

**A Thesis Submitted for the Degree of PhD at the University of Warwick**

**Permanent WRAP URL:**

<http://wrap.warwick.ac.uk/148299>

**Copyright and reuse:**

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it.

Our policy information is available from the repository home page.

For more information, please contact the WRAP Team at: [wrap@warwick.ac.uk](mailto:wrap@warwick.ac.uk)

**Navigating through the Child and Adolescent Mental Health Inpatient Unit:  
Adolescents' and Parents' Experiences**

Jacqui Trüter

This thesis has been submitted as part of the fulfilment of requirements for the  
degree of  
Doctorate in Clinical Psychology

**Coventry University, Faculty of Health and Life Sciences  
University of Warwick, Department of Psychology**

**July 2019**

## Contents

List of Tables .....	v
List of Figures .....	v
List of Appendices .....	vi
List of Abbreviations .....	vii
Acknowledgements .....	viii
Declaration .....	ix
Summary .....	x
Chapter 1: Systematic Literature Review: Adolescents' experiences of child and adolescent mental health inpatient units: A meta-ethnographic synthesis of the qualitative literature .....	1
1.0 Abstract.....	2
1.1 Introduction .....	4
1.1.1 Child and Adolescent Mental Health .....	4
1.1.2 CAMHS inpatient units .....	4
1.1.3 Children and adolescents' perspectives .....	5
1.1.4 Previous research .....	5
1.1.5 Rationale and Aims .....	6
1.2. Method .....	7
1.2.1 Systematic Literature Search .....	7
1.2.1.1 Search process .....	7
1.2.1.2 Search terms and strategy.....	8
1.2.2 Eligibility criteria.....	9
1.2.3 Classification of Studies .....	10
1.2.4 Quality assessment .....	12
1.2.5 Method of synthesis.....	12
1.3 Results .....	14
1.3.1 Characteristics of studies .....	14
1.3.2 Results from the meta-synthesis .....	24
1.3.2.1 'Navigating relationships' .....	26
1.3.2.1.1 'Relationships with patients' .....	26
1.3.2.1.2 'Relationships with staff' .....	28
1.3.2.1.3 'Relationships with therapy' .....	29
1.3.2.2 'Containment: safety versus confinement' .....	30
1.3.2.2.1 'Physical containment' .....	30
1.3.2.2.2 'Psychological containment' .....	32
1.3.2.3 'Impact of inpatient stay' .....	33

1.3.2.3.1 ‘Sense of Connection’ .....	33
1.3.2.3.2 ‘Process of change’.....	36
1.3.3 Critique of studies.....	38
1.3.3.1 Range and selection of participants .....	38
1.3.3.2 Transparency of analysis and results.....	39
1.3.3.3 Researcher bias.....	39
1.5 Discussion.....	39
1.5.1 Summary of findings.....	40
1.5.1.1 ‘Navigating relationships’ .....	40
1.5.1.2 ‘Containment: safety versus confinement’ .....	41
1.5.1.3 ‘Impact of inpatient stay’ .....	42
1.5.2 Limitations .....	43
1.5.3 Clinical implications .....	45
1.5.4 Future research .....	46
1.6 Conclusion .....	47
1.7 References.....	48
Chapter Two: Empirical Paper: “ <i>Completely shell-shocked</i> ”: Parents’ experiences of their child’s admission to a Child and Adolescent Inpatient Unit: An Interpretive Phenomenological Analysis.....	56
2.0 Abstract.....	57
2.1 Introduction .....	58
2.1.1 CAMHS inpatient units .....	58
2.1.2 Parents’ perspectives .....	58
2.1.3 Parenting a child with MH difficulties .....	58
2.1.4 Parents’ experiences of their child’s hospitalisation .....	59
2.1.5 Rationale .....	60
2.2 Method .....	61
2.2.1 Design .....	61
2.2.2 Participants.....	61
2.2.2.1 Recruitment .....	62
2.2.2.2 Inclusion and exclusion criteria .....	62
2.2.2.3 Participant characteristics .....	63
2.2.3 Ethical considerations.....	66
2.2.4 Procedure.....	66
2.2.4.1 Materials .....	66
2.2.4.2 Interview procedure .....	66
2.2.5 Analysis .....	67

2.2.5.1 Stages of analysis.....	67
2.2.5.2 Validity and credibility .....	67
2.2.5.3 Reflexivity .....	68
2.3 Findings .....	68
2.3.1 “It’s a bit of a minefield” .....	69
2.3.1.1 “World of safety and plastic” .....	69
2.3.1.2 “I’m in a maze” .....	71
2.3.1.3 “We hoped it would be a fix” .....	73
2.3.2 “Monster of mental health”.....	74
2.3.2.1 “It just rips your world apart” .....	74
2.3.2.3 “It won’t ever be the same again”.....	75
2.3.3 “I don’t live in Syria”.....	78
2.3.3.1 “You learn to cope” .....	78
2.3.3.2 “This is our new reality” .....	81
2.4 Discussion.....	83
2.4.1 “It’s a bit of a minefield” .....	83
2.4.2 “Monster of mental health”.....	85
2.4.3 “I don’t live in Syria” .....	86
2.4.4 Clinical implications .....	87
2.4.5 Limitations .....	88
2.4.6 Future research .....	89
2.5 Conclusion .....	89
2.6 References.....	91
Chapter 3: Reflective Paper: Navigating the research process: strengthening my research identity.....	97
3.1 Introduction .....	98
3.1.1 Personal and professional development.....	98
3.1.1.1 Reflection.....	98
3.1.1.2 Reflexivity in qualitative research.....	99
3.2 Navigating through the research .....	99
3.2.1 Narrative Therapy.....	100
3.2.2 The Tree of Life (ToL).....	100
3.2.2.1 My professional ToL prior to completing this research.....	101
3.2.2.2 My research narrative .....	102
3.2.3 “What is my role?” .....	105
3.2.3.1 “A clinician” .....	105
3.2.3.2 A researcher .....	106

3.2.3.3 A researcher and a clinician.....	107
3.2.4 A new learning experience .....	107
3.3 Redefining my research narrative .....	108
3.3.1 Developing a new narrative .....	108
3.3.2.2 My ToL following completion of this research .....	109
3.4 Conclusion .....	110
3.5 References.....	111

## **List of Tables**

Table 1.1	Databases included in the systematic investigation
Table 1.2	Key search terms
Table 1.3	Inclusion and exclusion criteria
Table 1.4	Characteristics of studies
Table 1.5	Meta-themes with corresponding main themes and subthemes
Table 2.1	Inclusion and Exclusion criteria
Table 2.2	Participant characteristics
Table 2.3	Superordinate and subordinate themes

## **List of Figures**

Figure 1.1	PRISMA flow diagram
Figure 2.1	Six stages of Interpretative Phenomenological Analysis
Figure 3.1	Professional Tree of Life prior to research
Figure 3.2	Professional Tree of Life following the research

## List of Appendices

- A Author guidelines for submission to the journal of Child and Adolescent Mental Health
- B Coventry University ethics approval for Chapter One Systematic Review
- C Adapted Critical Appraisal Framework
- D Inter-rater reliability coefficient (Kappa) scores
- E Noblit & Hare (1988) Meta-ethnographic method
- F Thematic maps illustrating themes
- G Table illustrating meta-themes, main themes and subthemes
- H Author guidelines for the British Journal of Psychology
- I Participant information sheet
- J Coventry ethics approval
- K HRA ethics approval
- L Consent form
- M Debrief information sheet
- N Semi-structured interview schedule
- O Stages of IPA
- P Example transcript and analysis
- Q Examples of stages of analysis
- R Examples of stages of developing themes
- S Table illustrating participant contributions to superordinate and subordinate themes
- T Examples of respondent validation
- U The Tree of Life professional identity questions

## List of Abbreviations

CAMHSIU	Child and Adolescent Mental Health Inpatient Unit
UK	United Kingdom
DH	Department of Health
MH	Mental Health
CAMHS	Child and Adolescent Mental Health
NHS	National Health Service
DE	Department for Education
UN	United Nations
WHO	World Health Organisation
QNIC	Quality Network for Inpatient CAMHS
PBS	Positive Behavioural Support
PCO	Population, Context Outcome Framework
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
CAF	Critical Appraisal Framework
MMAT	Mixed Methods Appraisal Tool
USA	United States of America
IPA	Interpretative Phenomenological Analysis
BPS	British Psychological Society
CU	Coventry University
HRA	Health Research Authority
CPA	Care Programme Approach
ToL	Tree of Life
DCP	Division of Clinical Psychology

## **Acknowledgements**

Firstly, I would like to thank all the parents who gave their time to take part in this research. I am extremely grateful for your willingness to openly share your experiences.

I would also like to thank my research team; Dr Magda Marczak, Mrs Jo Kucharska and Dr Felicity Gilbey for their support, guidance and encouragement throughout the research process, particularly during those stressful moments! A special thanks also goes to my appraisal tutor, Dr Carolyn Gordon for her continued support and encouragement over the last three years of the course.

To my fellow trainees (and friends), our journey together over the last three years has been like a rollercoaster. I could not have asked for a more supportive group of friends. Thank you for all your support and words of encouragement throughout training and particularly through my thesis journey.

To my family, a special thank you for your support over the years, for encouraging me to keep going even during the tough times. Thank you for the fun times that kept me going during the last three years in particular. To all my friends, particularly Michelle, Lisa, Gemma, Rhiannon, thank you for always being there for me, for the many cups of tea, cake, chats, laughter and much needed hugs!

Finally, my wonderful husband deserves special thanks for all his love, support and encouragement. Thank you for always being there with a hug or with your great problem-solving skills, for always believing in me and encouraging me to keep going even in the times when I did not believe in myself. Also, to our two lovely cats for keeping me company with lots of cuddles and fuss during the long hours spent in my study.

## **Declaration**

This thesis has been submitted for the Clinical Psychology Doctorate at the Universities of Coventry and Warwick. The work presented has been composed by myself and has not been submitted for any other qualification or to any other institution. This thesis is an original piece of my own work, which was undertaken with the academic and clinical supervision of Dr Magda Marczak (Coventry University), Mrs Jo Kucharska (Coventry University) and Dr Felicity Gilbey (Northamptonshire Healthcare NHS Foundation Trust). The literature review was written for submission to the Child and Adolescent Mental Health Journal, while the empirical paper was written in preparation for the British Journal of Psychology. Emergent findings from the empirical paper and literature review were presented at the Child and Adolescent Mental Health Clinical Psychology group and will be presented at the Child and Adolescent Mental Health Regional Inpatient Clinical Network Meeting.

## **Summary**

This thesis focuses on adolescents' and parents' experiences of a Child and Adolescent Mental Health Inpatient Unit (CAMHSIU).

Chapter one is a systematic literature review of adolescents' experiences of their CAMHSIU stay. A comprehensive search of the qualitative literature revealed 9 articles meeting the criteria for this study. A meta-ethnographic synthesis was conducted and three meta-themes were identified. These meta-themes related to adolescents' views of relationships on the unit, their experiences of safety and confinement and the overall impact of their inpatient stay. Clinical implications including the need for the development of trauma-informed environments and staff training are discussed. Limitations and research recommendations are also considered.

The second chapter of this thesis captures parents' lived experiences following their child's admission to a CAMHSIU. Interpretative Phenomenological Analysis was used to explore parents' experiences. Seven parents took part in individual semi-structured interviews. Three superordinate themes emerged that highlighted the challenges parents face in navigating the inpatient system, experiences of loss and grief and parents' process of understanding and adapting following their child's admission. The findings suggest that additional support is required for parents following their child's admission. Clinical implications, limitations and research recommendations are discussed.

The third and final chapter of this thesis presents a first-person reflective account of the author's experience of conducting the research. The author considers the value of personal and professional development through reflection and reflexivity in the research process. The author reflects on their research narrative prior to commencing the research and how their experiences and learning through the research process have shaped and developed their research narrative.

**Overall word count at submission: 19,610** (excluding abstracts, tables, figures, references and appendices)

## **Chapter 1: Systematic Literature Review**

### **Adolescents' experiences of child and adolescent mental health inpatient units: A meta-ethnographic synthesis of the qualitative literature**

*Written in preparation for the Journal of Child and Adolescent Mental Health  
(See Appendix A for author guidelines)*

Overall chapter word count at submission (excluding tables, figures and  
references): 7993

## **1.0 Abstract**

**Background:** At any one time approximately 1,300 adolescents receive treatment in Child and Adolescent Mental Health Inpatient Units (CAMHSIUs) in the United Kingdom (UK). Although the literature highlighted the importance of gaining adolescents' perspectives of this treatment there has not been a systematic review of the recent qualitative research focused on adolescents' contrasting experiences of the CAMHSIU. Therefore, the purpose of this review was to provide a systematic synthesis of the empirical qualitative research exploring adolescents' experiences of the CAMHSIU.

**Method:** A comprehensive systematic search of qualitative literature was conducted. A total of six electronic databases relevant to adolescent mental health were searched, leading to 9 articles that met inclusion criteria for this synthesis. A meta-ethnographic synthesis was conducted on the 9 articles.

**Results:** Three meta-themes were identified. '*Navigating relationships*' relates to adolescents' experiences of relationships with staff patients and therapy while on the CAMHSIU. '*Containment: safety versus confinement*' captures adolescents' experiences of adjusting to the unit. '*Impact of inpatient stay*' identifies adolescents' experiences of managing separation from their outside lives, developing connections and learning new skills on the CAMHSIU.

**Conclusions:** These findings identify the need for supportive staff and patient relationships that enable adolescents to adjust to and benefit from the inpatient environment. Clinical and research implications are discussed in the context of these findings.

**Word count:** 218

### **Key practitioner message**

*What is known?*

- Gaining adolescents' perspectives of treatment is important for guiding policy and practice.
- Previous qualitative literature has identified the contrasting experiences of adolescents admitted to a CAMHSIU.

*What is new?*

- Therapeutic relationships with staff are developed through informal interactions and activities.
- Supportive staff and patient relationships enable adolescents to adjust to and benefit from the inpatient environment.

*What is significant for clinical practice?*

- CAMHSIUs should develop a psychologically-informed environments, promoting the importance of therapeutic relationships with adolescents.
- The maintenance of adolescents' relationships with friends and family during their inpatient stay requires additional support from staff.

**Key words:** *adolescent mental health, experiences, inpatient unit, qualitative literature review, meta-ethnography*

## **1.1 Introduction**

This review aims to increase our understanding of adolescents' experiences of Child and Adolescent Mental Health Inpatient Units (CAMHSIUs).

### **1.1.1 Adolescent Mental Health**

The mental health (MH) of adolescents is an important area of national concern that has received growing attention in the United Kingdom [UK] in recent years (Department of Health [DH], 2015). Statistics in the UK indicate that approximately one in eight 5-19 year olds have a clinically significant MH difficulty (NHS Digital, 2018). When examining these statistics further, one in seven 11-16 years olds and one in six 17-19 years olds were found to have a diagnosable MH difficulty (NHS Digital, 2018). Between April 2016 and March 2017, 4,512 under 18-year olds were admitted to Child and Adolescent Mental Health Service (CAMHS) units (NHS Digital, 2017). Further, approximately 1,300 adolescents aged 10-19 receive inpatient treatment at any one time in the UK (DH & Department for Education [DE], 2017).

### **1.1.2 CAMHS inpatient units**

In the UK, CAMHSIUs provide specialist care for adolescents up to 18 years old with complex MH difficulties at risk to themselves or others (NHS England, 2014). The World Health Organisation (WHO, 2016) defines adolescence as those aged 10 to 19. Currently, inpatient services in the UK are provided for adolescents aged 13 to 18 in line with CAMHSIU specifications (NHS England, 2015).

The Quality Network for Inpatient CAMHS (QNIC, 2016) outlined standards to promote quality care on CAMHSIUs. These standards included requirements for improved consistency of staffing, service user involvement and increased psychological input (QNIC, 2016; Ables, Crosbie & Milson, 2015). Additionally, positive practice guidelines (DH, 2014) identify the need to reduce restrictive interventions. Positive Behavioural Support (PBS) provides a framework to do this, through developing a comprehensive understanding of an individuals'

difficulties, aiming to improve quality of life and reduce restrictive interventions (DH, 2014), for example, admission to inpatient units.

### **1.1.3 Adolescents' perspectives**

Falconbridge, Law and Laffan (2015), QNIC (2016) and Wallis, Potier, Milson and Beck (2015) emphasised the importance of gaining young people's feedback to provide quality care and to enhance the evaluation and development of CAMHSIU standards.

Previous research found that adolescents valued the 24-hour support provided by the CAMHSIU (Gill, Butler & Pistrang, 2016). Further, adolescents reported a sense of physical safety whereby they were unable to hurt themselves on the unit (Biering, Valgerður & Jenson, 2011). In contrast, adolescents shared frustration at a lack of individualised care (Offord, Turner & Cooper, 2006) and described feeling confined and restricted on the CAMHSIU (Haynes, Eivors & Crossley, 2011). Adolescents felt isolated from their lives in the community and experienced stigma about their MH following their admission (Mitten, Preyde, Lewis, Vanderkoov & Heintzman, 2016; Moses, 2011). These experiences of isolation and stigma led to difficulties in transitioning into the community, for instance, returning home, reconnecting with friends (Edwards et al., 2015) and reintegrating into school (Savina, Simon & Lester, 2014).

### **1.1.4 Previous research**

A factor analysis of qualitative and quantitative research demonstrated that adolescents' experiences were influenced by satisfaction with their treatment, the environment and relationships with staff (Beiring, 2010). This review predominately focused on quantitative research and therefore does not provide an insight into adolescents' experiences. Further, the majority of papers included in this review concentrated on outpatient care which may limit the generalisability of these findings to inpatient care.

Edwards et al. (2015) reviewed the risks to the impact on adolescents' social and emotional development associated with an inpatient stay. Results

suggested that adolescents were at risk of isolation from their lives outside the unit, learning unhelpful behaviour or forming unhelpful friendships during their admission. Despite this, Edwards et al.'s (2015) review included policy and guidance alongside staff, carer and adolescent perspectives. Subsequently, the views of each distinct group are unclear. Additionally, Edwards et al.'s (2015) use of researcher-constructed concepts may have led to bias in their results which limited the transferability of their findings.

Savina, Simon and Lester's (2014) review identified the challenges of school reintegration following discharge from a CAMHSIU. Findings suggested that adolescents were concerned about the attitudes and reactions of peers and teachers towards their MH and admission. This resulted in increased anxiety about returning to school (Savina et al., 2014). While Savina et al.'s (2014) review provides important findings relating to school reintegration, they only explore one aspect of the CAMHSIU experience.

Additionally, the reviews discussed above included a number of studies conducted prior to 2006. Since then, there has been an increase in qualitative research exploring adolescents' experiences of CAMHSIUs and changes to policy and practice focusing on improving quality of care (QNIC, 2016).

### **1.1.5 Rationale and Aims**

There has been an increased focus on adolescent MH (DH, 2015) alongside standards for improved inpatient care (QNIC, 2016). Previous reviews have explored adolescents' satisfaction with services (Biering, 2010), the impact of a CAMHSIU stay on adolescents' social and emotional development (Edwards et al., 2015) and challenges of reintegration to the school environment (Savina et al., 2014). However, these reviews focused on quantitative research (Bering, 2010), included staff, carer and adolescent perspectives (Edwards et al., 2015) or focused on one aspect of the inpatient experience (Savina et al., 2014). Recently, qualitative research has highlighted the contrasting experiences of adolescents admitted to CAMHSIUs (Mitten et al., 2016; Haynes et al., 2011). The increase in qualitative literature has the potential to

provide a more detailed picture of adolescents' experiences. To the author's knowledge, no review, to date, has explored the qualitative literature of adolescents' experiences of a CAMHSIU. This is an important area to explore as gaining an in-depth understanding of adolescents' experiences can identify areas for improvement and influence the quality of care, including access to psychological care on the CAMHSIU (Ables et al., 2015).

This study aims to provide a meta-ethnographic synthesis of empirical qualitative research exploring the experiences of adolescents who have been admitted to CAMHSIUs. This review will aim to answer the following question:

What are adolescents' experiences of CAMHSIUs?

## **1.2. Method**

### **1.2.1 Systematic Literature Search**

Ethical approval for conducting this review was obtained from Coventry University Ethics Committee (Appendix B).

#### *1.2.1.1 Search process*

A systematic search of the literature for qualitative studies that explored adolescents' experiences of CAMHSIU was conducted between 25<sup>th</sup> June and 12<sup>th</sup> December 2018. Advice was sought from a qualified librarian regarding the use of appropriate databases and search terms. Table 1.1 provides a list of relevant databases for literature on adolescent MH. References from identified articles were manually examined for additional relevant articles.

*Table 1.1 Databases included in the systematic investigation*

<b>Database</b>	<b>Host</b>
Academic Search Complete	EBSCO
AMED (The Allied and Complementary Medicine Database)	Ovid
MEDLINE (Medical Literature Analysis and Retrieval System Online)	Ovid
PsycINFO (Psychological Information Database)	Ovid
CINAHL (Cumulative Index to Nursing and Allied Health Language)	EBSCO
SCOPUS	Elsevier

#### *1.2.1.2 Search terms and strategy*

Table 1.2 presents the key search terms used to identify literature relevant to the subject area, organised using the Population, Context, Outcome (PCO) framework (Bulter, Hall & Copnell, 2016). They include the main terms of child, adolescent, inpatient CAMHS, mental health difficulties and experience. Synonyms of the main concepts were used to identify all relevant literature along with Boolean and truncation operators (Butler et al., 2016). These search terms were further refined by examining articles and identifying commonly used key words and synonyms from relevant studies (Butler et al., 2016). Location of the search terms were limited to title and abstract to increase the likelihood of identifying relevant research.

Table 1.2 Key Search Terms

	<b>Main term</b>	<b>Synonyms</b>	<b>Location</b>
<b>Population</b>	Child Adolescent	Child* OR adolescen*	Title, abstract
<b>Context</b>	Inpatient CAMHS	Inpatient or in-patient OR “psychiatric inpatient”	Title, abstract
<b>Context</b>	Mental health difficulties	“Mental health” OR “mental illness”	Title, abstract
<b>Outcome</b>	Experience	Experience* OR perspective* OR view* OR perception*	Title, abstract

### 1.2.2 Eligibility criteria

The current review included qualitative and mixed methods, peer reviewed articles published between 2007-2018, to capture the most up to date literature on this topic. This timeframe was deemed appropriate due to changes in provision of care on CAMHSIUs since 2007 (QNIC, 2008). These articles focused on acute, therapeutic and psychiatric intensive care units. All MH difficulties were included in this review to obtain a range of views and experiences. Aligned to the WHO (2016) definition of adolescence, participants were aged from 10 years old, up to and including 19 years old. All articles were required to be written in English as this is the first language of the author.

Quantitative studies which did not explore individuals’ in-depth experiences were excluded (Coolican, 2004). Articles focusing on forensic settings were excluded due to the differing nature of forensic experiences (MacInnes, Courtney, Flanagan, Bressington & Beer, 2014). Adolescents with learning difficulties and physical disabilities were excluded as these difficulties may add a level of complexity that is beyond the scope of this review.

Table 1.3 presents the specific inclusion and exclusion criteria for this review.

*Table 1.3 Inclusion and Exclusion Criteria*

<b>Criteria</b>	<b>Inclusion</b>	<b>Exclusion</b>
<b>Participants</b>	Adolescents (aged 10-19 years old)	Individuals aged 20 and over and under 10, Adults, Parents, Staff
<b>Time frame</b>	Articles published between 2007-2018	Articles published before 2007
<b>Language</b>	English	Articles not published in English
<b>Design</b>	Qualitative Qualitative part of a mixed methods	Quantitative
<b>Type</b>	Empirical papers	Commentary papers, Theoretical papers, Doctoral theses, Dissertations, Literature reviews
<b>Peer reviewed</b>	Peer reviewed	Grey literature Non peer reviewed
<b>CAMHS inpatient unit</b>	Acute, therapeutic or psychiatric intensive care	Forensic units
<b>Mental Health</b>	Depression, Anxiety Eating disorder, Psychosis, Self-harm	Learning disability Physical disability

### **1.2.3 Classification of Studies**

The process of selecting articles was recorded on the 'Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram, presented in *Figure 1.1* (Moher, Liberati, Tetzlaff & Altman, 2009). In total, 410 papers were identified following a search of electronic databases. A further 3 papers were identified through manual search of the references. Of those, 148 duplicates were removed. Further, 216 studies were excluded due to not meeting the inclusion criteria as shown in *Figure 1.1*. In total, 49 full text articles were reviewed for eligibility and 40 studies were removed. The 9 remaining studies met the inclusion criteria and were eligible for quality assessment.

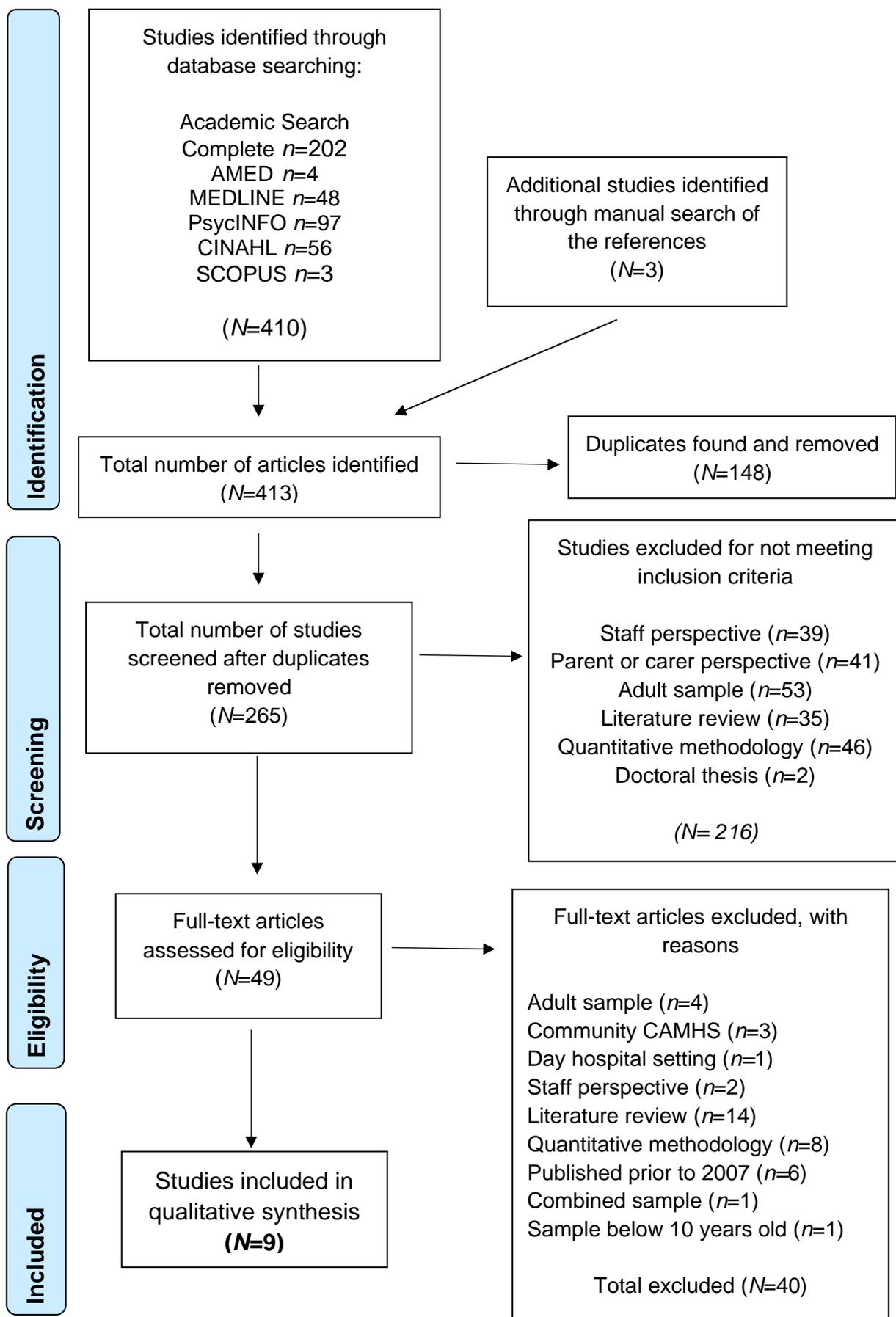


Figure 1.1 PRISMA flow diagram (Moher et al., 2009)

#### **1.2.4 Quality assessment**

The use of quality assessments in qualitative research is subject to debate, with researchers arguing that quality assessment does not fit with the subjective and interpretive nature of qualitative research (Dixon-Woods, Shaw, Agarwal & Smith, 2004). Several assessment tools have been developed and adapted by researchers to meet the needs of their studies (Ring, Ritchie, Mandava & Jepson, 2011). This review adapted Caldwell, Henshaw and Taylor's (2005) Critical Appraisal Framework (CAF) to include one question from Pluye et al.'s (2011) Mixed Methods Appraisal Tool (MMAT) relating to the researchers' influence (Appendix C). All papers were rated against 19 questions. Each item was scored 0 for 'No', 1 for 'Partially' and 2 for 'Yes' (Caldwell et al., 2005). The total scores were then converted to percentages.

##### *1.2.4.3 Outcome of quality assessment*

The overall quality of the studies included in this review ranged from 66-89%. To enhance reliability of the quality assessment, a second researcher independently assessed all papers using the same criteria. Inter-rater reliability analysis was conducted using the Kappa coefficient (Cohen, 1960). Scores ranged from  $k=0.70$  to  $k=1.0$  and the overall score was  $k=0.90$ , indicating very good inter-rater reliability (Altman, 1999; Appendix D).

Given the debate around the use of quality assessment tools, no study was excluded as a result of methodological quality. Rather, the CAF was used to facilitate discussion and identification of strengths and weaknesses of each study (Ring et al., 2011).

#### **1.2.5 Method of synthesis**

Synthesis of qualitative literature is a relatively new area that is surrounded by ongoing debate (Ring et al., 2011). The interpretation and presentation of qualitative findings may differ across studies depending on their specific aims, philosophical stance and methodology (Ring et al., 2011). As such, qualitative synthesis may not capture the context-specific meaning of the original studies

(Dixon-Woods et al., 2006). Despite this, there is a recognition of the importance of synthesising qualitative literature to provide a collective understanding of a topic (Bearman & Dawson, 2013). This is important for identifying clinical implications and contributing to policy, practice and decision-making in health care (Noyes et al., 2008). Further, there has been an increase in systematic reviews of qualitative studies utilising a range of qualitative review approaches (Lachal, Revah-Levy, Orri & Moro, 2017; Toye et al., 2013; Ring et al., 2011).

