Section Two:

Research Paper

How do Adolescents Experience Relationships During Admission to a Psychiatric Inpatient Unit?

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[1] See Appendix 1A for Author Guidelines

Abstract

Background: Adolescence is a period characterised by significant change. Developments in relationships during adolescence are of particular importance as both friendships and familial relationships have been associated with mental health outcomes. This research uses a qualitative design to explore adolescents' experiences of their relationships in the context of admission to an inpatient mental health unit.

Method: This research was designed and conducted in accordance with the principles of interpretative phenomenological analysis. Qualitative interviews were conducted with ten adolescents.

Results: Four themes were developed, "The complexity of the professional role – The incorporation of friendship and expertise", "Experiencing acceptance through the creation of new group norms", "Intense relationships can result in vulnerability," and "The unit as a temporary safe-haven".

Conclusions: The findings have implications for the provision of inpatient services, which are discussed along with suggestions for future research.

Key Words: inpatients; qualitative research; adolescent; interviews

Key Practitioner Message

- Relationships are known to influence adolescents' experiences of inpatient admission. However, researchers have not focused specifically on this area.
- This research demonstrates the complexity of adolescents' relationships with professionals in this setting.
- Admission represents an opportunity for the development of meaningful peer relationships in a setting which promotes acceptance.
- While friendships are a valued aspect of the experience of admission, entering into intense relationships can be associated with distress.

- Admission represents an opportunity for respite. However, separation from family and negotiation of reintegration into social circles can be challenging.

How do Adolescents Experience Relationships During Admission to a Psychiatric Inpatient Unit?

Theoretical Perspectives on Relationships in Adolescence

According to Hall's (1904) seminal work, adolescence is characterised by emotional upheaval and stress (for a historical overview of this area see Arnett, 1999). While this generalisation has been described as simplistic (Arnett, 1999), it is accepted that adolescence, and the associated physical, cognitive and emotional changes, can be challenging for some (Coleman, 2011). Furthermore, social networks alter significantly during this period as parent-child relationships evolve and peer and romantic relationships take on greater significance (see Smetana, Campione-Barr & Metzger, 2006, for a review).

A number of theoretical accounts attempt to provide frameworks within which developments during adolescence, and their association with changing social relationships, can be understood. What follows is a brief account of some relevant theoretical underpinnings behind three of the most commonly discussed areas of transformation: identity formation, parent-child relationships and the development of social cognition (Coleman, 2011; Noller & Atkin, 2014).

Firstly, according to Erikson's (1968) theoretical contribution regarding identity formation, the development of a coherent sense of self is a key challenge within adolescence, which is central to the ability to engage in intimate relationships. In an attempt to operationalise theoretical perspectives relating to identity development, Marcia (1966) developed a model encompassing four identity statuses; identity diffusion, identity foreclosure, identity moratorium and identity achievement. In his review of longitudinal research relating to adolescent identity formation, Meeus (2011) concludes that parent-child interactions influence this process, as the receipt of warm and supportive parenting during adolescence is associated with the development of a more mature identity. Taken in their

entirety, the aforementioned theoretical perspectives and empirical research regarding identity development during adolescence indicate that this process is both influenced by, and has a future impact upon, relationships.

Secondly, the development of understanding regarding parent-child relationships has been significantly influenced by attachment theory (Bowlby, 1969). According to this perspective, early experiences of relationships shape future expectations, influence social behaviour and impact upon self-worth via the development of internal working models (Shaver & Mikulincer, 2002). Attachment theory suggests that, ideally, parent-child relationships are characterised by stability as parents continue to provide a secure base from which their offspring develop intellectual and emotional autonomy (Laursen & Collins, 2009). Attachment theory has been supported by empirical evidence which demonstrates that the development of secure attachments with sensitive and responsive caregivers enhances individuals' future ability to maintain secure and supportive relationships as a result of the development of emotional awareness and empathy (Hershenberg et al., 2011; Laible, 2007). Moreover, secure attachment styles have been associated with the ability to develop extra-familial relationships (Collins & Laursen, 2004) and to balance parental relationships with autonomy (Becker-Stoll et al., 2008), further implicating the role of early relationships in the development and maintenance of relationships throughout adolescence and beyond.

Finally, theoretical perspectives and empirical research regarding the development of social cognition suggest that, during adolescence, the ability to understand others' thoughts, feelings and social behaviour is developed (Choudhury, Blakemore, & Charman, 2006). While it is acknowledged that research regarding social cognition appertains to a range of overlapping constructs and theoretical perspectives (Humfress et al., 2002), it is argued that developments in this area have important correlates with changing relationships during adolescence, as increasingly complex relationships demand sophisticated social awareness

and behaviour (Brown & Larson, 2009). These links have been supported by empirical research which indicates that the development of skills relating to social cognition, specifically mentalisation, can be associated with the quality of attachment relationships in early adolescence (Humfress et al., 2002). In summary, cognitive development during adolescence facilitates an enhanced appreciation of one's own and others' emotional experiences, allowing for the negotiation of the complexities of social relationships.

These theoretical perspectives highlight the potential for significant changes in relationships during adolescence. Given the complexity of these developments, it is unsurprising that some adolescents experience emotional difficulties requiring professional support, many of which relate to the management of the key relationships.

Relationships and Mental Health

Relationships are integral to theoretical perspectives relating to both adolescence and mental health (Brown & Larson, 2009; Graber & Sontag, 2009; Laursen & Collins, 2009). For example, research findings have indicated that positive parent-child relationships protect against the development and impact of mental health difficulties (Englund et al., 2011; Skrove, Romundstad, & Indredavik, 2013; Warren, Jackson, & Sifers, 2009). Moreover, research conducted from an attachment theory perspective (Bowlby, 1969) indicates that individuals who do not develop secure attachments are vulnerable to the impact of future stressors and are therefore at a higher risk of developing mental health difficulties (Muris et al., 2001; Van Durme, Braet & Goossens, 2015). Empirical research has further implicated the role of early attachment in mental health, suggesting that securely attached adolescents receiving inpatient care for mental health difficulties experience a greater reduction in internalising symptoms than those who are insecurely attached (Venta, Sharp & Newlin, 2015).

However, research regarding relationships and mental health does not exclusively focus on the significance of parent-child interactions. For example, positive peer relationships are associated with enhanced happiness (Bukowski, Burhmester & Underwood, 2011) and reductions in depressive symptoms (Nangle et al., 2003). Conversely, early experiences of social isolation have been shown to predict future loneliness and depression (Pelkonen, Marttunen & Aro, 2003). Furthermore, it is suggested that the relationship between peer interactions and mental health difficulties is likely to be bi-directional, as poor relationships lead to reduced emotional wellbeing which, in turn, impact upon social interactions (Graber & Sontag, 2009).

Moreover, empirical findings indicate that children and adolescents who experience mental health difficulties may lack social support as a result of stigma (Moses, 2010; O'Driscoll et al., 2012; Reavley & Jorm, 2011), resulting in a reduction in self-esteem (Corrigan, Rafacz & Rüsch, 2011) and a reluctance to seek help (Meredith et al., 2009). This evidence simultaneously demonstrates the importance of considering relationships in the context of mental health difficulties and psychological wellbeing.

Mental Health Care for Adolescents

While there is a lack of clarity regarding rates of referral to, and use of, mental health services for adolescents in the United Kingdom (UK; House of Commons Health Committee, 2014), international estimates indicate that between 12 and 29% of children and adolescents experience mental health difficulties (Güvenir, Taş, & Özbek, 2009). These figures provide some indication of the potential scale of mental health difficulties in adolescence. A small proportion of those who experience mental health difficulties access inpatient services (National Health Service [NHS] England, 2014) which, internationally, represent the most intensive level of support available (Green, 2002; McDougall et al., 2008).

