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

Some found the experience very exciting:

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

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

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

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

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

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

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

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

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

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

A powerful emotion during recovery process was that of confusion:

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

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

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

: *I guess that's kind of getting - me looking at myself is also another sign of me grasping that reality, trying to find it.*

And I'm just looking at myself and that really to me is just I'm working out the reality that "Just wait, I'm not okay." And it's okay to say that I'm not.

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

Face to face.

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

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

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

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

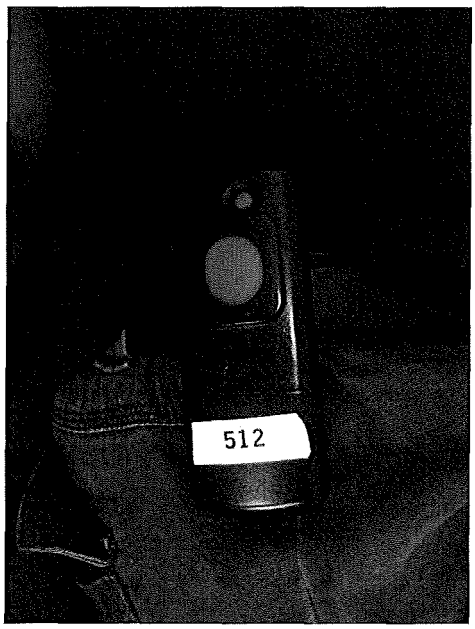
Because when and I met and started caring, I told I don't want people caring for me. I told a million people that I didn't want people to care for me, but was one stubborn person and kept caring, and then, yeah, that's how it began. I started caring for and we cared for each other. And that's how it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

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

For [redacted] it brought back memories of a previous detention centre:

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

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



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

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

[redacted] experience was similar in experiencing fear not just for [redacted] but for other potential inpatients in the future. [redacted] also took a photo to help tell the experience:

Well code blacks are very scary. Very emotionally charged, draining, tense. In some ways when new people come in I want them to be prepared for code blacks because we haven't had a lot of code blacks lately in the past few months and there's been loads of people. And I really want people to be prepared because I'm still quite scared whenever things happen like that. Because they're quite horrible sometimes, and I've seen things in here that's not very nice - involved with that kind of thing. [redacted] 2nd interview)

[redacted]

[redacted]

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

of wanting to lash out, while the code blacks were not "much of a problem" for

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

DW: *What's the meaning behind that scar for you?*

The scar is for me and they just show how depressed I am at times, and how I struggle. I try as hard as I can all the time, and I'm always really kind of going to myself "You're not trying hard enough" but I do constantly try. But everyone has moments where they just can't control it anymore and something happens, and that's really what happens with my scars. 2nd interview)

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

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

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

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

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

> DW: *Okay. So it's been about three months, has your view kind of changed then - since you first were admitted?*
>
> : *I understand this place more now. I understand why I'm here and why I need to be here. And I also understand the path that they want me to go on. Because it's been successful for some people. And I can see how it would be successful. But I still am undecided whether it will help.* ; 1st interview.)
>
> *It was really scary when I first came here because everyone else knew each other and they had been here for a while and that. So that was kind of confronting. But everyone was really welcoming and that made it a bit easier and that, but it was still really hard but it's gotten better.* ; 1st interview)

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

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

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

> 2nd interview)
> *Well we've had a doctor change, so that was a bit confusing – trying to get used to a new person to talk to. You don't know them at all and you're trying to tell them such important things. It's quite difficult.*

> 3rd interview)
> *But also since we last talked – I mean the patients on the ward are always changing. I mean the number and who's on the ward. Because we always get new people in and different nurses. And we've had a recent admission who's a bit different from other admissions in a sense, and that's caused – that's affected us more than any other new patient. Maybe because there's a lot of staff changing...I mean the ward's always changing but especially with different patients coming in. And then there's been a few issues with – I mean just the ward stresses and people's relationships changing anyway.*

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

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

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

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

recognised changes within particularly feeling 'normal' again:

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

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

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

The experience of the parents

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

Sub-theme 1: Self-blame

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

struggled with self-blame nonetheless:

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

Similar to felt like a failure for not 'providing normality'

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

For , the heaviest burden was guilt that made question

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

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

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

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

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

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

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

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

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

Similarly for misunderstanding led to social isolation:

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

DW: *Good clip under the ear.*

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

Sub-theme 2: Relief at the admission

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

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

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

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

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

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

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

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

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

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

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

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

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

It was. I didn't have to be constantly aware of And it was difficult because I was having to work at the same time.

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

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

Sub-theme 3: Loss

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

I think it's sad. [cries] Sorry. I mourn what lost.

DW: *What's the biggest loss?*

normal childhood. Being able to go out with friends, have a nice time. Just do normal teenage things. not been able to do any of that, not for a long time.

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

I think so. probably not so much aware of how I feel about it. But I just wish that could have had a more normal teenagerhood.

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

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

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

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

DW: *Really?*

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

DW: *The old*

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

Sub-theme 4: Barrett as the second parent

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

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

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

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

: *It was horrible.*

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

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

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

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

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

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

Sub-theme 5: Relationship

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

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

DW: *How do you know they care?*

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

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

However, for [redacted] some staff were perceived as helpful whereas others were perceived as not:

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

[redacted] *The good ones just seem to chat to you and tell you all about [redacted] and have a good chat to you, and seem to listen to you. And then...*

DW: *The communication again?*

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

[redacted] was especially appreciative of the relationships [redacted] was making and the benefits derived from them:

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

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

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

I truly do not think would be here.
It would be hell. I think so lucky, and we are so lucky to have Barrett.

Oh God, I'd hate to even think.

Pretty miserable.

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

The experience of the staff

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

Sub-theme 1: Recovery

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

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

Allied Health (3): *Too slow.*

DW: *Too slow? In what way?*

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

(Allied Health (3); individual interview)

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

> Allied Health (1): *I think those who stay here too long get worse. Yeah. That's like . Because when first came in had an eating disorder but when left it was worse, so I think overstayed accommodation.*
>
> DW: *Do you have any theories as to why it gets worse?*
>
> Allied Health (1): *Yeah. I think maybe they become so attached to us. I think they become so attached and dependent on us and they can't see themselves being anywhere else but here. I guess it's like being in a jail where your whole life is between those walls and you don't really see the outside world and for us to sort of discharge them or allow them to go out, it's like a scary or whatever world out there for them. Therefore for them not to go there, they decompensate for us to keep them in. So we just keep taking care of them. So I think they just develop this sicker role...I don't know. I think they just become so dependent on us and that they just develop new mental illnesses for us to keep them here.*

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

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

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

> *That was the problem; we didn't have a place to put them. They couldn't go home. They weren't suited for an adult acute ward that was just an inappropriate admission. So the kids were left in limbo...But we*

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

Sub-theme 2: Relationship

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

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

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

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

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

> Allied Health (1): *Two of us are parents and I'm curious from you not being a parent yourself how that fits for you?*
>
> Allied Health (2): *It's interesting because it does – because I'm not a parent – but it does feel like I'm a parent sometimes. Because I do run a lot of activities and at times I got to organise adolescents to get up and get them ready for school, go through all the homework stuff. Even during the holidays make sure their lunches are packed, all that money budgeting, all of that stuff. After school activities like swimming or whatever it is.*

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

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

As did another nurse:

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

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

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

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

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

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

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

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

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

Sub-theme 3: The 'BAC personality'

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

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

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

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

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

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

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

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

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

Sub-theme 4: Workplace pain

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

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

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

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

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

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

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

> *We're not recognised as the professional people that we are. Our opinion isn't sought. They'd like us to do all the menial tasks that you'd know an escort person may do if you were specialling somebody in the general hospital as a general nurse. But in their opinion we're sort of just there to guard the patient.* (Nurse (3); focus group)
>
> *I think that's where you get it from because you don't get it from the organisation - you definitely don't get validation from the organisation.* (Nurse (3); focus group)

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

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

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

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

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

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

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

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

Sub-theme 5: Workplace hope

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

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

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

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

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

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

Summary: converging and contrasting experiences

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

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

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

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

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

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

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

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

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

Conclusion

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

CHAPTER 7 COLLECTIVE VOICES OF INPATIENT LIFE

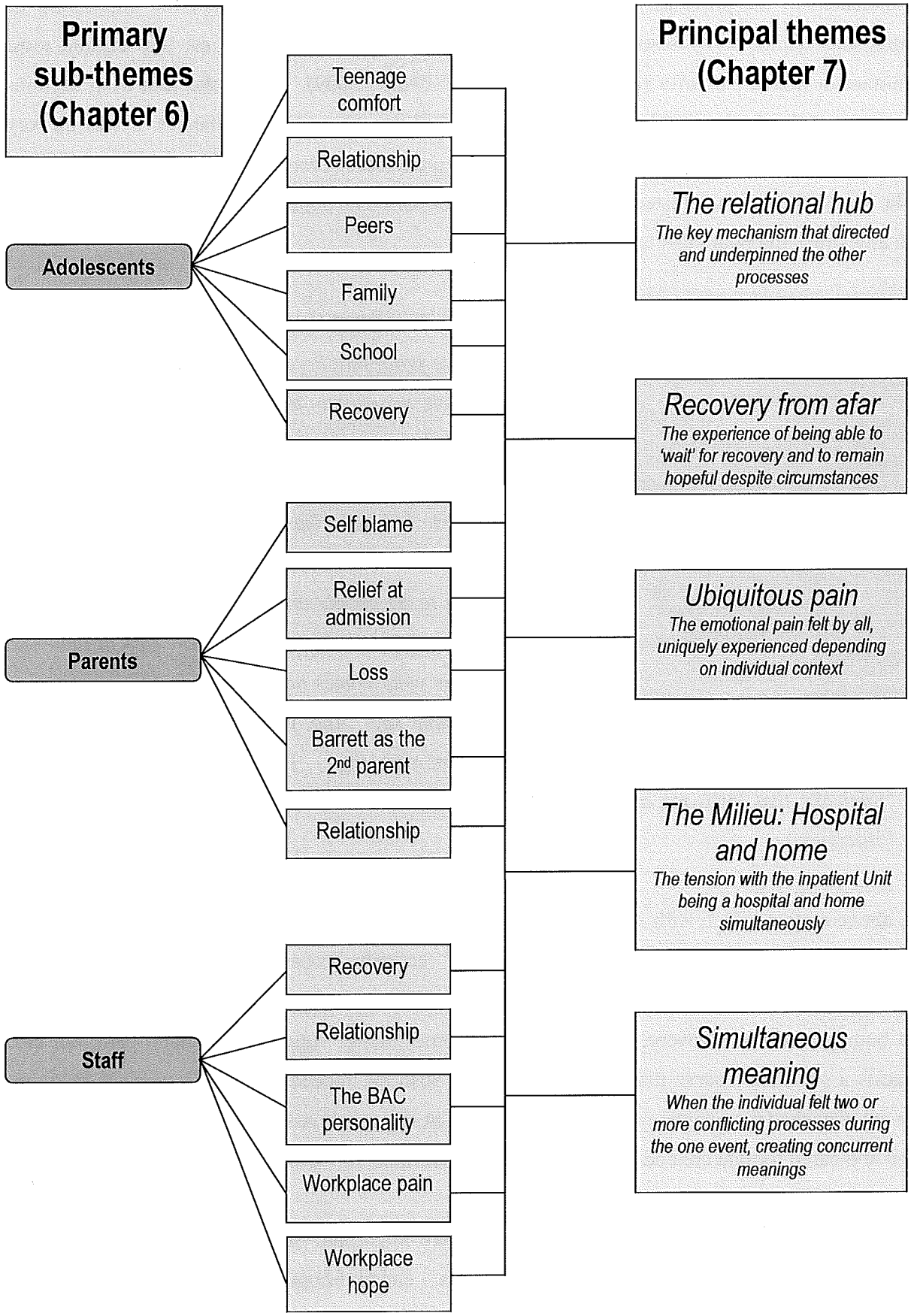
Introduction

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

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

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

Figure 8: Primary sub-themes & principal themes



Principal theme 1: The relational hub

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

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

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

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

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

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

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

DW: *Was that the kids or the staff?*

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

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

That really sums up a lot of my feelings these days, which is of being kind of trapped in a very sanitary environment...Before I came here

And I was just used to having him there for me 24 hours a day. So as soon as I got

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Week ending 7/10/11
> It's been a frustrating week for recruiting participants. Two have recently declined and I am running out of time to get sufficient numbers. I was thinking of the original plan for an external researcher to approach the adolescents rather than their CC [care nurse coordinator]. Maybe that would incline them further to get involved. My doubts about who should approach the adolescents and who should do the interviews were removed this morning though. Some adolescents piped up in the morning meeting complaining that student nurses would read their files, but have no actual contact with the kids. As one said it's "about our deep stuff" and "they don't work here and we don't know them". The [Psychiatry] Registrar asked them "Do you feel comfortable in talking to someone about your stuff when they are here 2 or 3 days a week?" "No" was the firm response. It confirmed to me the reality that to do this research requires someone who the adolescents are well acquainted with, and whom they can trust and relate to. In other words, a practitioner.

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

Principal theme 2: Recovery from afar

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

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

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

This picture I really like it because it's almost like the side of the lake that I'm on is I guess Barrett and my illness, and everything that's gone wrong, and I've gotta try and cross the lake to get to the other side where it's – I don't know – freedom and recovery and stuff. But if you look I'm not wearing the right clothes to get across. So there's like no boat or no walk or anything. And so I'm at the tree I guess puzzled and upset because I have no idea how I'm going to get across there. And it just seems so far away and so pointless and I'm not going to be able to get it. But I know that when the time is right I can just hop into the water and swim across, I guess. ([redacted] 2nd interview)

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

DW: *Okay. Thank you. 1A, that's' the picture of the butterflies on the lantern. Tell me about that.*

: *That was a picture I thought for hope, to show that there is hope in every place, no matter how small. And that I'd done a couple of weeks before I took that photo with one of my nurses, and on the back of all the butterflies – you can't really see it – but there's writing. We wrote inspirational quotes, and stuff like that, on the back of the butterflies. Just kind of like a lantern guiding us to somewhere hopeful. And, yeah, that was kind of an on the spot idea and we just said "Okay, we're going to do that" and we just did it overnight.*

DW: *Is that hope still there, ?*

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

DW: *Where does that come from?*

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

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

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

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

For , even the acceptance of admission was enough for to 'breathe again':

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> *I opened the door one day - the doorbell rang on Sunday. Must have been when and were here because we were locked. And I opened the door and this said "Can I see inside your seclusion room?" and I said "What?" And was playing – was on the golf course. And said "I spent many years in that seclusion room". And I said "Did you?" said "Yeah, I'm a lawyer now".* (Nurse (3); focus group)
>
> *Yeah, look, when a parent who you mightn't have seen for a few years come and visit the Unit and they come up and give you a big hug and say, "Thank you for bringing my back to me!" Or "Thank you for giving us a life again!" That sort of thing is just wonderful. It's very rare to get that in any other setting. You run into the kids a few years down the track, they've gone to university, they've got a job, they've got married, they've got children, they've moved on with their lives.* (Nurse (1); focus group)

For the above nursing staff, when a past patient or parent of the Unit returned for a visit – sometimes years later – and thanked them for their input, their past hard work felt so worthwhile. These moments were noteworthy because they gave the staff a sense of hope. It was this hope that encouraged them to continue with the work despite not seeing many positive gains in the short term.

