EXHIBIT 135

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

STATEMENT OF DAVID JOHN WARD

Name of Witness:	Dr David John Ward
Date of birth:	[redacted]
Current address:	[redacted]
Occupation:	Senior Social Worker
Contact details (phone/email):	[redacted]
Statement taken by:	Catherine Muir and Tara Bosworth

I, Dr David John Ward, make oath and state as follows:

1. I hold a Bachelor of Social Work, Bachelor of Arts, Graduate Diploma, Master of Counselling, Master of Philosophy and Doctor of Philosophy. Attached to this statement and marked **DJW-1** is a copy of my current curriculum vitae.

Relevant Employment

2. I have always worked in the area of child and family work that has included non-government child and family counselling, community Child and Youth Mental Health, Headspace, acute child and adolescent inpatient and extended adolescent treatment. I have also been involved in private practice.

3. From October 2004 until January 2013, I was employed as a full-time social worker at the Barrett Adolescent Centre (**BAC**).

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COMMISSIONER FOR DECLARATIONS
DEPT. OF JUSTICE & ATTORNEY-GENERAL
Reg.No.: 10662

4. Since October 2014, I have been employed part-time (38 hr fortnight) as a Senior Social Worker with the Child and Youth Acute Unit at the Robina Hospital (“**Child and Youth Unit**”), located at the Gold Coast . This unit is funded for eight beds for short-term crisis admissions for 0 – 17 year olds.

5. The Robina Hospital also has a separate 12 bed acute unit called the Acute Young Adult ward. It is adjacent to the Child and Youth Unit, and caters for young adults aged 18 to 25 with mental health disorders that require short term crisis admission. This unit also contains an extra 4 beds available for psychiatric intensive care that is shared with the adult population. Also, there is a 27 bed adult mental health rehabilitation unit as part of the Robina Hospital complex. I have no involvement with either of these units.

6. The referring pathways for admission to the Child and Youth Unit are usually through the community Child and Youth Mental Health clinics, or private Psychiatrists. They can also be admitted after an emergency assessment at the Hospital’s Emergency Department. The length of admission varies generally between 2 days to approximately 3 weeks depending on clinical severity. The unit admits child and adolescent patients with a variety of mental health issues, including a high proportion of eating disorders, trauma, mood disorders, self-harming and/or suicidal behaviour and some psychosis. Occasionally an adolescent is admitted for diagnostic clarification.

7. My role is to provide short term assistance. This includes individual and family therapy, group work, and sometimes assisting families to deal with financial issues such as accessing Centrelink or affordable housing.

8. I presently work in a multi-disciplinary team in the Child and Youth Unit. This team includes a Consultant psychiatrist, an occupational therapist, psychologist and nurses trained (though not always) in child and youth mental health. Whilst the admissions largely consist of adolescents (the 12 to 17 age bracket), occasionally children as young as 8 are admitted.

9. As the Child and Youth Unit is only able to cater for short term crisis admissions, the key purpose of the hospital stay is to stabilise the child/adolescent. The longer-term therapeutic work occurs after discharge by the community mental health teams or the private psychiatrist who made the initial referral.

10. I have noted firsthand during my 15 month employment at the Child and Youth Unit, that there are a number of adolescents who experience multiple admissions due to serious psychiatric instability. Those who experience such conditions such as eating disorders, significant suicidality/self harm or problematical family backgrounds can be discharged only to relapse whilst in the community and are subsequently readmitted.

Employment at BAC

11. Despite the challenges of working with adolescents with severe and complex mental health issues, I was very committed to my role as a social worker at the BAC and to the unique role played by the Centre. There were a wide range of conditions that initiated an admission, including chronic eating disorders, unresolved trauma, mood disorders, psychosis, and significant self harm and suicidality. Chronic anxiety and school refusal were also very common.

12. Over the 8 years that I worked at the BAC, I gained a considerable insight into how the centre worked effectively to assist the adolescents and their families.

13. In my role as a social worker at the BAC I often, and wherever possible, engaged with the families of the adolescents and involved them with the adolescents' treatment, as well as offering family therapy as a distinct therapeutic intervention. Being a State-based service meant offering the families weekend or after hours appointments, or when the parents travelled to Brisbane to visit their child. Like any therapeutic modality, some interventions were positive while other situations were more difficult. Some families refused to engage in family work, and so intervention focused on work with the adolescent, preparing them as much as possible for life apart from their families.

14. There were a number of components in the care the adolescents received while at the BAC that I felt were integral to their individual recovery; highlighting that The BAC was never a 'one size fits all' type of service, and tailored each adolescent's treatment individually.

15. Firstly, the adolescents were admitted to the centre because all other clinical options were exhausted, and subsequently by the time of their admission, were greatly desensitised to further mental health input. This made therapeutic rapport sometimes extremely difficult. However, the advantage of the extended stay was in providing an opportunity to create a fresh therapeutic platform from which to address the adolescents' mental health issues. That is, staff had time to develop and restore trust with the adolescent (which, depending on the circumstances, could take some months to form) and then subsequently engage with the adolescents therapeutically.

16. Secondly, an extended unit such as the Barrett was able to offer many therapeutic modalities that acute units are not able to offer such as adventure-based therapy, life-skills groups or other activities outside of the hospital grounds. For example, at the BAC my colleagues and I organised many activities such as taking the adolescents camping, beach trips, or cooking classes. These are typical developmental experiences that an adolescent should pursue, and often were very therapeutic.

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17. Closely connected to the above was the opportunity for staff to develop individual treatment plans for the adolescent. The range of conditions and issues of the cohort of adolescents admitted to the BAC were varied, as were the family backgrounds and available support. Consequently the multi-disciplinary team (consisting of teachers, occupational therapists, nurses, speech pathologist, psychologists and the Consultant psychiatrist) was crucial in offering the adolescents a full spectrum of treatment options.

18. Good continuity of staff and coordination of disciplines was critical to the care and treatment of each adolescent. By meeting regularly (weekly and then every six weeks), plans would be tailor-made to address individual need. During my time at the BAC, I considered that these individual plans were carried out well, reviewed regularly, and documented appropriately.

19. Furthermore, I found the BAC school to be a crucial part of the therapeutic process at the centre. Going to school is a typical and necessary teenage experience. However, most of the BAC patients did not previously have positive school experiences. Subsequently, when they attended the BAC school which had a high teacher/student ratio, teachers who were knowledgeable about mental health issues, as well as displaying a commitment to recovery, there was often a corrective emotional experience for the adolescents. In my opinion, this was a key part of what I call a "developmental reconstruction"; a process I consider to be a vital facet of mental health recovery for adolescents. I discuss this concept in my thesis.