In their non-systematic commentary, Blanz and Schmidt (2000) criticised much of the international research exploring the efficacy of inpatient services for children and adolescents. For instance, they highlighted failures to distinguish between care provided by social welfare and healthcare settings, the lack of detail regarding comparison groups and failures to use standardised measures. Despite these shortcomings, Blanz and Schmidt (2000) reached the cautious conclusion that inpatient admission is beneficial, particularly if aftercare services are provided, the treatment programme is completed and a good therapeutic alliance is developed with professionals. These conclusions have been supported by quantitative international findings which indicate that inpatient admission in Turkey (Güvenir et al., 2009) and the UK (Green et al., 2001; 2007) results in positive changes. Furthermore, a prospective cohort study which compared outcomes from a series of measures prior to admission, pre-discharge and one year post-discharge has indicated that improvements are maintained (Jacobs et al., 2009).

Although the aforementioned studies have provided relatively rigorous demonstrations of the positive effects of inpatient admission based on group analysis, not all individuals have such positive outcomes. Indeed, the results of a YoungMinds study (Street & Svanberg, 2003a; 2003b), which gathered data from 107 young people, 35 parents and 115 professionals from a range of UK settings including inpatient wards revealed that, while 43% of respondents felt that their admission was beneficial, 70% found aspects of the experience unhelpful. A number of suggestions were made regarding possible improvements to their experiences. For example, the challenges associated with being separated from friends and family and exposed to peer group influences were highlighted by 39% of respondents. However, being with other young people was not a universally negative experience as some participants identified this as a positive aspect of admission (30%). Moreover, participants stated that they appreciated relationships with professionals, with 21% indicating that

interactions with staff eased their experience of admission. Importantly, the findings of this study highlight how relationships with peers, professionals and family members influence adolescent experiences of inpatient admission. The significance of relationships has been further demonstrated in Grossoehme and Gerbetz's (2004) survey of 105 adolescents, which concluded that participants rated being with their peers as the most important aspect of inpatient care. Furthermore, Green et al.'s. (2001) regression-based study indicated that the outcome of admission can be predicted by the strength of the therapeutic alliance and family functioning pre-admission.

In conclusion, quantitative research using various designs has suggested that admission to inpatient settings may represent an effective approach for the treatment of mental health difficulties for some adolescents. It has also highlighted the importance of considering the complex effects of relationships with peers, professionals and adolescents' friends and family during admission.

Qualitative Explorations of Inpatient Admission

A limited number of studies have employed qualitative methods to explore adolescents' experiences of inpatient admission. For example, in Colton and Pistrang's (2004) interpretative phenomenological analysis (IPA) study with 19 females aged 12-17, the importance of relationships with peers and professionals during admission emerged as a strong theme. The findings highlighted the complexity of these relationships as participants described their friendships as being a source of both support and distress. Colton and Pistrang (2004) suggest that this distress may be associated with exposure to others' frightening behaviour and the potential for young people to engage in competition which counteracts therapeutic goals, such as striving for weight loss. Moreover, Colton and Pistrang (2004) have emphasised the importance of relationships with professionals in the inpatient context. They suggested that these relationships are influenced by the contrasting

experiences of "being seen as an individual vs. just another anorexic" (p.331) and negotiations relating to the uneven distributions of power and control. However, as all the participants who took part in Colton and Pistrang's (2004) study were exclusively females with a diagnosis of anorexia nervosa, these findings may be influenced by factors specifically associated with this context resulting in difficulties translating them to different settings and populations.

Using a different method (grounded theory), Haynes, Eivors and Crossley's (2011) study regarding the experiences of 10 participants aged 13-19 who had experience of admission to a generic mental health ward also revealed themes regarding the importance of relationships. The authors concluded that perceptions of admission were influenced by participants' experiences of being separated from family and friends and placed within an environment in which they were required to develop relationships with professionals and peers. Furthermore, participants in this study described polarities within their relationships which were understood to represent a period of adjustment during which they became increasingly tolerant of others' distress, culminating in the development of friendships based on shared experiences and mutual support. Additionally, both Haynes et al. (2011) and Colton and Pistrang (2004) indicated that admission was associated with feelings of isolation which are thought to be exacerbated by stigma associated with mental health difficulties.

However, despite explicitly acknowledging that adjustment to admission occurred over a period of time, Haynes et al. (2011) do not reflect on the variation within the duration of their participants admissions (between four weeks and 36 months). It could be argued that this variation may have resulted in significantly different experiences of admission which may have influenced the findings. Furthermore, some of Haynes et al.'s (2011) participants were no longer admitted to an inpatient setting. It is possible that these participants may have had

the opportunity to reflect on their experiences in a way which had not yet been afforded to the remainder of the sample.

Consequently, theoretical and empirical research demonstrates that relationships can be associated with aspects of development and psychological wellbeing during adolescence. Furthermore, difficulties within relationships have been found to impact upon adolescents' mental health. Specifically, quantitative enquiries, such as those discussed above, have demonstrated the importance of relationships with peers, professionals and family during inpatient admission. While researchers have used qualitative methods to explore the broader experiences of younger children (e.g. Hepper, Weaver & Rose, 2005), those of 16-23 year olds who have accessed a range of restrictive mental health placements (Polvere, 2011), and a small number of qualitative studies have explored the experiences of adolescents during inpatient admission (Colton & Pistrang, 2004; Haynes et al., 2011), researchers have yet to focus specifically on adolescents' relationships in a generic mental health ward for young people.

To address this gap in understanding, I have used a qualitative approach to understand how adolescents experience and understand their relationships with peers, professionals and family during their admission to a psychiatric inpatient unit. A qualitative approach was selected as this allows for the generation of rich and meaningful findings which are able to contribute to, and develop, current understanding via the provision of examples of individual experience. From a UK perspective, developing this kind of understanding is likely to be of particular importance as child and adolescent mental health services, including inpatient provision, are entering a period of significant development (CAMHS Tier Four Steering Group, 2014; Children and Young Peoples' Mental Health Taskforce, 2014).

Method

Design

Data was gathered via semi-structured interviews which were analysed in accordance with guidance relating to IPA (Smith, Flowers & Larkin, 2009). IPA was selected in order to allow for a specific focus on individuals' attempts to make sense of their relationships in this particular context (Smith et al., 2009). The exploration of lived experience encompasses the consideration of individuals in their social, cultural and historical context in an attempt to understand their "wishes, desires, feelings, motivations, (and) belief systems" (Eatough & Smith, 2008, p.181).

Theory can be integrated into IPA studies in various ways. For example, theoretical perspectives may influence the design of the research or, alternatively, be drawn upon as the data is interpreted and the implications of the research considered (Eccles, Murray & Simpson, 2011). In this instance, theoretical understandings influenced the design of the study (demonstrated in the decision to focus on relationships) and informed interpretation of participants' experiences (see Eccles et al., 2011 and Harman & Clare, 2006 for published examples of the integration of theory into IPA studies).

Participants

Participants were recruited from two NHS inpatient units in accordance with the methodological requirements of IPA. Specifically, participants were selected on the basis that they had sufficiently similar experiences of inpatient admission. This allowed for a detailed consideration of this particular experience. To ensure homogeneity, (which is a key methodological premise of IPA; Smith et al., 2009), a number of inclusion and exclusion criteria were employed. Inclusion was limited to participants who had been admitted for more than two weeks. Potential participants were excluded if their care team advised that they were too unwell or that the process was likely to have a detrimental effect on their mental health.

Individuals who had cognitive or communication difficulties which would hinder their involvement were also excluded, as were those who required an interpreter in order to participate. A total of 10 participants (seven females and three males) between the ages of 14 – 17 participated (sample size is discussed further in the Discussion section).

The capacity to provide informed consent in participants over the age of 16 was assessed in accordance with the principles of the Mental Capacity Act (Department of Health, 2005) and guidance provided by the British Psychological Society (BPS, 2005; 2010). Both assent and parental consent were sought for those under the age of 16. The research was approved by an NHS research ethics committee and the research and development departments of the two NHS Trusts from which recruitment took place (please refer to Section Four: Ethics Section for details of this process).

