there too. Maybe not directly, but certainly vicariously. They are my children; what happens to them, happens to me. What is in their world is, to varying degrees, is in mine and therefore affects my world. *The parents of BAC kids do have an inpatient experience; every time they see that empty bedroom, they have an inpatient experience. Every time they have to make a long-distance phone call just to talk to their child, they have an inpatient experience. Every time their other children ask when their sibling is coming home, they have an inpatient experience.*

The first extract shows how the diary helped me with a difficult ethical issue; the second, while a pragmatic/methodological one, could also be understood from an ethical frame. By including the parents, their voices too, could be heard; a choice that I would suggest elevated not only the richness of the study, but also the ethical imperative to include suppressed voices.

As the study progressed, and despite the aforementioned paucity of some narratives, rich material that needed clarification emerged. In particular, during the individual staff interviews, the idea of a 'certain type of worker' and the theme of 'parenting' started to emerge. Consequently, it was decided to include three small focus groups, each with participants of the same profession, to explore these. It was also thought a homogenous group would aid the freedom of expression when interviewed by an insider colleague. As the data was investigated further and as the above diary entry reveals, it was realised that one does not have to live or work in an inpatient facility to have an inpatient experience. Consequently, parents were included. *This was a tremendous lesson for me; to be open to fresh experiences and adjust methodological procedure accordingly in order to capture the richest possible data.* On the following page is a short chronology of these events from the study's inception to final data collection as well as recruitment rationale:

Figure 5: Chronology and rationale of participant recruitment



Researcher forestructures and pre-understandings

In a review of a number of phenomenological studies, it was shown that while the importance of the researcher's open attitude was mentioned, rarely was it clarified *how* this was accomplished (Norlyk & Harder, 2010). As this study also borrows from phenomenology as well as emerging from a practitioner-researcher perspective, the ability to track the research process and identify unhelpful researcher influence is important. This section explains my approach in addressing this issue.

While the broad phenomenological base of this project is drawn from Interpretative Phenomenological Analysis (Smith et al., 2009), this method itself draws from a range of phenomenological theory, including that of Gadamer (Gadamer, 1979). One aspect of Gadamer's phenomenology is that of identifying 'pre-understandings' (one's preconceptions and presuppositions of the phenomenon). In this regard, I have borrowed heavily from Geanellos' nursing research in which she utilises Gadamerian theory (Geanellos, 1997; Geanellos, 1998a, 1998b). Geanellos (1998b) – also with a background in adolescent inpatient work – points out that in hermeneutic research the focus is not on simply controlling researcher bias, but on working out pre-understandings. These are brought to consciousness, elaborated on, and incorporated into the research data. Her rationale is explained below:

'My aim in completing the work on forestructures prior to conducting my interviews was to become aware of ways I might influence information gathering...In doing this, I attempted to become conscious of my forestructures in order that the phenomenon under investigation could speak...These forestructures point to some of the assumptions I hold regarding the nature 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 assumed I would find...*When I became aware of their presence [her pre-understandings] I was prompted to question their origin, adequacy and legitimacy and I was alerted to look beyond them to other interpretations which were not foremost in my thinking...*In this way, pre-understandings (preconceived ideas, biases, beliefs) can be taken into consideration throughout all stages of the research, so the phenomenon under investigation is provided with the greatest opportunity to reveal itself*' (Geanellos, 1998b, pp. 241-245 emphasis mine).

Geanellos also acknowledges that not all forestructures can be brought to the surface and that the interview text is a co-created piece between researcher and participant. Essentially, forestructures consist of (a) the background practices that make some kind of interpretation possible in the first place ('forehaving'), (b) the background practices that carry a point of view by which an interpretation is made ('foresight') and (c), background practices that create expectations about what might happen via an interpretation ('foreconception'). Specifically, the process is:

1. Generation of statements

Spontaneous, reflective statements about some of the most strongly held beliefs about the topic under discussion are generated.

2. Interpretation of statement

Simply naming these structures is insufficient. They also need an interpretation.

3. Explicating the forestructures.

This involves further interpretation and reconceptualising each statement into a forestructure of the phenomenon under investigation.

Following on from Geanellos' work, I have outlined below some of my own pre-understandings of my work at the Barrett Adolescent Centre. Being my own pre-understandings, they therefore do not require general referencing to support the assertions. It is also important to highlight that these were completed at the proposal stage of the research, and therefore sighted by academic staff well before any interviews had taken place.

Statement One: The adolescent is neither child nor adult.

Interpretation: The adolescent is at a crucial time of their development as human beings; a time of biopsychosocial flux that offers tremendous opportunities as well as pitfalls. Consequently, there are a range of developmental tasks he/she must undertake if they are to maximise this period of growth that will also be the foundation for later developmental milestones.

Forestructure: The practitioner must take into consideration that the adolescent is a work in progress; emotionally, psychologically and socially. However, the adolescent's maturation can sometimes be a frustrating 'stop-start' process. The practitioner must therefore find ways to work

with each adolescent with their particular developmental trajectory and adjust intervention accordingly.

Statement Two: The Milieu is foundational to helping the adolescent

Interpretation: The milieu environment becomes home for the adolescents who are inpatients of BAC. The physical buildings, programs, relationships between peers and staff all coalesce into the phenomenon known as ‘milieu’. Subsequently, each part has a role to play and each facet can and will influence other facets of the inpatient experience.

Forestructure: Each practitioner has the responsibility of ensuring their niche in the milieu is affording the adolescent the best possible path for recovery. Regardless of profession, each offers the adolescent the very best of their expertise and experience. Should each individual practitioner complete his/her task appropriately, the wider milieu environment will produce the most therapeutic and recovery-focused environment possible.

Statement Three: Without hope, the prognosis is poorer.

Interpretation: By the time the adolescent arrives at the Unit, they are usually well versed in the mental health system and are knowledgeable about treatment and the roles of the various professions. In addition, often by this stage, hope has waned and expectations can be low for any sense of recovery.

Forestructure: Most staff, at some point or other, struggle with maintaining hope for some adolescents. With fragmented lives, complex presentations and sometimes no clear pathway for recovery, some adolescents find it hard to hope for a better future. The practitioner, while sometimes experiencing a parallel process, nonetheless must find enough hope for the adolescent and themselves if the future is to be better than the past.

Statement Four: The adolescents’ peers are both ‘blessing and curse’.

Interpretation: Typically during adolescence, ones’ peers exert a most significant influence and can have both have negative and positive consequences. The inpatient milieu is no different. They can be a source of encouragement and a source of emotional pain.

Forestructure: The practitioner will notice that deep bonds can form between the adolescents. They all share a range of things in common, the most obvious being they are living together because of similar difficulties. As such, they share a common experience, a common language and common milestone. However, the same pain that can bond them together is also a double-edged sword where contagion develops. Self-harm is an example where self-injury can act as a catalyst for a contagion effect amongst some adolescents. The practitioner must therefore contain as much as possible, intrapersonal and interpersonal traumatic spill-over.

Statement Five: Decisions are made that can last a lifetime.

Interpretation: Clinical decisions regarding treatment are made during an important developmental period by both adolescent and staff member. Given the sometimes pressured environment and the very nature of the adolescent's difficulties, decisions need to be through carefully.

Forestructure: The practitioner is essentially a *loco parentis*. It is important for practitioners to continually remember that they are looking after someone else's child. Consequently, individual and team decisions need to be thought through carefully. The decisions that the adolescents make may also reverberate throughout their lives. The decisions not to eat, receive help, or the relentless pursuit of self-harm, however constricted by mental illness, nonetheless will have repercussions later in life; physically, vocationally and psychologically.

Statement Six: Working with adolescents is both pleasure and pain.

Interpretation: Working with adolescents can be draining and evoke deep emotions in staff for a variety of reasons. Conversely, adolescents often have energy, enthusiasm and a sense of humour that is often refreshing.

Forestructure: Not all practitioners desire or indeed can, work with adolescents. It requires of the practitioner a healthy interpersonal configuration in their manner with the teenagers. The ability to laugh, shrug off insults while putting firm boundaries in place are daily skills required for working with this population. They are also not long out of childhood and consequently evoke sometimes deep emotions from the practitioner, ranging from sadness and helplessness to anger and emotional cut-off. The practitioner will sometimes experience conflictual and opposing emotional processes in short spaces of time. This emotional roller coaster is typical of adolescent inpatient work.

Statement Seven: The practitioner must never give up.

Interpretation: Some adolescents spend considerable time at the Unit, and often require intense, long-term support. The adolescents themselves sometimes feel like any further effort is not worth it. The practitioner can parallel this experience.

Forestructure: The practitioner is working in a long-term residential Unit; unique to the State. It is a long-term Unit due to the nature of the presentations of the adolescents. Progress is often slow and fragmented. Most practitioners who work in this environment do so because they value adolescents and sincerely believe in the capacity for change and a better future. However, when emotional reserves are low, particularly after a series of difficulties, one can easily slip into a sense of mediocrity and pessimism.

Statement Eight: Practitioner differentiation vs. practitioner despair.

Interpretation: It is sometimes easy for the practitioner to get caught up in the emotional processes between staff and patients. While this is unavoidable to some extent, the practitioner is the adult Professional and must retain a 'minimum level' of self-differentiation if he/she is going to help the adolescent inpatients.

Forestructure: The practitioner must be able to 'keep his/her head when those around are losing theirs'. Emergencies, verbal and sometimes physical abuse are also part of inpatient life. The practitioner must therefore be able to monitor and adjust his/her own emotional processes in a sometimes hostile environment. When a practitioner struggles to exhibit a mature sense of self and corresponding differentiation, he/she will be caught up in the confusing and draining emotional climate of the moment. Repeating this experience over time can lead to despair and scepticism in the practitioner.

Statement Nine: It takes a village to raise an adolescent.

Interpretation: These adolescent inpatients are amongst the most difficult to help for many reasons. No one profession or individual has all the skills to address such complex individuals. A unified team approach is crucial in helping them.

Forestructure: Not every staff member offers the adolescents therapy. However, each staff member, regardless of profession and experience has the capacity to be therapeutic. Such complex

adolescents require practitioners who are comfortable with not knowing all the answers and who are at ease with seeking opinions of others when in doubt.

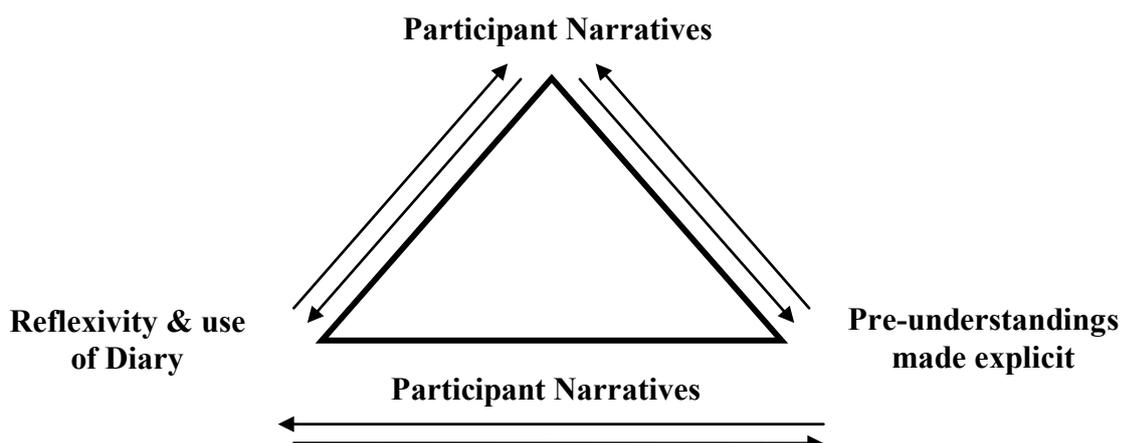
Statement Ten: Aim for ‘Fruit’ not ‘flowers’.

Interpretation: More often than not, progress with the adolescents is slow and spasmodic. Sometimes they are discharged with seemingly minor change. Little ‘fruit’ is sometimes gleaned from many hard work hours from a variety of staff.

Forestructure: A long-term vision is required of the practitioner. While it would be preferable to plant seeds that quickly see a bouquet of flowers that is pleasing to the eye, in reality, this is a rare occurrence in the therapeutic realm. A more accurate analogy would be that of trees that do not bear fruit for some years, yet it is the purposeful tender care that gets the tree to produce fruit in the first place. The practitioner must recognise that there may be little fruit seen while toiling hard in the soil of inpatient life. The ability to delay gratification is not only a skill taught to the adolescents; it is a mindset that will help the practitioner guard against unrealistic expectations and to work for seemingly small gain.

The above represents a sample of known pre-understandings that were open to modification as my experience changed. As the experiences of the participants also changed over time, there was a continual reflexive process in understanding the phenomenon. As explained previously, a reflective diary was utilised to record my own experiences and any significant events at the Unit. This greatly enhanced the capacity for reflexivity during the study. The interpretative process of the study is represented below.

Figure 6: An interpretative triad



The above respects and acknowledges each of the experiential vantage points of this study; both participant and practitioner. As there is constant movement between the parts, there is no true 'entrance point'; the whole and its parts are equally necessary in understanding the phenomenon (Geanellos, 1998a, p. 159). Dahlberg et al. (2008) state that 'Researchers who are not aware of their pre-understanding and neglect its associated problems, risk obtaining results that are primarily a reflection of their past experience or unrecognised beliefs' (p.135). The material above represents my own purposeful attempts at transparency regarding my pre-understanding of the phenomenon and to act as a reflexive tool during the interviews and analysis.

Summary

At the outset of this insider study, it was decided that a methodological transparency that would enhance the research's credibility was important. Both the methodology and this present chapter are the purposeful efforts at achieving this. What was known about the topic of research before the data collection commenced has been clearly outlined. Being a practitioner at the Unit for several years no doubt internalised much of the clinical and political culture that would have to varying degrees, influenced various aspects of the research process. It was therefore important that explicit steps be taken, not to disregard or block pre-existing knowledge of the phenomena, but to be mindful of this knowledge. In this regard, I have followed Geanello's (1998a) example:

In doing this, I attempted to take note of those dominant influences that predisposed me (through my traditions of living and nursing) to seek particular information (from research participants and reading material), or to favour particular textual interpretations (Geanellos, 1998a, p. 246).

This chapter has also outlined the difficulties during the course of the research. Data collection was slower than expected and required patience and stamina. However, certain aspects such as the inclusion of the parent participants evolved the study into far richer research than what would have otherwise occurred.

Extensive examples of the sub-themes will be provided in the next chapter; offering an explicit and comprehensive overview of the raw data behind the constructed categories. This is followed by the principal themes and fresh material in Chapter 7. Together, they represent the experiential findings of the study that will respond to the research question.

CHAPTER 6 INDIVIDUAL VOICES OF INPATIENT LIFE

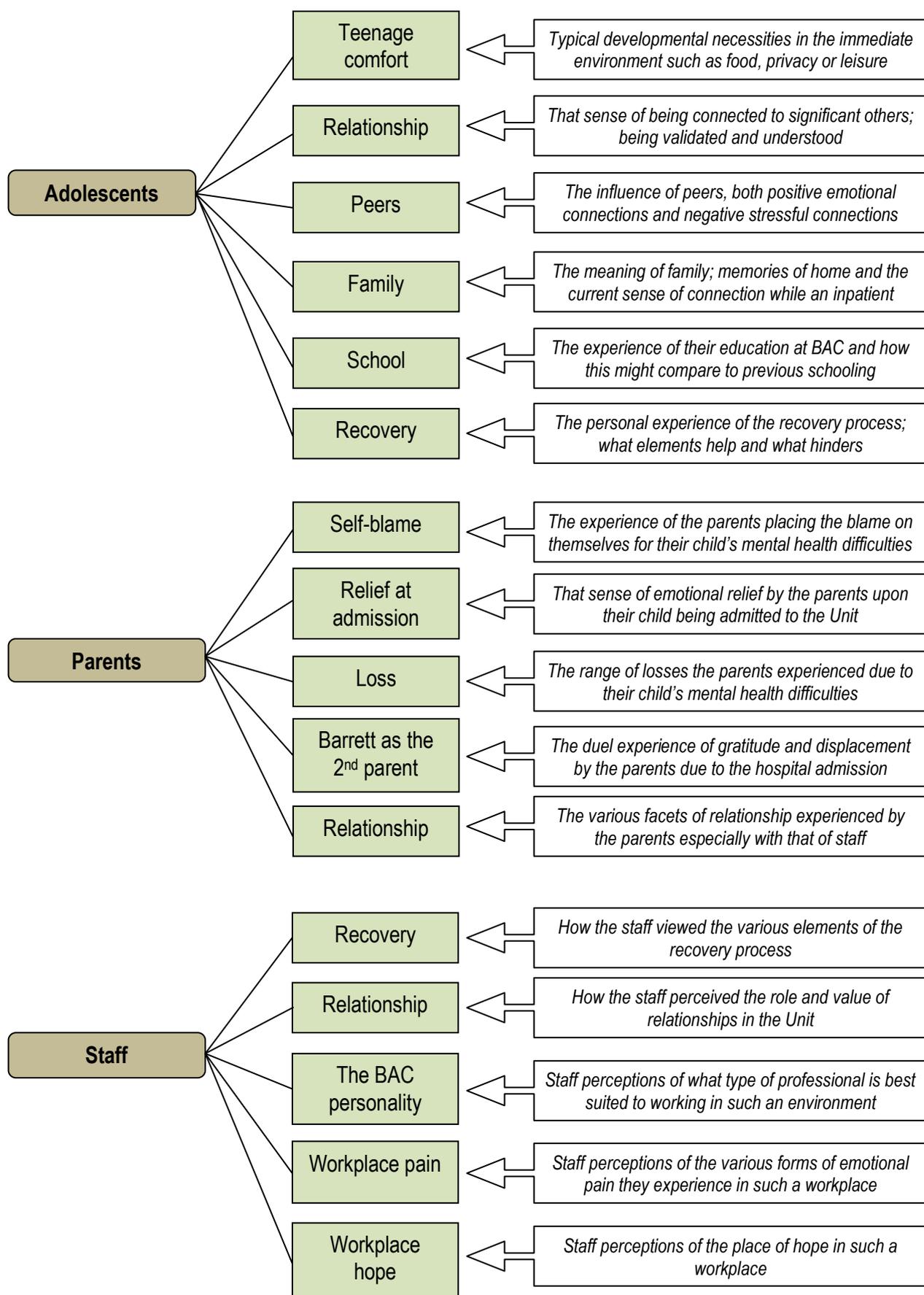
Introduction

The following two chapters present the experiential data for the study; containing the stories and themes derived from the participant transcripts. The chapters are also divided for specific reasons. Firstly, the purpose of Chapter 6 is to detail the primary sub-themes of inpatient life for the adolescent, parent and staff participants. It is purposefully descriptive with no comment from the extant literature, thereby focusing on the individual voices of the participants. This is in keeping with the IPA framework that typically separates a descriptive overview and subsequent analysis (Smith et al., 2009, pp. 112,113). Secondly, the combined stories will give a broader context for the master experiential themes that are analysed in more detail in Chapter 7. Finally, this chapter also purposefully incorporates numerous quotations in order to elevate the thematic transparency of the previous coding. While there is a clear group analysis, the group-level themes are illustrated with examples taken from individuals (Smith et al., 2009, p. 106); seeking to understand the group experience while valuing the individual experience that undergirds it. Chapter 7 then crystallises and focuses on the five principal experiential themes for the study. In contrast to Chapter 6, there is more interpretative work and the literature will also be consulted in order to analyse and help make sense of the participant narratives.

Substitute names are used for all participants and given the study involved minors, photographs of adolescents have been de-identified. Also, because of the specialist and consequently small work population of the Unit, only professions and gender are named.

In terms of the process of arriving at the final themes, the details of analysis and coding were previously explained in the methodology (see pp.79-81). What counts as a ‘theme’ in this study is defined as that which captures important information in relation to the research question and represents a patterned response within the data (Braun & Clarke, 2006, p. 82). Essentially, there were the *intratextual* readings that explored relationships between the texts of a single participant as well as the *intertextual* readings; exploring the relationships across the wider group of participants (Keats, 2009, p. 191). On the following page is a representation of the primary sub-themes for each individual participant group. Further thematic analysis is found in Chapter 7, where the principal themes are discussed.

Figure 7: Primary sub-themes for each participant group



The experience of the adolescents

Sub-theme 1: Teenage comfort

This theme is defined as the typical developmental necessities in the immediate environment of adolescents, such as food, privacy and leisure. Developmentally, this is a time when the physical environment is important; a time when ego boundaries are being developed and a time when the physical realm can impact the adolescent significantly. This is particularly important given that the BAC would be the adolescent's home for some time.

For some, such as Meg, the initial impressions of the physical buildings were quite noticeable when she was first admitted:

But it looked like a really cheerful place. All the kids were really together and stuff. But the building – it's not very soothing. And I remember thinking – it was during the day and they didn't have the lights on, and the corridors were really dark. (Meg 16yrs; 1st interview)

For Tracey and Ashley, the most noticeable aspect was the drab, sterile, hospital-like state of the Unit. It would seem that for these two adolescents, the physical environment played an important role in being conducive to the recovery process:

The bedrooms. The curtains for the girls and make them more girlier. I don't care about the boys end. They can stay like that. To make it seem more homely like and that. The showers I'd make them better. The paintings and that on the wall I would update them. I don't know. There is a lot of things that you could do. Just make it feel more homely and more friendly. (Tracey 15yrs; 1st interview)

This place looks so depressing. Seriously! The happiest thing about it is the garden. All the walls are these weird off-pastel colours, and it's just a really depressing environment. You're trying to get better here and see big happy positive things. Now and then you'll walk past a wall and see one happy thing, and then the next wall you'll look at the other wall and it'll be just this ugly colour. And you'll be like "Oh...okay". (Ashley 14yrs; 1st interview)

For Andy and Ken, the two aspects that needed improvement were the beds and food;

Andy: *The food. Mainly the food.*

DW: *Pretty ordinary?*

Andy: *Also the beds. The beds are too hard and the food is just – forgive me for saying it – it's really bad. Crap. (Andy 15yrs; 1st interview)*

Ken: *Beds.*

DW: *Beds?*

Ken: *They're terrible; they're bricks. Bricks I say! (Ken 15yrs; 1st interview)*

Discomfort in the physical environment such as food, bedrooms and general atmosphere were quickly picked up by these adolescents. This is discussed more fully in the following chapter that explores the hospital-home tension.

Sub-theme 2: Relationship

The sub-theme of Relationship is defined as that sense of being emotionally connected to significant others; where one is validated and understood. For Ashley, the importance of being understood was crucial, which was highlighted when casual nursing staff assumed they knew her:

DW: *So when you say support, Ashley, what really stands out with the support? What's been good?*

Ashley: *Just people just being there for me, trying to understand me. Just really taking an interest in how I think and how I feel...like they [casual nursing staff] have no right to judge me because I haven't talked to them at all, and they know none of my things. They've only read what's written down in my file, which doesn't really explain me well. My file is full of gaps and...*

DW: *So the real Ashley is bigger than just her file?*

Ashley: *Yeah. Pretty much.*

DW: *There's a lot more to know than what's written about you.*

Ashley: *Yeah. And I find the nurses they're just – well the casuals – are just like “Oh I'll just go and read your file and I'll understand then”. And you're just like “No, there's a lot more behind me than just what's in my file!”* (Ashley 14yrs; 2nd interview.)

Indeed, the issue of consistency of staff (and therefore any change in relationships) was a noteworthy issue for the adolescents. For different reasons, nursing staff in particular had the highest turnover as well as the typical difficulties found in shift work. Ashley's thoughts above were also reflected in Todd's experience with casual nursing staff who didn't know the Unit's routine or 'people's personal stories':

DW: *Has that been difficult for you – the nursing staff changing?*

Todd: *At the moment it's not too bad, but a couple of weeks ago there was a lot of different nurses coming in and out.*

DW: *And how was that difficult for you?*

Todd: *Just they all had different ideas as well with rules, like some of them don't know what time bed time is, and when we're allowed to watch TV and just stuff. And also just knowing people's personal stories and sort of understanding.* (Todd 16yrs; 2nd interview)

The issue of staff consistency was particularly important since as Meg described, the decisions staff make will certainly affect the adolescents:

But it's very hard with the nurses and the doctors making – because a lot of the time they – well they are basically making big decisions and little decisions about every aspect of your life and your daily functioning. And that takes away the personal autonomy. (Meg 16yrs; 2nd interview)

Sub-theme 3: Peers

This theme represents the peer influence; involving both positive emotional connections as well as the negative stressful connections during the inpatient stay. The relational climate between the adolescents tended to be mixed and reflective of their developmental stage. In the first quote below,

Rick acknowledged his distress at seeing unwell peers. For Matt in the second extract, any form of self-harm from his peers evoked anger:

DW: *Okay, yep. What's it like then for you when some of those kids aren't doing so well, like they could be suicidal, they could be self-harming and things like that? What's that like for you?*

Rick: *Well, it's actually quite distressing because, like I can openly say I've been there and, like, seeing other people there just makes me sad because I know what it's like and it's not fun at all. It makes me want to be able to do something to help them, but me being in that same situation you don't always want people your own age, or anyone for that matter, to necessarily help you. (Rick 16yrs; 1st interview)*

Matt: *Ah, maybe. But yeah, I want to punch Jay.*

DW: *Okay...why?*

Matt: *Because he's bloody self-harming. He deserves to be punched, right in the ribs.*

DW: *So you'd like to give him a good punch to sort of snap him out of it?*

Matt: *Yeah. I hate people who self-harm. (Matt 15yrs; 1st interview)*

The above quotes mirror the varied relational experiences of the adolescents. In this case, a mixture of anxiety, helplessness and anger was expressed. Particularly when some adolescents were not doing well emotionally, many adolescent participants described to varying degrees, their own personal distress:

I notice, it's like the other day when Michael was feeling down, then, like...Rob and Mimi, and a few people became down as well, and it was like, Samantha and everyone going down and stuff. A lot of emotions started to flare. (Peta 16yrs; 1st interview)

Samantha below described the process when a peer became the potential trigger for herself slipping emotionally and recounts her efforts at remaining psychologically afloat:

I guess I've noticed that I've been very, very edgy for the last probably couple of months now. If I see somebody go off or I see something happen - or something like that - I kind of get flashbacks - if that makes sense - and then I want to go off, pretty much. But I don't want to go off because I'm going through a really good stage at the moment. So the bad side is that every now and then I see somebody going off or if I see heaps of people just being so edgy I just start to go back - I'm going backwards pretty much. But I don't want to go backwards, and I just keep going forwards. (Samantha 16yrs; 2nd interview)

For others such as Tracey and Michael, there were feelings of sadness and apprehension:

DW: So tell me a bit more about what it's like for you when you see other kids aren't doing so well.

Tracey: It's really sad. And when other kids aren't doing very well it kind of makes you feel like "Oh". If they can't do it then I can't do it...And it's just - it brings everyone down. (Tracey 15yrs; 3rd interview)

Like you see people one day they'll be in the usual patient, and the next morning you wake up they'll be in a hospital gown with - on cat red with a nurse around them. And you just wonder what kind of went on there. (Michael 16yrs; 1st interview)

Conversely, most of the adolescents could also recall more positive times with their peers and the benefits that followed:

Whereas the other dorm I was in - with the giggly girls - that was a very different atmosphere. In my current dorm there's Mimi and Karen, and Samantha. And we're all pretty quiet and laid back, and have our own space, and very much more into ourselves. And the other dorm is like they're all like best friends in that dorm, and they're always giggling and talking and laughing, and stuff - where I was before. And that's a nice environment to be in. (Meg 16yrs; 1st interview)

DW: Okay. What's it like to live with the other kids here?

Andy: *It's actually quite fun. When I first came here I thought sleeping with a bunch of kids I didn't know would be very scary. Like most people, when you start something it's kind of scary. But I actually grew to be fond of them. They weren't nearly what I expected them to be.*

DW: *Yeah. And what changed?*

Andy: *They sort of tried to force me out of my shell.*

Interpersonal growth was also Louise's experience:

It's interesting. I think it's a good experience to have, so that if I want roommates later in life then I'll know how to deal with them. (Louise 16yrs; 1st interview)

Not unusual for adolescents, sometimes their accounts reveal contradictions. Consider Todd who can think of a range of positives, only to then minimise the growth:

It's definitely helping getting - sort of socialising and being around people my age and getting back on track. Yeah, it is helping. Not so much that I see a huge difference though. (Todd 15yrs; 1st interview)

Peers were a mixed blessing for Tracey. As mentioned previously, unwell peers can make the inpatient experience more difficult. However, peers can also be helpful for the recovery process:

Well the one thing – even though it's a big disadvantage - lots of people having the same issues - it's also good in some ways. Because there's an understanding. Like sure there's also a lot of backstabbing. Like you can say "Oh yeah, I've got post-traumatic stress disorder" and someone will be like "No, she doesn't. Geez. God.", and just go and talk behind your back about it. And that happens a lot. But at most times if you are really suicidal or something, you can go up to your friends and say "Well I'm really bad right now. Can you help me out?" and they'll help you use your techniques, which are like distraction and thinking about other stuff. And it really helps. (Tracey 3rd interview)

Kerry also found the environment and peers a mixed blessing:

Umm, it can be fun, at times, but at other times, it can be very stressful and tiring and you just want your own space, umm but it's good to have people your own age...well, it was good to have people around your own age, around...it was good, sometimes it just felt like a giant sleep over (Kerry 20yrs; 1st interview)

Sub-theme 4: Family

This sub-theme involves the meaning of family for the adolescents; both memories of home and the sense of connection of home that remained while in hospital. As the BAC was an inpatient Unit, the adolescents saw less of their family than if they were at home or day patients. For many of them this was a mixed experience:

DW: I'm also wondering about what it's been like for you to see less of your family.