A meta-ethnographic approach, developed by Noblit and Hare (1988; Appendix E) was adopted for this review. Meta-ethnography is an interpretive approach that produces a new third order interpretation of studies by analysing the participant findings and author interpretations reported in the original studies (Ring et al., 2011). Meta-ethnography has been used in a variety of published systematic reviews (Feast et al., 2018; Hannes & Macaitis, 2012) and has been described as “*a leading method for synthesising qualitative healthcare research*” (Ring et al., 2011, p. 16). This method has also been used to explore patients’ experiences of care and illness (Toye et al., 2013; Atkins et al., 2008) and therefore is appropriate for the current synthesis. Additionally, the inclusion of both participant findings and author interpretations allowed the researcher to provide a rich synthesis of studies that develops new interpretations and insights (Feast et al., 2018; Atkins et al., 2008).

Articles were read a number of times to become familiar with the detail of the studies. Articles were arranged in alphabetical order and key concepts from paper one were compared and revised with those from paper two and so on until all 9 papers had been synthesised (Toye et al., 2013). To reduce potential bias, an additional researcher extracted data from six articles, which were then compared in discussion with the lead researcher. Due to the number of themes identified during this stage, and in line with previous meta-ethnographic reviews (Purc-Stephenson & Thrasher, 2010; Atkins et al., 2008), a thematic analysis was conducted on the key themes to provide an overall framework describing the findings from all 9 studies. Meta-themes, main themes and

subthemes were developed in collaboration with two research supervisors, to identify new interpretations capturing the main elements of adolescents' experiences of CAMHSIUs. Thematic maps representing each meta-theme can be found in Appendix F. A comprehensive table illustrating the contributions of articles of each meta-theme can be found in Appendix G.

### **1.3 Results**

#### **1.3.1 Characteristics of studies**

Table 1.4 provides details of the studies included in this review.

Table 1.4 Characteristics of studies

Authors/Date /Country/ Quality Rating (QR)/ Kappa	Aim	Research design/ sampling method	Characteristics of participants (where provided)	Methods of data collection / analysis	Key Findings
Biering, Valgerður & Jensen 2011 Iceland QR:82% K=1.0	To explore adolescents' perception of quality of care	Qualitative Purposive sampling	N=14 Male n=6 Females n=8  Aged 14-17 years (M=15.9)  Length of stay 6 weeks-5 months	Individual interviews lasting from 30 to 90 minutes  Hermeneutic Methodology  Thematic Analysis  <i>Credibility:</i> <ul style="list-style-type: none"> <li>• Respondent validation</li> <li>• Peer debriefing</li> </ul>	Two main themes, each with subthemes describing factors that contributed to adolescents' perception of satisfaction and dissatisfaction with their care: <ol style="list-style-type: none"> <li>1. <i>Patient Satisfaction</i> Participants experienced the ward as a safe place where they felt sheltered, but isolated from the outside world. Participants valued activities on the ward for keeping busy and expressed desire for more activities off the ward. Rules and routines were experienced as irritating but necessary, particularly in relation to attending school. Peer relationships were viewed as important for sharing experiences, building trust and feeling supported. Feeling able to express themselves, either to ward staff or therapists and feeling like they were treated with respect and consideration contributed to satisfaction with their experiences on the unit.</li> <li>2. <i>Satisfying treatment outcomes</i> Participants felt satisfied with their treatment if they felt their health and mental health had improved. Participants described finding hope and learning new skills that helped to build their self-esteem and confidence. A number of participants experienced improved family relationships.</li> </ol>

Gill, Butler & Pistrang 2016 UK QR:89% K=0.70	To explore adolescents' perspectives of inpatient care focusing on their transition home	Qualitative Purposive sampling	N=12 Male n=2 Female n=10  Aged 13-18 years (M=16.3)  Mean length of stay: three and a half months	Individual semi-structured interviews lasting approximately 60 minutes* <sup>1</sup>  Thematic analysis  <i>Credibility:</i> <ul style="list-style-type: none"> <li>• Consensus approach to analysis</li> <li>• Peer debriefing</li> <li>• Bracketing of assumptions</li> </ul>	Five superordinate themes were identified, each with corresponding subthemes. The first two themes focused on perceived benefits and drawbacks of the CAMHSIU; the third theme on personal changes experienced; the final two themes on the anticipated transition from the unit. <ol style="list-style-type: none"> <li>1. <i>Feeling understood by others</i> Participants reported the value of shared experiences and developing friendships on unit which led to a sense of belonging. Relationships with staff and continuous support were viewed as helpful for support but unhelpful when participants felt their privacy was restricted.</li> <li>2. <i>"A fake world" (p. 60)</i> Participants described the unit as different from the outside world. They reported strong attachments to staff and patients but expressed fear of becoming too attached. Participants found the structure and routine helpful for providing physical safety and consistency but felt controlled and confined at times.</li> <li>3. <i>Feeling stronger</i> Participants described developing confidence in themselves and their ability to cope with difficulties. They reported developing a new perspective, a better understanding their difficulties and hope for their future.</li> <li>4. <i>Road to recovery</i> Thinking about discharge, some participants described improvement in their wellbeing while one participant felt</li> </ol>
---	--	-----------------------------------	---	--	---

<sup>1</sup> \*This was the only information provided in the study

					that their problems continued. Participants described feeling more able to manage their difficulties but expressed worries about becoming unwell again or missing the inpatient experience.
					5. <i>Getting back to normal life</i> Participants expressed goals of getting back to normality but felt concerned about leaving the unit, adjusting to life outside and worried about others' responses to them. Participants described changed views of mental health and inpatient units.
Haynes, Eivors & Crossley 2011	To explore adolescents' experiences of psychiatric hospitalisation	Qualitative Purposive sampling	<i>N</i> =10 Male <i>n</i> =4 Female <i>n</i> =6  Aged 13-19 years ( <i>M</i> =16.7)  Length of stay: 4 weeks-36 months	Individual interviews lasting from 20 and 100 minutes  Grounded Theory  <i>Credibility:</i> <ul style="list-style-type: none"> <li>• Constant comparative method</li> <li>• Research journal</li> <li>• Peer debriefing</li> </ul>	One core category, with seven subcategories emerged that described participants experiences of hospitalisation. 1. <i>Living in an alternative reality</i> Participants described negative consequences of their inpatient stay including feeling restricted by the rules and routines, a lack of privacy and feeling disconnected from their friends and family. The impact of these experiences led to isolation and loneliness. Participants described polarised relationships with staff and learning to manage other patients' distress on the unit. A number of factors helped participants to adjust and cope with life on the unit, including developing supportive relationships with patients, taking part in everyday activities to prevent boredom and manage the restrictions of the unit, and using strategies to manage the disconnection from their lives and cope with witnessing violence or self-harm.
UK					
QR:87%					
<i>K</i> =0.86					

Mitten, Preyde, Lewis, Vanderkooy & Heintzman 2016 Canada QR:79% K=0.89	To explore adolescents' perceptions of stigma and care receipt when receiving inpatient psychiatric care	Qualitative Exploratory cross-sectional design Purposive sampling	N=12 Male n=1 Female n=10 Other n=1  Aged 15-19 years (M=16.6, SD=1.4)	Semi-structured interviews lasting approximately 60 minutes*  Content analysis  <i>Credibility:</i> • Respondent validation • Peer debriefing	Three main themes, each with subthemes emerged: 1. <i>Stigma</i> Participants described experiencing stigmatising reactions from others including avoidance, fear or lack of understanding. Participants spoke of feeling labelled and wished to be seen as normal. 2. <i>Care receipt</i> Participants reported positive experiences with staff, describing key characteristics of staff, particularly empathy, compassion and acceptance. 3. <i>Stigma and care receipt</i> Participants highlighted unhelpful interactions with health care providers whereby they felt that staff made assumptions or minimised their problems.
Moses 2011 USA QR:82% K=1.0	To explore adolescents subjective accounts of the most helpful and unhelpful/harmful aspects of their first psychiatric inpatient treatment	Qualitative Purposive sampling	N=80 Male n=31 Female n=49  Aged 13-18 years (M=15.3)  Mean length of stay: 7.6 days	Semi-structured interviews  Thematic analysis  <i>Credibility:</i> • Constant comparative method • Inter-coder reliability which	Seven themes, each with subthemes emerged. The first three themes described the most helpful aspects of inpatient treatment, the last four themes described the most unhelpful aspects. 1. <i>Interpersonal support</i> Participants reported that relationships with peers on the unit offered companionship and normalisation. Relationships with staff were valued when staff were non-judgemental and participants felt cared for and respected. 2. <i>Therapy and psychoeducation</i> Participants described the benefits of learning coping skills, understanding their triggers and developing individualised goal-setting which helped them to manage

				formed a 'master' coding scheme used to code all interviews	<p>their difficulties. Participants found group therapy helpful for sharing their experiences.</p> <p>3. <i>Environment</i> Participants noted the importance of the ward environment for providing structure and safety, which offered a sense of comfort and time out from their lives whereby participants gained a new perspective on their difficulties.</p> <p>4. <i>Rigidity and confinement</i> Participants felt frustrated at the rules and restrictions on the ward, describing them as unfair and pointless.</p> <p>5. <i>Lack of treatment responsiveness</i> Participants described inconsistency or unhelpful responses from staff which led to feeling frustrated and dismissed. Activities were viewed as childish and therapy groups as detrimental and pointless. Participants felt disappointed at the limited one-to-one therapy and lack of individualised care.</p> <p>6. <i>Frightening/anxiety-provoking experiences</i> A small number of participants reported feeling distressed by being away from family, witnessing another patients' distress and feeling worried about stigma from friends.</p> <p>7. <i>Other</i> Two participants reported that other patients were not good to be around because they did not offer support.</p>
Reavey, Poole, Corrigall, Zundel, Byford,	To expand the understanding of adolescents'	Qualitative	N=20 Male n=8	Individual interviews*	<p>Three main themes emerged.</p> <p>1. <i>Behavioural surveillance as care surrogate</i></p>

<p>Sarhane, Taylor, Ivens &amp; Ourgin</p> <p>2017</p> <p>UK</p> <p>QR:84%</p> <p>K=0.87</p>	<p>experiences of the inpatient environment (with a focus on the ways in which feelings of distress are managed)</p>	<p>Purposive sampling</p>	<p>Female <math>n=12</math></p> <p>Aged 14-18 years</p> <p>(<math>M=16.8</math>)</p> <p>Mean length of stay: 65.8 days</p>	<p>Thematic decomposition analysis</p> <p><i>Credibility:</i></p> <ul style="list-style-type: none"> <li>• Group analysis</li> <li>• Peer review and debriefing</li> </ul>	<p>Participants reported feeling frustrated and confined under the constant observation and monitoring of staff and viewed the ward as an artificial environment. They noted concern about others' reactions to their inpatient admission and felt disconnected from their lives. Staff were perceived as more focused on medication and behaviour monitoring than therapeutic contact.</p> <ol style="list-style-type: none"> <li>2. <i>Monitoring relations with others</i> Participants described developing supportive peer relationships that continued after discharge. Participants struggled with inconsistency from staff about patient relationships, which affected their relationships with staff and increased participants' feelings of isolation.</li> <li>3. <i>The delicate emotional ecology of the ward: openness, triggering, sterility and relational entanglements</i> Participants reported feeling able to discuss feelings of distress and build connection and trust with some staff and patients. There were concerns around feeling triggered by others in groups and participants also described having to manage their own emotions for fear of triggering others. Learning to manage emotions was deemed important, but participants spoke of difficulties in exploring their emotions due to emotional distance of nursing staff that encouraged emotional suppression.</li> </ol>
<p>Salamone-Violi, Chur-Hansen &amp; Winefield</p>	<p>To identify and understand adolescents' experiences of</p>	<p>Qualitative Purposive sampling</p>	<p><math>N=11</math></p> <p>Male <math>n=6</math></p> <p>Female <math>n=5</math></p>	<p>Semi-structured individual interviews lasting between</p>	<p>Three main themes emerged, each with subthemes.</p> <ol style="list-style-type: none"> <li>1. <i>Emotional response to the inpatient experience</i> Participants described an acceptance that they needed support but experienced powerlessness that their</li> </ol>

2015	the admission process to a psychiatric inpatient unit		Aged 15-17 years	15 and 50 minutes	admission was beyond their control. Participants expressed feelings of uncertainty about the admission and a fear of how other patients would respond to them.
Australia			Length of stay: 4-15 days	Thematic analysis	2. <i>Experience of the admission itself</i> Relationships with staff were perceived as helpful if staff showed understanding and support, but unhelpful for participants who felt staff were always busy. Relationships with patients provided support and hope, while some participants expressed fear of other patients. The ward environment was described as confining but providing safety. Participants favoured individual therapy over group therapy.
QR:87%				<i>Credibility:</i>	
K=0.83				<ul style="list-style-type: none"> <li>Peer analysis and debriefing</li> <li>Participant validation offered but not taken up.</li> </ul>	3. <i>Outcomes</i> Participants felt the unit provided safety and containment whereby they gained support from staff and experienced improvement in their mental state. Participants expressed boredom at a lack of activities, felt they did not receive adequate information explaining their admission and did not feel included in discussions around discharge.
Tierney	To explore the views of young people with anorexia treated on an inpatient adolescent psychiatric unit	Qualitative	N=10	Individual semi-structured interviews lasting between 40 and 120 minutes	Five main themes emerged:
2008		Purposive sampling	Male n=1 Female n=9		1. <i>Accessing appropriate care</i> Participants described difficulties in accessing care in the community reporting that community professionals lacked expertise and missed the signs of eating difficulties. Participants reported initial resistance to accepting treatment, but accepted that it had been necessary.
UK			Aged 11-18 at time of treatment	Thematic analysis	2. <i>Balancing the physical and psychological</i> Participants described unhelpful experiences of staff focusing on physical over psychological reasons for their difficulties. Therapy was viewed as helpful but
QR:66%			(M=17, SD=1.8)	<i>Credibility:</i>	
K=0.90					

				<ul style="list-style-type: none"> <li>• Peer analysis and discussion of themes</li> <li>• Reflexive journal</li> </ul>	<p>participants experienced frustration at the lack of psychological input or constant changes of therapists.</p> <ol style="list-style-type: none"> <li>3. <i>Qualities required in professionals</i> Participants reported the need for professionals to have expertise in eating disorders and difficulties around staff not understanding their eating disorder which led to feeling unsupported by staff.</li> <li>4. <i>Help from non-professional routes</i> Participants had varied experiences of support, or lack of support, from family and self-help groups. They spoke of the importance of support from others with anorexia as well as an unhelpful competitive element that being around others with anorexia could evoke.</li> <li>5. <i>Perceived progress</i> Participants discussed moving from resenting admission to accepting it was needed. They saw motivation to change as essential for recovery. Participants longed to return to their lives but many continued to experience difficulties with food and socialising.</li> </ol>
van Ommen, Meerwijk, Kars, van Elburg & van Meijl 2009 The Netherlands QR:68%	To explore the patients' perspective of the effectiveness of inpatient nursing care of adolescents diagnosed with anorexia nervosa	Qualitative  Purposive sampling	N=13 females  Aged 13-17 years (M=15)  Mean length of stay: 131 days	Individual semi-structured interviews  Grounded theory  <i>Credibility:</i> <ul style="list-style-type: none"> <li>• Independent coding</li> <li>• Peer supervision</li> </ul>	Three categories described the process of regaining weight, which fell into three phases, each of which encompassed subcategories. <ol style="list-style-type: none"> <li>1. <i>Phase 1: Normalisation</i> Participants spoke of experiencing extreme stress at admission and during the first meals; they found staff control and structure to be helpful and experienced peer support as encouraging and reassuring.</li> <li>2. <i>Phase two: Structure and responsibility</i> Participants described the process of regaining control and responsibility for their eating and exercise through</li> </ol>

---

<i>K=0.90</i>	and debriefing	individual plans and building trusting relationships with staff. 3. <i>Phase three: Preparing for discharge</i> Participants reported taking responsibility for their eating and preparing for discharge. They felt trusted by staff, which led to increased self-esteem and confidence. Participants described anxiety about returning to school and learned to manage difficult situations around eating.
---------------	-------------------	---

---

While the studies included had a range of aims, all led to findings relating to adolescents' experiences of CAMHSIU. Four studies were conducted in the UK (Reavey et al., 2017; Gill, Butler & Pistrang, 2016; Haynes, Eivors & Crossley, 2011; Tierney, 2008), one in Canada (Mitten et al., 2016), one in Australia (Salamone-Violo, Chur-Hansen & Winefield, 2015), one in the United States of America (USA; Moses, 2011), one in the Netherlands (van Ommen, Meerwijk, Kars, van Elburg & van Meijl, 2009) and one in Iceland (Biering et al., 2011). All studies employed qualitative designs. One study included only females (van Ommen et al., 2009) while the remaining studies included both male and female participants. Two studies did not report the adolescents' length of stay on the inpatient unit (Mitten et al., 2016; Tierney, 2008), with the remaining studies reporting length of stay between 4 days (Salamone-Violi et al., 2015) and 36 months (Haynes et al., 2011). Sample sizes varied across studies ranging from 10 (Haynes et al., 2011; Tierney, 2008) to 80 adolescents (Moses, 2011).

### **1.3.2 Results from the meta-synthesis**

The findings of this synthesis identify adolescents' experiences of the CAMHSIU as a process of adjustment, development and transition which is highlighted by three meta-themes: '*Navigating relationships*', '*Containment: safety versus confinement*' and '*Impact of inpatient stay*'. Each meta-theme consists of corresponding main themes and subthemes (Table 1.5). Each meta-theme, along with their main themes and subthemes will be discussed in detail below.

Table 1.5 Meta themes with corresponding main themes and subthemes

<b>Meta-theme</b>	<b>Main theme</b>	<b>Subtheme</b>
<b>Navigating relationships</b>	<i>Relationships with patients</i>	Shared experiences
		Difficult experiences
	<i>Relationships with staff</i>	Connection and support
		Negative experiences
	<i>Relationships with therapy</i>	Helpful
		Unhelpful
<b>Containment: safety versus confinement</b>	<i>Physical containment</i>	Supportive
		Restrictive
	<i>Psychological containment</i>	Safety and structure
		Enforced confinement
<b>Impact of inpatient stay</b>	<i>Sense of connection</i>	Lost connection
		Connection on the ward
		Reconnection
	<i>Process of change</i>	Developing skills
		Improved wellbeing
		Changed perspective

### 1.3.2.1 'Navigating relationships'

This meta-theme relates to adolescents' experiences of navigating relationships with others while on the CAMHSIU and encompasses three main themes: '*Relationships with patients*', '*Relationships with staff*' and '*Relationships with therapy*'.

#### 1.3.2.1.1 '*Relationships with patients*'

This main theme highlights the crucial role of relationships with other patients in the CAMHSIU, which incorporates two subthemes: '*Shared experiences*' and '*Difficult experiences*'.

The '*Shared experiences*' subtheme describes the value adolescents placed on sharing their difficulties with others, whereby they experienced companionship, validation and acceptance (Gill et al., 2016; van Ommen et al., 2009). Adolescents in Haynes et al.'s (2011) high quality study, stated that sharing their experiences enabled them to connect with others on the unit. This seems to lead to a sense of belonging and feeling understood. Further, this connection and companionship facilitate the development of friendships, which has a positive impact on adolescents' wellbeing.

*"I became friends with [fellow patient] and things have been on an upward cycle since... everybody needs someone like that when they come to an environment like this"*

(Gill et al., 2016, 60<sup>2</sup>)

Further, the importance of shared experiences enables adolescents to build trusting relationships with each other, which seems to reduce isolation (Reavey et al., 2017; Haynes et al., 2011; Moses, 2011; van Ommen et al., 2009).

---

<sup>2</sup> Page number within article

*“...you feel like you’re totally alone in this sea of craziness. And then to meet people who had some more experiences (similar) to mine, just very eye opening. It helped me so much.”*

(Moses, 2011, 126)

In contrast, the subtheme *‘Difficult experiences’* captures the challenges a small number of adolescents’ across five studies faced in navigating peer relationships (Gill et al., 2016; Mitten et al., 2016; Salamone-Violi et al., 2015; Haynes et al., 2011; Moses, 2011). Some adolescents described difficulties with expressing their emotions for fear of triggering emotional reactions in other patients (Reavey et al., 2017). Consequently, adolescents withdrew from activities or suppressed their emotions, which appears to result in isolation and emotional suppression on the unit.

*“Say if I’m not feeling safe, and everyone wanted to go up to the games room...I couldn’t say anything about how I feel to the other people ‘cause it would trigger them, it’s really risky...”*

(Reavey et al., 2017, 214)

Further difficulties with patient relationships included witnessing distress or violence on the ward, as adolescents shared that *“...it’s hard when you’re living with all that violence...”* (Haynes et al., 2011, 154). Additionally, adolescents in Mitten et al.’s (2016) high quality study reported struggling to understand other patients’ difficulties, or thinking that others were more unwell than themselves. This seems to lead to segregation and feeling fearful of others.

*“...sometimes it’s a little cold, like the people with depression will be scared of the people who have anger issues and the people who have anger issues will be scared of people with depression.”*

(Mitten et al., 2016, 10)

#### 1.3.2.1.2 *'Relationships with staff'*

This main theme reflects adolescents' polarised experiences with staff, which fall into two subthemes: *'Connection and support'* and *'Negative experiences'*.

The subtheme *'Connection and support'* encompasses adolescents' experiences of developing supportive relationships with staff. There was an emphasis on these relationships being developed through informal interactions, such as general conversations or participating in activities together.

*"we'll have lunch together and tea together and we'll sit together and chat and talk, just about normal everyday things...it really makes you realise you're being nursed by people as well, not just machines really."*

(Haynes et al., 2011, 153)

These informal interactions with staff seem to be key to building relationships and facilitating adolescents' adjustment to the CAMHSIU. The relationships adolescents developed with staff enable them to feel supported, build trust and share their feelings as adolescents reflected that the staff *"understood you..."* (Biering et al., 2011, 7). Further, adolescents seem to feel genuinely cared for and respected by staff who show empathy and compassion, which may strengthen therapeutic relationships.

*"You can talk to them about anything, and, like, they didn't judge you about it"*

(Moses, 2011, 127)

Despite these supportive relationships, the subtheme *'Negative experiences'* highlights experiences of unhelpful interactions with staff. Some adolescents reported a lack of responsiveness and perceived lack of care from staff as they felt that staff *"... didn't really, like, care what I had to say..."* (Moses, 2011, 130) or *"...forget about you"* (Salamone-Violi et al., 2015, 572). Further, adolescents in Tierney's (2008) medium quality and Reavey et al.'s (2017) high quality study felt that staff focused on their physical symptoms or

behaviour rather than their emotions. This seems to result in frustration and anger that staff may be missing their underlying distress and led to adolescents questioning the usefulness of the unit.

*“She said “We don’t want you acting up like last time, you know? You just need to go to bed and stop acting out.” And I was like “You do realise I’m in a psychiatric ward, don’t you? I’m here because there’s something up. And if you tell me to just go away when there’s something up then what’s the point of being here.”*

(Reavey et al., 2017, 213)

#### 1.3.2.1.3 ‘Relationships with therapy’

This main theme is characterised by two subthemes relating to adolescents’ opposing views of therapies as ‘*Helpful*’ and ‘*Unhelpful*’.

The subtheme, ‘*Helpful*’ relates to adolescents’ positive views of therapy. Individual therapy was experienced as a safe place to discuss sensitive issues and explore their feelings (Tierney, 2008). For some, this experience was “...*at least very comforting, to be able to talk with someone for an hour...*” (Biering et al., 2011, 7).

In addition, some adolescents in Moses’s (2011) high quality study found group therapy beneficial for providing a space to open up without shame or judgement, to listen to others and share their experiences.

*“Group was just good ‘cause we all, like, opened up. And a lot of people ended up crying. And we just, like, got through, like, what happened to us. And, like, it just, it was kind of, like, a relief to get it off your chest and, like, finally open up to somebody...”*

(Moses, 2011, 127)

In contrast, the subtheme ‘*Unhelpful*’ encompasses adolescents’ negative experiences of therapy. Some adolescents found individual therapy unhelpful,

preferring to seek support from nursing staff with whom they had supportive relationships, commenting that *“it is better to talk with those you meet every day”* (Biering et al., 2011, 7). Group therapy also raised difficulties as adolescents found it detrimental to hear *“people complaining and complaining”* (Moses, 2011, 131) and felt that the group was not a safe place to talk as a result of intense emotions evoked by others’ stories.

Further difficulties around therapy related to adolescents’ finding family therapy artificial *“because everyone was on their best behaviour”* (Tierney, 2008, 371) and distressing: *“...The family meeting made me super upset [...]”* (Moses, 2011, 131).

Adolescents’ views of therapy were influenced by dissatisfaction with a lack of therapy (Salamone-Violi et al., 2015; Moses, 2011) or constant change of therapists, which appear to have a negative impact on their emotional wellbeing.

*“It’s been really hard, ’cause it’s just as I get to trust someone and know them and then they say, “Oh, I’m leaving on this date” and say “We’ve only got this many sessions left.” Then I think, “What’s the point?” It makes it harder to deal with some of the thoughts. I sort of get really depressed. I feel like I can’t talk to anybody.”*

(Tierney, 2008, 371)

### **1.3.2.2 ‘Containment: safety versus confinement’**

This meta-theme captures adolescents’ experiences of adjusting to the inpatient environment whereby two main themes describe a sense of *‘Physical containment’* and *‘Psychological containment’*.

#### **1.3.2.2.1 ‘Physical containment’**

This main theme encompasses adolescents’ experiences of physical containment on the ward in two subthemes: *‘Supportive’* and *‘Restrictive’*.

The subtheme ‘*Supportive*’ highlights the benefits of the physical containment provided by structure and routine on the CAMHSIU. For some, the continuous observation on the unit offers physical safety whereby adolescents in van Ommen et al.’s (2009) medium quality study and Salamone-Violi et al.’s (2015) high quality study benefited from being unable to harm themselves.

*“Of course being here keeps me safe, for a suicidal person, it keeps me safe”*

(Salamone-Violi et al., 2015, 573)

Further, adolescents valued regular activities for contributing to a familiar, nonhospital environment where they were able to have “*fun*” (Biering et al., 2011, 6). These regular activities were important for preventing boredom and providing support or distraction from difficult thoughts (Gill et al., 2016; Haynes et al., 2011; van Ommen et al., 2009), which seem to facilitate adolescents’ adjustment to the unit.

*“Routine’s important, it is necessary for managing yourself... the devil makes work for idle minds, but here you’re always two minutes away from something else to keep you busy”*

(Gill et al., 2016, 61)

In contrast, the subtheme ‘*Restrictive*’ illustrates adolescents’ experiences of the unit as confining and restrictive, which seems to emphasise the unusual nature of the ward environment. This was evident in adolescents’ descriptions of the CAMHSIU as a “*fake world*” (Gill et al., 2016, 60), “*kindergarten*” (Moses, 2011, 131) and “*zoo*” (Reavey et al., 2017, 213). Additionally, the continuous observation on the unit seems to result in frustration and a loss of freedom, autonomy and privacy.

*“I saw them as keeping me prisoner, keeping me prisoner inside this place...I just felt really hostile towards the staff for keeping me here, for locking me in.”*

(Haynes et al., 2011, 152)

The loss of freedom led to adolescents feeling that staff were in control of their lives (Gill et al., 2016). This seems to result in anger, frustration and powerlessness as adolescents reported: *“You can’t do anything. It’s not care”* (Reavey et al., 2017, 213).

#### 1.3.2.2.2 *‘Psychological containment’*

This main theme reflects adolescents’ experiences of psychological containment in terms of their mental and emotional wellbeing on the unit, which encompasses two subthemes: *‘Safety and structure’* and *‘Enforced confinement’*.

Within the subtheme *‘Safety and structure’*, the unit seems to be experienced as a refuge from their lives in the community, as adolescents described the CAMHSIU as providing safety and protection from their lives outside the unit (Reavey et al., 2017; Salamone-Violi et al., 2015; Biering et al., 2011; Moses, 2011). This feeling of safety enables adolescents to build confidence in their ability to cope with stress and manage their mental health in the community.

*“They get me here, so here is where I should get help so that I can cope outside. I know it’s not the real world, but it’s not as scary....”*

(Salamone-Violi et al., 2015, 573)

Further, adolescents described the benefits of consistent boundaries and routines whereby the “24/7” care meant they could *“always talk to someone”* for support in managing difficult thoughts and feelings (Gill et al., 2016, 60).

In contrast, the subtheme *‘Confinement’* illustrates the negative impact of safety on the ward, which reduces adolescents’ independence and self-confidence in managing their mental health. This was evident for adolescents who felt that the unit created a *“false sense of security”*, which led to feeling unprepared for returning to the *“real world”* (Gill et al., 2016, 62). Additionally, the sense of confinement relates to frustration about the rules around physical contact with peers on the unit. It seems that physical contact could offer

important comfort, connection and support during times of distress, which adolescents felt they were denied.

*“I just thought that it, like, all the rules were kind of ridiculous and stuff. Like, no touching and stuff, like, I don’t know. I feel like it’s those times when you need, like, a hug the most, you know?”*

(Moses, 2011, 129)

### **1.3.2.3 ‘Impact of inpatient stay’**

This meta-theme represents the impact of adolescents’ inpatient stay in two main themes: ‘*Sense of connection*’ and ‘*Process of change*’.

#### **1.3.2.3.1 ‘Sense of Connection’**

This main theme captures adolescents’ experiences of separation from their lives outside the CAMHSIU, developing new connections on the ward and reconnecting with their lives in the community. Three subthemes illustrate this: ‘*Lost connection*’; ‘*Connection on the ward*’ and ‘*Reconnection*’.

The subtheme ‘*Lost connection*’ signifies adolescents’ experiences of isolation and separation from their family, friends and school during their inpatient stay. For some adolescents, this isolation was associated with a loss of role within the family (Reavey et al., 2017; Haynes et al., 2011; Tierney, 2008), which led to feelings of helplessness at being unable to support their family. For others, lost connection seems to relate to a loss of their familiar environment which results in distress at being away from their home.

*“It kinda made me feel down ‘cause I mean, you get this room and it’s not your room and you don’t get to see your family or your animals.”*

(Moses, 2011, 132)

Feeling different in comparison to others was common for adolescents on the CAMHSIU, who wished to “*do things that normal teenagers do*” (Gill et al., 2016, 62), which may signify a loss of their expected life. This loss is disruptive

to adolescents' everyday life as their lives in the community are put on hold during their inpatient stay. Further, the disruption may impact adolescents' achievement as a result of missed school time.