20. Another important feature of the treatment at the BAC was to ensure there was as much time off the hospital grounds as possible. This allowed the teenagers to remain connected with previous interests or social connections i.e. if there were no clinical concerns, they were encouraged to go home on weekends.

21. I understand that the BAC has been criticised for having spare beds/not being at capacity. However, this 'empty bed count' does not appear to take into account that adolescent patients were expected to have leave from the unit as part of the therapeutic process. The BAC made every effort to encourage the teenagers to have as much leave as possible to allow them to partake in normal developmental activities.

22. There were issues, in my view, with regard to the length of stay at the BAC. In particular, those admissions that extended beyond 2 years. There were times that staff, myself included, voiced these concerns to Dr Sadler. However, there were usually reasonable explanations for such prolonged admissions. For example, discharge may have been planned, but the adolescent might subsequently deteriorate in order to try and stay longer.

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23. In my opinion, this was not reflective of some 'institutionalisation'; it reflected the depth of despair some of the adolescents experienced and the lengths they would go to, to remain emotionally and physically safe; for some an experience they had little knowledge of prior to the BAC.

24. Such behaviour was also directly related to the significant gap between services; that there was no interim service between adolescent and adult. My sense is that the admissions could have been shorter and with fewer discharge difficulties, had there been a specific service that catered for the 18-25 year age group.

25. In my view, the need to provide such services (outside of the adult mental health umbrella) for the 18 to 25 group of young people, such as those who were admitted to the BAC, is a yet-to-be rectified issue and one that needs to be addressed urgently.

26. My experience of the adolescents becoming 'institutionalised' is that this occurred with a very small minority of adolescents, due to a mixture of systemic reasons (lack of transitional resources) familial reasons (dysfunctional family dynamics) or entrenched personal pathology.

27. In any event, I have seen this occur in short-term acute wards as well. The propensity for some adolescents to become overly attached to a therapeutic milieu can occur in any context – including my present employment in the acute unit.

28. Some time prior to my leaving the BAC (I cannot recall the exact date), I remember there was much discussion that the BAC would move to a site at Redlands. The staff were happy and looking forward to the move. The BAC buildings were structurally old, run down and needed to be updated. I remember clearly the architectural drawings for Redlands that were drawn up, with much input from staff as to what features were required, what the Redlands facilities would look like and what programs would be provided. This generated considerable hope and excitement amongst staff and adolescents.

29. When the Redlands plan was cancelled, there was significant despondency, despair and high levels of anxiety amongst parents, adolescent and staff. The adolescents and parents in particular were worried as to their future. I recall many conversations attempting to contain the parents' and teenagers' anxieties about the future of their mental health treatment.

30. During 2012, I remember hearing a lot of contradictory information about the future of the BAC. First, that it was going to close at Christmas 2012, then January 2013, then possibly 2014. There was also much uncertainty as to whether there would be new services in place before the BAC closed.

31.

Struck Out by the Commissioner on 15 February 2016

32.

Thesis

33. In 2009, whilst I was employed at the BAC, I was accepted by The University of Queensland to start my thesis research part-time. In approximately May 2013, I was granted a scholarship to complete my thesis for my Doctor of Philosophy in a full-time capacity. In November 2014, I submitted the thesis, and the degree was conferred in May 2015. This thesis entitled 'The long sleep-over: the lived experience of teenagers, parents and staff in an adolescent psychiatric unit', is an exploration of the subjective experiences of inpatient life from the perspectives of the adolescents, parents and staff at the BAC. Attached and marked **DJW-2** is a copy of this thesis. All patient, parent and staff names in the thesis are pseudonyms.

34. The data collection for my thesis was carried out whilst I was still an employee at the BAC, with the data analysis and write-up completed after I left. Dr Trevor Sadler who was the Director of the BAC at the time, was very encouraging of me undertaking research, as were the staff. Typical ethical requirements were met via the Ipswich and West Moreton ethics committee, as well as the UQ ethics board. I remain very grateful for the invaluable assistance and support I received.

35. The data was collected through a series of face-to-face interviews, a focus group for staff and interviews with parents. Many of the BAC adolescents struggled with articulating their emotions and consequently a common tool is to utilise visual prompts that provide scaffolding for the adolescent to articulate their experiences. That in mind, I encouraged the adolescents to take photos to help them share their stories of inpatient life. The photography was a very effective tool for the adolescents to elicit their stories, and created some powerful imagery of their recovery journeys.

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Discussion Paper

36. I have read the Statewide Sub-Acute Beds Discussion Paper Executive Summary Draft prepared by the Child and Youth Mental Health Service (**Discussion Paper**), which I understand has been produced to the Commission. I did not know of the existence of this paper until it was provided to me by the Commission staff on 20 January 2016. I was honoured to see the Discussion Paper cite at length from my thesis and refer to it as *"a valuable addition to the literature as it appears to be the first qualitative examination of an adolescent inpatient unit in Australia"* (p4).

37. Having now had the opportunity to read the Discussion Paper, I am disappointed to see how the authors have used my thesis to support their arguments. I feel the summary has been overly selective of certain parts of my research for their paper, to the detriment of the original intent of my thesis. I feel the executive summary has used my material to give an unnecessary weight to the negative aspects of inpatient treatment. Below I have given some examples for consideration.

38. I note first of all the use of emotive language throughout the paper. On the first page the authors state "Inpatient care is also associated with considerable physical and emotional risk for young people, with episodes of aggression increasing with a longer length of stay". Whilst I have not seen the greater document from which this manuscript is a summary, I am unaware of any evidence to warrant such a claim. Indeed, I note that the word "risk" is regularly used throughout the paper when referring to inpatient care while there is not a corresponding term for the benefits of inpatient treatment. Rather, the neutral word "experiences" is used. The only exception is when they quote Moses (2011) and state how there can be "significant benefits" of a short-term admission (page 3). Noteworthy is the purposeful disinclination to use any positive imagery for inpatient care, whist the emotionally-laded term 'risk' is continually used to denote potentially unhelpful elements of inpatient life.

39. Corresponding to the above point, the authors quote approximately 3 pages of positive (my term) research excerpts about inpatient treatment, whilst there is approximately 7 pages devoted to the authors perception of the 'risks' of inpatient care. This to my mind, is biased. It is at this point, I shall focus on the document's use of my research in particular.