Kerry: Other side it was a real bonus, but it's not anymore. It's very hard, especially not being able to, because I live with such a close family, close umm...extended family, that um, it's been really hard like, not being able to see my cousins grow up that sort of thing, we're very close to them.

DW: So just to go back, initially it wasn't so bad, but things started to change. Take me step by step, tell me at the beginning how it wasn't so bad.

Kerry: I could be my own person, I didn't have the pressure of wanting to please family, making sure I didn't let them down, or ashamed because I was sick I felt like they judged me a lot, about not wanting to get better umm, but that slowly changed as my viewpoints slowly changed. (Kerry 20yrs; 1st interview)

Kerry's experience above was common for the adolescents; that of being initially away from the family was helpful, though over time, the separation proved painful as was for Todd and Rick:

It's pretty – you miss them a lot. But at the same time it's good to have a break as well. Like I tend to worry a lot about my family as well when I'm at home. Especially with mum. She has some problems as well. And it's good not having to worry about that sort of stuff while I'm here. (Todd 16yrs; 1st interview)

Like when I started as not with my family, like my relationship with them actually grew

better than it was previously...Whilst I had that period away from them I managed to repair those problems, which I caused them. (Rick 16yrs; 1st interview)

With BAC being a long-term residential Unit, some adolescents appreciated opportunities to visit home. However, for some such as Michael, there was a measure of culture shock:

I went home on the weekend, and it was, yeah, a big change. Just after you've been here for two weeks you really kind of get into the routine of doing certain things at certain times. And it was hard to adjust back into being able to have such low restrictions. (Michael 16yrs; 1st interview)

Michael also recognised that the family itself changed due to his absence:

Yeah, they feel sort of pretty much anxious around the house with somebody that has been there so long just suddenly gone. They obviously feel sad that I'm gone. It is a whole new sort of world where there was four, and now there's three, and that the second oldest has become the oldest in the household. And it, yeah, it's very different for them. (Michael 16yrs; 1st interview)

As some of the quotes above reveal, the time at BAC was for some, a temporary, but welcome break from family. However for others, the pain of being separated from family was most acute. The photo below taken by Tracey and accompanying extract, reveals how for her, the pain of separation was deeply felt:



I really like this photo because it goes down towards a girls dorm and so like for me when I'm at home and I'm going to bed my mum and my little sisters will come and say "Goodnight" to me. And they'd give me a kiss and a hug, and sometimes my little sisters will sleep in my bed with me if I'm like scared or if I have a nightmare, or if they do too.

And this just shows that down the end of the hallway I'm in my bedroom and if I'm

scared I have no one to hop in my bed with me, no one to keep me warm, no one to say goodnight or comfort me when I'm scared and stuff like that. Because it says no visitors are allowed down to the bedrooms. And so it makes me very sad and very homesick because even though my parents and family won't be there at night time it's just my room – I dance in my room and also with my little sisters when I go home and – I don't know. My room is very like – I do a lot of things with my sisters in my room and stuff like that, whereas here it's just like – makes me very homesick. (Tracey 15yrs; 2nd interview)

Sub-theme 5: School

This represents the adolescents' experiences of their education while at BAC and how this compares to previous schooling. With the BAC having its own school, the adolescents' education was important. A common story that the adolescents reported about the inpatient school was how it became a 'corrective educational experience' for them:

I think the teachers are the main reason why the school is the way it is. Because the teachers have seen kids like us for so many years, they understand what we need. They don't ask questions. They don't push us too hard. They're very nice, laid back. (Ashley 14yrs; 1st interview)

It's a lot better. It's not the stress of having so many other kids around, because it's such a small school...They got more time to help you with what you need help with. (Todd 16yrs; 1st interview)

DW: *Tell me a bit more about that caring part with the school. What's that about?*

Tracey: *Like so say if you were at normal school and you got up to walk away they'd just be like "Ah!" - just to give a detention. Whereas here it's just like "What are you doing? Do we need to like to talk to you? Do you need any help?" and stuff like that. And I don't know. You feel safer and more cosy here, because it's a better environment. (Tracey 15yrs; 1st interview)*

For Meg, the distinction between the school and the ward was quite pronounced, with the school environment less stressful as she recounts with her photo:



I mean I just like the fact that they're smiling and that. It's not particularly artistic or symbolic or anything, it's just they all look happy and they're coming out of the school and they're the teachers. It is quite like – their smiling is very suitable for the photo because the teachers over at the school – it's much better than the ward because it's more free, unrestricted, there's more smiling and

laughing and having fun. (Meg 16yrs; 2nd interview)

The quote below from Samantha is noteworthy. She felt the school experience was so healing, that there was a transformation from an old self to a new self:

Samantha: Um, other school experiences were quite bad because I used to self-harm myself at school all the time because I just thought that I didn't belong and I shouldn't be at school because I had no reason to be at school because I didn't know anything and everyone would tease me...I don't try and get myself suspended or anything like that. So it's quite good that I've changed my way from my old self to my new self.

(Samantha 16yrs; 1st interview)

Sub-theme 6: Recovery

A goal of this study was to have a clearer picture of the experience of recovery for the adolescents. Consequently, this theme represents their personal experiences of the recovery process and what elements might help or hinder that process. As the methodology explained, the use of a camera was to help the adolescents articulate their stories of recovery and inpatient life. It proved to be a most valuable technique. Interestingly for Meg, she was thankful that I was not her therapist and therefore felt comfortable in telling her story, though she expressed some reserve at the idea that I might not capture or understand her experience fully:

DW: I guess my sense Meg is that the camera has helped you really express some of the stuff that has already been there, that it just helps draw it out. Is that right?

Meg: *Yeah. But it's also very personal and subconscious and I guess if you were my psychologist or something I would feel a little more uncomfortable with you seeing it, but I don't know if you can see all the stuff. I mean because it's very personal.* (Meg 16yrs; 3rd interview)

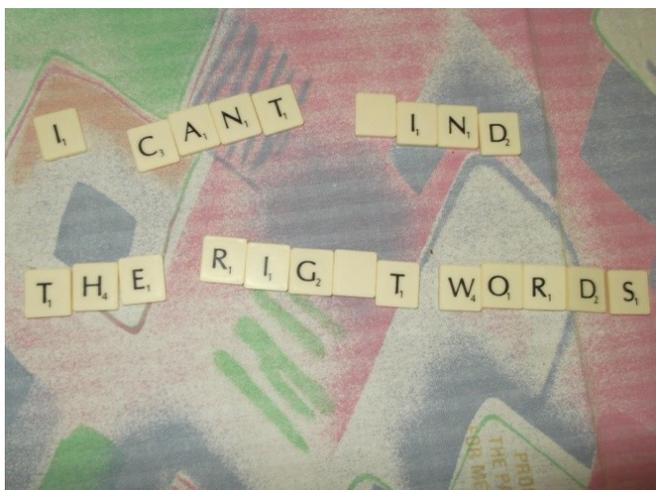
Some found the experience very exciting:

It was really cool because I guess when you first gave it to me I was so excited. I'm like "Oh my God, what am I going to take photos of?" I was just like trying to like run around and find all these ideas. But then I'm like "No, wait. Get over the excitement and start like figuring out what to do". So, yeah, it was fun. (Tracey 15yrs; 2nd interview)

Ashley found it therapeutic and a most useful tool to express emotion and feel in control:

It was actually quite good, because I could express a lot of things that I couldn't express verbally. Such emotions that I have no control over and kind of taking photos of them, that's kind of like taking control of them, which is good – feeling in control. And it calms me down in a sense. (Ashley 14yrs; 2nd interview)

For two of the adolescents, their photos revealed how useful visual material can be in sharing their stories:



Tracey: *It's just basically like I can't find the right words to talk about my problems. And as you can see there's spaces in there, and that...Yeah. And I just – it's like for when I'm talking to someone I feel like I can't find the right words to express my feelings.*

DW: *Yeah. And what's that like for you?*

Tracey: *It really makes me angry and disappointed in myself. And sometimes I feel like I'm stupid and that.* (Tracey 15yrs; 3rd interview)

Tracey gives an idea of how frustrating it can be to explain difficult experiences with a resultant sense of being ‘stupid’ when trying. The camera helped the adolescents considerably in sharing such stories.

The recovery process itself was rarely linear, with a range of positive and negative experiences affecting the journey. Similar to the other areas for the adolescents, there were parallels and contrasts. For Samantha it was a forwards/backwards process:

So the bad side is that every now and then I see somebody going off or if I see heaps of people just being so edgy I just start to go back – I’m going backwards pretty much. But I don’t want to go backwards, and I just keep going forwards. But I know that sometimes I have to go backwards just to take a couple more steps forward (Samantha 16yrs; 2nd interview).

A powerful emotion during Peta’s recovery process was that of confusion:

I’m plagued by confusion. Because there’s just so many emotions going through my mind at different times and it just gets to a point where you’re like “Stop. Okay, freeze. Don’t want to go on any further” and that’s when I get most suicidal I think...Even though you may be completely suicidal and want to kill yourself, you still love your parents and want to be there for them. So there’s always going to be contradicting things going on within someone’s mind, and I think that’s just natural with everyone. (Peta 16yrs; 2nd interview)

This photo was taken by Ashley as we discussed her own recovery process:



DW: *The last one is you in the bathroom looking at yourself in the mirror. Tell me about that.*

Ashley: *I guess that’s kind of getting - me looking at myself is also another sign of me grasping that reality, trying to find it. I’m in a seclusion garment and I’ve got my beanie on. My beanie*

is kind of like a security blanket for me, so I have that on. And I'm just looking at myself and that really to me is just I'm working out the reality that "Just wait, I'm not okay." And it's okay to say that I'm not.

DW: *Okay. I was going to ask you: what's it like for you to come face to face with that reality? And this photo it's literally face to face...*

Ashley: *Face to face.*

DW: *...with yourself, with that reality.*

Ashley: *Yeah. And it's scary. It's one of the scariest things I've ever had to go through. And I'm probably going to have to keep going through it until I die, because there's always going to be challenges in our life. There's always going to be another obstacle to climb, and really sometimes we just have to sit ourselves down and look in the mirror and say "This is where I am at and it's scary".*

The above is rich with meaning and reveals themes of fear, recovery and the struggle with reality during the recovery process. The 'obstacles to climb' in the recovery process requires a resolute mindset that demands a good look at oneself despite the fear.

While Samantha found relationships initially difficult, when a friend refused to give up on her, the friendship became a catalyst for her recovery. I asked her about the meaning behind the following photo:



Because when Peta and I met and she started caring, I told her I don't want people caring for me. I told a million people that I didn't want people to care for me, but she was one stubborn person and kept caring, and then, yeah, that's how it began. I started caring for her and we cared for each other. And that's how it began - caring for each other.
(Samantha 16yrs; 2nd interview)

It also must be mentioned that there were a range of issues that the adolescents reported as being unhelpful or stressful during their impatient stay that may have impacted the recovery process. One of the more notable aspects were ‘code blacks’, where a duress alarm would be set off should there be imminent concerns about a patient or staff member’s safety. It is extremely loud with all staff required to attend to help if necessary.

For Samantha, it brought back memories of a previous detention centre:

Things just bring back towards the detention centre because this is—the code blacks and stuff just bring all memories of me being put down and stuff like that, and seeing these kids getting the same treatment is just kind of petrifying for me because I know it’s [for their] safety, but I don’t like it so. (Samantha 16yrs; 1st interview)

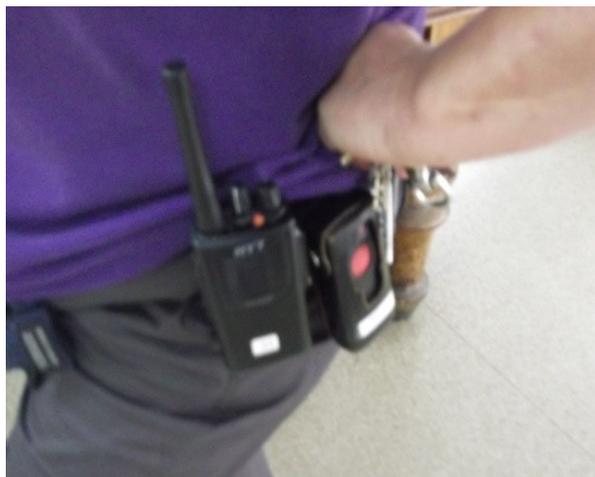
The code blacks were an important, albeit distressing, experience for the adolescents. While the effect varied from person to person, there was nonetheless a feeling of dread; realising that when the alarm is triggered, one of their peers is very distressed in a potentially serious situation. For Tracey, it was worthy of a camera shot:



DW: *Alright. A picture of a duress alarm.*

Tracey: Oh God! I know I’ve set off a few of them. I don’t know. They’re probably like the worst thing to see people going to press or pretending to press. Because once that little red button is pressed the never ending ringing and sound is in your head for so long. And it’s just people come running, patients are getting anxious but also are very nosy, so want to know what’s happening and where people are and stuff like that. Nurses get stressed out and are telling you to “Get back!” or “Get into your room!” or “Shut the curtains!” And they’re running around everywhere. This noise is never ending, going off. Usually there’s a person kicking and screaming and being like, dragged away into seclusion. And it’s really upsetting, and it’s just – I don’t know. I don’t know. It’s depressing. (Tracey 15yrs; 2nd interview)

Meg's experience was similar in experiencing fear not just for herself, but for other potential inpatients in the future. She also took a photo to help tell the experience:



Well code blacks are very scary. Very emotionally charged, draining, tense. In some ways when new people come in I want them to be prepared for code blacks because we haven't had a lot of code blacks lately in the past few months and there's been loads of people. And I really want people to be prepared because I'm still quite scared whenever things happen like that. Because they're quite horrible sometimes, and I've seen things in here that's not

very nice - involved with that kind of thing. (Meg 16yrs; 2nd interview)

For the boys it appeared to be less of a problem:

It's just like I know the nurses have it under control so I just don't really pay attention to it. (Ken 15yrs 1st interview)

DW: *Do you think it affects – the code blacks – do you think they affect the boys and girls differently?*

Matt: *Yeah. It's generally only the girls that are code black problems.*

DW: *Okay.*

Matt: *And like Lorraine was saying at night a code black went off in her room and she saw everything. It was pretty horrible for her I think. And it generally happens over there so we don't really see much of it for the boys. So it doesn't really tend to be much of a problem. (Matt 15yrs; 2nd interview)*

It is beyond the scope of data in this study to speculate on the negative impact of code blacks on the recovery process. However, I suggest that like the recovery process itself, the impact of duress alarms is a highly individual experience, dependant on a range of variables such as personality and past personal history. I also suggest that particular issues bring idiosyncratic responses. For example, Matt in a previous extract above stated self-harm by others made him angry, to the point

of wanting to lash out, while the code blacks were not “much of a problem” for him.

The recovery process for the adolescents was at times, a significant struggle. With Ashley, there was the struggle to push on despite the inertia of mental illness:



DW: *What’s the meaning behind that scar Ashley, for you?*

Ashley: *The scar is for me and they just show how depressed I am at times, and how I struggle. I try as hard as I can all the time, and I’m always really kind of going to myself “You’re not trying hard enough” but*

I do constantly try. But everyone has moments where they just can’t control it anymore and something happens, and that’s really what happens with my scars. (Ashley 14yrs; 2nd interview)

Some of the adolescents described certain areas as important spaces to have a break. They described them as special individual places that facilitated their recovery:



Music is my escape, David. It’s really important to be alone. I find it so relaxing and calming to just let my fingers dance. (Peta 16yrs; 2nd interview)

For Samantha, the garden allowed her to escape the pressures of inpatient life and for a while, get a sense of freedom:



Yeah. I really like the garden. I feel like when I go in there everything just kind of disappears and I just kind of go in the zone and... Because it reminds me of a little bit of freedom because its leaves are like really, really big and it blocks out every single sound that comes. And it lives like near the sea and stuff like that. And it just reminds me of freedom, pretty much, because it can block out sound and it's really pretty.
(Samantha 16yrs; 2nd interview)

An advantage of offering interviews over a period of time was it provided an opportunity for the adolescents to reflect on any changes during the recovery process. In this regard, the responses were mixed:

DW: Okay. So it's been about three months, has your view kind of changed then - since you first were admitted?

Ashley: I understand this place more now. I understand why I'm here and why I need to be here. And I also understand the path that they want me to go on. Because it's been successful for some people. And I can see how it would be successful. But I still am undecided whether it will help. (Ashley 14yrs; 1st interview.)

It was really scary when I first came here because everyone else knew each other and they had been here for a while and that. So that was kind of confronting. But everyone was really welcoming and that made it a bit easier and that, but it was still really hard but it's gotten better. (Tracey 15yrs; 1st interview)

At Michael's initial admission, he had difficulty understanding how anything could improve given the level of distress the adolescents were experiencing:

Challenging. Stressful. A bit sort of really – it's very different. You got all these kids that are such in a worst position than I am, and they don't really seem to be showing – or not from my perspective – any really signs of improvement. (Michael 16yrs; 1st interview)

When questioning the adolescents about change, the most noted topic was actually the issue of change in the wider context of ward life, particularly the issue of new patients or staff disturbing their sense of stability. In other words, any sense of destabilising of relationships was deeply felt:

(Meg 16yrs; 2nd interview)

Well we've had a doctor change, so that was a bit confusing – trying to get used to a new person to talk to. You don't know them at all and you're trying to tell them such important things. It's quite difficult.

(Meg 16yrs; 3rd interview)

But also since we last talked – I mean the patients on the ward are always changing. I mean the number and who's on the ward. Because we always get new people in and different nurses. And we've had a recent admission who's a bit different from other admissions in a sense, and that's caused – that's affected us more than any other new patient. Maybe because there's a lot of staff changing...I mean the ward's always changing but especially with different patients coming in. And then there's been a few issues with – I mean just the ward stresses and people's relationships changing anyway.

A lot of changes. There was a lot of people coming and going, which really affected my treatment. Because I can't handle when people leave and stuff like that. So that was a big change. (Tracey 15yrs; 3rd interview)

Others such as Rick felt the changes were most notable in his relationships with others:

Well, what I am now is a person who can get along with say, random Bob on the street and I get along with them all right, but previously—like I could have known someone

really, really well and then I'd bite their head off for the stupidest little things. (Rick 16yrs; 1st interview)

Samantha recognised changes within herself; particularly feeling 'normal' again:

DW: Has coming to Barrett changed the way that you see yourself?

Yes, because when I was at home I just thought I was a fat, ugly-looking person. Here I just think I'm just normal. I just wake up normally. I don't feel anything. I just think I'm a normal person. I don't tend to think of all of those negative thoughts that I thought at home or anything like that so it has changed my ways of knowing what I am or how I feel and stuff like that, because at home I never felt, or thought of anything. I just thought I was just ugly so. Here I've changed. Like I just think I'm just a normal person. (Samantha 16yrs; 2nd interview)

The above notion of change for the adolescents overlaps considerably with other areas such as relationships. For example, both staff and adolescents mention the difficulty of casual nursing staff and the impact on relationships. Adolescent patients being admitted and being discharged also were mentioned when the issue of change was explored. In other words, when the adolescents were questioned about change – expecting they would discuss their own individual therapeutic change – they instead tended to focus on wider change issues such as staff rotation or new patients. 'Relational change' then, was the most impactful facet of change for these adolescent inpatients.

The experience of the parents

The parents of the adolescents also reported a range of deeply-felt and often contradictory emotions and thoughts. These occurred both before and after the admission. Their first experience of self-blame, gives some sense of what was experienced long before Barrett.

Sub-theme 1: Self-blame

This sub-theme encapsulates the experience of the parents placing the blame on themselves for their child's mental health problems. Not uncommonly for parents with children with mental health difficulties, Susan knew at one level her child's illness and consequent losses were not her fault, but

struggled with self-blame nonetheless:

Well there's so many but you blame yourself. Like I always think "What could have I done?"...But you take on a lot of ownership. I blame myself even though it's not – I know that it's not anything that I've caused but yeah, you just look at different ways of "Well what if this?" and "What if that?" (Susan)

Similar to Susan, Alex herself felt like a failure for not 'providing normality' for her daughter:

Well you still have them now because you feel like your child is not able to cope as a normal family would with another child...So you do feel a little bit of parent remorse that you couldn't – bit of a failure that your child couldn't grow up as normal. (Alex)

For Cindy, the heaviest burden was guilt that made her question herself:

That's a tricky – that's an interesting question. The heaviest burden? It's just – from my point of view the heaviest burden is that constant feeling of guilt. Why is my child there? What have I done? (Cindy)

Even sickness could be a catalyst for feelings of guilt as Anne experienced:

And I had eight months where I was sick and I would have recuperated easier except that that was the time that Meg really went downhill. Really noticeably downhill. And I don't know whether it was because I was home and I was unable to really deal with her. So there's a lot of guilt in there too because I was so sick I was unable to really be very – I mean I tried to be – I was stable and all the rest. So I didn't spend days in bed or anything like that. But a lot of stuff was just removed because I was processing and things. (Anne)

The quote below from Patricia is revealing and sums up the essence of the parents' feelings of guilt:

Yeah. Or "What did I do? What genetics did I bring into this? Did I do something wrong? Was I not loving or attentive enough?" and all this. (Patricia)

For Susan, she found there was understanding and sympathy from others for *physical* illness, but little understanding or sympathy for *mental* illness:

Susan: *Yeah. It frustrated – that actually really angers me or frustrates me, that you'll be in a work environment or amongst friends or something, and someone will say "Oh yeah, my child fell down the stairs and broke his leg. And he's in plaster for the next nine months". It'll be like "Oh my gosh. You poor thing" and...*

DW: *The world's at an end.*

Susan: *The world's ending! And you say the same thing "Oh yeah, my daughter's living in hospital with a mental illness" and it's not the same. But it doesn't make sense to me.*

Similarly for Lana, misunderstanding led to social isolation:

Lana: *Yeah, that's been the hardest thing. I found that I stopped talking to a lot of people, compared to what I used to now. Because they just don't understand it or a lot of people just say "She just needs a good hiding" or...*

DW: *Good clip under the ear.*

Lana: *Yeah. And then fix it! You know what I mean? Like lots of people don't understand and so I just guess I stopped associating with a lot of people. And most of them like the close, close family are coming around to it now, but they're still not fully. And I guess that's been the hardest thing is the support. It just doesn't seem like the support has been there a great deal. Because people just don't get it I suppose.*

Sub-theme 2: Relief at the admission

Given the above stressors, all the parents in the study shared the enormous relief at the admission of their child to the Unit. This theme captures that sense of emotional relief of the parents upon their child finally being admitted:

When she first came to Barrett it was actually a relief. It was like for the first two years we had just been head banging our, banging our, heads, trying to get help. And coming

to Barrett it was actually a relief for us. It was also very scary, because you've got a child that's sick in hospital, and you're leaving them full-time in someone else's care. But for us the two years before – it was almost like the two years before that we were actually ready for Barrett by the time we'd gotten to the – and it was like “Oh my gosh. Thank goodness. Finally got in one environment all your therapists and social workers and doctors, and everyone that she needs. (Susan)

For Cindy, the fact that BAC was a long-term Unit was most appreciative:

And things seemed to change and I knew they would when she went there because it is just set up for more long term stay. Which I have to say gave me a huge sense of relief. And that's when I felt relieved and could breathe again. And I just felt more a sense of hope because I knew that she'd get all the help that she possibly could there. (Cindy)

For Anne, the admission of her daughter to Barrett was a mixture of relief as well as a sense of loss in an empty home:

I think it was great relief, as much as anything...And so I was really relieved. But I was also very lost. Because I had suddenly two children leave in the space of a matter of weeks. And so it was really different...So it was quite an empty feeling. But I sort of – I was thinking of her quite constantly and I was really relieved that she was finding somewhere where people who had the expertise and knowledge would be able to help her. (Anne)

For Jasmine, due to the sheer weariness and trauma of having a daughter who was self-harming and suicidal, the relief was most significant:

DW: *What was like for you when she first came here?*

Jasmine: *Total relief. Thank God. Somebody's going to help me with my baby. And it wasn't just me.*

DW: *Tell me more about the relief. What kind of relief?*

Jasmine: *As in not having to come home and think “Oh my God, what am I coming to this time? Is there blood that I’m going to have to clean up? Have we overdosed again? Do I need to keep [sibling] away - when we go home - just to make sure that everything is okay?”*

DW: *Okay. And just listening to you it sounds like when she first came here, it’s like you started breathing again?*

Jasmine: *It was. I didn’t have to be constantly aware of Peta. And it was difficult because I was having to work at the same time.*

DW: *What was it like for you not having to be constantly aware?*

Jasmine: *It was a relief. Because I’d spent eight to nine months constantly I feel either working, or supervising my child. I’d get up early, do the normal routine check on Peta, go to work, worry, worry, worry, worry all day, come home, supervise Peta in and out. If she was distressed I’d be the one that would be calming her down. I wouldn’t often get to bed until late o’clock – sorry – late in the evening because I would be sitting with her and then I’d go to sleep and then I’d get up and have to do it again the next day.*

Sub-theme 3: Loss

Closely related to the above sense of self blame were the numerous and varied losses of the parents. This facet represents the range of losses experienced by the parents due to their child’s mental illness. For Jasmine, her own losses were painful, but seeing what her daughter was missing added an extra dimension to the pain. Ironically, brief experiences of past normality highlighted those losses:

Jasmine: *I think it’s sad. [cries] Sorry. I mourn what she’s lost.*

DW: *What’s the biggest loss?*

Jasmine: *Her normal childhood. Being able to go out with friends, have a nice time. Just do normal teenage things. She's not been able to do any of that, not for a long time.*

DW: *Would I be right in saying that's a loss that's shared with both mother and daughter?*

Jasmine: *I think so. She's probably not so much aware of how I feel about it. But I just wish that she could have had a more normal teenagerhood.*

DW: *What every mum wants for their kids.*

Jasmine: *And to be a part of the family. Because she's missed out on that as well. It was nice last night. We picked her up. She went home with us. She had a bit of dinner with us, even though she'd had some dinner here as well. And then her and [sibling] sat at the coffee table and [sibling] did her homework and Peta did some of her art homework. It was just a nice normal family thing. And we haven't had that in a long time. [sibling] came and talked to me in the kitchen. Peta could hear that we were joking around. That's something very rare in our household these days, as in Peta being there and able to enjoy the family setting.*

The extensive and deeply rich quote below from Susan has many themes; loss of friends, loss of a future, loss of employment and loss of a daughter. In essence, a 'death that keeps on going':

Susan: Like you lose a lot actually. Like you lose your child. Because they're not the same child. They develop into a different person. So the child you once had – so I think she was about 14 when we first noticed some problems. So that the child up until the age of 14 was this one particular child that you raised and developed and you've got goals for and everything for them, and then this happens, or it develops and they are just a completely different person. So you then need to adapt to having – it's almost like a new child. Yeah. Yeah. And you lose friends over it, or you can lose your job. Like I...

DW: *Really?*

Susan: *Yeah. Well I lost my job but it wasn't because – I wasn't fired, but I wasn't able to commit the time that was required of me and so I was lacking in my performance and then I was lacking in my – like my mental health as well. I was just so emotionally caught up at the time – especially in the beginning – and you just can't focus on everything. It's just all too much...Well it is a death that keeps on going because you still remember the old – it's – yeah. Yeah. But at some point I think you do accept, well she's gone, and it's a new person now. It's a new daughter. But then you see little snippets of...*

DW: *The old daughter?*

Susan: *Yeah. Of the old. Yeah. Yeah. But it is. I think it's still – there is a large grieving process because for a long time you're sort of wishing they were back. You wish – where's my daughter?*

Sub-theme 4: Barrett as the second parent

Another aspect of dissonance for the parents was that while the Unit was a most welcome relief, there was another aspect; that of a mild resentment and loss at no longer being the primary caregiver. This sub-theme represents the dual experience of positive gratitude but negative displacement of the parents due to the hospital admission:

So that's been an issue – trying to stay involved and still – because I felt in a way I didn't – you feel in a way like you're abrogating parental responsibility. That the parents become Barrett. It's like putting children into childcare. If you put them into childcare continually who's parenting them? I mean the only good thing is you get them back at the end of the day and then you parent and you try and cover all that. So there's nothing much can you do about it. If they've got to go into childcare, they got to go into childcare. Like if they've got to come to Barrett, they've got to come to Barrett. So that's been a really big issue for me. (Anne)

The difficulty for Luke as a parent was losing control over the parenting of his child:

DW: *What was it like not to have that control?*

Luke: *It was horrible.*

DW: *I'm curious. Can you tell me a bit about that lack of control?*

Luke: *...Just not being able to sort of be there and hug him and say everything's going to be okay. So it was very hard...It was knowing that we couldn't sort of ring every day to find out what was going on. That was hard. Because we knew that things had to go on and he couldn't know that we were in contact and that's otherwise he'd want to come home all the time.*

Lana felt the parenting role was taken away at admission, which made communication crucial. When it didn't occur, it was a frustrating experience:

Lana: *I think the Royal [Hospital] was much better at communication. I do believe that. Because any time there was an incident with Tracey, no matter what, I would be contacted by them. Whereas here I find that sometimes I'm not contacted straight away.*

DW: *Okay. Has that been somewhat frustrating for you?*

Lana: *Yes. Yeah. Because it feels like I get really angry sometimes because - she's my child, and I still believe I'm the parent, but I feel like sometimes being here, that parental role is taken away from you a little bit. And, yeah, I get really frustrated with that.*

Sub-theme 5: Relationship

This theme involves the various facets of relationship experienced by the parents, particularly between them and the staff. For example, Susan felt this in her relationship with the BAC team:

Susan: *Well they care, or they seem to care.*

DW: *How do you know they care?*

Susan: *Because it's a feeling. Unless they're very good at faking! No, they just – they're genuinely knowledgeable in the area as well. That is another big thing. Is that they all seem to be specialised in the mental health industry or mental health field. But they also just seem to care. They'll call you or they'll stop and actually talk to you.*

When you arrive to see your daughter they'll actually stop and actually speak to you and they're always friendly, and say hello and say goodbye. And they tell you to ring... And the doctor – I know [Doctor] is not here anymore - but that just one thing that always I'll remember – and he said to me “We will fix your daughter. We will help her and we will fix it” and I'd never heard that from the two years of seeing that many doctors, psychologists, social workers, counsellors - you name it. Nurses, just specialists that different – not one of them said “Well we'll do something. We'll help you”. Yeah. And that was a big thing for me too. Yeah.