*"I should've been to college and I should be doing all these things that other people my age are doing, and I feel a bit trapped in here in that"*

(Haynes et al., 2011, 153)

The subtheme '*Connection on the ward*' represents adolescents' experiences of developing strong attachments with staff and patients on the CAMHSIU, who they described as a "*substitute family*" (Gill et al., 2016, 60). These relationships are important for attempting to recreate a sense of normality on the CAMHSIU. Additionally, close relationships appear to reduce the impact of disconnection from adolescent's outside lives. Despite this, adolescents expressed concern of becoming too attached or settled on the unit and worried that this would make it difficult to return home (Reavey et al., 2017; Gill et al., 2016).

*"I don't want to get comfortable because one day I will have to leave... I don't want to be really attached with this place because I will just get disappointed in the end..."*

(Gill et al., 2016, 60)

The subtheme '*Reconnection*' highlights adolescents' experiences of reconnecting with their lives outside the CAMHSIU. For some adolescents in Gill et al.'s (2016) and Biering et al.'s (2011) high quality studies, the CAMHSIU experience had a positive impact on their relationships with family. Adolescents felt more confident in their family's ability to understand and support them, reported improved family relationships and felt more comfortable sharing their difficulties.

*"And things between me and mama were also fixed. I had really never spoken with her. Now I can easily talk to her if have some problems..."*

(Biering et al., 2011, 8)

The process of reconnecting with friends was more complex. The disconnection adolescents felt from their friends while on the unit led to deterioration of friendships, anxiety about friends' reaction to their admission and a fear that others would view them differently (Gill et al., 2016; Haynes et al., 2011).

*"People might get worried in the sense that I'm not the same person anymore, that I'm different. But I don't want to be perceived as that"*

(Gill et al., 2016, 63)

These worries about friends' responses to adolescents' inpatient admission seem to increase isolation and exacerbate difficulties for adolescents in reconnecting with their lives outside the unit and maintaining their mental health:

*"I do have friends that don't really know what to do about it and I guess that's part of the stigma is that they are just scared because they don't know what to do. [...] I wish that part wasn't there because if people weren't scared of asking me what's wrong, maybe I wouldn't feel so crappy about myself because maybe I'd know that people care."*

(Mitten et al., 2016, 8)

In addition, the challenges of reconnecting with their lives outside the unit seem to result in difficulties in reintegrating back into the school environment:

*"Yes, in relation with school. When I came back, I felt lost in school. I felt like an outsider in my class and did not know what they were talking about."*

(Biering et al., 2011, 5)

#### 1.3.2.3.2 *'Process of change'*

This main theme illustrates adolescents' experiences of gaining new skills and knowledge through their CAMHSIU journey that fall within three subthemes; *'Developing new skills'*, *'Improved wellbeing'* and *'Changed perspective'*.

The *'Developing new skills'* subtheme describes adolescents' experiences of learning skills including anger management, social and coping skills (Gill et al., 2016; Biering et al., 2011; Moses, 2011). These skills enable adolescents to understand and manage their emotions in new ways. For example, adolescents learned that *"...all I have to do is just sit down sometimes..."* (Moses, 2011, 128) and took things *"one step at a time"* (Gill et al., 2016, 62). These skills seem to help adolescents to manage their MH through learning to be mindful of their needs and self-soothe during times of distress.

The subtheme *'Improved wellbeing'* reflects adolescents' process of developing their sense of self. Adolescents' new skills seem to empower them and lead to increased confidence in their ability to manage difficulties, which enhanced their self-respect and self-esteem (Gill et al., 2016; Biering et al., 2011; Haynes et al., 2011). For some, key components to improved wellbeing were motivation and desire to change (Tierney, 2008), which link to a desire to return to their lives.

*"I started to have a small taste of normal life again...it was really, really helpful. It shows why you're doing it and you discover that not all things are as scary as they seem to be at first."*

(van Ommen et al., 2009, 2805)

The subtheme *'Changed perspective'* captures the changes adolescents experienced as a result of their journey through the CAMHSIU. For many adolescents, there seems to be a process of acceptance whereby adolescents are able to reflect on the need for their admission and additional support.

*“I resented my family pushing me to get professional help, but it was the best thing they could have done because although I wouldn’t admit it, I just wasn’t ready to cope on my own, I just couldn’t do it...”*

(Tierney, 2008, 370)

There is a sense that exposure to others’ distress on the CAMHSIU helps to put adolescents’ own experiences into perspective (Gill et al., 2016; Biering et al., 2011; Tierney, 2008). It appears that adolescents develop acceptance of their difficulties and that through this, they are able to find hope and purpose in life.

*“I learned how life is, the reasons for it. To live in the day, but not in what had happened, to live in the moment. It is like this. It was a very nice experience... Yes, before I came here I found everything hopeless, no purpose in life.”*

(Biering et al., 2011, 8)

Finally, some adolescents described a process of being transformed as a result of their inpatient stay (Gill et al., 2016). The inpatient stay seems to enable adolescents to develop a more balanced perspective of themselves, understanding their strengths and vulnerabilities.

*“All these little things all kind of add up to one big change... I feel like I’ve been transformed in a way, like upgraded to a new me.”*

(Gill et al., 2016, 61)

Within these findings, it is important to note that two papers (Tierney, 2008; van Ommen et al., 2009) included in this review focused on adolescents accessing treatment for anorexia nervosa. While the overall experiences across studies were similar and were represented within the above meta-themes, adolescents in Tierney’s (2008) and van Ommen et al.’s (2009) studies identified a few subtle differences within the meta-themes which are important to highlight.

While adolescents in other studies identified the detrimental focus on behaviour, adolescents in Tierney (2008) and van Ommen et al.'s (2009) studies stressed the negative impact of staff focusing on their physical symptoms above their emotional distress. This focus seems to result in a lack of change in adolescents' underlying distress:

*“getting your weight up, and then they expect everything else to level off in your head, but it doesn't.”*

(Tierney, 2008, 370)

Adolescents with eating disorders experienced similar anxieties about discharge in terms of reconnecting with their friends, however, anxiety about discharge also centred around a fear of eating and regaining weight that may have further complicated their continued recovery in the community (van Ommen et al., 2009).

A final experience that was more strongly emphasised by adolescents in Tierney's (2008) and van Ommen et al.'s (2009) studies was the importance of motivation and desire to change alongside regaining a sense of responsibility over their eating and exercise patterns, which seems to lead to increased confidence in their ability to manage their eating disorder:

*“It just felt nice that I could show that I could do everything by myself again ... and that I did not have to be told everything I had to do.”*

(van Ommen et al., 2009, 2805)

### **1.3.3 Critique of studies**

When considering the findings discussed above, it is important to address limitations of the studies included in the synthesis.

#### *1.3.3.1 Range and selection of participants*

All studies had a higher percentage of female participants, with one study (van Ommen et al., 2009) including only females. Additionally, only five studies

(Reavey et al., 2017; Gill et al., 2016; Mitten, 2016; Haynes et al., 2011; Tierney, 2008), reported the ethnicity of participants, who were predominantly from white ethnic backgrounds. Furthermore, participants were selected by ward staff in two studies (Gill et al., 2016; Tierney, 2008) and self-selected in the remaining studies, which researchers acknowledged as a limitation. As a result, the findings from these studies may only be representative of a subgroup of adolescents. Therefore, the limited range of gender, ethnicity of participants and selection of participants calls into question the transferability of the findings from these studies to all adolescents accessing CAMHSIUs.

#### *1.3.3.2 Transparency of analysis and results*

A number of studies reported limited detail of the steps of qualitative analysis (Mitten et al., 2016; Biering et al., 2011; van Ommen et al., 2009; Tierney, 2008). This may limit the reliability and replicability of their findings as details around the auditing of data analysis were unclear. Further, Salamone-Violi et al. (2015) provided limited description about participant quotations which led to highly descriptive accounts that lacked detail and depth of participants' experiences and may affect the credibility of their findings.

#### *1.3.3.3 Researcher bias*

All studies reported taking steps to improve the credibility of their findings through respondent validation, group analysis or peer debriefing, which are important considerations in qualitative research (Sanjari, Bahramnezhad, Fomani, Shoghi & Cheraghi, 2014). However, no study discussed the impact of the researchers' influence on the interpretation of findings, which may lead to interpretation bias and reduce the reliability and confirmability of the findings.

## **1.5 Discussion**

The aim of this systematic literature review was to produce a meta-ethnographic synthesis of qualitative research exploring adolescents' experiences of CAMHSIUs. Nine articles contributed to this review, which led to the development of three meta-themes: '*Navigating relationships*',

*'Containment: safety versus confinement'* and *'Impact of inpatient stay'*. There were many commonalities across the studies indicating a degree of 'reciprocal translation', whereby concepts from one study translated into another (Noblit and Hare, 1988). However, there were differences both within and between articles that highlight the intricate nature of adolescents' experiences.

### **1.5.1 Summary of findings**

#### *1.5.1.1 'Navigating relationships'*

This meta-theme emphasised the complexities of adolescents' experiences with patients, staff and therapy. Two medium quality articles contributed to this meta-theme (Tierney, 2008; van Ommen et al., 2009), while the remaining seven articles were of high quality. Relationships with patients enabled adolescents to feel supported and accepted through sharing their experiences and building friendships (Gill et al., 2016; Biering et al., 2011; Haynes et al., 2011). However, some patient relationships were experienced as detrimental to adolescents' sense of support, belonging and emotional expression (Reavey et al., 2017; Mitten et al., 2016; Haynes et al., 2011). While Edwards et al. (2015) briefly outlined similar findings, the current review extended these by providing a detailed picture of relationships with patients on the CAMHSIU as both supportive and potentially harmful.

This review identified that relationships with staff were viewed as supportive when staff engaged adolescents in everyday conversation (Haynes et al., 2011), but unhelpful when adolescents perceived staff as uncaring or dismissive (Moses, 2011). Previous reviews have recognised the importance of staff relationships on CAMHSIUs (Edwards et al., 2015; Biering, 2010). The current review expands these findings, identifying the qualities of staff, for example, empathy and compassion that influence adolescents' experiences of these relationships (Mitten et al., 2016; Salamone-Violi et al., 2015). Therapeutic relationships are a key component of person-centred care in community CAMHS (Gondek et al., 2016). Further, research has identified the role of therapeutic relationships for improving the treatment climate on the

CAMHSIU (Tulloch et al., 2008) and providing a secure base, which facilitates recovery (Bucci, Roberts, Danquah & Berry, 2015).

Experiences of therapy on CAMHSIUs is an area that has received little attention in the literature. Previous research has identified that adults (Hopkins, Loeb & Fick, 2009) and young people (Mitchison, Jakes, Kelly & Rhodes, 2015) with psychosis expressed a desire for psychological input during their admission. The findings of this review enhance our understanding of the aspects of therapy adolescents consider to be helpful and unhelpful. However, while this review provides some insight into this area, only five studies discussed adolescents' views of therapy (Reavey et al., 2017; Salamone-Violi et al., 2015; Biering et al., 2011; Moses, 2011; Tierney, 2008).

#### *1.5.1.2 'Containment: safety versus confinement'*

This meta-theme provides a deeper insight into the complexities of adolescents' experiences of safety and confinement on the CAMHSIU. One medium quality article contributed to this meta-theme (van Ommen et al., 2009), while the remaining six articles were of high quality. On the one hand, routine and observation resulted in adolescents feeling safe and contained; protected from their difficulties in the community (Salamone-Violi et al., 2015). This has been found in previous research of adults who reported the inpatient environment provided physical safety and refuge from their lives outside the unit (Hopkins et al., 2009). In contrast, adolescents felt that the rules and regulations were restrictive and confining (Reavey et al., 2017), which impacted on their adjustment to the unit. In order to manage and adjust to the unusual environment, this review highlights the importance of ward activities, which provided distraction and support for adolescents during their admission (Gill et al., 2016; Biering et al., 2011). This is consistent with Edwards et al.'s (2015) review, which noted the role of activities for normalising the inpatient experience. Additionally, this review identified that although the unit provides short-term safety, it also leads to adolescents feeling unprepared for discharge (Gill et al., 2016). It is possible that adolescents became reliant on the continuous support on the unit, which may lead to a lack of confidence in their

ability to manage in the community, leading to fear of discharge. This has been noted in previous research on adults who have reported that continuous support on inpatient units leads to vulnerability following discharge (Offord et al., 2014).

#### *1.5.1.3 'Impact of inpatient stay'*

The final meta-theme highlights the consequences of admission to a CAMHSIU. Two medium quality articles contributed to this meta-theme (Tierney, 2008; van Ommen et al., 2009), while the remaining seven articles were of high quality. This review identified that adolescents felt disconnected from their family, friends and lives outside the CAMHSIU during their stay (Gill et al., 2016; Haynes et al., 2011). This is supported by Edwards et al.'s (2015) review which found that disconnection from family, friends and school impacted adolescents' ability to transition home following discharge. Further, the importance of connection on the ward whereby adolescents experienced staff and patients as a "*substitute family*" (Gill et al., 2016, 60) is consistent with previous reviews of adult inpatient experiences (Hopkins et al., 2009). This could be understood in the context of attachment theory (Bowlby, 1969) whereby adolescents develop new relationships on the unit and staff become interim attachment figures. While connection on the unit seemed to facilitate adolescents' adjustment to the ward, returning to their lives outside the CAMHSIU was a challenging process (Biering et al., 2011; Haynes et al., 2011). Consistent with previous research (Edwards et al., 2015; Savina et al., 2014) this review identified that adolescents experienced difficulties with friendships and school following discharge. This review extended these findings indicating the ongoing role of stigma around MH as a factor contributing to difficulties with friendships.

This review highlighted the process of change and development adolescents experienced as a result of learning skills during their inpatient stay. Previous research has found that adolescents' perspectives of satisfying treatment outcomes are linked to positive changes in their thoughts, feelings or behaviours (Biering, 2010). The current review extended these findings, noting

the positive impact of developing coping skills on adolescents' overall wellbeing (Haynes et al., 2011; Moses, 2011). These skills could be seen as enhancing adolescents' resilience to MH, reducing the negative impact of their inpatient stay and facilitating recovery (Southwick & Charney, 2018).

The findings of this review may be understood within the framework of attachment theory (Bowlby, 1969). It seems that CAMHSIUs provide a safe base, enabling adolescents to build supportive relationships, or attachments. Supportive staff relationships allow adolescents to believe in others' good intentions and enable them to manage and accept the boundaries of the unit (Silver, 2013). As a result of these relationships, adolescents are able to explore the unit from a secure base, develop knowledge, skills and confidence, which enable them to manage their difficulties and work towards discharge.

### **1.5.2 Limitations**

This review excluded quantitative research that has explored satisfaction with, and outcomes of inpatient treatment (Lee, Martin, Hembry & Lewis, 2018; Bunge, Maglio, Musich & Savage, 2014) as quantitative studies do not capture individuals' in-depth experiences (Coolican, 2004). Additionally, literature exists that incorporates adolescents' experiences of both inpatient and outpatient treatment (Gros, Parr, Wright, Montreuil & Frechette, 2016), which was excluded due to the data being combined. The exclusion of this research may have resulted in valuable insights being omitted and may limit the generalisability of the current findings. However, as this study focused solely on adolescents' experiences, the inclusion of only qualitative research from adolescents' perspectives was deemed appropriate.

A further potential limitation of this review may relate to the search terms used during the identification of articles. It is possible that extending the search terms to include "young person or teenag\*", more specific mental health diagnoses for example, "depression" or "psychosis", or more broader terms such as "emotional dysregulation" or "self-harm" or "suicide" may have resulted in further articles being identified. These search terms were not

included at the time due to the initial search terms being deemed appropriate for this study and a number of relevant articles being identified.

It is possible that the inclusion of only two papers focusing on anorexia nervosa may limit the findings of this synthesis as adolescents' experiences of inpatient treatment for anorexia nervosa may not be fully represented. While there were many commonalities in adolescents' experiences, minor differences were identified regarding the physical aspects of anorexia nervosa. Therefore, this review may not provide a detailed understanding of adolescents' experiences of the focus on their physical health on the unit, or additional difficulties around eating and weight gain that may have affected their experiences of their inpatient stay and discharge. Further, the inclusion of these two papers may have influenced the findings of this synthesis due to focus on physical health and weight gain in the treatment of anorexia nervosa (van Ommen et al., 2009, Tierney, 2008), that was not present in the treatment of other mental health difficulties (Reavey et al., 2017; Gill et al., 2016). Despite this, the inclusion of these two articles was deemed appropriate due to the varied range of papers that were identified for this review. While the heterogenous range of the articles included may be a limitation of this review, this seems to be a reflection of the early stages of research in this area of adolescent mental health.

Due to the interpretive nature of meta-ethnography (Toye et al., 2013) the current review took steps to minimise interpretation bias through supervision and consultation of an additional researcher. However, initial categories identified in the first article may have limited the emergence of new themes from subsequent studies (Atkins et al., 2008) and therefore may have resulted in interpretation bias. Additionally, issues arose around the unequal contribution of articles to the overall themes (Appendix G). It is unclear whether this may have been due to interpretation bias, or the lower quality ratings for some papers (van Ommen et al., 2009; Tierney, 2008). Credibility could have been enhanced through a team-based approach to each stage of analysis as utilised in Toye et al.'s (2013) review.

### **1.5.3 Clinical implications**

Given the value of therapeutic relationships with staff, it is important to ensure appropriate staff support and training around MH and child development (DH, 2015). This may be achieved through creating attachment-informed (Bucci et al., 2015), psychologically-informed (Johnson & Haigh, 2011), or trauma-informed environments (Sweeney, Clement, Filson & Kennedy, 2016). This may enhance staff understanding of psychological difficulties, attachment and trauma on CAMHSIUs. This might be facilitated through the use of Positive Behavioural Support (PBS) plans to develop staff understanding of the underlying reasons for adolescents' behaviour (DH, 2014). PBS plans may also enhance quality of life and reduce the need for restrictive interventions (DH, 2014). Clinical psychologists are well placed to provide this support through shared formulation, consultancy, supervision and training (Ables et al., 2015).

Due to the importance of safety and containment in hospital and anxiety around reintegration with the community, it is important to consider the impact of prolonged or repeated admissions. It is possible that if adolescents do not receive adequate support in the community, they may be at higher risk of readmission. Previous research has identified that post-discharge support reduces the risk of readmission for adults (Zhang, Harvey & Andrew, 2011) and young people (James et al., 2010). It is therefore important to ensure appropriate support is provided in the community following discharge (QNIC, 2016; Ables et al., 2015).

The complexities of 'lost connection' and 'reconnection' highlight the importance of supporting adolescents to maintain their relationships with family and friends during their CAMHSIU stay. Facilitating family connections could be achieved through involving families throughout adolescents' inpatient stay, which is consistent with QNIC (2016) standards. Maintaining friendships can be encouraged through the use of mobile phones and enlisting family support to promote visits from friends.

Further, support is required to build adolescents' confidence in managing their difficulties in the community. This may be achieved through skills-based groups on the unit and encouraging adolescents to practice skills during home leave. Additionally, due to the influence of MH stigma on adolescents' friendships, these skills groups might incorporate ideas of how to share their MH difficulties with friends (Mental Health Foundation, 2019). Further, it would be beneficial for policy to explore ways of delivering MH teaching to young people in schools.

#### **1.5.4 Future research**

Given the contrasting experiences of therapy and only a small number of medium and high quality articles in this review highlighting experiences of therapy, future research should explore this area. This is important in light of QNIC (2016) standards identifying the need for increased psychological therapies on CAMHSIUs. Further, QNIC's (2016) report found that 85% of CAMHSIUs had met the standard for one full time clinical psychologist. Therefore, psychological provision on CAMHSIUs may have increased in recent years and further research in this area would benefit practice and policy.

Additionally, exploring adolescents' experiences of discharge, transition and reintegration into the community could be explored in more depth due to the limited research in this area. It would be beneficial to explore this area of research in the UK as previous studies have been conducted in the USA (Weiss et al., 2015; Savina et al., 2014).

Finally, given the heterogenous range of papers included in this review, future research and reviews could explore adolescents' experiences of CAMHSIUs, focusing on specific mental health difficulties to identify similarities and differences in adolescents' experiences of treatment. Exploring these areas in more detail will provide a more comprehensive understanding of adolescents' experiences of CAMHSIUs in relation to specific mental health difficulties, which can further inform policy and practice on CAMHSIUs.

## **1.6 Conclusion**

Understanding the impact of a CAMHSIU stay has been largely driven by quantitative research measuring satisfaction of care and outcomes of inpatient treatment (Biering, 2010). Given the increase in qualitative research exploring adolescents' perspectives of CAMHSIUs alongside improved quality standards for inpatient care (QNIC, 2016), the current review synthesized adolescents' qualitative experiences of the CAMHSIU. The findings from this review highlight the need for supportive relationships with staff and patients to enable adolescents to feel safe and accepted on the CAMHSIU. These relationships help adolescents to navigate inpatient life and protect against feelings of confinement and isolation from their lives. This in turn enables adolescents to develop skills and confidence in managing their difficulties, which may facilitate their reintegration to the community following discharge. It is therefore important for healthcare professionals to be aware of the essential role of relationships on the unit with an understanding of how these relationships impact adolescents' experiences.

## **1.7 References**

- Abeles, P., Crosbie, V. and Milson, G. (2015). Delivering psychological services for children, young people and their families in inpatient settings. *Child & Family Clinical Psychology Review*, (3), 60-70
- Altman, D. G. (1999). Statistics in the medical literature. *Statistics in Medicine*, 18(4),487–490.doi:10.1002/(SICI)1097-0258(19990228)18:4<487::AID-SIM106>3.0.CO;2-J
- Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A. & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*. 8(21), 1-10. doi:10.1186/1471-2288-8-21
- Bearman, M. & Dawson, P. (2013). Qualitative synthesis and systematic review in health professions education. *Medical Education*. 47, 252-260. doi:10.1111/medu.12092
- Biering, P. (2010). Child and adolescent experience and satisfaction with psychiatric care: a critical review of the research literature. *Journal of Psychiatric and Mental Health Nursing*. 17, 65-72. doi: 10.1111/j.1365-2850.2009.01505.x
- Biering, P., Valgerður, H. & Jensen, V. H. (2011). The concept of patient satisfaction in adolescent psychiatric care: A qualitative study. *Journal of Child & Adolescent Psychiatric Nursing*, 30(4), 162-169. doi: 10.1111/j.1744-6171.2010.00261.x
- Bowlby, J. (1958). A secure base: Clinical application of attachment theory. London: Routledge.
- Bucci, S., Roberts, N. H., Danquah, A. N. & Berry, K. (2015). Using attachment theory to inform the design and delivery of mental health services: a systematic review of the literature. *Psychology and Psychotherapy: Theory, Research and Practice*. 88, 1-20. DOI:10.1111/papt.12029
- Bulter, A., Hall, H. & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews on Evidence-Based Nursing*, 13(3), 241-249. doi:10.1111/wvn.12134

- Bunge, E. L., Maglio, A. L., Musich, F. M. & Savage, C. (2014). Consumer satisfaction with private child and adolescent mental health services in Buenos Aires. *Children and Youth Services Review*. 47, 291-296.  
<http://dx.doi.org/10.1016/j.chilyouth.2014.10.002>
- Caldwell, K., Henshaw, L., & Taylor, G. (2011). *Developing a framework for critiquing health research: An early evaluation*  
 doi:<https://doi.org/10.1016/j.nedt.2010.11.025>
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement* 20, 37-46.
- Coolican, H., (2004). *Research methods and statistics in psychology*. 4<sup>th</sup> ed. Hodder & Stoughton: London
- Department of Health (2014). *Positive and Proactive Care: reducing the need for restrictive interventions*. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300293/JRA\\_DoH\\_Guidance\\_on\\_RP\\_web\\_accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf)
- Department of Health (2015). *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. London: HMSO. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)
- Department of Health and Department for Education (2017). *Transforming children and Young People's Mental health provision: a green paper*. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/664855/Transforming\\_children\\_and\\_young\\_people\\_s\\_mental\\_health\\_provision.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf)
- Dixon-Woods, M., Shaw, R. L., Agarwal, S. & Smith, J. A. (2004). The problem of appraising qualitative research. *Developing Research*. 223-225
- Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., Shaw, R. L., Smith, J. A. & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*. 6(1), 27-44. DOI: 10.1177/1468794106058867

- Edwards, D., Evans, N., Gillen, E., Longo, M., Prymachuk, S., Trainor, G. & Hannigan, B. (2015). What do we know about the risks for young people moving into, through and out of inpatient mental health care? Findings from an evidence synthesis. *Child and Adolescent Psychiatry and Mental Health*. 9(55), 1-17. DOI 10.1186/s13034-015-0087-y
- Falconbridge, J., Law, D & Laffan, A. (2015). The core requirements of good services. *Child & Family Clinical Psychology Review*, (5), 23-30.
- Feast, A., Orrell, M., Charlesworth, G., Poland, F., Featherstone, K., Melunsky, N. & Moniz-Cook, E. (2018). Using meta-ethnography to synthesize relevant studies: capturing the bigger picture in dementia with challenging behaviour within families. *SAGE Research Methods Cases*. doi: <http://dx.doi.org/10.4135/9781526444899>
- Gill, F., Butler, S., & Pistrang, N. (2016). The experience of adolescent inpatient care and the anticipated transition to the community: Young people's perspectives. *Journal of Adolescence*, 46, 57-65. <http://dx.doi.org/10.1016/j.adolescence.2015.10.025>
- Gondek, D., Edbrooke-Childs, J., Velikonja, T., Chapman, L., Saunders, F., Hayes, D. & Wolpert, M. (2016). Facilitators and barriers to person-centred care in child and young people mental health services: a systematic review. *Clinical Psychology and Psychotherapy*. 23, 870-886. DOI: 10.1002/cpp.2052
- Gros, C. P., Parr, C., Wright, D. K., Montreuil, M. & Frechette, J. (2017). Hospital rules and regulations: the perspective of youth receiving psychiatric care. *Journal of Child and Adolescent Psychiatric Nursing*. 30, 18-24 DOI: 10.1111/jcap.12166
- Hannes, K. & Macaitis K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: update on a review of published papers. *Qual Res* 2012;12:402–42. <http://dx.doi.org/10.1177/1468794111432992>
- Haynes, C., Eivors, A. & Crossley, J. (2011). 'Living in an alternative reality': adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health Journal*. 16(3), 150-157. doi: 10.1111/j.1475-3588.2011.00598.x

- Hopkins, J. E., Loeb, S. J. & Fick, D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: a literature review. *Journal of Psychiatric and Mental Health Nursing*. 16, 927-937. doi: 10.1111/j.1365-2850.2009.01501.x
- James, S., Charlemagne, S. J., Gilman, A. B., Alemi, Q., Smith, R. L., Tharayil, P. R. & Freeman, K. (2010). Post discharge services and psychiatric rehospitalization among children and youth. *Adm Policy Mental Health*. 37(5), 433-445. doi: 10.1007/s10488-009-0263-6
- Johnson, R. & Haigh, R. (2010). Social psychiatry and social policy for the 21st century: new concepts for new needs - the 'enabling environments' initiative. *Social Policy*. 15(1), 17-23. doi: 10.5042/mhsi.2011.0054
- Lachal, J., Revah-Levy, A., Orri, M. & Moro, M. R. (2017). Metasynthesis: an original method to synthesize qualitative literature in psychiatry. *Frontiers in Psychiatry*. 8, 269. doi: 10.3389/fpsy.2017.00269
- Lee, Y., Martin, P., Hembry, P., & Lewis, S. (2018). Outcomes of inpatient psychiatric treatment for adolescents: A multiple perspectives evaluation. *Clinical Child Psychology & Psychiatry*, 23(3), 409-424. DOI: 10.1177/13591045177
- MacInnes, D., Courtney, H., Flanagan, T., Bressington, D., & Beer, D. (2014). A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in forensic mental health settings. *BMC Research Notes*, 7, 657-657.
- Mental Health Foundation (2019) *Friendships and mental health*. Accessed from: <https://www.mentalhealth.org.uk/a-to-z/f/friendship-and-mental-health>
- Mitchison, D., Jakes, S., Kelly, S. & Rhodes, J. (2015). Are young people hospitalised with psychosis interested in psychological therapy? *Clinical Psychology and Psychotherapy*. 22, 22-31. DOI: 10.1002/cpp.1864
- Mitten, N., Preyde, M., Lewis, S., Vanderkooy, J., & Heintzman, J. (2016). The perceptions of adolescents who self-harm on stigma and care following inpatient psychiatric treatment. *Social Work in Mental Health*, 14(1), 1-21. doi:10.1080/15332985.2015.1080783

- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G. et al. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(6): e1000097.  
DOI.org/10.1371/journal.pmed.1000097
- Moses, T. (2011). Adolescents' perspectives about brief psychiatric hospitalization: What is helpful and what is not? *Psychiatric Quarterly*, 82(2), 121-137. DOI 10.1007/s11126-010-9151-1
- NHS Digital (2017). Mental Health Services Monthly Statistics: Final March 2017, Experimental, NHS Digital, June 20, 2017. Retrieved from: <http://www.digital.nhs.uk/catalogue/PUB30000>
- NHS Digital (2018). *Mental Health of Children and Young People in England, 2017 [PAS]* Retrieved from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>
- NHS England (2014). *Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report*. Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>
- NHS England (2015). *Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3)*. NHS England 2018 *The Government's green paper on mental health: failing a generation*. Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2018/04/mod-camhs-tier-2-3-spec.pdf>
- NHS England (2018). Child and Adolescent Mental Health Services (CAMHS) Tier 4: General adolescent services including specialist eating disorder services. Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2018/02/tier-4-camhs-general-adolescent-service-specification-v3.pdf>
- Noblit GW, Hare RD. (1988). *Meta-ethnography: synthesising qualitative studies*. London: Sage.
- Noyes, J., Popay, J., Pearson, A., Hannes, K. & Booth, A. (2008). Qualitative research and Cochrane reviews. In Higgins, J. P. T. & Green, S. (Eds). *Cochrane Handbook for Systematic Reviews of Interventions*. Available from <http://www.cochrane-handbook.org>.