40. The authors have selectively and purposefully, used parts of my thesis out of context. A case in point is the quote from my thesis referred to on page 3 ('The recovery process'... para 5) of the Discussion Paper. I notice the same quote from my thesis reappears on page 15. The quote they are using does not refer to the quality - good or bad - of inpatient life,

nor does it represent a total summary. That quote refers to just one facet of the inpatient experience. Particularly on page 15, it gives a distorted view of what I was originally stating and was never intended to come under any third party view of 'risk' of inpatient treatment.

41. What the thesis was trying to highlight was how the journey in adolescent mental health recovery and the inpatient experience generally are never linear; they are unique to each individual and almost always, involves a plethora of experiences, emotions, successes and struggles. There is much in that quote that speaks of the benefits of inpatient treatment (e.g. forming attachments) and should not be viewed too negatively.

42. Secondly, throughout the document, quotes are used from my research and then placed under the 'risk' label. The authors are, in effect, re-coding my quotes to suit their own pre-conceived perceptions. An example is the use of another researcher's thematic categories such as "rigidity and confinement", "dislocations" and "families" and superimpose them on my data.

43. Furthermore, the sections labelled "Perceptions of parents on risks" and "Perspectives of staff on risks" (pages 12, 13) come dangerously close to misrepresenting an author's work. None of these excerpts used in the executive summary represent any 'risk'. Just because the participants found an experience challenging or even painful, does not necessarily mean it warrants a relabelling to 'risk'.

44. I do want to acknowledge that the paper rightfully points out on the first page that "there is inconsistent evidence to demonstrate that longer stays are associated with improved outcomes". I believe there are many methodological challenges in researching such outcomes, and I do acknowledge the divergent opinion on the topic.

45. Nonetheless, I would draw attention to alternative examples such as pages 173 and 174 of exhibit DJW-2, where two adolescents and two parents describe positive experiences of inpatient life.

46. Moreover, the Discussion Paper fails to refer to my conclusion that the research data advocates for the usefulness of extended treatment. This is based on my eight years experience at the BAC as well as my interpretation of the data I collected. Given its importance, I feel it needs to be reproduced below:

47. "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

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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". (DJW-2, page 202)

48. I consider my thesis to be balanced. Its intention was to reveal the hope and despair of adolescent mental health recovery, as well as the promises and pitfalls of extended inpatient treatment. There are certainly factors that need to be carefully considered before an admission to an extended residential unit. However in my view, the narratives of the patients, parents and staff in my study revealed many advantages of an extended admission, and that in my opinion, the advantages of such a facility outweigh the disadvantages.

49. Finally, the Discussion Paper cites a number of recommendations by the Adolescent Mental Health Extended Treatment Initiative (AMHETI) to meet the need for intensive treatment not offered by community clinics. I welcome such recommendations. I agree generally with what is stated in the first paragraph of the executive summary of the Discussion Paper, namely that a "small sub-group" of young people "may" benefit from extended admission. I would qualify that however, and suggest more than just a "small sub-group" of adolescents most definitely "will" benefit from an extended admission. In my experience, the numbers of adolescents requiring such admission are increasing.

Moving forward

50. If a new extended stay, state-wide sub-acute unit is to be established in Queensland, (and I certainly hope that one is), I submit that there are three fundamental matters that need to be taken into consideration for such a project. First, there must be an onsite school facility. As previously mentioned, such a resource is crucial for an extended facility.

51. Secondly, while there are benefits for such a facility having immediate access to medical services, it is also important that the unit does not have an overly 'medicalised environment'. That is, it should be built with an adolescent-friendly and developmentally-informed purpose in mind. As my research suggests, such a facility is both 'hospital and home' for the young people and subsequently requires facets that parallel some positive aspects home life e.g. private bedrooms, quiet relaxation areas etc.

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52. Thirdly, the staff should be multi-disciplinary as they were at the BAC. A new facility that focuses on such clinical severity and complexity subsequently demands a diversity of specialised staff to address such challenging presentations. There should also be a focus on recruiting permanent staff who have specific adolescent mental health experience, as well as staff who can meet the personal and professional challenges of working in this difficult but rewarding area of mental health.

53. The question of how long an adolescent should stay in such a unit is a very difficult one to answer, and one that remains controversial. There are many variables to consider. Given the breadth and depth of clinical presentations of this population, I don't believe there is a 'typical' length of stay. My position is that discharge planning occurs on admission, and that both the benefits and disadvantages of an extended stay be ever forefront in the minds of the multidisciplinary team.

54. However, in my opinion, for the very specific cohort of patients admitted to units such as the BAC, the length of stay should be made available up to approximately 12-18 months, with the possibility of 2 years should the presentation warrant it. This of course should not preclude 6 month admissions. Essentially, all would agree that the young person be discharged as soon as practically possible.

55. Finally, I personally believe there is a 'recovery bell curve' with this population; one where there can be enormous gains made in extended treatment over a certain length of time, as well as a point in which the benefits begin to wane, and the young person needs to leave. However, it is impossible to give such a hard and fast time, due to the wide ranging individual, clinical and contextual factors of each adolescent.

OATHS ACT 1867 (DECLARATION)

I, Dr David John Ward, do solemnly and sincerely declare that:

(1) This written statement by me dated 4/2/16 is true to the best of my knowledge and belief: and

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oath*[redacted]

………[redacted]………Signature

Taken and declared before me at Robina this 4th day of February 2016.

Taken B[redacted]

~~Justice of the Peace~~ / Commissioner for Declarations / ~~Lawyer~~

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Reg.No.: 101068

………[redacted]………

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………[redacted]………

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EXHIBIT 135

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

INDEX OF ANNEXURES

Bound and marked "**DJW-1**" to "**DJW-2**" are the annexures to the Statutory Declaration of **David John Ward** declared ....4/2............ 2016:

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DJW-2	Thesis of Dr David Ward entitled "The long sleep-over: the lived experience of teenagers, parents and staff in an adolescent psychiatric unit."	2015	16

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~~Lawyer~~

EXHIBIT 135

'DJW - 1'

Curriculum Vitae

David John Ward

Academic qualifications

1997	Bachelor of Social Work Bachelor of Arts	University of Queensland
2001	Graduate Diploma (CpleThpy)	Relationships Australia
2004	Master of Counselling	University of New England
2008	Master of Philosophy	University of Queensland
2015	Doctor of Philosophy	University of Queensland

Memberships

Accredited Mental Health Social Worker (Membership No: 200460)

Clinical Experience

- Senior Social Worker
  Robina Child & Youth Inpatient Unit
  October 2014 – present

- Part-time private practice
  June 2015 – present

- Private Practitioner
  Headspace Meadowbrook
  Feb – Dec 2015

- Senior Social Worker
  Barrett Adolescent Centre
  October 2004 – January 2013

- Social Worker
Child & Youth Mental Health Service, Southport
April 2003–October 2004

- Child & Family Counsellor
Brisbane Lifeline
Dec 1998- March 2003

- Social Worker
Child & Youth Mental Health Service, Ipswich
January - November 1998

Publications & papers related to child & adolescent mental health

Ward, D. (2014) "Recovery": does it fit for adolescent mental health?
Journal of Child and Adolescent Mental Health, 26(1): 83–90

Ward, D., (2009) 'Five Messages Every Adolescent Needs to Hear'
Psychotherapy in Australia, 15 (3) 48-54.