As the literature review demonstrated, the topic of recovery is a broad and diverse area. However, how the concept of recovery is linked with adolescence has not been so well researched and I suggest that because adolescents are a 'developmental work in progress', our conceptualisations need to be grounded in adolescent-generated data (Weisz & Hawley, 2002). The adolescent-generated data in this research revealed that the theme "*Recovery from afar*" is firmly linked with the concept of hope. This is also reflected in the literature where hope has been demonstrated to be an outcome variable in adolescent residential treatment (McNeal et al., 2006). The theme was strong in all the participant narratives. As one teenage girl declared, "*I've gotta try and cross the lake to get to the other side where it's – I don't know – freedom and recovery and stuff*". However, it is also clear that this hope waxed and waned for all participants as well.

As the adolescents recounted their stories of recovery, it was clear that hope could be cultivated through much internal searching and processing. However, it was also closely tied in to their circle of authentic relationships. Throughout the adolescent narratives, it became clear that should any internal hope be lacking, then hope could still be imparted via the input of compassionate others. Often this was imputed via the contribution of staff, but occasionally also through peers who understood firsthand the difficult journey mental illnesses created. The photographs in the study strongly suggest that the recovery process was made surer in the context of a supportive and understanding relationship with an adult. Interestingly, the adolescents said little about their parents contributing to their recovery process, but rather focussed on the relationships they shared with staff. However, to read too much into that silence would morph to speculation. In this sample, the adolescents clearly remained attached to their parents and most verbalised how they missed their family while an inpatient.

It also needs to be highlighted that developmentally, adolescence is a time for developing attachments outside the family. Such diversification of attachments assists in the regulation of negative emotions as well as contributing to the construction of the secure base (Scharf & Mayseless, 2011, p. 12). The adolescent narratives continually highlighted the negative consequences of any perceived superficiality of relationships (i.e., casual staff) or when significant relationships were threatened with loss (adolescent discharge or staff relocation). The data in this study therefore suggests that the recovery process of these adolescents was inextricably linked with their immediate relationships. The relationships were fundamental in furthering or repairing the secure base from which to address any mental health issues and were instrumental in generating hope.

While the adolescents clearly voiced their appreciation for these one-on-one relationships, the parents tended to put their hope in the organisation. Being a tertiary Unit, all other community-based and privately-based options needed to be exhausted first before their child could be admitted. For some, this translated into a long and draining journey before finally arriving at the only long term residential Unit in the country. That both psychiatric and educational options were available in the one location was also very containing for the parents. Their continual use of the word 'relief' also suggested a more hopeful future. Their narratives suggested a very draining and sometimes despairing experience in their care of very unwell adolescent children. This is consistent with research that has found that the severity of child symptoms was related to greater experiences of caregiver strain and parenting stress (Vaughan et al., 2013). While not directly investigated in this research, it has been generally accepted that the mental health of the parent and adolescent child can

be closely linked. In one study of 174 eleven to seventeen year-olds with depression (Wilkinson et al., (2013), the association between parent mental health and adolescent mental health was substantiated. However, while there was an association, the study was not able to establish the *direction* of that association or whether it was bi-directional.

This points to the need to systemically address wherever possible, the needs of both generations in order to produce the best possible outcome. The parents' narratives in this study strongly suggested that the quality of their own mental health improved as they obtained fresh hope and an emotionally containing presence through their child's inpatient admission. In other words, I propose that the parents – maybe for the first time – experienced some of their own recovery process.

The sense of hope for the staff was also prominent and like the adolescents and the parents, it also vacillated. However, despite the long-term nature of the adolescents' difficulties, it appeared that any gains made – at all – were sufficient enough to keep the majority of staff working at the Unit. For some temporary or casual staff, this type of work did not fit and they eventually moved on to other areas. This raises questions then, that if hope is such an important variable in the recovery process, how do staff create such therapeutic optimism? While there have been concerns about the negative impact peers and psychiatric facilities generally have on adolescents (Huefner & Ringle, 2012; Taiminen et al., 1998), there is also evidence to suggest that hope can be created and utilised to aid the recovery process (McNeal et al., 2006). Again, given the stories heard in this study, an adolescent psychiatric impatient Unit can be a stressful experience for all concerned. Nonetheless, it could be argued that working in such an environment demands a reasonable level of personal differentiation and ego strength in order to rise above any emotional fray that so often characterises such organisations. Lipschitz-Elhawi (2009) asserts that workers must have the ability to pull themselves out of any emotional quicksand if they are to help others:

> Besides being able to contain hopelessness, anger and anxiety, and to accept them as part of the therapeutic process, social workers must be capable of extricating themselves from passive despair and adopting an actively hopeful stance towards the adolescent (p.456).

Just as every adolescent experiences the developmental lesson of gratification delay, so too was there a sense of 'recovery gratification delay' for staff. They often saw in the adolescents, a sporadic, uneven recovery process. Being a long stay centre, the Unit had the benefit of having the time to create meaningful relationships with the adolescents. Subsequently, this gave the staff

opportunity to view the adolescents' recovery journey over an extended period. It did however in the process, mean that the staff would also vicariously experience that stop/start recovery journey. This required staff to regularly recall that fruit from their labours might not be forthcoming, if at all. This emotional pain felt was, of course, experienced by all the participants and is discussed further below.

Principal theme 3: Ubiquitous Pain

Within this study, the primary experiential themes are regarded as those which are common to all participants and shed insight into inpatient life generally. Ubiquitous pain is such an example where all felt various forms of discomfort or distress, but with varying meanings attached to the experience. By definition then, this was the emotional pain felt by all participants, uniquely experienced depending on individual context.

For example, pain was in terms of coming to grips with reality and a lack of control. The lack of control lends itself to a deep fear that manifests cognitively and somatically. The end result is a very confusing loss of orientation:

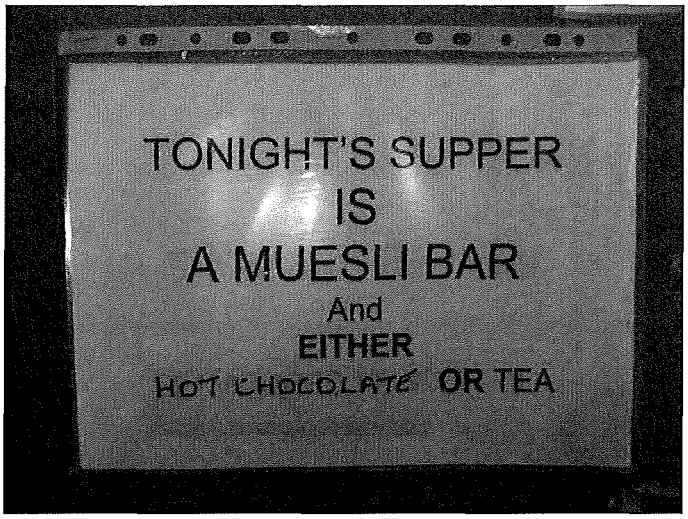
> *The reality that you're not always perfect. Sometimes things are going to happen and you won't have control over them. And having no control is one of the scariest things that ever happens. I know when I lose control I just get scared out of my mind. I get to the point where I'm shaking and I can't talk, and I forget where I am, and I just lose all sense of everything.* (2nd interview)

Living in such an environment and then trying to explain to those outside can be difficult. explained that for this was very awkward. It is not a boarding school, but the family is still separated. recounts some of frustration in trying to answer a peer's question:

> *It is quite awkward. Usually I've been – I mean because everyone expects you to be in school and they're like "What school are you going to?" and "Where do you live" and my family lives in so I'm like, "Do I live in or do I live in ?" And it is confusing.* (; 1st interview)

While the BAC was not a medical hospital, it nonetheless had rules and policies regarding food, access to certain areas and expectations of behaviour. The environment then, was a source of pain

for some of the teenagers. Some perceived the facility as being rather overbearing and intrusive, giving way to a sense of anxiety and intimidation as explained in second interview:



Well if I had to do that differently I'd probably rewrite all the kitchen rules. It's quite – it's not very friendly. Well I mean once again it's scary, intimidating. The font, the words, the bold, the different writing. It's...very intimidating to me. I mean all the kitchen – everything to do with the kitchen for me is intimidating and not like many people's – well I guess an idea of many people's home kitchens where they're warm and safe and welcoming and a centre for activity and you don't have doors locked there. And you don't have people standing at the door watching you and waiting for you. It's very different. (: 2nd interview)

experience above was echoed in a number of the adolescents' stories when they compared the BAC to similar places such as home or other places of emotional security. A number of the adolescent participants felt the Unit was not "warm and safe and welcoming" with unfriendly locked kitchens. While the teenagers could acknowledge the necessity of such safety measures, it nonetheless created a sense of confinement; with people "watching you and waiting for you".

In this controlled environment when fellow teenagers are not doing well, it can create a tense atmosphere. describes a rather precarious environment where it doesn't take much for the other adolescents to be triggered by the difficulties of others. Understandably, mentions that appreciated 'escaping' such a tense environment:

: *Probably all the different dramas that happen on the ward because when we leave the ward we get to escape the tense environment, and over on the ward there's always a tense environment in someone's life and it affects everyone else on the ward so...*

DW: *Yeah, okay. Can you give me an example, when things get tense?*

> *Well, for example, with all the new patients that are coming in, like they're bringing in, like, their new problems and they are affected with everyone else's problems that have already been dealt with, or are still in the process of dealing with them.* (1st interview)

The parents too, felt pain; pain that was felt – as the other participants – simultaneously at a range of levels. Maybe the most prominent for these parents was the self-blame that created a hurtful questioning of self:

> *And I have felt like the bad parent, and 'what have I done for my child to be like this?' and things like that.* ( )

> *However the big burden for me would have to be just the huge – the feeling of guilt and feeling so awful that was there.* ( )

Rarely was there only one emotion or thought process involved. felt a number of things. felt blamed for doing the wrong thing, guilt for child's illness and blamed for poor parenting skills. also felt there was little help at the end; given trite answers with medication as the solution:

> *And they also try and – like you feel a little bit blamed as a parent. Like "Why is your child like this? What have you done as a parent? How are your parenting skills?" But again there's a lot of focus on that, and then also "Right. This is what's wrong with them! Give them medication and out they go!* ( )

For some of the parent participants, the pain extended beyond the parent and unwell child and into other family relationships. For example, in the extract below, revealed what it is like to be spread thinly as a parent, where is called upon to be the caring parent, not just for the ill child, but for those back at home. finds it hard to be caught in the middle where energy is being drained from different directions. A particularly painful scenario is when a sibling of the ill child feels left out in the process. There is a sense of injustice; a sense of the ill child getting more things, more attention and ultimately, more love from the parent. One can understand the predicament found in, in trying to explain to younger siblings such a difficult situation:

DW: *Because there's only one* [redacted] *and saying 'yes' to something means 'no' to others. And I'm wondering what that does to you. Where it's almost like you have to say no to one child in order to say yes to another.*

[redacted]

In dealing with a population with such complex needs, it is not surprising that the staff were also confronted with a range of equally complex decisions to make. Few decisions were straightforward, and as the previous extracts showed, there was a strong sense of adopting a parenting role with the adolescents. Consequently, any decisions were not made lightly and given the sincere desire to help the teenagers, it was a difficult process to decide at what point nothing more could be done:

They can't stay here forever. It's upsetting them and it's upsetting for quite a lot of staff. In fact we have some of our more spirited discussions in case confidence over when to discharge someone or when someone should move on. You're going to have a lot of staff who have different ideas on all of this. Can we help them? Can we continue to help them or is it time to move on and accept the fact that there is nothing much more we can do? (Nurse (3); individual interview)

I think the negatives would be for those who don't move on and it's just hard that they won't or are not willing to take on everything that we're offering them. Yeah. Like they'll just put up a wall and there's nothing we can do. I think that's hard to deal with, as well. (Allied Health (1); individual interview)

For one nurse participant, he recalled that the work sometimes entailed double binds. Some of the parents of the adolescents were not so helpful in their child's recovery. Consequently, difficult decisions had to be made by the staff as to the well-being of the teenager. For some, it meant steering the adolescent away from the parent in the hope of a smoother recovery process. For others, the advantages in having more contact with the parent outweighed the disadvantages despite the

home situation being far from ideal. Here is an important example of one of the primary themes overlapping the different participant groups. In the extract below, the staff response is strikingly similar to the parent responses already noted; that of asking themselves 'Am I doing the right thing?':

> *And we take kids away from their parents. That decision with [redacted] basically taking away from the parent and saying [redacted] could only go every second weekend. Huge emotional stuff for that. Because, yeah, it's that whole moral ethics thing, it's sort of a thing...Yeah. And [redacted] Letting [redacted] stay with [redacted] even though it was a shocking situation. But there's a lot of moral ethical things, and a lot of emotion in "Am I doing the right thing?"* (Nurse (1); focus group)

The above parallel extends even further. The parents of the adolescents were blamed by others – particularly by those in authority such as health professionals – for the difficulties their adolescent children were experiencing. The message given to the parents was clearly "Your actions or inaction are the reasons why your child is the way they are". This experience was also that of the staff. Below is an extract from a frustrated staff member who is blamed for the bad behaviour of the adolescents and despairs at the lack of insight by the management into adolescent issues:

> *And when the kids do typical teenage things – and you'd think that people with kids would know this – that there's times when the kids are going to be little bastards and do things, that are going to make us look like dicks because they want to – and that's what the kids job is at times. And [manager] goes to meetings and [redacted] there – and things "Well your kids did this, your kids did that!" and I mean well, they don't' understand...* (Nurse (2); focus group)

Continuing on, we discover more thematic overlay between the participants. Many of the adolescents previously experienced significant physical or emotional abuse and as a result, displayed typical symptoms of being traumatised such as suicidality or significant self-harming behaviour. Particularly for those parents whose son or daughter was suicidal or seriously self-harming, the experiences were subsequently traumatic for them as well. Not uncommon in the helping professions, staff can also be affected by such stories of pain. In other words, there was a common thread of emotional pain for all the participants. For example, the parenting role that the staff shared with the biological parents was therapeutically crucial for the adolescents, but came at a cost:

> *Yeah. The distress of hearing [redacted] talk - when [redacted] dissociative and holding [redacted] down* [in restraint], *that would probably be another personally quite touching thing.* (Allied Health (3); individual interview)

> *I just remember hearing about [redacted] case and it was probably one of the worst cases that we've had and just how sad that was. I mean, often when [School Principal] has told us about kids who come in at staff meetings, and there's not a dry eye in the house.* (Teacher (3); individual interview)

All of the principal themes by definition are themes that are common to all participants and help understand the inpatient experience. *Ubiquitous pain* represents a common experiential thread of emotional pain felt by all participants despite their developmental stage or connection to the Unit. One of these interesting parallels occurred between the parents and staff, who were both blamed for the adolescents' behaviour. As previously noted, the parents in the study clearly experienced significant self-blame for their child's illness. In a study of parental self-blame, Moses (2010b) found that 60% of the 70 caregiver sample felt fully or partially responsible for their adolescents' mental illness. The most common reasons for self-blame were (a) bad parenting, (b) ineffective oversight of their child's mental health, (c) passing on 'bad' genes and (d) negative family environment.