- Offord, A., Turner, H. & Cooper, M. (2006). Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. *European Eating Disorders Review*. 14, 377-387. DOI: 10.1002/erv.687
- Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews*. Retrieved from <http://mixedmethodsappraisaltoolpublic.pbworks.com>. Archived by WebCite® at <http://www.webcitation.org/5tTRTc9yJ>
- Purc-Stephenson, R. J. & Thrasher, C. (2010). Nurses' experiences with telephone triage and advice: a meta-ethnography. *Journal of Advanced Nursing*. 66(3), 482–494. doi: 10.1111/j.1365-2648.2010.05275.x
- Quality Network for Inpatient CAMHS (2008). *Annual Report: Review Cycle 7: 2007-2008*. Royal College of Psychiatrists. Retrieved from: <https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/child-adolescent-inpatient-services/qnic-standards-and-publications>
- Quality Network for Inpatient CAMHS (2016). *Quality Network for Inpatient CAMHS annual report Cycle 15*. Royal College of Psychiatrists. Retrieved from: [https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/child-and-adolescent-inpatient-services-\(cahms\)/camhs-qnic-annual-report-2016.pdf?sfvrsn=f03cdac2\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/child-and-adolescent-inpatient-services-(cahms)/camhs-qnic-annual-report-2016.pdf?sfvrsn=f03cdac2_2)
- Reavey, P., Poole, J., Corrigan, R., Zundel, T., Byford, S., Sarhane, M., Taylor, E., Ivens, J. & Ourgin, D. (2017). The ward as emotional ecology: Adolescent experiences of managing mental health and distress in psychiatric inpatient settings. *Health & Place*, 46, 210-218. <http://dx.doi.org/10.1016/j.healthplace.2017.05.008>
- Ring, N., Ritchie, K., Mandava, L. & Jepson, R. (2011). A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews. Available from: <http://www.nhshealthquality.org/nhsqis/8837.html>

- Salamone-Violi, G. M. L., Chur-Hansen, A., & Winefield, H. R. (2015). 'I don't want to be here but I feel safe': Referral and admission to a child and adolescent psychiatric inpatient unit: The young person's perspective. *International Journal of Mental Health Nursing*, 24(6), 569-576. doi: 10.1111/inm.12163
- Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M & Cheraghi, M. A (2014) Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine*. 7, 14.
- Savina, E., Simon, J. & Lester, M. (2014). School reintegration following psychiatric hospitalisation. *Child Youth Care Forum*. 43, 729-746. DOI 10.1007/s10566-014-9263-0
- Silver, M. (2013). *Attachment in Common Sense and Doodles: A Practical Guide*. Jessica Kingsley Publishers: London & Philadelphia.
- Southwick, S. M. & Charney, D. S. (2018). *Resilience: The science of mastering life's greatest challenges*. 2<sup>nd</sup> Ed. Cambridge University Press, UK
- Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*. 21(3), 174-192. DOI 10.1108/MHRJ-01-2015-0006
- Tierney, S. (2008). The individual within a condition: A qualitative study of young people's reflections on being treated for anorexia nervosa. *Journal of the American Psychiatric Nurses Association*, 13(6), 368-375.
- Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., Andrews, J. & Barker, K. (2013). A meta-ethnography of patients' experiences of chronic non-malignant musculoskeletal pain. *Health Services and Delivery Research*. 1(12), 1-208. DOI 10.3310/hsdr01120
- Tulloch, S., Lelliott, P., Bannister, D., Andiappan, M., O'Herlihy, A., Beecham, J. & Ayton, A. (2008). The costs, outcomes and satisfaction for inpatient child and adolescent psychiatric services (COSI-CAPS) study. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO).

- The United Nations (UN) Convention on the Rights of the Child (1989). UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, 3. Retrieved from: <http://www.refworld.org/docid/3ae6b38f0.html>
- van Ommen, J., Meerwijk, E. L., Kars, M., van Elburg, A. & van Meijl, B. (2009). Effective nursing care of adolescents diagnosed with anorexia nervosa: the patients' perspective. *Journal of Clinical Nursing*. 8, 2801-2808. doi: 10.1111/j.1365-2702.2009.02821.x
- Wallis, P., Potier, J., Milson, G. & Beck, A. (2015) Delivering psychological services for children and young people with emotional and behavioural issues, and their families, in specialist CAMHS settings. *Child & Family Clinical Psychology Review*. 48-59.
- Weiss, C. L., Blizzard, A. & Stephan, S. H. (2015) Supporting the transition from inpatient hospitalisation to school. *Child and Adolescent Psychiatric Clinical of North America*. 24, 371-383
- World Health Organisation (WHO). (2016). Adolescent development. Retrieved from [who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/](http://who.int/maternal_child_adolescent/topics/adolescence/dev/en/)
- Zhang, J., Harvey, C. & Andrew, C. (2011) Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study, *Australian and New Zealand Journal of Psychiatry*, 45:7, 578-585

## **Chapter Two: Empirical Paper**

### **“Completely shell-shocked”: Parents’ experiences of their child’s admission to a Child and Adolescent Inpatient Unit: An Interpretive Phenomenological Analysis**

*Written in preparation for the British Journal of Psychology (See Appendix H  
for author guidelines)*

Overall chapter word count at submission (excluding tables, figures and  
references): 7976

## **2.0 Abstract**

**Aims:** The purpose of this research was to explore parents' lived experiences following their child's admission to a Child and Adolescent Mental Health Inpatient Unit (CAMHSIU).

**Background:** The importance of gaining parents' views of services has been highlighted in the literature. Parents experience distress prior to and during their child's hospitalisation. However, much of the previous research has focused on children with a diagnosis of psychosis, or more generally on child mental health, rather than on exploring parents' experiences following their child's admission to a CAMHSIU in depth.

**Method:** This study adopted an interpretive, qualitative approach using Interpretative Phenomenological Analysis. Seven parents from three inpatient units took part in individual semi-structured interviews.

**Findings:** Three superordinate themes emerged; *"It's a bit of a minefield"* describes the challenges parents faced in navigating the inpatient unit; *"Monster of mental health"* captures parents experiences of loss and grief following their child's admission; *"I don't live in Syria"* encompasses parents' process of understanding and adapting following their child's admission.

**Conclusions:** These findings identify the need to support parents during their child's admission to manage feelings of loss and grief, and to enhance parental confidence and understanding of their child's mental health difficulties and the CAMHSIU.

**Word count:** 200

**Key words:** *parent experiences, child mental health, inpatient unit, qualitative research, IPA*

## **2.1 Introduction**

This research aimed to explore parents' experiences following their child's admission to a Child and Adolescent Mental Health Inpatient Unit (CAMHSIU).

### **2.1.1 CAMHS inpatient units**

CAMHSIUs provide specialist care to children and adolescents experiencing complex mental health (MH) difficulties who present with a high risk to themselves or others (Frith, 2017). Statistics in the United Kingdom (UK) have highlighted that approximately 1,300 children receive inpatient care at any one time (Department of Health [DH] & Department for Education [DE], 2017). The DH (2004) identified the need to include families in services for young people, as gaining their views facilitates the planning, delivery and evaluation of services.

### **2.1.2 Parents' perspectives**

The importance of gaining parents' perspectives has been highlighted by the Government initiative, *Future in Mind* (DH, 2015) and the Quality Network for Inpatient CAMHS (QNIC, 2016). Involving parents in their children's care facilitates the identification of appropriate services and promotes individualised care (Vaughan, Feinn, Bernard, Brereton & Kaufman, 2012). Parental involvement may enhance parental well-being as it improves support and facilitates empowerment in bringing about changes to services, policy and practice (DH, 2004). Parents' well-being also effects family relationships and promotes positive child adjustment (Palamaro Munsell, Kilmer, Cook & Reeve, 2012).

### **2.1.3 Parenting a child with MH difficulties**

Parenting a child with MH difficulties has far-reaching effects on parents' emotional and physical health (Vaughan et al., 2012) and impacts parents' social and financial resources (Shpigner, Possick & Buchbinder, 2013). Moses (2010), Mohr and Regan-Kubinski (2001), and Wade (2006) reported parents to experience loss, guilt, self-blame and isolation as a result of their child's MH difficulties. While managing their child's MH in the community can be

distressing for parents (Milliken, 2001), admission to a CAMHSIU often occurs during times of increased psychological distress when parents feel unable to manage their child's difficulties at home (Gross & Goldin, 2008).

#### **2.1.4 Parents' experiences of their child's hospitalisation**

Previous qualitative research found that admission to an inpatient unit provided relief and respite for carers who felt that the unit was a place of safety for their child (Salamone-Violi, Chur-Hansen & Winefield, 2017; Hickman, Newton, Fenton, Thompson, Boden & Larkin, 2016). Despite this, admission was experienced as distressing, overwhelming and traumatic (Salamone-Violi et al., 2017; Hickman et al., 2016; Gerson et al., 2009). Carers expressed feelings of guilt, self-blame and a fear of being blamed by others following their child's admission (Geraghty, McCann, King & Eichmann, 2011; Gerson et al., 2009).

Additionally, carers reported grief and loss following their child's admission, feeling that their child had changed as a result of their MH difficulties (Geraghty et al., 2011). Carers have voiced anxiety about the impact of their child's MH difficulties on the family (Geraghty et al., 2011). Moreover, carers expressed anger and frustration towards the inpatient unit. This centred around feeling excluded from their child's care and receiving limited communication, which heightened carers' distress (Hickman et al., 2016; Geraghty et al., 2011; Gerson et al., 2009).

Furthermore, discharge was experienced as anxiety-provoking, as carers expressed a fear of relapse and lacked confidence in their ability to keep their child safe following discharge (Salamone-Violi et al., 2017; Hickman et al., 2016). Carers expressed dissatisfaction with the length of their child's admission, which could be linked to anxiety about discharge (Salamone-Violi et al., 2017).

While these findings add valuable insights into carers' experiences of their child's hospitalisation, there are a number of limitations. Firstly, Hickman et al.

(2016) and Gerson et al. (2009) focused on parents of children up to 24 years old who were diagnosed with psychosis. Therefore, the sample was not specific to a CAMHSIU and was limited to carers of young people with psychosis. Secondly, Salamone-Violi et al. (2017) included children receiving both inpatient and outpatient treatment and therefore lacked detail around parents' experiences of a CAMHSIU. Thirdly, Geraghty et al. (2011) used written records of discussions and their findings were therefore not based on parents' first-hand accounts, which question the reliability of their findings. Finally, the majority of previous studies have been conducted in Australia (Salamone-Violi et al., 2017; Geraghty et al., 2011) and the United States of America (USA; Gerson et al., 2009) and therefore their findings may not be generalisable to carers in the UK.

### **2.1.5 Rationale**

The importance of parents' involvement in services (DH, 2004) highlights the need to gain parents' experiences of inpatient CAMHS (QNIC, 2016). Previous research has identified parents' distress prior to and during their child's hospitalisation (Salamone-Violi et al., 2017; Hickman et al., 2016). As highlighted above, much of the previous research has focused on carers of children with a diagnosis of psychosis (Hickman et al., 2016; Gerson et al., 2009) or more generally on carers' experience of their child's MH difficulties in CAMHS (Salamone-Violi et al., 2017). Further, while previous research highlights similarities in carers' experiences of inpatient units, only one study was conducted in the UK, however, this was not based on a CAMHSIU sample (Hickman et al., 2016).

To the author's knowledge, there has been no study, to date, that has provided an in-depth understanding of parents' experiences of their child's admission to a CAMHSIU in England. Given parents' distress in managing their child's MH in the community (Milliken, 2001) and the emotions parents experience following their child's admission (Geraghty et al., 2011), it is important to explore parents' experiences in more depth. Additionally, gaining a deeper

understanding of parents' experiences may aid the planning, delivery and evaluation of services (DH, 2004).

This research aimed to address the following question: What are parents' lived experiences following their child's admission to a CAMHSIU?

## **2.2 Method**

### **2.2.1 Design**

This study adopted an interpretivist epistemological position, which views knowledge as socially constructed through individual's lived experiences (Larkin & Thompson, 2012). Interpretivism is concerned with exploring how individuals attach meaning and purpose to their world, aiming to understand individuals' experiences in the context of their lives (Ormston, Spencer, Barnard & Snape, 2014). Within the interpretivist epistemology, an Interpretative Phenomenological Analysis (IPA) methodology was used for this study (Smith, Flowers & Larkin, 2009). IPA is rooted in phenomenology, which is interested with individuals' perspective of their world, and hermeneutics, which explore how individuals interpret their experiences (Smith et al., 2009). The role of the researcher is considered throughout the research process and IPA acknowledges the 'double hermeneutic', which explains how the researcher interprets participants' experiences (Smith et al., 2009). IPA was consistent with the research aim, as it enabled the researcher to gain an in-depth insight into participants' interpretations of their lived experiences (Smith et al., 2009).

### **2.2.2 Participants**

IPA is interested in gaining a detailed account of individuals' experiences, and benefits from a small, homogenous sample where quality of experience is valued over quantity (Smith et al., 2009). Therefore, non-probability, purposive sampling was used to identify a homogenous sample based on specific inclusion and exclusion criteria (Smith et al., 2009). Seven participants were recruited to this study in line with IPA guidelines (Smith et al., 2009).

### *2.2.2.1 Recruitment*

Participants were recruited through three CAMHSIUs in England. The lead researcher met with Clinical Psychologists on each CAMHSIU to discuss the research and provide information sheets (Appendix 1). In addition, posters about the research were displayed on each CAMHSIU, on both the ward and in the waiting areas. Clinical Psychologists approached parents of children currently on the ward to discuss the research with them. Clinical Psychologists used their clinical judgement to determine whether it was ethical and appropriate to discuss this research with parents of children on the ward, for example, if parents were experiencing significant distress, they were not approached about the study. If parents expressed interest in the research, Clinical Psychologists on the ward provided each parent with the information sheet and answered any initial questions. Parents were then directed to either contact the lead researcher to arrange interviews, or in some cases, parents consented to their details being shared with the researcher, who then contacted them to arrange interviews.

Clinical Psychologists also identified parents of children who had been discharged within the last three years and covering letters were sent with the participant information sheet enclosed. No participants responded to these letters.

### *2.2.2.2 Inclusion and exclusion criteria*

A number of inclusion and exclusion criteria were adopted for this study to enhance homogeneity of the sample (Table 1.2). Participants were included if they were the primary caregiver legally responsible for the child. Children aged 11-18 years were included, as this represents the sample of children accessing CAMHSIUs (QNIC, 2015). Children with MH difficulties relating to eating difficulties, depression, anxiety, self-harm or psychosis were included as statistics highlight these as common difficulties of children admitted to CAMHSIUs (Frith, 2017). Children admitted within the last 3 years were included to ensure participants' ability to recall their experiences (Hassan, 2005). Children with learning disabilities and physical disabilities were

excluded due to the differing nature of their experiences (Dallos & Denford, 2008; Mattsson, Arman, Castren & Forsner, 2014). Participants unable to speak English were excluded as this is the first language of the author.

*Table 2.1: Inclusion and Exclusion criteria*

<b>Criteria</b>	<b>Inclusion</b>	<b>Exclusion</b>
<b>Participants</b>	Parents or primary caregivers of children age 11-18	Primary caregivers of children younger than 11 or older than 18
<b>CAMHS inpatient unit</b>	Acute NHS units	Forensic, low, medium or high secure
<b>Time frame</b>	Admitted within the last 3 years	Last admission over 3 years ago
<b>Reason for admission</b>	Risk to self or others	
<b>Mental health difficulty</b>	Depression, Anxiety, Psychosis, Self-harm, Eating disorder	Learning disability Physical Disability
<b>Location</b>	England	Wales, Scotland, Ireland
<b>Language</b>	Spoken English	Non-English speakers

### *2.2.2.3 Participant characteristics*

Five female and two male parents participated in this study. All participants were the biological parents of children admitted to a CAMHSIU and lived in the same home as the child. Two participants were the parents of one child and were interviewed separately. All children were admitted to CAMHSIUs in England. Three children were currently inpatients, while four children had been discharged within the last month. All children had difficulties with self-harm and emotional regulation. Five children did not have a specific diagnosis, one child had a diagnosis of eating disorder and one child had a diagnosis of Autism. No children had a history of psychosis and were not described to be experiencing psychosis at the time of their parents' involvement in this

research. While all parents had more than one child, three parents had younger children living at home. The number of inpatient admissions ranged from 1 to 6 and length of stay ranged from 6 weeks to 6 months. Travelling time to the CAMHSIU ranged from 15-180 minutes. Table 2.2 provides details of the participants.

Table 2.2. Participant characteristics

<b>Pseudonym<sup>3</sup></b>	<b>Relationship to child</b>	<b>Age</b>	<b>Child's age</b>	<b>Childs' sex</b>	<b>Number and type of admissions</b>	<b>Maximum length of admission</b>	<b>Childs' difficulties</b>	<b>Siblings in family</b>
Alice	Mother	55	17	Female	More than 1 Section	3 months	Eating difficulties, self-harm, suicide attempts, emotional regulation difficulties	More than 1
Paula	Mother	53	18	Female	1 Voluntary	6 weeks	Self-harm, suicide attempts, ASD traits	1
David	Father	49	17	Female	More than 1 Section	6 months	Self-harm, suicide attempts, emotional regulation difficulties, eating difficulties	More than 1
Lindsey	Mother	48	17	Female	More than 1 Section	6 months	Self-harm, suicide attempts, emotional regulation difficulties, eating difficulties	More than 1
Matthew	Father	47	17	Female	More than 1 Section	4 months	Self-harm, suicide attempts, eating difficulties/anorexia	More than 1
Sophia	Mother	55	16	Female	More than 1 Voluntary	4 weeks	Anxiety, depression, self-harm, ASD	1
Elizabeth	Mother	46	15	Female	1 Section	6 weeks	Eating disorder, ASD, anxiety, self-harm	1

<sup>3</sup> Pseudonym utilised to ensure anonymity

### **2.2.3 Ethical considerations**

This research was conducted in line with the British Psychological Society's (BPS) Code of Ethics (2009) and Code of Human Ethics (BPS, 2010). Ethical approval was granted by Coventry University (CU) Ethics Committee and The Black Country Research Ethics Committee and the Health Research Authority (HRA) prior to commencing the study (Appendix J and K).

Participants were given a detailed information sheet (Appendix I). The information sheet and consent form outlined the study and participants' rights, including their right to withdraw. Additionally, children were aware of their parents' participation in this research. Written consent was gained from participants prior to commencing the interview (Appendix L). Following interviews, a debrief sheet (Appendix M) was provided and participants were given the opportunity to discuss any questions or issues arising from the interview.

### **2.2.4 Procedure**

#### *2.2.4.1 Materials*

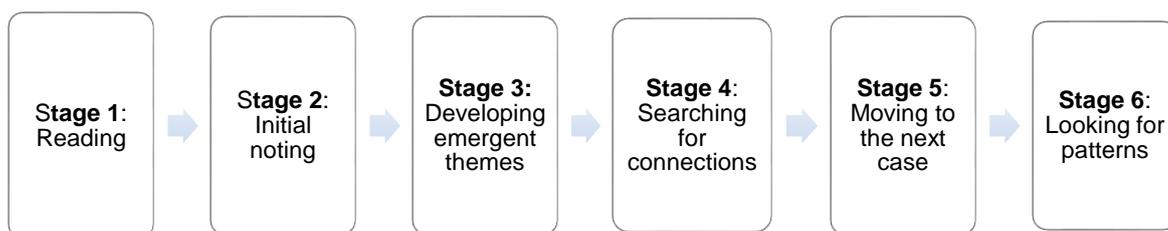
A semi-structured interview schedule was developed (Appendix N) in line with IPA guidelines (Smith et al., 2009). Feedback was gained through the Patient Participation Panel at CU. The interview schedule provided a guide for the interview while allowing the researcher to flexibility respond to and explore participants' individual experiences (Smith et al., 2009).

#### *2.2.4.2 Interview procedure*

Following IPA guidelines, one-to-one semi-structured interviews were conducted (Smith et al., 2009). Participants were interviewed between November 2018 and March 2019. Six interviews were conducted in participants' homes while one interview was conducted in a private room at the CAMHSIU, as per participants' requests. Interviews ranged from 73 to 129 minutes ( $M=98$  minutes) and were audio recorded.

## 2.2.5 Analysis

Audio recordings were transcribed as outlined by Smith et al. (2009) and identifying information was omitted or substituted as appropriate. Interviews were analysed following Smith et al.'s (2009) six stage framework (Figure 2.1 and Appendix O). This analytic process enabled the researcher to develop a detailed understanding of participants' lived experiences and the meaning they place on these experiences (Smith et al., 2009).



*Figure 2.1 Six stages of IPA*

### 2.2.5.1 Stages of analysis

Following transcription, interviews were read a number of times to enhance familiarity (Smith et al., 2009). The researcher then noted descriptive, linguistic and conceptual codes, providing a summary close to participants' narrative. Analysis then moved to an interpretive level, focusing on conceptual and linguistic codes to identify emerging themes across the transcript to capture the essence of participants' experiences (Appendix P). Emerging themes were organised chronologically and mapped out to identify connections between themes (Appendix Q). Analysis of each transcript followed the above steps before moving to the final stage of searching for patterns across all interviews. Thematic maps were used alongside discussion with the research supervisors to identify superordinate themes (Appendix R). A comprehensive table illustrating participants' contributions to each superordinate theme can be found in Appendix S.

### 2.2.5.2 Validity and credibility

Validity and credibility were ensured in this qualitative research study through a number of methods (Ring, Ritchie, Mandava & Jepson, 2011). Firstly, an

independent researcher coded part of a transcript, identifying initial notes and emergent themes, which were discussed with the lead researcher. Secondly, emerging themes and final superordinate themes were discussed with the research team. All participants consented to respondent validation and were contacted to feed back the final themes of analysis. Five parents responded providing feedback validating the findings (Appendix T).

#### *2.2.5.3 Reflexivity*

The hermeneutic cycle underpinning IPA recognises and embraces researcher's influence through their process of interpreting participants' experiences (Smith et al., 2009). Therefore, reflection of the researcher's role was important and reduced the risk of researcher bias (Bell, 2010). To enhance reflection and self-awareness, a bracketing interview was conducted prior to commencing data collection. The bracketing interview highlighted the researchers' assumption that parents' experiences would be predominantly negative, that strong emotions may arise during the interviews and that parents may express guilt or shame about their child's admission. Bracketing these assumptions reduced the researcher's influence on data analysis and enabled parents' experiences to be held as central to the research (Smith & Osborne, 2008). Additionally, the researcher kept a reflective journal and attended regular supervision throughout the research process.

### **2.3 Findings**

Three superordinate themes emerged from the IPA analysis: *"It's a bit of a minefield"*, *"Monster of mental health"* and *"I don't live in Syria"*. Each superordinate theme contains corresponding subordinate themes as shown in Table 2.3. The superordinate and subordinate themes, represented by verbatim participant quotations, are discussed below.

Table 2.3 Superordinate and subordinate themes

Superordinate theme	Subordinate theme
<b><i>“It’s a bit of a minefield”</i></b>	1. <i>“World of safety and plastic”</i>
	2. <i>“I’m in a maze”</i>
	3. <i>“We hoped it would be a fix”</i>
<b><i>“Monster of mental health”</i></b>	1. <i>“It just rips your world apart”</i>
	2. <i>“It won’t ever be the same again”</i>
<b><i>“I don’t live in Syria”</i></b>	1. <i>“You learn to cope”</i>
	2. <i>“This is our new reality”</i>

### 2.3.1 ***“It’s a bit of a minefield”***

This superordinate theme encapsulates parents’ experiences of navigating the inpatient system, which was experienced as a *“minefield”* (Elizabeth, 752<sup>4</sup>). Within this superordinate theme, three subordinate themes emerged; *“World of safety and plastic”*, *“I’m in a maze”* and *“We hoped it would be a fix”*

#### 2.3.1.1 *“World of safety and plastic”*

This subordinate theme captures parents’ initial experiences of the CAMHSIU environment, which encompassed a sense of unanticipated difference to the outside world:

*“oh my goodness, I’ve entered this world of safety and plastic. Okay, that’s a good thing, but it’s really really weird”*

(Lindsey, 54-56)

Lindsey’s description seems to highlight the stark contrast between the unit and the home environment whereby the unit was experienced as strange and

<sup>4</sup> Line numbers within transcript.

unusual. For Lindsey, there also appeared to be an acceptance of the steps required by the CAMHSIU to ensure her child's safety.

The sense of entering into a different world was further noted by parents who felt that their child had moved *"into this other world"* (Alice, 501) that was *"all close and intense"* (David, 196). These descriptions emphasise the significant difference between the unit and the outside world, that was unlike anything parents had experienced before. This sense of difference was amplified by the physical barrier created by the *"airlock"* (Lindsey, 49) whereby parents felt that their child was *"locked away"* (Alice, 502).

In contrast, six parents reflected that the ward felt like a *"safe haven"* (Sophia, 739) where their child was protected, which was of paramount importance and seemed to offer reassurance:

*"I knew she was safe there. That was the most important thing, that she was safe"*

(Paula, 49-50)

For many parents, the safety that admission provided led to a sense of *"relief"* (Mathew, 1128) that their child was in a place where their needs could be met. For Matthew, admission provided *"respite"* (Matthew, 1141) for the family, who had been struggling to manage at home. Matthew described the difficulties of managing the unexpected response to his child's admission, which seemed to conflict with his wish to care for his child at home:

*"So, our experience following our child's admission, was one of joy and relief, which is conflicting, because the last thing you want is for your child to go to hospital"*

(Matthew, 1127-1129)

This seems to emphasise the challenges that parents face following their child's admission, whereby parents appear to work through a process of

understanding and accepting the need for admission, while managing their own emotional responses.

### 2.3.1.2 “I’m in a maze”

This subordinate theme encapsulates parents’ experiences of feeling lost in the system, which centred around having “*absolutely no idea*” (Matthew, 766) what a CAMHSIU was, or how the system worked:

*“...at the beginning you haven’t got a clue it’s like you’re wondering around the wood and you don’t know the way out. This wood is so dark, it has so many trees, the sun is completely blocked out and you cannot remember where the exit is and that’s what it feels like to be in this process...”*

(Alice, 969-973)

Alice’s powerful image highlights the intensity of confusion and bewilderment that parents experienced in trying to understand the CAMHSIU. For many parents, the process of understanding the system was problematic and frustrating and was amplified by a sense of there being a “*parent-professional divide*” (David, 180-181). For some parents, this divide centred around being excluded from decisions, which resulted in feelings of frustration at the lack of parent involvement:

*“in practice it’s, kept at arm’s length, excluded from important discussions about the young person. And those CPA meetings feel very... even though at the end there is an unmet needs section, I always come away feeling slightly dissatisfied, like there has been something missing, like I’ve got an unmet need”*

(Matthew, 755-759)

Matthew’s sense of having “*an unmet need*” may suggest a difficulty in sharing his needs as a parent in an environment where the focus is on the child. The divide between parents and professionals was further evident during ward

meetings as four parents spoke of feeling frustrated and intimidated in meetings and struggled to understand the use of professional language:

*“...you are in this big meeting, which like I said, some people can be intimidating [...] then one person is talking and you don’t understand so you ask, and then another person gets involved, but then you don’t understand what they’ve said.”*

(Paula, 782-785)

This lack of understanding seemed to undermine parents’ ability to ask questions, build an understanding of the system, or to ensure their child was receiving the appropriate support:

*“But when you’re trying to argue your case [...] they’re quite business-like [...] unless you go in with a list of questions ready prepared you would go in and you might feel quite bamboozled, and come out and think that I didn’t quite get my questions answered, or I didn’t quite understand what was going on”*

(David, 140-144)

While feelings of frustration around not understanding the system were common across parents’ narratives, it seemed that parents felt reassured when they were included or supported to understand the process:

*“we had meetings and we talked about it. [...] that was fine, they were always very good, there were never any barriers that were put up it was all very open”*

(Paula, 176-177)

For Alice, this centred around feeling she could understand the language used:

*“I think the psychologists were the only two people that I can actually understand what they were saying to me”*

(Alice, 441-442)

#### 2.3.1.3 *“We hoped it would be a fix”*

All parents held high expectations of the unit to provide a solution for their child’s difficulties at the beginning of the admission, expressing feelings of hope for change:

*“You have these feelings of immense... hope... absolutely, that these people are the ones that are going to turn things around”*

(Lindsey, 161-162)

This hope seemed to stem from desperation for a solution as to how to support their children, which parents imagined would be the outcome of their child’s admission. However, some parents expressed deep sadness and frustration with the system around the lack of improvement for their child. For two participants, this appeared to be linked to the multiple admissions their children experienced:

*“I just broke down, I just felt like we’ve been sitting in those rooms saying the same things for a year now and nothing has happened. And I don’t know, she is no better [...] nothing has changed”*

(Alice, 1043-1045)

Alice’s narrative may suggest the depth of sadness she experienced as a result of her child’s lack of improvement despite numerous admissions to the CAMHSIU. Additionally, there was a sense of frustration and sadness for Paula, who felt that the admission had not benefited her child:

*“It was a different process than what I thought it would be, but to think that [daughter]’s admission helped her, not really”*

(Paula, 47-49)

Parents' unmet expectations also appeared to result in a loss of hope or trust in the system:

*“at the beginning of the process I thought you know, I trust the system, I trust the process, there isn't another option, we'll go on that journey and will make it work. It's now, it's now too late for my daughter”*

(Matthew, 904-907)

Matthew's sense that it is now *“too late for [his] daughter”* highlights the loss of hope he experienced. This may be understood in the context of his child's upcoming transition to adult services and the actions she may have taken to end her life. This seemed to lead to a sense of hopelessness that things would not change for his child.

### **2.3.2 “Monster of mental health”**

This superordinate theme captures parents' experiences of overwhelming loss and grief as a result of their child's admission and mental health difficulties. Mental health difficulties were described as a *“monster”* (Matthew, 1141); something unexpected and alarming, that had completely overtaken family life. Parents' experiences of loss and grief flowed through their narratives and are represented by two subordinate themes: *“it just rips your world apart”* and *“it won't ever be the same again”*.

#### **2.3.2.1 “It just rips your world apart”**

Six parents expressed a sense that their world had been turned *“upside down”* (Lindsey, 514) by their child's admission. For many parents, the experience of leaving their child at the unit resulted in intense emotions of loss and separation, which was evident in the language parents used to describe their experiences, for example, *“heart-wrenching”* (Alice, 501) and *“traumatic”* (Paula, 39). David reflected that leaving his child at the unit was *“the worst day of [their] lives”* (399), which was echoed by Paula who felt *“upset because [she didn't] to leave her [daughter] there”* (519). Parents' use of language

emphasises the significance of the loss they experienced following their child's admission.