Ward, D., (Spring 2003) 'Counselling *Children Part 1: Assessment'*,
Counselling Australia.

Ward, D., (Summer 2003) '*Counselling Children Part 2: Intervention'*,
Counselling Australia.

"Recovery in Adolescence; views from the camera lens"
23nd Annual Mental Health Services Conference Inc (TheMHS) of Australia and New Zealand
Melbourne
20th - 23rd August 2013

"The long sleep-over: an exploration of how consumers, parents and staff navigate life in an adolescent psychiatric unit"
Seminar & Practical Workshop: Taking your Research to the Next Level: School of Social Work, University of Melbourne
4th October 2013

"The camera never lies: the use of photography to aid research and recovery for traumatised adolescents"
Australasian Conference of Child Trauma: Research, Response, Recovery
Gold Coast, Queensland
4th - 6th July 2012

"Practitioner Research: the mess, the mayhem and the necessity"
Social Work and Mental Health: Building Research Capacity
Post-graduate Research Conference
School of Social Work and Human Services, University of Queensland
16th - 17th July 2012

Other Publications & papers presented

Ward, D., (2011) 'The lived experience of spiritual abuse'
Journal of Mental Health, Religion & Culture, 14 (9) 899-915.

Ward, D., (2002) '*Cults and the Family*'
Australian & New Zealand Journal of Family Therapy, (23) (2) 61-68.

Ward, D., (2000) 'Where do I start?; *Assessment and Intervention with ex-cult members*' ***Australian Social Work, (53) (2) 37-42.***

Ward, D., (2000) '*Domestic Violence as a Cultic System*'
Cultic Studies Journal, (17) (1), 42-55.

"Spiritual Abuse and the Family"
29th Australian & New Zealand Family Therapy Conference,
Brisbane October 2008

"Counselling ex-members of cults and other controlling groups"
National Conference of the Australian Counselling Association,
Brisbane October 2004

EXHIBIT 135

EXHIBIT 135 'DJW - 2'

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

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.

A thesis submitted for the degree of Doctor of Philosophy at
The University of Queensland in 2014
School of Social Work and Human Services

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.

I have clearly stated the contribution of others to my thesis as a whole, including statistical assistance, survey design, data analysis, significant technical procedures, professional editorial advice, and any other original research work used or reported in my thesis. The content of my thesis is the result of work I have carried out since the commencement of my research higher degree candidature and does not include a substantial part of work that has been submitted to qualify for the award of any other degree or diploma in any university or other tertiary institution. I have clearly stated which parts of my thesis, if any, have been submitted to qualify for another award.

I acknowledge that an electronic copy of my thesis must be lodged with the University Library and, subject to the General Award Rules of The University of Queensland, immediately made available for research and study in accordance with the *Copyright Act 1968*.

I acknowledge that copyright of all material contained in my thesis resides with the copyright holder(s) of that material. Where appropriate I have obtained copyright permission from the copyright holder to reproduce material in this thesis.

Publications during candidature

Ward, D. (2009). Five messages every adolescent needs to hear. *Psychotherapy in Australia* (15) 3, 48-54.

Ward, D. (2014). 'Recovery'; Does it fit for adolescent mental health? *Journal of Child and Adolescent Mental Health*, 26 (1), 83-90.

Conference presentations during candidature

'The camera never lies: the use of photography to aid research and recovery for traumatised adolescents'
Australasian Conference of Child Trauma: Research, Response, Recovery
Gold Coast, Queensland 4th - 6th July 2012

'Practitioner Research: the mess, the mayhem and the necessity'
Social Work and Mental Health: Building Research Capacity
Post-graduate Research Conference SWAHS University of Queensland 16th - 17th July 2012

'Recovery in Adolescence; views from the camera lens'
23rd Annual TheMHS Conference - Melbourne 20-23 August 2013

Publications included in this thesis

No publications included.

Contributions by others to the thesis

No contributions by others.

Statement of parts of the thesis submitted to qualify for the award of another degree

None.

Acknowledgements

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

Australian and New Zealand Standard Research Classifications (ANZSRC)

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ANZSRC code: 111718, Residential Client Care, 20%

ANZSRC code: 160701, Clinical Social Work Practice, 60%

Fields of Research (FoR) Classification

FoR code: 1117, Public Health and Health Services, 20%
FoR code: 1607, Social Work, 80%

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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. [redacted]

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 & Jasperson, 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 & Jasperson, 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 → social context.
2. The domain that investigates how the characteristics of the setting influence the adolescent. That is, the social context → the adolescent.
3. The third domain is the specific contribution of developmental contextualism that investigates the continuous, bidirectional interactions of both spheres;
   individual attributes ←→ 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 though, 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
Role of family 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).	Connection with others	*Role of family* A crucial influence for the recovery journey, with attachment and individuation processes ongoing (Collins & Laursen, 2004).
	Hope for the future	
Peers The recovery process for adults can be enhanced by supportive peers (Topor, et al. 2009).		*Peers* Peers exert tremendous pressure on the developmental trajectory with peer contagion a strong factor in adolescent difficulties (Dishion & Tipsord, 2011).
	Developing & maintaining Identity	
Identity development 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)	Discovering & maintaining meaning in life	*Identity development* 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.
Physiological change Apart from typical ageing processes, physical development has been completed.	Empowerment & control over one's life	*Physiological change* Profound physiological change that could have significant implications for later life (Sisk and Foster 2004, Spear 2000).

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 interprets 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-intense 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 extend 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 Dean[1] 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,

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[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 measureable 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 reality[2], 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.