However, for Lana some staff were perceived as helpful whereas others were perceived as not:

DW: What stands out with the good ones, and what stands out with the unhelpful ones?

Lana: The good ones just seem to chat to you and tell you all about Tracey and have a good chat to you, and seem to listen to you. And then...

DW: The communication again?

Lana: Yeah. Yeah. Whereas some of the others are just really blunt and to the point, or just don't seem friendly at all, or don't seem like they want to listen to what you've got to say.

Cindy was especially appreciative of the relationships her daughter was making and the benefits derived from them:

It was just a massive improvement because she was terribly bullied at school. So her high school experience was all negative...she didn't experience any of that at Barrett. And in fact that was one of the main things that helped her was forming those friendships. Having a peer group who accepted her, and they were all going through similar issues. That was just something also that she gained there. She didn't have that anywhere else. (Cindy)

Nonetheless, despite the pain of having a hospital as a second parent, and the difficulties in maintaining the family relationships, the experience was worth it. This can be seen in the parents' responses when I asked what would life be like without Barrett:

Horrible. Yeah. Just for me I don't know whether we would have survived it really.
(Susan)

I truly do not think she would be here. (Cindy)

It would be hell. I think she's so lucky, and we are so lucky to have Barrett. (Anne)

Oh God, I'd hate to even think. (Patricia)

Pretty miserable. (Luke)

I think by now she would be – if she hadn't come here she would be really bad. Really, really bad and I'd be at my wit's end. (Alex)

The experience of the staff

Working at the Barrett Unit brings its own stressors and benefits. Some of these mirror that of the parents and adolescents; others are unique given the fact that they are employees. Below are the primary sub-themes for the staff.

Sub-theme 1: Recovery

This sub-theme explored how the staff viewed the various elements of the recovery process and was on occasion, keenly debated. One of the primary debates within the BAC staff was the question of the length of the inpatient stay for the adolescents and how this related to recovery. One staff member felt the problem was an organisational issue:

DW: So what thoughts come up for you when you think about the overall treatment process for the kids, from the time they're admitted to the time they're discharged?

Allied Health (3): Too slow.

DW: Too slow? In what way?

Allied Health (3): I think we keep kids for way too long.

(Allied Health (3); individual interview)

Other staff felt the difficulty lay in the adolescents' attachment to the Unit:

Allied Health (1): *I think those who stay here too long get worse. Yeah. That's like Kerry. Because when she first came in she had an eating disorder but when she left it was worse, so I think she overstayed her accommodation.*

DW: *Do you have any theories as to why it gets worse?*

Allied Health (1): *Yeah. I think maybe they become so attached to us. I think they become so attached and dependent on us and they can't see themselves being anywhere else but here. I guess it's like being in a jail where your whole life is between those walls and you don't really see the outside world and for us to sort of discharge them or allow them to go out, it's like a scary or whatever world out there for them. Therefore for them not to go there, they decompensate for us to keep them in. So we just keep taking care of them. So I think they just develop this sicker role...I don't know. I think they just become so dependent on us and that they just develop new mental illnesses for us to keep them here.*

The above thoughts were also echoed by one of the nurse participants:

Bev. *Bev was here way too long. I don't think we take the chance on kids. I come from a community clinic where you had to take a chance on kids and give the responsibility to the parents. I think we tend to take away the parental rights a little bit...I think this becomes a safe place for kids. So safe that they don't want to leave and then they often sabotage their treatment so that they end up here longer because they're frightened of what's going to happen on the outside.* (Nurse (2); individual interview)

For another nurse, the issue lay in the availability of supports once discharged and the duty of care to look after them until they were ready:

Yeah, look, we've had two girls here four years... But those two who were here for four year periods, huge difficulty in where to put them. That was the problem; we didn't have a place to put them. They couldn't go home. They weren't suited for an adult acute ward that was just an inappropriate admission. So the kids were left in limbo...But we

can't abandon these kids. We have a duty of care. We were working very hard to keep them alive and to get to that point where developmentally and maturely they could move on. (Nurse (1); individual interview)

Sub-theme 2: Relationship

For all staff regardless of profession, the notion of relationship was a strong narrative and this theme reflects how the staff perceived the role and value of relationship within the Unit. It was a guiding theme for treatment and a principal in working in this area:

I'm thinking of people like Susan. I'm thinking those sort of students who've come to us with not a single relationship of any consequence. Within a space of six or seven months, a year, they've developed 10. They have a relationship with 10 at least, more than 10 adults and other children in their own social [unclear], when they're at the ward. They've developed all these relationships that are workable, positive relationships. I think that is, that's got to be what heals in the end. Not the teaching, not the knowledge, not the content, not the whatever. It's that being able to relate to people. (Teacher (1); focus group)

Continuing with the theme of relationship, the need for regular staff who can connect with the adolescents was viewed as most important for one nurse:

Yeah, look, I guess in the last couple of years it's been particularly difficult. Nearly all the nursing staff are new. It's been very difficult trying to get people trained up in what Barrett is about...There's a number of staff with the redevelopment that don't have a commitment to what happens on the Unit. They're here to earn money and they don't connect with the kids. The kids pick up on it very quickly. You'll have some shifts where they have nobody that they can approach and they find it very difficult and they'll go and hide in their room. You can actually see the negative effect it has on them because they have nobody they can actually communicate with. It makes it hard for them. (Nurse (1); individual interview)

As highlighted in the parents' narratives, the notion of taking on a parenting role was a strong theme for the staff. During the Allied Health focus group, one staff member put a question to a colleague:

Allied Health (1): *Two of us are parents and I'm curious from you not being a parent yourself how that fits for you?*

Allied Health (2): *It's interesting because it does – because I'm not a parent – but it does feel like I'm a parent sometimes. Because I do run a lot of activities and at times I got to organise adolescents to get up and get them ready for school, go through all the homework stuff. Even during the holidays make sure their lunches are packed, all that money budgeting, all of that stuff. After school activities like swimming or whatever it is.*

The above dialogue is interesting and reflects just one aspect of the multifaceted roles staff take. The first staff member assumes that being a parent will affect one's work at the BAC. Conversely, the second staff member feels that despite not being a parent, she nonetheless undertakes parenting duties at the Unit. For a member in the nursing focus group, there was the acknowledgement of a cautious parenting role, similar to grand parenting:

Well I mean - look you do. When I first came to the Unit the message was "You're not a parent. Don't be a parent". Over the years I've sort of come to the understanding it's more like being a grandparent. Where you have the kids, you impart some wisdom and help and support, and that therapeutic relationship, but at the end of the day you give them back to the parents or wherever... So it's probably more of a – as I see it – a grandparent role. (Nurse (1); focus group)

As did another nurse:

I mean you're in an inpatient setting and people are here, it's their home here. And for all intents and purposes, call us what you like, but we are the parent figures here, because we're the ones that are enforcing – it's our household and we're enforcing what rules and regulations we are having in our household...We know in the list of the 15 or 20 odd tasks of parenting nursing staff probably address three quarters of them at least. (Nurse (2); focus group)

Interestingly, the above nurse called the Unit “our household” and then explains that the staff carry out most of the usual parenting duties. Other staff such as the teacher below are more cautious and described this process as walking a ‘fine line’:

...there have been times when I have to speak to the student: "I am a teacher and you're a student. I'm not a father. I'm not your best friend". Even though they've been crying out for it. And it's a very sort of fine line I have to tread all the time. (Teacher (2); focus group)

However for one Allied Health member, given the fact that most workers at the Unit are parents, there must be a space created to reflect on the potential impact that could have in the workplace. Consequently, supervision is important:

So I think the problem stems if people are acting in a way that's informed by their own parenting style or the way they were parented. If that is – there's no capacity for that actually to be reflected on and that of course requires a supervision process and so many of the staff here don't have supervision or they have supervision by people who are outside and have no knowledge or who are inside but too close to the issue. Yeah. So I think supervision is more the issue rather than if we parent. (Allied Health (3); focus group)

The 'household' analogy goes one step further. For one Allied Health member, transference issues not only encroach into relationships with the adolescents, but within staff relations as well:

Because it's easy to react in your own – like the kind of transference stuff – in having your own stuff react to it. And not only that too – because it's not just in our relationships with the kids, then all of that, because our families and that parenting stuff are our templates for relationships. So then it becomes our relationships with each other as well, and then we start having sibling squabbles. (Allied Health (1); focus group)

Finally, the issue of parenting tasks at the BAC might best be summed up by one staff participant:

I think a difficulty is unlike a home where you have a mum and a dad, here there's lots of mums and dads. (Allied Health (2); focus group)

Sub-theme 3: The 'BAC personality'

Another sub-theme closely related to the issue of parenting is the idea that it takes a certain type of personality to work in such an environment. Subsequently, this sub-theme captures what type of professional is best suited to work at the BAC. It is a personality type that has a relational style at its core:

DW: *Do you think it takes a certain type of person to work here?*

It does. You can see it fairly quickly. If a staff member doesn't connect with the kids, if the kids can't connect with them, then it's very hard for them to do anything effective here. You see staff quite often, the good staff are the ones that will be sitting with and connecting with the kids. The staff that don't get it spend their time in the office or on the computer, not actually interacting with the kids. Probably, for me, one of the most important things is getting that therapeutic relationship and connecting with the kids. Even at the moment, there's only a few staff that have that connection. It's a drain on the staff that have that connection. I guess that is a big problem at the moment. (Nurse (1); individual interview)

It is interesting to note that for the above Nurse participant, if there is a shortfall of staff that can 'connect' with the teenagers, those that can, compensate. This possibly may have been a contributing factor in the stress levels of the regular nursing staff (see below). The staff member below not only agreed that a certain personality is required for this work, but that it actually changes the worker:

I think over the last four years I've done a lot of reflecting and I know that I have the personality to work here with the adolescents. I think that's been a big positive for my sense of understanding who I am as a person to be in this environment. Because obviously we've seen lots of people come and go and lots of people stress out about this place and stuff like that, but to really stick it here and stay for four years, I think you need a certain personality...At the end of the day, it's all for them and I think that's something that I've learnt about myself personally.

DW: *How is that?*

Because before working I was very selfish. It was all about me...But coming here made me realise that these adolescents really have a shit life and they've got nothing at all...I think it just made me realise that I take life for granted and I really shouldn't take life for granted anymore. (Allied Health (2); individual interview)

The teachers also felt that those 'on the outside' might not be able to connect with Barrett adolescents:

A mainstream teacher who is fairly confident in their ability to teach a curriculum would find it very frustrating here. Because there wouldn't be enough lessons that they could teach and follow up. Students wouldn't be as receptive or compliant as they might be used to. (Teacher (3); focus group)

This theme was also described by one of the nurses; again recalling the issue of casual nursing staff:

I had a casual nurse down here the other day and something was going on and she said "That would not happen in my country! I would just slap them!" (Nurse (2); focus group)

Sub-theme 4: Workplace pain

Of course this line of work can be stressful and the staff participants outlined some of the difficulties in working at the BAC. This element therefore captures the staff perceptions of these various stressors in such a workplace. With such a large team it is not surprising that staff relations can be strained:

Dealing with staff. Not so much the adolescents, because the adolescents are very easy to deal with and manage. Probably dealing with the consistency of how we manage the adolescents. Just a typical example would be, like, you can walk in a case conference and all these plans will be place. Everyone agrees on it and the next day things have changed without us realising or knowing and it's like, wait a minute, who made that decision? It was decided in case conference but then someone can just override that decision without bringing it to the team. I think that's probably the most difficult thing, to work in such a big team. (Allied Health (3); individual interview)

Different staff could also have different views on discipline or appropriate behaviour:

For example, like for cooking groups, we always cook. Over dinner the kids will just be talking. You know, making conversation and they could be talking about, I don't know, random things about "I dare you to do this" or "I dare you to do that"; "If you do this I'll punch you in the face". It's all very normal teenage, adolescent talk or conversation. If they were at a school, that's normal. It really frustrates me when the nurses jump in every two seconds telling the kids not to say that, not to say this. "You know, if you say that you'll be on a program!" (Allied Health (2); individual interview)

For the nursing staff, the 'front-line' work of nurses can be overlooked leading to frustration and invalidation:

DW: I sense some frustration with you, that you can see something, but you can't do anything about it.

Nurse (2): That's right. There's a lot of times you can't. As nurses, I think we're here 24 hours a day. I appreciate and recognise the whole team's professionalism. But I think sometimes when the nursing staff here say this, this and this, I think other professionals or expertise is taken into consideration rather than listening to or even including those that are on the floor. An example of that is yesterday was intensive case workup, and the nurse that was involved says, I don't really know why I'm writing all this crap because it's not going to be listened to anyway. (Nurse (2); focus group)

This was a strong theme for the nurses; one that did not reach the same intensity for the rest of the BAC staff. Some nursing staff felt they were not being recognised by their peer nurses in other areas of practice:

We're not recognised as the professional people that we are. Our opinion isn't sought. They'd like us to do all the menial tasks that you'd know an escort person may do if you were specialising somebody in the general hospital as a general nurse. But in their opinion we're sort of just there to guard the patient. (Nurse (3); focus group)

I think that's where you get it from because you don't get it from the organisation - you definitely don't get validation from the organisation. (Nurse (3); focus group)

Yeah. Psych nursing is the lowest form of nursing. That is there no other [profession] under psych nursing. We're the lowest form of life. (Nurse (2); focus group)

Then there is the stress of working with such an emotionally draining population:

Staff get very despondent when they see the behaviour by kids that - it's very challenging; especially the aggressive, self-harming type behaviours...It can be career altering. Some staff decide they just cannot work here under these conditions and they leave. (Nurse (2): focus group)

For the two nurses below, working in such a large team brings its own challenges:

Pressure cooker; you see the best and the worst in people. Not just the kids but the staff as well. (Nurse (3); individual interview)

It's a thankless role at times, and it also brings us into conflict with allied health staff at times as well...Consistency is difficult. When you've got near two dozen staff you're going to have two dozen different ideas...We're not parents, and yet we still do the tasks of parenting...It's difficult with, like I say, up to two dozen different personalities to deal with. (Nurse (2); focus group)

Most of the narratives about workplace stress emerged from the nursing staff. A teacher's comments below share his insights into what they might have been experiencing:

Certainly the nurses have always said that evenings are very difficult time over there... So the nurses may be in a situation that is – it's evening time, there are meals going on, there's early TV and homework activities. They're almost in the position of parents. And they've got a lot of dysfunctional students who are giving them – adolescents who are giving them grief, so I can see that they might just dread that evening shift. And they might say "Well enough is enough. I've had it. I'm out of here". So that may be a factor in why they want to leave. (Teacher (2); focus group)

Sub-theme 5: Workplace hope

Despite the stressors outlined above, there was also the sub-theme of workplace hope: that optimistic sense of resolution that the adolescents can indeed recover from their mental illness experience. For one nurse participant, contrasting adult and adolescent mental health helped put things in perspective, thereby creating some of that hope:

You have [adult] patients who aren't going to get better. Very few do get better...Over here in the adolescent Unit what you see is the big difference is that the kids are still fairly early on in their illness. Even though they may go back a few years with their pre-disposing factors and that, you find that they're still fairly early on, they've still got a lot of hope, there's still a lot of things that you can do for them. They're not so ground down by their illness that they can't be helped still. Sure we'd like to be able to do more for some of the kids that we get. But the reality is that the difference between the adults and the kids is you still can do things with them. You get a fair amount of job satisfaction just by knowing that what you're doing is helping them and it sticks with them. (Nurse (3); focus group)

So what is it that keeps the staff here? Probably the successes are that satisfying that it over rules the bad stuff. But, then again, when you're dealing with crisis situations and everything you get a certain job satisfaction in that as well. That you've helped someone. (Nurse (2); focus group)

This theme of having an opportunity to make a difference cuts across professions, shown by the teachers' reply to my question about what has kept them working at the BAC:

Here, I get - what keeps me here is I get the opportunity to help students who really need it in a one-on-one situation. I have identified many times that - I used to have classes of 30 and I could always spot one or two students in every class who seemed to be suffering a mental health issue, now that I look back at it. I always wished I could have done more. But the demands of teaching were that I had 30 students and they all needed and I tended to teach to the centre and help where I could. Here, I can actually teach and help on an individual basis. Long answer, but that's what has kept me here. (Teacher (1); individual interview)

The thing that keeps me here is you really can build up much closer relationships with students and know them to a far greater extent than you could in a class of – when you've got say 100 students that you're teaching. Yeah. I find that is what's kept me here, despite the rather difficult times that I've experienced with seeing students disassociating and screaming out loud for half the night, despite hearing of suicides of ex-students. These are very terrible things, and that's also very stressful I find. However I'm hoping that I'm making some sort of real difference to some of the students here. (Teacher (3); focus group)

Summary: converging and contrasting experiences

The foregoing chapter represents the initial results of the study, highlighting a number of converging and contrasting experiences. The summary below reviews these experiences from each of the participant groups.

Firstly, the importance of relationship was central to all three participant groups. Especially for the adolescents, the circle of relationships that included both peer and adult remained crucial for their developmental pathway generally and their recovery process in particular. Indeed, the adolescents reported that many of the relationships they shared with staff were the starting point for a corrective emotional experience. Conversely, those staff relationships that were perceived by the adolescents as negative may have been unhelpful for the recovery process. A useful finding of the research in this regard was the impact of casual nursing staff. Some of the teenagers felt there was 'shallowness' in some casual nursing staff. The adolescents were adamant that should staff not take the initiative and time to develop an authentic relationship with them, mistrust and resentment surfaced. This occurred for example, when a casual staff member assumed they knew the adolescent merely by looking into their file. Few of the adolescent narratives revealed concerns specifically related to the staff taking on a parenting role. However, they did verbalise core parenting themes such as the importance of nurturance, authenticity, and emotional containment.

A corollary to this was evident when the teenagers queried change. Some did mention change in terms of personal recovery, but many chose to explain change that was in reference to the inpatient milieu. Any changes in the adolescent or staff populations were keenly noted by the teenagers and some recalled this as having a detrimental effect on their well-being. Other adolescents underscored aspects such as personal space and other environmental elements such as food and general comfort. The recovery process for the adolescents therefore, is closely informed by developmental issues.

In terms of the role of family, the adolescents were to varying degrees, still attached to their family of origin and for some, the separation was most painful. For others, it was a temporary relief from the pressures of home.

The narratives of the adolescents also suggest that the benefits of living with peers had its costs. Many of the adolescents experienced longstanding social anxiety and school refusal before their admission. Consequently, to be thrust into a residential Unit such as Barrett was both a therapeutic positive and a confronting experience. For example, their schooling narratives were noteworthy and most found the BAC school to be a vehicle for healing past distressing schooling experiences. On the other hand, when a peer was struggling emotionally, it could create a range of experiences for the rest of the adolescents, including anger, fear, despair or initiate further self-harm.

In terms of the parents' experiences, their narratives revealed a mixture of pain and "total relief" at their child's admission. Their pain however, emerged long before the BAC and continued for different reasons during their child's hospital stay. Much of their experience mirrors what is known about stigma and loss caused by mental illness. The parent participants divulged a range of losses; lost opportunities for themselves and their child, a lost sense of 'normality', the lost sense of 'family' and of course a lost sense of emotional and psychological well-being. The inpatient admission, while most welcome, also brought about a sense of lost parenthood. The impact of their adolescent child's illness on siblings also surfaced. The stories told by these parents point to a residual build-up of stressors before and after Barrett that was suggestive of burnout. This is discussed further in the next chapter. Noteworthy was the finding of how the Unit became a 'second parent'; that uneasy position for the parents where they were thankful for the security and hope the inpatient stay gave, while at the same time feeling displaced by the experience.

The staff also shared stories of what it is like to work in such an environment. The "pressure cooker" as one staff participant described it, was an environment that had multiple and often contradictory meanings. Despite experiences of frustration and sometimes despair, there were also themes of hope and the ideal of 'making a difference'. All permanent staff saw the value of persevering and developing a sound relationship with the teenagers. What emerged in the study however, was the perennial question of how far this relationship extended. The ambiguous concept of 'parenting' was a common theme and while all staff acknowledged it was their job to accept and develop the tasks of parenting in such an environment, there was debate as to its 'shadow side'. Transference and boundary issues and worker personality type were all factors noted by the staff in the process of helping the adolescents. The size of the multidisciplinary team as well as the clinical

complexity of the young people, added to the intensity of working in the milieu. For some staff such as the nurses, there was the added experience of being unappreciated and misunderstood from colleagues, internally and externally to the Unit.

Finally, the camera proved to be a valuable tool in helping the adolescent patients articulate their stories. There were no concerns using the camera, and for some, it generated excitement at being able to use this particular medium to express the many inchoate experiences of inpatient life. If we accept the notion that providing an opportunity for those with mental health problems to share their experiences is a professional and ethical imperative, then I suggest that the camera lent itself to elevating the ethical status of the research.

Conclusion

In conclusion, multiple simultaneous experiences by the participants emerged in the study, and a strength of the research lay in the way it demonstrates how that for all participants, there was a cost/benefit experience to residential treatment. The adolescents experienced the benefits of safety and treatment, while doing so in an environment away from family and among unwell peers. The parents enjoyed the knowledge that their child was safe and getting help, but doing so in the care of another. The staff took much satisfaction from seeing progress in their hard work, while at the same time trying to contain their own anxiety and despair when there was little progress. Some experiences were unique to the respective sub-group; others were experiences that were common to all. It is the latter notion of common experiences that the next chapter continues with. It is these collective voices that will further the understanding of the inpatient experience.

CHAPTER 7 COLLECTIVE VOICES OF INPATIENT LIFE

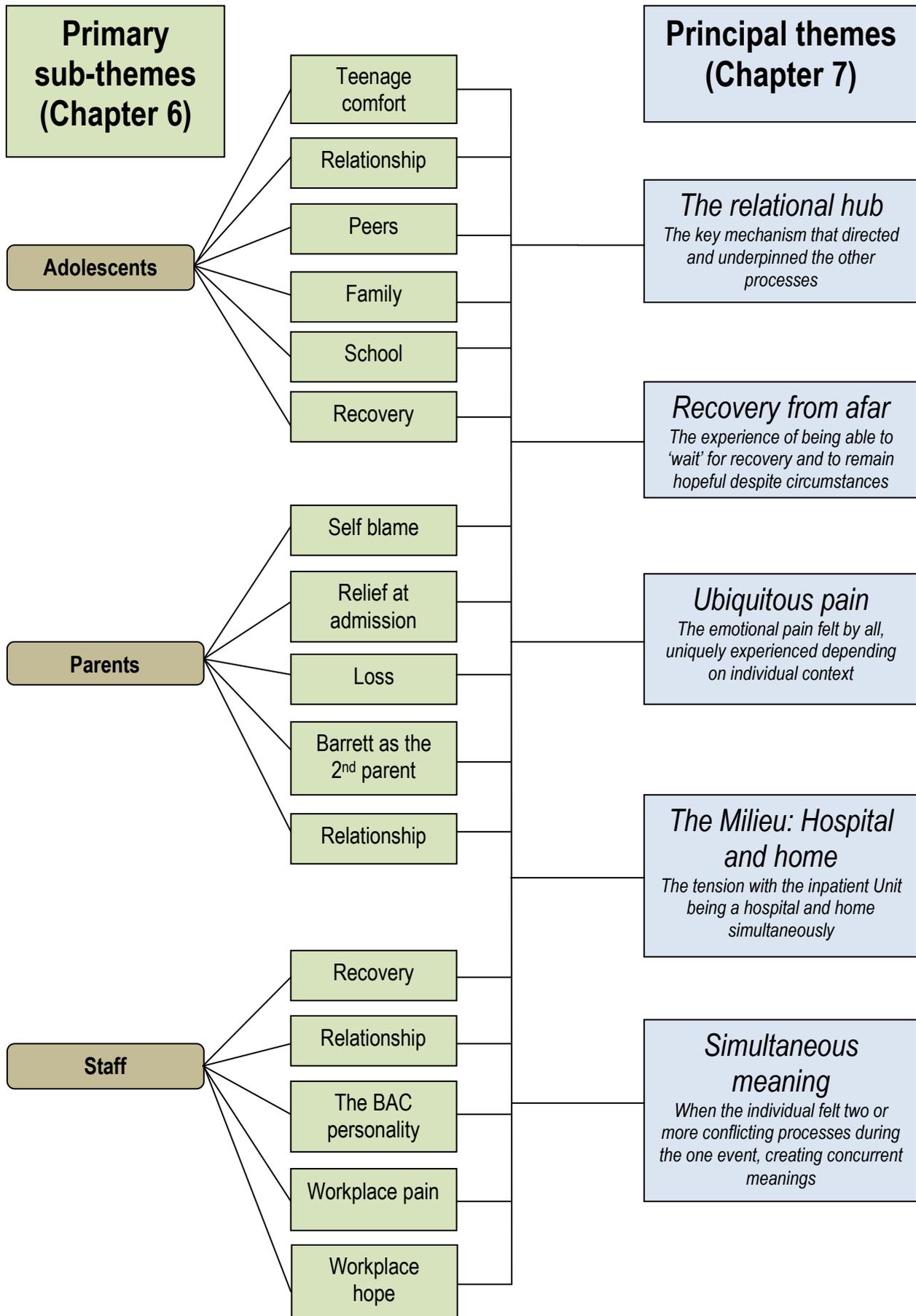
Introduction

This chapter builds on the previous by focusing on the five principal themes that were generated from the participant narratives. Chapter 6 presented an outline of the sub-themes that were of concern to the individual participants and gave an introduction to some of the interlocking experiences. This chapter provides a continuation and synthesis of those interlocking stories, to help understand the experience of residential care as a whole. These themes represent experiences common to all participants and can rightly be termed the ‘phenomenon of inpatient life’. These five core experiential domains are presented as foundational themes that will be used to respond to the primary research question; that of how can these collective experiences inform practice in adolescent residential care.

This chapter is however, different from the preceding chapter as the literature will be integrated to further explore the meaning behind the experiences. As the methodology explained, an interpretative phenomenological analysis judiciously applies any literature in order to make sense of participant narratives. Consequently, it represents the key analysis chapter for the thesis; highlighting the mechanisms and processes behind the descriptive experiences.

On the following page in Figure 8, is the representative summary of the coding and key themes for the study. Some of these were introduced in Chapter 6 with the primary sub-themes for each of the participant sub-groups. In addition to these, are the associated principal themes for the research that are the overarching thematic domains common to all participants and which represent the key qualitative findings of the research. Each is explored in turn.

Figure 8: Primary sub-themes & principal themes



Principal theme 1: The relational hub

As indicated in the previous chapter, the participant narratives suggest that the importance of relationship cannot be overestimated. The *Collins Dictionary* defines hub as, ‘the central, most important or active part of a place or organisation’ (‘Hub’, 2009) and as the following sections reveal, the ‘hub of relationship’ connected and steered the other principal themes. It was the key mechanism that directed and underpinned the other processes. It was arguably the strongest theme of the study, though manifested in different ways for different populations. This section will start with an extract and photo that captures this:



That’s my hand and Beth’s hand. I don’t know. It’s kind of just the proof that here even though we’re very different people as you can tell – Beth’s got very old wrinkly hands but I’ve got a younger kind of hand but I’ve also got scars on my hands – so we’re two very different people but we’re holding hands and it’s just that to let me know that no matter what happens here there’s going to be people around that care and that are basically going to hold my hand every step of the way no matter what comes along, I guess, the bumpy road that people say. And, yeah, I don’t know. It’s comforting knowing that – I don’t know – I’ve got someone that loves me and cares for me as much as Beth does. (Tracey 15yrs; 2nd interview)

The above extract is rich with meaning. Firstly, the adolescent participant declares that attachment with a significant other has been crucial for her recovery process. Despite obvious age and developmental differences, it is the knowledge that another cares that allows this adolescent to walk “the bumpy road” of recovery. “No matter what comes along” suggests a difficult path, but also suggests a steadfast reserve that encourages one to push on. Indeed, the above suggests far more than any detached therapeutic relationship; this girl felt she was loved and it was this sense of being loved and cared for that created a feeling of hope in the midst of recovery from mental illness.