The separation from their child seemed to encompass a sense of loss of a part of themselves through the process of "*handing over one of the most precious things in [their] life to this place*" (Lindsey, 43). This process of relinquishing their child to the CAMHSIU seemed to be experienced as a threat to their parenting identity, whereby parents expressed guilt and shame as a result of feeling unable to help their child:

*"...and it was my child and I'm her mother, and I couldn't fix her... I can't even find the words to describe it, because you should be able to help your child"*

(Alice, 629-630)

Alice's struggle to "*find the words*" highlights the significant emotional impact of feeling unable to help her child. This contributed to parents feeling out of control and questioning themselves in a process of trying to make sense of their experiences:

*"...go through all the guilt in your head about what you could have done differently, or what you've done to cause it and all that sort of stuff so... I think, emotionally, that's a really difficult place to be"*

(Elizabeth, 516-518)

Elizabeth's vague description of "*all that sort of stuff*" may represent a struggle to talk about the depth of her emotions, which may include unspeakable feelings of grief and shame. This was reflected across many parents' narratives and seemed to result in a loss of confidence in their parenting abilities.

### 2.3.2.3 "*It won't ever be the same again*"

This subordinate theme voices parents' experiences of the ripple effect of loss through their lives. Given the distances some parents travelled and their wish

to visit their child regularly, many parents spoke of a loss of time both for themselves and their families, which impacted family life:

*“if you’re driving there spending a few hours there, and then driving back, basically a whole evening is gone [...] you’re turning your work days from finishing at 4.30, to finishing an 10 o’clock at night [...] and that’s tough”*

(David, 220-223)

This loss of time affected some parents’ relationships, limiting the time they spent together, as Elizabeth reflected: *“we don’t really get time just us”* (Elizabeth, 675). For Alice, the experience resulted in strain on her relationship as she stated *“...this thing has really pushed us apart”* (Alice, 246). Alice’s description of *“this thing”* may be indicative of the difficulty in talking about mental health as something that cannot be explained, which Matthew described as a *“monster”* (Matthew, 1141).

The impact on the wider family was emphasised in parents’ narratives, which for Matthew seemed to encompass a sense that the family had been shattered by his child’s mental health:

*“so [daughter]’s mental health issues [...] it sounds a bit melodramatic but, on some levels, it has broken the family”*

(Matthew, 306-307)

In addition, parents described the emotional impact of their child’s admission on their other children who were *“crying all the time [...] struggling with things”* (Elizabeth, 553). For David, visiting his child on the unit resulted in spending less time with his other children:

*“...every time you’re doing that you’ve got [other children] who are at home looking after themselves, they both grew up a lot in that period of time. Yeah, so it wasn’t the easiest [time] of our lives”*

(David, 229-231)

Many parents reflected on their struggle to balance their parenting role and meet their family's needs, which seemed to be intensified by their child's mental health difficulties and placed strain on the family:

*“we’ve got all of these conflicting needs and priorities on the family, how do we [...] manage that so that we can, we can, love, live and cope, you know. And it’s distressing. It’s stressful”*

(Matthew, 333-336)

The increased pressure parents seemed to be under following their child's admission impacted parents' social lives. Many parents expressed a loss of desire to socialise and difficulties in maintaining friendships. Parents' reduced socialising seemed to be linked to a perception that others would not understand their experiences, which may have exacerbated the social isolation they experienced:

*“you’re faced with this social, social isolation as well, [...] you don’t feel like doing things”*

(Elizabeth, 534-535)

The struggles parents shared appeared to signify the significant loss they experienced. For three parents, there was a sense that the child they expected to have was now lost, which led to intense grief:

*“...almost like a grieving process, because the child you thought you had isn’t the child that you’ve got [...] you’re going to go through that anger and denial, depression [...] because that’s how it makes you feel.”*

(Alice, 598-600)

For six parents, this also linked to a loss of their expected future, as they felt that *“everything you want to do you just put on hold”* (Paula, 620). Linked to this, parents seemed to go through a grieving process for the life they felt they had lost:

*“So, I don’t think our life, this is like our new life sort of thing, and... you know, you, this is going to sound so dramatic if I say sort of like you grieve for your old life, but I do”*

(Elizabeth, 605-607)

### **2.3.3 “I don’t live in Syria”**

This superordinate theme encompasses parents’ process of finding ways to manage throughout their child’s admission which includes adapting to their new reality. For many parents, there seemed to be an awareness of the difficulties they had experienced, while recognising that their situation could be worse. This was evident in Sophia’s statement; *“I don’t live in Syria”* (Sophia, 790-791) whereby she compared her current situation to the trauma of living in a war zone. Two subordinate themes reflect parents’ experiences within this superordinate theme: *“You learn to cope”* and *“This is our new reality”*.

#### **2.3.3.1 “You learn to cope”**

This subordinate theme signifies parents’ ongoing struggle with the impact of their child’s difficulties while searching for ways to cope. This was reflected in parents’ language as they shared that their child’s mental health difficulties in the build-up to, and during admission, were *“all consuming”* (Paula, 235) and had *“overtaken our lives”* (Matthew, 278). For some parents, their ability to manage was influenced by how their child was progressing and how visits went:

*“I couldn’t concentrate, I couldn’t stop crying, um, everything felt like an effort, I was struggling to get out of bed and you know”*

(Elizabeth, 513-514)

Finding ways to cope for themselves was evident across parents’ narratives whereby a number of parents found medication to be a useful coping strategy:

*“antidepressants did numb a lot of it... So that you weren’t absolutely on your knees in tears every minute of the day”*

(Lindsey, 308-310)

Lindsey’s use of *“on your knees”* could indicate a struggle of managing the intensity of emotions, whereby medication was seen as necessary to manage. The use of medication could indicate parents’ need to numb or avoid their emotional experience as a way of coping. David and Sophia echoed the benefits of medication, acknowledging that while medication reduced feelings of anxiety, it did not eliminate their feelings:

*“I’m still worried, but it took the edge off. You know, my brain still worries. You know when you’re really prickly and you’re tired and I was, I was irritable”*

(Sophia, 865-867)

In light of their lack of knowledge about a CAMHSIU, four parents reflected that seeing the unit prior to, or during their child’s admission provided relief and reassurance, enabling them to *“picture now where she is”* (Lindsey, 240). This alleviated some parents’ fears and preconceptions that had been shaped by stigma around inpatient units:

*“so I think [seeing the unit], it eased, it eased those bad thoughts I guess, it just made me feel like it wasn’t a bad place to go to”*

(Elizabeth, 339-341)

Through finding ways to manage, all parents voiced giving up their jobs, or reducing working hours. The importance of regaining their working lives was highlighted by five parents and seemed to help parents to cope with the loss of their child following admission:

*“I don’t know what I would have done had I not had that. I think work has been really important because when your child is away from you, you just think about all the time”*

(Alice, 679-681)

For Sophia, working enabled her to regain a sense of control, which helped to manage the lack of control and uncertainty she experienced following admission:

*“if I go to work, I’m in control, I can deal with it, I’m trained in it. [...] I know what I’m doing. I don’t know what I’m doing with this, I’m trying to feel my way”*

(Sophia, 770-772)

While working seemed important for managing the self and regaining a sense of identity, parents acknowledged the difficulties of balancing their work and parenting roles. For four parents, this led to guilt, which they attempted to reconcile through reassuring themselves:

*“I carry a huge amount of guilt about going to work about maybe not being here 24/7, but you can’t do that...because like I said, you would just crumble in the end”*

(Paula, 243-245)

Paula’s use of “*crumble*” could be suggestive of a fragility, a sense of herself being crumbled into pieces, which she took steps to manage through maintaining her working role.

In contrast, Elizabeth felt unable to return to work, which could be understood in terms of a loss of a part of her identity:

*“I loved my job [...] although I’m on a year’s career break, I can’t see me going back to it”*

(Elizabeth, 607-608)

External support was seen as essential for helping parents to manage. For Paula, this centred around support from the family as she felt she had “a good family setup” (Paula, 14). For five parents, support came through friends: “I have friends who will listen to me and that’s helpful, that’s how I cope” (Sophia, 887-888). For four parents, talking to those with shared experiences offered a sense of support that could not be provided elsewhere:

*“there’s only really certain people, who you feel really understand because they’ve had a similar experience”*

(Lindsey, 129-130)

#### 2.3.3.2 “This is our new reality”

This subordinate theme captures parents’ process of learning, adapting and accepting their “new reality” (Elizabeth, 519). For some parents, this process involved gaining a new understanding of their child’s mental health difficulties through the CAMHSIU experience:

*“so we got some insights about the [...] correlation between the way that mental health can affect physical health, which we perhaps hadn’t been aware of quite so much”*

(David, 113-115)

There was also a sense of coming to terms with the effects of their child’s mental health difficulties, which may signify parents feeling they had little choice but to accept their situation:

*“you can’t wave a magic wand and there’s going to be an impact or whatever [...] if you accept the reality of where she is, there’s going to be an impact”*

(Matthew, 990-992)

Elizabeth shared this experience, reflecting on the ongoing process of acceptance, which seems to emphasise a continued work of adapting to parents’ continually changing lives:

*“we have to accept that this is our new reality, but it’s still changing, so [...] you get used to one stage and then it changes, and then you get used to another stage and it changes again, so, I don’t know what the final reality looks like, or maybe it just keeps changing”*

(Elizabeth, 652-655)

For Sophia, the process of adapting centred around slowing things down, and reassuring herself through positive statements, which may reflect what she would like to say to her daughter:

*“One step in front of the other, if necessary, half a step in front of the other. You will get there. You will survive. You will get through it”*

(Sophia, 905-907)

This process of adapting and understanding seemed to be linked to parents concerns about their child’s relationships with other children on the unit. While a number of parents expressed concern about their child’s exposure to other young people on the ward; Alice viewed these new friendships as seeming to “empower” (Alice, 656) her daughter. For Sophia, there was an acknowledgement that despite some difficult situations on the ward, these experiences had a positive impact on her daughter:

*“She saw things, I would prefer that she didn’t have to see, but any parent would, but that’s nobody’s fault. [...] I think in some respects, [...] it puts some of her things into perspective where she sees the difficulties, but also the differences in life as well”*

(Sophia, 739-743)

Improved relationships seemed to be a positive outcome for three parents and Elizabeth felt that her relationship was “probably stronger” (Elizabeth, 640) as a result of their experiences. Alice echoed this, noting that her family relationships had improved, which she attributed to being “down to the psychological support we’ve had” (Alice, 1049):

*“out of all this horror, has come something really special. You know, it’s like... [...] traumatic growth [...] And that is a really big thing for us as a family, we have grown out of it”*

(Alice, 279-282)

This process of understanding and accepting their new reality seemed to highlight parents’ resilience in the face of their experiences and continued difficulties. For four parents, their experiences seemed to result in their wish to help and support others through the process in a way that they may have wished for this support themselves:

*“...it won’t help [my daughter] but it might help another family who might have to go through it [...] So, I do know that I need to do that, to get it down and get it out”*

(Paula, 259-261)

## **2.4 Discussion**

This research aimed to explore parents’ lived experiences following their child’s admission to a CAMHSIU. The experiences of seven parents contributed to three superordinate themes: *“It’s a bit of a minefield”*, *“Monster of mental health”* and *“I don’t live in Syria”*. These superordinate themes identify parents’ struggles to understand the unusual world of the CAMHSIU; manage overwhelming loss of both their child and part of themselves, while searching for ways to cope and adapt to their new reality.

### **2.4.1 “It’s a bit of a minefield”**

This superordinate theme demonstrated the complexities of navigating the CAMHSIU whereby parents felt they had entered an unusual world that separated them from their child. Experiences of the ward as different to the outside world have been highlighted in research exploring adolescents’ experiences of CAMHSIUs (Gill, Butler & Pistrang, 2016; Haynes, Eivors & Crossley, 2011). Although the CAMHSIU was experienced as unusual, parents felt unexpected relief following their child’s admission, which centred

around knowing their child was safe. This is consistent with previous research whereby parents felt relieved to be relinquishing responsibility for their child's safety to the CAMHSIU (Salamone-Violi et al., 2017; Gerson et al., 2009). The present study furthered these findings, indicating that relief was also linked to the respite parents experienced while their child was on the unit. This is understandable in the context of parents' difficulties in managing their child's MH at home (Mohr & Regan-Kubinski, 2001).

The in-depth qualitative approach of the present study enabled a deeper understanding of parents' experiences of confusion and bewilderment in entering the CAMHSIU. Difficulties around navigating the CAMHSIU seemed to undermine parental responsibility and evoked feelings of anger and frustration. Challenges around parental inclusion have been noted in previous research (Hickman et al., 2016; Geraghty et al., 2011; Gerson et al., 2009). The present study suggests that this is an ongoing issue in these inpatient services, which is in contrast to research and guidance highlighting the importance of parental involvement (Giacco, Dirik, Kaselionyte & Priebe., 2017; QNIC, 2016).

Notably, all parents voiced expectations of the CAMHSIU to resolve their child's difficulties. Similarly, Salamone-Violi et al. (2017) reported that parents viewed inpatient admission as preferable to community treatment due to the increased support offered on the CAMHSIU. The present study provides a deeper insight, highlighting parents' desperation for support and solutions for their child and disappointment and frustration with the system resulting from their child's lack of improvement. On the other hand, some parents acknowledged the reality of the slow progress seen in MH, which is highlighted in the literature (Milliken, 2001). Additionally, parents who expressed more anger and frustration with services had experienced multiple admissions, or their child's transition to adult services, which seemed to exacerbate their distress. This could be related to parents' understanding of recovery. Previous research identified that service users' viewed recovery as a process of regaining something that had been lost, while nurses held a more medical understanding of recovery as a reduction in MH symptoms (Aston & Coffey,

2011). Therefore, it is possible that parents' expectations for change may be influenced by their understanding of recovery and what this means to them.

#### **2.4.2 “Monster of mental health”**

A sense of loss and grief was overwhelmingly prevalent throughout participants' narratives, highlighting the emotions and turmoil parents in the present study experienced. While previous research identifies trauma and loss as a result of child MH difficulties (Richardson, Cobham, McDermott & Murray., 2013; Mohr & Regan-Kubinski, 2001), the present study provides deeper insight into the significant impact of loss and grief parents experienced in terms of the loss of not only their child but a part of their identity and the life they expected.

In an attempt to manage their loss, parents searched for explanations to make sense of their experiences, which is a common response to loss and grief (Hall, 2014). This often centred around questioning or blaming themselves for being unable to support their child. Parents' experiences and responses to loss could be understood in terms of Acceptance and Commitment Therapy (ACT; Harris, 2019). Parents in the present study sought ways to avoid or change their experiences through the use of medication or self-blame, which is conceptualised as 'experiential avoidance' in ACT and may lead to increased psychological distress (Davis, Deane & Lyons, 2016). Parental guilt and self-blame have been highlighted in previous research in response to child MH difficulties (Richardson et al., 2013; Shpigner et al., 2013) and admission to inpatient units (Geraghty et al., 2011). The current study builds on these findings, highlighting the impact of their child's admission on parents' sense of identity and parenting confidence. Previous research has described this as a process of redefining parental identity, which is ongoing for parents due to the continuing changes inherent in MH difficulties (Milliken, 2001).

The intensity of loss parents shared in the current study could be conceptualised as disenfranchised grief, whereby grief could not be openly acknowledged or recognised (Doka, 1989). This concept has been applied to parents of children with MH difficulties whereby loss and grief may be

overlooked by others (Richardson et al., 2013; Young et al., 2004). Loss and grief within the context of parenting a child with MH difficulties has received increasing attention over the years with a recognition that parents may experience ongoing grief as a result of the continuous and changing nature of MH (Young et al., 2004).

Despite grief and loss being a dominant experience for most parents in the current study, one parent did not share the intense feelings of loss experienced by the majority, instead focusing on the positive aspects of their child's improvement. This fits with Richardson et al.'s (2013) findings that focusing on positive aspects of their child's potential was an important coping strategy for parents of children with MH difficulties. This may also fit with ACT (Harris, 2019), which highlights the importance of acceptance of the difficulties that arise in life and moving towards valued-living, both of which are important for adjusting to loss (Davis et al., 2016).

### **2.4.3 “I don't live in Syria”**

The final superordinate theme conveyed the ongoing difficulties parents experienced while searching for ways to cope and adapt to their changed lives. The struggle to manage and understand their child's MH difficulties alongside the exhaustion parents felt is consistent with previous research (Wade, 2016; Shpigner et al., 2013). Parents' experiences in the present study highlight the unrelenting nature of MH and overwhelming feelings resulting from their children's admission. Previous research reported that parents of children with MH difficulties feel out of control and attempt to manage their emotions through avoidance (Richardson et al., 2013). The current study extends these findings, highlighting the ways in which parents manage, through the use of medication, to numb but not completely avoid their intense emotions. Further, parents in the current study emphasised the importance of working to manage their loss and to regain a sense of control over their lives. This could be understood in terms of responses to trauma whereby parents in the current study used work as an avoidant coping strategy to provide respite from their distressing experiences (Hunt & McHale, 2010).

The need for external support from family and friends is consistent with previous research identifying the positive impact of emotional support on parent's ability to cope with their child's MH (Richardson et al., 2013; Puotiniemi, Kyngäs, & Nikkonen, 2002). Further, research has identified the importance of external support as a protective factor against adversity (Hamby, Grych & Banyard., 2018). Within this, the current study highlighted the value of support from those with shared experiences, which builds on previous research (Geraghty et al., 2011).

Learning about their child's MH difficulties enabled parents to support and understand their child and facilitated parents' adaptation to their situation. Similar findings were reported by Salamone-Voili et al. (2017) whereby gaining insight into their child's MH difficulties was a positive outcome of inpatient treatment. Consistent with previous findings (Richardson et al., 2013), some parents in the current study reflected on the positive impact of their experiences. In the current study, this related to a sense of post-traumatic growth and parents' wish to support others. Post-traumatic growth is commonly reported in physical health (Hungerbuehler, Vollrath & Landolt., 2011) and bereavement literature (Znoj, 2009). In the current study, parents' ability to manage and adapt despite the challenges they faced could indicate their psychological resilience, which may lead to post-traumatic growth (Southwick & Charney, 2018).

#### **2.4.4 Clinical implications**

The current study provides insight into the significant distress parents experienced following their child's admission. Due to the stressful and traumatic nature of admission, it is possible that parents struggle to fully understand and process the information provided (Thomas & Karanjan, 2019; Quaedflieg & Schwabe, 2018). Therefore, parents should have regular contact with staff throughout their child's admission to provide explanations and support. Additionally, given the difficulties parents voiced in sharing their experiences, it will be beneficial to provide peer support through parents with shared lived experiences, which can provide emotional and practical support for families during times of distress (Geraghty et al., 2011).

Owing to parents feeling excluded from their child's care, CAMHSIUs should promote parental involvement and routinely gain feedback from parents about their experiences to enhance standards of care. Improving communication and support for parents is crucial to facilitate parental well-being and to enable parents to support their children (Palamaro et al., 2012). Further, due to the loss parents experienced following their child's admission and the potential impact this may have on parent-child attachments, CAMHSIUs should endeavour to support family relationships. This support could be provided through psychological therapy which may draw on approaches such as ACT (Harris, 2019), which has been used to help individuals to process grief and loss (Speedlin, Milligan, Haberstroh & Duffey, 2016). This support is particularly important given the distances some parents have to travel to visit their child, which impacts on the whole family. Policy and guidance should explore ways to support families during their child's admission and liaise with local CAMHS to ensure ongoing support for the child and family in the community.

Additionally, parents' difficulties around understanding professional language and feeling intimidated during Care Programme Approach (CPA) need to be considered. This could be achieved through creating trauma-informed services that promote transparency, collaboration and choice (Sweeney, Clement, Filson & Kennedy, 2016). In line with this, young people and their families can assert choice and control over processes on the CAMHSIU, including the format of CPA meetings, which may facilitate empowerment (Sweeney et al., 2016). Furthermore, trauma-informed services will raise staff awareness of their language use, encouraging professionals to consider the way they share information (Sweeney et al., 2016). Clinical psychologists are well placed to facilitate trauma-informed environments through developing training and providing consultation and supervision (Ables, Crosbie & Milson, 2015).

#### **2.4.5 Limitations**

While this study provides an in-depth understanding of parents' experiences, limitations need to be considered. The predominantly female (5) sample may

have influenced the findings and fathers' experiences may not be as well represented. Moreover, all participants were birth parents of daughters admitted to CAMHSIUs and were from white British backgrounds. While these characteristics enhanced the homogeneity of the sample, the findings do not represent the experiences of parents of sons, those who are not birth parents or parents from other ethnic backgrounds.

Further, the inclusion of a range of MH difficulties may have affected the homogeneity of the sample. Additionally, it is possible that this sample represented parents who felt confident enough to speak about their experiences. Consequently, the findings may not represent parents who struggled to access services or support their children.

#### **2.4.6 Future research**

Further research exploring the impact of loss and grief on different family relationships could be beneficial, given the significant impact on parents. Additionally, given parents' concerns about other children in the family, exploring the experiences of siblings of children admitted to CAMHSIUs could provide deeper insight into the impact of admission on the wider family.

It may be helpful to explore parents' understanding of recovery in MH as this may influence parents' expectations of services and treatment. Gaining an understanding of parent's views of recovery may identify areas of support in the future.

Finally, given the importance of parental involvement and support for parents, future research could explore these areas in more depth, evaluating parent involvement and support systems within CAMHSIUs.

#### **2.5 Conclusion**

The findings of this research highlighted parents' journey of understanding and navigating the CAMHSIU; the loss and grief they experienced and their process of finding ways to cope in spite of the difficulties they faced. Despite

the limitations, the use of IPA enabled a comprehensive understanding of parents' experiences following their child's admission, which has not previously been explored in this depth. This research has contributed to the current literature identifying the areas where parents struggle and highlighting ways to enhance support during their child's admission. It is hoped that this research will provide a platform for further in-depth research in this area and influence practice and policy for parental support in CAMHSIUs.

## **2.6 References**

- Abeles, P., Crosbie, V. and Milson, G. (2015). Delivering psychological services for children, young people and their families in inpatient settings. *Child & Family Clinical Psychology Review*, (3), 60-70
- Aston, V. & Coffey, M. (2011). Recovery: what mental health nurses and services users say about the concept of recovery. *Journal of Psychiatric Mental Health Nursing*. 19, 257-263. doi/pdf/10.1111/j.1365-2850.2011.01776.x
- Bell, J. (2010). *Doing your research project: A guide for first-time researchers* (Eds.). Berkshire, England: Open University Press.
- British Psychological Society (2009). *Code of Ethics and Conduct*. Leicester: British Psychological Society. Retrieved from: <https://www.bps.org.uk/files/code-ethics-and-conduct-2009pdf>
- British Psychological Society (2010). *Code of Human Ethics*. Leicester: British Psychological Society. Retrieved from: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf>
- Dallos, R., & Denford, S. (2008). A qualitative exploration of relationship and attachment themes in families with an eating disorder. *Clinical Child Psychology and Psychiatry*, 13(2), 305-322. Doi: 10.1177/1359104507088349
- Davis, E. L., Deane, F. P. & Lyons, G. C. B. (2016). Prediction of individual differences in adjustment to loss: acceptance and valued-living as critical appraisal and coping strengths. *Death Studies*. 40(4), 211-222. Doi: <http://dx.doi.org/10.1080/07481187.2015.1122677>
- Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services: Core Document*. London: Department of Health. Retrieved from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/199952/National\\_Service\\_Framework\\_for\\_Children\\_Young\\_People\\_and\\_Maternity\\_Services\\_-\\_Core\\_Standards.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf)

- Department of Health (2015). *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. London: HMSO. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf)
- Department of Health and Department for Education (2017). *Transforming children and Young People's Mental health provision: a green paper*. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/664855/Transforming\\_children\\_and\\_young\\_people\\_s\\_mental\\_health\\_provision.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf)
- Doka, K. J. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, Massachusetts: Lexington Books
- Frith, E. (2017). Inpatient provision for children and young people with mental health problems. Education Policy Institute. Retrieved from:  
[https://epi.org.uk/wp-content/uploads/2018/01/EPI\\_Inpatient-care\\_mental-health.pdf](https://epi.org.uk/wp-content/uploads/2018/01/EPI_Inpatient-care_mental-health.pdf)
- Geraghty, K., McCann, K., King, R., & Eichmann, K. (2011). Sharing the load: Parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. *International Journal of Mental Health Nursing*, 20(4), 253-262. doi: 10.1111/j.1447-0349.2011.00730.x
- Gerson, R., Davidson, L., Booty, A., Wong, C., McGlashan, T., Malespina, D., Pincus, H. A. & Corcoran, C. (2009). Families' experience with seeking treatment for recent-onset psychosis. *Psychiatric Services*, 60(6), 812-816. doi:10.1176/appi.ps.60.6.812.
- Giacco, D., Dirik, A., Kaselionyte, J. & Priebe, S. (2017). How to make carer involvement in mental health inpatient units happen: a focus group study with patients, carers and clinicians. *BMC Psychiatry*. 17(101). doi: 10.1186/s12888-017-1259-5
- Gill, F., Butler, S., & Pistrang, N. (2016). The experience of adolescent inpatient care and the anticipated transition to the community: Young people's perspectives. *Journal of Adolescence*, 46, 57-65. <http://dx.doi.org/10.1016/j.adolescence.2015.10.025>

- Gross, V. & Goldin, J. (2008). Dynamics and dilemmas in working with families in inpatient CAMH services. *Clinical Child Psychology and Psychiatry*, 13(3), 449-461. Doi: 10.1177/1359104507088350
- Hall, C. (2014). Bereavement theory: recent developments in our understanding of grief and bereavement. *Cruse Bereavement Care*, 33(1), 7-12. doi.org/10.1080/02682621.2014.902610
- Hamby, S., Grych, J., & Banyard, V. (2018). Resilience portfolios and poly-strengths: Identifying protective factors associated with thriving after adversity. *Psychology of Violence*, 8(2), 172-183. doi:10.1037/vio0000135
- Harris, R. (2019). *ACT Made Simple: an easy-to-read primer on Acceptance and Commitment Therapy*. 2<sup>nd</sup> Ed. New Harbinger.
- Hassan, E. (2005). Recall bias can be a threat to retrospective and prospective research designs. *The Internet Journal of Epidemiology*, 3(2), 339-412. Retrieved from <http://ispub.com/IJE/3/2/13060>
- Haynes, C., Eivors, A. & Crossley, J (2011). 'Living in an alternative reality': adolescents' experiences of psychiatric inpatient care. *Child and Adolescent Mental Health*. 16(3), 150-157.
- Hickman, G., Newton, E., Fenton, K., Thompson, J. Boden, Z. V. R., & Larkin, M. (2016). The experiential impact of hospitalisation: Parents' accounts of caring for young people with early psychosis. *Clinical Child Psychology & Psychiatry*, 21(1), 145-155. Doi: 10.1177/1359104515581716
- Hunt, N. C. & McHale, S. (2010). *Understanding Traumatic Stress*. Sheldon Press: London
- Hungerbuehler, I., Vollrath, M. E. & Landolt, M. A. (2011). Posttraumatic growth in mothers and fathers of children with severe illnesses. *Journal of Health Psychology*. 16(8), 1259-1267. Doi: 10.1177/1359105311405872
- Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In Thompson, A. & Harper, D. (Eds.). *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. 99-116. Oxford, England: John Wiley & Sons.

- Mattsson, J. Y., Arman, M., Castren, M., & Forsner, M. (2014). Meaning of caring in pediatric intensive care unit from the perspective of parents: A qualitative study. *Journal of Child Health Care*. 18(4), 336-345.
- Mayberry, L. S. & Heflinger, C. A. (2013). How caregivers make meaning of child mental health problems: toward understanding caregiver strain and help seeking. *Families in Society*. 94(2), 105-113. doi:10.1606/1044-3894.4286.
- Milliken, J. (2001). Disenfranchised mothers: caring for an adult child with schizophrenia, *Health Care for Women International*. 22, 149-166. Doi: 10.1080/073993301300003135
- Mohr, W. K & Regan-Kubinski, M. J. (2001). Living in the fallout: parents' experiences when their child becomes mentally ill. *Archives of Psychiatric Nursing*. XV(2), 69-77.
- Moses, T. (2010). Exploring parents' self-blame in relation to adolescents' mental disorders. *Family Relations*. 59(2), 103-120
- Nicholls, D. (2009). Qualitative research: part one – philosophies. *International Journal of Therapy and Rehabilitation*. 16(10), 526-533.
- NHS Digital (2018). *Mental Health of Children and Young People in England, 2017 [PAS]* Retrieved from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>
- Ormston, R., Spencer, L., Barnard, M., & Snape, D. (2014). The foundations of qualitative research. In J. Ritchie, J. Lewis, C. Nicholls, & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers*. 1-25. London, England: Sage.
- Palamaro Munsell, E., Kilmer, R. P., Cook, J. R., & Reeve, C. L. (2012). The effects of caregiver social connections on caregiver, child, and family well-being. *American Journal of Orthopsychiatry*. 82(1), 137-145. Doi: 10.1111/j.1939-0025.2011.01129.x
- Puotiniemi, T. A., Kyngäs, H. A & Nikkonen, M. J. (2002). The resources of parents with a child in psychiatric inpatient care. *Journal of Psychiatric and Mental Health Nursing*. 9, 15-22
- Quaedflieg, C. W. E. M., & Schwabe, L. (2018). Memory dynamics under stress. *Memory*. 26(3), 364-376. doi:10.1080/09658211.2017.1338299

- Quality Network for Inpatient CAMHS (QNIC; 2016). *Quality Network for Inpatient CAMHS annual report Cycle 15*. Royal College of Psychiatrists. Retrieved from: [https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/child-and-adolescent-inpatient-services-\(cahms\)/camhs-qnic-annual-report-2016.pdf?sfvrsn=f03cdac2\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/child-and-adolescent-inpatient-services-(cahms)/camhs-qnic-annual-report-2016.pdf?sfvrsn=f03cdac2_2)
- Richardson, M., Cobham, V., McDermott, B. & Murray, J. (2013). Youth mental illness and the family: parents' loss and grief. *Journal of Child and Family Studies*. 22, 719-736. Doi 10.1007/s10826-012-9625-x
- Ring, N., Ritchie, K., Mandava, L. & Jepson, R. (2011). A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews. Retrieved from: <http://www.nhshealthquality.org/nhsqis/8837.html>
- Salamone-Violi, G., Chur-Hansen, A., & Winefield, H. R. (2017). In this day and age why is it still so hard to find the right type of help? carers' perspectives regarding child and adolescent mental health services: A qualitative study. *Advances in Mental Health*. 15(1), 58-70. doi.org/10.1080/18387357.2016.1195697
- Shpigner, E., Possick, C., & Buchbinder, E. (2013). Parents' experience of their child's first psychiatric breakdown: "Welcome to hell". *Social Work in Health Care*. 52(6), 538-557. Doi: 10.1080/00981389.2013.780835
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method and Research*. London: Sage
- Smith, J. A. & Osborne, M. (2008). Interpretive Phenomenological Analysis. In Smith, J. A. (Ed) *Qualitative Psychology: A Practical Guide to Research Methods*. 53-80. London, UK: Sage
- Southwick, S. M. & Charney, D. S. (2018). *Resilience: The science of mastering life's greatest challenges*. 2<sup>nd</sup> Ed. Cambridge University Press, UK
- Speedlin, S., Milligan, K., Haberstroh, S. & Duffey, T. (2016). Using Acceptance and Commitment Therapy to negotiate losses and life transitions. *VISTAS Online: ACA Knowledge Centre*. Retrieved from: <file:///E:/Thesis/Empirical/Using%20ACT%20to%20negotiate%20losses%20and%20life%20transitions.pdf>

- Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*. 21(3), 174-192. DOI 10.1108/MHRJ-01-2015-0006
- Thomas, A. K., & Karanian, J. M. (2019). *Acute stress, memory, and the brain*. doi:<https://doi.org/10.1016/j.bandc.2019.04.004>
- Vaughan, E. L., Feinn, R., Bernard, S., Brereton, M., & Kaufman, J. S. (2013). Relationships between child emotional and behavioral symptoms and caregiver strain and parenting stress. *Journal of Family Issues*. 34(4), 534-556. Doi: 10.1177/0192513X12440949
- Ward, L., & Gwinner, K. (2014). 'It broke our hearts': Understanding parents' lived experiences of their child's admission to an acute mental health care facility. *Journal of Psychosocial Nursing and Mental Health Services*. 52(7), 24-29.
- Wade, J. (2006). "Crying alone with my child:" parenting a school age child diagnosed with bipolar disorder, *Issues in Mental Health Nursing*. 27(8), 885-903. DOI: 10.1080/01612840600842493
- Young, J., Bailey, G. & Pycroft, P. (2004). Family grief and mental health: a systemic, contextual and compassionate analysis. *Australian and New Zealand Journal of Family Therapy*. 25(4), 188-197
- Znoj, H. (2009). Bereavement and posttraumatic growth. In Calhoun, L. G. & Tedeschi, R. G. (Eds) *Handbook of Posttraumatic Growth: research and practice*, 176-196. Psychology Press: London.