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[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

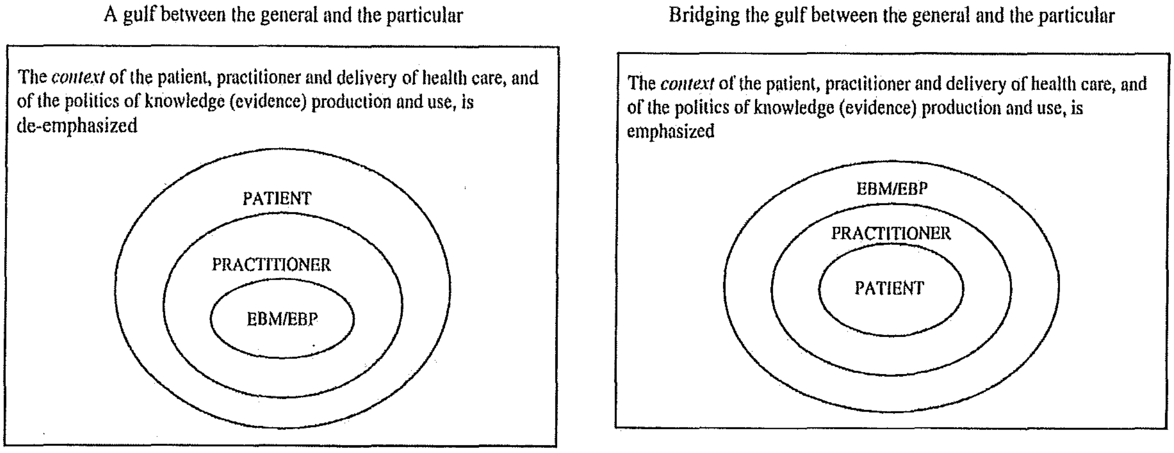


Figure 1 The relationship between evidence-based practice (EBP), practitioner, patient and context in the pro EBP discourses. EBM, evidence-based medicine.

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.

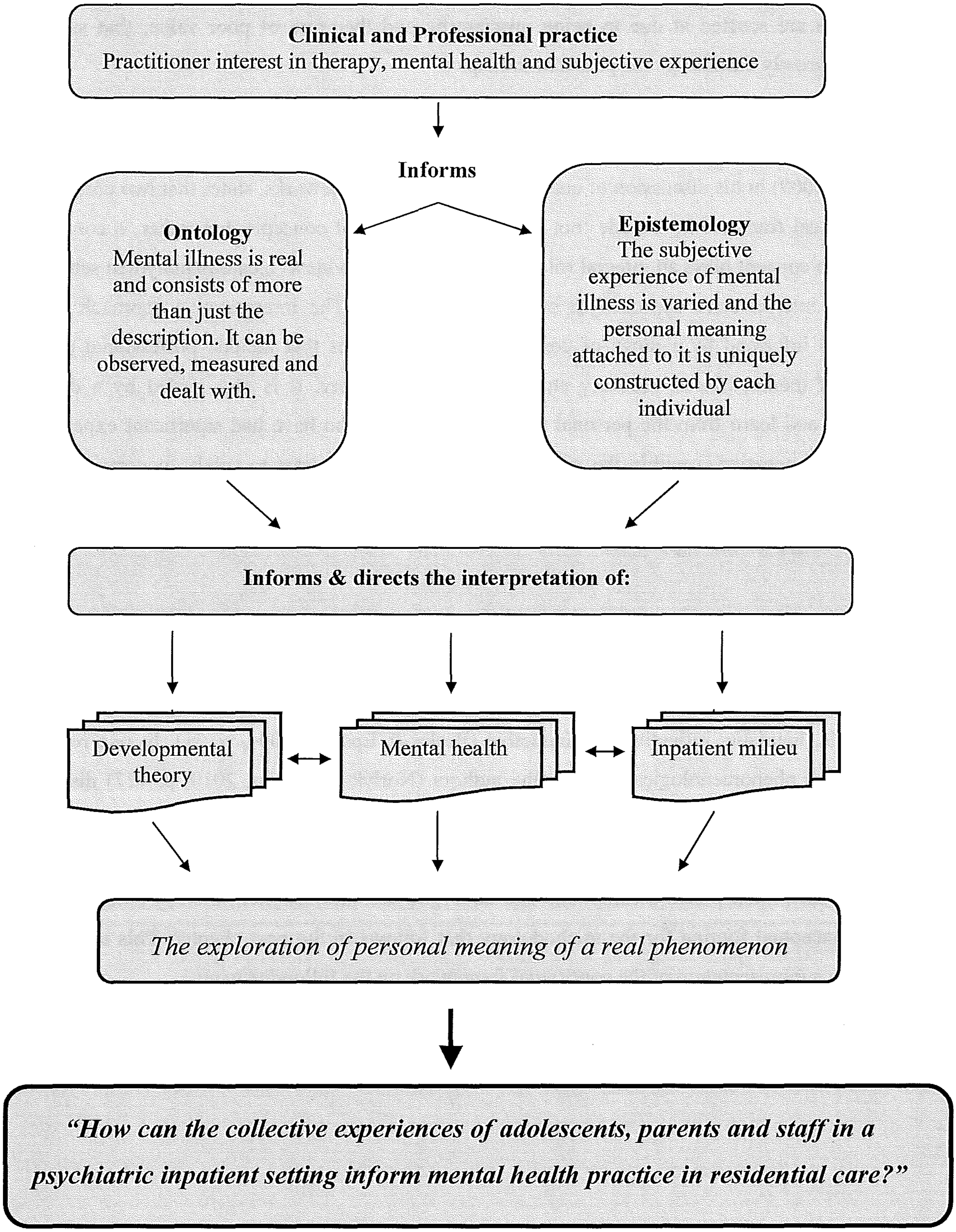
Summary

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.

EXHIBIT 135

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, Mereau-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

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[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, Jenkings, 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 (Nunkoosing, 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