Similarly, a process occurred in this present research where parent blame morphed into staff blame. This occurred when it was perceived by management that the staff were responsible for any misbehaviour by the adolescents. The accusation that, *"Well your kids did this, your kids did that!"* by management to staff could have easily been directed to a parent from a family member or a member of the public. Particularly for the nurses, many of the staff participants in this study reported various stressors in working with adolescent inpatients. This was particularly highlighted in their perceptions of the lack of appreciation and understanding of their professional role at the BAC. As one staff member recalled, it was very encouraging to see gains made by the adolescents and to receive the occasional 'thanks', as they felt validation was rare:

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

I suggest that unless there is adequate support and emotional containment from management, the effect could be yet another unhelpful adolescent/staff parallel as Foster (2009) describes:

> 'The cumulative impact of the trauma of caring for adolescents in mental distress...is that the fabric of their defences is attacked on all sides and unravels (p.19).

[redacted] then suggests that:

> The core tasks of the consulting practitioner are therefore to try to provide emotional containment for both the young person and the staff, and to be able to think about and make sense of their experiences; which is filled with intense and continually shifting transference relationships (p.21).

The extracts have also helped to appreciate the manifold pains that the adolescents experience. The recovery process for the teenagers was rarely straightforward. It was often a disjointed and confusing experience 'seen from afar'. The inpatient experience itself held a range of experiences for the adolescents, ranging from confusion to almost terror. [redacted] experience of "*I can't talk, and I forget where I am, and I just lose all sense of everything*" reflects the latter, while [redacted] rhetorical question, "*Do I live in* [redacted] *or do I live in* [redacted] *?*" suggests a perplexity of where [redacted] belongs. As the following theme, *The milieu: hospital & home* shortly explains, physical location can be linked with identity for an adolescent and there is a complicated juxtaposition of meaning for the adolescents as they try to explain their experience to others.

The adolescent participants in this study also experienced pain emerging from their relationships with their peers. There remains however, some controversy as to how severely unhelpful peer influences can be and the effects differ greatly depending on the context of the adolescent (Huefner & Ringle, 2012). For the adolescents in this study, their relationships with their peers were certainly impactful. Some found the experience of being thrust into residential care initially anxiety-provoking, but eventually helpful. Others such as [redacted] found issues such as peer self-harm confronting. As far as [redacted] was concerned, when a [redacted] peer self-harms "[redacted] *deserves to be punched, right in the ribs*". [redacted] response is not unusual. Deliberate self-harm by an adolescent inpatient often leaves the other teenagers feeling angry or with a burdened sense of responsibility (Crouch & Wright, 2004).

It was interesting that few adolescents mentioned restraint in their stories about their inpatient experience despite being offered sufficient opportunity. The use of seclusion and restraint for adolescents is controversial, with little Australian literature and compounded by international differences in its use (Fryer et al., 2004). What the adolescents did commonly report however, was

any disturbance in the 'relationship equilibrium' of the BAC. For some, the change of staff or patients was seen as a rupture in any therapeutic progress. comment "*There was a lot of people coming and going, which really affected my treatment*" strongly suggests that any instability in the inpatient relationships were a source of pain for the teenagers. It is noteworthy that in the above extract with photo of in the High Acuity section, despite feeling "*trapped in a very sanitary environment*", the most pronounced facet of experience was the lack of connection with others. Despite nursing staff being with 24/7, there was a deeper sense of aloneness and lack of relationship. Ubiquitous pain then, is a collective experience felt by all the participants. Psychodynamic and systemic factors merge, whereupon adolescents, patients and staff require an external Other to contain the anxiety typically experienced in such an environment.

Principal theme 4: The milieu: hospital & home

This theme is defined as the tension or balance of the inpatient Unit being both a hospital and home simultaneously. As a result, there were sometimes confusing or contradictory experiences. For example, the parents were well aware that their child was in a hospital for teenagers struggling with mental health difficulties. They also knew the Unit was their child's temporary home during the course of their stay, accompanied by many typical 'home activities' such as bedtime routine and outings. These teenagers like most adolescents, regularly felt the need to escape and have time in solitude to recharge emotionally (James, 2001).

When was first interviewed mentioned the difficulty of finding such a spot. By the time of the second interview four months later, had found such a place for as explained in the second extract with photo:

> *Mmm...I don't really like...there's always the people around, it's very hard to find a spot to be by yourself for a while, like...I don't know, I just don't like having so many people around all the time.* (**1st interview**)

I just find it really helpful to have a place to be creative and to let your emotions and feelings to come out in just a different way than words and speaking. And I just like how here there's a room just devoted to creativity like that. (**2nd interview**)

The significance of physical space was in a number of the adolescent narratives, particularly as they recalled how overwhelming the ward could be sometimes. photo below reveals something of the 'craziness' of it all:

DW: *2B is there with the TV, with static in the background, and holding your hands over your ears. Tell me about that one.*

It's basically like when we're over at the ward and everyone's got things going on, it just gets too much sometimes. And it gets too loud and noisy and stuff like that. And so – and it can really get inside my head and make me feel bad and stuff.

DW: *Is that what the static reminds you of, the stuff that's going on inside your head?*

: *Yeah.*

DW: *What's it like to have so much static in your head?*

: *Crazy. It's really crazy. You can't even explain what it's like. It's a mixture of feelings and emotions. Yeah. (* 2nd interview)

Again, the value of a qualitative study with photo elicitation proved most useful. shared that the ward sometimes "just gets too much" especially when "everyone's got things going on"; suggestive of what can occur when unwell adolescent peers live together. It can escalate to the point where words fail and "you can't even explain what it's like". Obviously from the extracts above, the desire for physical space is linked with the desire for emotional space. These feelings of wanting space are reflective of the restrictive side of residential life; a context where limits and policies must be adhered to. For example, the nurses were required to check on the adolescents regularly as part of their role. Some teenagers such as found this intrusive:

> *Mostly when I've been upset and distressed, and the restrictions that have made it really hard. And the lack of personal space and privacy. And the nurses checking up on you and sharing with other and just lack of – you can't – there's no private space you can go, without the nurses being there with you.* (1st interview)

too, found the experience initially difficult especially having to sleep there, but was thankful for the times when could leave the Unit for some respite:

> *If I was to describe it to a stranger, I'd tell them it's a – to be honest, I normally tell them it's a hell hole. That's what I used to say. Because I didn't like sleeping there every day. But it's a lot better when you sort of get out more.* (1st interview)

When the adolescents could not leave the premises, they sometimes felt trapped. Sometimes they reminisced about home and missed the freedoms they previously enjoyed. photo below captures that experience well:

DW: *Okay. Now here you are, in behind some bars here, out in the courtyard.*

: *Yeah. That's I feel really – at night when the doors get locked you feel really trapped because you can't get out, and you can't go for a walk. And if you're at home you'd be able to just go outside and feel the breeze, and stuff like that. But you can't do that here. I guess it's for our safety but it kind of sucks in a way.*

DW: *As I look at that photo it looks like you're in prison.*

: *Yeah.*

DW: *And I'm wondering if that comes up for you sometimes?*

: *Yeah. Yeah, it definitely feels like that sometimes.* (3rd interview)

The photo above is both powerful and meaning-rich for . Once the doors were locked, it declared the restriction of freedom and the creation of two worlds. One is inside and the other is where one can go for a walk and "feel the breeze" which I suggest is another way of stating 'feeling the freedom'. Similar to many other meanings given by the adolescents, contrasted inpatient life with life at home where "you can just go outside". I suggest that many, if not all, of the adolescents reminisced about home and the freedoms once enjoyed. However, recognised the BAC was locked for safety reasons, but nonetheless lamented the fact. With such a photo, it was difficult for me not to suggest a 'prison' analogy. readily agreed though, that it was indeed applicable to experience.

Conversely, physical environments can provide a sense of safety and security. Adolescent bedrooms in particular are usually reflective of their personality and interior worlds. noted this in their first interviews. In the first extract compares previous comfortable home to "a psychiatric Unit":

> *...when you go home from a really rough day at school you're just like "Yes!" and you go into your bedroom and you can just like listen to music or go on the computer, and it just feels good. Whereas here, it's kind of like, rough day and you're like "Oh, I'm still in a psychiatric Unit!"* (1st interview)

> *This place looks so depressing...All the walls are these weird off-pastel colours, and it's just a really depressing environment.* (1st interview)

The inpatient experience also involved positive elements of the ward being a home as well as a hospital. One element is that of having fun with family or peers. recalled that sometimes life

on the ward can also be like a "mass sleepover" that is reminiscent of other families sitting around the TV:

> DW: *If there was one thing you would want to keep about Barrett, what would that be? That you wouldn't want to lose.*
>
> *I don't know. Because it really depends on my mood at the time. I don't know. Just the fun things that we do. Like the other night when State of Origin was on, we went and got packets of chips and chocolate and Coke. That was amazing. We all sat down and watched the Origin and it was really loud and that was fun. Just the bond. Oh my God, I would never change that! It's so amazing. Sometimes it's really fun. It's like a mass sleepover.* (1st interview)

The recurrent theme of relationship surfaces in this area too. Healthy home life involves steady and secure relationships as well as being taught and encouraged to interact accordingly with ones' family. When the staff population fluctuated, it was deeply felt by the adolescents. For instance, when it was put to what positive aspects of the BAC would keep, explained it would be a permanent staff population that created deeper relationships. When this does not occur, one gets the sense of feeling let down; echoing the experience of children who have sporadic contact with a parent:

> *Probably having a set group of staff. Because it's good when you can have like a set of staff that you can build a relationship that understands you, instead of having new nurses coming in every week that you have to explain your whole story to again and sort of build up that relationship and then they're gone the next week after that and you don't see them again.* (; 1st interview)

However, when the relationships at the BAC were perceived to be genuine, it had the capacity to initiate growth and security in the adolescents and the creation of hope for the future:

> *Like I felt like - before coming to Barrett I felt like no one cared. I had no hope. And what's the point of loving someone when it's hard enough to love your own feelings, let alone care about someone else's. And then when I went to camp everyone was hugging and praising me, and saying how much – and it was just like amazing to see that people actually can care and that there is hope for me to be able to have a good relationship*

> *with people. And all the positive cards and stuff, that was just amazing.* (1st interview)

The parents of the adolescents likewise had mixed and simultaneous feelings about the BAC being both a hospital and home for their child. As shown in the other themes, the parents felt relief at the admission of their son or daughter to the Unit. found the experience very containing:

> *...and there were nights when I couldn't go to sleep. I had to stay up. I was too scared would go, run to the train. Because you can't physically control a 16 year old. There were nights even when I couldn't go to sleep, so when went to Barrett you could sleep through the night - just those little things. Knowing was safe.* ( )

also found the admission a relief, while simultaneously trying to deal with "sending away feelings":

> *I suppose the pressure was off from the daily grind of having to go to bedroom and try and coerce into getting dressed or talking about going to school. Then obviously there was the sending away feelings because going to be there for a [initial] fourteen day stint sort of thing before you could go and see But obviously I knew it was good for so had to take that step.* ( )

Typically for all the parents connected to the Unit, these parents above felt relief knowing their child was going to experience a fundamental element of home life – safety. However again, there was a cost involved; the sense of guilt and disrupted relationship that accompanies a hospital stay.

In terms of the staff, they were keenly aware that they were both professionals working in a hospital as well as taking on a parenting role with the adolescents. For one staff member, this was a necessity should the parents not be able to offer it themselves:

> *We need to keep those tasks of parenting, so if they're not going to do it, we have to step in.* (Allied Health (3); focus group)

Another staff member felt that the consistency the Unit brings could offset any previous lack:

> *The fact that we're very structured and they know what's coming in lots of ways. They know ICW, case conference, and yes that can lead to institutionalisation, but it also can be consistency which they haven't had.* (Allied Health (2); individual interview)

The two nurse participants below suggested that one of their roles was to offer that which one would normally experience in families:

> *I think they experience family that they wouldn't a lot of times experience outside of here.* (Nurse (2); individual interview)

> *Being able to go on outings and show people experiences that they just never got before. They have - some will come from families who've never, ever taken to the beach or taken them to the mountains or taken them to the river to do canoeing. Just experiences that they've never done; it's great to be able to see them do things like that and interact with staff and their peers.* (Nurse (3); individual interview)

The staff above believed that one of their primary professional roles was that of providing the tasks of parenting. This was a core belief for the staff at the Unit. Consequently, offering experiences that would typically be found in the family home would also be presented to the adolescents at the BAC. This was balanced with their respective work role depending on the profession. The staff then, aimed to balance up the dual phenomenon of the Unit being both a psychiatric hospital and a caring home for youth.

I suggest that given the above extracts, inpatient life was perceived as both hospital and home. It is, as one study described, 'living in an alternate reality' (Hayes et al., 2011, p. 150). The family environment of the adolescent has been one of the most researched given its developmental importance (Collins & Laursen, 2004; Steinberg, 2000). Characterised by meaningful and secure attachments, any threats to the stability of such can have a number of repercussions. I suggest that this aspect mirrors the experiences of adolescent inpatients.

In their study of thirteen 16-18 year old psychiatric inpatients, Harper et al (2013) argued that loss and continuity were most important for the teenagers and any losses experienced while in hospital may well re-enact past losses or broken attachments. The narratives of the adolescents in this study continually revealed a similar theme where the core feature of inpatient life centred on the relationships. This was most pronounced when there was the use of casual nursing staff or others

who were perceived as not genuine, as well as when staff or other adolescents left the BAC. I suggest that the adolescents in this study may have re-experienced past historical pain when inpatient life mirrored past relational ruptures (Braxton, 1995; Robins et al., 2005).

As described, the milieu also offered some positive reminders of home life such as watching a fun movie with friends or family. As one teenager described it, when the hospital became a giant "sleep over" it was reminiscent of happier times. The adolescents also recounted another aspect of those happier times, when they contrasted the privacy and space of home with that of the Unit. Their stories revealed a developmentally understandable desire for physical and emotional space.