Procedure

A group of service users who had experience of inpatient admission were consulted regarding advertisement of the study and recruitment. This information contributed to the development of the research protocol (Section Four: Ethics Section, p. 4:1). Potential participants were made aware of the project via my attendance at ward community meetings, information posters (Section Four: Ethics Section, p. 4:18) and participant information sheets (Section Four: Ethics Section, p. 4:19). Interested individuals completed a declaration of interest form (Section Four: Ethics Section, p. 4:23) which was placed in a sealed box on the ward. The care teams were contacted in order to establish if potential participants met the inclusion and exclusion criteria. Once appropriate assent and consent were obtained, a convenient time for the interview was agreed.

Service users also offered suggestions regarding topics for the Interview Guide (Section Four: Ethics Section, p. 4-16). Their ideas were diverse and many were not related to the research question (e.g., requests for a focus on catering). Therefore, the interview

guide was primarily developed via reference to the existing literature. For example, Haynes et al. (2011) focussed on "events that had led up to hospitalisation; experiences of hospitalisation; relationships with staff and other inpatients; and coping strategies" (p. 152), ideas which were used flexibly to explore issues arising in each interview (Eatough & Smith, 2008). Interviews, which lasted between 29 minutes and 1 hour and 8 minutes, took place on the units and were recorded using a digital audio device. These recordings were transcribed and anonymised.

Researcher's Context and Epistemological Stance

As a trainee clinical psychologist, I have worked with adolescents, families and carers in a range of settings. These experiences have influenced my understanding of these aspects of mental health care. I used supervision and a reflective notebook to consider my experiences and pre-conceptions and to acknowledge their influence on research design, data collection and analysis (Finlay, 2002).

It is recognised that the development and implementation of this research was influenced by my beliefs about what it is possible to know and the methods used to access this information. In summary, I most closely identify with a critical realist perspective (for a further exploration see Section Three: Critical Appraisal, pp. 3:1 – 3:4).

Data Analysis

Data analysis adhered to the standard six stage process recommended by Smith et al. (2009). In accordance with the idiographic nature of IPA, analysis focused on individual transcripts before consideration was given to the entire data set. As such, the first stage of analysis involved repeatedly reading an individual transcript. This allowed me to become familiar with the data. The second stage of analysis involved the noting of exploratory comments relating to descriptive, linguistic and conceptual aspects of the data (see Table 1 for an example).

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INSERT TABLE 1

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In the third stage, these exploratory comments were used to develop emergent themes relating to the transcript. This involved the identification of connections and patterns between the exploratory comments and the reduction of data into concise statements (Smith et al., 2009). An example is provided in Table 1.

The fourth stage of analysis focused on the exploration and examination of connections between emergent themes within the transcript. This process occurred via abstraction, "putting like with like and developing a new name for the cluster" (Smith et al., 2009, p. 96), polarization, "examining transcripts for the oppositional relationships between emergent themes" (Smith et al., 2009, p. 97) and subsumption, a process of identifying an emergent theme which "acquires a super-ordinate status as it helps bring together a series of related themes" (Smith et al., 2009, p. 97). See Figure 1 for an example.

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INSERT FIGURE 1

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This process resulted in the development of several "super-ordinate themes" (Smith et al., 2009, p. 96) for each transcript. In order to support this process I wrote a short narrative description of the super-ordinate themes from each transcript. While this step of analysis is not prescribed in the method outlined by Smith et al. (2009), researchers are encouraged to take a creative and flexible approach. This process supported the development of a detailed conceptualisation of the super-ordinate themes within each transcript and allowed me to work more easily with the entire data set (see Table 2 for an example).

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INSERT TABLE 2

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The fifth stage of analysis involved repeating the stages outlined above for the remaining transcripts, resulting in a set of emergent and super-ordinate themes for each participant (see Table 3 for details). In order to maintain my commitment to an idiographic approach, I attempted to "bracket" (Smith et al., 2009, p. 100) understandings and interpretations associated with previous transcripts via discussions in supervision and use of reflective notes.

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INSERT TABLE 3

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The sixth stage of analysis involved consideration of the entire data set in order to establish how the super-ordinate themes developed in stages one to four could be organised into a meaningful whole. I then embarked on an iterative process during which I explored a range of ways of organising the data, accounting for both similarities and differences, in order to preserve the integrity of individual participants' experience (see Table 4 for an example of theme development). This involved taking individual super-ordinate themes and mapping them onto one another by combining, reconfiguring and renaming them. Through this process, I created groups of super-ordinate themes which were similar across the transcripts. However, some super-ordinate themes were very particular to individuals. In order to make sense of this data I revisited the emergent themes comprising these super-ordinate themes and reconsidered how the data related to the individual experience and the entire dataset. This process led to the development of four cross-participant super-ordinate themes which related to the entire data set (see Table 5 for details).

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INSERT TABLE 4

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Results

Analysis of the data resulted in the development of four themes. Each theme will be addressed individually to enable a full exploration of the data[2].

Theme One: The Complexity of the Professional Role – The Incorporation of Friendship and Expertise

This theme encompasses participants' views of their relationships with professionals. Interactions with professionals appeared to be characterised by humour and reciprocity which contributed to the perception that these relationships were like friendships. Professionals' willingness to engage in light-hearted interactions was particularly important for Tom, who perceived their ability to use humour as a representation of their ability to understand him: "If you are having banter with the staff you get good relationships with them (…) and they can understand you better". Furthermore, professionals' ability to adapt their communication style facilitated difficult conversations in a non-threatening manner. For example, Hannah described feeling relaxed and able to discuss her difficulties at her own pace when this happened: "Erm I'll start off with what's bothering me and then we will sort of go off topic into something more sort of light hearted and the come back to it and keep sort of jumping".

Participants who were satisfied with their relationships with professionals perceived them to be reciprocal in nature. They described feeling emotionally closer to staff who

[2] Please note all names (participant and otherwise) are pseudonyms.

shared personal experiences: “I basically told him what happened and then he explained his ex-relationship and it was basically the same and we could relate to each other like what we had been through” (Tom). This reciprocity enhanced the perception that these relationships were like friendships, characterised by flexible boundaries and the disclosure of personal experiences.

However, while participants commonly likened their relationships with professionals to friendships, these interactions were characterised by a hidden complexity, as professionals engaged participants while retaining their professionalism. This is demonstrated in the following quote, in which Hannah describes professionals as being approachable as well as knowledgeable: “I can get sort of another person’s insight (…) whilst being completely honest, yeah? And someone who’s got, someone who sort of knows what they are talking about”. Furthermore, participants’ experiences of their relationships with professionals extended beyond what might be expected in a casual friendship. For example, while Louise repeatedly refers to professionals being “friendly”, she also commented on their constant presence, reliability and ability to respond to difficult emotions. In this way, while some participants’ descriptions of their relationships with professionals are permeated by narratives of friendship, a concurrent thread of professionalism adds an additional element to their experiences.

Laura’s experience varied slightly as she needed professionals to consider her past experiences of receiving care in order to avoid overwhelming her: “It’s a different type of caring (…) it’s ok because it’s a professional type”. It would appear that Laura felt that staff responded to her needs by adapting their interactions to make them more acceptable, empower her and protect their therapeutic relationship.

However, not all participants felt that professionals effectively met their needs via the creation of friendly relationships. This was particularly true for Rebecca who, unlike her

peers, appeared to prefer that professionals took control. Rebecca's desire for a caring yet controlling adult was not always met, possibly as a function of professionals' attempts to relate to her as an adult rather than meeting her need to be in a childlike role. As a result, Rebecca was left feeling uncontained and disappointed: "I was really angry for the staff not doing anything (…) it could have prevented me from being upset". Rebecca's experience further demonstrates the complexity of the professional role which necessitates flexible ways of interacting with, and responding to, adolescents' emotional needs.

Theme Two: Experiencing Acceptance through the Creation of New Group Norms

This theme encompasses participants' experiences of being accepted by their peers, the formation of group norms relating to acceptance and the limits to tolerance. Seemingly, acceptance was conveyed in various ways. Paul describes a physical experience: "They were practically all waiting for me and just welcome with open arms. I had loads of hugs"; whereas Sarah described acceptance in emotional terms: "It can be like you just give each other a look and it's both, like, you know, like, encouraging".