Other adolescents strongly felt that relationships were important. Some adolescents such as Meg despaired when these relationships – staff or patients – ended; bringing a painful sense of loss. For

this adolescent female, the severing of relationships was painful enough that she felt they impacted on her treatment:

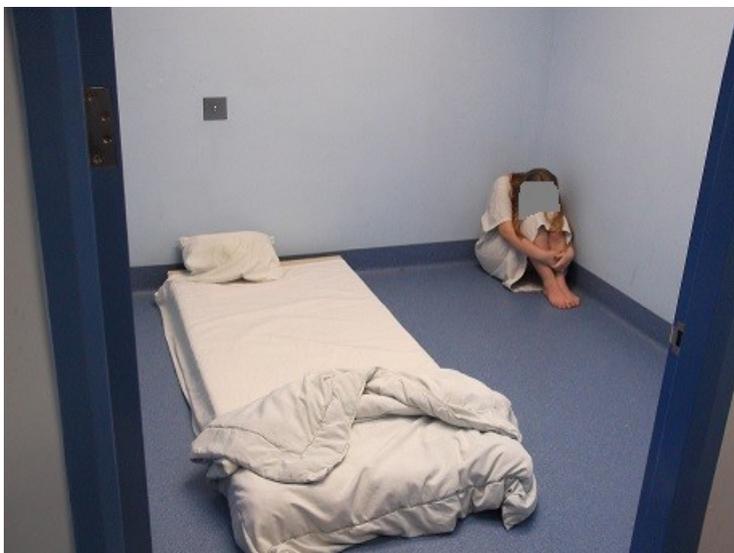
DW: I'm just wondering look, since November what stands out since last time we spoke? The high points, the low points. What stood out since just before Christmas?

Meg: A lot of changes. There was a lot of people coming and going, which really affected my treatment. Because I can't handle when people leave and stuff like that. So that was a big change.

DW: Was that the kids or the staff?

Meg: Both. So when the staff left it was really sad, and when kids left it was sad too because it was like we'd built a relationship and then it got taken away. (Meg 16yrs; 3rd interview)

This theme of relationship was indeed the 'hub' for the inpatient experience. Of all the various themes that emerged in the study, this one tended to have an experiential depth that was sometimes surprising to myself as a researcher; despite working there for several years. For example, during the interviews there were times when I wrongly (but silently) predicted what meaning a picture would have for the adolescents. Below is an example, where prior to the adolescent's interpretation, there was the assumption that it would be about a recovery issue or an experience around the use of High Acuity (HA)⁴ rooms such as this one. Instead, Ashley spoke about the issue of relationships:



That really sums up a lot of my feelings these days, which is of being kind of trapped in a very sanitary environment...Before I came here I lived solely with my dad, because my mum was a full-time worker. And I was just used to having him there for me 24 hours a day. So as soon as I got

⁴ The High Acuity section could house 2 adolescents separately. It was a bland room with safety in mind; no windows or potential hanging points. All adolescents were dressed in a safety gown and monitored 24/7. At no point are the adolescents left alone for any reason. It was designed for patients with immanent risk of significant self harm.

worried, tell my dad. And I was so used to that, but here I can't really talk to the nurses I feel. Especially the casuals. I don't feel as if I can talk to them. So I feel quite alone, and isolated. (Ashley 14yrs; 2nd interview)

The above narrative has a range of meanings embedded in the interpretation of the photo; again highlighting the usefulness of such a technique. Firstly, Ashley contrasted the ‘sanitary environment’ of the HA section of BAC with home. She felt ‘trapped’ there and explains that such an experience is alien to her. This is in contrast to having a close parent ‘24 hours a day’. What is significant is that for an adolescent to be in the HA, there is at least one nurse personally monitoring the young person every minute of the day; the adolescent is never left unattended due to safety risks. Despite the staff also being there ‘24 hours a day’, it is not the same. Ashley then recounted how the relationships with the casual nursing staff are insufficient, to the point of not being able to truly speak openly with them. Consequently, feelings of loneliness and isolation are the result. This again highlights the crucial role authentic, stable and *long term* relationships play in the recovery process for the adolescents.

The staff also recognised this. The teacher in the extract below linked ‘healing’ and ‘relationship’ during the inpatient experience. She recognised that the adolescents may not have had relationships of any significance, and consequently, the BAC provides an opportunity for these relationships to develop:

DW: Just hearing you speak, you used the word ‘relationship’ so much. That seems to be the bread and butter of Barrett?

Teacher (1): I think so. I can kind of see that. It is. The way that people relate to one another here is, I think, that's the healing force. That is what heals in the end. We have students who have not had significant relationships in their lives. Not had that, and to be able to come to a place and be able to develop a number of significant, of really significant relationships, with a number of staff across all these disciplines in the health and education area has to heal. (Teacher (1); individual interview)

For one of the nurse participants, the concept of relationship was so crucial he felt it was the catalyst for identity development within the adolescents. He described a ‘craving’ within the adolescents that, he argued, could be filled by the adolescent-staff relationships in the inpatient

milieu. So strongly does this happen he suggested, that it then provided the foundation for adult identity:

The male staff they [male adolescents] connect with they follow around like puppy dogs. They crave that male role model and we give it to them, very happy to give it to them... You can just see it, it's craving of the nurturing and the caring and the looking up to people. It comes out at the other end when these kids want to become a nurse, want to become a social worker, want to become a psychologist. I can't tell you how many kids have wanted to follow in the footsteps of their role model, as a kid in a normal home will say, I want the job that my parent has because I admire them. That sort of stuff is hugely important. (Nurse (1); individual interview)

Notice again that for this staff member, he drew parallels between a child in a 'normal home' identifying with a biological parent and the BAC adolescents identifying with staff as their parent substitutes. The "craving, nurturing and caring" he referred to also reflected a deep relational connection.

The importance of relationship was also seen in the parents' narratives. Susan appreciated the help her daughter was receiving. However, she also greatly appreciated that staff take time to ask her how she was doing; taking the time to connect and recognise that the parents also experience a range of stressors. By doing so, she felt she had an ally – someone 'on her side':

No, look what's helped me with the – time. I think just time. And talking about it of course. Being able to – I think also with - what I've found with Barrett was that there always someone to talk to. Yeah. Just always asking – because everyone would focus so much on Tegan - which is great. Understandable and that's what I wanted – but for someone to actually say now and then "How are you? How are you coping? Are you okay?" That sort of – it was almost like someone's on my side too. (Susan)

As stated above, this theme contained a valuable experiential richness that is a most useful starting point for understanding the inpatient experience. All the participants – adolescent, parent and staff member – could verbalise concrete experiences of the various relationships at the Unit. Some were perceived as negative, others very positive. The narratives revealed that a connection to another was a key developmental and recovery principal for the adolescents. The adolescents themselves verbalised the benefits of a warm, empathic relationship with staff. Interestingly, while the staff

sometimes struggled with the limits of a parenting role, the adolescents failed to mention any specific concerns about viewing the staff as *loco parentis*. They attached themselves to various staff and once on a secure base, saw recovery as less daunting. As one adolescent stated, “*no matter what happens here there’s going to be people around that care*” (Tracey 15yrs). This is consistent with the literature where it has been regarded that despite various models of therapy, the attachment to significant others remains a crucial factor in ameliorating symptoms of mental illness (Moses, 2000). The stories of these adolescents would confirm this.

Not surprisingly then, any breach of these relationships was keenly felt by the teenagers. Many of the adolescents would be admitted to the Unit with ambivalent attachment styles and as the teacher above stated, the relationship with the inpatients was the “*healing force*”. When this ‘healing force’ was threatened there was a noticeable sense of loss for the adolescents. This occurred even if the relationship was perceived as shallow or temporary. As one stated, “*I don’t feel as if I can talk to them*” and consequently felt “*quite alone, and isolated*”. The effects of attachment rupture with significant others in adolescent inpatient units are not uncommon. In their study of 10 adolescent users of psychiatric services in the UK, Harper et al. (2013) reported that a primary point of concern for the adolescents were any broken therapeutic relationships while connected to the service. In their interpretative phenomenological analysis, they reported that therapeutic termination was difficult for the adolescents as was the subsequent trusting of a new therapist.

Another related element emerges from the adolescents’ perceptions of the importance of therapeutic relationships; that the quality of the relationship seems to be linked to its length. In other words, from the adolescents’ point of view, *it takes time* to develop a relationship that is sufficiently trustworthy and consequently secure. The benefit of a long-stay Unit is that such relationships have the opportunity to be formed. This may well be linked to the fact that prior to the BAC, the adolescents were consumers of a succession of other community-based and hospital-based services. In Florsheim et al.’s (2000) study of the working alliance in a community setting, while there could be a positive working alliance between the third and fourth weeks, it was not necessarily associated with progress. These researchers suggested that for the relationship to have value, it needs to be developed over an extended period of time.

The parents in the present study too, experienced the benefits of a warm empathic relationship. Parents can feel judged by service providers (Kerkorian et al., 2006) and like the adolescents, they want to feel some sense of compassion and want to contribute to their children’s needs (Noble & Douglas, 2004). Other studies of consumer satisfaction show that interactions with staff are a source

of both positive and negative experiences and interestingly in one study, inconsistent nursing staff was cited as one of the difficulties of adolescent residential care (Marriage et al., 2001). Conversely, as Susan in the above extract explained, she felt cared for when a staff member asked her the simple question about whether ‘she is ok.’ The parents in the study were grateful to the staff for looking after their child; many found that the BAC being a ‘one stop shop’ as well as being a long-term Unit most useful. However, it is clear from their experiences that they too appreciated the same care, consideration and emotional containment that their adolescent children were receiving.

The staff in this study saw therapeutic relationships as core business in the Unit. They appreciated the difficult backgrounds and chronic mental health issues the adolescents were facing and recognised the potential healing effects of their relationships on the adolescents. As the nurse stated above, for those adolescents ‘craving’ identification, they can follow the staff around ‘like a puppy dog’. Such therapeutic identification could only occur if there was a sound relationship initially. The experiences of the participants demonstrate not only that a genuine relationship offers a corrective emotional experience, but that unhelpful staff interactions could become a stumbling block to the recovery process. These therapeutic ruptures may well remind the adolescent of past traumas or broken attachments leading to a breakdown in the recovery process (Braxton, 1995). The teacher’s quote above concerning the healing nature of relationships also has ground in the literature where the quality of relationship is important for student outcomes and changes in behaviour (Meehan et al., 2003). The importance of relationship as a vehicle for change is also commonly found in the social work (Bland et al., 2009) and the nursing (Wheeler, 2011) literature.

As the experiences and meanings given are investigated across all participants, the complexities of *The relational hub* within the inpatient Unit begin to emerge. It is clear from the narratives thus far that the adolescents will form alliances and relationships with some staff and not others. Typically for this developmental period, peer relationships will be created with some and not others. Equally, some parents will be drawn to some staff who take the time to offer consolation and support during their child’s stay. Furthermore, staff may engage with some adolescents more deeply than others – particularly if there is an identification that is helpful for the adolescent.

These narratives and emergent themes are consistent with other research in adolescent psychiatric care that demonstrates that parental involvement is important for adolescent treatment and that parents’ positive expectations – heavily reliant on their interactions with staff – are key for any participation in their child’s care (Brinkmeyer et al., 2004).

Finally, this section will end with an extract from my research diary. As the methodology and analytic trail chapters explained, the diary is not considered data, but proved to be a useful reflective tool to help analyse the data. The diary was also used to record significant events during the data collection phase. The extract below recalls some concern on my part regarding the issue of slow data collection. However, after some reflection after a morning meeting at the BAC, my concerns regarding the interviews were relieved:

Week ending 7/10/11

It's been a frustrating week for recruiting participants. Two have recently declined and I am running out of time to get sufficient numbers. I was thinking of the original plan for an external researcher to approach the adolescents rather than their CC [care nurse coordinator]. Maybe that would incline them further to get involved. My doubts about who should approach the adolescents and who should do the interviews were removed this morning though. Some adolescents piped up in the morning meeting complaining that student nurses would read their files, but have no actual contact with the kids. As one said it's "about our deep stuff" and "they don't work here and we don't know them". The [Psychiatry] Registrar asked them "Do you feel comfortable in talking to someone about your stuff when they are here 2 or 3 days a week?" "No" was the firm response. It confirmed to me the reality that to do this research requires someone who the adolescents are well acquainted with, and whom they can trust and relate to. In other words, a practitioner.

Scott (1997) argues that the personal responses of the researcher, rather than potentially 'contaminating' data, can help demonstrate the complexity of the research process. The diary extract above reinforced the usefulness – and I would argue the necessity – of an insider perspective for this research. A core sub-narrative of this theme is that trust is crucial before an adolescent is ready to self-disclose. Given the narratives examined so far, I suggest that unless there is a consistent, authentic and sufficiently extended relationship, the material above and that which is to follow would be difficult to extract.

Principal theme 2: Recovery from afar

This theme represents the experience of being able to 'wait' for recovery; that is, to remain hopeful of a better future despite difficult circumstances. Recovery for the adolescents represented a yet-to-

be-realised state where they could once again enjoy life with hope and purpose. It also represented a ‘now and not yet’ mindset where they are in the process of recovery, but there remained an ‘ideal’ recovery still on the horizon. Consequently, the notion of hope played an important role.

The picture below taken by Tracey richly encapsulates much of the recovery experience – for adolescents, parents and staff:



This picture I really like it because it's almost like the side of the lake that I'm on is I guess Barrett and my illness, and everything that's gone wrong, and I've gotta try and cross the lake to get to the other side where it's – I don't know – freedom and recovery and stuff. But if you look I'm not wearing the

right clothes to get across. So there's like no boat or no walk or anything. And so I'm at the tree I guess puzzled and upset because I have no idea how I'm going to get across there. And it just seems so far away and so pointless and I'm not going to be able to get it. But I know that when the time is right I can just hop into the water and swim across, I guess. (Tracey 16yrs; 2nd interview)

The above has a rich, primary theme of recovery being seen from afar; visible, hoped-for, but distant. This experiential thread was throughout all the participant narratives. In this extract, Tracey reveals the confusion of knowing recovery and ‘freedom’ are achievable. However, using the analogy of ‘not wearing the right clothes’ she likens the experience to being ‘puzzled’ and consequently ‘upset’ about how to reach the bank of recovery. Yet, despite despair and resignation attempting to thwart the process, she declares that she can nonetheless ‘just hop in the water and swim across’. This idea of hope against the odds was a strong component of the recovery process for other participants, as Ashley recounts:



DW: *Okay. Thank you. IA, that's the picture of the butterflies on the lantern. Tell me about that.*

Ashley: *That was a picture I thought for hope, to show that there is hope in every place, no matter how small. And that I'd done a couple of weeks before I took that photo with one of my*

nurses, and on the back of all the butterflies – you can't really see it – but there's writing. We wrote inspirational quotes, and stuff like that, on the back of the butterflies. Just kind of like a lantern guiding us to somewhere hopeful. And, yeah, that was kind of an on the spot idea and we just said "Okay, we're going to do that" and we just did it overnight.

DW: *Is that hope still there, Ashley?*

Ashley: *Hope's always there, even if it's tiny. For me, it's always there.*

DW: *Where does that come from?*

Ashley: *I'm not sure exactly. I guess inside myself there's always going to be a part of me that wants to go on, which sometimes I don't like to accept. I think "No, I'm just depressed and I don't want to go on". But I think there's always going to be a part of me that says "Ashley you want to go on, and you don't want to die". So there is a bit of hope in me. Even if it's small. (Ashley 14yrs; 2nd interview)*

In contrast to the adolescents, the parents in this study saw recovery bound with the admission to Barrett. It was, according to these parents, 'the last resort' in finding answers. Consequently, hope rose:

But for us the two years before – it was almost like the two years before that we were actually ready for Barrett by the time we'd gotten to the – and it was like "Oh my gosh!

Thank goodness! Finally got in one environment all your therapists and social workers and doctors, and everyone that she needs. (Susan)

For Cindy, even the acceptance of admission was enough for her to ‘breathe again’:

And that’s where we fought to get her a place in there. And things seemed to change and I knew they would when she went there because it is just set up for more long term stay. Which I have to say gave me a huge sense of relief. And that’s when I felt relieved and could breathe again. And I just felt more a sense of hope because I knew that she’d get all the help that she possibly could there. (Cindy)

Interestingly for these parents – and experienced also by the other caregivers – the fact that the BAC was a long stay Unit brought enormous comfort. Previously, the adolescents of these parents attempted short (1-2 month) stays in acute residential units with little progress. To be admitted to the Barrett Unit therefore, offered a sense of hope and that recovery was indeed possible.

The theme of *Recovery from afar* had meaning for the staff as well. The staff reported a ‘stop/go’ movement with the adolescents which they had to allow for in working with them. As one staff recalled, there is a ‘floundering’ until the adolescent can find a ‘goodness of fit’ with a staff member that allows them to move forward:

They have somewhere to go or someone who's on their side in the process. I think often it's a goodness of fit to a staff member. Often we find kids flounder a bit until they find just that right person at that right time. You can't always just really put your finger on who that might be. I wouldn't have naturally thought of Bob [staff] and Mick [adolescent], but it turned him around. His aggression just petered. He suddenly had a role. (Allied health (3); individual interview)

When asking a teacher about any patterns to the recovery process, there was the acknowledgement of the process not being a clean, linear process:

The students, when they first come in, are great. Then they all get worse. They all get a lot worse...Then, the general pattern is that they start to get better and then they are discharged. So they're good when they first come in, there is a big drop and then there

is a slow, gradual climb back up. That's the pattern I've noticed. (Teacher (2); individual interview)

Recovery from afar is not always seen looking forward. For some staff the recovery process while sometimes lengthy could only be viewed by looking back:

I guess, just seeing the kids come and go, especially go, I really like to see that. That's certainly been a high point, when you see kids who've been here for a long time. I think they always go with a more positive attitude and helped. Do you know what I mean? Even though sometimes we don't think that they're helped enough, when you think back to what they were and what they are when they leave, I think that's a really high point for me, when they actually do move on. (Teacher (3); individual interview)

The above participant revealed a sub-theme that cut across the theme of *Recovery from afar* as well as the next one of *Ubiquitous pain*. That is, staff sometimes experienced a measure of emotional pain and despair at the progress of some of the adolescents. During part of the inpatient experience, the staff member wondered how the adolescent patients would fare; will they leave the BAC better than when they came in? For one allied health staff member, there can be considerable frustration at seeing progress only to be disappointed later with a relapse:

What I have noticed is in the recovery process, as they get better, there are lots of false starts. There are lots of, "Yes, I'm ready, I'm ready" and then pulling back. "No, I'm not ready". "I do something and I can't do anything". I find Casey a lot like that. She's almost ready to move on. Then something happens and she has to start back again. (Allied Health (2); focus group)

When one of the Doctors was asked about the recovery process, he described a process of offering the adolescents a range of therapeutic inputs, but being mindful that there might not be any sign of benefit for some time:

Doctor: I think it always has to be individualised. Not only individualised but one has to go at the adolescent's rate and that's really quite important. It certainly makes manualised therapies very difficult and it also makes research difficult because you might at a certain time, say for instance, with adventure therapy or with sand play or one of the other interventions, an intervention may not mean much to a certain

adolescent but then five or six months down the track they're able to process things differently and it may be really quite pivotal in making changes. (Psychiatrist, sole interview)

However, some staff could recall very positive experiences; ones that they would not have initially expected:

I opened the door one day - the doorbell rang on Sunday. Must have been when Gina and Casey were here because we were locked. And I opened the door and this bloke said "Can I see inside your seclusion room?" and I said "What?" And he was playing – he was on the golf course. And he said "I spent many years in that seclusion room". And I said "Did you?" He said "Yeah, I'm a lawyer now". (Nurse (3); focus group)

Yeah, look, when a parent who you mightn't have seen for a few years come and visit the Unit and they come up and give you a big hug and say, "Thank you for bringing my son back to me!" Or "Thank you for giving us a life again!" That sort of thing is just wonderful. It's very rare to get that in any other setting. You run into the kids a few years down the track, they've gone to university, they've got a job, they've got married, they've got children, they've moved on with their lives. (Nurse (1); focus group)

For the above nursing staff, when a past patient or parent of the Unit returned for a visit – sometimes years later – and thanked them for their input, their past hard work felt so worthwhile. These moments were noteworthy because they gave the staff a sense of hope. It was this hope that encouraged them to continue with the work despite not seeing many positive gains in the short term.

As the literature review demonstrated, the topic of recovery is a broad and diverse area. However, how the concept of recovery is linked with adolescence has not been so well researched and I suggest that because adolescents are a 'developmental work in progress', our conceptualisations need to be grounded in adolescent-generated data (Weisz & Hawley, 2002). The adolescent-generated data in this research revealed that the theme "*Recovery from afar*" is firmly linked with the concept of hope. This is also reflected in the literature where hope has been demonstrated to be an outcome variable in adolescent residential treatment (McNeal et al., 2006). The theme was strong in all the participant narratives. As one teenage girl declared, "*I've gotta try and cross the lake to get to the other side where it's – I don't know – freedom and recovery and stuff*". However, it is also clear that this hope waxed and waned for all participants as well.

As the adolescents recounted their stories of recovery, it was clear that hope could be cultivated through much internal searching and processing. However, it was also closely tied in to their circle of authentic relationships. Throughout the adolescent narratives, it became clear that should any internal hope be lacking, then hope could still be imparted via the input of compassionate others. Often this was imputed via the contribution of staff, but occasionally also through peers who understood firsthand the difficult journey mental illnesses created. The photographs in the study strongly suggest that the recovery process was made surer in the context of a supportive and understanding relationship with an adult. Interestingly, the adolescents said little about their parents contributing to their recovery process, but rather focussed on the relationships they shared with staff. However, to read too much into that silence would morph to speculation. In this sample, the adolescents clearly remained attached to their parents and most verbalised how they missed their family while an inpatient.

It also needs to be highlighted that developmentally, adolescence is a time for developing attachments outside the family. Such diversification of attachments assists in the regulation of negative emotions as well as contributing to the construction of the secure base (Scharf & Mayseless, 2011, p. 12). The adolescent narratives continually highlighted the negative consequences of any perceived superficiality of relationships (i.e., casual staff) or when significant relationships were threatened with loss (adolescent discharge or staff relocation). The data in this study therefore suggests that the recovery process of these adolescents was inextricably linked with their immediate relationships. The relationships were fundamental in furthering or repairing the secure base from which to address any mental health issues and were instrumental in generating hope.

While the adolescents clearly voiced their appreciation for these one-on-one relationships, the parents tended to put their hope in the organisation. Being a tertiary Unit, all other community-based and privately-based options needed to be exhausted first before their child could be admitted. For some, this translated into a long and draining journey before finally arriving at the only long term residential Unit in the country. That both psychiatric and educational options were available in the one location was also very containing for the parents. Their continual use of the word 'relief' also suggested a more hopeful future. Their narratives suggested a very draining and sometimes despairing experience in their care of very unwell adolescent children. This is consistent with research that has found that the severity of child symptoms was related to greater experiences of caregiver strain and parenting stress (Vaughan et al., 2013). While not directly investigated in this research, it has been generally accepted that the mental health of the parent and adolescent child can

be closely linked. In one study of 174 eleven to seventeen year-olds with depression (Wilkinson et al., (2013), the association between parent mental health and adolescent mental health was substantiated. However, while there was an association, the study was not able to establish the *direction* of that association or whether it was bi-directional.

This points to the need to systemically address wherever possible, the needs of both generations in order to produce the best possible outcome. The parents' narratives in this study strongly suggested that the quality of their own mental health improved as they obtained fresh hope and an emotionally containing presence through their child's inpatient admission. In other words, I propose that the parents – maybe for the first time – experienced some of their own recovery process.

The sense of hope for the staff was also prominent and like the adolescents and the parents, it also vacillated. However, despite the long-term nature of the adolescents' difficulties, it appeared that any gains made – at all – were sufficient enough to keep the majority of staff working at the Unit. For some temporary or casual staff, this type of work did not fit and they eventually moved on to other areas. This raises questions then, that if hope is such an important variable in the recovery process, how do staff create such therapeutic optimism? While there have been concerns about the negative impact peers and psychiatric facilities generally have on adolescents (Huefner & Ringle, 2012; Taiminen et al., 1998), there is also evidence to suggest that hope can be created and utilised to aid the recovery process (McNeal et al., 2006). Again, given the stories heard in this study, an adolescent psychiatric inpatient Unit can be a stressful experience for all concerned. Nonetheless, it could be argued that working in such an environment demands a reasonable level of personal differentiation and ego strength in order to rise above any emotional fray that so often characterises such organisations. Lipschitz-Elhawi (2009) asserts that workers must have the ability to pull themselves out of any emotional quicksand if they are to help others:

Besides being able to contain hopelessness, anger and anxiety, and to accept them as part of the therapeutic process, social workers must be capable of extricating themselves from passive despair and adopting an actively hopeful stance towards the adolescent (p.456).

Just as every adolescent experiences the developmental lesson of gratification delay, so too was there a sense of 'recovery gratification delay' for staff. They often saw in the adolescents, a sporadic, uneven recovery process. Being a long stay centre, the Unit had the benefit of having the time to create meaningful relationships with the adolescents. Subsequently, this gave the staff

opportunity to view the adolescents' recovery journey over an extended period. It did however in the process, mean that the staff would also vicariously experience that stop/start recovery journey. This required staff to regularly recall that fruit from their labours might not be forthcoming, if at all. This emotional pain felt was, of course, experienced by all the participants and is discussed further below.

Principal theme 3: Ubiquitous Pain

Within this study, the primary experiential themes are regarded as those which are common to all participants and shed insight into inpatient life generally. Ubiquitous pain is such an example where all felt various forms of discomfort or distress, but with varying meanings attached to the experience. By definition then, this was the emotional pain felt by all participants, uniquely experienced depending on individual context.

For example, Ashley's pain was in terms of coming to grips with reality and a lack of control. The lack of control lends itself to a deep fear that manifests cognitively and somatically. The end result is a very confusing loss of orientation:

The reality that you're not always perfect. Sometimes things are going to happen and you won't have control over them. And having no control is one of the scariest things that ever happens. I know when I lose control I just get scared out of my mind. I get to the point where I'm shaking and I can't talk, and I forget where I am, and I just lose all sense of everything. (Ashley 14yrs; 2nd interview)

Living in such an environment and then trying to explain to those outside can be difficult. Meg explained that for her this was very awkward. It is not a boarding school, but the family is still separated. She recounts some of her frustration in trying to answer a peer's question:

It is quite awkward. Usually I've been – I mean because everyone expects you to be in school and they're like "What school are you going to?" and "Where do you live" and my family lives in Townsville so I'm like, "Do I live in Townsville or do I live in Brisbane?" And it is confusing. (Meg 16yrs; 1st interview)

While the BAC was not a medical hospital, it nonetheless had rules and policies regarding food, access to certain areas and expectations of behaviour. The environment then, was a source of pain

for some of the teenagers. Some perceived the facility as being rather overbearing and intrusive, giving way to a sense of anxiety and intimidation as Meg explained in her second interview:



Well if I had to do that differently I'd probably rewrite all the kitchen rules. It's quite – it's not very friendly. Well I mean once again it's scary, intimidating. The font, the words, the bold, the different writing. It's...very intimidating to me. I mean all the kitchen – everything to do with the kitchen for me is intimidating and not like many

people's – well I guess an idea of many people's home kitchens where they're warm and safe and welcoming and a centre for activity and you don't have doors locked there. And you don't have people standing at the door watching you and waiting for you. It's very different.
(Meg 16yrs: 2nd interview)

Meg's experience above was echoed in a number of the adolescents' stories when they compared the BAC to similar places such as home or other places of emotional security. A number of the adolescent participants felt the Unit was not “warm and safe and welcoming” with unfriendly locked kitchens. While the teenagers could acknowledge the necessity of such safety measures, it nonetheless created a sense of confinement; with people “watching you and waiting for you”.

In this controlled environment when fellow teenagers are not doing well, it can create a tense atmosphere. Rick describes a rather precarious environment where it doesn't take much for the other adolescents to be triggered by the difficulties of others. Understandably, he mentions that he appreciated ‘escaping’ such a tense environment:

Rick: Probably all the different dramas that happen on the ward because when we leave the ward we get to escape the tense environment, and over on the ward there's always a tense environment in someone's life and it affects everyone else on the ward so...