Unfortunately, privacy and inpatient work are often in conflict (Hutton, 2008). In one study where unwell adolescents in a medical ward were asked to design their own hospital, the need for privacy was noticeably high on the list (Hutton, 2005). described above, when it is difficult to find a place of solitude, *"it can really get inside my head and make me feel bad and stuff"*. This has implications for such issues as ward design and how to incorporate developmentally-informed policies for adolescent inpatient units. A fundamental starting point could be the recognition of the importance teenagers place on bedrooms, As Kopec (2006) explains:

> Although older adolescents seek affiliation with their peers, they often seek solitary places to relax and gain perspective...Bedrooms are personal territories. Children need and desire their own territories not only for self expression and identification, but also as private places for contemplation and relaxation (pp.147-148).

Arguably the most important aspect to creating a developmentally-informed milieu would be developmentally-minded staff. Staff knowledge and attitudes play a crucial role in how therapeutic adolescent/staff relationships will play out, especially with emotionally-charged issues such as adolescent self-harm (Wheatley & Austin-Payne, 2009). As the staff extracts revealed, the staff participants felt it was their job to simulate the positives of a home environment, including aspects such as discipline and boundaries.

This has implications for such techniques as time-out for misbehaviour. While the technique can be useful in reinforcing limits and boundaries, care needs to be taken that the adolescent is not being punished for some deficit or that important underlying issues are dismissed (Delaney, 1999). One needs to be mindful that the adolescents in this study were there because of the debilitating nature of their mental health difficulties. Consequently, their sometimes difficult behaviours required a

sound understanding of the context that brought them there in the first place. Should such an understanding be lacking, the consequences would be to the detriment of both staff and adolescent. Ward (2003) argues for the importance of the Winnicottian concept of creating a holding environment not just for the patients, but for the staff as well, 'if they are to feel sufficiently secure and resilient to provide for the children' (p.30). Some staff divulged a deep sense of professional isolation while at the BAC, and while it is beyond the data in this study to speculate too assuredly on its potential impact on staff-adolescent relations, one can assume it may have influenced at least some staff decision making. The need for staff themselves to be offered emotionally-containing support now becomes apparent; especially in such a concentrated pool of relationships. Sexton (1999: cited in Webb 2011) warns of the potential effects:

> The more distressed a client group, the stronger the effects of unconscious counter transference on staff, and the more likely client issues will be repeated within the organisation (pp. 56-57).

Both the literature and the stories of the participants in this study strongly suggest that sound therapeutic practice with adolescent inpatients requires sound anxiety-containing policies and anxiety-containing relationships from Management.

Finally, the parents too, shared common anxieties with their teenage children and the staff who were charged to care for them. The parents were relieved knowing that they had finally found a facility that was long term and could attend to their child's needs. For one could finally "*sleep through the night*". Indeed, a number of the parents' experiences in this study suggest a very emotionally draining experience; one that speaks of despair, exhaustion and deep anxiety. I suggest that the experience for these parents are similar to other forms of parental burnout such as when one must look after a chronically (physically) ill child (Lindström et al., 2010). I would highlight however, that a physically ill child tends to be more 'visible'. The parents in this study recalled numerous occasions where friends and family could not understand or appreciate the burden in looking after a teenager with 'mental' health issues.

One final observation needs to be highlighted for this theme. Despite the temporary separation of parent and teen, the family system continued to exert tremendous influence on the recovery process as well as developmental growth generally. What was noticeably lacking in the staff-parent narratives were any sense of 'joint parenting'. It appears that the staff aimed to emulate the tasks of parenting within the milieu. The parents recognised this and, albeit with some sense of

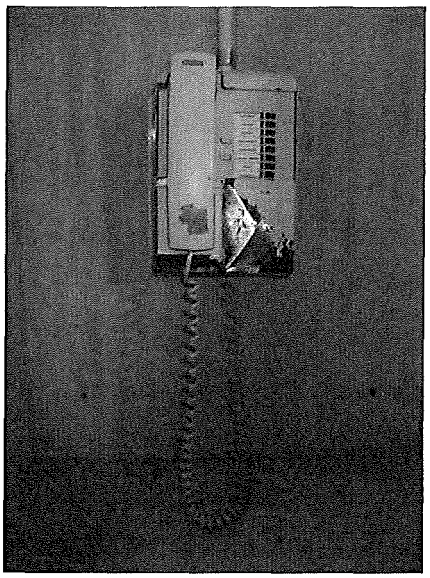
displacement, allowed such to happen. For reasons not yet understood, there appeared to be little narrative about the linkage between these two phenomena. Possibly for the first time, the parents enjoyed their own psychological 'space' and appreciated the 'extended BAC family' raising their child. Possibly for the staff, it was simply a given that they would absorb such a role. In any case, such amorphous circumstances again reflect the multiple and complex relational structures of the inpatient experience which are elaborated further below.

Principal theme 5: Simultaneous meaning

The last of the five primary themes is one which is entwined with the other four and requires a brief explanation. Throughout the narratives of all the participants, there was a strong sense that the experiences were not clear-cut and this layering of experience was sometimes difficult to make sense of. I suggest that this meaning-making experience was simultaneous. It needs to be acknowledged that there is some debate as to whether one can actually experience two conflicting emotions simultaneously or whether divergent affect is experienced sequentially (Brehm & Miron, 2006). However, given the neurological rapidity of our physiological systems and the fact that this study is not investigating affective experience at such a micro level, it is of secondary importance.

For the purpose of this study, the term 'simultaneous meaning' refers to the occasions where the individual concerned felt two or more conflicting processes; equally valid, but all undergone as part of the one experiential event. Consequently, multiple meanings may be attached to the same experience creating a sense of ambivalence. It is also acknowledged that the previous four themes may have contained this aspect. However, after extensively examining the breadth and depth of the stories of the participants, the decision was made for this facet of inpatient life to be a separate theme in its own right.

I suggest again that the adolescents found the photography an exceptional medium through which to capture the meaning of these complex experiences. For instance, narrative below is very rich as explains the simultaneous meaning behind the foyer telephone; used by the adolescents to take calls:



DW: *The telephone in the foyer.*

Yes. That's the only telephone that we can – I don't know – use. And if you look at it, it doesn't look like a very happy telephone to be using every day because my mum calls me every night. And so I pick up that phone every night. And if you look at it, it's just – it doesn't look like you could have a happy conversation through the other person on the other line. And it's just – I don't know. It also symbolises that you can't call out. So you've got to wait for someone to call in. That's also very – it sucks because you can't just pick up the phone whenever you want and call someone. It also is a fact that if your mum's on the other side of the line and you're feeling very homesick and you want to talk to you're picking up this ugly rusty old phone to talk to your lovely beautiful mum on the other side. So you don't really feel very happy picking up this phone because straightaway looking at it, it just doesn't show any warmth or niceness at it. It's just – so it doesn't really make the person on the other side of the line feel good. I don't know. 2nd interview)

explains that there is much incongruence between the state of the phone and those whom is speaking to via the phone. The phone itself is old and dilapidated, making it difficult to have a "happy conversation" with someone loves. It has no "warmth or niceness", unlike "lovely beautiful mum". It also symbolises a linkage to the outside world that misses. However, that aspect is also difficult. Just because the phone is there, it does not necessarily mean the adolescents are allowed to use it. It was BAC policy that calls could not be made from this phone – only taken. Consequently, one has to wait for someone outside to make the effort to connect with those inside, creating a sense of homesickness. All these elements are experienced simultaneously; a mixture of hope, sadness, expectation and longing.

Another example of simultaneous meaning is found in photo and narrative below. I suggest that the extract and photo are valuable windows into the experience of all the participants. All participants looked forward to a better place beyond their experience of mental illness. However, all – depending on the perspective of adolescent, parent or staff – were still keenly aware

that the past is still 'present'. Consequently, we again have multiple meanings occurring simultaneously:

DW: *Tell me about this photo.*

Well my scars represent a lot of things and a lot of difficult times. And I obviously when I was having bad times, and so that was in the past. Yeah. So it's basically that everything on my arm means something different and it means something really big to me, but it's in the past. And I've got to try and keep it there, and not let it control me, not let them scars control me.

DW: *So even though you've written "The past is in the past" sometimes it still is in the present?*

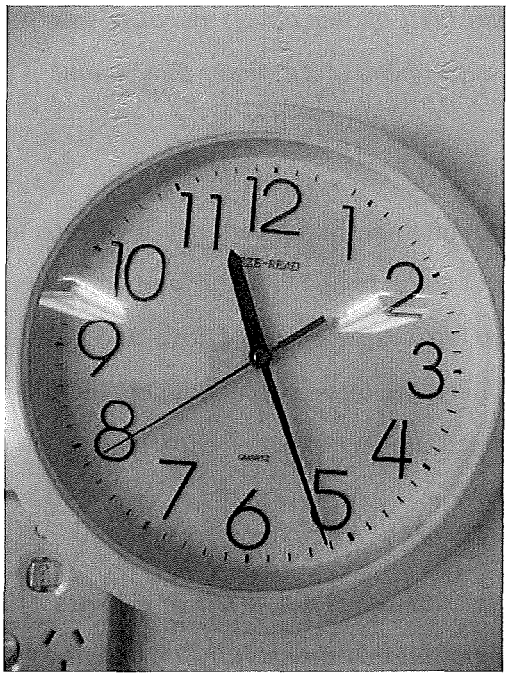
Yeah.

DW: *And still comes up? As I look at it – and tell me if I'm wrong – it's like the scars remind me of, yeah, lots of pain, but it's like you're making a statement that says "No, stuff ya; The past is in the past" and you're rewriting over it?*

Yeah, that's exactly what it's meant to say.

For then, the scars tell a story; the story of a painful past. However attempts to keep that story in the past and not let it dominate again. Drawing story out a little more, readily agreed that there was a rewriting of the past in an attempt to be in more control. The picture itself is rich in symbolic meaning. All participants – adolescents, parents and staff – wanted to 'rewrite stories', albeit from different vantage points.

also had much meaning embedded in another photograph, this time of a clock; representing both restriction and release:



DW: DW: *Picture of the clock.*

: *Oh gosh! The clock! Oh my gosh! I don't even know what to say! So much routine is in the clocks at Barrett. When you wake up, when you have your meal times, when it's homework time, when it's bed time. It's just 15 minute Observations so every 15 minutes if you look at the clock then there's going to be a nurse peering through your window or telling you to go to school. At 7:30 every morning it's time to get up and get ready. At five o'clock every day it's dinner time and it's just like clocks are kind of really daunting at Barrett because they can either – you can either be – for me I wait every Friday afternoon for four o'clock because that's when I go on weekend leave, so I'm staring at the clock all the time just like "Hurry up. Hurry up. Hurry up for me four o'clock!" But other times when it's like – I don't know – Sunday afternoon, I'm driving back and I'm just like "Oh my God". I look at the clock and it's just like "Oh". But it can be both - when you look at the clocks it could be like "Yay!" because you're going to do something, or it could be like "Oh my God, I just want to pull the batteries out and just burn the clock!" because it just means so much.*

For , routine is embedded in the clocks. There is so much meaning behind this mechanism, doesn't "even know what to say" when we first started talking. The clocks are powerful. They dictate what is to be done and when – regardless of any intrusiveness. However, they can also declare positives such as freedom on a Friday afternoon and one can hear the pleading in voice, "*Hurry up for me four o'clock!*" recognises this double meaning and states "it can be both" positive and negative.

Parents too, found themselves struggling with an internal dissonance. All the parents expressed a desire to help their child and their stories suggest a high price paid to find that help. Sometimes in the midst of one experience, there were others superimposed, such as found:

> *And that's what you feel like – you're really prisoned [sic] by this child. Because you have to be vigilant and always trying to think three steps ahead and counter things, and be prepared.* ( )

use of the word "prisoned" suggests captivity to the situation. In the very act of helping and protecting one's child, there is also a sense of being in jail. One has to be "vigilant" and "think three steps ahead" to prevent a tragedy occurring. By doing so, the experiences of love and care are juxtaposed over feeling trapped in a hypervigilant state. Like the other parents, given such pain, felt relief at child's admission. However, it created another layer of experience; that of giving parenting away:

> *So that's been an issue – trying to stay involved and still – because I felt in a way I didn't – you feel in a way like you're abrogating parental responsibility. That the parents becomes Barrett.* ( )

too, felt that despite willingly admitting adolescent into the Unit and being thankful for such, there was nonetheless another level of experience; a sense of loss over familiar role as a parent:

> *... my child, and I still believe I'm the parent, but I feel like sometimes being here that parental role is taken away from you a little bit.* ( )

At child's admission, simultaneously experienced relief, shock and the pain of reality:

> *...things had progressed so badly it was a mixture of relief, and also total – just shock and just that feeling that your child can't be at home and is in hospital for the reasons that was.* ( )

Stories by the other parents also reflected the theme of *simultaneous meaning*. Their child's inpatient stay was a mixed, sometimes confusing experience. They experienced the prospect of finally receiving long term help for their teenager, a sense of parental displacement, fresh hope for the future, as well as an opportunity to give some time back to children back at home. It clearly became a pivotal point in the life of the families.

Likewise for the staff, there were sometimes contradictory experiences and subsequent unease at making sense of them. The parenting issue was a case in point, where most staff acknowledged such a role, despite the role having sometimes very ambiguous boundaries. The issue of how long should the adolescents remain patients is another, with simultaneous yet dissonant implications. While there was the acknowledgement of the benefits of a longer term stay, it also created potential dependency issues. Where one drew the line was open to debate among the staff:

> *So that's what I'd say would be the negatives for the kids, that we're delaying that process of potentially moving on to something that's better than us.* (Allied Health (3); focus group)

> *I think this becomes a safe place for kids. So safe that they don't want to leave and then they often sabotage their treatment so that they end up here longer because they're frightened of what's going to happen on the outside.* (Nurse (2); focus group)

I suggest again the above extracts are another parent-staff parallel. Given the parenting role staff take on with the adolescents, it is not surprising that it can be difficult to know when to launch them out of the 'family nest'. The staff were obviously concerned about how they will they fare on the "outside", but are aware that there are some necessities of life that they could not provide: "something that's better than us". Consequently for the staff, there is the desire to give what they can, while simultaneously steering away from an unhealthy dependence.

This section shall open with another short extract from my reflective diary:

> Week ending 20/5/11
> Interesting discussion in Case Conference this week where one of the adolescent boys was being discussed. There was vigorous debate as to whether the presenting issue was one of "can't" or "won't". Such simple words, but loaded with so much meaning! The repercussions for which term 'wins' are far reaching, including treatment issues and discharge. Funny how often the staff are split between the two alternatives, with really little discussion about a 'both/and' rather than an 'either/or'.