Being accepted in this setting was particularly significant as it contrasted with participants' experiences of feeling different, and consequently isolated, from their peers. This is demonstrated in the following quote in which Rob discusses his experiences in the community: "Well if you told someone in the outside world your problems, who don't go through it themselves, they would probably just judge you like, oh! He's crazy." Heather also reflected upon her experiences of being rejected and isolated by her peers when they became aware of her mental health difficulties: "All these boys, they want to holla at me until they meet me. Until they get to know me. Until they see, wow this girl is fucked". These experiences appear to have taught participants to attempt to conceal their emotions or their authentic selves in order to avoid further isolation.

Participants held the belief that shared experiences facilitated the development of relationships: “I think the reason we all get on so well is because we’ve all experienced very similar things” (Louise). These shared experiences generated an implicit acknowledgement of similarity which reduced feelings of isolation: “I think being in a place like this, it also helped me realise that I’m not the only person that’s struggling” (Laura).

Participants’ commitment to tolerance and acceptance appeared to create an environment in which behaviours which would usually flout social norms, such as the expression of extreme emotions, were met with understanding. This resulted in an experience which contrasted with the stigma and rejection previously experienced. Acceptance featured as a central part of group identity, contributing to expectations which shaped participants’ behaviour. These processes are demonstrated by Amy: “I think the best thing is to act like everything is normal and like don’t judge them or anything and know that everyone is struggling with different things”. However, the group norms also set limits to behaviour resulting in some individuals being excluded: “There was one girl (…) She was, she said some absolutely vulgar things, just vulgar. She was very judgemental. She, she just didn’t fit in” (Rob).

Furthermore, while shared experiences promoted the development of relationships, these similarities also resulted in division. For example, Rebecca reported that some groups were formed on the basis of identification with specific difficulties, such as eating disorders. This resulted in the isolation of those who did not share experience these problems. Rebecca’s experiences further demonstrate the power of the group to exclude individuals as they impose limits to their willingness to demonstrate acceptance.

Theme Three: Intense Relationships can Result in Vulnerability

This theme encompasses participants’ descriptions of the intensity of their friendships and the vulnerabilities associated with these relationships. The intensity within participants’

friendships is exemplified by Tom's choice of language which can be interpreted as an attempt to communicate his commitment to his friendship: "We are like brothers. We are always there for each other (…) So we are basically brothers in here".

For Rob, these intense friendships were protective as he sought comfort in order to adapt to adverse circumstances: "Some traumatic event has brought us all together in this one place in time. Fate. And we all just band together to keep ourselves going now". Rob's reference to "fate" mirrors Louise's experiences of initiating relationships, a process she perceived to be inevitable: "Me and Jenna we clicked straight away (...) I don't know what it is, just like same personality or something". The immediate formation of connections appeared to contribute to the perception that these friendships were special.

Furthermore, these intense friendships appeared to be built upon participants' ability to empathise with others: "I used to feel like a lot of how Zoe felt and that's why it upsets me more (…) I know what she was feeling" (Louise). Seemingly, the ability to empathise with the distress of others promoted meaningful connections which, in turn, motivated attempts to alleviate the discomfort experienced by others.

Specific reference was made to the impact of hearing safety alarms which were interpreted as an indication that others were in danger. For example, Rob described the emotional impact of being exposed, and alerted by alarms to his friends' distress: "Someone could be ligaturing (…) someone could be doing a terrible thing and you worry about people because you all build like a special relationship". For Amy, being in a position of powerlessness enhanced her own discomfort: "It can be quite upsetting (…) it's like you want to help but you don't know how".

The experience of witnessing and being exposed to the distress of others was different for Rebecca, who interpreted the expression of emotion as an indulgence which triggered personal feelings of frustration:

> It makes me erm feel bad, not for them but for myself (…) you feel angry because it's happened so publically … I just wanna like be angry and be able to let it out just as much as they were.

These findings demonstrate the potential effect of being emotionally and physically close to others during admission.

Theme Four: The Unit as a Temporary Safe-haven

This theme includes participants' experiences of finding solace and comfort as they described admission as representing an opportunity to be protected from difficulties within relationships outside of the unit and exposed to interactions which allowed them to experience different ways of interacting with others. However, participants recognised the transient nature of their relief as they acknowledged that admission was not a permanent solution.

For Louise, admission was perceived to be a period of respite which allowed for the repair of ruptures within her relationships: "I think being away from my mum for a bit helped actually 'cuz when she missed me and I missed her then we just started getting on better". Furthermore, admission represented an opportunity to practise communicating about emotional experiences which had previously been concealed. For Hannah, this meant that she was able to be honest with professionals as she no longer feared the consequences of acknowledging her difficulties: "I'm not sort of restricting what I say to them because I'm worried (…) I'll end up in a place like here because I am already here". It would appear that repeated opportunities to discuss their experiences encouraged participants to communicate with people outside of the ward, "There was like lots of secrets and stuff but now like everything's like out in the open so it's easier to talk to them" (Sarah). In this way, admission represented an opportunity to develop different or improved ways of communicating with, and relating to, others.

For Amy, admission represented an opportunity to shelter from the expectations of wider society in a non-judgemental environment (the creation of which is explored in Theme Two): "You don't feel like you have to act a certain way or look a certain way here like they don't really judge you (…) it just like takes the pressure off being perfect". In this instance, admission can be understood to represent an opportunity to experience novel ways of relating to others.

However, participants recognised that admission was unable to provide a permanent solution to their difficulties. For Laura, the temporary nature of admission was perceived as a positive as she experienced frustration regarding the restrictive nature of the unit: "I still feel like it's the safest and most secure place I've been ever but I also still feel like I'd like to leave". These experiences contrast with those expressed by Paul who shared his concerns regarding his ability to cope with reintegrating into his "normal life": "My main worry is doing all this, you know? Being in here, isolated from everything (…) then going back out to my normal life and all the shit comes back (…) and then I'll have to come back".

Despite the temporary nature of admission, participants intended to maintain their friendships post-discharge. In this respect, it would appear that participants felt motivated to maintain the acceptance they had received during admission, perhaps because they recognised that these relationships enhanced their resilience and provided support which was absent outside of unit. However, Tom reflected upon difficulties maintaining relationships through other transitions, therefore drawing into question if friendships would realistically be preserved.

Discussion

The findings of this study evidence the complexities within the relationships adolescents develop with professionals during inpatient admission. These relationships were experienced as being akin to friendships, characterised by reciprocity and humour. It could

be argued that these findings are unsurprising given that relationships in adolescence increase in reciprocity as young people learn how to both receive and provide care (Allen, 2008). Therefore, it could be suggested that adolescents may actively seek reciprocity within their relationships with professionals in order to meet their developmental needs. These findings contrast with previous research with young people which indicates that relationships with professionals are characterised by uneven power distributions (Haynes et al., 2011; Polvere, 2011).

The findings of this research build upon current understanding as they highlight the multi-faceted nature of adolescents' relationships with professionals in the inpatient context. It is suggested that professionals' ability to oscillate between the roles of caregiver and friend may enable adolescents to practise and develop the social-emotional competencies necessary for healthy peer relationships, while seeking comfort and containment within adult relationships (Laible, 2007). These findings can be understood with reference to research exploring parent-child relationships which has suggested that a warm, consistent parenting style, referred to as authoritative parenting, is beneficial for psychological wellbeing (Steinberg, 2001). Participants' descriptions of their relationships with professionals appear to mirror this style of interaction, as they experienced reciprocity and warmth within clear boundaries.

In line with existing literature, the second and third themes demonstrate the importance of peer relationships in adolescence (Berndt, 1989; Brown & Klute, 2006). Furthermore, researchers have argued that group identity becomes of central importance during adolescence as young people seek acceptance (Kroger, 2000). It is argued that "normative regulation" occurs within groups of adolescents, resulting in the development of commonly accepted norms (Brown & Klute, 2006, p. 336). These processes, which are evident in the findings of Theme Two, have been demonstrated in empirical research which

indicates that group norms are affirmed via social interactions (Dishion, Poulin & Burraston, 2001).