DW: *Yeah, okay. Can you give me an example, when things get tense?*

Rick: *Well, for example, with all the new patients that are coming in, like they're bringing in, like, their new problems and they are affected with everyone else's problems that have already been dealt with, or are still in the process of dealing with them.* (Rick 16yrs; 1st interview)

The parents too, felt pain; pain that was felt – as the other participants – simultaneously at a range of levels. Maybe the most prominent for these parents was the self-blame that created a hurtful questioning of self:

And I have felt like the bad parent, and 'what have I done for my child to be like this?' and things like that. (Lana)

However the big burden for me would have to be just the huge – the feeling of guilt and feeling so awful that she was there. (Cindy)

Rarely was there only one emotion or thought process involved. Susan felt a number of things. She felt blamed for doing the wrong thing, guilt for her child's illness and blamed for poor parenting skills. She also felt there was little help at the end; given trite answers with medication as the solution:

And they also try and – like you feel a little bit blamed as a parent. Like "Why is your child like this? What have you done as a parent? How are your parenting skills?" But again there's a lot of focus on that, and then also "Right. This is what's wrong with them! Give them medication and out they go!" (Susan)

For some of the parent participants, the pain extended beyond the parent and unwell child and into other family relationships. For example, in the extract below, Lana revealed what it is like to be spread thinly as a parent, where she is called upon to be the caring parent, not just for the ill child, but for those back at home. She finds it hard to be caught in the middle where her energy is being drained from different directions. A particularly painful scenario is when a sibling of the ill child feels left out in the process. There is a sense of injustice; a sense of the ill child getting more things, more attention and ultimately, more love from the parent. One can understand the predicament Lana found herself in, in trying to explain to younger siblings such a difficult situation:

DW: *Because there's only one mum and saying 'yes' to something means 'no' to others. And I'm wondering what that does to you. Where it's almost like you have to say no to one child in order to say yes to another.*

Lana: *Yeah, that's very hard. Yeah. I've been finding that really hard. Especially – Lucy's fine because she's only just turned four. But Cathy, she's seven turning eight this year and it's really hard with her, because she's like "You're always going and doing stuff with Tracey". And I try and explain that but I'm home with her during the week and Tracey's not home. And she finds that hard. Or if Tracey will come home and you go to the shops and you buy Tracey something she'll be like "You're always buying stuff for Tracey!"*

In dealing with a population with such complex needs, it is not surprising that the staff were also confronted with a range of equally complex decisions to make. Few decisions were straightforward, and as the previous extracts showed, there was a strong sense of adopting a parenting role with the adolescents. Consequently, any decisions were not made lightly and given the sincere desire to help the teenagers, it was a difficult process to decide at what point nothing more could be done:

They can't stay here forever. It's upsetting them and it's upsetting for quite a lot of staff. In fact we have some of our more spirited discussions in case confidence over when to discharge someone or when someone should move on. You're going to have a lot of staff who have different ideas on all of this. Can we help them? Can we continue to help them or is it time to move on and accept the fact that there is nothing much more we can do? (Nurse (3); individual interview)

I think the negatives would be for those who don't move on and it's just hard that they won't or are not willing to take on everything that we're offering them. Yeah. Like they'll just put up a wall and there's nothing we can do. I think that's hard to deal with, as well. (Allied Health (1); individual interview)

For one nurse participant, he recalled that the work sometimes entailed double binds. Some of the parents of the adolescents were not so helpful in their child's recovery. Consequently, difficult decisions had to be made by the staff as to the well-being of the teenager. For some, it meant steering the adolescent away from the parent in the hope of a smoother recovery process. For others, the advantages in having more contact with the parent outweighed the disadvantages despite the

home situation being far from ideal. Here is an important example of one of the primary themes overlapping the different participant groups. In the extract below, the staff response is strikingly similar to the parent responses already noted; that of asking themselves ‘Am I doing the right thing?’:

And we take kids away from their parents. That decision with Matt, basically taking away from the parent and saying he could only go every second weekend. Huge emotional stuff for that. Because, yeah, it's that whole moral ethics thing, it's sort of a thing...Yeah. And Rick. Letting him stay with mum, even though it was a shocking situation. But there's a lot of moral ethical things, and a lot of emotion in "Am I doing the right thing?" (Nurse (1); focus group)

The above parallel extends even further. The parents of the adolescents were blamed by others – particularly by those in authority such as health professionals – for the difficulties their adolescent children were experiencing. The message given to the parents was clearly “Your actions or inaction are the reasons why your child is the way they are”. This experience was also that of the staff. Below is an extract from a frustrated staff member who is blamed for the bad behaviour of the adolescents and despairs at the lack of insight by the management into adolescent issues:

And when the kids do typical teenage things – and you'd think that people with kids would know this – that there's times when the kids are going to be little bastards and do things, that are going to make us look like dicks because they want to – and that's what the kids job is at times. And [manager] goes to meetings and he's there – and things "Well your kids did this, your kids did that!" and I mean well, they don't understand... (Nurse (2); focus group)

Continuing on, we discover more thematic overlay between the participants. Many of the adolescents previously experienced significant physical or emotional abuse and as a result, displayed typical symptoms of being traumatised such as suicidality or significant self-harming behaviour. Particularly for those parents whose son or daughter was suicidal or seriously self-harming, the experiences were subsequently traumatic for them as well. Not uncommon in the helping professions, staff can also be affected by such stories of pain. In other words, there was a common thread of emotional pain for all the participants. For example, the parenting role that the staff shared with the biological parents was therapeutically crucial for the adolescents, but came at a cost:

Yeah. The distress of hearing Gina talk - when she's dissociative and holding her down [in restraint], that would probably be another personally quite touching thing. (Allied Health (3); individual interview)

I just remember hearing about her case and it was probably one of the worst cases that we've had and just how sad that was. I mean, often when [School Principal] has told us about kids who come in at staff meetings, and there's not a dry eye in the house. (Teacher (3); individual interview)

All of the principal themes by definition are themes that are common to all participants and help understand the inpatient experience. *Ubiquitous pain* represents a common experiential thread of emotional pain felt by all participants despite their developmental stage or connection to the Unit. One of these interesting parallels occurred between the parents and staff, who were both blamed for the adolescents' behaviour. As previously noted, the parents in the study clearly experienced significant self-blame for their child's illness. In a study of parental self-blame, Moses (2010b) found that 60% of the 70 caregiver sample felt fully or partially responsible for their adolescents' mental illness. The most common reasons for self-blame were (a) bad parenting, (b) ineffective oversight of their child's mental health, (c) passing on 'bad' genes and (d) negative family environment.

Similarly, a process occurred in this present research where parent blame morphed into staff blame. This occurred when it was perceived by management that the staff were responsible for any misbehaviour by the adolescents. The accusation that, "*Well your kids did this, your kids did that!*" by management to staff could have easily been directed to a parent from a family member or a member of the public. Particularly for the nurses, many of the staff participants in this study reported various stressors in working with adolescent inpatients. This was particularly highlighted in their perceptions of the lack of appreciation and understanding of their professional role at the BAC. As one staff member recalled, it was very encouraging to see gains made by the adolescents and to receive the occasional 'thanks', as they felt validation was rare:

I think that's where you get it from because you don't get it from the organisation - you definitely don't get validation from the organisation. (Nurse (3); focus group)

I suggest that unless there is adequate support and emotional containment from management, the effect could be yet another unhelpful adolescent/staff parallel as Foster (2009) describes:

‘The cumulative impact of the trauma of caring for adolescents in mental distress...is that the fabric of their defences is attacked on all sides and unravels (p.19).

She then suggests that:

The core tasks of the consulting practitioner are therefore to try to provide emotional containment for both the young person and the staff, and to be able to think about and make sense of their experiences; which is filled with intense and continually shifting transference relationships (p.21).

The extracts have also helped to appreciate the manifold pains that the adolescents experience. The recovery process for the teenagers was rarely straightforward. It was often a disjointed and confusing experience ‘seen from afar’. The inpatient experience itself held a range of experiences for the adolescents, ranging from confusion to almost terror. Ashley’s experience of “*I can’t talk, and I forget where I am, and I just lose all sense of everything*” reflects the latter, while Meg’s rhetorical question, “*Do I live in Townsville or do I live in Brisbane?*” suggests a perplexity of where she belongs. As the following theme, *The milieu: hospital & home* shortly explains, physical location can be linked with identity for an adolescent and there is a complicated juxtaposition of meaning for the adolescents as they try to explain their experience to others.

The adolescent participants in this study also experienced pain emerging from their relationships with their peers. There remains however, some controversy as to how severely unhelpful peer influences can be and the effects differ greatly depending on the context of the adolescent (Huefner & Ringle, 2012). For the adolescents in this study, their relationships with their peers were certainly impactful. Some found the experience of being thrust into residential care initially anxiety-provoking, but eventually helpful. Others such as Matt found issues such as peer self-harm confronting. As far as he was concerned, when a male peer self-harms “*He deserves to be punched, right in the ribs*”. His response is not unusual. Deliberate self-harm by an adolescent inpatient often leaves the other teenagers feeling angry or with a burdened sense of responsibility (Crouch & Wright, 2004).

It was interesting that few adolescents mentioned restraint in their stories about their inpatient experience despite being offered sufficient opportunity. The use of seclusion and restraint for adolescents is controversial, with little Australian literature and compounded by international differences in its use (Fryer et al., 2004). What the adolescents did commonly report however, was

any disturbance in the ‘relationship equilibrium’ of the BAC. For some, the change of staff or patients was seen as a rupture in any therapeutic progress. Meg’s comment “*There was a lot of people coming and going, which really affected my treatment*” strongly suggests that any instability in the inpatient relationships were a source of pain for the teenagers. It is noteworthy that in the above extract with Ashley’s photo of herself in the High Acuity section, despite feeling “*trapped in a very sanitary environment*”, the most pronounced facet of her experience was the lack of connection with others. Despite nursing staff being with her 24/7, there was a deeper sense of aloneness and lack of relationship. Ubiquitous pain then, is a collective experience felt by all the participants. Psychodynamic and systemic factors merge, whereupon adolescents, patients and staff require an external Other to contain the anxiety typically experienced in such an environment.

Principal theme 4: The milieu: hospital & home

This theme is defined as the tension or balance of the inpatient Unit being both a hospital and home simultaneously. As a result, there were sometimes confusing or contradictory experiences. For example, the parents were well aware that their child was in a hospital for teenagers struggling with mental health difficulties. They also knew the Unit was their child’s temporary home during the course of their stay, accompanied by many typical ‘home activities’ such as bedtime routine and outings. These teenagers like most adolescents, regularly felt the need to escape and have time in solitude to recharge emotionally (James, 2001).

When Peta was first interviewed she mentioned the difficulty of finding such a spot. By the time of the second interview four months later, she had found such a place for herself as explained in the second extract with photo:

Mmm...I don't really like...there's always the people around, it's very hard to find a spot to be by yourself for a while, like...I don't know, I just don't like having so many people around all the time. (Peta 16yrs; 1st interview)



I just find it really helpful to have a place to be creative and to let your emotions and feelings to come out in just a different way than words and speaking. And I just like how here there's a room just devoted to creativity like that. (Peta 16yrs; 2nd interview)

The significance of physical space was in a number of the adolescent narratives, particularly as they recalled how overwhelming the ward could be sometimes. Samantha's photo below reveals something of the 'craziness' of it all:



DW: 2B is Sam there with the TV, with static in the background, and holding your hands over your ears. Tell me about that one.

Samantha: It's basically like when we're over at the ward and everyone's got things going on, it just gets too much sometimes. And it gets too loud and noisy and stuff like that. And so – and it can really get inside my head and make me feel bad and stuff.

DW: Is that what the static reminds you of, the stuff that's going on inside your head?

Samantha: Yeah.

DW: What's it like to have so much static in your head?

Samantha: Crazy. It's really crazy. You can't even explain what it's like. It's a mixture of feelings and emotions. Yeah. (Samantha 16yrs; 2nd interview)

Again, the value of a qualitative study with photo elicitation proved most useful. Samantha shared that the ward sometimes “just gets too much” especially when “everyone’s got things going on”; suggestive of what can occur when unwell adolescent peers live together. It can escalate to the point where words fail and “you can’t even explain what it’s like”. Obviously from the extracts above, the desire for physical space is linked with the desire for emotional space. These feelings of wanting space are reflective of the restrictive side of residential life; a context where limits and policies must be adhered to. For example, the nurses were required to check on the adolescents regularly as part of their role. Some teenagers such as Meg found this intrusive:

Mostly when I’ve been upset and distressed, and the restrictions that have made it really hard. And the lack of personal space and privacy. And the nurses checking up on you and sharing with other girls, and just lack of – you can’t – there’s no private space you can go, without the nurses being there with you. (Meg 16yrs; 1st interview)

Andy too, found the experience initially difficult especially having to sleep there, but was thankful for the times when he could leave the Unit for some respite:

If I was to describe it to a stranger, I’d tell them it’s a – to be honest, I normally tell them it’s a hell hole. That’s what I used to say. Because I didn’t like sleeping there every day. But it’s a lot better when you sort of get out more. (Andy 15yrs; 1st interview)

When the adolescents could not leave the premises, they sometimes felt trapped. Sometimes they reminisced about home and missed the freedoms they previously enjoyed. Samantha’s photo below captures that experience well:



DW: Okay. Now here you are, in behind some bars here, out in the courtyard.

Samantha: Yeah. That’s I feel really – at night when the doors get locked you feel really trapped because you can’t get out, and you can’t go for a walk. And if you’re at home you’d be able to just go outside and feel the breeze, and stuff like that. But you can’t do that here. I guess it’s for our safety but it kind of sucks in a way.

DW: *As I look at that photo it looks like you're in prison.*

Samantha: *Yeah.*

DW: *And I'm wondering if that comes up for you sometimes?*

Samantha: *Yeah. Yeah, it definitely feels like that sometimes.* (Samantha 16yrs; 3rd interview)

The photo above is both powerful and meaning-rich for Samantha. Once the doors were locked, it declared the restriction of freedom and the creation of two worlds. One is inside and the other is where one can go for a walk and “feel the breeze” which I suggest is another way of stating ‘feeling the freedom’. Similar to many other meanings given by the adolescents, she contrasted her inpatient life with life at home where “you can just go outside”. I suggest that many, if not all, of the adolescents reminisced about home and the freedoms once enjoyed. However, Sam recognised the BAC was locked for safety reasons, but nonetheless lamented the fact. With such a photo, it was difficult for me not to suggest a ‘prison’ analogy. Samantha readily agreed though, that it was indeed applicable to her experience.

Conversely, physical environments can provide a sense of safety and security. Adolescent bedrooms in particular are usually reflective of their personality and interior worlds. Two of the adolescent girls noted this in their first interviews. In the first extract Tracey compares her previous comfortable home to “a psychiatric Unit”:

...when you go home from a really rough day at school you're just like “Yes!” and you go into your bedroom and you can just like listen to music or go on the computer, and it just feels good. Whereas here, it's kind of like, rough day and you're like “Oh, I'm still in a psychiatric Unit!” (Tracey 15yrs; 1st interview)

This place looks so depressing...All the walls are these weird off-pastel colours, and it's just a really depressing environment. (Ashley 14yrs; 1st interview)

The inpatient experience also involved positive elements of the ward being a home as well as a hospital. One element is that of having fun with family or peers. Louise recalled that sometimes life

on the ward can also be like a “mass sleepover” that is reminiscent of other families sitting around the TV:

DW: If there was one thing you would want to keep about Barrett, what would that be? That you wouldn't want to lose.

Louise: I don't know. Because it really depends on my mood at the time. I don't know. Just the fun things that we do. Like the other night when State of Origin was on, we went and got packets of chips and chocolate and Coke. That was amazing. We all sat down and watched the Origin and it was really loud and that was fun. Just the bond. Oh my God, I would never change that! It's so amazing. Sometimes it's really fun. It's like a mass sleepover. (Louise 15yrs; 1st interview)

The recurrent theme of relationship surfaces in this area too. Healthy home life involves steady and secure relationships as well as being taught and encouraged to interact accordingly with ones' family. When the staff population fluctuated, it was deeply felt by the adolescents. For instance, when it was put to Todd what positive aspects of the BAC would he keep, he explained it would be a permanent staff population that created deeper relationships. When this does not occur, one gets the sense of his feeling let down; echoing the experience of children who have sporadic contact with a parent:

Probably having a set group of staff. Because it's good when you can have like a set of staff that you can build a relationship that understands you, instead of having new nurses coming in every week that you have to explain your whole story to again and sort of build up that relationship and then they're gone the next week after that and you don't see them again. (Todd 16yrs; 1st interview)

However, when the relationships at the BAC were perceived to be genuine, it had the capacity to initiate growth and security in the adolescents and the creation of hope for the future:

Like I felt like - before coming to Barrett I felt like no one cared. I had no hope. And what's the point of loving someone when it's hard enough to love your own feelings, let alone care about someone else's. And then when I went to camp everyone was hugging and praising me, and saying how much – and it was just like amazing to see that people actually can care and that there is hope for me to be able to have a good relationship

with people. And all the positive cards and stuff, that was just amazing. (Tracey 15 yrs; 1st interview)

The parents of the adolescents likewise had mixed and simultaneous feelings about the BAC being both a hospital and home for their child. As shown in the other themes, the parents felt relief at the admission of their son or daughter to the Unit. Cindy found the experience very containing:

...and there were nights when I couldn't go to sleep. I had to stay up. I was too scared she would go, run to the train. Because you can't physically control a 16 year old. There were nights even when I couldn't go to sleep, so when she went to Barrett you could sleep through the night - just those little things. Knowing she was safe. (Cindy)

Alex also found the admission a relief, while simultaneously trying to deal with “sending away feelings”:

I suppose the pressure was off from the daily grind of having to go to her bedroom and try and coerce her into getting dressed or talking about going to school. Then obviously there was the sending away feelings because she's going to be there for a [initial] fourteen day stint sort of thing before you could go and see her. But obviously I knew it was good for her so she had to take that step. (Alex)

Typically for all the parents connected to the Unit, these parents above felt relief knowing their child was going to experience a fundamental element of home life – safety. However again, there was a cost involved; the sense of guilt and disrupted relationship that accompanies a hospital stay.

In terms of the staff, they were keenly aware that they were both professionals working in a hospital as well as taking on a parenting role with the adolescents. For one staff member, this was a necessity should the parents not be able to offer it themselves:

We need to keep those tasks of parenting, so if they're not going to do it, we have to step in. (Allied Health (3); focus group)

Another staff member felt that the consistency the Unit brings could offset any previous lack:

The fact that we're very structured and they know what's coming in lots of ways. They know ICW, case conference, and yes that can lead to institutionalisation, but it also can be consistency which they haven't had. (Allied Health (2); individual interview)

The two nurse participants below suggested that one of their roles was to offer that which one would normally experience in families:

I think they experience family that they wouldn't a lot of times experience outside of here. (Nurse (2); individual interview)

Being able to go on outings and show people experiences that they just never got before. They have - some will come from families who've never, ever taken to the beach or taken them to the mountains or taken them to the river to do canoeing. Just experiences that they've never done; it's great to be able to see them do things like that and interact with staff and their peers. (Nurse (3); individual interview)

The staff above believed that one of their primary professional roles was that of providing the tasks of parenting. This was a core belief for the staff at the Unit. Consequently, offering experiences that would typically be found in the family home would also be presented to the adolescents at the BAC. This was balanced with their respective work role depending on the profession. The staff then, aimed to balance up the dual phenomenon of the Unit being both a psychiatric hospital and a caring home for youth.

I suggest that given the above extracts, inpatient life was perceived as both hospital and home. It is, as one study described, 'living in an alternate reality' (Hayes et al., 2011, p. 150). The family environment of the adolescent has been one of the most researched given its developmental importance (Collins & Laursen, 2004; Steinberg, 2000). Characterised by meaningful and secure attachments, any threats to the stability of such can have a number of repercussions. I suggest that this aspect mirrors the experiences of adolescent inpatients.

In their study of thirteen 16-18 year old psychiatric inpatients, Harper et al (2013) argued that loss and continuity were most important for the teenagers and any losses experienced while in hospital may well re-enact past losses or broken attachments. The narratives of the adolescents in this study continually revealed a similar theme where the core feature of inpatient life centred on the relationships. This was most pronounced when there was the use of casual nursing staff or others

who were perceived as not genuine, as well as when staff or other adolescents left the BAC. I suggest that the adolescents in this study may have re-experienced past historical pain when inpatient life mirrored past relational ruptures (Braxton, 1995; Robins et al., 2005).

As described, the milieu also offered some positive reminders of home life such as watching a fun movie with friends or family. As one teenager described it, when the hospital became a giant “sleep over” it was reminiscent of happier times. The adolescents also recounted another aspect of those happier times, when they contrasted the privacy and space of home with that of the Unit. Their stories revealed a developmentally understandable desire for physical and emotional space.

Unfortunately, privacy and inpatient work are often in conflict (Hutton, 2008). In one study where unwell adolescents in a medical ward were asked to design their own hospital, the need for privacy was noticeably high on the list (Hutton, 2005). As one of the teenage girls described above, when it is difficult to find a place of solitude, *“it can really get inside my head and make me feel bad and stuff”*. This has implications for such issues as ward design and how to incorporate developmentally-informed policies for adolescent inpatient units. A fundamental starting point could be the recognition of the importance teenagers place on bedrooms, As Kopec (2006) explains:

Although older adolescents seek affiliation with their peers, they often seek solitary places to relax and gain perspective...Bedrooms are personal territories. Children need and desire their own territories not only for self expression and identification, but also as private places for contemplation and relaxation (pp.147-148).

Arguably the most important aspect to creating a developmentally-informed milieu would be developmentally-minded staff. Staff knowledge and attitudes play a crucial role in how therapeutic adolescent/staff relationships will play out, especially with emotionally-charged issues such as adolescent self-harm (Wheatley & Austin-Payne, 2009). As the staff extracts revealed, the staff participants felt it was their job to simulate the positives of a home environment, including aspects such as discipline and boundaries.

This has implications for such techniques as time-out for misbehaviour. While the technique can be useful in reinforcing limits and boundaries, care needs to be taken that the adolescent is not being punished for some deficit or that important underlying issues are dismissed (Delaney, 1999). One needs to be mindful that the adolescents in this study were there because of the debilitating nature of their mental health difficulties. Consequently, their sometimes difficult behaviours required a

sound understanding of the context that brought them there in the first place. Should such an understanding be lacking, the consequences would be to the detriment of both staff and adolescent. Ward (2003) argues for the importance of the Winnicottian concept of creating a holding environment not just for the patients, but for the staff as well, ‘if they are to feel sufficiently secure and resilient to provide for the children’ (p.30). Some staff divulged a deep sense of professional isolation while at the BAC, and while it is beyond the data in this study to speculate too assuredly on its potential impact on staff-adolescent relations, one can assume it may have influenced at least some staff decision making. The need for staff themselves to be offered emotionally-containing support now becomes apparent; especially in such a concentrated pool of relationships. Sexton (1999: cited in Webb 2011) warns of the potential effects:

The more distressed a client group, the stronger the effects of unconscious counter transference on staff, and the more likely client issues will be repeated within the organisation (pp. 56-57).

Both the literature and the stories of the participants in this study strongly suggest that sound therapeutic practice with adolescent inpatients requires sound anxiety-containing policies and anxiety-containing relationships from Management.

Finally, the parents too, shared common anxieties with their teenage children and the staff who were charged to care for them. The parents were relieved knowing that they had finally found a facility that was long term and could attend to their child’s needs. For one mother, she could finally “*sleep through the night*”. Indeed, a number of the parents’ experiences in this study suggest a very emotionally draining experience; one that speaks of despair, exhaustion and deep anxiety. I suggest that the experience for these parents are similar to other forms of parental burnout such as when one must look after a chronically (physically) ill child (Lindström et al., 2010). I would highlight however, that a physically ill child tends to be more ‘visible’. The parents in this study recalled numerous occasions where friends and family could not understand or appreciate the burden in looking after a teenager with ‘mental’ health issues.

One final observation needs to be highlighted for this theme. Despite the temporary separation of parent and teen, the family system continued to exert tremendous influence on the recovery process as well as developmental growth generally. What was noticeably lacking in the staff-parent narratives were any sense of ‘joint parenting’. It appears that the staff aimed to emulate the tasks of parenting within the milieu. The parents recognised this and, albeit with some sense of

displacement, allowed such to happen. For reasons not yet understood, there appeared to be little narrative about the linkage between these two phenomena. Possibly for the first time, the parents enjoyed their own psychological ‘space’ and appreciated the ‘extended BAC family’ raising their child. Possibly for the staff, it was simply a given that they would absorb such a role. In any case, such amorphous circumstances again reflect the multiple and complex relational structures of the inpatient experience which are elaborated further below.

Principal theme 5: Simultaneous meaning

The last of the five primary themes is one which is entwined with the other four and requires a brief explanation. Throughout the narratives of all the participants, there was a strong sense that the experiences were not clear-cut and this layering of experience was sometimes difficult to make sense of. I suggest that this meaning-making experience was simultaneous. It needs to be acknowledged that there is some debate as to whether one can actually experience two conflicting emotions simultaneously or whether divergent affect is experienced sequentially (Brehm & Miron, 2006). However, given the neurological rapidity of our physiological systems and the fact that this study is not investigating affective experience at such a micro level, it is of secondary importance.

For the purpose of this study, the term ‘simultaneous meaning’ refers to the occasions where the individual concerned felt two or more conflicting processes; equally valid, but all undergone as part of the one experiential event. Consequently, multiple meanings may be attached to the same experience creating a sense of ambivalence. It is also acknowledged that the previous four themes may have contained this aspect. However, after extensively examining the breadth and depth of the stories of the participants, the decision was made for this facet of inpatient life to be a separate theme in its own right.

I suggest again that the adolescents found the photography an exceptional medium through which to capture the meaning of these complex experiences. For instance, Meg’s narrative below is very rich as she explains the simultaneous meaning behind the foyer telephone; used by the adolescents to take calls:



DW: *The telephone in the foyer.*

Meg: *Yes. That's the only telephone that we can – I don't know – use. And if you look at it, it doesn't look like a very happy telephone to be using every day because my mum calls me every night. And so I pick up that phone every night. And if you look at it, it's just – it doesn't look like you could have a happy conversation through the other person on the other line. And it's just – I don't know. It also symbolises that you can't call out. So you've got to wait for*

someone to call in. That's also very – it sucks because you can't just pick up the phone whenever you want and call someone. It also is a fact that if your mum's on the other side of the line and you're feeling very homesick and you want to talk to her you're picking up this ugly rusty old phone to talk to your lovely beautiful mum on the other side. So you don't really feel very happy picking up this phone because straightaway looking at it, it just doesn't show any warmth or niceness at it. It's just – so it doesn't really make the person on the other side of the line feel good. I don't know. (Meg 16yrs; 2nd interview)

Meg explains that there is much incongruence between the state of the phone and those whom she is speaking to via the phone. The phone itself is old and dilapidated, making it difficult to have a “happy conversation” with someone she loves. It has no “warmth or niceness”, unlike her “lovely beautiful mum”. It also symbolises a linkage to the outside world that she misses. However, that aspect is also difficult. Just because the phone is there, it does not necessarily mean the adolescents are allowed to use it. It was BAC policy that calls could not be made from this phone – only taken. Consequently, one has to wait for someone outside to make the effort to connect with those inside, creating a sense of homesickness. All these elements are experienced simultaneously; a mixture of hope, sadness, expectation and longing.

Another example of simultaneous meaning is found in Tracey's photo and narrative below. I suggest that the extract and photo are valuable windows into the experience of all the participants. All participants looked forward to a better place beyond their experience of mental illness. However, all – depending on the perspective of adolescent, parent or staff – were still keenly aware

that the past is still 'present'. Consequently, we again have multiple meanings occurring simultaneously:



DW: *Tell me about this photo.*

Tracey: *Well my scars represent a lot of things and a lot of difficult times. And I obviously cut myself when I was having bad times, and so that was in the past. Yeah. So it's basically that everything on my arm means something different and it means*

something really big to me, but it's in the past. And I've got to try and keep it there, and not let it control me, not let them scars control me.

DW: *So even though you've written "The past is in the past" sometimes it still is in the present?*

Tracey: *Yeah.*

DW: *And still comes up? As I look at it – and tell me if I'm wrong – it's like the scars remind me of, yeah, lots of pain, but it's like you're making a statement that says "No, stuff ya; The past is in the past" and you're rewriting over it?*

Tracey: *Yeah, that's exactly what it's meant to say.*

For Tracey then, the scars tell a story; the story of a painful past. However she attempts to keep that story in the past and not let it dominate her again. Drawing her story out a little more, she readily agreed that there was a rewriting of the past in an attempt to be in more control. The picture itself is rich in symbolic meaning. All participants – adolescents, parents and staff – wanted to 'rewrite stories', albeit from different vantage points.

Tracey also had much meaning embedded in another photograph, this time of a clock; representing both restriction and release:



DW: DW: *Picture of the clock.*

Tracey: *Oh gosh! The clock! Oh my gosh! I don't even know what to say! So much routine is in the clocks at Barrett. When you wake up, when you have your meal times, when it's homework time, when it's bed time. It's just 15 minute Observations so every 15 minutes if you look at the clock then there's going to be a nurse peering through your window or telling you to go to school. At 7:30 every morning it's time to get up and get ready. At five o'clock every day it's dinner time and it's just like clocks are kind of really daunting at Barrett because they can either – you can either be – for me I wait every Friday afternoon for four o'clock because that's when I go on weekend leave, so I'm staring at the clock all the time just like "Hurry up. Hurry up. Hurry up for me four o'clock!" But other times when it's like – I don't know – Sunday afternoon, I'm driving back and I'm just like "Oh my God". I look at the clock and it's just like "Oh". But it can be both - when you look at the clocks it could be like "Yay!" because you're going to do something, or it could be like "Oh my God, I just want to pull the batteries out and just burn the clock!" because it just means so much.*

For Tracey, routine is embedded in the clocks. There is so much meaning behind this mechanism, she doesn't "even know what to say" when we first started talking. The clocks are powerful. They dictate what is to be done and when – regardless of any intrusiveness. However, they can also declare positives such as freedom on a Friday afternoon and one can hear the pleading in Tracey's voice, "*Hurry up for me four o'clock!*" She herself recognises this double meaning and states "it can be both" positive and negative.