The above extract though written midway through the research, still reflects a reality now in the analysis stage generally and in this theme in particular. It reflects that the events and experiences of the participants can have several meanings attached – a 'both/and' phenomena. As the methodology

explained, no efforts were aimed at finding an objective truth in the narratives of the participants, though behind their experiences lay all the various elements of their very real mental health difficulties. The multiple narratives seen thus far are therefore recognised as these various elements of a real phenomenon. Rather than contradictory, they instead bear witness to the many-sided forms of inpatient life. As Ribbens and Edwards (1998) argue:

> Rather than assuming that multiple interviews necessarily provide more information (which in many cases they can), it is probably more accurate to say that multiple interviews help to reveal the complexities, contradictions, and tensions in people's accounts and in their daily lives (pp.19,20).

The variegated nature of the data in this research then, reflects the considerable variety and interconnected experiences for the three participant populations. The adolescents were experiencing many processes; living away from home in a hospital that is now their home; living with peers from whom they rarely can escape and in whom they find both solace and distress. They form attachments with adults who offer a nurturing parenting role thereby encouraging attachment while being mindful that this parenting relationship is temporary and will one day come to an end. The adolescents lived through a kaleidoscope of experiences that few other teenagers would ever understand.

The parents likewise felt much internal dissonance while their teenage child was in a psychiatric facility. Similar to other parents who experienced near-burnout with chronically ill children (Lindström et al., 2010; Taylor-Richardson et al., 2006) the parents in this study sometimes may have felt *"really [in]prisoned by this child"* though obviously fought sometimes very hard for a place at the BAC. When it did occur, the initial relief came at a cost with the parenting of their child now shared with an organisation; an organisation that included individuals who sometimes might not be congruent in their management of the adolescents. Still, from the parents' perceptions, the Unit offered a 'good enough' environment for their child and allowed them to take a long-awaited emotional breath. Parenting from a distance was the price they were prepared to pay for any chance of recovery for their child.

This parenting also came at price for staff as well. The regular staff were employed at the Unit for many years; suggesting – given the stressful nature of the work – that they saw their career as something worthwhile; an opportunity to make a difference to troubled youth. They did this knowing observable results would often be slow. Nonetheless, any glimpse of progress, or the

occasional past adolescent consumer taking the time to return later and offer thanks, was all it seemed to take to recharge the emotional batteries for inpatient work. While most staff found the work sometimes stressful, it was the lack of supportive input from some sections of management that they felt was equally disheartening. To what extent this experience aggravated any unhelpful transference issues is still unclear. What is clearer is the necessity for adverse reactions to be revealed and addressed accordingly. Webb (2011) cautions against any tendency to ignore parallel processes in human service organisations. To do so would be to the detriment of all concerned:

> Without sufficient reflective practices at individual, team and organisational levels, the risk of client-worker interactions being replicated more broadly across an organisation is increased...If client-worker dynamics appear to be replicated systemically within a team or the entirety of an organisation, a managerial call to action is needed (p.64).

I suggest that the opportunity for reflexive practice is crucial to disentangle any unhelpful elements of *simultaneous meaning*. Contradictions in experience or other contributors to internal dissonance may elevate stress levels and given the close emotional proximity within inpatient life, these stress levels could be easily transferred to other individuals connected with the Unit. Here at the end of the master themes, one can now begin to see the relationship between reflexivity, the phenomenological attending to and valuing of, subjective experience and practitioner research (Finlay, 2011). I argue that without reflexivity, one's own subjectivity will simply be projected onto others and our own unique phenomenological experience will remain hidden. Without openness to the phenomenological lived experience of others – 'back to the things themselves' – we are left with dry empirical observations with the practitioner (and ultimately the consumer) the poorer for it. Conversely, when both reflexivity and openness to the lived experience of others are valued, fresh phenomena may be seen for the first time.

Summary

The inpatient experience is foremost a multifaceted and multilayered experience. While some themes emerged stronger than others, no one particular essence of the experience could claim to be *the* experience. At first glance, these experiences were often seemingly contradictory. However, upon closer examination, the contradictions were recognised as divergent elements of the greater whole as well as being experienced simultaneously. For example, the primary theme of *Milieu: Hospital and Home* reflected this where, due to their mental illness, the adolescents found themselves in the care of a hospital environment while also experiencing the milieu as a temporary home. Equally so, the staff were well aware that they were professionals working in a hospital

environment. Yet one of the very things they attempted to do was to help make the adolescents feel they were *not* in a hospital and to create an environment that recreated facets of home life.

The inpatient experience was also situated in a *strong developmental context*. The experiences of the teenagers were sifted through the lifecycle stage of adolescence. Consequently, as the parents of these teenagers, their families too were immersed in this developmental context. This same developmental circumstance guided the staff in their inpatient work with the teens. This expressed itself clearly in the parental tasks the staff took on in their professional capacity. Finally, the experience was firmly grounded in, and directed by, the *relational interactions* of all participants. These relational interactions between adolescents, parents and staff created a complex relational matrix that was principal to the inpatient experience. A discussion of this matrix in relation to adolescent mental health recovery will now be discussed in the following chapter.

CHAPTER 8 DISCUSSION AND CONCLUSION

Introduction

The preceding two chapters detailed the key thematic findings of the study for each of the participant groups. In particular, Chapter 7 presented a more detailed analysis of the principal themes comprising the inpatient experience. This final chapter synthesises the previous material and summarises the key contributions of the present study. I argue that the study has provided both theoretical and practical contributions to the field. Theoretically, it contends that adolescent mental health recovery must be conceptualised as a developmental reconstruction. Practically, this is facilitated through the 5 principal themes as well as the development and cultivation of a 'developmental mindfulness' which entails a firm reflexive stance for practice in the 3 primary domains of practitioner, team and organisation. The thesis began with the topic of mental health practice and shall likewise close on the topic of mental health practice. Limitations of the study are acknowledged, as well as critical reflections on the progression of the data as well the progression of the researcher. The chapter concludes the study with potential areas for future research.

To begin, Creswell's (2007) criteria in assessing phenomenological research are reviewed:

- Does the researcher convey an understanding of the philosophical tenets of phenomenology?
- Does the author have a clear "phenomenon" to study that is articulated in a concise way?
- Does the author use procedures of data analysis conducive to phenomenology?
- Does the author convey the overall essence of the experience of the participants? Does this essence include a description of the experience and the context in which it occurred?
- Is the author reflexive throughout the study? (pp. 215-216)

I offer the following in response. Firstly, the phenomenological thrust has been recurrent throughout the study, with a phenomenon clearly articulated. Two chapters were given to describing and interpreting the experience and the notion of reflexivity has been valued throughout. The conceptual underpinnings, methods and focus of the present research were all congruent with phenomenological principals, and worked well in furthering our understanding of the inpatient

experience. Uncovering the phenomenon has subsequently demonstrated the benefits of a qualitative, phenomenological methodology for practitioners (Finlay, 2011). One of its strengths has been its ability to capture meaning 'close to' everyday experience with its inductive nature encapsulating complex phenomena. In this regard I suggest that the study has created a 'good description' of the experience of inpatient life as portrayed by van Manen (1997):

> A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way (p. 39).

The present study also falls in line with trends in recent years that investigated the relational aspects of adolescent life beyond the family, as well as recognising various developmental contexts (Smetana et al., 2006). Furthermore, it parallels research trends that explored the impact of multiple contexts in the adolescent's life (van Dulmen, 2005). This present research then, builds on previous work and acknowledges its contribution.

At the end of the study, the primary and secondary research questions need to be revisited. The key research question that drove the study was:

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

Closely related secondary questions were also put forward:

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

What follows below are the data-driven responses to these research questions, firstly by outlining the key theoretical contributions of the study, followed by the key practical contributions of the study.

Recovery in adolescence: a developmental reconstruction

As the literature review demonstrated, the notion of recovery has various defining features, though historically adolescent mental health has borrowed heavily from the adult recovery literature. During its theoretical and conceptual investigation, this present research uncovered the following:

- The literature on recovery has yet to be adequately applied to adolescent mental health.
- There has yet to be the merging of recovery theory and developmental theory for the benefit of adolescent mental health.
- Consequently what is missing is an adequate conceptual model of adolescent mental health recovery.

Moreover, the review showed that of the extant literature on adolescence, there is much material on how characteristics, attributes or other features of the adolescent influence others; that is, how the adolescent influences their social context. There is also significant research that has explored how the characteristics of the setting influence the adolescent. The present study revealed that there is little material that incorporates a developmental contextualism that appreciates the continuous, bidirectional interactions of *both* spheres. This developmental contextualism recognises adolescence as a multifaceted work in progress; one that both influences the immediate context, as well as being influenced by, the immediate context.

A key theoretical contribution of the study therefore, lies in the demonstration that adolescent mental health recovery must involve a developmental reconstruction. In light of the results of the study, I define such a reconstruction as:

> *The re-creation of personal resources for mental health recovery that appreciate developmental constraints while pursuing developmental growth.*

A brief explanation of the above is required. The notion of 'mental health recovery' does not necessarily refer to replicating a previous state of wellness. Rather, it refers to the active, purposeful movement towards emotional and psychological well-being; a mindset of growing towards health. Hence the 'recreation of personal resources' points to an active rediscovery of individual hope, meaning and strength towards a better life, regardless of the presence or absence of mental illness. Also, the term 'developmental constraints' should not be interpreted too negatively. Adolescents – due to the very lifecycle stage they find themselves in – experience physical, cognitive and psychological boundaries that are typical and normative for this stage of life. As this thesis has

highlighted, these developmental boundaries should be taken into consideration with regard to any mental health context. Finally, despite the effects of mental illness, there are still developmental milestones that will need to be addressed. The degree to which this is achieved will subsequently influence latter stages of life. Therefore, the 'pursuit of developmental growth' remains a core task (particularly) during the adolescent years.

Developmental growth is interpreted by contemporary developmental theory. Consequently, this developmental reconstruction is likewise informed by such bodies of knowledge. The sections below are presented as examples of how developmental theory can guide practice in mental health contexts, particularly in the domain of adolescent identity formation.

Firstly, Piagetian theory (Muuss, 1996) reminds clinicians that teenagers will be developing the capacity for abstract thinking and as such, start to imagine a better future; one without the limitations of mental illness (though some will struggle with any idea of a better future). Consequently, they will value input into their own treatment and plans for their lives generally. They will also value a strong sense of justice for themselves and their peers. They may be somewhat militant in their expression of strongly-felt ideals. An example might be the right to personal freedom, but failing to see potential safety issues generated by the sense of indestructibility (e.g., going for an unsupervised walk at night).

Secondly, Erikson's theory (Erikson, 1963) posits that the adolescent identity crisis was preceded by and built upon, earlier development experiences. Consequently, while the present study investigated the experiences of adolescents, they were all at one stage, children with varying backgrounds that have led them to this point. Some adolescents will have a more secure sense of attachment than some of their peers (trust vs. mistrust) while other teenagers will differ in their sense of achievement (industry vs. inferiority). This should remind all staff working in residential care that each adolescent is unique in their ego strength and other developmental capacities; that chronological age does not necessarily reflect developmental age.

Thirdly, during this phase the creation of a sense of identity is acutely rooted in the present-day interactions with one's peers. They become the mirror that reflects the adolescent ego that is still a work in progress. During this time, there is intensive peer group involvement; usually a helpful mechanism, though there is always the risk of conforming to the values of others prematurely and creating a sense of dependency. With the many physiological changes that occur through puberty and adolescence, the desire to be seen as attractive physically and intellectually means the peer

group becomes the ego sounding board for the teenager. This has important implications for adolescents in residential care. Given that identity formation is ongoing, and that this can occur in the context of a mental health Unit, caution must be exercised in the mixing of the adolescent inpatient population. Not only do the adolescents vary widely in their particular recovery journey, they also vary widely in their journey into identity formation. Both clinical and policy guidelines must consider that the adolescent inpatients will influence each other; sometimes for better, sometimes for worse. In either case, the social context the adolescents are in, as well as the mental health difficulties they must concurrently address, will have implications for identity formation.

Fourthly, the identity statuses of achievement, moratorium, foreclosure and diffusion (Kroger & Marcia, 2011) can be useful concepts for young people in residential care. They offer some conceptualisation of what the adolescents might be experiencing, and while they should not be accepted too rigidly, they still present a starting point for where the adolescent might be on the road to identity achievement and commitment. They also serve as a reminder to ensure an adequate assessment of any identity stress experienced by the adolescent. Behaviour problems in adolescents have been associated with distress over identity issues (Hernandez et al., 2006) and given that identity distress and mental health difficulties may be reciprocal, the clarification of any identity problems could prove useful (Wiley & Berman, 2013).

The struggles and responses reported by the adolescents that constituted their recovery processes also highlighted the crucial necessity of an adequate individual-environment fit. Linking this with the above observations about having a developmental standpoint, we can now begin to appreciate the potential benefits that residential care could have for adolescent identity. 'Identity, as a psychological structure, is a *self-regulatory system* which functions to *direct* attention, *filter* or *process* information, *manage* impressions, and *select* appropriate behaviours' (Adams & Marshall, 1996, p. 433 emphasis original). All these components of adolescent identity formation are crucial for the recovery process. This underscores the fundamental task of creating an appropriate environmental fit for teenagers during their journeys of mental health recovery. The literature review pointed to little research that linked stage-environment fit with residential care. Subsequently, this present study narrowed that gap by demonstrating such a fit is most important.

The findings also highlighted that the recovery processes were far from linear. Despite the adolescents experiencing the same principal themes, their recovery was still their own unique individual journey as well as being experienced in the midst of their own personal developmental reconstruction. In other words, the recovery process was dependant on many variables. Not only did

the 5 principal themes influence the recovery process, so too did the individual recovery process influence how the principal themes were expressed. As Adams and Marshall (1996) suggest, there is a close interplay between identity construction and any external systems:

> An individual's personal or social identity not only is shaped, in part, by the living systems around the individual, but the individual's identity can shape and change the nature of these living systems (p.432).

The above was observed in the experiences of the adolescent participants. Again, the inpatient experience was rarely linear; it involved a number of mutually influential systems at individual, familial and organisational levels. This point is important to recall for all adolescents, parents and staff; to not expect the recovery process to have a consistent, predictable pattern, but rather to be prepared for unexpected disappointments or disjunctures.

The data from the study also showed that a key process in accommodating such disappointment and disjunctures for the adolescents was the relational context provided by the parents and staff. It is here that we can recognise the role parents and mental health professionals play in the developmental reconstruction. The participant narratives indicated that the adults provided a sense of relational and emotional security that buffered the effects of mental illness for the adolescent inpatients. Moreover, this reveals that for the participants in this study, the parents and staff were key influences in the adolescents' developmental reconstruction. The parent participants communicated an emotionally draining experience while they attempted to salvage what developmental normality they could before the BAC admission. Once admitted, a subsequent focus was restoring some developmental familiarity to the siblings still at home.

The staff also were seen by the adolescents as either contributing to or detracting from this process. Numerous times the adolescent participants would recount how some staff would be instrumental to their recovery journey, while disheartened at the responses by others. Those staff who appreciated the developmental stage the adolescents were in incorporated such a mindset into their practice. Providing a parental perspective, offering developmentally appropriate leisure activities and appreciating an adolescent's worldview were all examples of integrating a developmental mindfulness with accepted recovery principles.