These processes can be understood with reference to social identity theory, which states that membership of a particular social group contributes to identity development and self-esteem (Tajfel, 1982). Furthermore, according to Self-Categorisation Theory (Turner et al., 1987), social identities are developed as a result of social comparison and are influenced by the immediate social context. Adolescents who experience a period of inpatient admission encounter a significant alteration in their social environment. They are removed from their homes, schools and communities and placed in a situation in which they are required to negotiate new social relationships. Furthermore, individuals who access inpatient mental health services can be considered to be members of a low-status group, an experience which may further impact upon social identity (Jackson et al., 2009). Therefore, the findings of this research indicate that the inpatient setting impacts upon the ways that adolescents perceive themselves and interact with others.

The importance of feeling accepted, as explored in Theme Two, can be best understood in the context of experiences of stigma and isolation. For example, Roe and Ronen's (2003) qualitative exploration with adult mental health service users suggests that attempts to recreate familiar interactions with fellow service users may arise from the desire to distance oneself from the stigma associated with mental illness, and to mitigate any associated reduction in self-esteem. This hypothesis is supported by Haynes et al. (2011) who suggest that self-esteem is bolstered via peer relationships as adolescents who experience mental health difficulties avoid unfavourable comparisons with those who do not share this experience. The findings of this investigation are further supported by research conducted by Eriksen et al., (2012) which highlights the inherent value of being accepted and

acknowledged by others, especially for those experiencing mental health difficulties (Myung-Yee & Woochan, 2009).

The findings communicated in Theme Three indicate that the friendships developed were also a source of distress as adolescents empathised with their peers. It has been suggested that empathy develops during adolescence as cognitive and relational changes impact upon adolescents' ability to adopt others' perspectives (Van der Graff et al., 2014). While is it recognised that empathy is integral to close emotional relationships (Bukowski, Newcomb & Hartup, 1996), there are associated emotional costs (Smith & Rose, 2011). Smith and Rose (2011) refer to empathic distress, a construct which encompasses the experience of empathising entirely with others' emotional distress, rendering it indistinguishable from personal distress. The findings of this investigation support and build upon previous research, as they provide a possible explanation for the processes underpinning the difficulties experienced when adolescents are exposed to others' distress.

Theme Four encompasses adolescents' perception of admission as an opportunity to be temporarily removed from stressors within their usual environment. In accordance with current understandings, participants commonly reflected on difficulties in their relationships which had contributed to their deteriorating psychological wellbeing (Green, 2002). However, the findings of this study contribute to current understandings as they encompass participants' reports of distress arising from separation and relief associated with a period of respite.

According to Jones (2007), admission to a psychiatric inpatient unit can be conceptualised as a "retreat" (p.327). However, in her psychodynamically informed commentary on adolescents' admission to inpatient settings, she also suggests that the relative safety of the unit serves to prevent meaningful engagement with therapeutic work, as admission is experienced as being less emotionally challenging than life in the community.

In contrast, the findings of this investigation suggest an understanding of the safety of the unit from a different perspective as participants felt more able to communicate openly and it is suggested that, as confidence communicating with professionals increased, participants felt more able to communicate with those within their wider support system. These findings relate to Jones' (2007) suggestion that, ideally, inpatient units should function as "transitional thinking space – on the boundary of inside and out" (p. 328). According to Jones (2007), this would require that inpatient units face "in two directions at the same time … not only on the therapeutic work … but also on the progressive moves outward" (p. 329). It is suggested that the findings of this investigation indicate that adolescents have experienced their admission on these terms as they recognise and accept the transitory nature of their admission while being supported to develop skills which serve to improve their experience following discharge.

Theme Four also included adolescents' reflections on the challenges of discharge and their expectations regarding the continuation of the relationships they had cultivated during their admission. In the context of these findings, it is interesting to consider the impact of the transitory nature of admission, and therefore the inevitability of therapeutic and peer relationships ending. According to Jones (2007), it is not only service users who reflect upon these issues, as professionals also acknowledge that discussions around discharge go "much deeper than medical and clinical responsibility … they cannot be discharged into nothing" (p. 327). Jones (2007) reflects the concerns expressed by adolescents in this investigation, which suggest that they were worried about the maintenance of improvements post discharge in a comparably less supportive environment.

Limitations

As previously mentioned, participants were recruited in accordance with the methodological requirements of IPA. One such requirement demands that participants be

homogeneous in order that a specific experience is captured in detail. A possible limitation of this study relates to the homogeneity of the sample as there were variations in the duration of the admission and previous experiences of hospitalisation which may have contributed to alterations in individual experience. For example, individuals who had experience of longer admissions will, consequentially, have been afforded the opportunity to familiarise themselves with group norms and adapt their behaviour accordingly. However, despite this variation within the sample, it is argued that appropriate homogeneity was achieved as all participants had experienced mental health difficulties necessitating inpatient admission.

It is recognised that debate exists regarding the appropriateness of recruiting larger samples for IPA studies, partly due to the potential impact upon researchers' ability to demonstrate a commitment to an idiographic approach (Reid, Flowers & Larkin, 2005). Therefore, the recruitment of 10 participants could be highlighted as a potential limitation of the research. However, Smith et al. (2009) indicate that it is appropriate to conduct up to 10 interviews for research undertaken as part of a professional doctorate. Furthermore, there are numerous examples of published, peer-reviewed IPA studies conducted with children and adolescents which have sample sizes between 9 and 12 (Back et al. 2011; Hogwood, Campbell & Butler, 2013; Madigan et al. 2013; Petalas et al. 2015; Wallace, Harcourt & Rumsey, 2007).

Furthermore, it is recognised that this relatively small-scale, qualitative study is not able to represent the experience of every young person who accesses inpatient services. Therefore, the applicability of the findings of this research to other contexts should be considered with caution. (For an extended exploration of the concepts of transferability and generalisability, please see Section Three: Critical Appraisal). Nevertheless, this research represents the first qualitative study to specifically explore how adolescents experienced their relationships in the context of inpatient admission.

Implications

These findings highlight the complexity of the professional role, the demands of which would undoubtedly be addressed via the provision of clinical supervision focussing on the therapeutic relationship and the challenges associated with working with groups of adolescents. Therefore, it is recommended that health care support workers, who spend the majority of their time interacting with service users, access supervision to support them to consider these challenges and nurture reflective practice.

In accordance with existing guidance (Green et al., 2007), it is suggested that the maintenance of adolescents' pre-existing relationships be prioritised in order to maximise the benefits of these networks. This is particularly important given participants' concerns regarding the temporary nature of admission and the maintenance of therapeutic gain.

The development of person-centred psychological formulations could be particularly useful in this context given the complex systemic and relational factors found in this research, e.g. that exposure to stigma and social isolation may have a significant impact upon some young people's wellbeing. This approach is endorsed by the UK Division of Clinical Psychology (DCP), who identify the use of formulation within teams as a key skill for clinical psychologists (DCP, 2001). These formulations could be shared informally (Christofides, Johnstone & Musa, 2012) or, alternatively, developed directly with the team (Lake, 2008). This approach, which encourages reflective practice and an enhanced awareness of the impact of transference, may be suited to supporting the consideration of the relational aspects of adolescents' experiences.

Future Research

Further exploration of the impact of admission on adolescents' wider relationships, using either qualitative or quantitative methods, will enhance understanding of how improvements can be maintained following discharge and prompt consideration of ways to

integrate existing support during admission. A quantitative study using techniques such as regression analysis could assess whether wellbeing post-discharge would be predicted by levels of support, having controlled for other relevant factors such as length of admission. Moreover, while a cross-sectional design may be more pragmatic, a longitudinal design may more accurately predict cause and effect relationships. Alternatively, qualitative interviews with adolescents and their family or friends could be conducted in order to explore their experiences of separation imposed by admission.