## **Chapter 3: Reflective Paper**

### **Navigating the research process: strengthening my research identity**

Overall chapter word count (exclusive of references and figures): 3641

### **3.1 Introduction**

This chapter outlines my reflections on the process of carrying out qualitative research exploring adolescents' and parents' experiences of a Child and Adolescent Mental Health Inpatient Unit (CAMHSIU). I will consider the value of personal and professional development and reflection during clinical training and research. Using notes from the reflective journal that I kept throughout the research process, I will discuss my journey of navigating through the research process and strengthening my research identity. Drawing on Narrative Therapy (White & Epston, 1990) and the Tree of Life (ToL; Ncube-Mlilo, & Denborough, 2007; Ncube, 2006), I consider how my experiences of conducting research has strengthened my research narrative and influenced my journey of becoming a clinical psychologist.

#### **3.1.1 Personal and professional development**

Personal and professional development is a fundamental part of clinical psychology (British Psychological Society [BPS], 2008). More recently, the BPS emphasised the importance of clinical psychologists adopting a "*reflective scientist-practitioner model*" (BPS, 2019, p. 15), which facilitates personal and professional development. This model recognises the role of clinical psychologists in contributing to evidence-based research, embracing practice-based evidence and promoting reflective practice (BPS, 2019).

##### *3.1.1.1 Reflection*

Reflection or reflective practice is an important element of personal and professional development and enables clinical psychologists to develop greater self-awareness (Division of Clinical Psychology [DCP], 2010). Through reflection, clinical psychologists become aware of the impact of diversity, social and cultural context and ethical issues in both clinical practice and research (BPS, 2019). Throughout training, I have used Gibbs' Reflective Cycle (1988) to reflect on my experiences and subsequent personal and professional development. I have valued reflection in my clinical work with clients, teams and systems as it has enabled me to gain a deeper insight into my own emotional responses and the impact this may have on my clinical work

(Binks, Jones & Knight, 2013). During the research process, I gained an understanding of the importance of reflection in qualitative research. I have found reflection to be particularly important in enhancing my awareness of my own assumptions, considering my experiences of participants following interviews and aiding my understanding and analysis of participants' experiences.

#### *3.1.1.2 Reflexivity in qualitative research*

Reflexivity or 'reflection in action' is essential in qualitative research as it enables researchers to consider how their experiences intersect with and impact on their interpretations of participants' narratives (D'Cruz et al., 2007; Finlay, 2002). Reflexivity involves a continuous dialogue and critical self-evaluation alongside an explicit recognition of the researcher's influence on the research process and outcome (Berger, 2015). Through reflexivity, researchers are able to gain awareness of their role in co-constructing meaning and enhance the trustworthiness and transparency of their study by explicitly stating the impact of their influence on the research (Finlay, 2002). Within Interpretative Phenomenological Analysis (IPA), reflection on the researcher's role encourages self-awareness and is essential for enabling the researcher to remain grounded in participants' experiences (Larkin and Thompson, 2012). Throughout the research process, I considered the influence of my position, assumptions, biases and personal and professional experiences. This enabled me to bracket my assumptions and preconceptions, allowing me to focus solely on participants' experiences. I therefore gained an understanding of the benefit of using reflexivity as well as reflection during the research process.

### **3.2 Navigating through the research**

I have particularly valued reflection and reflexivity in the research process as it has greatly enhanced my self-awareness and my research skills. During the course I have been drawn to Narrative Therapy (White & Epston, 1990) and the ToL (Ncube-Mlilo, & Denborough, 2007). I will consider my learning through the research process, drawing on Narrative Therapy (White & Epston,

1990) and the ToL (Ncube-Mlilo, & Denborough, 2007; Ncube, 2006) where appropriate to explore my research experiences.

### **3.2.1 Narrative Therapy**

Narrative Therapy (White & Epston, 1990) outlines the way individuals make sense of their experiences through creating narratives or stories about their lives (White & Denborough, 1998). Individuals may become focused on dominant narratives of their lives, which shape their perceptions and interpretations of their present and future experiences (Morgan, 2000). Problems can arise if an individual's narrative is problem-saturated, which may obscure individuals hopes, dreams, skills and achievements. Narrative Therapy explores these problem-saturated narratives, encouraging individuals to externalise or separate the problem from themselves to reduce blame and defensiveness (Morgan, 2000). This is achieved through understanding the individuals' experiences and exploring exceptions to the problem. This process of re-authoring narratives enables individuals to develop a richer, alternative narrative about their problems and their lives, focusing on their strengths (Morgan, 2000).

Considering my personal and professional narratives, I acknowledged that I had developed a self-critical narrative about my research abilities. During the research process, I reflected on my professional ToL and my research identity, which raised my awareness of my research narrative prior to commencing this research.

### **3.2.2 The Tree of Life (ToL)**

The ToL is a group psychosocial support tool based on narrative principles designed to support children experiencing adversity (Ncube-Mlilo, & Denborough, 2007; Ncube, 2006). The ToL is designed as a full day group programme aiming to support groups and communities to overcome difficult life experiences while avoiding re-traumatisation. The ToL facilitates discussion of the past, present and future, to elicit problem-saturated narratives and develop alternative, strengths-focused narratives that build on

the individual's identity (Binnie & Cayzer, 2017). Over the years, the ToL has been developed to be used in a variety of contexts in both individual and group work (Binnie & Cayzer, 2017; Baum & Shaw, 2014; German, 2013).

#### *3.2.2.1 My professional ToL prior to completing this research*

During the course, I created a professional ToL (Figure 3.1) based on previously developed professional identity questions (Kis-Sines & Pluznick, 2018; Appendix U). Using these questions as a guide, I explored the roots of my ToL which represent what brought me to this work, who or what inspired me. The ground characterises the present time, how long I have been in my current role, the values of the role that are important to me and why. The trunk signifies the skills and knowledge I bring to the role. The branches signify the hopes and dreams I have for my work and my future career. The leaves represent the people who support me in the work I do. The fruits represent the contributions of the team to my development and the flowers represent the contributions that I have made to the development of others.

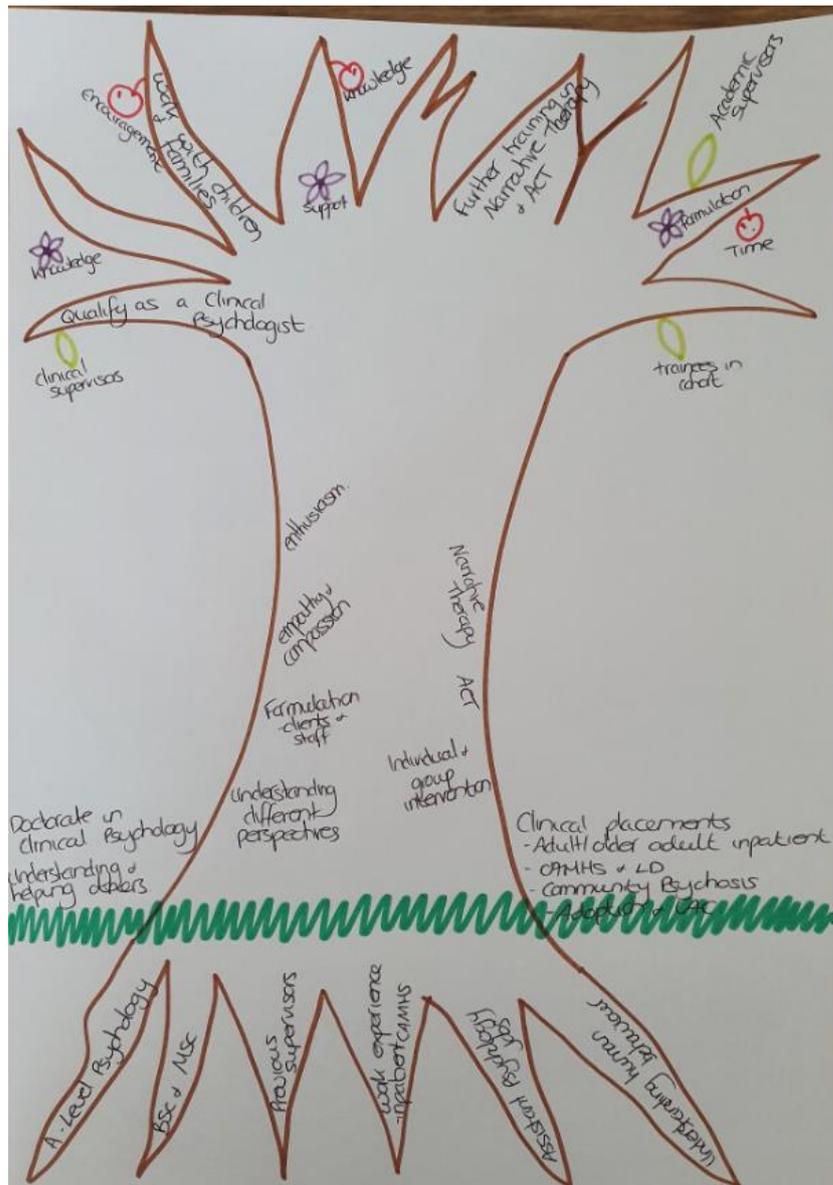


Figure 3.1: My professional ToL prior to this research

While I was conducting my research, I noticed that the trunk of my tree identified only clinical skills. I became aware of how this fitted with a number of self-critical thoughts I recognised during the research process and I noticed that I held a narrative that I struggle with research and critical analysis.

### 3.2.2.2 My research narrative

Drawing on Narrative Therapy (White & Denborough, 1998) and the ToL (Ncube-Mlilo, & Denborough, 2007), I considered my research narrative prior to commencing this research. Despite the excitement I felt after identifying my

research topic, I noticed some trepidation at embarking on the research journey. While I have been previously in a researcher position, I was aware of unexpected anxiety and self-critical thoughts during the research process. The anxiety and self-critical thoughts were exacerbated by difficulties I experienced with delays during the ethics process and recruiting participants. The ethics process brought unexpected challenges as a result of recruiting through different NHS trusts in England, which impacted the recruitment of participants. During this time, I perceived myself to be falling behind other trainees in my cohort, which further intensified the self-critical thoughts. I recognised that I began comparing myself to my fellow trainees, and berated myself for being unable to meet the original timeline I had envisaged for the research. I recognised feeling increasingly overwhelmed and frustrated with the research process, which was intensified by discussions around the possibility of deferring my thesis submission. Reflecting on this stressful time, I recognised that I originally viewed the decision to defer as a reflection on my academic and research ability. I felt that if I was unable to submit my thesis for the original deadline, it meant that I was a failure in some way. Acknowledging these self-critical thoughts enabled me to challenge them and to be more self-compassionate.

Over time, I learnt that deferral did not mean failure and I came to accept that the difficulties with ethics and recruitment were out of my control. This acceptance was challenging at times due to my own expectations of meeting the deadline. This experience enabled me to acknowledge and understand the nature of research, accepting the elements that were out of my control and adapting to focus on the parts of the research that were in my control, for example, my literature review. This process facilitated my self-compassion, reduced the anxiety I felt and enabled me to make the decision to defer. In addition, I identified that accepting the position I was in and deferring significantly reduced the anxiety and pressure I was under. This had a two-fold effect.

Firstly, I recognised that I was able to concentrate on my writing, which reminded me of the 'optimal emotional learning zone' I learned about during

the first year of training (James, Blackburn & Reichelt, 2001). I noticed that the anxiety I experienced as a result of the research challenges had pushed me out of the optimal learning zone. As a consequence of this, the standard of my writing was affected, which in turn affected my confidence and intensified the self-critical thoughts. In contrast, the reduction in anxiety following my decision to defer resulted in my enhanced ability to concentrate and write to the academic standard required at the doctoral level, which in turn reduced the self-critical thoughts.

Secondly, I noted a positive impact on my emotional wellbeing and self-care. Self-care is a crucial factor in developing as a clinician and has been emphasised throughout training (Norcross, 2000). During the course, teaching on emotional regulation and self-care has strongly resonated with me, and I actively encourage both clients and colleagues to ensure time for self-care. Despite this, I have become aware of the difficulties in applying these principles to myself, particularly during times of increased stress. I observed that my self-care significantly diminished during my final year on the course as I felt the pressure mounting. I acknowledged that I had stopped doing the things that I enjoyed as I felt pressure to meet the deadlines. I pushed myself to work during evenings and weekends, despite being aware of the negative impact this would have on my emotional and physical wellbeing. Deciding to defer my thesis allowed me to reassess the position I was in and re-align myself with my values and self-care. Factoring in self-care time further reduced the anxiety I had been experiencing, enabled me to spend focused time on my thesis and facilitated my self-compassion.

This learning has been invaluable and has enabled me to gain a deeper insight into the nature of research. In the future, I will be more able to acknowledge and accept the potential challenges that may arise during research, adapt to situations that are out of my control, practice my self-compassion during times of stress, and take steps to ensure my own self-care. In clinical practice I will also be more able to recognise when I need to use more self-care, which will benefit both myself and the clients I work with, as well as enhancing my future career as a clinical psychologist.

### **3.2.3 “What is my role?”**

Moving through the research process, I considered my role as a researcher and a clinician. Looking through my reflective journal I observed that I asked the question “*What is my role in this? A researcher or a clinician?*” a number of times, particularly during the interview stage. I noted that both of these roles are parts of my identity, however, I felt that my strengths lay predominantly within my clinical skills. I acknowledged how this fitted with my professional ToL and the self-critical research narrative I had developed prior to, and during the initial stages of the research.

#### *3.2.3.1 “A clinician”*

Conducting the interviews, I learnt that the clinical skills I had developed throughout the course enabled me to build rapport with the parents, which facilitated their willingness to share their experiences. During analysis, I became aware of the usefulness of my skills in formulation that facilitated my understanding and interpretation of both adolescents’ and parents’ experiences. I noted the similarities between the interviews with parents and initial assessments I have conducted in clinical practice. I recognised that during assessments, I spend a great deal of time listening to the individual, asking questions with curiosity to gain a detailed understanding of their experiences and what they may need from the service. I noticed adopting a similar stance during interviews, asking open questions with interest to gather in-depth information about parents’ experiences.

I am aware of my initial tendency to reassure or rescue individuals during times of distress, which comes from a desire to help others and reduce suffering. However, personal and professional development throughout the course has enabled me to build confidence in acknowledging and sitting with intense emotions with clients. This was particularly helpful during interviews as many parents understandably became tearful while sharing their stories. I noted the usefulness of my clinical skills at these times and reflected on my increased

capacity to be with parents in their distress without being drawn into the 'rescuer' role of Karpman's (1968) Drama Triangle<sup>5</sup>.

### 3.2.3.2 *A researcher*

Prior to conducting interviews, I noted feelings of anxiety about how to respond to parents without being drawn into a clinician role. Despite this initial anxiety, I was struck by parents' willingness and openness to share their experiences in detail, which was evident in the depth and the length of the interviews. I recognised the therapeutic nature of providing parents with a safe space to share their experiences without stepping into the clinician role, or engaging in an intervention. In this way I acknowledged that conducting research interviews enabled me to focus solely on parents' experiences without an agenda, time restrictions or service pressures. This experience highlighted the value of conducting research interviews and has enhanced my awareness of the benefits of providing a safe space for participants, as well as for clients in clinical practice.

Considering my self-critical research narrative, I recognised a pressure to understand parents' experiences in a helpful way and to identify ways to improve their experiences. I wondered if this was also linked to the pressures of the course and the demands of completing a doctoral thesis. I became more aware of these pressures during analysis as I felt a responsibility to capture parents' experiences in a valuable way and to produce high quality work for publication and dissemination. Acknowledging these pressures and making space for the resulting anxiety enabled me to remain focused on the analysis and manage the pressure through self-care, for example, ensuring I structured regular breaks during analysis and write up. This has been valuable learning that will facilitate my ability to manage and adapt when working under pressure in the future as a qualified clinical psychologist.

---

<sup>5</sup> Karpman's (1968) drama triangle is a model of social interaction and power in conflicts. The triangle maps three roles in conflict; the victim, the rescuer, the persecutor.

### 3.2.3.3 A researcher and a clinician

Acknowledging my role as a clinician and a researcher has enhanced my awareness of the value of my clinical skills throughout the research process. During analysis, I noted a range of intense emotions that I experienced in response to parents' narratives. Drawing on my clinical skills, I recognised how my emotional responses, thoughts and reactions to parents' experiences could be understood in terms of psychodynamic concepts such as transference and countertransference (Lemma, 2016). This enabled me to separate my emotions from those of my participants and identify my own desire to find something positive in parents' narratives when their experiences were predominantly focused on distress and anguish. For example, in my reflective diary I wrote, *"I am feeling weighed down by parents' distress, there must be something positive, a small glimmer of hope in their narratives?"*. Acknowledging this enabled me to re-focus on parents' experiences and bracket my emotions and wish to find a positive experience. Further, reflecting on my experience has enabled me to identify the benefits of my clinical skills in a research capacity as well as the importance of self-care to manage my emotional responses within research as well as clinical practice. Acknowledging the overlap between my clinical and research skills has greatly enhanced my confidence in my research abilities and will enable me to adapt to both clinical and research roles in the future as a qualified clinical psychologist.

### 3.2.4 A new learning experience

Throughout the analysis process I felt that I was learning as I went along and continuously asked the question: *"Am I doing this right? Am I capturing what is important for parents?"*. I became aware of the struggle of holding both the individual and the collective experience in mind, which seemed to exacerbate the pressure I felt to represent parents' experiences. Similarly, the process of developing final superordinate themes was challenging as I felt a pressure to include all emerging themes from parents' narratives. To manage this, I noticed frequently referring to Smith et al.'s (2009) IPA book to ensure that I was following the guidelines and capturing the heart of parents' experiences while holding my own assumptions and biases in mind.

This process, alongside regular supervision, enabled me to become more comfortable in the researcher position which facilitated my understanding and interpretation of parents' experiences. Further, acknowledging that I am a novice with regards to IPA enabled me to accept the challenging nature of the process and enabled me to be self-compassionate and less self-critical. For example, an entry from my reflective diary read, "*I don't have to be a perfect IPA researcher, there is a process of learning and this is part of becoming a clinical psychologist*".

### **3.3 Redefining my research narrative**

Completing this research has enabled me to redefine my research narrative through a process of continual self-reflection.

#### **3.3.1 Developing a new narrative**

My understanding of qualitative analysis, particularly IPA, has developed and my confidence as a researcher has significantly increased through the research process. I have learnt to trust my own abilities, drawing on my previous experiences from both clinical and research capacities. In doing so, I have been able to challenge the self-critical thoughts about my research and academic ability, re-defining my research identity in the process. I have developed a strengths-focused, alternative research narrative that centres around the skills I have developed as a qualitative researcher. I feel more confident in my ability to conduct interviews as well as qualitative analysis for both systematic reviews and empirical research. While I have previously considered my strengths to lie predominantly within my clinical skills, I have come to view myself as both a clinician and a researcher. As a result of my experiences, I will seek out opportunities and approach research with more enthusiasm and confidence in myself and my abilities. Additionally, I feel more able to manage the challenges that may arise during research, drawing on my enhanced self-compassion, self-care and strengths-based research narrative.

Further, through this research, I have developed a deeper insight into parents' and adolescents' experiences of CAMHSIUs that will influence my future work.

For example, understanding the experiences of loss and separation that parents' and adolescents' experienced following admission. This learning will be valuable in my future clinical practice, enabling me to hold in mind the perspectives and experiences of the whole family, which is not only relevant to working in CAMHS but in a variety of clinical settings.

### 3.3.2.2 My ToL following completion of this research

Following my completion of the research, I recognised that I have begun to develop an alternative narrative, through the use of the ToL (Ncube-Mlilo, & Denborough, 2007), around my research and academic abilities. I reflected on my learning and adapted my ToL, as seen in figure 3.2 with additions to my skills and hopes.

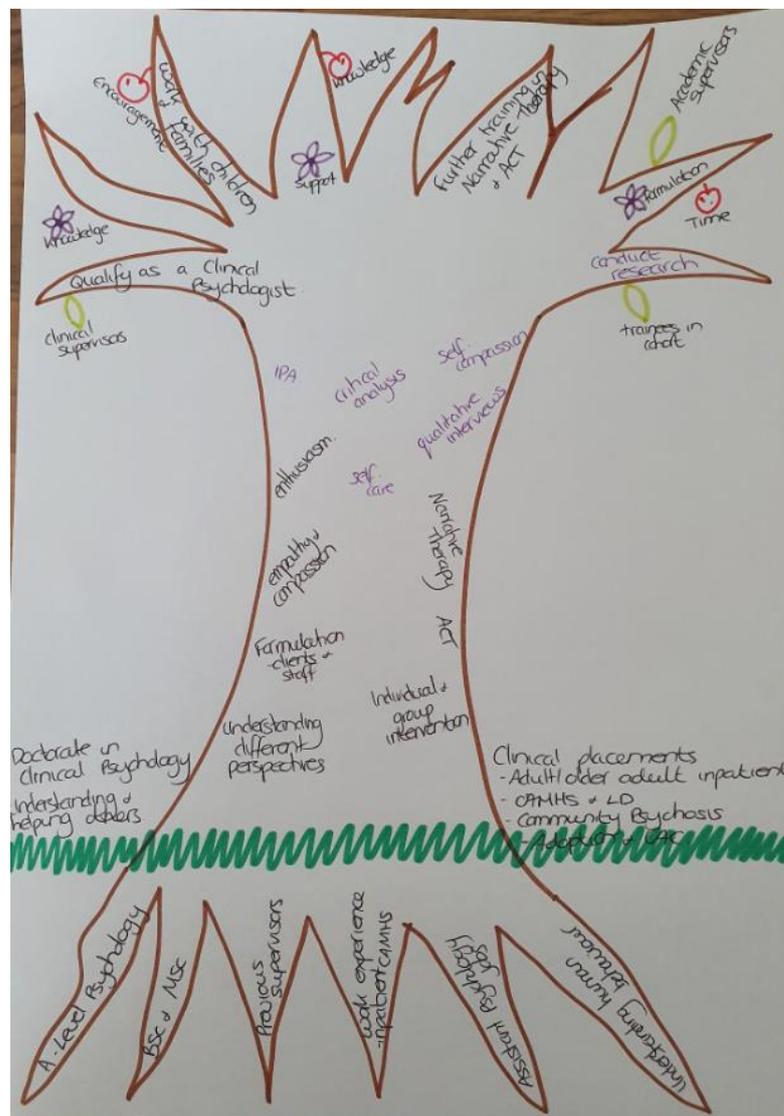


Figure 3.2: My professional ToL following this research

Considering my new ToL, I acknowledged that engaging in the research process led to an increased confidence in my ability to conduct qualitative research and critical analysis. Additionally, my self-care and self-compassion have been strengthened through my research experiences. While these skills are still developing, I noticed the contrast between my views of research now, in comparison to my research narrative prior to conducting the research (Figure 3.1). This has led to an increased understanding of the continuous process of development that will continue throughout my career as a qualified clinical psychologist in both clinical and research capacities. Further, I have identified a new hope for my future career in terms of conducting research. Throughout the research process, I have recognised a significant shift in my research narrative and in turn, my research identity, which I feel has been developed and strengthened. This has also enhanced my professional development as a 'reflective scientist-practitioner' and I will feel more confident in using these skills in both a clinical and research capacity in the future as a clinical psychologist.

### **3.4 Conclusion**

Conducting and reflecting on the research process has been an invaluable learning curve for me. Prior to commencing this research, I identified a range of self-critical thoughts and problem-saturated narratives around my research and academic abilities. Engaging with the research and ensuring continuous reflection throughout has enabled me to develop an alternative narrative around my research and academic ability, acknowledging the new skills I have developed along the way. The skills I have developed during the past three years of training, alongside my research skills have highlighted the importance and value of conducting research that I hope to take forward in my future career as a Clinical Psychologist.

### **3.5 References**

- Baum, S. & Shaw, S. (2015). The tree of life methodology used as a group intervention for people with learning disabilities. *The Bulletin of the Faculty for People with Intellectual Disabilities*, 13(1), 14-19.
- Bell, J. (2010). *Doing your research project: A guide for first-time researchers* (Eds.). Berkshire, England: Open University Press.
- Binnie, C. & Cayzer, M. (2017). The Race of Life: Adapting the 'Tree of Life' methodology with a man with learning and physical disabilities. *The Bulletin of the Faculty for People with Intellectual Disabilities*, 15(3), 40-44.
- Binks, C., Jones, F. W. & Knight, K. (2013). Facilitating reflective practice groups in clinical psychology training: a phenomenological study. *Reflective Practice*, 14(3), 305-318. DOI: 10.1080/14623943.2013.767228
- British Psychological Society (BPS). (2008). *Criteria for the accreditation of postgraduate training programmes in clinical psychology*. Leicester: British Psychological Society.
- British Psychological Society. (2019). *Standards for the accreditation of Doctoral programs in clinical psychology*. Leicester: British Psychological Society.
- D'Cruz, H., Gillingham, P., & Melendez, S. (2007). Reflexivity, its meanings and relevance for social work: A critical review of the literature. *The British Journal of Social Work*, 37(1), 73-90. doi:10.1093/bjsw/bcl001
- Denborough, D. (2008). The tree of life: a collective narrative approach to working with vulnerable children. In *Collective Narrative Practice, responding to individuals' groups and committed who have experience trauma*. Adelaide: Dulwich centre publications.
- German, M. (2013). Developing our cultural strengths: Using the 'Tree of Life' strength-based, narrative therapy intervention in schools, to enhance self-esteem, cultural understanding and to challenging racism. *Educational and Child Psychology*, 30(4), 75–98.
- Gibbs, G (1988) *Learning by doing: a guide to teaching and learning methods*. Oxford: Further Education Unit, Oxford Polytechnic

- Hughes, G. (2014). Finding a voice through 'The Tree of Life': A strength-based approach to mental health for refugee children and families in schools. *Clinical Child Psychology and Psychiatry*, 19(1), 139–153. doi:10.1177/1359104513476719
- James, I. A., Blackburn, I. M. & Reichelt, F. K. (2001). *Manual of the Revised Cognitive Therapy Scale (CTS-R)*. Retrieved from: <https://www.getselfhelp.co.uk/docs/CTSRmanual.pdf>
- Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39-43.
- Kis-Sines, K. & Pluznick, R. (2018). Tree of Life: Questions about professional identity for child and youth workers. *The Dulwich Centre*. Retrieved from: <https://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-professional-identity.pdf>
- Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In Thompson, A. & Harper, D. (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 99-116). Oxford, England: John Wiley & Sons. doi:10.1002/9781119973249
- Lemma, A. (2016) *Introduction to the Practice of Psychoanalytic Psychotherapy*. 2<sup>nd</sup> ed. Wiley-Blackwell
- Lock, S. (2016). The Tree of Life: A review of the collective narrative approach. *Educational Psychology Research and Practice*, 2(1), 2-20.
- Morgan, A. (2000). *What is Narrative Therapy? An easy-to-read introduction*. Adelaide: Dulwich centre publications.
- Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. *International Journal of Narrative Therapy and Community Work*, 1, 3–16.
- Ncube-Mlilo, N. & Denborough, D. (2007). *The Tree of Life: The Mainstreaming Psychosocial Care and Support: A Manual for Facilitators*. Johannesburg: Regional Psychosocial Support Initiative (REPSSI).
- Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice*, 31(6), 710. doi: 10.1037/0735-7028.31.6.710

- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method and Research*. London: Sage
- White, C. & Denborough, D. (1998). *Introducing narrative therapy*. Adelaide: Dulwich Centre Publications
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W. W. Norton & Company.

## **Appendices**

### **Appendix A: Child and Adolescent Mental Health Journal Author Guidelines**

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice; Narrative Matters.

**Review Articles:** These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: [\*\*http://mc.manuscriptcentral.com/camh\\_journal\*\*](http://mc.manuscriptcentral.com/camh_journal) and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from the Editorial Office at ACAMH (email: [\*\*publications@acamh.org\*\*](mailto:publications@acamh.org))

4. Authors' professional and ethical responsibilities

*Disclosure of interest form*

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

### *Ethics*

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the **Ethical principles of psychologists and code of conduct** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

### *Informed consent and ethics approval*

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

### *Recommended guidelines and standards*

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis.