In this regard, the present study both confirms and challenges the utility of recovery theory. It acknowledges and confirms underlying recovery principles such as maintaining hope, living well

despite the presence or absence of mental illness, meaning and empowerment. However, the present study also challenges mainstream recovery theory, by revealing the lack of recognition of developmental factors for young people. The notion of a developmental reconstruction must therefore be assimilated into the adolescent mental health recovery literature.

How this reconstruction is assimilated in relation to residential care is equally important. Herein lies the practical contribution of this present research; that each of the principal themes can act as a guiding template for practice in adolescent residential care. Below I have outlined each of the principal themes and their contribution to adolescent residential care work.

The practitioner facilitates recovery via the relational hub

The stories of the participants clearly demonstrated that relationships were the core feature of residential life and that they were the conduit for the recovery process. The fact that all the participants had this theme at the centre of their narratives reveals the importance and significance of this element. A representation of this inpatient experience and the principal themes could be depicted as follows:

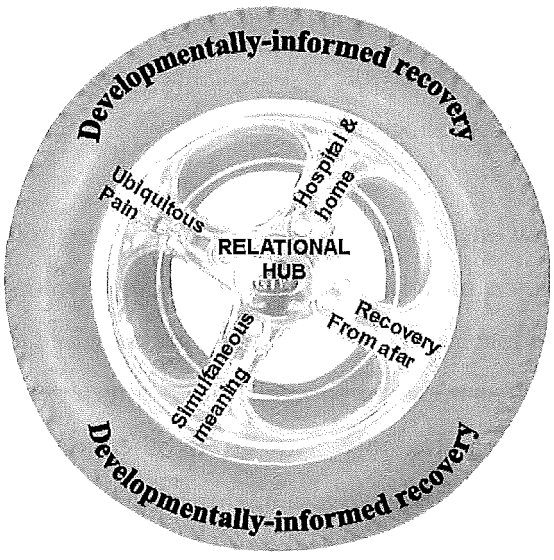


Figure 9: A visual representation of the inpatient experience

As the depiction on the left shows, all wheels contain hubs at their centre; their job being to transfer energy outward. Likewise, I suggest that relationships were the key domain of the inpatient experience that 'energised' and directed inpatient life. They correlate with the critical realist notion of hidden, yet real influences of a stratified reality (Houston, 2001a). These influences were 'real' given their observable impact. For instance, the relational hub was expressed through ubiquitous pain in the way relationships were perceived in the recovery process. Should an adolescent experience solace in a therapeutic relationship from staff or peers, emotional pain would subside. Conversely, shallow responses from staff or emotional contagion from peers could instead contribute to their pain.

At this point, some clarification is required in terms of locating the issue of *causality* in the above figure. The conceptual framework previously explained that one of the areas of interest in this research was the exploration of any unseen mechanisms that might generate events. One could get the impression for example, that the relational hub 'caused' certain effects. While this theme was truly the 'hub' for the inpatient experience, caution is warranted in declaring this theme 'the' causal factor as Houston (2001b) advises from a critical realist standpoint:

> However, in constructing a formulation, the social worker needs to maintain a tentative stance about causal factors. This is because a critical realism perspective promotes the idea that we can only ever achieve a partial understanding (or transitive view) of the real world. This understanding may be refined over time – increasing in its veracity – but it will never reach a point where it has grasped reality directly (contrary to the correspondence theory of truth within positivism) (p.224).

Therefore, the principal theme of *the relational hub* while a key mechanism in the inpatient experience, is only one of several. Each mechanism influenced, and was influenced by, the others. Nonetheless, this theme is consistent with previous research that demonstrates that relational matters are usually the key elements in recovery and residential practice with adolescents (Rabley et al., 2014; Soenen et al., 2013; Soldevila et al., 2013). In this capacity, the present research builds upon previous studies. However, it also closes the gap in terms of first-hand accounts from the adolescents themselves about the role of relationships in residential care.

A subsequent key finding in this study revealed how intensely *social* the recovery process is (Topor et al., 2009). However, 'social' can have a range of meanings depending on the developmental context. For example, in their qualitative study of adolescent recovery from depression and anxiety, Simonds et al. (2013) argued that while adolescents share some parallels with adults experiencing recovery (such as a loss of self) some teenagers have much more difficulty in other areas, such as reflecting on 'future selves'(i.e., beyond the illness) due to developmental constraints. They point out that the term 'social' is often quoted within adult and adolescent conceptualisations of recovery. These researchers argue that more investigation is needed to explore how concepts such as 'social' can be reconfigured for adolescent recovery.

Arguably, this present research has contributed to such an investigation. The results demonstrated that recovery is deeply embedded in a number of diverse and sometimes challenging relationships, and confirmed that recovery needs to be a deeply social process for adolescents. However, the data

also showed how deeply social it was for the parents and staff. The parents' narratives displayed a very clear sense of emotional containment and increased hope with their child's inpatient admission. Subsequent relationships with staff continued to benefit the parents. Equally apparent was how the staff understood relationships and their purpose in the recovery process. They appreciated how therapeutic relationships can be for both parent and adolescent. They offered a listening ear, practical help and clinical wisdom. In other words, the mental health practitioners at the BAC facilitated the recovery journey through relationship; the 'hub' – from which other facets of the inpatient experience were extended.

The practitioner pursues hope in the midst of delayed recovery

As the previous sub-themes and principal themes revealed, if one could delay gratification for recovery and remain hopeful of a better future, then one's general sense of well-being might be enhanced accordingly. Some of the adolescents for example, experienced considerable suicidality, self-harm and despair. Yet in the midst of such emotional darkness, some could still declare that recovery – despite being seen away off – remained achievable. An internal struggle sometimes prevailed though, between the desire for recovery and the inertia of despair. As one adolescent lamented, *'I guess inside myself there's always going to be a part of me that wants to go on, which sometimes I don't like to accept'* (, 2nd interview). They saw 'recovery from afar'.

The parents likewise viewed recovery for their teenage child in the distance, though 'brought closer' by the admission to the BAC. Their particular narratives suggested that their hope was invested in the organisation; that they had finally found a facility that could do what other treatment facilities could not do. This was evidenced in the deep sense of relief at the admission as well as being able to re-focus on other priorities back at home. Prior to the BAC, the parents recounted a long and stressful process of 'hanging on' until their fortune changed. The descriptions of their experience resembled that of burnout. One got the distinct impression that they were 'hanging by a thread' before the admission and should the BAC not have been available, their predicted futures were extremely dark.

Similarly, the staff 'clung on' to hope, realising that signs of recovery could take a while to emerge. After seeing many adolescents come and go at the Unit, they realised that they had no choice but to be patient; understanding that despite the hard and intense work from multiple staff, there still could be the chance of no observable benefit of the inpatient stay. This element of the recovery process must be highlighted; that the recovery journey demands the ability to 'sit' with pain or despair while not losing hope. That is, the recovery passage *simply takes time*; with 'recovery' understood as a

process in the present, as well as a longed-for dream in the future. Dealing with the present while aiming for the future has been conceptualised as recovery 'in', as Davidson and Roe (2007) suggest:

> We understand recovery ''in'' mental illness to refer to a process of minimizing the destructive impact of the illness while simultaneously identifying and building on a person's strengths and interests in order for the person to have an identity and a life beyond that of ''mental patient'' (p.464).

The above formulation of recovery complements earlier thoughts on a developmental reconstruction. As adolescents are a 'developmental work in progress', the recovery process is not one of 'return' to health, but one of 'towards' health. This nuance is important, directing one's efforts at what is possible, rather than what has been lost.

Finally, some staff could recall – with a deep measure of satisfaction – the occasions where a prior consumer would take the time to return and let the staff know they were doing well; suggestive of the attachment they shared with staff. Or, a parent might exclaim, *"Thank you for giving us a life again"*. I suggest that the ability to tolerate delayed recovery gratification for any of the participants was firmly connected to the aforementioned relational hub. Whether this relational hope was transferred from staff to staff, staff to parent, or parent to teen, given such a stressful context, only a secure relational base would have been sufficient to see the process through. This also is a key contribution; *that it is not just consumers who must experience the recovery journey "in" mental illness, so too do parents and staff.* These parallel experiences have not been adequately captured in the literature until now. Whilst the place of hope in recovery has been documented in the literature (Copic et al., 2011; Lipschitz-Elhawi, 2009) this study presents a novel approach by collating the experiences of three participant groups mutually connected by the goal of adolescent mental health recovery. It subsequently points to the importance of practitioners 'creating' and 'fostering' hope in the midst of what is often a confusing and painful journey (Lipschitz-Elhawi, 2009).

The practitioner facilitates recovery while managing hurt and unrealised dreams

The inpatient Unit and the topic of this research are at various levels, pain-laden; pain that was ubiquitous. Another key finding reveals that such pain was both diluted and sometimes intensified by the relational structures of the Unit. The best example emerged from the adolescent narratives. The adolescents spoke on numerous occasions about how relationships were central to their inpatient experience. Positive relationships with staff or peers were described by the adolescents as

being deeply appreciated and had a direct bearing on their recovery process. Other relationships, whether adult or peer, were sometimes viewed not so favourably and also had varying degrees of impact on their recovery journey.

The parents equally experienced pain from various sources that formed part of their inpatient experience. Like their children, their pain started before the BAC when their child's mental illness began to emerge. Guilt, loss and despair formed much of their pre-BAC experience. However, upon admission, this morphed into a sense of parent displacement despite the benefits of admission. Still, the parents recounted how compassionate staff helped direct this sense of alienation away to look towards a chance of recovery for their teenager. This represents another key contribution of the study; that of increasing our knowledge of the parental experiences of loss and pain while caring for a psychologically unwell child.

The staff too, were very aware of the pain that accompanied adolescent mental health issues. They saw firsthand the self-harm, suicidality and hopelessness that mental illness can bring. For some, they also had the experience of being unappreciated and misunderstood from management, presenting them with yet another source of pain. Indeed, some of the staff were explicit that it takes a certain type of worker to be in this area, given the discomfort experienced.

Again, recovery is a process that occurs in the midst of pain. All participants experienced pain or distress either as one *experiencing* recovery (adolescents) those who *searched for* recovery (parents) or those who *facilitated* recovery (staff). One of the strengths of this research has been its capacity to capture such pain from three different, yet connected standpoints. The use of such first person recovery narratives has the capacity to move beyond the pain associated with mental illness and discover fresh stories that do not fit the sometimes fatalistic or deterministic constructs that tend to dominate the public (and professional!) sphere:

> Recovery narratives are an important resource...These stories provide an alternative "counter plot" that challenges and overturns the master decline narrative, the story of inevitable life-long disability that holds the out-moded "chronicity" or "deficit paradigm" in place...We must appreciate, recount, and add to our storehouse of recovery narratives (Ridgway, 2001, p. 342).

I suggest that despite the ubiquitous pain that mental health practitioners will experience, they nonetheless must seek out such 'alternative counter plots'. By doing so, they will encourage the adolescents 'toward' growth and contribute to their developmental reconstruction.

The practitioner facilitates recovery in the context of both hospital and home

For the adolescents, residential care clearly had a dual, yet equally valid meaning. On the one hand, the adolescents were in a hospital context with the aim of addressing significant mental health issues. The photographs that the adolescents took revealed how aware they were of this and they sometimes lamented the sterile elements of the Unit. On the other hand, they also experienced memorable comfort, guidance and nurturance. Even in the midst of living with unwell peers, their adolescent friendships in the BAC still could offer solace from those who had experienced firsthand the same struggles. In distinction to these helpful relationships, there were others that were seen as less than helpful. In particular were those occasions where knowledge of a person was built around the contents of an adolescent's file rather than the adolescent. However, the Unit was also seen in the context of a home, with multiple parents and siblings. The teenagers could also recall fun times in the milieu; times reminiscent of a 'long sleep-over'.

The staff likewise expressed their relational activity in these two primary ways. Being health professionals, they understood the importance of a sound therapeutic relationship during the helping process, contained within certain professional boundaries. They understood that the adolescents were temporary patients in a government facility. However, they also appreciated the parenting tasks they were called to do and sought to offer the adolescents a secure emotional base. Being mindful of the biomedical nature of the facility and the 'tyranny of distance' experienced by some adolescents and their families,[5] they took upon themselves to offset a 'hospital culture' and create an atmosphere that more resembled a home.

The parents too, were keenly aware of contradictory elements. They were highly relieved at the admission and experienced firsthand the emotional containment that comes with considerate and compassionate staff-parent relationships. They were equally aware that it was a long-stay residential Unit which became home for their teenage children. Subsequently, their parenting role was diminished with a resultant sense of anxious displacement.

This particular finding then points to recovery in residential care occurring in an environment that has a dual and sometimes contradictory nature; that of hospital *and* home. This has significant

[5] Recalling that the Unit serviced the entire state of Queensland.

implications for practitioners creating a developmentally-informed milieu that subsequently facilitates the aforementioned developmental reconstruction. The data highlighted the necessity to develop an adolescent-centred framework for recovery and given the residential context, the psycho-physical environment must reflect this. For instance, one of the sub-themes for the adolescents was that of 'teenage comfort'; that which represents typical adolescent comforts that are developmentally appropriate such as privacy, leisure and individual pursuits. Both adolescent and staff accounts revealed that residential facilities for adolescent mental health recovery must be developmentally cognisant of such features in order to achieve best possible outcomes. The practitioner can facilitate this by incorporating an appropriate developmental standpoint that appreciates and caters for the maturational needs of adolescents.

The practitioner facilitates recovery while accommodating compound meanings

With such a complex environment, it is understandable that the meanings given to personal experience can be seemingly contradictory or confusing. Especially for these adolescents who, by the lifecycle stage they were in, had to accommodate and assimilate a range of both organisational and developmental processes such as the influence of peers, residential culture and sense of displacement at being an inpatient. These experiences were common to all, though experienced and expressed uniquely.

The parents also experienced this. Long before the admission, they knew the effort they put into the lives of their unwell teens, only to still receive messages of blame, failure and misunderstanding by others. Self-doubt was the result. However, while their relationships with staff were far from perfect, they nonetheless felt that relational energy being expressed in the sympathetic containment they received. As a parent recalled in conversation with the Registrar, *'"We will help and we will fix it" and I'd never heard that...And that was a big thing for me'*. I suggest that some of the previously unhelpful messages the parents in this study received were diminished by the curative relationships they experienced at the BAC. In similar fashion to their teenage children, they too experienced a corrective emotional experience, though their narratives revealed they often held the contradictory messages in tension.