Parents too, found themselves struggling with an internal dissonance. All the parents expressed a desire to help their child and their stories suggest a high price paid to find that help. Sometimes in the midst of one experience, there were others superimposed, such as Anne found:

And that's what you feel like – you're really prisoned [sic] by this child. Because you have to be vigilant and always trying to think three steps ahead and counter things, and be prepared. (Anne)

Anne's use of the word "prisoned" suggests captivity to the situation. In the very act of helping and protecting one's child, there is also a sense of being in jail. One has to be "vigilant" and "think three steps ahead" to prevent a tragedy occurring. By doing so, the experiences of love and care are juxtaposed over feeling trapped in a hypervigilant state. Like the other parents, given such pain, Anne felt relief at her child's admission. However, it created another layer of experience; that of giving her parenting away:

So that's been an issue – trying to stay involved and still – because I felt in a way I didn't – you feel in a way like you're abrogating parental responsibility. That the parents becomes Barrett. (Anne)

Lana too, felt that despite willingly admitting her adolescent daughter into the Unit and being thankful for such, there was nonetheless another level of experience; a sense of loss over her familiar role as a parent:

...she's my child, and I still believe I'm the parent, but I feel like sometimes being here that parental role is taken away from you a little bit. (Lana)

At her child's admission, Cindy simultaneously experienced relief, shock and the pain of reality:

...things had progressed so badly it was a mixture of relief, and also total – just shock and just that feeling that your child can't be at home and is in hospital for the reasons that she was. (Cindy)

Stories by the other parents also reflected the theme of *simultaneous meaning*. Their child's inpatient stay was a mixed, sometimes confusing experience. They experienced the prospect of finally receiving long term help for their teenager, a sense of parental displacement, fresh hope for the future, as well as an opportunity to give some time back to children back at home. It clearly became a pivotal point in the life of the families.

Likewise for the staff, there were sometimes contradictory experiences and subsequent unease at making sense of them. The parenting issue was a case in point, where most staff acknowledged such a role, despite the role having sometimes very ambiguous boundaries. The issue of how long should the adolescents remain patients is another, with simultaneous yet dissonant implications. While there was the acknowledgement of the benefits of a longer term stay, it also created potential dependency issues. Where one drew the line was open to debate among the staff:

So that's what I'd say would be the negatives for the kids, that we're delaying that process of potentially moving on to something that's better than us. (Allied Health (3); focus group)

I think this becomes a safe place for kids. So safe that they don't want to leave and then they often sabotage their treatment so that they end up here longer because they're frightened of what's going to happen on the outside. (Nurse (2); focus group)

I suggest again the above extracts are another parent-staff parallel. Given the parenting role staff take on with the adolescents, it is not surprising that it can be difficult to know when to launch them out of the 'family nest'. The staff were obviously concerned about how they will they fare on the "outside", but are aware that there are some necessities of life that they could not provide: "something that's better than us". Consequently for the staff, there is the desire to give what they can, while simultaneously steering away from an unhealthy dependence.

This section shall open with another short extract from my reflective diary:

Week ending 20/5/11

Interesting discussion in Case Conference this week where one of the adolescent boys was being discussed. There was vigorous debate as to whether the presenting issue was one of "can't" or "won't". Such simple words, but loaded with so much meaning! The repercussions for which term 'wins' are far reaching, including treatment issues and discharge. Funny how often the staff are split between the two alternatives, with really little discussion about a 'both/and' rather than an 'either/or'.

The above extract though written midway through the research, still reflects a reality now in the analysis stage generally and in this theme in particular. It reflects that the events and experiences of the participants can have several meanings attached – a 'both/and' phenomena. As the methodology

explained, no efforts were aimed at finding an objective truth in the narratives of the participants, though behind their experiences lay all the various elements of their very real mental health difficulties. The multiple narratives seen thus far are therefore recognised as these various elements of a real phenomenon. Rather than contradictory, they instead bear witness to the many-sided forms of inpatient life. As Ribbens and Edwards (1998) argue:

Rather than assuming that multiple interviews necessarily provide more information (which in many cases they can), it is probably more accurate to say that multiple interviews help to reveal the complexities, contradictions, and tensions in people's accounts and in their daily lives (pp.19,20).

The variegated nature of the data in this research then, reflects the considerable variety and interconnected experiences for the three participant populations. The adolescents were experiencing many processes; living away from home in a hospital that is now their home; living with peers from whom they rarely can escape and in whom they find both solace and distress. They form attachments with adults who offer a nurturing parenting role thereby encouraging attachment while being mindful that this parenting relationship is temporary and will one day come to an end. The adolescents lived through a kaleidoscope of experiences that few other teenagers would ever understand.

The parents likewise felt much internal dissonance while their teenage child was in a psychiatric facility. Similar to other parents who experienced near-burnout with chronically ill children (Lindström et al., 2010; Taylor-Richardson et al., 2006) the parents in this study sometimes may have felt *“really [in]prisoned by this child”* though obviously fought sometimes very hard for a place at the BAC. When it did occur, the initial relief came at a cost with the parenting of their child now shared with an organisation; an organisation that included individuals who sometimes might not be congruent in their management of the adolescents. Still, from the parents’ perceptions, the Unit offered a ‘good enough’ environment for their child and allowed them to take a long-awaited emotional breath. Parenting from a distance was the price they were prepared to pay for any chance of recovery for their child.

This parenting also came at price for staff as well. The regular staff were employed at the Unit for many years; suggesting – given the stressful nature of the work – that they saw their career as something worthwhile; an opportunity to make a difference to troubled youth. They did this knowing observable results would often be slow. Nonetheless, any glimpse of progress, or the

occasional past adolescent consumer taking the time to return later and offer thanks, was all it seemed to take to recharge the emotional batteries for inpatient work. While most staff found the work sometimes stressful, it was the lack of supportive input from some sections of management that they felt was equally disheartening. To what extent this experience aggravated any unhelpful transference issues is still unclear. What is clearer is the necessity for adverse reactions to be revealed and addressed accordingly. Webb (2011) cautions against any tendency to ignore parallel processes in human service organisations. To do so would be to the detriment of all concerned:

Without sufficient reflective practices at individual, team and organisational levels, the risk of client-worker interactions being replicated more broadly across an organisation is increased...If client-worker dynamics appear to be replicated systemically within a team or the entirety of an organisation, a managerial call to action is needed (p.64).

I suggest that the opportunity for reflexive practice is crucial to disentangle any unhelpful elements of *simultaneous meaning*. Contradictions in experience or other contributors to internal dissonance may elevate stress levels and given the close emotional proximity within inpatient life, these stress levels could be easily transferred to other individuals connected with the Unit. Here at the end of the master themes, one can now begin to see the relationship between reflexivity, the phenomenological attending to and valuing of, subjective experience and practitioner research (Finlay, 2011). I argue that without reflexivity, one's own subjectivity will simply be projected onto others and our own unique phenomenological experience will remain hidden. Without openness to the phenomenological lived experience of others – 'back to the things themselves' – we are left with dry empirical observations with the practitioner (and ultimately the consumer) the poorer for it. Conversely, when both reflexivity and openness to the lived experience of others are valued, fresh phenomena may be seen for the first time.

Summary

The inpatient experience is foremost a multifaceted and multilayered experience. While some themes emerged stronger than others, no one particular essence of the experience could claim to be *the* experience. At first glance, these experiences were often seemingly contradictory. However, upon closer examination, the contradictions were recognised as divergent elements of the greater whole as well as being experienced simultaneously. For example, the primary theme of *Milieu: Hospital and Home* reflected this where, due to their mental illness, the adolescents found themselves in the care of a hospital environment while also experiencing the milieu as a temporary home. Equally so, the staff were well aware that they were professionals working in a hospital

environment. Yet one of the very things they attempted to do was to help make the adolescents feel they were *not* in a hospital and to create an environment that recreated facets of home life.

The inpatient experience was also situated in a *strong developmental context*. The experiences of the teenagers were sifted through the lifecycle stage of adolescence. Consequently, as the parents of these teenagers, their families too were immersed in this developmental context. This same developmental circumstance guided the staff in their inpatient work with the teens. This expressed itself clearly in the parental tasks the staff took on in their professional capacity. Finally, the experience was firmly grounded in, and directed by, the *relational interactions* of all participants. These relational interactions between adolescents, parents and staff created a complex relational matrix that was principal to the inpatient experience. A discussion of this matrix in relation to adolescent mental health recovery will now be discussed in the following chapter.

CHAPTER 8 DISCUSSION AND CONCLUSION

Introduction

The preceding two chapters detailed the key thematic findings of the study for each of the participant groups. In particular, Chapter 7 presented a more detailed analysis of the principal themes comprising the inpatient experience. This final chapter synthesises the previous material and summarises the key contributions of the present study. I argue that the study has provided both theoretical and practical contributions to the field. Theoretically, it contends that adolescent mental health recovery must be conceptualised as a developmental reconstruction. Practically, this is facilitated through the 5 principal themes as well as the development and cultivation of a ‘developmental mindfulness’ which entails a firm reflexive stance for practice in the 3 primary domains of practitioner, team and organisation. The thesis began with the topic of mental health practice and shall likewise close on the topic of mental health practice. Limitations of the study are acknowledged, as well as critical reflections on the progression of the data as well the progression of the researcher. The chapter concludes the study with potential areas for future research.

To begin, Creswell’s (2007) criteria in assessing phenomenological research are reviewed:

- Does the researcher convey an understanding of the philosophical tenets of phenomenology?
- Does the author have a clear “phenomenon” to study that is articulated in a concise way?
- Does the author use procedures of data analysis conducive to phenomenology?
- Does the author convey the overall essence of the experience of the participants? Does this essence include a description of the experience and the context in which it occurred?
- Is the author reflexive throughout the study? (pp. 215-216)

I offer the following in response. Firstly, the phenomenological thrust has been recurrent throughout the study, with a phenomenon clearly articulated. Two chapters were given to describing and interpreting the experience and the notion of reflexivity has been valued throughout. The conceptual underpinnings, methods and focus of the present research were all congruent with phenomenological principals, and worked well in furthering our understanding of the inpatient

experience. Uncovering the phenomenon has subsequently demonstrated the benefits of a qualitative, phenomenological methodology for practitioners (Finlay, 2011). One of its strengths has been its ability to capture meaning ‘close to’ everyday experience with its inductive nature encapsulating complex phenomena. In this regard I suggest that the study has created a ‘good description’ of the experience of inpatient life as portrayed by van Manen (1997):

A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way (p. 39).

The present study also falls in line with trends in recent years that investigated the relational aspects of adolescent life beyond the family, as well as recognising various developmental contexts (Smetana et al., 2006). Furthermore, it parallels research trends that explored the impact of multiple contexts in the adolescent’s life (van Dulmen, 2005). This present research then, builds on previous work and acknowledges its contribution.

At the end of the study, the primary and secondary research questions need to be revisited. The key research question that drove the study was:

‘How can the collective experiences of adolescents, parents and staff in a psychiatric inpatient setting inform mental health practice in residential care?’

Closely related secondary questions were also put forward:

- How is the notion of ‘recovery’ experienced by adolescents and how does it relate to the wider literature?
- What meaning is given by the adolescents about their relationships with staff?
- What are the parents’ experiences of having a child in the Unit?
- What commonalities of experience do patients, staff and parents have?

What follows below are the data-driven responses to these research questions, firstly by outlining the key theoretical contributions of the study, followed by the key practical contributions of the study.

Recovery in adolescence: a developmental reconstruction

As the literature review demonstrated, the notion of recovery has various defining features, though historically adolescent mental health has borrowed heavily from the adult recovery literature. During its theoretical and conceptual investigation, this present research uncovered the following:

- The literature on recovery has yet to be adequately applied to adolescent mental health.
- There has yet to be the merging of recovery theory and developmental theory for the benefit of adolescent mental health.
- Consequently what is missing is an adequate conceptual model of adolescent mental health recovery.

Moreover, the review showed that of the extant literature on adolescence, there is much material on how characteristics, attributes or other features of the adolescent influence others; that is, how the adolescent influences their social context. There is also significant research that has explored how the characteristics of the setting influence the adolescent. The present study revealed that there is little material that incorporates a developmental contextualism that appreciates the continuous, bidirectional interactions of *both* spheres. This developmental contextualism recognises adolescence as a multifaceted work in progress; one that both influences the immediate context, as well as being influenced by, the immediate context.

A key theoretical contribution of the study therefore, lies in the demonstration that adolescent mental health recovery must involve a developmental reconstruction. In light of the results of the study, I define such a reconstruction as:

The re-creation of personal resources for mental health recovery that appreciate developmental constraints while pursuing developmental growth.

A brief explanation of the above is required. The notion of ‘mental health recovery’ does not necessarily refer to replicating a previous state of wellness. Rather, it refers to the active, purposeful movement towards emotional and psychological well-being; a mindset of growing towards health. Hence the ‘recreation of personal resources’ points to an active rediscovery of individual hope, meaning and strength towards a better life, regardless of the presence or absence of mental illness. Also, the term ‘developmental constraints’ should not be interpreted too negatively. Adolescents – due to the very lifecycle stage they find themselves in – experience physical, cognitive and psychological boundaries that are typical and normative for this stage of life. As this thesis has

highlighted, these developmental boundaries should be taken into consideration with regard to any mental health context. Finally, despite the effects of mental illness, there are still developmental milestones that will need to be addressed. The degree to which this is achieved will subsequently influence latter stages of life. Therefore, the ‘pursuit of developmental growth’ remains a core task (particularly) during the adolescent years.

Developmental growth is interpreted by contemporary developmental theory. Consequently, this developmental reconstruction is likewise informed by such bodies of knowledge. The sections below are presented as examples of how developmental theory can guide practice in mental health contexts, particularly in the domain of adolescent identity formation.

Firstly, Piagetian theory (Muuss, 1996) reminds clinicians that teenagers will be developing the capacity for abstract thinking and as such, start to imagine a better future; one without the limitations of mental illness (though some will struggle with any idea of a better future). Consequently, they will value input into their own treatment and plans for their lives generally. They will also value a strong sense of justice for themselves and their peers. They may be somewhat militant in their expression of strongly-felt ideals. An example might be the right to personal freedom, but failing to see potential safety issues generated by the sense of indestructibility (e.g., going for an unsupervised walk at night).

Secondly, Erikson’s theory (Erikson, 1963) posits that the adolescent identity crisis was preceded by and built upon, earlier development experiences. Consequently, while the present study investigated the experiences of adolescents, they were all at one stage, children with varying backgrounds that have led them to this point. Some adolescents will have a more secure sense of attachment than some of their peers (trust vs. mistrust) while other teenagers will differ in their sense of achievement (industry vs. inferiority). This should remind all staff working in residential care that each adolescent is unique in their ego strength and other developmental capacities; that chronological age does not necessarily reflect developmental age.

Thirdly, during this phase the creation of a sense of identity is acutely rooted in the present-day interactions with one’s peers. They become the mirror that reflects the adolescent ego that is still a work in progress. During this time, there is intensive peer group involvement; usually a helpful mechanism, though there is always the risk of conforming to the values of others prematurely and creating a sense of dependency. With the many physiological changes that occur through puberty and adolescence, the desire to be seen as attractive physically and intellectually means the peer

group becomes the ego sounding board for the teenager. This has important implications for adolescents in residential care. Given that identity formation is ongoing, and that this can occur in the context of a mental health Unit, caution must be exercised in the mixing of the adolescent inpatient population. Not only do the adolescents vary widely in their particular recovery journey, they also vary widely in their journey into identity formation. Both clinical and policy guidelines must consider that the adolescent inpatients will influence each other; sometimes for better, sometimes for worse. In either case, the social context the adolescents are in, as well as the mental health difficulties they must concurrently address, will have implications for identity formation.

Fourthly, the identity statuses of achievement, moratorium, foreclosure and diffusion (Kroger & Marcia, 2011) can be useful concepts for young people in residential care. They offer some conceptualisation of what the adolescents might be experiencing, and while they should not be accepted too rigidly, they still present a starting point for where the adolescent might be on the road to identity achievement and commitment. They also serve as a reminder to ensure an adequate assessment of any identity stress experienced by the adolescent. Behaviour problems in adolescents have been associated with distress over identity issues (Hernandez et al., 2006) and given that identity distress and mental health difficulties may be reciprocal, the clarification of any identity problems could prove useful (Wiley & Berman, 2013).

The struggles and responses reported by the adolescents that constituted their recovery processes also highlighted the crucial necessity of an adequate individual-environment fit. Linking this with the above observations about having a developmental standpoint, we can now begin to appreciate the potential benefits that residential care could have for adolescent identity. 'Identity, as a psychological structure, is a *self-regulatory system* which functions to *direct* attention, *filter* or *process* information, *manage* impressions, and *select* appropriate behaviours' (Adams & Marshall, 1996, p. 433 emphasis original). All these components of adolescent identity formation are crucial for the recovery process. This underscores the fundamental task of creating an appropriate environmental fit for teenagers during their journeys of mental health recovery. The literature review pointed to little research that linked stage-environment fit with residential care. Subsequently, this present study narrowed that gap by demonstrating such a fit is most important.

The findings also highlighted that the recovery processes were far from linear. Despite the adolescents experiencing the same principal themes, their recovery was still their own unique individual journey as well as being experienced in the midst of their own personal developmental reconstruction. In other words, the recovery process was dependant on many variables. Not only did

the 5 principal themes influence the recovery process, so too did the individual recovery process influence how the principal themes were expressed. As Adams and Marshall (1996) suggest, there is a close interplay between identity construction and any external systems:

An individual's personal or social identity not only is shaped, in part, by the living systems around the individual, but the individual's identity can shape and change the nature of these living systems (p.432).

The above was observed in the experiences of the adolescent participants. Again, the inpatient experience was rarely linear; it involved a number of mutually influential systems at individual, familial and organisational levels. This point is important to recall for all adolescents, parents and staff; to not expect the recovery process to have a consistent, predictable pattern, but rather to be prepared for unexpected disappointments or disjunctures.

The data from the study also showed that a key process in accommodating such disappointment and disjunctures for the adolescents was the relational context provided by the parents and staff. It is here that we can recognise the role parents and mental health professionals play in the developmental reconstruction. The participant narratives indicated that the adults provided a sense of relational and emotional security that buffered the effects of mental illness for the adolescent inpatients. Moreover, this reveals that for the participants in this study, the parents and staff were key influences in the adolescents' developmental reconstruction. The parent participants communicated an emotionally draining experience while they attempted to salvage what developmental normality they could before the BAC admission. Once admitted, a subsequent focus was restoring some developmental familiarity to the siblings still at home.

The staff also were seen by the adolescents as either contributing to or detracting from this process. Numerous times the adolescent participants would recount how some staff would be instrumental to their recovery journey, while disheartened at the responses by others. Those staff who appreciated the developmental stage the adolescents were in incorporated such a mindset into their practice. Providing a parental perspective, offering developmentally appropriate leisure activities and appreciating an adolescent's worldview were all examples of integrating a developmental mindfulness with accepted recovery principles.

In this regard, the present study both confirms and challenges the utility of recovery theory. It acknowledges and confirms underlying recovery principles such as maintaining hope, living well

despite the presence or absence of mental illness, meaning and empowerment. However, the present study also challenges mainstream recovery theory, by revealing the lack of recognition of developmental factors for young people. The notion of a developmental reconstruction must therefore be assimilated into the adolescent mental health recovery literature.

How this reconstruction is assimilated in relation to residential care is equally important. Herein lies the practical contribution of this present research; that each of the principal themes can act as a guiding template for practice in adolescent residential care. Below I have outlined each of the principal themes and their contribution to adolescent residential care work.

The practitioner facilitates recovery via the relational hub

The stories of the participants clearly demonstrated that relationships were the core feature of residential life and that they were the conduit for the recovery process. The fact that all the participants had this theme at the centre of their narratives reveals the importance and significance of this element. A representation of this inpatient experience and the principal themes could be depicted as follows:

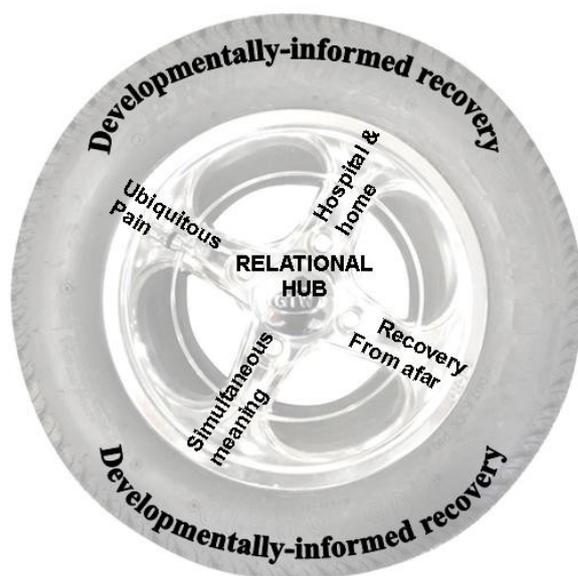


Figure 9: A visual representation of the inpatient experience

As the depiction on the left shows, all wheels contain hubs at their centre; their job being to transfer energy outward. Likewise, I suggest that relationships were the key domain of the inpatient experience that ‘energised’ and directed inpatient life. They correlate with the critical realist notion of hidden, yet real influences of a stratified reality (Houston, 2001a). These influences were ‘real’

given their observable impact. For instance, the relational hub was expressed through ubiquitous pain in the way relationships were perceived in the recovery process. Should an adolescent experience solace in a therapeutic relationship from staff or peers, emotional pain would subside. Conversely, shallow responses from staff or emotional contagion from peers could instead contribute to their pain.

At this point, some clarification is required in terms of locating the issue of *causality* in the above figure. The conceptual framework previously explained that one of the areas of interest in this research was the exploration of any unseen mechanisms that might generate events. One could get the impression for example, that the relational hub ‘caused’ certain effects. While this theme was truly the ‘hub’ for the inpatient experience, caution is warranted in declaring this theme ‘the’ causal factor as Houston (2001b) advises from a critical realist standpoint:

However, in constructing a formulation, the social worker needs to maintain a tentative stance about causal factors. This is because a critical realism perspective promotes the idea that we can only ever achieve a partial understanding (or transitive view) of the real world. This understanding may be refined over time – increasing in its veracity – but it will never reach a point where it has grasped reality directly (contrary to the correspondence theory of truth within positivism) (p.224).

Therefore, the principal theme of *the relational hub* while a key mechanism in the inpatient experience, is only one of several. Each mechanism influenced, and was influenced by, the others. Nonetheless, this theme is consistent with previous research that demonstrates that relational matters are usually the key elements in recovery and residential practice with adolescents (Rabley et al., 2014; Soenen et al., 2013; Soldevila et al., 2013). In this capacity, the present research builds upon previous studies. However, it also closes the gap in terms of first-hand accounts from the adolescents themselves about the role of relationships in residential care.

A subsequent key finding in this study revealed how intensely *social* the recovery process is (Topor et al., 2009). However, ‘social’ can have a range of meanings depending on the developmental context. For example, in their qualitative study of adolescent recovery from depression and anxiety, Simonds et al. (2013) argued that while adolescents share some parallels with adults experiencing recovery (such as a loss of self) some teenagers have much more difficulty in other areas, such as reflecting on ‘future selves’(i.e., beyond the illness) due to developmental constraints. They point out that the term ‘social’ is often quoted within adult and adolescent conceptualisations of recovery. These researchers argue that more investigation is needed to explore how concepts such as ‘social’ can be reconfigured for adolescent recovery.

Arguably, this present research has contributed to such an investigation. The results demonstrated that recovery is deeply embedded in a number of diverse and sometimes challenging relationships, and confirmed that recovery needs to be a deeply social process for adolescents. However, the data

also showed how deeply social it was for the parents and staff. The parents' narratives displayed a very clear sense of emotional containment and increased hope with their child's inpatient admission. Subsequent relationships with staff continued to benefit the parents. Equally apparent was how the staff understood relationships and their purpose in the recovery process. They appreciated how therapeutic relationships can be for both parent and adolescent. They offered a listening ear, practical help and clinical wisdom. In other words, the mental health practitioners at the BAC facilitated the recovery journey through relationship; the 'hub' – from which other facets of the inpatient experience were extended.

The practitioner pursues hope in the midst of delayed recovery

As the previous sub-themes and principal themes revealed, if one could delay gratification for recovery and remain hopeful of a better future, then one's general sense of well-being might be enhanced accordingly. Some of the adolescents for example, experienced considerable suicidality, self-harm and despair. Yet in the midst of such emotional darkness, some could still declare that recovery – despite being seen away off – remained achievable. An internal struggle sometimes prevailed though, between the desire for recovery and the inertia of despair. As one adolescent lamented, *'I guess inside myself there's always going to be a part of me that wants to go on, which sometimes I don't like to accept'* (Ashley 14yrs; 2nd interview). They saw 'recovery from afar'.

The parents likewise viewed recovery for their teenage child in the distance, though 'brought closer' by the admission to the BAC. Their particular narratives suggested that their hope was invested in the organisation; that they had finally found a facility that could do what other treatment facilities could not do. This was evidenced in the deep sense of relief at the admission as well as being able to re-focus on other priorities back at home. Prior to the BAC, the parents recounted a long and stressful process of 'hanging on' until their fortune changed. The descriptions of their experience resembled that of burnout. One got the distinct impression that they were 'hanging by a thread' before the admission and should the BAC not have been available, their predicted futures were extremely dark.

Similarly, the staff 'clung on' to hope, realising that signs of recovery could take a while to emerge. After seeing many adolescents come and go at the Unit, they realised that they had no choice but to be patient; understanding that despite the hard and intense work from multiple staff, there still could be the chance of no observable benefit of the inpatient stay. This element of the recovery process must be highlighted; that the recovery journey demands the ability to 'sit' with pain or despair while not losing hope. That is, the recovery passage *simply takes time*; with 'recovery' understood as a

process in the present, as well as a longed-for dream in the future. Dealing with the present while aiming for the future has been conceptualised as recovery ‘in’, as Davidson and Roe (2007) suggest:

We understand recovery “in” mental illness to refer to a process of minimizing the destructive impact of the illness while simultaneously identifying and building on a person’s strengths and interests in order for the person to have an identity and a life beyond that of “mental patient” (p.464).

The above formulation of recovery complements earlier thoughts on a developmental reconstruction. As adolescents are a ‘developmental work in progress’, the recovery process is not one of ‘return’ to health, but one of ‘towards’ health. This nuance is important, directing one’s efforts at what is possible, rather than what has been lost.

Finally, some staff could recall – with a deep measure of satisfaction – the occasions where a prior consumer would take the time to return and let the staff know they were doing well; suggestive of the attachment they shared with staff. Or, a parent might exclaim, “*Thank you for giving us a life again*”. I suggest that the ability to tolerate delayed recovery gratification for any of the participants was firmly connected to the aforementioned relational hub. Whether this relational hope was transferred from staff to staff, staff to parent, or parent to teen, given such a stressful context, only a secure relational base would have been sufficient to see the process through. This also is a key contribution; *that it is not just consumers who must experience the recovery journey “in” mental illness, so too do parents and staff*. These parallel experiences have not been adequately captured in the literature until now. Whilst the place of hope in recovery has been documented in the literature (Copic et al., 2011; Lipschitz-Elhawi, 2009) this study presents a novel approach by collating the experiences of three participant groups mutually connected by the goal of adolescent mental health recovery. It subsequently points to the importance of practitioners ‘creating’ and ‘fostering’ hope in the midst of what is often a confusing and painful journey (Lipschitz-Elhawi, 2009).

The practitioner facilitates recovery while managing hurt and unrealised dreams

The inpatient Unit and the topic of this research are at various levels, pain-laden; pain that was ubiquitous. Another key finding reveals that such pain was both diluted and sometimes intensified by the relational structures of the Unit. The best example emerged from the adolescent narratives. The adolescents spoke on numerous occasions about how relationships were central to their inpatient experience. Positive relationships with staff or peers were described by the adolescents as

being deeply appreciated and had a direct bearing on their recovery process. Other relationships, whether adult or peer, were sometimes viewed not so favourably and also had varying degrees of impact on their recovery journey.

The parents equally experienced pain from various sources that formed part of their inpatient experience. Like their children, their pain started before the BAC when their child's mental illness began to emerge. Guilt, loss and despair formed much of their pre-BAC experience. However, upon admission, this morphed into a sense of parent displacement despite the benefits of admission. Still, the parents recounted how compassionate staff helped direct this sense of alienation away to look towards a chance of recovery for their teenager. This represents another key contribution of the study; that of increasing our knowledge of the parental experiences of loss and pain while caring for a psychologically unwell child.