It may also be beneficial to explore group processes and interactions within the inpatient setting. Given the subject matter, qualitative approaches such as focus groups or interviews could be used to gather individual and group perspectives. Alternatively, future research could focus on the therapeutic function of reciprocity within relationships with professionals. Qualitative methods could be used to capture the perspectives of adolescents and professionals in order to explore issues such as the mutual negotiation of therapeutic boundaries.

Conclusion

This investigation has provided insight into adolescents' perceptions of their relationships during inpatient admission and demonstrated the centrality of relational factors to this experience. It is concluded that clinical psychologists working within inpatient settings should attend to these factors and utilise skills in formulation, training and supervision to support the wider system (Onyett, 2007).

References

Allen, J.P. (2008). The attachment system in adolescence. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of Attachment: Theory, Research and Clinical Application* (2nd ed) (pp. 419-435). London: The Guildford Press.

Arnett, J. J. (1999). Adolescent storm and stress, reconsidered. *American Psychologist, 54*(5), 317. doi:10.1037/0003-066X.54.5.317

Back, C., Gustafsson, P. A., Larsson, I., & Berterö, C. (2011). Managing the legal proceedings: An interpretative phenomenological analysis of sexually abused children's experience with the legal process. *Child Abuse & Neglect, 35*(1), 50-57. doi:10.1016/j.chiabu.2010.08.004

Becker-Stoll, F., Fremmer-Bombik, E., Wartner, U., Zimmermann, P., & Grossmann, K. (2008). Is attachment at ages 1, 6, and 16 related to autonomy and relatedness behaviour of adolescents in interaction towards their mothers? *International Journal of Behavioral Development, 32*(5), 372–380. doi:10.1177/0165025408093654

Berndt, T. J. (1989). Obtaining support from friends during childhood and adolescence. In D. Belle (Ed.), *Children's social networks and social supports* (pp. 308–331). New York: John Wiley & Sons, Inc.

Blanz, B., & Schmidt, M. H. (2000). Practitioner review: Preconditions and outcome of inpatient treatment in child and adolescent psychiatry. *Journal of Child Psychology and Psychiatry, 41*(6), 703-712. doi:10.1111/1469-7610.00658

Bowlby, J. (1969). *Attachment and Loss: Vol. 1. Attachment*. New York: Basic Books.

British Psychological Society. (2005). *Mental Capacity Act 2005: A short reference guide for psychologists and psychiatrists.* London, Law Society. Retrieved from http://www.bps.org.uk/content/mental-capacity-act-2005-short-reference-guide-psychologists-and-psychiatrists

British Psychological Society. (2010). *Code of human research ethics*. Leicester: BPS. Retrieved from http://www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli

Brown, B. B. & Klute, C. (2006). Friendships, cliques, and crowds. In G. R. Adams & M.D. Berzonsky (Eds.), *Blackwell Handbook of Adolescence* (pp. 330-348). Malden, MA: Blackwell. doi:10.1002/9780470756607.ch16

Brown, B. B., & Larson, J. (2009). Peer relationships in adolescence. In R. M Lerner & L. D Steinberg (Eds.), *Handbook of adolescent psychology* (pp. 74-103). Hoboken, New Jersey: John Wiley & Sons. doi:10.1002/9780470479193.adlpsy002004

Bukowski, W. M., Burhmester, D., & Underwood, M. K. (2011). Peer relations as a developmental context. In M. K. Underwood & L. H. Rosen (Eds.), *Social Development: Relationships in Infancy, Childhood, and Adolescence* (pp. 153–179). New York: Guilford Press.

Bukowski, W.M., Newcomb, A.F., & Hartup, W.W. (Eds.), (1996). *The company they keep: Friendship in childhood and adolescence*. New York: Cambridge University Press.

CAMHS Tier Four Steering Group. (2014). *Child and Adolescent Mental Health Services Tier 4 Report*. Retrieved from www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

Children and Young Peoples' Mental Health Taskforce. (2014). *Future in mind – Promoting, protecting and improving our children and young peoples' mental health and wellbeing*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414022/Childrens_Mental_Health.pdf

Choudhury, S., Blakemore, S. J., & Charman, T. (2006). Social cognitive development during adolescence. *Social Cognitive and Affective Neuroscience, 1*(3), 165–174. doi:10.1093/scan/nsl024

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice, 85*(4), 424-435. doi:10.1111/j.2044-8341.2011.02041.x

Coleman, J.C. (2011). *The Nature of Adolescence* (4th Ed.). Retrieved from http://www.myilibrary.com?ID=310299

Collins, W. A., & Laursen, B. (2004). Changing relationships, changing youth interpersonal contexts of adolescent development. *The Journal of Early Adolescence, 24*(1), 55-62. doi:10.1177/0272431603260882

Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient treatment for anorexia nervosa. *European Eating Disorders Review, 12*(5), 307-316. doi:10.1002/erv.587

Corrigan, P. W., Rafacz, J., & Rüsch, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research, 189*(3), 339-343. doi:10.1016/j.psychres.2011.05.024

Department of Health. (2005). *Mental Capacity Act.* London, HMSO. Retrieved from http://www.legislation.gov.uk/ukpga/2005/9/contents

Dishion, T. J., Poulin, F., & Burraston, B. (2001). Peer group dynamics associated with iatrogenic effect in group interventions with high-risk young adolescents. *New Directions for Child and Adolescent Development, 91*, 79-92. doi:10.1002/cd.6

Division of Clinical Psychology. (2001). *The Core Purpose and Philosophy of the Profession*. Leicester: The British Psychological Society. Retrieved from

http://shop.bps.org.uk/clinical-psychology-the-core-purpose-and-philosophy-of-the-profession.html

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology*. (pp. 179-194). London: Sage.

Eccles, F. J., Murray, C., & Simpson, J. (2011). Perceptions of cause and control in people with Parkinson's disease. *Disability and Rehabilitation, 33*(15-16), 1409-1420. doi:10.3109/09638288.2010.533241

Englund, M.M., Kuo, S.I., Puig, J, & Collins, W.A. (2011). Early roots of adult competence: The significance of close relationships from infancy to early adulthood. *International Journal of Behavioral Development, 35*(6), 490-496. doi:10.1177/0165025411422994

Erikson, E. (1968). *Identity, Youth and Crisis*. New York: Norton.

Eriksen, K.A., Sundfor, B., Karlsson, B., Raholm, M., & Arman, M. (2012). Recognition as a valued human being: Perspectives of mental health service users. *Nursing Ethics, 19*(3), 357–368. doi:10.1177/0969733011423293.

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*(2), 209-230. doi:10.1177/146879410200200205

Graber, J. A., & Sontag, L. M. (2009). Internalizing problems during adolescence. In R. M Lerner & L. D Steinberg (Eds.), *Handbook of adolescent psychology* (pp. 642 – 682). Hoboken, New Jersey: John Wiley & Sons. doi: 10.1002/9780470479193.adlpsy001020

Green, J. (2002). Provision of intensive treatment: Inpatient units, day units and intensive outreach. In M. Rutter & E. Taylor (Eds.), *Child and Adolescent Psychiatry* (pp. 1038 – 1050) Oxford: Blackwell Publishing.

Green, J., Jacobs, B., Beecham, J., Dunn, G., Kroll, L., Tobias, C., & Briskman, J. (2007). Inpatient treatment in child and adolescent psychiatry – A prospective study of health gain and costs. *Journal of Child Psychology and Psychiatry, 48*(12), 1259–1267. doi:10.1111/j.1469-7610.2007.01802.x

Green, J.M., Kroll, L., Imre, D., Frances, F.M., Begum, K., Gannon, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(3), 325 – 332. doi:10.1097/00004583-200103000-00012

Grossoehme, D.H., & Gerbetz, L. (2004). Adolescents perceptions of the meaningfulness of psychiatric hospitalization. *Clinical Child Psychology and Psychiatry*, *9*(4), 589–596. doi:10.1177/1359104504046162

Güvenir, T., Taş, F. V., & Özbek, A. (2009). Child and adolescent mental health inpatient services in Turkey: Is there a need and are they effective? *Archives of Neuropsychiatry/Noropsikiatri Arsivi*, *46*(4), 143-148. Retrieved from http://web.a.ebscohost.com.ezproxy.lancs.ac.uk/ehost/pdfviewer/pdfviewer?sid=67236946-d108-4541-a126-367303e43d6e%40sessionmgr4003&vid=1&hid=4101

Hall, G. S. (1904). *Adolescence*. New York: Appleton-Century-Crofts.