The staff were also well aware of the many simultaneous meanings found in inpatient work. Paralleling the parent's experiences, they too were sometimes blamed for being 'bad parents' by those who had little understanding of adolescent mental health care. They too, felt the emotional drainage that accompanies such work. However, in like manner, they also experienced consolation through a team large enough to spread the care and responsibility. Despite typical staff tensions in

such a 'pressure cooker' workplace, they could still recall their appreciation of each other and could name the benefits the adolescents received from the team. The sometimes precarious balance of carrying out parenting tasks without the title of parent, was made more steady by the input of colleagues; highlighting again the key role of *the relational hub*.

Finally, accommodating compound meanings can be readily linked with what is known about recovery. The literature contains much material about what constitutes recovery, and how some of the primary elements of the concept involve tension, such as hope vs. despair and now vs. future (Andresen et al., 2011; Davidson et al., 2005; Meehan et al., 2008; Noordsy et al., 2002) This study concurs with such research on recovery, that suggests multiple and sometimes contradictory meanings within the one event are common. Adolescence is a period of accommodating and assimilating many contradictory experiences, and when this is coupled with mental health problems, the difficulty of processing the emotional workload increases accordingly. The practitioner then, can offer him/herself as an 'external mind' to adolescents, parents and even fellow staff; one which can help facilitate the emotional processing of the many confusing experiences one finds in mental health recovery.

Further implications for residential care work

As formerly suggested, a developmental reconstruction involves a re-creation of available personal resources that appreciates developmental constraints while at the same time pursuing developmental growth. The previous sections suggested how this could occur in relation to the principal experiential themes. This section presents further implications by explicating the role of reflexivity. However, I shall start first by recalling Geanellos' (2000) portrayal of an adolescent therapeutic milieu and drawing some parallels with this present research. As the literature review explained, such a definition drawn from robust qualitative research is rare and so again is repeated here:

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

Geanellos' description of adolescent residential care has a number of elements that coincide with this present research. Firstly, the use of relationship is central; involving "fun", "companionship"

and "safety". Essentially, it is 'homelike'. Indeed, her description seems rather distant from the realities of inpatient life. Nonetheless, her description above parallels the experiences of the adolescents in this study that included outings, watching the football and enjoying positive adult and peer relationships. Secondly, such an environment also presents the adolescents with "opportunities". This suggests the creation of occasions to develop the adolescents in their respective developmental trajectory. The descriptive use of "freedom, familiarity and belonging" also suggests a two-way relationship between adolescent and staff. Geanellos' depiction of inpatient life suggests an awareness of the developmental domain in adolescent mental health practice, and seeks to incorporate such into the residential environment. Likewise, I suggest that a key implication drawn from this present research is the necessity for workers in this area to have what I term a 'developmental mindfulness'. By developmental mindfulness I am recalling that not only do adolescents influence their immediate social context or that the social context influences the adolescent. Rather, developmental mindfulness emphasises a developmental contextualism that appreciates and incorporates the continuous, cyclic and bi-directional interactions of both spheres. The practical outworking of such a position could entail the following.

Firstly, it acknowledges that adolescents are not smaller versions of their adult counterparts. As this study had discussed, there are significant developmental differences between the two groups and these must be taken into consideration when envisioning developmentally-informed residential care. For example, the adolescent participants shared their thoughts regarding the physical structures of the facility. Typically for such a life-cycle stage, the physical environment was sometimes seen as sterile and uninviting. Adolescents often change and create their own immediate environment as an expression of themselves. The principal theme *hospital and home* clearly revealed a double meaning for the adolescents whilst in care and how they would have liked to change some physical aspects of the Unit. The results of this study highlighted the importance of the environment-stage fit for adolescent residential care, and the unwelcome response by the adolescents when their developmentally appropriate needs were dismissed.

Secondly, there are implications for residential care such as therapeutic programs, educational needs and the use of leisure, with such areas usually having a sizable impact on the development of adolescent identity. I suggest therefore, that typical adolescent domains such as leisure and education be seen as avenues to reconstruct those personal resources that mental health difficulties have previously eroded. The adolescents in this study saw the educational facility as a key factor in addressing past educational distress. Their narratives clearly pointed to the benefits of an 'educational second chance' through the therapeutic efforts of the BAC teaching staff. Likewise, a

developmental mindfulness must permeate all aspects of residential care in order to best re-construct the developmental pathways and ultimately, move beyond the developmental moratorium that mental illness often brings. I suggest therefore that an appropriate stage-environment fit during residential care is crucial for adolescent mental health recovery.

Related to the above point is the issue of not just acquiring a good stage-environment fit, but also allowing an adequate amount of time to fully progress. This raises the question of the length of treatment time in a residential facility. Based on the data in this present research, the adolescents required time to develop trust via long-term, stable relationships. Identity formation and role modelling – also elements raised by the participants – were nurtured over an extended period of time. The mental health issues themselves were chronic in nature and simply required time to be addressed. I argue that all these factors cannot be adequately met in short-term residential care. While the data suggests the healing process was psychodynamic in nature, the overall process is far more dynamic, intimate and interactively based; one that formed a large part of its success. Consequently, I suggest that the data from this study advocates for the beneficial nature of longer term residential facilities.

However, the results also revealed a number of processes that are important for residential care regardless of length of stay. In the literature review, an outline of the major forms of residential care were presented (see page 34). It was shown that facets of residential care such as the importance of therapeutic relationships, presenting clinical issues, and subsequent treatments, were common themes for most models of care. I suggest that the principal themes derived from this study are generalisable to many other forms of adolescent out-of-home care.

Finally, there are implications for the staff who work with such adolescents; implications that are most important given this study's focus on informing mental health practice. The principal theme of *the relational hub* clearly demonstrated the repercussions of staff not appreciating the personhood of the adolescents. Adolescence is a time for emerging identity. With the onset of mental illness, that emerging identity may experience a moratorium or foreclosure that could have repercussions for the next lifecycle stage. Practically, this calls for specialisation in staff training that will create a therapeutic team that can be consistent and unambiguous in the goal of adolescent mental health recovery; one that appreciates the difficulty of developmental reconstruction and the necessity of developmental mindfulness. However, I would argue that inherent in any concept of developmental mindfulness is the capacity to appreciate the intersubjective domain; a key dimension of reflexivity

(Finlay & Gough, 2003). Suggestions on how reflexivity can inform residential care practice in the three primary domains of practitioner, team and organisation are now explored below.

The importance of reflexivity in the practitioner

The conceptual framework explained that at the heart of reflexivity is the process of continually reflecting upon our interpretations; of self, others and wider systems. Another finding of the present study was the usefulness of reflexivity in a mental health professional's psyche. Some suggest that as practitioners develop over the years, there is the movement from external expertise to internal expertise, and that this reflexivity becomes the central developmental process for the worker (Skovholt & Ronnestad, 1995). Such reflection is crucial if workers are to utilise relationships in inpatient units therapeutically. In a review of the qualitative literature of how adolescents viewed helping professionals (Freake et al., 2007) , there was a high proportion of relational qualities such as being sympathetic, non-judgmental, trust, consistency and respect. Practitioner reflexivity is axiomatic in achieving this as well as having a compassionate view of personhood; recognising that personhood is constructed through relationship (Bland et al., 2009). The results of this study showed that the 'relational hub' drove many facets of the inpatient experience. This cannot occur unless there is a 'good enough reflexivity' as well as a corollary 'good enough compassion' expressed through the practitioner. In exploring the little-researched topic of compassion and its relationship to recovery, Spandler and Stickley (2011) argue that compassionate relationships must be expressed through a healing environment and that 'No amount of rhetoric around recovery, it seems, can substitute for the reality of those actions that provide a catalyst for hope to flourish'(p.563).

The data from the parent participants can also inform mental health practice by noting that there is a 'dual parenting' that occurs within inpatient units and that parental voices can sometimes go unheard. Mental health workers therefore need to be mindful to include parents and value their 'lay knowledge' of their child's situation. For example, in her qualitative study of the experiences of 25 parents who had a teenager with mental health difficulties, Harden (2005) explored 'reskilled' and 'deskilled' parents in their relationship with mental health services. She found that what reskilled parents included (1) critiquing psychiatric knowledge and practice, (2) acquiring knowledge and (3) renegotiating the parental caregiving role. I suggest that these areas of reskilling parallel closely with the areas of the social work practitioner. Each of these respectively call for (1) a critical appraisal of hegemonic knowledge, (2) a reflexivity investigating one's own knowledge and (3) the valuing of parental knowledge. I propose that a reflexive practitioner is obligated to do likewise; with a reflexive – and compassionate – stance.

Finally, reflexive practitioners recognise the usefulness of phenomenology for practice generally and any future practitioner research. Longhofer and Floersch (2012) suggest that phenomenology is a most useful construct to understand the practice of social workers: in understanding the everyday worlds of clients, in understanding our own worlds as practitioners, and thirdly, in understanding 'what is' (individuals, families, organisations) (p. 511). They further argue that a phenomenological reflexivity is essential not only for social work practitioners understanding these domains, but also for the wider – albeit controversial issue – of establishing a science of social work (p.512). I do acknowledge that reflexivity itself is not a panacea for either research or practice (Pillow, 2003), but it does encourage the practitioner to consider what hegemonic discourses are being produced and their impact on mental health practice (Larson, 2008; Morley, 2003).

The importance of reflexivity in the team

The present research also points to the necessity of the mental health team incorporating a clear reflexive stance for practice. To illustrate this, I have utilised Boss and Couden (2002) who detail various reasons why ambiguity surrounding an illness can increase helplessness, conflict or anxiety in families:

> *First*, the ambiguity surrounding the illness keeps people confused, so they don't know what to do or what decisions to make.
> *Second*, the ambiguity surrounding the prognosis prevents reorganization of family roles, rules and rituals. Everyone stays as they were, waiting for the illness to go away.
> *Third*, without the customary markers of loss, the family's distress remains unverified.
> *Fourth*, the ambiguity surrounding the illness can cause individuals and families to question their view of the world as fair and just.
> *Fifth*, an ambiguous loss of long duration becomes physically and psychologically exhausting. Symptoms may be a result of fatigue more than psychological weakness (Boss & Couden, 2002, p. 1353).

The above observations have two elements relevant to this discussion. Firstly, much is reflective of the parents' experiences in this present study. They too, experienced confusion, exhaustion and the reorganisation of family life. They also found the interactions with the BAC staff largely supportive and helpful. This suggests that a role for teams could be to act as a reflexive sounding board for parents who are usually in a state of anxious confusion about their child's well-being. By doing so, teams have the opportunity to challenge some of the myths of mental illness with the parents while at the same time addressing their own biases and assumptions (Moses, 2010b). Geraghty et al.'s

(2011) study of 50 caregiver experiences also revealed that when staff took the time to respond to parent needs, frustration and stress were considerably reduced.

Secondly, if we reframe the above, the experience is strikingly similar to that of the staff participants:

- The staff in this study also experienced ambiguity with mental illness, and sometimes decisions were put on hold, with an uncertain clinical direction. This would have implications for the adolescents and their families.
- Prognosis and recovery prospects at the BAC could also be ambiguous with a resultant 'holding pattern' waiting for a break in the adolescents' recovery journey.
- The teams in this research felt some staff were not suited to this work, with some eventually leaving. It appeared that their assumptive worlds were shaken when exposed to such difficult work and subsequently moved on.
- The BAC team also experienced fatigue and loss of hope. The theme *ubiquitous pain*, by the very nature of the work, is inescapable.

It is argued that reflexivity would help staff make sense of work-related issues such as the above. A team that has such a capacity for reflexive practice is more likely have a greater insight and appreciation for team health, potential burnout and ultimately, adolescent recovery. A team that is open to a reflexive attitude develops a 'collaborative reflexivity [that] offers the opportunity to hear and take into account multiple voices and conflicting positions' (Finlay & Gough, 2003, p. 12).

The importance of reflexivity in the organisation

The findings of the present research also point to the organisation requiring a good-enough reflexivity in the pursuit of adolescent mental health recovery. The data from the staff participants in particular suggested that organisational life can certainly be impactful. Some recalled feelings of powerlessness working in such an organisation. Others reported feeling unsupported by management while some staff recalled the challenges in working in such a large and diverse team. In such a multidisciplinary mental health organisation, professional culture and values may sometimes collide with misunderstanding as a result (Peck & Norman, 1999) or the staff indulging in splitting or projection (Heginbotham, 1999). Consequently, I would argue that a further implication for practice is found in the role reflexivity plays in organisations as 'social critique'; questioning the social construction of power (Finlay & Gough, 2003, p. 14). An organisation that appreciates a reflexive culture is more aware of the potential to objectify both consumers and staff

and the subsequent need to encourage multiple voices to be heard; not just that of the 'voice of authority' (Finlay & Gough, 2003, pp. 14,15). Institutional stigma can be as real and as impactful as other forms of stigma (Heflinger & Hinshaw, 2010) and the data from this present research suggests that organisational context can have an important influence in working in such an environment.

Finally, the parent participants suggested that their experience of the organisation was largely positive, though there was a sense of parental displacement as they admitted their child to the Unit. For the adolescents, consistency of staff was perceived as most important in their recovery journey. I argue that these two elements are also organisational issues, and ones that are impactful. Heflinger and Hinshaw (2010) contend that not recognising 'the multiple and intersecting aspects' of the young person's life – such as family – and exclusively focusing on the mental health disorder, is one expression of institutional stigma (pp. 62,63). I propose that the degree to which an organisation is able to reflexively investigate the impact of its organisational practices and subsequently modify them, will to an extent determine how helpful it will ultimately be.

Limitations of the study

While the study researched and depicted the inpatient experience, it will always remain an imperfect picture. Consequently the study will also have limitations. Firstly, generalisability has been questioned in phenomenological research and qualitative research generally (Denscombe, 2003; Morse, 1999). The hermeneutic nature of the study produced one interpretation of the participants' narratives; other researchers may produce alternatives with divergent findings. Nonetheless, I suggest that the present research offers 'moderatum generalisations' where the scope of what is claimed is moderate, as well as being moderately 'held' – that which is open to change or adjustment (Payne & Williams, 2002). The extent of generalisation depends on parallels between the topic of study and other sites in which generalisation is attempted (Payne & Williams, 2002, p. 305). Apart from the length of stay for the adolescents at the BAC and a biomedical standpoint, the mental health problems addressed were very similar to other residential circumstances.

Secondly, as explained in the literature review, the underlying therapeutic processes of residential care are common to all models. Morse (2003, p. 892) argues that in extending theoretical generalisations, if the research problem is similar to other settings, the findings can inform other domains and cautions against 'biasphobia' paralysing good research. Subsequently, the data collected from this study may be conservatively generalised to similar situations – adolescents in residential settings. Given the congruence of the parent narratives with what is already known about

caregiver strain in raising a child with a mental illness, as well as what has been written about staff working in such an environment, the present findings may extend to similar settings as well.