The staff too, were very aware of the pain that accompanied adolescent mental health issues. They saw firsthand the self-harm, suicidality and hopelessness that mental illness can bring. For some, they also had the experience of being unappreciated and misunderstood from management, presenting them with yet another source of pain. Indeed, some of the staff were explicit that it takes a certain type of worker to be in this area, given the discomfort experienced.

Again, recovery is a process that occurs in the midst of pain. All participants experienced pain or distress either as one *experiencing* recovery (adolescents) those who *searched for* recovery (parents) or those who *facilitated* recovery (staff). One of the strengths of this research has been its capacity to capture such pain from three different, yet connected standpoints. The use of such first person recovery narratives has the capacity to move beyond the pain associated with mental illness and discover fresh stories that do not fit the sometimes fatalistic or deterministic constructs that tend to dominate the public (and professional!) sphere:

Recovery narratives are an important resource...These stories provide an alternative “counter plot” that challenges and overturns the master decline narrative, the story of inevitable life-long disability that holds the out-moded “chronicity” or “deficit paradigm” in place...We must appreciate, recount, and add to our storehouse of recovery narratives (Ridgway, 2001, p. 342).

I suggest that despite the ubiquitous pain that mental health practitioners will experience, they nonetheless must seek out such ‘alternative counter plots’. By doing so, they will encourage the adolescents ‘toward’ growth and contribute to their developmental reconstruction.

The practitioner facilitates recovery in the context of both hospital and home

For the adolescents, residential care clearly had a dual, yet equally valid meaning. On the one hand, the adolescents were in a hospital context with the aim of addressing significant mental health issues. The photographs that the adolescents took revealed how aware they were of this and they sometimes lamented the sterile elements of the Unit. On the other hand, they also experienced memorable comfort, guidance and nurturance. Even in the midst of living with unwell peers, their adolescent friendships in the BAC still could offer solace from those who had experienced firsthand the same struggles. In distinction to these helpful relationships, there were others that were seen as less than helpful. In particular were those occasions where knowledge of a person was built around the contents of an adolescent’s file rather than the adolescent. However, the Unit was also seen in the context of a home, with multiple parents and siblings. The teenagers could also recall fun times in the milieu; times reminiscent of a ‘long sleep-over’.

The staff likewise expressed their relational activity in these two primary ways. Being health professionals, they understood the importance of a sound therapeutic relationship during the helping process, contained within certain professional boundaries. They understood that the adolescents were temporary patients in a government facility. However, they also appreciated the parenting tasks they were called to do and sought to offer the adolescents a secure emotional base. Being mindful of the biomedical nature of the facility and the ‘tyranny of distance’ experienced by some adolescents and their families,⁵ they took upon themselves to offset a ‘hospital culture’ and create an atmosphere that more resembled a home.

The parents too, were keenly aware of contradictory elements. They were highly relieved at the admission and experienced firsthand the emotional containment that comes with considerate and compassionate staff-parent relationships. They were equally aware that it was a long-stay residential Unit which became home for their teenage children. Subsequently, their parenting role was diminished with a resultant sense of anxious displacement.

This particular finding then points to recovery in residential care occurring in an environment that has a dual and sometimes contradictory nature; that of hospital *and* home. This has significant

⁵ Recalling that the Unit serviced the entire state of Queensland.

implications for practitioners creating a developmentally-informed milieu that subsequently facilitates the aforementioned developmental reconstruction. The data highlighted the necessity to develop an adolescent-centred framework for recovery and given the residential context, the psycho-physical environment must reflect this. For instance, one of the sub-themes for the adolescents was that of ‘teenage comfort’; that which represents typical adolescent comforts that are developmentally appropriate such as privacy, leisure and individual pursuits. Both adolescent and staff accounts revealed that residential facilities for adolescent mental health recovery must be developmentally cognisant of such features in order to achieve best possible outcomes. The practitioner can facilitate this by incorporating an appropriate developmental standpoint that appreciates and caters for the maturational needs of adolescents.

The practitioner facilitates recovery while accommodating compound meanings

With such a complex environment, it is understandable that the meanings given to personal experience can be seemingly contradictory or confusing. Especially for these adolescents who, by the lifecycle stage they were in, had to accommodate and assimilate a range of both organisational and developmental processes such as the influence of peers, residential culture and sense of displacement at being an inpatient. These experiences were common to all, though experienced and expressed uniquely.

The parents also experienced this. Long before the admission, they knew the effort they put into the lives of their unwell teens, only to still receive messages of blame, failure and misunderstanding by others. Self-doubt was the result. However, while their relationships with staff were far from perfect, they nonetheless felt that relational energy being expressed in the sympathetic containment they received. As a parent recalled in her conversation with the Registrar, *“We will help her and we will fix it” and I’d never heard that...And that was a big thing for me’*. I suggest that some of the previously unhelpful messages the parents in this study received were diminished by the curative relationships they experienced at the BAC. In similar fashion to their teenage children, they too experienced a corrective emotional experience, though their narratives revealed they often held the contradictory messages in tension.

The staff were also well aware of the many simultaneous meanings found in inpatient work. Paralleling the parent’s experiences, they too were sometimes blamed for being ‘bad parents’ by those who had little understanding of adolescent mental health care. They too, felt the emotional drainage that accompanies such work. However, in like manner, they also experienced consolation through a team large enough to spread the care and responsibility. Despite typical staff tensions in

such a ‘pressure cooker’ workplace, they could still recall their appreciation of each other and could name the benefits the adolescents received from the team. The sometimes precarious balance of carrying out parenting tasks without the title of parent, was made more steady by the input of colleagues; highlighting again the key role of *the relational hub*.

Finally, accommodating compound meanings can be readily linked with what is known about recovery. The literature contains much material about what constitutes recovery, and how some of the primary elements of the concept involve tension, such as hope vs. despair and now vs. future (Andresen et al., 2011; Davidson et al., 2005; Meehan et al., 2008; Noordsy et al., 2002) This study concurs with such research on recovery, that suggests multiple and sometimes contradictory meanings within the one event are common. Adolescence is a period of accommodating and assimilating many contradictory experiences, and when this is coupled with mental health problems, the difficulty of processing the emotional workload increases accordingly. The practitioner then, can offer him/herself as an ‘external mind’ to adolescents, parents and even fellow staff; one which can help facilitate the emotional processing of the many confusing experiences one finds in mental health recovery.

Further implications for residential care work

As formerly suggested, a developmental reconstruction involves a re-creation of available personal resources that appreciates developmental constraints while at the same time pursuing developmental growth. The previous sections suggested how this could occur in relation to the principal experiential themes. This section presents further implications by explicating the role of reflexivity. However, I shall start first by recalling Geanellos’ (2000) portrayal of an adolescent therapeutic milieu and drawing some parallels with this present research. As the literature review explained, such a definition drawn from robust qualitative research is rare and so again is repeated here:

...the therapeutic adolescent milieu is characterised by lightheartedness, laughter and fun, and by an open unpressured, accessible and homelike environment where the adolescents have opportunities for involvement, companionship, solitude and silence and where nurses provide protection, safety, stability, consistency and attention. The milieu is experienced as a place of respite and shelter; there is a sense of freedom, familiarity, belonging, support and acceptance (Geanellos, 2000, p. 646).

Geanellos’ description of adolescent residential care has a number of elements that coincide with this present research. Firstly, the use of relationship is central; involving “fun”, “companionship”

and “safety”. Essentially, it is ‘homelike’. Indeed, her description seems rather distant from the realities of inpatient life. Nonetheless, her description above parallels the experiences of the adolescents in this study that included outings, watching the football and enjoying positive adult and peer relationships. Secondly, such an environment also presents the adolescents with “opportunities”. This suggests the creation of occasions to develop the adolescents in their respective developmental trajectory. The descriptive use of “freedom, familiarity and belonging” also suggests a two-way relationship between adolescent and staff. Geanellos’ depiction of inpatient life suggests an awareness of the developmental domain in adolescent mental health practice, and seeks to incorporate such into the residential environment. Likewise, I suggest that a key implication drawn from this present research is the necessity for workers in this area to have what I term a ‘developmental mindfulness’. By developmental mindfulness I am recalling that not only do adolescents influence their immediate social context or that the social context influences the adolescent. Rather, developmental mindfulness emphasises a developmental contextualism that appreciates and incorporates the continuous, cyclic and bi-directional interactions of both spheres. The practical outworking of such a position could entail the following.

Firstly, it acknowledges that adolescents are not smaller versions of their adult counterparts. As this study had discussed, there are significant developmental differences between the two groups and these must be taken into consideration when envisioning developmentally-informed residential care. For example, the adolescent participants shared their thoughts regarding the physical structures of the facility. Typically for such a life-cycle stage, the physical environment was sometimes seen as sterile and uninviting. Adolescents often change and create their own immediate environment as an expression of themselves. The principal theme *hospital and home* clearly revealed a double meaning for the adolescents whilst in care and how they would have liked to change some physical aspects of the Unit. The results of this study highlighted the importance of the environment-stage fit for adolescent residential care, and the unwelcome response by the adolescents when their developmentally appropriate needs were dismissed.

Secondly, there are implications for residential care such as therapeutic programs, educational needs and the use of leisure, with such areas usually having a sizable impact on the development of adolescent identity. I suggest therefore, that typical adolescent domains such as leisure and education be seen as avenues to reconstruct those personal resources that mental health difficulties have previously eroded. The adolescents in this study saw the educational facility as a key factor in addressing past educational distress. Their narratives clearly pointed to the benefits of an ‘educational second chance’ through the therapeutic efforts of the BAC teaching staff. Likewise, a

developmental mindfulness must permeate all aspects of residential care in order to best reconstruct the developmental pathways and ultimately, move beyond the developmental moratorium that mental illness often brings. I suggest therefore that an appropriate stage-environment fit during residential care is crucial for adolescent mental health recovery.

Related to the above point is the issue of not just acquiring a good stage-environment fit, but also allowing an adequate amount of time to fully progress. This raises the question of the length of treatment time in a residential facility. Based on the data in this present research, the adolescents required time to develop trust via long-term, stable relationships. Identity formation and role modelling – also elements raised by the participants – were nurtured over an extended period of time. The mental health issues themselves were chronic in nature and simply required time to be addressed. I argue that all these factors cannot be adequately met in short-term residential care. While the data suggests the healing process was psychodynamic in nature, the overall process is far more dynamic, intimate and interactively based; one that formed a large part of its success. Consequently, I suggest that the data from this study advocates for the beneficial nature of longer term residential facilities.

However, the results also revealed a number of processes that are important for residential care regardless of length of stay. In the literature review, an outline of the major forms of residential care were presented (see page 34). It was shown that facets of residential care such as the importance of therapeutic relationships, presenting clinical issues, and subsequent treatments, were common themes for most models of care. I suggest that the principal themes derived from this study are generalisable to many other forms of adolescent out-of-home care.

Finally, there are implications for the staff who work with such adolescents; implications that are most important given this study's focus on informing mental health practice. The principal theme of *the relational hub* clearly demonstrated the repercussions of staff not appreciating the personhood of the adolescents. Adolescence is a time for emerging identity. With the onset of mental illness, that emerging identity may experience a moratorium or foreclosure that could have repercussions for the next lifecycle stage. Practically, this calls for specialisation in staff training that will create a therapeutic team that can be consistent and unambiguous in the goal of adolescent mental health recovery; one that appreciates the difficulty of developmental reconstruction and the necessity of developmental mindfulness. However, I would argue that inherent in any concept of developmental mindfulness is the capacity to appreciate the intersubjective domain; a key dimension of reflexivity

(Finlay & Gough, 2003). Suggestions on how reflexivity can inform residential care practice in the three primary domains of practitioner, team and organisation are now explored below.

The importance of reflexivity in the practitioner

The conceptual framework explained that at the heart of reflexivity is the process of continually reflecting upon our interpretations; of self, others and wider systems. Another finding of the present study was the usefulness of reflexivity in a mental health professional's psyche. Some suggest that as practitioners develop over the years, there is the movement from external expertise to internal expertise, and that this reflexivity becomes the central developmental process for the worker (Skovholt & Ronnestad, 1995). Such reflection is crucial if workers are to utilise relationships in inpatient units therapeutically. In a review of the qualitative literature of how adolescents viewed helping professionals (Freake et al., 2007), there was a high proportion of relational qualities such as being sympathetic, non-judgmental, trust, consistency and respect. Practitioner reflexivity is axiomatic in achieving this as well as having a compassionate view of personhood; recognising that personhood is constructed through relationship (Bland et al., 2009). The results of this study showed that the 'relational hub' drove many facets of the inpatient experience. This cannot occur unless there is a 'good enough reflexivity' as well as a corollary 'good enough compassion' expressed through the practitioner. In exploring the little-researched topic of compassion and its relationship to recovery, Spandler and Stickley (2011) argue that compassionate relationships must be expressed through a healing environment and that 'No amount of rhetoric around recovery, it seems, can substitute for the reality of those actions that provide a catalyst for hope to flourish'(p.563).

The data from the parent participants can also inform mental health practice by noting that there is a 'dual parenting' that occurs within inpatient units and that parental voices can sometimes go unheard. Mental health workers therefore need to be mindful to include parents and value their 'lay knowledge' of their child's situation. For example, in her qualitative study of the experiences of 25 parents who had a teenager with mental health difficulties, Harden (2005) explored 'reskilled' and 'deskilled' parents in their relationship with mental health services. She found that what reskilled parents included (1) critiquing psychiatric knowledge and practice, (2) acquiring knowledge and (3) renegotiating the parental caregiving role. I suggest that these areas of reskilling parallel closely with the areas of the social work practitioner. Each of these respectively call for (1) a critical appraisal of hegemonic knowledge, (2) a reflexivity investigating one's own knowledge and (3) the valuing of parental knowledge. I propose that a reflexive practitioner is obligated to do likewise; with a reflexive – and compassionate – stance.

Finally, reflexive practitioners recognise the usefulness of phenomenology for practice generally and any future practitioner research. Longhofer and Floersch (2012) suggest that phenomenology is a most useful construct to understand the practice of social workers: in understanding the everyday worlds of clients, in understanding our own worlds as practitioners, and thirdly, in understanding ‘what is’ (individuals, families, organisations) (p. 511). They further argue that a phenomenological reflexivity is essential not only for social work practitioners understanding these domains, but also for the wider – albeit controversial issue – of establishing a science of social work (p.512). I do acknowledge that reflexivity itself is not a panacea for either research or practice (Pillow, 2003), but it does encourage the practitioner to consider what hegemonic discourses are being produced and their impact on mental health practice (Larson, 2008; Morley, 2003).

The importance of reflexivity in the team

The present research also points to the necessity of the mental health team incorporating a clear reflexive stance for practice. To illustrate this, I have utilised Boss and Couden (2002) who detail various reasons why ambiguity surrounding an illness can increase helplessness, conflict or anxiety in families:

First, the ambiguity surrounding the illness keeps people confused, so they don’t know what to do or what decisions to make.

Second, the ambiguity surrounding the prognosis prevents reorganization of family roles, rules and rituals. Everyone stays as they were, waiting for the illness to go away.

Third, without the customary markers of loss, the family’s distress remains unverified.

Fourth, the ambiguity surrounding the illness can cause individuals and families to question their view of the world as fair and just.

Fifth, an ambiguous loss of long duration becomes physically and psychologically exhausting. Symptoms may be a result of fatigue more than psychological weakness (Boss & Couden, 2002, p. 1353).

The above observations have two elements relevant to this discussion. Firstly, much is reflective of the parents’ experiences in this present study. They too, experienced confusion, exhaustion and the reorganisation of family life. They also found the interactions with the BAC staff largely supportive and helpful. This suggests that a role for teams could be to act as a reflexive sounding board for parents who are usually in a state of anxious confusion about their child’s well-being. By doing so, teams have the opportunity to challenge some of the myths of mental illness with the parents while at the same time addressing their own biases and assumptions (Moses, 2010b). Geraghty et al.’s

(2011) study of 50 caregiver experiences also revealed that when staff took the time to respond to parent needs, frustration and stress were considerably reduced.

Secondly, if we reframe the above, the experience is strikingly similar to that of the staff participants:

- The staff in this study also experienced ambiguity with mental illness, and sometimes decisions were put on hold, with an uncertain clinical direction. This would have implications for the adolescents and their families.
- Prognosis and recovery prospects at the BAC could also be ambiguous with a resultant 'holding pattern' waiting for a break in the adolescents' recovery journey.
- The teams in this research felt some staff were not suited to this work, with some eventually leaving. It appeared that their assumptive worlds were shaken when exposed to such difficult work and subsequently moved on.
- The BAC team also experienced fatigue and loss of hope. The theme *ubiquitous pain*, by the very nature of the work, is inescapable.

It is argued that reflexivity would help staff make sense of work-related issues such as the above. A team that has such a capacity for reflexive practice is more likely have a greater insight and appreciation for team health, potential burnout and ultimately, adolescent recovery. A team that is open to a reflexive attitude develops a 'collaborative reflexivity [that] offers the opportunity to hear and take into account multiple voices and conflicting positions' (Finlay & Gough, 2003, p. 12).

The importance of reflexivity in the organisation

The findings of the present research also point to the organisation requiring a good-enough reflexivity in the pursuit of adolescent mental health recovery. The data from the staff participants in particular suggested that organisational life can certainly be impactful. Some recalled feelings of powerlessness working in such an organisation. Others reported feeling unsupported by management while some staff recalled the challenges in working in such a large and diverse team. In such a multidisciplinary mental health organisation, professional culture and values may sometimes collide with misunderstanding as a result (Peck & Norman, 1999) or the staff indulging in splitting or projection (Heginbotham, 1999). Consequently, I would argue that a further implication for practice is found in the role reflexivity plays in organisations as 'social critique'; questioning the social construction of power (Finlay & Gough, 2003, p. 14). An organisation that appreciates a reflexive culture is more aware of the potential to objectify both consumers and staff

and the subsequent need to encourage multiple voices to be heard; not just that of the ‘voice of authority’ (Finlay & Gough, 2003, pp. 14,15). Institutional stigma can be as real and as impactful as other forms of stigma (Heflinger & Hinshaw, 2010) and the data from this present research suggests that organisational context can have an important influence in working in such an environment.

Finally, the parent participants suggested that their experience of the organisation was largely positive, though there was a sense of parental displacement as they admitted their child to the Unit. For the adolescents, consistency of staff was perceived as most important in their recovery journey. I argue that these two elements are also organisational issues, and ones that are impactful. Heflinger and Hinshaw (2010) contend that not recognising ‘the multiple and intersecting aspects’ of the young person’s life – such as family – and exclusively focusing on the mental health disorder, is one expression of institutional stigma (pp. 62,63). I propose that the degree to which an organisation is able to reflexively investigate the impact of its organisational practices and subsequently modify them, will to an extent determine how helpful it will ultimately be.

Limitations of the study

While the study researched and depicted the inpatient experience, it will always remain an imperfect picture. Consequently the study will also have limitations. Firstly, generalisability has been questioned in phenomenological research and qualitative research generally (Denscombe, 2003; Morse, 1999). The hermeneutic nature of the study produced one interpretation of the participants’ narratives; other researchers may produce alternatives with divergent findings. Nonetheless, I suggest that the present research offers ‘moderatum generalisations’ where the scope of what is claimed is moderate, as well as being moderately ‘held’ – that which is open to change or adjustment (Payne & Williams, 2002). The extent of generalisation depends on parallels between the topic of study and other sites in which generalisation is attempted (Payne & Williams, 2002, p. 305). Apart from the length of stay for the adolescents at the BAC and a biomedical standpoint, the mental health problems addressed were very similar to other residential circumstances.

Secondly, as explained in the literature review, the underlying therapeutic processes of residential care are common to all models. Morse (2003, p. 892) argues that in extending theoretical generalisations, if the research problem is similar to other settings, the findings can inform other domains and cautions against ‘biasphobia’ paralysing good research. Subsequently, the data collected from this study may be conservatively generalised to similar situations – adolescents in residential settings. Given the congruence of the parent narratives with what is already known about

caregiver strain in raising a child with a mental illness, as well as what has been written about staff working in such an environment, the present findings may extend to similar settings as well.

Due to a phenomenological methodology emphasising individual experience, the present research may be criticised for its lack of expression or capacity for social change. However, practitioner research such as this may initially elevate the awareness of a range of issues pertinent to adolescent mental health and initiate the addressing of organisational concerns. It has also been argued that phenomenology generally does not have a clear ‘recipe’ for research (Dukes, 1984) and the paradigm is limited to those participants who are able to articulate their experience with reasonable sophistication (Willing, 2001). Nevertheless, the phenomenological paradigm has steadily grown in popularity over the years and consequently offers broad, but methodologically sound processes for understanding a phenomenon (Creswell, 2007). In terms of articulating experience, simple exploratory questions were used for the interview schedule, and prompts offered to help the participants articulate their experience. The use of a camera was also a considerable help in this regard.

While the adolescents in this sample were representative of the BAC clinical population, alternative cultures were not available at the time of participant recruitment. It would be worthwhile for future research to include Aboriginal or Torres Strait Islander adolescents and their families or culturally and linguistically diverse populations given their interpretations of identity and family may well differ, giving an even wider understanding of the inpatient experience.

Finally, the issue of intrusive bias might be charged against practitioner or insider research. I use the term ‘intrusive’ purposefully here, as all research has bias and is not necessarily negative. While this has been addressed in the methodology, a brief rejoinder is offered to suggestions of bias or social desirability. Firstly, in terms of initial recruitment and data collection there were concentrated efforts – in part due to firm ethical requirements – to restrict undue coercion via the BAC clinical team’s input through the use of third parties to recruit participants. The distinctiveness of my role as researcher was also emphasised numerous times. In terms of my relationships with the participants *after* the data collection, personal circumstances allowed me to leave my employment at the BAC after the data collection was finalised. This allowed the data analysis to occur *outside* of the Unit with no direct influence from past participants. With regard to ‘data selectivity’, Chapters 6 and 7 purposefully made use of extended extracts to offer a transparent line of reasoning in the creation of any themes.

Notwithstanding the above limitations, the present study has contributed to the body of practitioner research. It demonstrates that practitioners can be researchers and practical data can be the result. Given that the study was situated in the researcher's practice, it sought to recognise and apply the oft-quoted social worker's 'use of self' (Reupert, 2007). It will therefore add to the growing body of practitioner research in social work (Mitchell et al., 2010) and paralleling other forms of practice-based research, '...answer questions that emerge from practice in ways that inform practice' (Epstein, 2001, p. 17). It will provide other practitioners with some initial scaffolding for projects they may be considering. In this regard, this project has revealed some of the more difficult and sometimes frustrating elements of researching one's own practice or organisation. The study has subsequently highlighted the importance of a reflexive, developmentally-mindful stance to data progression and researcher development.

Further critical reflections

As Creswell (2007) suggests of good phenomenological research, it is important to critically reflect on elements of the research process that stand out; both in terms of progression of data and progression as an emerging researcher. Firstly, it is important to acknowledge any unanticipated themes or themes that did not emerge from the study; a transparency that is essential to document in phenomenological research (Smith et al., 2009). In this study three primary observations were noted. Firstly, I expected greater differences with how gender might influence the inpatient experience. The only difference of note appeared to be the way the male and female adolescents processed the 'code black' alarms. The boys seemingly were less affected, while the girls openly acknowledged how it affected them personally and how the alarms were a catalyst for emotional contagion. However, there were other areas that were expressed by some boys such as the impact of others' (male or female) self-harm on them emotionally. The staff did not report any observable differences in this regard. Also, the girls tended to be more creative in the use of the camera. I am unsure if this is reflective of the inpatients at the time or more of a specific gender difference. While this particular study did not pick this up as a primary theme, further research may well do.

Secondly, three of the six males and four of the seven adolescent females were under involuntary treatment orders. This was not mentioned in a single narrative from any participant. Admittedly, this was not the focus, and the interview schedule attempted to be as less intrusive as possible. In hindsight, it may have been preferable to explicitly examine 'involuntary treatment orders' given their potential importance for areas such as treatment goals and relationships with staff. Conversely, given that the issue was not spontaneously mentioned suggests that other facets of the experience were more noteworthy for the participants. The same could be said for medication issues. While

perceptions and adherence to psychotropic medication during adolescence fluctuates for a variety of reasons (Moses, 2011b), this issue also failed to be mentioned by any of the participants. Nonetheless, the primary sub-themes and principal themes for the study were consistent and suggest the key aspects of the phenomenon were adequately captured.

Thirdly, it was initially anticipated that there would be more divergence between the interviews. What primarily surfaced were an elaboration and clarification of various themes such as the role of relationships or ongoing experience of various losses. There were however, some differences noted between the first interviews and subsequent interviews where the adolescents shared some of their anxiety upon initial admission. As time went on, they expressed a more settled position, especially once they had more opportunity to get to know the staff and their peers. Note however, that the photographs were congruent with the interviews. When the adolescent participants discussed the photos they had taken, they were congruent with the overall narrative as individuals, as well as a collective group.

Another key finding of the research is linked with the phenomenological lens and my pre-understandings. In particular, there was noticeable development as a researcher. Each of my pre-understandings and fore-structures were confirmed in the analysis and remained useful concepts to be mindful of during the research process. What was underestimated however, was the *depth* of some of these concepts and their impact in the inpatient experience. Only now after a thorough investigation of the phenomenon, did I appreciate that while an awareness of any pre-understandings of the phenomenon is necessary, so too could the narratives reveal fresh pre-understandings. As Smith et al. (2009) explain:

In other words, while the existence of fore-structures may precede our encounters with new things, understanding may actually work the other way, from the thing to the fore-structure. For example, when encountering a text, I don't necessary know which part of my fore-structure is relevant. *Having engaged with the text, I may be in a better position to know what my preconceptions were.* This is an important and neglected way of considering what happens in interpretation (p.25, emphasis mine).

With the above in mind, I now suggest a fresh pre-understanding that emerged only *after* interrogating the data:

Statement Eleven: Pain is inevitable, but Relationship is a choice.

Interpretation: Regardless of whether one is patient, parent or staff, each will experience various forms of, and varying degrees of, emotional pain during the adolescent recovery process. While this pain is unavoidable, the opportunity to utilise various relationships during this recovery process remains a choice.

Forestructure: Working in the inpatient milieu, the practitioner will witness (and experience) various forms of pain that accompanies being employed in such an environment. However, the worker understands that relationships are the ‘therapeutic glue’ that allows one to hold fast under adverse conditions. Mindful of wider contexts, the mental health practitioner is placed in a position to link individuals, create and nurture hope as well as role model the healing nature of therapeutic relationships. The decision to trust another however, remains an individual choice for adolescent, parent and staff. Should they so choose, a compassionate relationship may well draw an individual out of despair and toward a more optimistic future.

Despite working at the Unit for a number of years, it was gratifying to capture fresh understandings of such phenomena. As the *Analytic Trail* explained, there was a measure of relief during the analysis stage where I incorporated three, rather than one or two standpoints of inpatient life. This required perseverance and an openness to new material during the research process. I too, absorbed a restrictive view of the ‘milieu’ by initially not including the parents. Only after seeking to expand the linkages did I ‘see’ the systemic nature of the experience. The opportunity to analyse the data *after* leaving the Unit also greatly helped my clarity in making sense of the phenomenon. Over the course of the project, there was significant methodological and professional transformation that I believe, resulted in a richer and more informative piece of practice research.

Future research directions

The study has raised a number of areas that would be useful for future research. First, there must be a more purposeful linkage between recovery theory and developmental theory for the benefit of adolescent mental health recovery. This would be the start of a more thorough conceptualisation of an adolescent-centred model of mental health recovery. Hitherto, theory has been heavily borrowed from adult recovery literature. This must change whereby a complimentary body of knowledge is cultivated that encapsulates the developmental domain.

Secondly, on the basis of this study and the wider literature, one of the key tasks of adolescent mental health recovery is a developmental reconstruction; that as the present research put forward, is a rebuilding of developmental tasks. Consequently, more research needs to be initiated exploring how residential life influences the developmental trajectory in general and identity formation in particular. The inpatient environment incorporates a range of developmental features such as access to a social group, education and various parenting experiences. It could prove fruitful for future mixed method studies to measure changes in the adolescents' developmental pathways while qualitatively understanding more fully what enhances or detracts from this.

The interviews of all participants were purposefully oriented to allow them to discuss what issues were most pertinent to them. While some strength-based narratives emerged, more could be explored for all the three participant groups in relation to resiliency (Hawkins-Rodgers, 2007). What specifically enables adolescents, parents or staff members to rise above the difficulties of adolescent mental health problems would also be a worthy contribution to the field. This also raises the suggestion of incorporating phenomenological principles as a therapeutic tool to focus on the lived experience.

In terms of the parents, more needs to be explored around the ambiguous loss they experience and how services help or hinder coping with such loss. Just as potential research could investigate the developmental trajectory of the adolescents while an inpatient, there could also be consideration of the development of the family that remains outside the Unit. The family continues on while the teenage son or daughter remains in hospital. Consequently, the wider impact and 'reconstruction' that occurs at a family level needs to be examined.

Finally, the exploration of diagnostic diversity was not a key feature of the present research. However, future research could explore what relationships there are between different diagnoses (especially anxiety, depression and eating disorders) and residential treatment and the recovery journey.