### *CrossCheck*

An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your

manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

*Key Practitioner Message:* Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

*Keywords:* Please provide 4-6 keywords

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have

their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

*Contributorships:* Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

*Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of

interest".

10. For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

### **Review Articles**

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain

high standards of scientific practice by conforming to systematic guidelines as set out in the **PRISMA statement**. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

**Appendix B: Coventry University ethics approval for conducting  
Systematic Review**



**Certificate of Ethical Approval**

Applicant:

Jacqui Truter

Project Title:

Adolescents' experiences of child and adolescent mental health units: a systematic  
review of the literature

This is to certify that the above named applicant has completed the Coventry  
University Ethical Approval process and their project has been confirmed and  
approved as Low Risk

Date of approval:

05 December 2017

Project Reference Number:

P62402

## Appendix C: Adapted Quality Appraisal Framework

Example quality assessment framework, adapted from Caldwell et al., (2010) and Pluye et al., (2011).

Quality criteria For all studies	Yes or N/A	Partially	No	Can't tell
1. Does the title reflect the content?				
2. Are the authors credible?				
3. Does the abstract summarise the key components?				
4. Is the rationale for undertaking the research clearly outlined?				
5. Is the literature review comprehensive and up to date?				
6. Is the aim of the research clearly stated?				
7. Are the ethical issues identified and addressed?				
8. Is the methodology identified and justified?				
9. Are the results presented in a way that is appropriate and clear?				
10. Is the discussion comprehensive?				
11. Is the conclusion comprehensive?				
QUALITATIVE studies	Yes or N/A	Partially	No	Can't tell
12. Is the philosophical background and the study design clearly identified? Is the rationale for choice of design clear evident?				
13. Are the major concepts identified?				
14. Is the context of the study outlined?				
15. Is the selection of the participants described and the sampling method identified?				
16. Is the method of data collection auditable and relevant to address the research question?				
17. Is the method of data analysis credible, confirmable and relevant to address the research question?				
18. Is appropriate consideration given to how the findings relate to the researcher's influence?				
19. Are the results transferable?				

Raw score and Percentage:	
---------------------------	--

Scoring:

Yes = 2

Partially= 1

No = 0

Can't tell= 0

N/A is not included within the final possible total.

### Lead researcher's and independent researcher's quality assessment ratings for included studies

	Biering et al. 2011		Gill et al. 2016		Haynes et al. 2011		Mitten et al. 2016		Moses 2011		Reavey et al. 2017		Salamone-Violi et al. 2015		Tierney 2008		Van Ommen et al. 2009	
<b>Rater</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>
<b>Criteria</b>																		
1. Does the title reflect the content?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
2. Are the authors credible?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
3. Does the abstract summarize the key components?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
4. Is the rationale for undertaking the research clearly outlined?	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	2	2	2
5. Is the literature review comprehensive and up-to-date?	1	1	1	1	2	2	2	2	2	2	2	2	2	1	1	1	1	1
6. Is the aim of the research clearly stated?	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2

7. Are all ethical issues identified and addressed?	2	2	2	1	2	1	1	1	1	1	1	1	2	2	1	1	1	1
8. Is the methodology identified and justified?	1	1	2	2	2	2	1	2	1	1	2	2	2	2	1	2	1	1
9. Are the results presented in a way that is appropriate and clear?	2	2	2	2	2	2	1	1	2	2	1	1	1	2	2	2	2	2
10. Is the discussion comprehensive?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	1	2
11. Is the conclusion comprehensive?	1	1	2	2	2	2	2	2	2	2	1	0	2	2	1	1	1	1
12. Are the philosophical background and study design identified and the rationale for choice evident?	1	1	1	1	1	1	1	1	0	0	2	2	1	1	1	1	1	1
13. Are the major concepts identified?	2	2	2	2	2	2	2	2	2	2	1	1	2	2	1	1	1	1
14. Is the context of the study outlined?	2	2	2	2	2	2	2	2	2	2	2	2	1	1	2	2	2	2
15. Is the selection of participants described and	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2

sampling method identified?																		
16. Is the method of data collection auditable and relevant to address the research question?	<b>2</b>	2	<b>1</b>	1	<b>1</b>	1												
17. Is the method of data analysis credible, confirmable and relevant to address the research question?	<b>1</b>	1	<b>2</b>	2	<b>1</b>	1	<b>1</b>	1										
18. Is appropriate consideration given to how the findings relate to the researcher's influence?	<b>0</b>	0																
19. Are the results transferable?	<b>2</b>	2	<b>2</b>	1	<b>1</b>	1	<b>1</b>	1	<b>1</b>	1	<b>2</b>	2	<b>2</b>	2	<b>1</b>	1	<b>1</b>	1
<b>Total</b>	<b>31</b>	31	<b>34</b>	32	<b>33</b>	32	<b>30</b>	32	<b>31</b>	31	<b>32</b>	31	<b>33</b>	32	<b>25</b>	26	<b>26</b>	27
<b>Percentage</b>	<b>82</b>	82	<b>89</b>	84	<b>87</b>	84	<b>79</b>	84	<b>82</b>	82	<b>84</b>	82	<b>87</b>	84	<b>66</b>	68	<b>68</b>	71

**Appendix D: Inter-Rater Reliability Coefficient (Kappa) Outputs for All Papers Reviewed**

	<b>Value</b>	<b>Significance (p value)</b>
<b>Overall Kappa</b>	.902	.000
<b>Biering et al., 2011</b>	1.000	.000
<b>Gill et al., 2016</b>	.703	.000
<b>Haynes et al., 2011</b>	.862	.000
<b>Mitten et al., 2016</b>	.891	.000
<b>Moses, 2011</b>	1.00	.000
<b>Reavey et al., 2017</b>	.874	.000
<b>Salamone-Violi et al., 2015</b>	.833	.000
<b>Tierney, 2008</b>	.902	.000
<b>van Ommen et al., 2009</b>	.904	.000

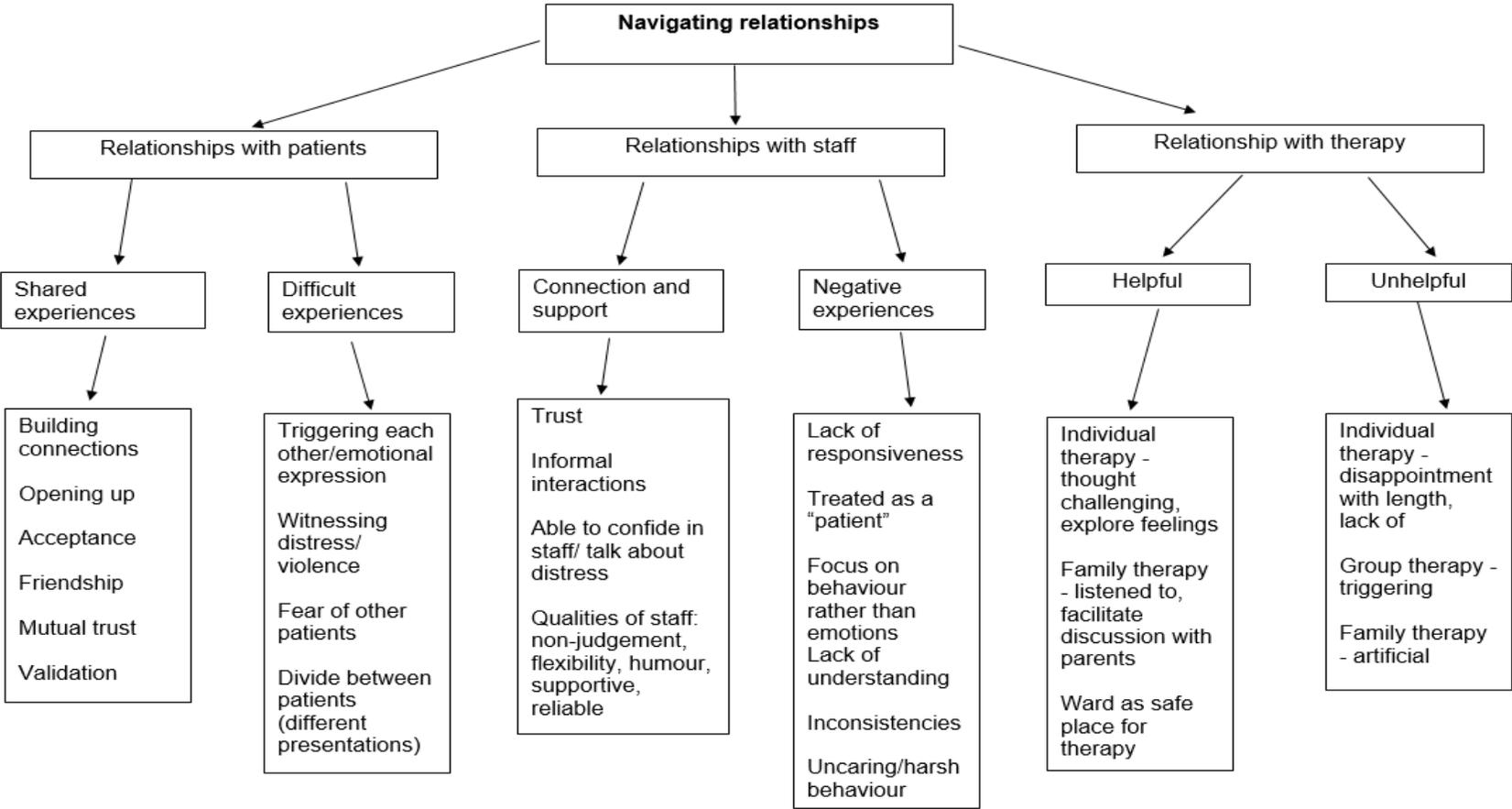
## Appendix E: Meta-ethnographic method

Stages of meta-ethnography based on Noblit and Hare (1988)

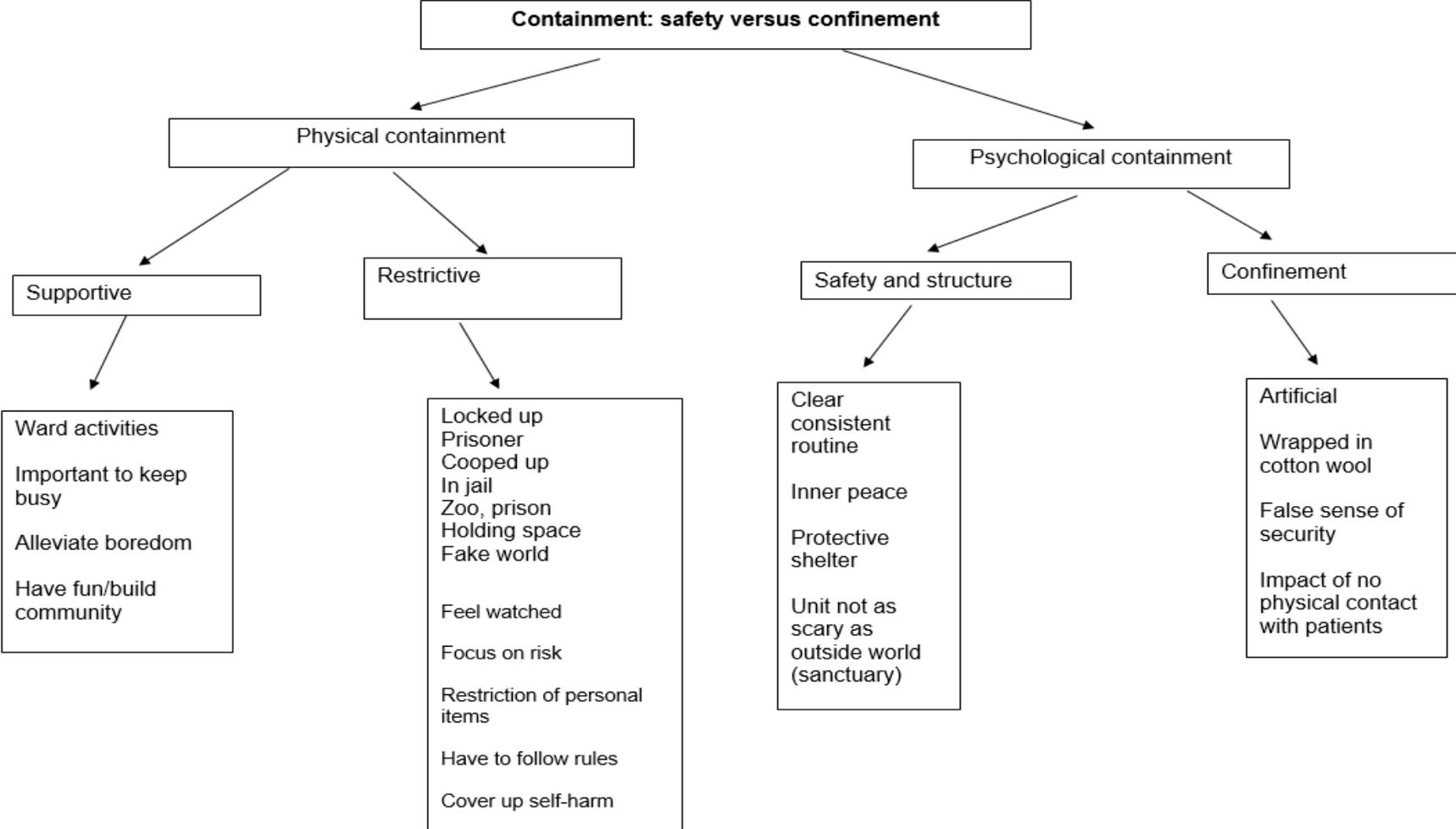
<b>Stage</b>	<b>Description</b>
<b>1: Getting started</b>	The researcher identified an area of interest relevant to qualitative research.
<b>2: Describing what is relevant</b>	The researcher searched for all literature relevant to the topic of interest, which were then refined in line with exclusion and inclusion criteria.
<b>3: Reading the studies</b>	The researcher read through each article, noting metaphors and concepts.
<b>4: Determining how the studies are related</b>	A list of metaphors and concepts were created for each study to identify relations between each article.
<b>5: Translating the studies into one another</b>	The researcher then compared metaphors or concepts from each article, translating the metaphors or concepts from one article into the next until all 11 articles were synthesised.
<b>6: Synthesising translations</b>	These translations were then compared to identify similarities and differences between concepts. The researcher explored how concepts related to each other in an interpretive order.
<b>7: Expressing the synthesis</b>	The synthesis was then drawn together in written form in language appropriate for the intended audience.

**Appendix F: Thematic maps detailing three meta-themes along with their main themes, subthemes and corresponding comments.**

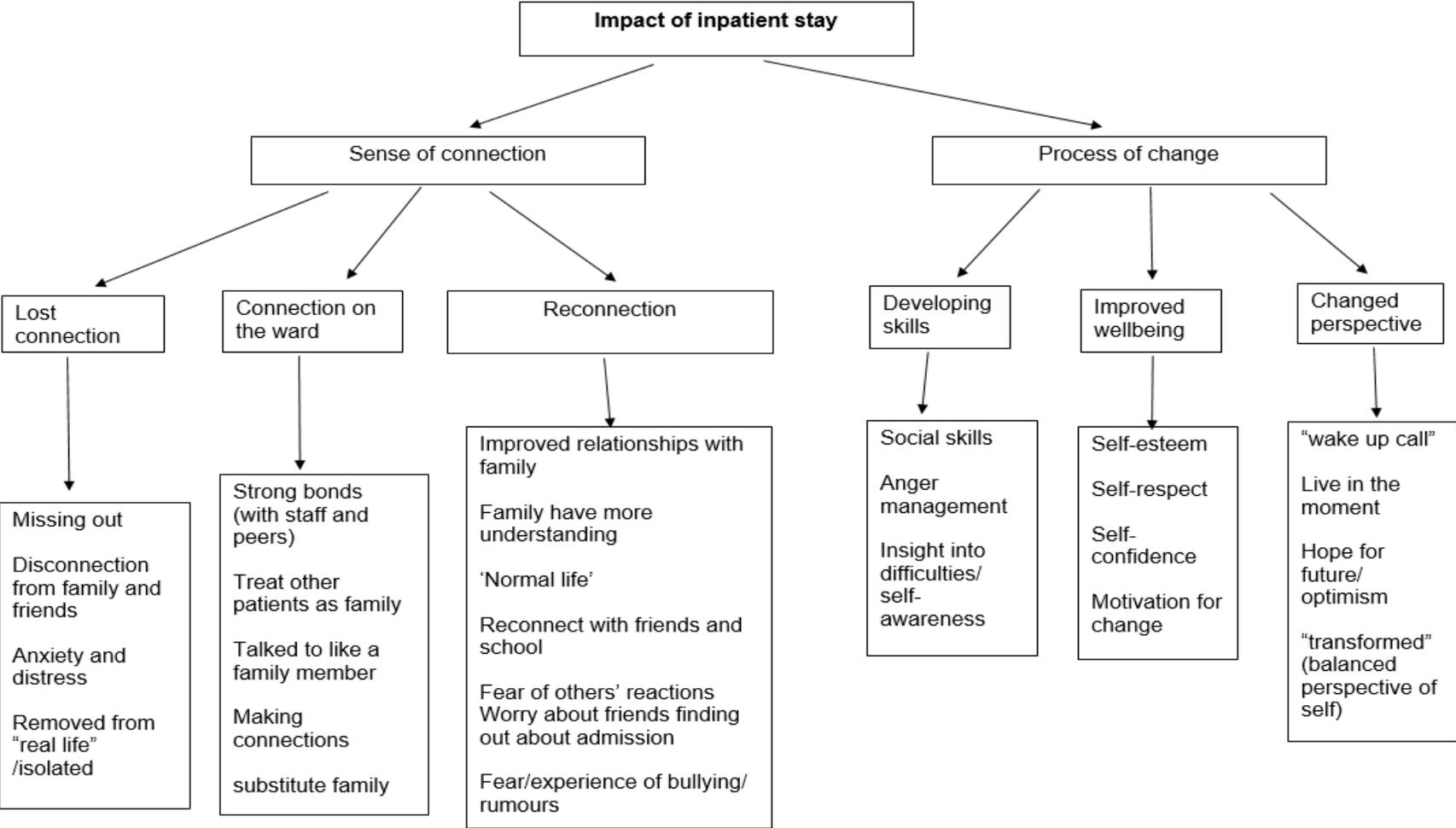
Theme one:



Theme two:



Theme three:



### Appendix G: Meta-themes, main themes and subthemes illustrating articles contributions

Meta theme	Navigating relationships						Containment				Impact of inpatient stay					
Main theme	Relationships with patients		Relationships with staff		Relationship with therapy		Physical		Psychological		Sense of connection			Process of change		
Sub-theme	Shared experiences	Difficult experiences	Connection and support	Negative experiences	Helpful	Unhelpful	Supportive	Restrictive	Safety and structure	Enforced confinement	Lost connection	Connection on ward	Reconnection	Developing skills	Improved wellbeing	Changed perspective
Biering et al., 2011	✓		✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Gill et al., 2016	✓	✓	✓				✓	✓	✓	✓		✓	✓	✓	✓	✓
Haynes et al., 2011	✓	✓	✓				✓			✓	✓	✓	✓		✓	✓
Mitten et al., 2016		✓	✓	✓									✓			
Moses, 2011	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Reavey et al., 2017	✓		✓	✓		✓		✓	✓		✓	✓		✓		
Salamone-Violi et al., 2015	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓			✓	
Tierney, 2008	✓		✓	✓	✓	✓					✓				✓	✓
van Ommen et al., 2009	✓		✓	✓			✓								✓	

## **Appendix H: Author guidelines for the British Journal of Psychology**

### **1. SUBMISSION**

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

#### **Data protection:**

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed.

### **2. AIMS AND SCOPE**

The *British Journal of Psychology* publishes original research on all aspects of general psychology including cognition; health and clinical psychology; developmental, social and occupational psychology.

We attract a large number of international submissions each year which make major contributions across the range of psychology, particularly where the work has the following characteristics:

- articles or groups of articles dealing with topics which are of interest to researchers from more than one specialism;
- sections of psychology or which address topics or issues at the interface between different specialisms or sections of psychology;
- articles or groups of articles which take different or contrasting methodological or theoretical approaches to a single topic;
- articles or groups of articles dealing with novel areas, theories or methodologies;
- integrative reviews, particularly where the review offers new analysis (e.g. meta-analysis), new theory or new implications for practice;
- articles or groups of articles dealing with the history of psychology;
- interdisciplinary work, where the contribution from, or to, psychological theory or practice is clear.

It enjoys a wide international readership and features reports of empirical studies, critical reviews of the literature and theoretical contributions which aim to further our understanding of psychology.

The journal additionally publishes a small number of invited articles by people who lead their field on a topic that provokes discussion. These articles include a short peer commentary.

### 3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- All papers should be no more than 8000 words (excluding the abstract, reference list, tables and figures). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.
- Please refer to the separate guidelines for [Registered Reports](#).
- All systematic reviews must be pre-registered.

### 4. PREPARING THE SUBMISSION

Contributions must be typed in double spacing. All sheets must be numbered.

#### Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

#### Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

#### Title Page

You may like to use **this template** for your title page. The title page should contain:

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's [best practice SEO tips](#));
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Acknowledgments.

#### Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that

each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

### **Abstract**

Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

### **Keywords**

Please provide appropriate keywords.

### **Acknowledgments**

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

### **Main Text File**

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

### **References**

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume

begins with page 1, and a DOI should be provided for all references where available.

### **Tables**

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and \*, \*\*, \*\*\* should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

### **Figures**

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

**Colour figures.** Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

### **Supporting Information**

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

### **General Style Points**

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

### Wiley Author Resources

**Manuscript Preparation Tips:** Wiley has a range of resources for authors preparing manuscripts for submission available [here](#). In particular, we encourage authors to consult Wiley's best practice tips on **Writing for Search Engine Optimization**.

**Editing, Translation, and Formatting Support: Wiley Editing Services** can greatly improve the chances of a manuscript being accepted. Offering expert help in English language editing, translation, manuscript formatting, and figure preparation, Wiley Editing Services ensures that the manuscript is ready for submission.

## 5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

### Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. The **qualitative guidelines** explain how the quality of research papers using qualitative methods will be judged. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

We aim to provide authors with a first decision within 90 days of submission. Further information about the process of peer review and production can be found in **'What happens to my paper?'** Appeals are handled according to the **procedure recommended by COPE**. Wiley's policy on the confidentiality of the review process is [available here](#).

### Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)

- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

### **Conflict of Interest**

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

### **Funding**

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: <https://www.crossref.org/services/funder-registry/>

### **Authorship**

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

*“Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline.” (p.18)*

### **Data Sharing and Data Accessibility**

The *British Journal of Psychology* recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open

access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, please access the **FAQs** for additional detail.

### **Publication Ethics**

This journal is a member of the **Committee on Publication Ethics (COPE)**. Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

## **6. AUTHOR LICENSING**

If a paper is accepted for publication, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons License.

General information regarding licensing and copyright is available [here](#). To review the Creative Commons License options offered under OnlineOpen, please [click here](#). (Note that certain funders mandate a particular type of CC license be used; to check this please click [here](#).)

**Self-Archiving Definitions and Policies:** Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please click [here](#) for more detailed information about self-archiving definitions and policies.

**Open Access fees:** Authors who choose to publish using OnlineOpen will be charged a fee. A list of Article Publication Charges for Wiley journals is available [here](#).

**Funder Open Access:** Please click [here](#) for more information on Wiley's compliance with specific Funder Open Access Policies.

## 7. PUBLICATION PROCESS AFTER ACCEPTANCE

### Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

### Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

### Publication Charges

**Colour figures.** Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures, they will be sent a Colour Work Agreement once the accepted paper moves to the production process. If the Colour Work Agreement is not returned by the specified date, figures will be converted to black and white for print publication.

### Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with **Wiley Author Services**). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

## 8. POST PUBLICATION

### Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

### Promoting the Article

To find out how to best promote an article, click [here](#).

### Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

## 9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Vicki Pang, Senior Editorial Assistant (██████████) or phone ██████████.

*Author Guidelines updated 10<sup>th</sup> April 2019*

## Appendix I: Participant information sheet



### Participant information sheet

#### ***Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit***

This research aims to explore parents' or primary caregivers' experiences following their child's admission to a child and adolescent mental health services (CAMHS) inpatient unit. You have received this information sheet because your child has been admitted to a CAMHS inpatient unit.

#### **What does the study involve?**

Your participation would involve a one-to-one interview with the lead researcher lasting up to 120 minutes. The interview will take place at an NHS site, or a venue where you feel most comfortable. If the interview takes place in your own home, it will be important to make sure you are able to talk openly without being disturbed by family members. You have the right to leave the interview at any time without giving a reason.

At the beginning of the interview, you will be asked to provide some basic demographic information about yourself and your child. This information will be kept anonymously and used to provide an overview of who has taken part in the study, for example whether participants have been fathers, mothers, adoptive parents, how many admissions the children have had and how many other children there are in the family.

The interview will then invite you to share your experiences of the process of your child's admission to the CAMHS inpatient unit. At the end of the interview you will be given a debrief information sheet and an opportunity to ask any questions.

You will receive a summary of the main findings from the study and an opportunity to give feedback to make sure the findings are grounded in your experiences. You can indicate on the consent form whether you would like to receive this summary.

**What are the benefits of taking part?**

It is hoped that your participation in this study will help to make recommendations of how to support parents or primary caregivers whose children have been admitted to CAMHS units. It is hoped that this research will be presented at conferences and published in a scientific journal for health professionals.

**What are the risks associated with this project?**

Talking about your experiences of your child's admission can bring up a number of emotions and memories. *If you are feeling upset or concerned following your participation, a list of support services and their contact details are included at the end of this document.*

**Do I have to take part?**

No, it is entirely up to you. If you do decide to take part, please keep this Information Sheet and we will complete an Informed Consent Form at the beginning of the interview to show that you understand your rights in relation to the research, and that you are happy to participate. You are free to withdraw your information from the project data set at any time until the data are destroyed on the 30<sup>th</sup> June 2023. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (contact details are provided below). You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you, or your child, in any way.

**Who has reviewed this study?**

This study forms part of the lead researcher's doctoral thesis from the Universities of Coventry and Warwick. Ethical approval has been granted by Coventry University Ethics Committee. This study has also been reviewed by the Black Country Research Ethics Committee.

**Data protection and confidentiality**

Your data will be processed in accordance with the Data Protection Act 1998 (up until 24th May 2018) and the General Data Protection Regulation 2016 (GDPR) thereafter. All information collected about you will be kept strictly confidential. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Pseudonyms will be given to each participant during transcription. Your data will only be viewed by the researcher and the research team. All electronic data will be stored on an encrypted drive on a password-protected computer. All paper records will be stored in a locked filing cabinet in the academic supervisors' office at Coventry University. Your consent information will be kept separately from your responses in order to

minimise risk in the event of a data breach. Coventry University will take responsibility for data destruction and all collected data will be destroyed on or before the 30<sup>th</sup> June 2023.

Only the researcher, supervisors, university examiners and in rare cases research auditors will have access to the data from this study.

In circumstances where the researcher feels that information shared poses a risk to yourself or to others, they will be obliged to share this information with their research team and the lead clinician on the ward.

### **Data Protection Rights**

Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the Data Protection Act 1998 (up until 24th May 2018) and the General Data Protection Regulation 2016 (GDPR) thereafter. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit [www.ico.org.uk](http://www.ico.org.uk). Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - [enquiry.ipu@coventry.ac.uk](mailto:enquiry.ipu@coventry.ac.uk)

### **What if there is a problem?**

If you have any concerns or complaints please speak to the research team in the first instance. If you require further assistance or if there are any problems not resolved by the research team, please contact:

*Name:* Professor Olivier Sparangano

*Address:* University Applied Research Committee, Coventry University, Priory Street, Coventry, CV1 5FB

*Email:* [iras-sponsor@coventry.ac.uk](mailto:iras-sponsor@coventry.ac.uk)

Additionally, you may contact the Patient Advice and Liaisons Service for general queries and complaints.

\*the appropriate details were sent for each trust\*

### **Who can I contact for further information?**

The research team can be contacted on the details provided below if you have any further questions

## Research team

Jacqui Trüter  
Lead Researcher  
Trainee Clinical Psychologist

Dr Magda Marczak  
Research Supervisor  
Lecturer in Clinical Psychology

Jo Kucharska  
Research Supervisor  
Clinical Director

Dr Felicity Gilbey  
Clinical Supervisor  
Northamptonshire Healthcare NHS Foundation Trust

## Contact Details of Support Services

Your local CAMHS service

### **Counselling support from Mind**

\*the appropriate details were sent for each NHS trust\*

### **Young Minds – *help for parents and parent’s survival guide***

Parents Helpline: 0808 802 5544

Web: <https://youngminds.org.uk/>

Web: <https://youngminds.org.uk/find-help/for-parents/parents-survival-guide/#looking-after-yourself>

### **Family Lives – *national family support charity***

Parent helpline: 0808 800 2222

Web: <https://www.familylives.org.uk/>

### **The Project – support for parents**

Tel: 01404 549045

Email: [info@theprojectyp.org.uk](mailto:info@theprojectyp.org.uk)

Web: <http://theprojectyp.org.uk/support-groups/for-parents/>

**National Alliance on Mental Illness – *taking care of yourself***

Web: <https://www.nami.org/Find-Support/Family-Members-and-Caregivers/Taking-Care-of-Yourself>

***General Advice and Support***

**Mind – the mental health charity**

Phone: 0300 123 3393

Email: [infor@mind.org.uk](mailto:infor@mind.org.uk)

Web: <https://www.mind.org.uk/>

**Anxiety UK**

Phone: 08444 775 774

Email: [support@anxietyuk.org.uk](mailto:support@anxietyuk.org.uk)

Web: <https://www.anxietyuk.org.uk/>

**Appendix J: Coventry University ethics approval for Chapter Two  
Empirical Paper**



**Certificate of Ethical Approval**

Applicant:

Jacqui Truter

Project Title:

Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as High Risk

Date of approval:

20 March 2018

Project Reference Number:

P62419

## Appendix K: Health Research Authority ethical approval



Mrs Jacqui Truter  
Clinical Psychology Doctorate, School of Psychological,  
Social and Behavioural Sciences  
Clinical Psychology Doctorate, School of Psychological,  
Social and Behavioural Sciences  
Priory Street, Coventry  
CV1 5FB

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)  
[Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

06 June 2018

Dear Mrs Truter

**HRA and Health and Care  
Research Wales (HCRW)  
Approval Letter**

<b>Study title:</b>	Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit.
<b>IRAS project ID:</b>	239288
<b>Protocol number:</b>	n/a
<b>REC reference:</b>	18/WM/0130
<b>Sponsor</b>	Coventry University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**  
You should now provide a copy of this letter to all participating NHS organisations in England and Wales\*, as well as any documentation that has been updated as a result of the assessment.