EXHIBIT 135

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

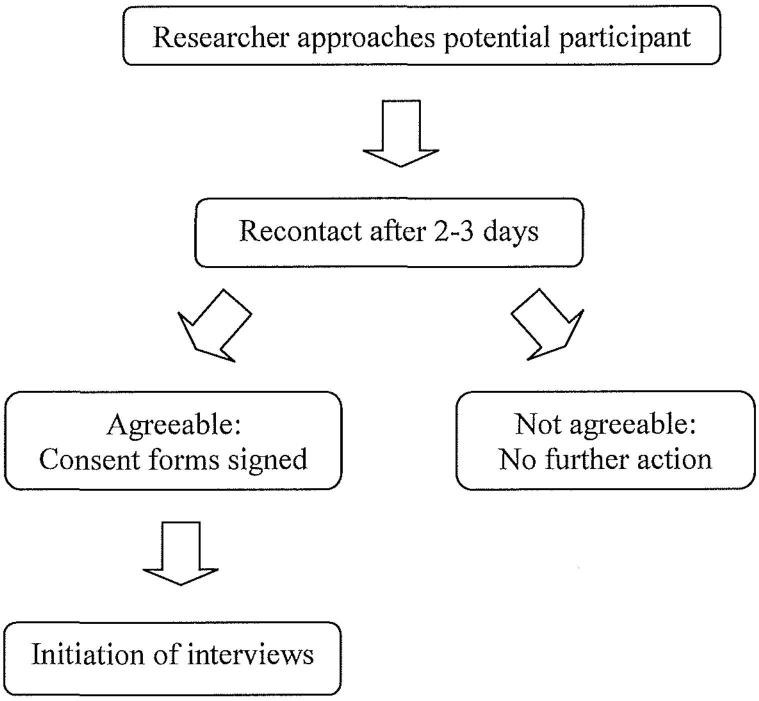

Figure 4: Adolescent and parent recruitment process

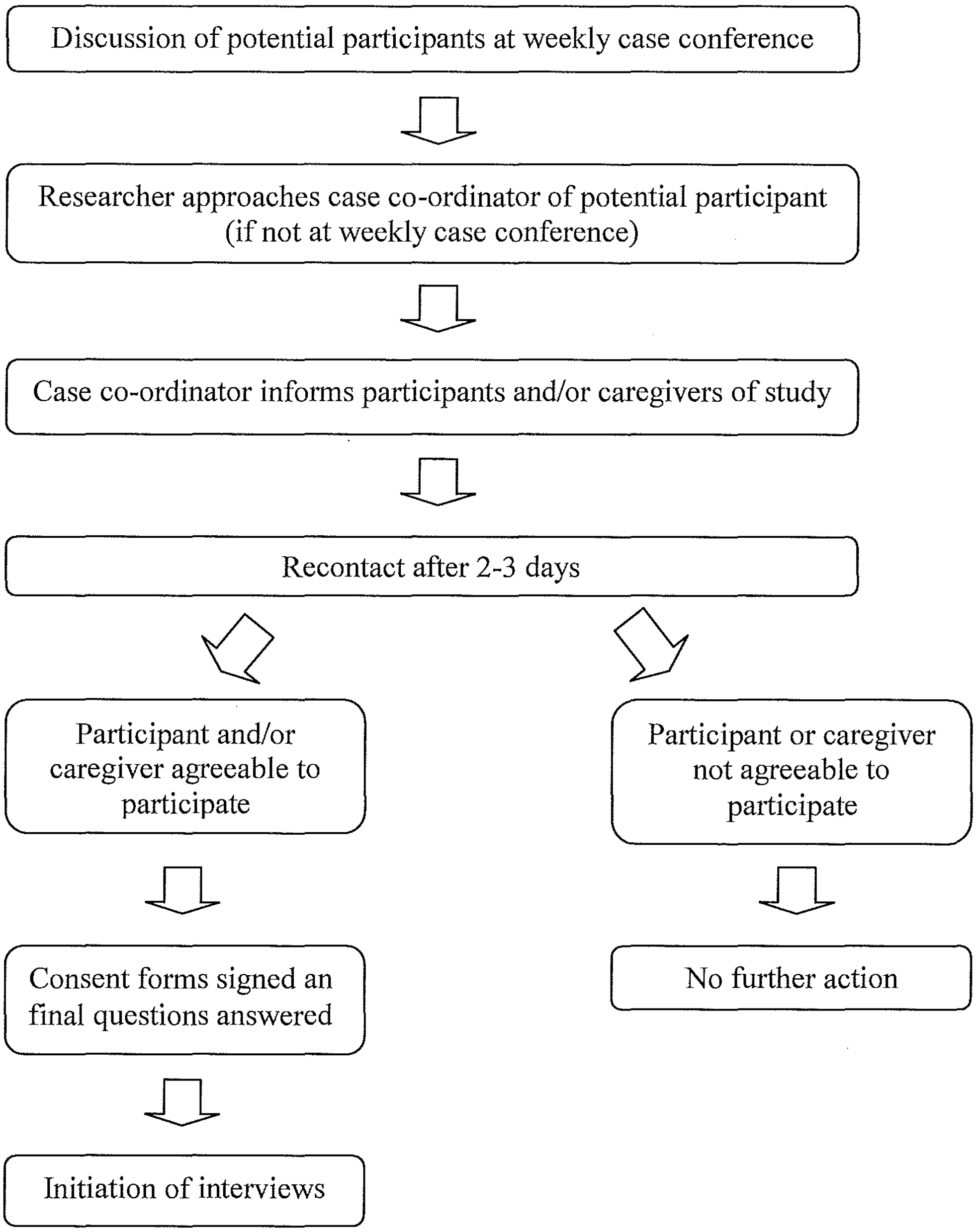

Table 4: Study sample

Adolescent sample		Parent sample	Staff sample	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Average age	16yrs 2mths		Individual interviews	10
Involuntary treatment [redacted]	[redacted]		Focus groups (involving 3 individuals from the 3 professions of allied health, education & nursing)	3
Number of 1st interviews	13			
Number of 2nd Interviews	7			
Number of 3rd 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. [redacted] 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)	[redacted]	✓	✓
Allied Health (2)	[redacted]	✓	✓
Allied Health (3)	[redacted]	✓	✓
Nurse (1)	[redacted]	✓	✓
Nurse (2)	[redacted]	✓	✓
Nurse (3)	[redacted]	✓	✓
Teacher (1)	[redacted]	✓	✓
Teacher (2)	[redacted]	✓	✓
Teacher (3)	[redacted]	✓	✓
Psychiatrist	[redacted]	✓	✗

Adolescents	1st interview	2nd Interview	3rd Interview	[redacted]
[redacted]	✓	✓	✓	[redacted]
[redacted]	✓	✓	✓	[redacted]
[redacted]	✓	✓	✓	[redacted]
[redacted]	✓	✓		[redacted]
[redacted]	✓	✓		[redacted]
[redacted]	✓	✓		[redacted]
[redacted]	✓	✓		[redacted]
[redacted]	✓			[redacted]
[redacted]	✓			[redacted]
[redacted]	✓			[redacted]
[redacted]	✓			[redacted]
[redacted]	✓			[redacted]
[redacted]	✓			[redacted]

Parents	Location of Parent interview
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

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, Whittemore 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 care-givers 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 participant 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

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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.* [redacted] *how would you describe yourself as a person?*
[redacted] *I don't know.*
DW: *You're not sure?*
[redacted] *No.*
DW: *What kind of person are you?*
[redacted] [Laughs] *Ask other people.*
DW: *What do you think they would say about you?*
[redacted] *I don't know.*
DW: *All right. Your friends here at Barrett; what would they say?*

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[redacted] [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?*

[redacted] *They're all teenagers; they're not going to give a really good answer.*

DW: *Yeah?*

[redacted] *Just like me.*

[redacted]; 1st interview)

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

DW: A tyre and a…

[redacted] A tree.