Due to a phenomenological methodology emphasising individual experience, the present research may be criticised for its lack of expression or capacity for social change. However, practitioner research such as this may initially elevate the awareness of a range of issues pertinent to adolescent mental health and initiate the addressing of organisational concerns. It has also been argued that phenomenology generally does not have a clear 'recipe' for research (Dukes, 1984) and the paradigm is limited to those participants who are able to articulate their experience with reasonable sophistication (Willing, 2001). Nevertheless, the phenomenological paradigm has steadily grown in popularity over the years and consequently offers broad, but methodologically sound processes for understanding a phenomenon (Creswell, 2007). In terms of articulating experience, simple exploratory questions were used for the interview schedule, and prompts offered to help the participants articulate their experience. The use of a camera was also a considerable help in this regard.

While the adolescents in this sample were representative of the BAC clinical population, alternative cultures were not available at the time of participant recruitment. It would be worthwhile for future research to include Aboriginal or Torres Strait Islander adolescents and their families or culturally and linguistically diverse populations given their interpretations of identity and family may well differ, giving an even wider understanding of the inpatient experience.

Finally, the issue of intrusive bias might be charged against practitioner or insider research. I use the term 'intrusive' purposefully here, as all research has bias and is not necessarily negative. While this has been addressed in the methodology, a brief rejoinder is offered to suggestions of bias or social desirability. Firstly, in terms of initial recruitment and data collection there were concentrated efforts – in part due to firm ethical requirements – to restrict undue coercion via the BAC clinical team's input through the use of third parties to recruit participants. The distinctiveness of my role as researcher was also emphasised numerous times. In terms of my relationships with the participants *after* the data collection, personal circumstances allowed me to leave my employment at the BAC after the data collection was finalised. This allowed the data analysis to occur *outside* of the Unit with no direct influence from past participants. With regard to 'data selectivity', Chapters 6 and 7 purposefully made use of extended extracts to offer a transparent line of reasoning in the creation of any themes.

Notwithstanding the above limitations, the present study has contributed to the body of practitioner research. It demonstrates that practitioners can be researchers and practical data can be the result. Given that the study was situated in the researcher's practice, it sought to recognise and apply the oft-quoted social worker's 'use of self' (Reupert, 2007). It will therefore add to the growing body of practitioner research in social work (Mitchell et al., 2010) and paralleling other forms of practice-based research, '...answer questions that emerge from practice in ways that inform practice' (Epstein, 2001, p. 17). It will provide other practitioners with some initial scaffolding for projects they may be considering. In this regard, this project has revealed some of the more difficult and sometimes frustrating elements of researching one's own practice or organisation. The study has subsequently highlighted the importance of a reflexive, developmentally-mindful stance to data progression and researcher development.

Further critical reflections

As Creswell (2007) suggests of good phenomenological research, it is important to critically reflect on elements of the research process that stand out; both in terms of progression of data and progression as an emerging researcher. Firstly, it is important to acknowledge any unanticipated themes or themes that did not emerge from the study; a transparency that is essential to document in phenomenological research (Smith et al., 2009). In this study three primary observations were noted. Firstly, I expected greater differences with how gender might influence the inpatient experience. The only difference of note appeared to be the way the male and female adolescents processed the 'code black' alarms. The boys seemingly were less affected, while the girls openly acknowledged how it affected them personally and how the alarms were a catalyst for emotional contagion. However, there were other areas that were expressed by some boys such as the impact of others' (male or female) self-harm on them emotionally. The staff did not report any observable differences in this regard. Also, the girls tended to be more creative in the use of the camera. I am unsure if this is reflective of the inpatients at the time or more of a specific gender difference. While this particular study did not pick this up as a primary theme, further research may well do.

Secondly, [redacted] were under involuntary treatment orders. This was not mentioned in a single narrative from any participant. Admittedly, this was not the focus, and the interview schedule attempted to be as less intrusive as possible. In hindsight, it may have been preferable to explicitly examine 'involuntary treatment orders' given their potential importance for areas such as treatment goals and relationships with staff. Conversely, given that the issue was not spontaneously mentioned suggests that other facets of the experience were more noteworthy for the participants. The same could be said for medication issues. While

perceptions and adherence to psychotropic medication during adolescence fluctuates for a variety of reasons (Moses, 2011b), this issue also failed to be mentioned by any of the participants. Nonetheless, the primary sub-themes and principal themes for the study were consistent and suggest the key aspects of the phenomenon were adequately captured.

Thirdly, it was initially anticipated that there would be more divergence between the interviews. What primarily surfaced were an elaboration and clarification of various themes such as the role of relationships or ongoing experience of various losses. There were however, some differences noted between the first interviews and subsequent interviews where the adolescents shared some of their anxiety upon initial admission. As time went on, they expressed a more settled position, especially once they had more opportunity to get to know the staff and their peers. Note however, that the photographs were congruent with the interviews. When the adolescent participants discussed the photos they had taken, they were congruent with the overall narrative as individuals, as well as a collective group.

Another key finding of the research is linked with the phenomenological lens and my pre-understandings. In particular, there was noticeable development as a researcher. Each of my pre-understandings and fore-structures were confirmed in the analysis and remained useful concepts to be mindful of during the research process. What was underestimated however, was the *depth* of some of these concepts and their impact in the inpatient experience. Only now after a thorough investigation of the phenomenon, did I appreciate that while an awareness of any pre-understandings of the phenomenon is necessary, so too could the narratives reveal fresh pre-understandings. As Smith et al. (2009) explain:

> In other words, while the existence of fore-structures may precede our encounters with new things, understanding may actually work the other way, from the thing to the fore-structure. For example, when encountering a text, I don't necessary know which part of my fore-structure is relevant. *Having engaged with the text, I may be in a better position to know what my preconceptions were.* This is an important and neglected way of considering what happens in interpretation (p.25, emphasis mine).

With the above in mind, I now suggest a fresh pre-understanding that emerged only *after* interrogating the data:

Statement Eleven: Pain is inevitable, but Relationship is a choice.

Interpretation: Regardless of whether one is patient, parent or staff, each will experience various forms of, and varying degrees of, emotional pain during the adolescent recovery process. While this pain is unavoidable, the opportunity to utilise various relationships during this recovery process remains a choice.

Forestructure: Working in the inpatient milieu, the practitioner will witness (and experience) various forms of pain that accompanies being employed in such an environment. However, the worker understands that relationships are the 'therapeutic glue' that allows one to hold fast under adverse conditions. Mindful of wider contexts, the mental health practitioner is placed in a position to link individuals, create and nurture hope as well as role model the healing nature of therapeutic relationships. The decision to trust another however, remains an individual choice for adolescent, parent and staff. Should they so choose, a compassionate relationship may well draw an individual out of despair and toward a more optimistic future.

Despite working at the Unit for a number of years, it was gratifying to capture fresh understandings of such phenomena. As the *Analytic Trail* explained, there was a measure of relief during the analysis stage where I incorporated three, rather than one or two standpoints of inpatient life. This required perseverance and an openness to new material during the research process. I too, absorbed a restrictive view of the 'milieu' by initially not including the parents. Only after seeking to expand the linkages did I 'see' the systemic nature of the experience. The opportunity to analyse the data *after* leaving the Unit also greatly helped my clarity in making sense of the phenomenon. Over the course of the project, there was significant methodological and professional transformation that I believe, resulted in a richer and more informative piece of practice research.

Future research directions

The study has raised a number of areas that would be useful for future research. First, there must be a more purposeful linkage between recovery theory and developmental theory for the benefit of adolescent mental health recovery. This would be the start of a more thorough conceptualisation of an adolescent-centred model of mental health recovery. Hitherto, theory has been heavily borrowed from adult recovery literature. This must change whereby a complimentary body of knowledge is cultivated that encapsulates the developmental domain.

Secondly, on the basis of this study and the wider literature, one of the key tasks of adolescent mental health recovery is a developmental reconstruction; that as the present research put forward, is a rebuilding of developmental tasks. Consequently, more research needs to be initiated exploring how residential life influences the developmental trajectory in general and identity formation in particular. The inpatient environment incorporates a range of developmental features such as access to a social group, education and various parenting experiences. It could prove fruitful for future mixed method studies to measure changes in the adolescents' developmental pathways while qualitatively understanding more fully what enhances or detracts from this.

The interviews of all participants were purposefully oriented to allow them to discuss what issues were most pertinent to them. While some strength-based narratives emerged, more could be explored for all the three participant groups in relation to resiliency (Hawkins-Rodgers, 2007). What specifically enables adolescents, parents or staff members to rise above the difficulties of adolescent mental health problems would also be a worthy contribution to the field. This also raises the suggestion of incorporating phenomenological principles as a therapeutic tool to focus on the lived experience.

In terms of the parents, more needs to be explored around the ambiguous loss they experience and how services help or hinder coping with such loss. Just as potential research could investigate the developmental trajectory of the adolescents while an inpatient, there could also be consideration of the development of the family that remains outside the Unit. The family continues on while the teenage son or daughter remains in hospital. Consequently, the wider impact and 'reconstruction' that occurs at a family level needs to be examined.

Finally, the exploration of diagnostic diversity was not a key feature of the present research. However, future research could explore what relationships there are between different diagnoses (especially anxiety, depression and eating disorders) and residential treatment and the recovery journey.

Summary

This final chapter of the thesis has discussed the key contributions of the study. It contends that the key element in adolescent mental health recovery is a developmental reconstruction. It also elucidated how the 5 principal themes from the participant narratives could act as a template for practitioners working in residential care and has reinforced the importance of reflexivity at different levels. Critical reflections on the progression of the data were put forward, as well as the

progression of myself as researcher. Limitations were also acknowledged. The present study was built upon previous work in the field, and readily acknowledges the efforts that preceded it. I suggest this present research has contributed to the literature, and has 'grasped the nature and significance of this experience in a hitherto unseen way' (van Manen, 1997, p. 39).

At the beginning of the thesis, the question "What is this kind of experience like?" (van Manen, 1997, p. 9) was quoted as a guiding thought for this study. In light of the narratives explored throughout the present research, I suggest that the experience captured is complex, rich and fluid. I also acknowledge that what has been captured is still incomplete; that the inpatient experience of adolescent mental health recovery remains larger than this study has explicated. It nonetheless granted the participants an opportunity to voice their lived experience. While I expect further research to be built upon this study, I suggest that the very act of listening to human experience has been a worthwhile endeavour, at a time when many stories still go unheard.

POSTSCRIPT

As explained in the introduction to the thesis, after over a year of considerable debate and speculation as to the future of the BAC (particularly in the media), the Unit was shut down in February 2014. Reasons as to why vary considerably, depending on who one talks to. The official Government position, based on an external review, believed a better, more 'contemporary' model of service delivery was needed, as opposed to long-term inpatient care. To date, there are still no concrete plans for such.

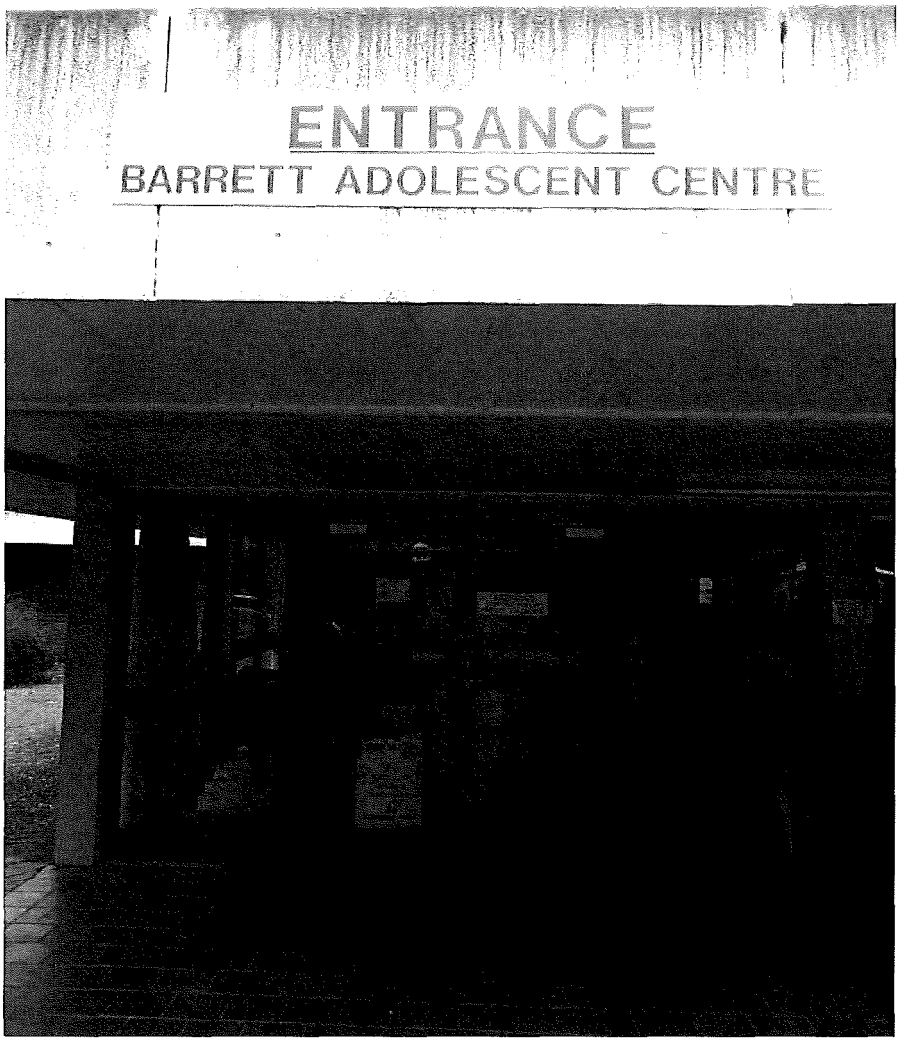
Those BAC adolescents who were able, are presently attending another temporary school elsewhere. They then live at home if residing in the Brisbane area. Those outside Brisbane have gone back home, with an uncertain future. In terms of mental health input, they have been discharged back into the hands of community-based Child and Youth Mental Health Clinics, though many staff expect the adolescents who remain unwell to now frequent their local emergency departments in their respective mental health catchment area. It is noteworthy that the teenagers were at the BAC in the first place because the community clinics could not offer the intensive treatment they required.

In early March 2014 I visited the BAC one last time. In keeping with the rest of the thesis, one final photograph was taken – this time by myself. Shown on the following page, it reveals the main entrance to the Centre. However, upon closer inspection, it is locked with packing boxes inside. It seems the theme of *simultaneous meaning* remains even now. While it invites an 'entrance', a closer look reveals it is 'shut'. It was with a sense of hope that the adolescents and parents who experienced its closure would be guarded against further pain and offers of access, only to be denied entry.

Sadly, this was not the case.

From March to August 2014, three young people who were discharged from the Barrett Unit tragically took their own lives. I remember these young people and their families very well; clearly recalling their courage and determination in their journeys toward a better life.

With both sadness and admiration, this thesis is dedicated to these three young people.


ENTRANCE
BARRETT ADOLESCENT CENTRE

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