Harman, G., & Clare, L. (2006). Illness representations and lived experience in early-stage dementia. *Qualitative Health Research, 16*(4), 484–502. doi:10.1177/1049732306286851

Haynes, C., Eivors, A., & Crossley, J. (2011). 'Living in an alternative reality': Adolescent's experiences of psychiatric inpatient care. *Child and Adolescent*

Mental Health, *16*(3), 150–157. doi:10.1111/j.1475-3588.2011.00598.x

Hepper, F., Weaver, T., & Rose, G. (2005). Children's understanding of a psychiatric in-patient admission. *Clinical Child Psychology and Psychiatry, 10*(4), 557-573. doi: http://dx.doi.org/10.1177/1359104505056318

Hershenberg, R., Davila, J., Yoneda, A., Starr, L., Miller, M., Stroud, C., & Feinstein, B. (2011). What I like about you: The association between adolescent attachment security and emotional behavior in a relationship promoting context. *Journal of Adolescence, 34*(5), 1017-1024. doi:10.1016/j.adolescence.2010.11.006

Hogwood, J., Campbell, T., & Butler, S. (2013). I wish I could tell you but I can't: Adolescents with perinatally acquired HIV and their dilemmas around self-disclosure. *Clinical Child Psychology and Psychiatry, 18*(1), 44-60. doi: 10.1177/1359104511433195

House of Commons Health Committee. (2014). *Children's and adolescents' mental health and CAMHS*. Third Report of Session 15. Retrieved from http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/

Humfress, H., O'Connor, T. G., Slaughter, J., Target, M., & Fonagy, P. (2002). General and relationship-specific models of social cognition: Explaining the overlap and discrepancies. *Journal of Child Psychology and Psychiatry, 43*(7), 873-883. doi:10.1111/1469-7610.0013_7

Jackson, L., Tudway, J. A., Giles, D., & Smith, J. (2009). An exploration of the social identity of mental health inpatient service users. *Journal of Psychiatric and Mental Health Nursing, 16*(2), 167-176. doi: 10.1111/j.1365-2850.2008.01361.x

Jacobs, B., Green, J., Kroll, L., Tobias, C., Dunn, G., & Briskman, J. (2009). The effect of inpatient care on measured health needs in children and adolescents. *Journal of*

Child Psychology and Psychiatry, 50(10), 1273-1281. doi:10.1111/j.14697610.2009.02093.x

Jones, S. G. (2007). Negotiating time: the significance of timing in ending inpatient work. *Journal of Child Psychotherapy, 33*(3), 325-344. doi:10.1080/00754170701667205

Kroger, J. (2000). *Identity development: Adolescence through adulthood*. Thousand Oaks, California: Sage.

Laible, D. (2007). Attachment with parents and peers in late adolescence: Links with emotional competence and social behaviour. *Personality and Individual Differences, 43*(5), 1185-1197. doi:10.1016/j.paid.2007.03.010

Lake, N. (2008). Developing skills in consultation 2: A team formulation approach. *Clinical Psychology Forum, 186,* 18–24. Retrieved from http://shop.bps.org.uk/clinical psychology-forum-no-186-june-2008.html

Laursen, B., & Collins, W. A. (2009). Parent—child relationships during adolescence. In R. M Lerner & L. D Steinberg (Eds.), *Handbook of adolescent psychology* (pp. 3-42). Hoboken, New Jersey: John Wiley & Sons. doi: 10.1002/9780470479193.adlpsy002002

Madigan, S., Quayle, E., Cossar, J., & Paton, K. (2013). Feeling the same or feeling different? An analysis of the experiences of young people in foster care. *Adoption & Fostering, 37*(4), 389-403. doi:10.1177/0308575913508719

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology, 3*(5), 551-558. doi:10.1037/h0023281

McDougall, T., Worrall-Davies, A., Hewson, L., Richardson, G., & Cotgrove, A. (2008). Tier 4 Child and Adolescent Mental Health Services (CAMHS) - Inpatient Care, Day services and alternatives: An overview of Tier 4 CAMHS provision in the UK. *Child and Adolescent Mental Health, 13*(4), 173-180. doi:10.1111/j.14753588.2007.00481.x

Meeus, W. (2011). The study of adolescent identity formation 2000–2010: A review of longitudinal research. *Journal of Research on Adolescence, 21*(1), 75-94. doi:10.1111/j.1532-7795.2010.00716.x

Meredith, L. S., Stein, B. D., Paddock, S. M., Jaycox, L. H., Quinn, V. P., Chandra, A., & Burnam, A. (2009). Perceived barriers to treatment for adolescent depression. *Medical Care, 47*(6), 677-685. doi:10.1097/MLR.0b013e318190d46b

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine, 70*(7), 985–993. doi:10.1016/j.socscimed.2009.12.022

Muris, P., Meesters, C., van Melick, M., & Zwambag, L. (2001). Self-reported attachment style, attachment quality, and symptoms of anxiety and depression in young adolescents. *Personality and Individual Differences*, *30*(5), 809-818. doi:10.1016/S0191-8869(00)00074-X

Myung-Yee, Y., & Woochan, S. (2009). Couples with schizophrenia 'becoming like others' in South Korea: Marriage as part of a recovery process. *Family Process, 48*(3), 429-440. doi:10.1111/j.1545-5300.2009.01293.x

Nangle, D. W., Erdley, C. A., Newman, J. E., Mason, C. A., & Carpenter, E. M. (2003). Popularity, friendship quantity, and friendship quality: Interactive influences on children's loneliness and depression. *Journal of Clinical Child and Adolescent Psychology*, *32*(4), 546-555. doi:10.1207/S15374424JCCP3204_7

National Health Service England. (2014). *C07. Tier 4 Child and Adolescent Mental Health Services (CAMHS)*. Retrieved from http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-c/c07/

Noller, P., & Atkin, S. (2014). *Family Life in Adolescence.* Retrieved from: http://www.degruyter.com/viewbooktoc/product/447873

O'Driscoll, C., Heary, C., Hennessy, E., & McKeague, L. (2012). Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence. *Journal of Child Psychology and Psychiatry, 53*(10), 1054–1062. doi:10.1111/j.1469-7610.2012.02580.x

Onyett, S. (2007). *New Ways of Working for Applied Psychologists in Health and Social Care - Working Psychologically in Teams.* Leicester: British Psychological Society.

Pelkonen, M., Marttunen, M., & Aro, H. (2003). Risk for depression: A 6-year follow-up of Finnish adolescents. *Journal of Affective Disorders, 77*(1), 41-51. doi:10.1016/S0165-0327(02)00098-8

Petalas, M. A., Hastings, R. P., Nash, S., & Duff, S. (2015). Typicality and subtle difference in sibling relationships: Experiences of adolescents with autism. *Journal of Child and Family Studies, 24*(1), 38-49. doi:10.1007/s10826-013-9811-5

Polvere, L. (2011). Youth perspectives on restrictive mental health placement: Unearthing a counter narrative. *Journal of Adolescent Research, 26*(3), 318 – 343. doi:10.1177/0743558410391257

Reavley, N. J., & Jorm, A. F. (2011). Young people's stigmatizing attitudes towards people with mental disorders: Findings from an Australian national survey. *Australian and New Zealand Journal of Psychiatry*, *45*(12), 1033-1039. doi:10.3109/00048674.2011.614216

Reid, K., Flowers, P., & Larkin, M. (2005). Interpretative phenomenological analysis: An overview and methodological review. *The Psychologist, 18*(1), 20–23. Retrieved from: http://thepsychologist.bps.org.uk/volume-18/edition-1/exploring-lived-experience