DW: Tell me a little about that.

[redacted] Yeah. Not quite so…[long pause]

DW: Deep?

[redacted] 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?

[redacted] It's not really that…[long pause]

DW: That's okay.

[redacted] Yeah. It's not that…

DW: Significant?

[redacted] …significant really. Yeah.

[redacted]; 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).

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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

[redacted]

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:

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Figure 5: Chronology and rationale of participant recruitment

Timeline: Initial stages of the Research

Participants: Adolescents

Rationale: It was originally planned to investigate the inpatient experience of adolescents given the lack of formal research on the topic in Australia as well as creating an opportunity for their voices to be heard in adult-directed systems.

Timeline: Middle stages of the Research

Participants: Staff – individual interviews

Rationale: The quality of adolescent data varied and took longer than expected. When the material was richer however, some emerging themes needed clarification and further analysis required.

Action: Individual staff interviews initiated.

Timeline: Middle to later stages of the Research

Participants: Staff – focus groups

Rationale: The data from the individual staff interviews and adolescent interviews needed clarification. Fresh material began to emerge that needed to be investigated.

Action: Staff focus group interviews initiated.

Timeline: Latter stages of the Research

Participants: Parents

Rationale: Upon further reflection of the staff and adolescent narratives, there was the realisation that the parents, despite not living or working at the Unit, also experience an inpatient experience. The inclusion of the three groups would be a tremendous asset in exploring the inpatient experience from each population linked to the Unit. The phenomenon under study would be far more rich.

Action: Parents recruited as participants.

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

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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.

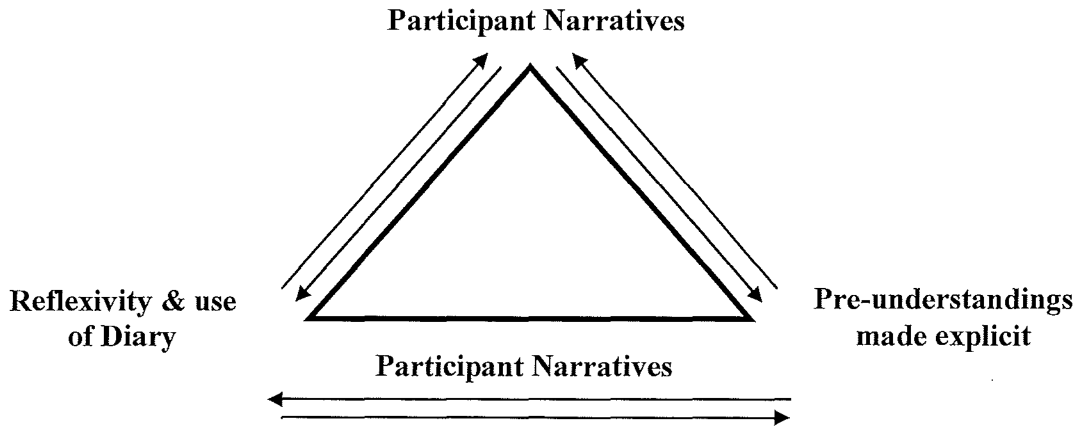
Statement Ten: Aim for 'Fruit' not 'flowers'.

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.

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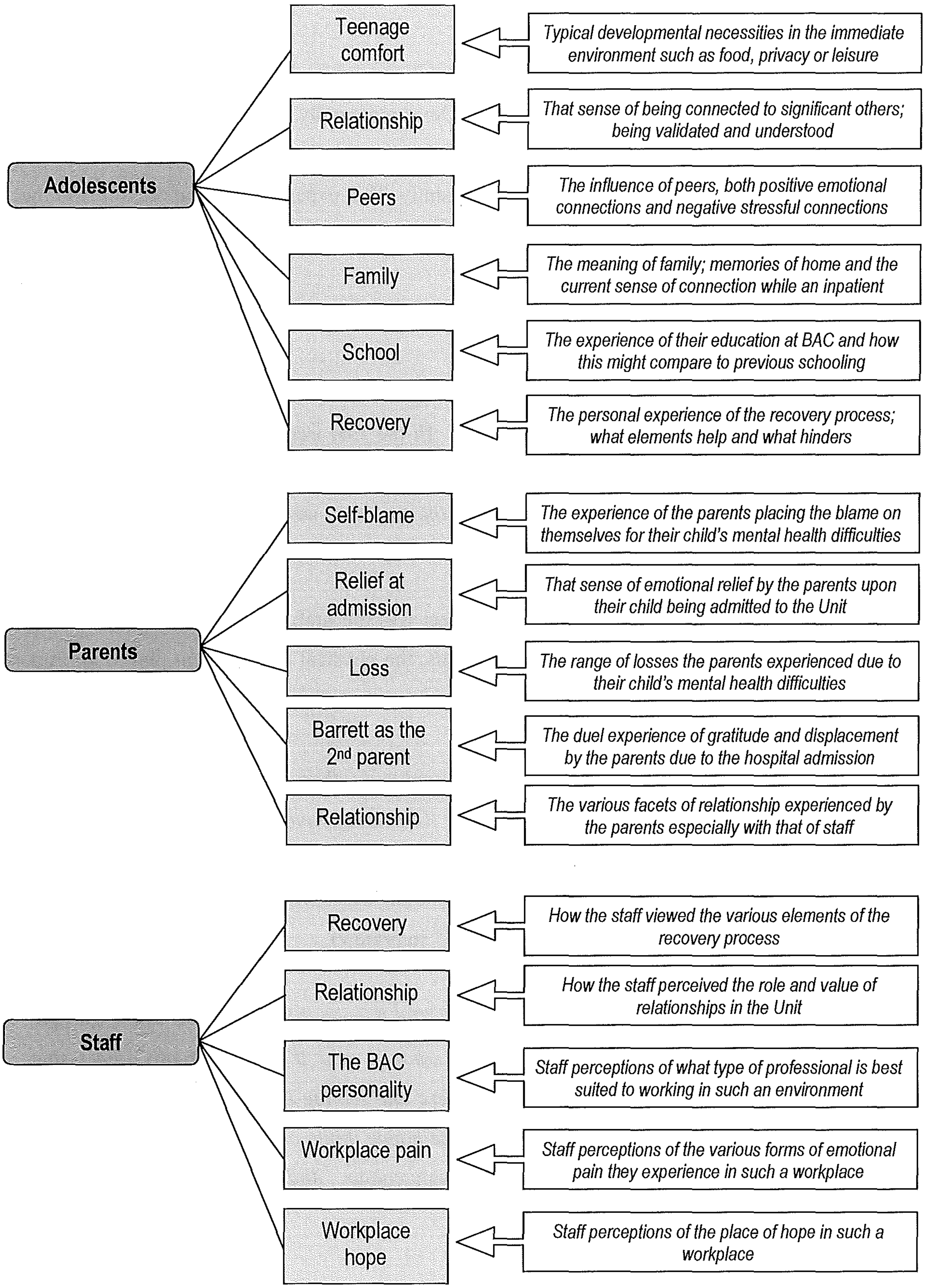
Figure 7: Primary sub-themes for each participant group