\*In flight studies' which have already started an SSI (Site Specific Information) application for NHS organisations in Wales will continue to use this route. Until 10 June 2018, applications on either documentation will be accepted in Wales, but after this date all local information packs should be shared with NHS organisations in Wales using the Statement of Activities/Schedule of Events for non-commercial studies and template agreement/ Industry costing template for commercial studies.

Following the arranging of capacity and capability, participating NHS organisations should formally confirm their capacity and capability to undertake the study. How this will be confirmed is detailed in the "summary of assessment" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

#### **How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

#### **How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

#### **What are my notification responsibilities during the study?**

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

#### **I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

IRAS project ID	239288
-----------------	--------

Name: Prof Olivier Sparagano  
Email: iras-sponsor@coventry.ac.uk

**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 239288. Please quote this on all correspondence.

Yours sincerely

Andrea Bell  
Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

## List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Recruitment poster]	2	30 May 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		26 March 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity]		26 March 2018
HRA Schedule of Events [IRAS 239288_SoE]	1	01 May 2018
HRA Statement of Activities [IRAS 239288_SoA]	1.0	01 May 2018
Interview schedules or topic guides for participants [Interview Schedule]	2	30 May 2018
IRAS Application Form [IRAS_Form_26042018]		26 April 2018
IRAS Application Form XML file [IRAS_Form_26042018]		26 April 2018
Letter from sponsor [Sponsor letter]		26 March 2018
Other [Gatekeeper letter]	1	17 April 2018
Other [Debrief information sheet]	1	17 April 2018
Other [Demographic info]	1	17 April 2018
Other [CU ethics approval]	1	26 March 2018
Other [R&D Email]	1	26 March 2018
Other [R&D Email]	1	26 March 2018
Other [R&D Email]		26 March 2018
Other [Academic Supervisor CV]		30 March 2018
Other [Debrief information sheet]	2	30 May 2018
Participant consent form [Consent form]	2	30 May 2018
Participant information sheet (PIS) [PIS]	3	30 May 2018
Research protocol or project proposal [Study Protocol]	2	30 May 2018
Response to Request for Further Information		04 June 2018
Summary CV for Chief Investigator (CI) [JTruter CV]		30 March 2018
Summary CV for supervisor (student research) [MM CV]		30 March 2018

### Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

### Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The HRA Statement of Activities will act as the agreement for NHS organisations to participate in the study.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding will be made. There is no funding available for the participating organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	received for applicable studies		
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England and Wales

<p><i>This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.</i></p> <p>There is one site type. All organisations will undertake the activities as detailed in the IRAS application and protocol.</p> <p>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.</p> <p>If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at <a href="mailto:hra.approval@nhs.net">hra.approval@nhs.net</a> or HCRW at <a href="mailto:Research-permissions@wales.nhs.uk">Research-permissions@wales.nhs.uk</a>. We will work with these organisations to achieve a consistent approach to information provision.</p>
--

### Principal Investigator Suitability

<p><i>This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).</i></p> <p>A Local Collaborator (LC) is required for this type of study. A LC has been identified at each of the participating NHS sites.</p> <p>GCP training is <u>not</u> a generic training expectation, in line with the <a href="#">HRA/HCRW/MHRA statement on training expectations</a>.</p>
---

IRAS project ID	239288
-----------------	--------

### HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

### Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

## Appendix L: Consent form



### **Consent form**

Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit

		Initials
1	I confirm that I have read and understood the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and I have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Faculty Research Support Office at any time until the date specified in the Participant Information Sheet.	
3	I understand that I can withdraw from this interview at any point without needing to give a reason and this will not affect my child's treatment.	
4	I understand that all the information I provide will be held securely and treated confidentially as stated in the Participant Information Sheet.	
5	I understand that I can contact the researchers at any point if I would like more information about the study, if anything is not clear or I were experiencing distress following my participation and would like advice or support.	
6	I understand that my comments will be pseudonymised and that neither my child nor myself can be identified from the information I have provided.	
7	I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs.	
8	I would like the researcher to send me a summary of the main findings from the interviews and to contact me to discuss whether the findings are grounded in my experiences.	
9	I consent for the collection of my child's demographic information (age, gender)	
10	I am happy for the interview to be audio recorded	
11	I agree to take part in the research project	

Name of participant: .....

Signature of participant: .....

Date: .....

Name of Researcher:.....

Signature of researcher: .....

Date:.....

\* If you would like a copy of your consent form, please provide an email or postal address where this can be sent:

.....  
.....

\*if you would like to receive a summary of the main findings of the study, please indicate below how you would like the researcher to contact you, along with contact details.

(please tick)

Email

address:

.....

OR

Phone (please tick)

Phone

number:

.....

## Research team

Jacqui Trüter  
Lead Researcher  
Trainee Clinical Psychologist

Dr Magda Marczak  
Research Supervisor  
Lecturer in Clinical Psychology

Jo Kucharska  
Research Supervisor  
Clinical Director

Dr Felicity Gilbey  
Clinical Supervisor  
Northamptonshire Healthcare NHS Foundation Trust

## Appendix M: Debrief information sheet



### Debrief Information Sheet

Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit

Thank you for taking the time to share your experiences of your child's admission to a CAMHS inpatient unit.

This research hopes to improve our understanding of the unique experiences of parents or primary caregivers of children who have been admitted to CAMHS inpatient units. The findings of this research project will be used to make recommendations about how to support parents or primary caregivers whose children have been admitted to CAMHS inpatient units.

Talking about your experiences of your child's admission to a mental health unit can be difficult and may bring up a number of different emotions and memories. If you are feeling upset or concerned following your participation in this research, please see the list of support services and their contact details that are provided at the end of this document.

I would like to remind you that you have the right to withdraw your information from this research without giving a reason at any time until the date specified in the Participant Information Sheet. Withdrawing from this study will not affect you or your child's treatment in any way.

Do you have any questions or concerns you would like to raise now?  
Thank you for your participation

### Research team

Jacqui Trüter  
Lead Researcher  
Trainee Clinical Psychologist  
[REDACTED]

Dr Magda Marczak  
Research Supervisor  
Lecturer in Clinical Psychology

Jo Kucharska  
Research Supervisor  
Clinical Director

Dr Felicity Gilbey  
Clinical Supervisor  
Northamptonshire Healthcare NHS Foundation Trust

### **Contact Details of Support Services**

Your local CAMHS service

#### **Counselling support from Mind**

\*the appropriate details were sent for each NHS trust\*

#### **Young Minds – *help for parents and parent's survival guide***

Parents Helpline: 0808 802 5544

Web: <https://youngminds.org.uk/>

Web: <https://youngminds.org.uk/find-help/for-parents/parents-survival-guide/#looking-after-yourself>

#### **Family Lives – *national family support charity***

Parent helpline: 0808 800 2222

Web: <https://www.familylives.org.uk/>

#### **The Project – *support for parents***

Tel: 01404 549045

Email: [info@theprojectyp.org.uk](mailto:info@theprojectyp.org.uk)

Web: <http://theprojectyp.org.uk/support-groups/for-parents/>

**National Alliance on Mental Illness – *taking care of yourself***

Web: <https://www.nami.org/Find-Support/Family-Members-and-Caregivers/Taking-Care-of-Yourself>

***General Advice and Support***

**Anxiety UK**

Phone: 08444 775 774

Email: [support@anxietyuk.org.uk](mailto:support@anxietyuk.org.uk)

Web: <https://www.anxietyuk.org.uk/>

## **Appendix N: Semi-structured interview schedule**

### **Semi-Structured Interview Schedule**

#### ***Exploring parents' experiences following their child's admission to a Child and Adolescent Mental Health inpatient unit***

The purpose of this interview is to explore your experiences of your child's admission to a CAMHS inpatient unit. I am interested to hear how you found this experience and would encourage you to be as open as you can during the interview. Although I will be asking you some questions, I hope to be led by you and your experiences. At times I may ask you what you mean by something or for further details, this is to ensure that I am able to try to understand your experiences in as much detail as you are comfortable to share. However, in general the questions will focus on your experiences of the process of your child's admission to the inpatient unit.

- 1. To begin with, it would be helpful to find out a little bit about you, your child and your family.**
  - a. What is your age?
  - b. What is your relationship to your child?
  - c. What is your marital status?
  - d. What is your child's age and what gender do they identify with?
  - e. Is this your child's first admission?
  - f. How long has your child been here for?
  - g. How far have you had to travel (on average) to visit your child on the ward?
  - h. Do you have any other children living with you?
    - i. What are their ages, and relationship to you?
  
- 2. Can you tell me about your experiences of what led to your child's admission?**
  - a) Can you tell me about the process leading to the admission?
    - i) Assessments, contact with services, support
  - b) What did you notice?
  - c) What was happening for your child at that time?
  - d) What was happening for you at that time?
  - e) What was your experience of CAMHS and other services at this time?

**3. Can you tell me about your experiences in the first week of your child's admission?**

- a) What did you notice?
- b) What was happening for your child at the time?
- c) What was happening for you at the time?
- d) What was your experience of CAMHS and other services at this time?

**4. Can you tell me about your experiences during the rest of your child's admission?**

- a) What did you notice?
- b) What was happening for your child at the time?
- c) What was happening for you at the time?
- d) What was your experience of CAMHS and other services at this time?

**5. Have there been any experiences that have been similar or different since your child was admitted?**

- a. What has it been like since your child was admitted? (prompts: work, family, relationships, hobbies, activities, general life)

**6. Thank you for taking part in this interview. based on your experiences, is there anything else you would like to tell me?**

**General prompts:**

- Can you tell me what you mean?
- Can you tell me more about that?
- What did that mean to you?
- How did that leave you feeling?

## Appendix O: Stages of IPA

Stages of IPA based on Smith, Flowers & Larkin, 2009

<b>Stage</b>	<b>Description</b>
<b>1: Reading</b>	The researchers own ideas and assumptions were bracketed to reduce bias prior to commencing the interviews. Following transcription, the transcripts were read a number of times to become familiar with the data.
<b>2: Initial noting</b>	Exploratory phase, where the researcher noted anything of interest in the transcript using descriptive, linguistic and conceptual codes that are closely linked to the participants narrative.
<b>3: Developing emerging themes</b>	Initial linguistic and conceptual notes were then used to identify emerging themes within each transcript. The aim was to capture the psychological essence of participants' narratives while reducing the volume of data and moving to a more interpretive position.
<b>4: Searching for connections</b>	The emerging themes were organised chronologically and the researcher searched for patterns across the emerging themes, mapping how they may fit together.
<b>5: Moving to the next case</b>	The researcher then repeated steps 1-4 for each transcript, bracketing any ideas emerging from the previous transcripts.
<b>6 Looking for patterns</b>	The researcher organised the themes to begin to look for patterns across the transcripts. The research team were consulted and facilitated the search for patterns across themes. Superordinate and subordinate themes were identified and the researcher created a word document of quotes for each subordinate theme to ensure theme coherence.

## Appendix P: Example transcript and analysis

Interview 5

Emerging themes	Original transcript	Exploratory comments (descriptive)	Exploratory comments (linguistic and conceptual)
Admission as respite/ relief	<p>M: So, the, for me, um, one of the, um aspects of the admission, is that life is actually <b>better</b> with it. So, with [daughter], out of the house, we can, we can, <b>so much</b> of the stress and fear and threat is lifted. So, she's in a place where, um, her, psychological, medical, spiritual, nutritional needs can be um, understood, you know, all of which are in a little bit of turmoil, can be understood by people who <b>know</b> that stuff and make sure that the right, you know the risk, her security, her safety, um, social needs, that all the right things are being met. Where if you're in a busy family where in the home and somebody is in the place of turmoil, it is going to completely turn your entire family on its head, which it does. So, you know, exploring parents' experiences following their child's admission... So, our experience following our child's admission, was one of joy and relief, which is <b>conflicting</b>, because the last thing you want is for your child to go to hospital, but it's like, so, for ourselves it was like, okay a sense of relief and, and, contrasting that, the prospect of her coming out fills us with fear. You know, because that Tidal Wave, the tsunami is just over the horizon and you know that prospect is, [pause] yeah, we're crapping ourselves, you know. It's like um, which is why when I was talking about earlier, when we'd</p>	Life is better with admission	<i>Emphasis indicating meaning</i>
Unit as reassuring/ containing		Stress/fear is lifted	<u>Admission as providing relief/respite for family. Reduction in stress/fear/threat. Opportunity to regain sense of normality?</u>
Unit as able to meet needs (beginning)		Daughters needs met by unit	<u>Sense of reassurance that daughters' needs are better met on the unit than at home?</u> <i>emphasis indicating importance</i>
Ripple effect through family		Family turmoil	<u>Importance of professionals who know about mental health. Is there a sense of hope that the unit will provide answers?</u> <u>Unit as important for making sure daughters' needs are met. she is the focus</u>
Conflicting emotions		Things turn upside down	<u>Mental health as turning family on its head. Language indicating huge impact on family, life turned upside down</u>
Managing the self/ emotions		Joy/relief but conflicting emotions	<u>Conflicting emotions of admission. Relief but sadness or loss at admission?</u> <i>Emphasis indicating meaning of conflicting emotions</i>
Fear of the unknown		Relief at admission	
Fear of discharge/ coping at home		Fear of discharge	<u>Contrast relief to fear of discharge. Is there a fear of how they will manage at home? a sense of imminent threat?</u> <u>Unknown threat?</u>
		Tidal wave/ tsunami of mental health	



- Managing the self
  - Compromise, emotions
  - Support from others
    - Marriage
    - Lack of support as problematic
  - Coping strategies
    - Humour, problem solving, rationalising, putting things in perspective
    - Emotional disconnection?

- Identity
  - Managing roles (parenting/self)
    - Parental role/responsibility (protecting daughter/family)
  - Questioning the self, assertive self
  - Positivity (self-identity)

- Impact of mental health/experiences
  - Burnout, sadness, hopelessness/depression?
  - Guilt (fear of discharge)

- Loss
  - Self
    - Expected parenting role
    - Excitement/happiness
    - Social life
  - Future
    - Expected future, normal family life, expected life
    - Loss of hope/belief?
  - Hope for daughter (no change)
  - Systems
    - Loss of trust/hope in system
    - Hopelessness for change in system

- Adapting/adjusting
  - Adapting parenting role
  - Adapting priorities
  - Frustration at adapting/compromise
  - Work as accepting/ accepting

- Managing relationships
  - Family
    - Problematic, prioritising
    - Impact on family/siblings
    - Fragility of relationships
    - Change to relationships
    - Mental health as barrier to connecting
  - Staff/unit
    - Relationships with staff as supportive vs problematic
    - Peers as problematic

- Managing mental health
  - Unexpected
    - Shock/uncertainty of MH
    - Build-up over time
  - Understanding daughter
    - Searching for understanding
    - Daughter as vulnerable / agent for change
    - Desperation for change
  - Managing at home
    - Stress, fear, hypervigilance, unmanageable, traumatic

Interview  
5

- Uncertainty
  - Fear of the unknown/ not knowing as problematic
  - Future
    - Uncertainty/fear for daughter's future
    - Discharge as anxiety provoking
  - Adult mental health
    - Fear of adult MH/ adult inpatient

- Extras
  - Retelling story as tiring

- Admission
  - Hopefulness
    - Respite (regain life?)
    - Safety as reassuring
  - Entering the unknown
    - Lack of choice

- Emotional response
  - Unanticipated relief, conflicting emotions

- Navigating the system (process of learning)
  - Understanding systems
    - Looking for answers/ solutions
    - Questioning the system/ service/ processes
  - Fighting for support
    - Voice for daughter, fighting for daughter/ for a plan
    - Fighting to be heard/ for support for self
  - Anger/ frustration at services
    - Processes, structure (top-down), diagnosis-led

- Unmet expectations
  - Service/ system
    - Lack of plan, patient-centred care, focus on risk, communication as problematic
    - Lack of continuity, admission as unhelpful
    - Frustration/ anger at unmet expectations
  - For family
    - Not feeling understood/ heard/ parental involvement as problematic
    - Lack of support/ unmet needs
    - Information sharing as problematic
    - Frustration/ anger at unmet needs
  - Improvement
    - Frustration at lack of change/ improvement (daughter)

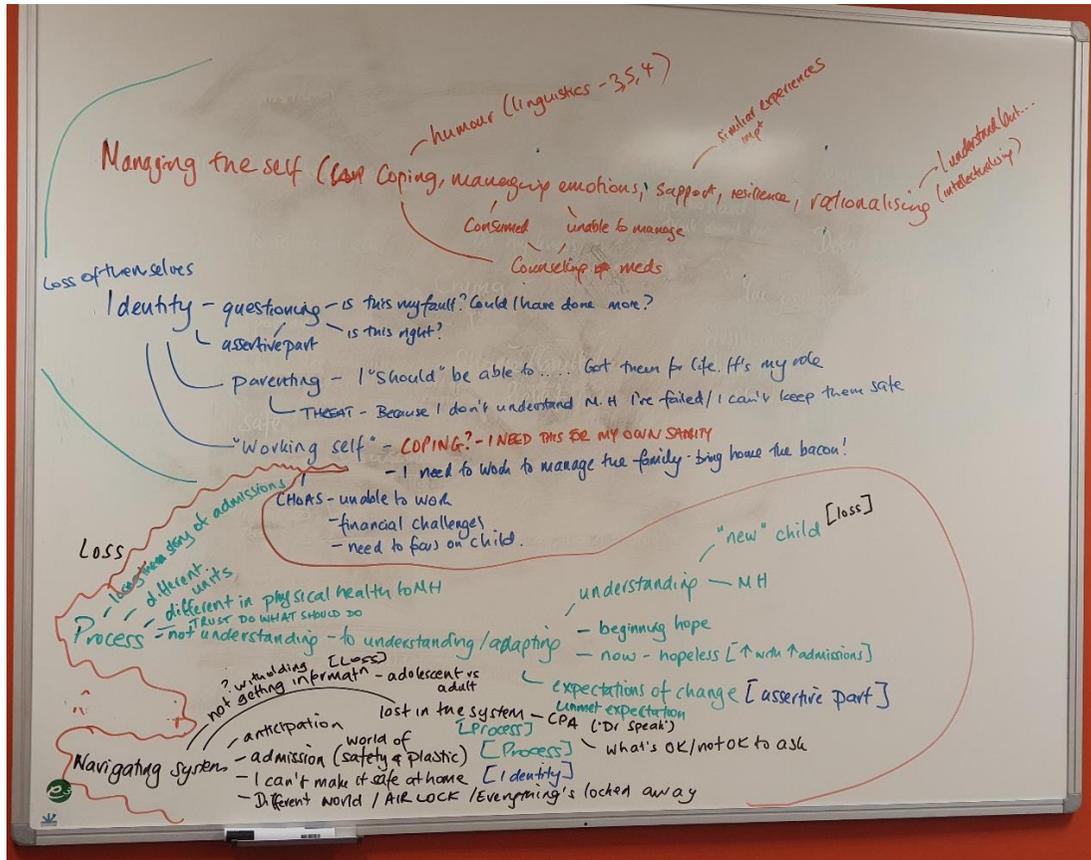
- Making sense of experiences
  - Timeline as important, process of understanding
    - Interview as helpful for reflection

- Changes to services
  - Guidance, early support, family support
  - Planning, preparation important for managing uncertainty
  - Continuity, understanding, information sharing
  - Patient-centred care

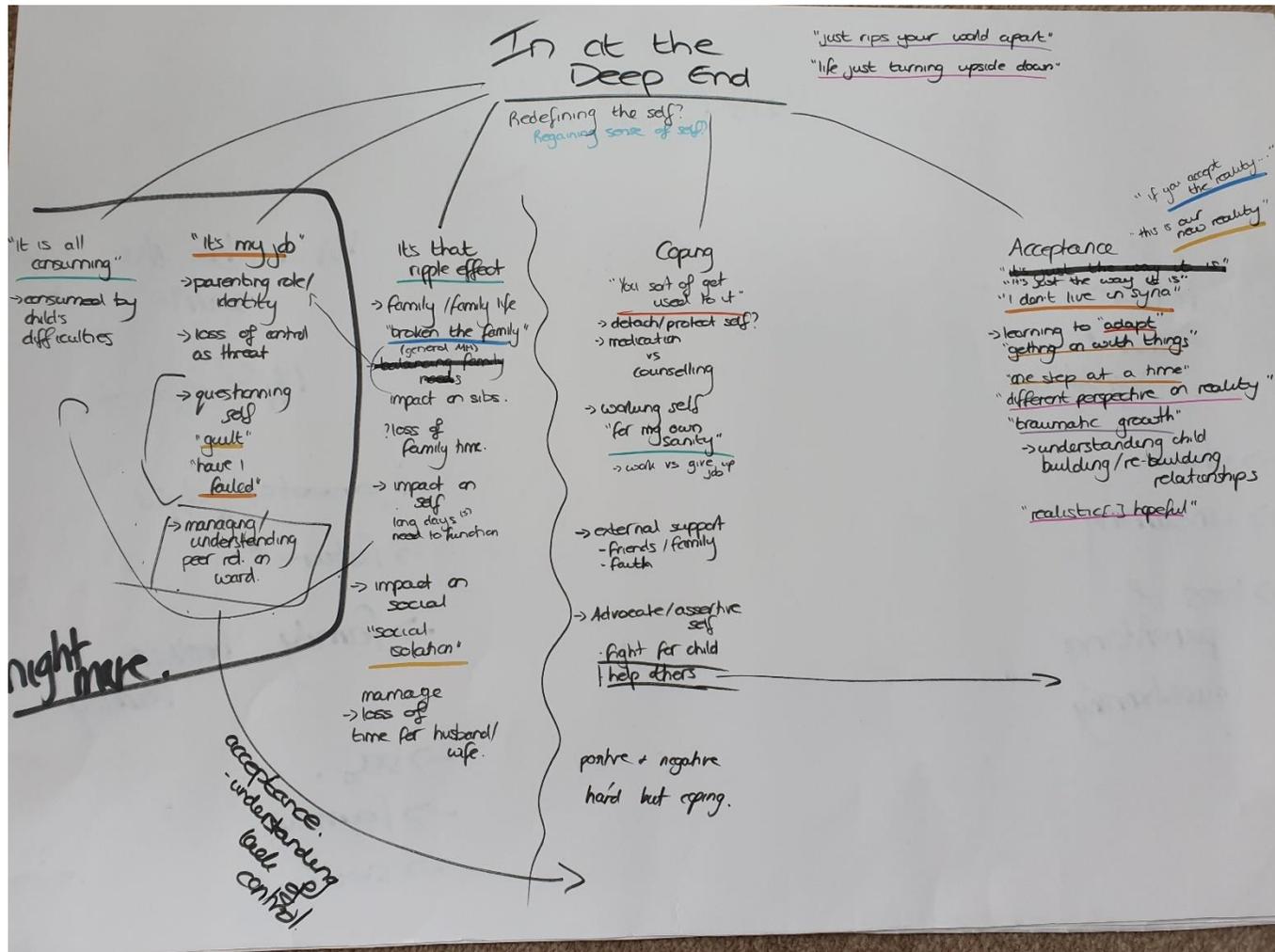
## Appendix R: Example of stages of developing final superordinate themes

### Stages of developing superordinate and subordinate themes

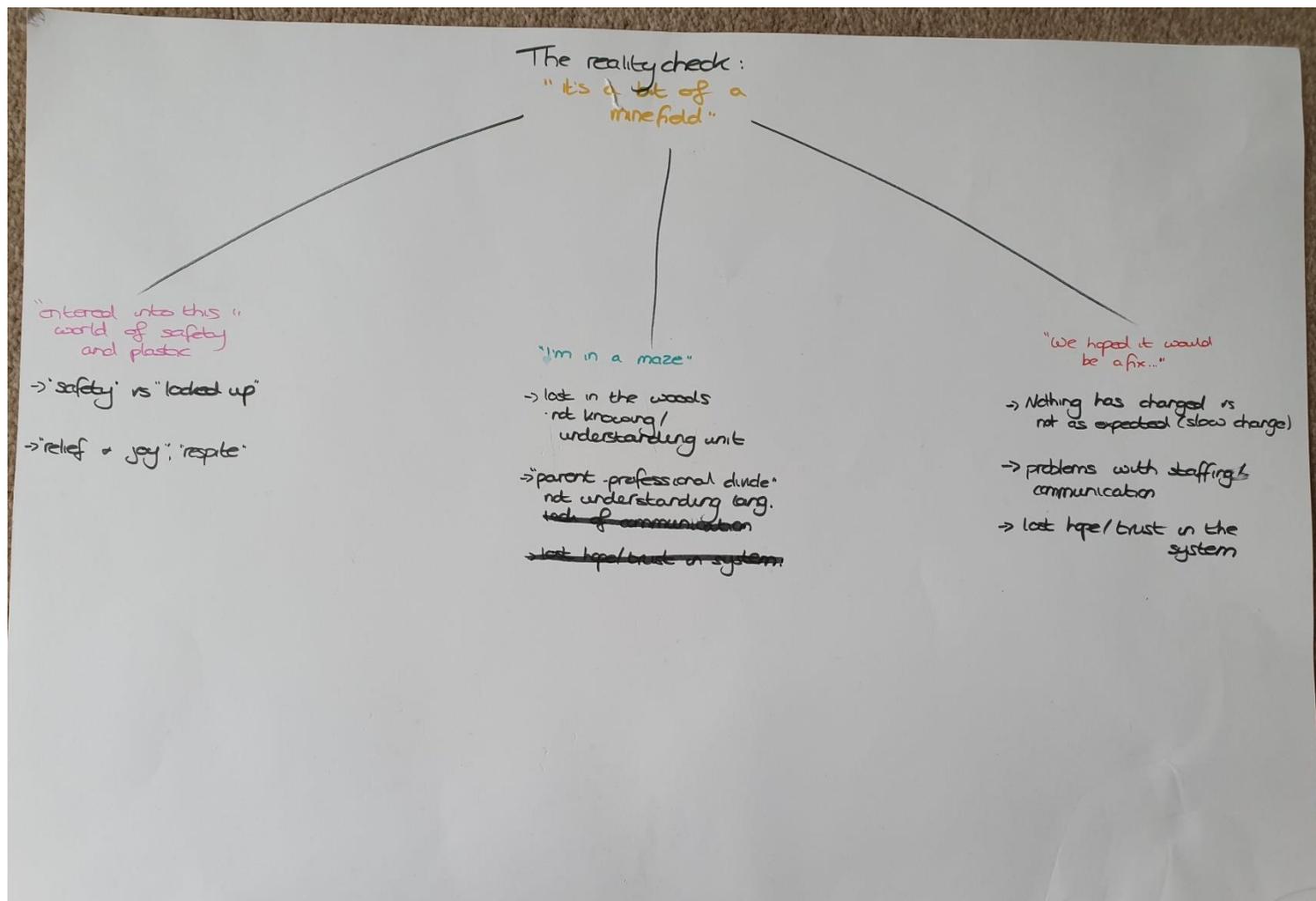
#### Stage 1:



Stage 2:



### Stage 3: Example of final superordinate theme



**Appendix S: Superordinate and subordinate themes illustrating participant contributions**

<b>Superordinate theme</b>	<b>“It’s a bit of a minefield”</b>			<b>“Monster of mental health”</b>		<b>“I don’t live in Syria”</b>	
<b>Subordinate theme</b>	<b>“World of safety and plastic”</b>	<b>“I’m in a maze”</b>	<b>“We hoped it would be a fix”</b>	<b>“It just rips your world apart”</b>	<b>“It won’t ever be the same again”</b>	<b>“You learn to cope”</b>	<b>“This is our new reality”</b>
Alice	✓	✓	✓	✓	✓	✓	✓
Paula	✓	✓	✓	✓	✓	✓	✓
David	✓	✓	✓	✓	✓	✓	✓
Lindsey	✓	✓	✓	✓	✓	✓	✓
Matthew	✓	✓	✓	✓	✓	✓	✓
Sophia	✓	✓		✓		✓	✓
Elizabeth	✓	✓	✓	✓	✓	✓	✓

## **Appendix T: Examples of respondent validation**

### **Email feedback from participant 7: Received 8<sup>th</sup> July 2019**

Hi Jacqui

Thank you for sending that over, it was nice to read about other peoples experiences as we all went through similar emotions which makes me feel strangely comforted!

Thanks

(Name of participant 7)

### **Email feedback from participant 5: Received 8<sup>th</sup> July 2019**

Hi Jacqui,

Many thanks for sending this through. It must have been a challenging study to carry out for you. I sincerely appreciate the time and energy that has gone into this and I do hope that it can be used to improve outcomes for families in the future.

Many thanks once more and good luck with your training.

(Name of participant 5)

## Appendix U: The Tree of Life professional identity questions

### **Tree of Life: Questions about professional identity for child and youth workers**

**By Natasha Kis-Sines and Ruth Pluznick**

[Natasha Kis-Sines and Ruth Pluznick developed the following questions to use with fellow colleagues at Oolagen House in Toronto, Canada. We hope they will be useful for workers in other contexts. To read more about the Tree of Life methodology they draw on, visit [www.dulwichcentre.com.au/tree-of-life.html](http://www.dulwichcentre.com.au/tree-of-life.html)]

#### **PART ONE – The tree and professional identity**

##### **Roots of the tree**

- What brought you to this work?
- Events/person that influenced you (Who and what inspired you)?

##### **The ground**

- How long have you been with this team?
- What are some of the values and commitments of the team that are most meaningful to you? Why is it meaningful?
- How does this “fit” with your preferred directions for your work?

##### **Trunk of the tree**

- What skills and knowledge do you bring to your work with young people?
- What is the history of these skills and knowledge?
- Who in your life first noticed these skills and knowledge? Can you tell us a story about how it might have been visible to them?
- Who on the team is most aware that you have these skills? Is there an example of a time when these skills and knowledge would be most evident to that person?

##### **Branches of the tree**

- What are your hopes and dreams for the young people that you work with? For the work you do? For yourself as a child and youth worker?
- What are some of the next steps in your career and life?

**Leaves of the tree**

- Who are the people who support you in the work you do?

**Fruits – contributions**

- What has the team and others contributed to your development in work and life?
- What does the team most appreciate about your skills and knowledge? What would they say you have contributed to their work and life?

[This document was downloaded from [www.dulwichcentre.com.au/tree-of-life-professional-identity.pdf](http://www.dulwichcentre.com.au/tree-of-life-professional-identity.pdf)

To find out more about Oolagen Community Services, visit [www.oolagen.org](http://www.oolagen.org)]