Summary

This final chapter of the thesis has discussed the key contributions of the study. It contends that the key element in adolescent mental health recovery is a developmental reconstruction. It also elucidated how the 5 principal themes from the participant narratives could act as a template for practitioners working in residential care and has reinforced the importance of reflexivity at different levels. Critical reflections on the progression of the data were put forward, as well as the

progression of myself as researcher. Limitations were also acknowledged. The present study was built upon previous work in the field, and readily acknowledges the efforts that preceded it. I suggest this present research has contributed to the literature, and has ‘grasped the nature and significance of this experience in a hitherto unseen way’ (van Manen, 1997, p. 39).

At the beginning of the thesis, the question “What is this kind of experience like?” (van Manen, 1997, p. 9) was quoted as a guiding thought for this study. In light of the narratives explored throughout the present research, I suggest that the experience captured is complex, rich and fluid. I also acknowledge that what has been captured is still incomplete; that the inpatient experience of adolescent mental health recovery remains larger than this study has explicated. It nonetheless granted the participants an opportunity to voice their lived experience. While I expect further research to be built upon this study, I suggest that the very act of listening to human experience has been a worthwhile endeavour, at a time when many stories still go unheard.

POSTSCRIPT

As explained in the introduction to the thesis, after over a year of considerable debate and speculation as to the future of the BAC (particularly in the media), the Unit was shut down in February 2014. Reasons as to why vary considerably, depending on who one talks to. The official Government position, based on an external review, believed a better, more ‘contemporary’ model of service delivery was needed, as opposed to long-term inpatient care. To date, there are still no concrete plans for such.

Those BAC adolescents who were able, are presently attending another temporary school elsewhere. They then live at home if residing in the Brisbane area. Those outside Brisbane have gone back home, with an uncertain future. In terms of mental health input, they have been discharged back into the hands of community-based Child and Youth Mental Health Clinics, though many staff expect the adolescents who remain unwell to now frequent their local emergency departments in their respective mental health catchment area. It is noteworthy that the teenagers were at the BAC in the first place because the community clinics could not offer the intensive treatment they required.

In early March 2014 I visited the BAC one last time. In keeping with the rest of the thesis, one final photograph was taken – this time by myself. Shown on the following page, it reveals the main entrance to the Centre. However, upon closer inspection, it is locked with packing boxes inside. It seems the theme of *simultaneous meaning* remains even now. While it invites an ‘entrance’, a closer look reveals it is ‘shut’. It was with a sense of hope that the adolescents and parents who experienced its closure would be guarded against further pain and offers of access, only to be denied entry.

Sadly, this was not the case.

From March to August 2014, three young people who were discharged from the Barrett Unit tragically took their own lives. I remember these young people and their families very well; clearly recalling their courage and determination in their journeys toward a better life.

With both sadness and admiration, this thesis is dedicated to these three young people.



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APPENDICES

Appendix A

SELECT LITERATURE REVIEW

Theses – ‘Adolescents in inpatient settings’	Country	Sample	Study
Cimaglia 1991 “Inpatient experiences: Adolescents’ perspectives”	US	Not stated	Small Phenomenological study in partial fulfilment for M.Sc. degree
Johnson, 1997 “The role of adolescent inpatient care”	Aus	Unknown	Unknown; submitted for M.Psy. Med. at Monash University.
Luiker 2008 “Predictors of outcome for severely emotionally disturbed children in treatment”	Aus	159	Explored what child, family and treatment variables affected outcome.
Henderson 2007 “Consumer perspectives of recovery from the effects of a severe mental illness: a grounded theory study”	Aus	15	Qualitative study on adults. University of WA
Frischknecht 2006 “Peer influences on the behaviour of adolescent females in residential treatment”	US	10	Retrospective study (≤ 5 yrs) using mixed methods exploring possible iatrogenic peer group effect.
Nagarajan 2006 “A Qualitative look at social support through the eyes of adolescent girls in residential treatment”	US	21	Qualitative study using interviews exploring social support at a short-term treatment facility
Porter 2006 “Bullying behaviours among inpatient adolescents: Relationships between current behaviour and history”	US	78	Explored possible links between bullying and other psycho/social variables. Information was collected via patient files.

Theses – ‘Adolescents in inpatient settings’	Country	Sample	Study
Money 2007 “Adolescent girls’ perception of change in residential treatment centers: A qualitative study of how treatment works”	US	Not stated	Phenomenological retrospective study of what was most helpful while in treatment.
Gibson 2008 “The experience of change during residential treatment of adolescents”	US	42	Grounded Theory methodology. Interviewed patients, parents and staff.
Anderson 1992 “Evaluating the relationship between milieu countertransference and symptom change in an inpatient adolescent milieu”	US	34 staff 30 adolescents	Quantitative study exploring statistical significance across several variables.
Schwartz 2002 “The relationship between self-efficacy and adjustment on an adolescent inpatient unit”	US	70	Quantitative study exploring statistical significance between self-efficacy and adjustment.
Rederstorff 2003 “Ego development, psychiatric symptomatology, and gender in an adolescent inpatient sample”	US	305	Quantitative study exploring statistical significance between ego development, symptoms and gender.
Greene 2004 “The lived experience of psychiatric-mental health nurses who work with suicidal adolescents in inpatient psychiatric settings”	US	Not stated	Phenomenological study exploring the Nurses’ experiences
Bertisch 2005 “Psychosis and neuropsychological impairment as predictors of outcome in adolescent inpatients	US	102	Retrospective study, 5.9yrs post discharge.

Theses – ‘Adolescents in inpatient settings’	Country	Sample	Study
Radcliffe 2005 “The formation of the therapeutic alliance with the trans-theoretical stages of change in adolescent inpatients”	US	16	Explored whether the therapeutic alliance influences stages of change.
Laursen 1996 “Adolescents’ perceptions of success: A Qualitative study of adolescents in three residential treatment centers”	US	Not stated	Phenomenology & Ethnography methodology. Focused on the notion of ‘success’ in residential care.
Ceaser 2007 “When in Rome: A Grounded theory analysis of service users’ experiences of Ward rounds”	UK	10	Qualitative study exploring experiences of Ward rounds at an adolescent hospital.
Mulcahy 2006 “The relationship between somatic complaints and emotional distress in adolescents in residential treatment settings”	US	56	Correlational study to analyse relationship between somatic complaints and emotional distress. Various quantitative scales used.
Swales 1996 “Psychological processes of change in adolescents in a residential treatment setting”	UK	Unknown	Unknown (could not access)
Norris 1997 “Adolescent and staff experience of self-cutting behaviour in residential settings: a qualitative study”	UK	Unknown	Unknown (could not access)
McHugh 2004 “The role of readiness for change in the residential treatment recovery outcomes among female adolescents with anorexia nervosa”	US	Not stated	Explored statistically significant variables in the concept of change for females 14-19 with anorexia

Journal articles – Recovery	Country	Sample	Study
Meehan et al 2008 “Recovery-based practice: do we know what we mean or mean what we know”	Aus	Nil	Theoretical paper. Adult mental health
Noordsy et al 2002 “Recovery from severe mental illness: an intrapersonal and functional outcome definition”	USA	Brief adult case example	Theoretical paper. Adult mental health (psychosis)
Chadwick 1997 Recovery from psychosis: Learning from patients	UK	Nil	Autobiographical Adult mental health (psychosis)
Borg & Davidson 2008 “The nature of recovery as lived in everyday experience”	Norway	13	Qualitative study exploring experience. Adult mental health (mainly schizophrenia)
Davidson et al 2005 “Recovery in Serious Mental Illness: A new wine or just a new bottle?”	USA	Nil	Theoretical paper. Adult mental health.
Davidson et al 2005 “Processes of Recovery in Serious Mental Illness: Findings from a Multinational Study”	USA	12	Qualitative study exploring experience. Adult mental health (psychosis)
Davidson & Roe 2007 “Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery”	USA	Nil	Theoretical paper Adult mental health (psychosis)
Macdonald et al 2005 “What happens to social relationships in early psychosis? A phenomenological study of young people’s experiences”	Aus	6	Qualitative study In their early 20’s. (psychosis)

Journal articles – Recovery	Country	Sample	Study
Wisdom et al 2008 “Stealing me from myself”: identity and recovery in personal accounts of mental illness”	Aus	45	Qualitative, retrospective. Adult mental health
Jacobson 2001 “Experiencing Recovery: A Dimensional Analysis of Recovery Narratives”	USA	Nil	Theoretical paper Adult mental health
Mancini et al 2005 “Making sense of it all: consumer provider’s theories about factors facilitating and impeding recovery from psychiatric disabilities”	USA	15	Qualitative study Adult mental health
Ochocka et al 2005 “Moving foward: Negotiating self and external circumstances in recovery”	USA	28	Qualitative, longitudinal Adult mental health
Bradshaw et al 2007 “Finding a place in the world; The experience of recovery from severe mental illness”	USA	45	Phenomenological study Adult mental health

Appendix B
INTERVIEW SCHEDULES

Adolescent Interview Schedule (1st interview)

1. MILIEU

- a) Can you tell me how long you have been at Barrett now for?
- b) What's it like for you to live here at Barrett?
- c) What have been the most positive and negative experiences since you have been here?
- d) Tell me how you have found the staff at Barrett.
- e) How helpful do you think living on the Ward has been?
- f) If you had to describe Barrett to a stranger, what would you say?

2. RECOVERY

- a) Tell me a bit about why you are here.
- b) Has your stay at Barrett helped you getting back on track with your life? If so/not, how?
- c) How do you think life would be like if you were not at Barrett?

3. SCHOOL

- a) Can you tell me a bit about how the Barrett school has been for you?
- b) How does the Barrett school compare with your past school experiences?

4. PEERS

- a) Tell me a bit about what it's like to live with other teenagers.
- b) How have you found the 'code blacks' at Barrett?
- c) What is it like for you when some of the other kids aren't doing so well?
- d) Do you see any advantages in having the teenagers living together? If so/not, how?

5. PARENTS/FAMILY

- a) What's it been like to see less of your family since coming to Barrett?
- b) How do you think your family feels about your stay in Barrett?
- c) Has your stay at Barrett changed anything in your family? If so/not, how?

6. SELF CONCEPT

- a) How would you describe yourself as a person?
- b) Has coming to Barrett changed the way you think or feel about yourself? If so/not, how?
- c) How do you see yourself in say, six months?

7. FINAL QUESTIONS

- a) If there was one thing you would change about Barrett, what would that be?
- b) If there was one thing you would keep about Barrett, what would that be?
- c) Is there anything else you haven't told me that might be helpful for me to know?

Adolescent Interview Schedule

(2nd – 4th interviews)

1. When you think about your experiences since our last interview, what stand out for you?
Prompts: Relational, emotional, experiential domains.

2. The exploration and clarification of significant themes derived from the previous interview.
Prompts: Relational, emotional, experiential domains.

3. Photo exploration:
 - a. What was it like using the camera?
 - b. ‘Tell me a bit about the photos you have taken’ ...
 - c. What stands out?
 - d. Anything especially negative?
 - e. Anything especially positive?
 - f. What was that like for you?
 - g. How has that changed since last time we spoke?

Prompts: Relational, emotional, experiential domains.

4. Is there anything that feels a bit unfinished for you that you would like to talk about?

Final question of the study during 4th or final interview:

5. Now that we are at the end of the interviews, is there anything you would like to add about our time together or about the study?

Staff Interview Schedule
(Single interview)

1. Can you tell me how long you have been working at Barrett for?
2. If you had to describe the Barrett Centre to a stranger, what would you say?
3. When you think about the last *X* years, what experiences *stand out* for you personally?
 - a. Prompts: Positive and negative experiences
 - b. Personal meaning of particular events
4. What do you think are the most *positive* experiences the adolescents have at Barrett?
 - a. Prompts: Staff/adolescent relations
 - b. The recovery process
 - c. Peers
 - d. Specific programs
5. What do you think are the most *negative* experiences the adolescents have at Barrett?
 - a. Prompts: Staff/patients/treatment.
 - b. Code blacks
 - c. Contagion effect of peers
 - d. Missing family
6. What thoughts come up for you when you consider the overall treatment process for the adolescents?
7. What have you noticed about any processes of change for the adolescents while they are at Barrett?
8. How do you think life would be like for the adolescents if they were *not* at Barrett?
9. Is there anything else you haven't told me that might be helpful for me to know?

Staff Focus Group Discussion Questions

1. Do you get a sense of if, or how, the inpatient experience is different between male and female adolescents?
2. The school has come up a lot in the adolescent interviews. Can you say a bit from your perspective about the impact of the Barrett school on the adolescents' journey of recovery?
3. The topic of supportive relationships has been brought up in both staff and adolescents in the previous interviews, where the staff take on parental roles with the kids. I'm wondering if you have noticed any difficulties or challenges in any of the roles the staff may have with the adolescents?
4. The topic of developmental tasks for the adolescents has also arisen in the interviews. Could you say a bit about how your particular profession might contribute to addressing the developmental tasks of the adolescents?
5. Some staff have shared how stressful it can sometimes be working at the Barrett Unit. I'm wondering from your perspective what specific organisational, emotional or diagnostic difficulties might impel staff to leave BAC and look for work elsewhere.

Appendix C
VALIDITY CRITERIA

Taken from Whitemore et al. (2001)

Criteria	Definition	Application of Criteria
Credibility & authenticity	To assure that there is an accurate interpretation of the meaning of the data; an accurate reflection of the experience of the participants.	Copious participant extracts to show links between raw data and themes. Pre-understandings made explicit.
Criticality & integrity	A critical analysis that also embraces open inquiry and reflexivity.	An awareness of researcher bias & attempts to make explicit. Openness to contradictions and alternative explanations.
Explicitness	Clarity of the researcher's trail of interpretations.	An awareness of researcher bias and be explicit about same. Use of log trail/chapter 5
Vividness	'Thick descriptions' utilising imagination and clarity.	Emphasis on rich subjective 'emic' experience. Use of photography. Multiple perspectives incorporated.
Creativity	A flexible and imaginative approach.	The use of multiple knowledge bases to explore emerging themes within a phenomenological framework. Use of photography.
Thoroughness	Adequacy of data and sampling, attention to connection between themes and ideas.	Sufficient data has been sought. Comparisons made between themes noted in interviews and coding. A specific phenomena in sufficient depth.
Congruence	Adequate connection between research questions, methods and analysis.	Clear links between the phenomenon, methodology and methods.
Sensitivity	Research that is sensitive and ethically informed. Sensitive to context.	A range of ethical considerations addressed.

Appendix D
Letter to BAC nurses

Thursday 7th October

Dear Nursing staff,

We often hear about the need for research here at Barrett, particularly as we are an extended unit.

Some time back, [REDACTED] graciously gave me the ok for some research here exploring the adolescents' experiences of inpatient life over a period of time. After almost 2 years of preparation, the time has come. The ethics approval was time consuming as well as nutting out stuff with UQ.

Both [REDACTED] and [REDACTED] have given the ok.

The research involves interviewing all adolescents who are inpatients about their experiences here at Barrett. I hope to get a picture of the recovery process, what is helpful, unhelpful etc etc. I have included the information sheets to give you some idea of what the study is about and what will be given out. At the Case Conferences, it will be decided if a particular adolescent is suitable (almost all will be unless there is significant impairment).

In order for the study to go ahead, I need to ask 2 things of the nursing staff:

- 1) Because I am a staff member, I cannot approach the kids themselves. I need the CC to approach the adolescent and if under 18, their parent(s) as well to see if they would like to be involved. I am happy to explain more details when I see you. Involvement is voluntary, but I cannot approach them myself due to any perceived 'coercion'.
- 2) Secondly, I need to distance myself from a therapeutic role for several months. This includes the family therapy. However, I don't need to withdraw completely. I am suggesting that the CC's take any family sessions, with the exceptions that if there is a particularly tricky case, I will have more involvement. I will give the CC one on one supervision as well as one-way mirror supervision during the data collection phase which will last around 9 mths or so. It will be a great opportunity for any nurse to get acquainted with family therapy, and the fact that it will go over several months is quite unique. Rarely do you find any family therapy training that last more than a couple of days! I am happy to give materials, discuss cases, and give some fairly intense family supervision over a period of time. I have quite a lot of material these days, and am keen to share it.

If you have an adolescent who has no need for family work, it is easier. If you do, by offering your help in this regard, you will be helping me do some research that really has yet to be done in Australia. ***The above is voluntary, but I do hope you will take up the opportunity - particularly as the data will be in before we move to Redlands and it may prove very useful in how we do things over there.***

If you have any concerns or questions, please see me.

Regards,

David Ward
Social Worker

Appendix E

Information & Consent Forms



Barrett Adolescent Unit, The Park - Centre for Mental Health

WMSBHSD RESEARCH PROJECT PARTICIPANT INFORMATION SHEET (Adolescent)

Title of Research: "The long sleep-over: an exploration of how consumers, parents and staff navigate life in an adolescent psychiatric unit"

Research Project Contact

Name: David Ward, Social Worker
Address: Barrett Adolescent Centre, The Park, Orford Drive, Wacol 4076
Telephone: 3271 8742 Fax 3271 8743
Email: davidj_ward@health.qld.gov.au

Description of Research Project

The purpose of this study is to better understand the experience of living in a long-term adolescent unit such as Barrett. The aim is to appreciate from an adolescent's perspective what it is like to live here for such a long period. This project is for David Ward's PhD thesis at the University of Queensland.

Participation

Your participation in this project is totally voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with staff at Barrett or The Park.

Your part in the project involves answering David's questions about what it's like to live at the Barrett Adolescent Unit. David will spend some time interviewing you about any positive or negative experiences you have had since coming to Barrett. The interviews will be audio-taped and later transcribed into words. There are no right or wrong answers. David is curious about what you think and feel about living on the Ward, especially given that some adolescents live at Barrett for quite some time.

All together, there will be four interviews over twelve months. If you are not here that long, that's ok. David would still like to interview you. The interviews will take about an hour or however you would like to talk for.

Expected benefits

It is not expected that your involvement in this project will have direct benefits for you apart from the satisfaction of being involved. However, your involvement will help us get a better understanding of what it is like for adolescents to live in a long-stay residential unit such as Barrett. This information might help future consumers of the Barrett Unit.

Risks

There are no risks beyond normal day-to-day living associated with your participation in this project. We are aware that this could be a sensitive topic for you though, and we will completely respect your feelings throughout our involvement with you. However, should your participation in the project at any time cause distress, you have the opportunity to speak to David at any point. If you feel you need to speak to someone other than David, your case co-ordinator is aware that they need to be available if you would like to speak to them. Again, you are free to withdraw at any stage.

Confidentiality

The taped interviews that you complete with David will be written out and personal details like your name will be changed. The only people who will have access to the information will be David himself and his research supervisors. However, your real names will not be used. If photographs are taken for later interviews, they will be changed to protect your privacy. No-one will find out from this study that you are staying at Barrett.

Also, none of the staff at Barrett will know the author of the content in the interviews.

Because the study will be looking at what it is like for you at Barrett, this means that your personal history and your family history are not the focus.

Also, David is a researcher in this study. While he will still be involved in many activities at Barrett, he will not provide any personal counselling or therapy during the time of the interviews. He will still be doing a variety of jobs at Barrett, but during the time of the interviews he will not be as available.

Consent to Participate

If you have considered the study and would like to be involved, we need you to sign a written consent form (enclosed) to confirm your agreement to participate. We also need your parent or guardian to sign as well. Once again, you can change your mind and withdraw from the study at any time. Your case co-ordinator will see you again in three or four days to see if you might be interested.

Questions / further information about the project

Please feel free to see David and ask any questions you have.

Concerns / complaints regarding the conduct of the project

WMSBHSD & Qld Health is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the Research Ethics Officer on 3271 8656 WMHSD_Ethics@health.qld.gov.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner. Or if you wish, you can contact David's University supervisors. They are Dr Rob Bland (3365 1501) or Dr Peter Newcombe (3381 1501).

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.



Barrett Adolescent Unit, The Park - Centre for Mental Health

WMSBHSD RESEARCH PROJECT
CONSENT FORM
(Adolescent)

Title of Research: "The long sleep-over: an exploration of how consumers, parents and staff navigate life in an adolescent psychiatric unit"

Statement of consent

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
• have had any questions answered to your satisfaction
• understand that if you have any additional questions or concerns you can contact David
• understand that you are free to withdraw at any time, without comment or penalty
• should you withdraw, all material from the interviews can still be used for the research
• understand that you can contact the Research Ethics Officer on 3271 8656 or WMHSD_Ethics@health.qld.gov.au.
if you have concerns about the ethical conduct of the project.
• agree to participate in the project

Participants Name _____

Signature _____

Date ____ / ____ / ____

Investigator Name: David Ward, Social Worker, Barrett Adolescent Unit

Investigator Signature: Date:/...../.....

Witness Name:

Witness Signature: Date:/...../.....

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.



Barrett Adolescent Unit, The Park - Centre for Mental Health

WMSBHSD RESEARCH PROJECT PARTICIPANT INFORMATION SHEET (Parent/Caregiver)

Title of Research: "The long sleep-over: an exploration of how consumers, parents and staff navigate life in an adolescent psychiatric unit"

Research Project Contact

Name: David Ward, Social Worker
Address: Barrett Adolescent Centre, The Park, Orford Drive, Wacol 4076
Telephone: 3271 8742 Fax 3271 8743
Email: davidj_ward@health.qld.gov.au

Description of Research Project

The purpose of this study is to better understand the experience of living in a long-term adolescent unit such as Barrett. The aim is to appreciate from an adolescent's perspective what it is like to live in an inpatient facility for such an extended period.

This project is for David Ward's PhD thesis at the University of Queensland.

Participation

Your child's participation in this project is totally voluntary. However, they cannot participate without your permission. If you do agree to their participation, you can withdraw your permission at any time during the project without comment or penalty. Your decision will in no way impact upon your current or future relationship with staff at Barrett or The Park.

Your child's part in the project involves exploring what it's like to live at Barrett Adolescent Unit. David Ward the social worker will spend some time interviewing your child about their experiences they have had had since coming to Barrett. This interview will be audio-taped and later transcribed.

The focus of the study is the adolescent's experience of living at Barrett. Consequently, personal life issues such as family life or family history are not the focus of the research.

All together, there will be four interviews over twelve months. If your child is not here that long, that's ok. David would still like to interview them.

Expected benefits

It is not expected that your child's involvement in this project will have direct benefits for you or your child apart from the satisfaction of being involved. However, their involvement will help us get a better understanding of what it is like for adolescents to live in a long-stay residential unit such as Barrett. This information might help future consumers of the Barrett Unit.

Risks

There are no risks beyond normal day-to-day living associated with your participation in this project. We are aware that this could be a sensitive topic for them, and we will completely respect their feelings throughout our involvement with them. However, should their participation in the project at any time cause distress, they have the opportunity to speak to David at any point. If you feel they need to speak to someone other than David, their case co-ordinator will be available if

you would like to speak to them. Again, your child is free to withdraw at any stage.

Confidentiality

The interviews completed will be typed out and personal information like names will be changed. The only people who will have access to the information will be David Ward himself and his research supervisors at the University of Queensland.

However, your child's real name will not be used. No-one will find out from this study that you have a child at Barrett.

Also, none of the staff at Barrett will know the author of the content in the interviews.

In terms of the content that your child shares with David, it too is confidential and it is up to your child as to whether they want to share the interview content with you. However, in accordance with Barrett policy, should issues of harm surface, (to self or others) the adolescents know that the Team will need to be informed.

Also, David Ward is a researcher in this study. While he will still be involved in many activities at Barrett, he will not provide any personal counselling or therapy during the time of the interviews. He will still be doing a variety of jobs at Barrett, but during the time of the interviews he must keep his roles of researcher and social worker more separate.

Consent to Participate

If you have considered the study and are comfortable with your child being involved, we need you to sign a written consent form (enclosed) to confirm your agreement to participate.

As the child's guardian, you can change your mind and withdraw your child from the study at any time.

Your child's case co-ordinator will call you again in three or four days to see if you might be interested.

Questions / further information about the project

Please feel free to see David and ask any questions you have or call him on 3271 8742.

Concerns / complaints regarding the conduct of the project

WMSBHSD & Qld Health is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the Research Ethics Officer on 3271 8656 WMHSD_Ethics@health.qld.gov.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner. Or if you wish, you can contact David's University supervisors. They are Dr Rob Bland (3365 1501) or Dr Peter Newcombe (3381 1501).

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.



Barrett Adolescent Unit, The Park - Centre for Mental Health

**WMSBHSD RESEARCH PROJECT
CONSENT FORM
(Parent/Caregiver)**

Title of Research: "The long sleep-over: an exploration of how consumers, parents and staff navigate life in an adolescent psychiatric unit"

Statement of consent

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions or concerns you can contact David Ward on 3271 8742
- understand that you can withdraw your child at any point without penalty
- understand that you can contact the Research Ethics Officer on 3271 8656 or WMHSD_Ethics@health.qld.gov.au if you have concerns about the ethical conduct of the project.
- agree to let your child participate in the project

Signature

Date.....

Researcher Name: David Ward, Social Worker, Barrett Adolescent Unit

Researcher Signature: Date:/...../.....

Witness Name:

Witness Signature: Date:/...../.....

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.



Barrett Adolescent Unit, The Park - Centre for Mental Health

WMSBHSD RESEARCH PROJECT PARTICIPANT INFORMATION SHEET (Staff)

Title of Research: "Companionship, Containment and Contagion: The lived experience of adolescents in an inpatient unit."

Research Project Contact

Name: David Ward, Social Worker
Address: Barrett Adolescent Centre, The Park, Orford Drive, Wacol 4076
Telephone: 3271 8742 Fax 3271 8743
Email: davidj_ward@health.qld.gov.au

Description of Research Project

The purpose of this study is to better understand the experience of living in a long-term adolescent unit such as Barrett. The aim is to appreciate from an adolescent's perspective what it is like to live in an inpatient facility for such an extended period.

This project is for David Ward's PhD thesis at the University of Queensland.

Participation

Your participation in this project is totally voluntary. If you do agree to your participation, you can withdraw your permission at any time during the project without comment or penalty. Your decision will in no way impact upon your current or future relationship with staff at Barrett or The Park.

Your part in the project involves exploring what it's like for the adolescents to live at the Barrett Adolescent Unit. David Ward the social worker will spend some time interviewing you about their experiences they have had had since coming to Barrett. This interview will be audio-taped and later transcribed.

The focus of the study is the adolescent's experience of living at Barrett. Consequently, your own personal life issues such as family life or family history are not the focus of the research. However, as you have been working at Barrett for some time, your perspective on their inpatient stay will be most valuable for the project.

There is only one interview for the staff. The interview should take around an hour.

Expected benefits

It is not expected that your involvement in this project will have direct benefits for you apart from the satisfaction of being involved. However, your involvement will help us get a better understanding of what it is like for the adolescents to live in a long-stay residential unit such as Barrett. This information might help future consumers of the Barrett Unit.

Risks

There are no risks beyond normal day-to-day living associated with your participation in this project. We are aware that this could be a sensitive topic for you, and we will completely respect your feelings throughout our involvement with you. However, should your participation in the project at any time cause distress, you have the opportunity to speak to David at any point. If you feel you need to speak to someone other than David, their case co-ordinator will be available if you would like to speak to them, or your professional supervisor. Again, you are free to withdraw at any stage.

The interviews completed will be typed out and personal information like names will be changed. The only people who will have access to the information will be David Ward himself and his research supervisors at the University of Queensland.

However, your real name will not be used.

Also, none of the staff at Barrett will know the author of the content in the interviews.

Also, David Ward is a researcher in this study. While he will still be involved in many activities at Barrett, he will not provide any personal counselling or therapy during the interviews. He will still be doing a variety of jobs at Barrett, but during the time of the interviews he must keep his roles of researcher and social worker separate.

Consent to Participate

If you have considered the study and are comfortable with being involved, we need you to sign a written consent form (enclosed) to confirm your agreement to participate.

You can change your mind and withdraw from the study at any time.

Questions / further information about the project

Please feel free to see David and ask any questions you have or call him on 3271 8742.

Concerns / complaints regarding the conduct of the project

WMSBHSD & Qld Health is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the Research Ethics Officer on 3271 8656 WMHSD_Ethics@health.qld.gov.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner. Or if you wish, you can contact David's University supervisors. They are Dr Rob Bland (3365 1501) or Dr Peter Newcombe (3381 1501).

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.



Barrett Adolescent Unit, The Park - Centre for Mental Health

**WMSBHSD RESEARCH PROJECT
CONSENT FORM
(Staff)**

Title of Research: "Companionship, Containment and Contagion: The lived experience of adolescents in an inpatient unit."

Statement of consent

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions or concerns you can contact David Ward on 3271 8742
- understand that you can withdraw at any point without penalty
- should you withdraw, material from the interviews can still be used for the research
- understand that you can contact the Research Ethics Officer on 3271 8656 or WMHSD_Ethics@health.qld.gov.au if you have concerns about the ethical conduct of the project.

Signature

Date.....

Researcher Name: David Ward, Social Worker, Barrett Adolescent Unit

Researcher Signature: Date:/...../.....

Witness Name:

Witness Signature: Date:/...../.....

You will be given a copy of this Participant Information Sheet and Consent Form to keep for your records.