Typical developmental necessities in the immediate environment such as food, privacy or leisure

That sense of being connected to significant others; being validated and understood

The influence of peers, both positive emotional connections and negative stressful connections

The meaning of family; memories of home and the current sense of connection while an inpatient

The experience of their education at BAC and how this might compare to previous schooling

The personal experience of the recovery process; what elements help and what hinders

The experience of the parents placing the blame on themselves for their child's mental health difficulties

That sense of emotional relief by the parents upon their child being admitted to the Unit

The range of losses the parents experienced due to their child's mental health difficulties

The duel experience of gratitude and displacement by the parents due to the hospital admission

The various facets of relationship experienced by the parents especially with that of staff

How the staff viewed the various elements of the recovery process

How the staff perceived the role and value of relationships in the Unit

Staff perceptions of what type of professional is best suited to working in such an environment

Staff perceptions of the various forms of emotional pain they experience in such a workplace

Staff perceptions of the place of hope in such a workplace

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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 [redacted] the initial impressions of the physical buildings were quite noticeable when [redacted] 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.* [redacted] 1st interview)

For [redacted] and [redacted] 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.* [redacted] *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.* ([redacted] 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".* [redacted]; 1st interview)

For [redacted] and [redacted], the two aspects that needed improvement were the beds and food;

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[redacted] *The food. Mainly the food.*

DW: *Pretty ordinary?*

[redacted] *Also the beds. The beds are too hard and the food is just – forgive me for saying it – it's really bad. Crap.* ([redacted] 1st interview)

[redacted] *Beds.*

DW: *Beds?*

[redacted] *They're terrible; they're bricks. Bricks I say!* ([redacted]; 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 [redacted] the importance of being understood was crucial, which was highlighted when casual nursing staff assumed they knew [redacted]:

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

[redacted]: *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* [redacted] *is bigger than just* [redacted] *file?*

[redacted]: *Yeah. Pretty much.*

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

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> [redacted] *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!* ([redacted]; 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. [redacted] thoughts above were also reflected in [redacted] 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?*
>
> [redacted] *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?*
>
> [redacted] *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.* [redacted] 2nd interview)

The issue of staff consistency was particularly important since as [redacted] 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.* [redacted] 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, [redacted] acknowledged [redacted] distress at seeing unwell peers. For [redacted] in the second extract, any form of self-harm from [redacted] 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?*
>
> [redacted] *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.* [redacted] 1st interview)

> [redacted] *Ah, maybe. But yeah, I want to punch* [redacted]
>
> DW: *Okay...why?*
>
> [redacted] *Because* [redacted] *bloody self-harming.* [redacted] *deserves to be punched, right in the ribs.*
>
> DW: *So you'd like to* [redacted]
>
> [redacted] *Yeah. I hate people who self-harm.* [redacted] 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* [redacted] *was feeling down, then, like...* [redacted] *and* [redacted] *and a few people became down as well, and it was like,* [redacted] *and everyone going down and stuff. A lot of emotions started to flare.* [redacted] 1st interview)

[redacted] below described the process when a peer became the potential trigger for [redacted] slipping emotionally and recounts [redacted] 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.* [redacted] 2nd interview)

For others such as [redacted] and [redacted], 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.*
>
> [redacted] *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.* ([redacted] 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.* ([redacted]; 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 -* [redacted] *- that was a very different atmosphere. In my current dorm there's* [redacted] *and* [redacted]*, and* [redacted] *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.* ([redacted] 1st interview)
>
> DW: *Okay. What's it like to live with the other kids here?*

> [redacted]: *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?*
>
> [redacted]: *They sort of tried to force me out of my shell.*

Interpersonal growth was also [redacted] 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.* [redacted] 1st interview)

Not unusual for adolescents, sometimes their accounts reveal contradictions. Consider [redacted] 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.* [redacted]; 1st interview)

Peers were a mixed blessing for [redacted]. 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,* [redacted] *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.* [redacted] 3rd interview)

[redacted] also found the environment and peers a mixed blessing:

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> *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* ([redacted]; 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.*
>
> [redacted] *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.*
>
> [redacted]: *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.* ([redacted]: 1st interview)

[redacted] 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 [redacted] and [redacted]:

> *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.* [redacted] *has some problems as well. And it's good not having to worry about that sort of stuff while I'm here.* ([redacted], 1st interview)
>
> *Like when I started as not with my family, like my relationship with them actually grew*

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> *better than it was previously...Whilst I had that period away from them I managed to repair those problems, which I caused them.* [redacted]; 1st interview)

With BAC being a long-term residential Unit, some adolescents appreciated opportunities to visit home. However, for some such as [redacted] 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.* [redacted]; 1st interview)

[redacted] also recognised that the family itself changed due to [redacted] 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.* [redacted]: 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 [redacted] and accompanying extract, reveals how for [redacted] the pain of separation was deeply felt:

> *I really like this photo because it goes down towards a* [redacted] *dorm and so like for me when I'm at home and I'm going to bed my mum and my little* [redacted] *will come and say "Goodnight" to me. And they'd give me a kiss and a hug, and sometimes my little* [redacted] *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*

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> *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* [redacted] *when I go home and – I don't know. My room is very like – I do a lot of things with my* [redacted] *in my room and stuff like that, whereas here it's just like – makes me very homesick.* [redacted]; 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.* [redacted]; 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.* [redacted]; 1st interview)

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

> [redacted] *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.* ([redacted]; 1st interview)

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For [redacted] the distinction between the school and the ward was quite pronounced, with the school environment less stressful as [redacted] recounts with [redacted] photo:

[redacted]

> *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.* [redacted]; 2nd interview)

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

> [redacted]: *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.* [redacted]; 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 [redacted] was thankful that I was not [redacted] therapist and therefore felt comfortable in telling [redacted] story, though [redacted] expressed some reserve at the idea that I might not capture or understand [redacted] experience fully:

> DW: *I guess my sense* [redacted] *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?*