Roe, D., & Ronen, Y. (2003). Hospitalization as experienced by the psychiatric patient: A therapeutic jurisprudence perspective. *International Journal of Law & Psychiatry, 26*(3), 317-332. doi:10.1016/s0160-2527(03)00041-4

Shaver, P. R., & Mikulincer, M. (2002). Attachment-related psychodynamics. *Attachment & Human Development, 4*(2), 133-161. doi:10.1080/14616730210154171

Skrove, M., Romundstad, P., & Indredavik, M. S. (2013). Resilience, lifestyle and symptoms of anxiety and depression in adolescence: The Young-HUNT study. *Social Psychiatry and Psychiatric Epidemiology, 48*(3), 407-416. doi:10.1007/s00127-012-0561-2

Smetana, J. G., Campione-Barr, N., & Metzger, A. (2006). Adolescent development in interpersonal and societal contexts. *Annual Review of Psychology, 57*, 255-284. doi:10.1146/annurev.psych.57.102904.190124

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Smith, R.L., & Rose, A.J. (2011). The "cost of caring" in youths' friendships: Considering associations among social perspective taking, co-rumination, and empathic distress. *Developmental Psychology, 47*(6), 1792–1803. doi:10.1037/a0025309

Steinberg, L. (2001). We know some things: Parent – adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence*, 11(1), 1-19. doi:10.1111/1532-7795.00001

Street, C., & Svanberg, J. (2003a). *Where Next? New directions in in-patient mental health services for young people. Report 1. Different models of provision for young people: facts and figures.* London: YoungMinds

Street, C., & Svanberg, J. (2003b). *Where Next? New directions in in-patient mental health services for young people. Report 2. Issues emerging: views from young people, parents and staff*. London: YoungMinds.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Review of Psychology, 331 (1),* 1–39. doi: 10.1146/annurev.ps.33.020182.000245

Turner, J.C., Hogg, M.A., Oakes, P.J., Reicher, S.D., & Wetherell, M.S. (1987). *Rediscovering the social group: A self-categorization theory*. Oxford, UK: Blackwell.

Van der Graaff, J., Branje, S., De Wied, M., Hawk, S., Van Lier, P., & Meeus, W. (2014). Perspective taking and empathic concern in adolescence: Gender differences in developmental changes. *Developmental Psychology, 50*(3), 881-888. doi:10.1037/a0034325

Van Durme, K., Braet, C., & Goossens, L. (2015). Insecure attachment and eating pathology in early adolescence: Role of emotion regulation. *The Journal of Early Adolescence, 35*(1), 54-78. doi:10.1177/0272431614523130

Venta, A., Sharp, C., & Newlin, E. (2015). A descriptive study of symptom change as a function of attachment and emotion regulation in a naturalistic adolescent inpatient setting. *European Child & Adolescent Psychiatry, 24*(1), 95-104. doi:10.1007/s00787-014-0532-0

Wallace, M., Harcourt, D., & Rumsey, N. (2007). Adjustment to appearance changes resulting from meningococcal septicaemia during adolescence: A qualitative study. *Developmental Neurorehabilitation, 10*(2), 125-132. doi:10.1080/13638490701217313

Warren, J. S., Jackson, Y., & Sifers, S. K. (2009). Social support provisions as differential predictors of adaptive outcomes in young adolescents. *Journal of Community Psychology, 37*(1), 106–121. doi:10.1002/jcop.20273

Table 1. Table showing examples of exploratory comments (developed in step two of analysis) and emergent themes (developed in step three of analysis) for a section taken from the transcript of the interview with Hannah

Emergent Themes	Transcript	Exploratory Comments
Symptoms of mental health cloud relationships	R: Erm there's a lot of sort of quite a bit of bitchiness let's say not sure if I'm allowed to say that	Implies pettiness / bullying 'lets say' uncertainty? Unsure if she can say this ?power of the researcher
	I: No its fine	
	R: Yeah its quite quite a bit of that but you would expect that because there's a lot of girls erm and there's like they get on but I'm not sort of sure to what extent it is that they get on it sort of seems that they are almost but like with some of them it's sort of difficult to know because some people's symptoms are sort of more visible and they are more dominant than others	Repeated word? Expectations re: female relationships ?sincerity Difficult to understand the relationships that other young people develop Impact of 'symptoms' – illness impacts on relationships Does 'illness' link to personality i.e. dominance? Are illness and dominance perceived as two separate things?
	I: Mmmm	
The process of "fitting in" can be related to identification with mental illness	R: So it's sort of like just sort of it seems like are getting by but some of them seem to enjoy being here erm some of them erm seem to have fit in rather quickly than what I did like they seem to feel quite comfortable here quite quickly	Trying to acknowledge impact of mental health? Some people have relationships to 'get by' – necessary to survive the experience? Influent – difficult to describe or understand? Implying that it would be unusual to enjoy being on the unit? Dubious about those who fit in quickly – because it's different from their experience
	I: Mmm	
	R: But yeah I don't know if that answers your questions	Some but not all? There are exceptions?
	I: Yeah it does yeah its interesting so you've kind of chosen to keep yourself away from that environment do you think that the can you kind of describe what you see in the nature of the relationships young people develop here?	Desire to 'get it right'? Please the interviewer?
	R: I don't get it	
	I: Like you said that some people fit in quite quickly	
	R: Yeah	
	I: What do you think that's about?	
	R: Erm not sure	Finding it difficult to understand the relationships developed with others?
	I: Difficult to know	

Informal interactions underpin relationships Power imbalances within relationships can be apparent Choosing to disclose as a consequence of 'personal' relationships Disclosure aided by professionalism and approachability	R: Yeah I: What about the staff can you tell me about the staff R: Some of the staff well quite a few of the staff are good they are great can like have a chat with them and sort of have a laugh with them but some of them are a bit erm (laughs) a bit erm not so great (laughs) but only some not not most of them and they they are not horrible don't get me wrong but they are just a bit they can seem a bit arsey sometimes but erm the staff are like they're supportive and you can sort of go to them when you've got a problem and they will try and sort it out and yeah I: Can you tell me about your relationships then with the staff? R: In what way I: What are they like are they like any other relationships that you have in your life could you compare or contrast them with others? R: Erm the relationships are more personal than what you would have say with my teacher they are a lot more personal than that because I'm sort of like able to speak about the things that are personal to me and there's not sort of like almost I can't I'm not sort of restricting what I say to them because I'm worried about that they I don't know will tell student support and then I'll end up in a place like here because I am already here so erm its more personal but its good because I can get sort of another person's insight into sort of and advice into what's happening without like whilst being completely honest yeah and someone who's got someone who sort of knows what they are talking about so that's quite good I: Ok so those relationships are different then to other adults I suppose other teachers and stuff like that R: Yeah I: Erm so how did you develop those relationships how did you find that first initial getting to know each other stage?	Language used implies casual conversations 'chat' – pleasant interactions Reluctant to criticise the staff Qualifying previous comment in order to 'neutralise' negative comment? 'arsey'? lacking something? Or intent? Doing it on purpose? Approachable? Staff can be trusted to help with problems – they are able to help / resolve difficulties. Is she referring to practical difficulties or to emotional help. These relationships are different ?personal – honest / candid? Feels more able to disclose? Depth of relationship? Not restricted because of fears of implications There are usually implications when you disclose personal difficulties – the worst has already happened? Implies that it would usually be bad for relationships to be more personal – this is a different experience Staff are able to offer trusted advice The importance of honesty, implies that has previously withheld information Staff 'know what they are talking about' – experience or expertise

	R: Erm found it ok cuz they were like they sort of all of them approached me like o your X oh hi I'm X how are you doing? how are you settling in? so they were all quite friendly so there wasn't no sort of erm there wasn't anyone who was sort of (inaudible) really I: So they made those first steps	Initiation of relationships eased because staff took responsibility 'friendly' like peer relationships or does she mean approachable / kind

Figure 1. Figure showing how polarisation was used to develop a super-ordinate theme for Hannah (step four of analysis)

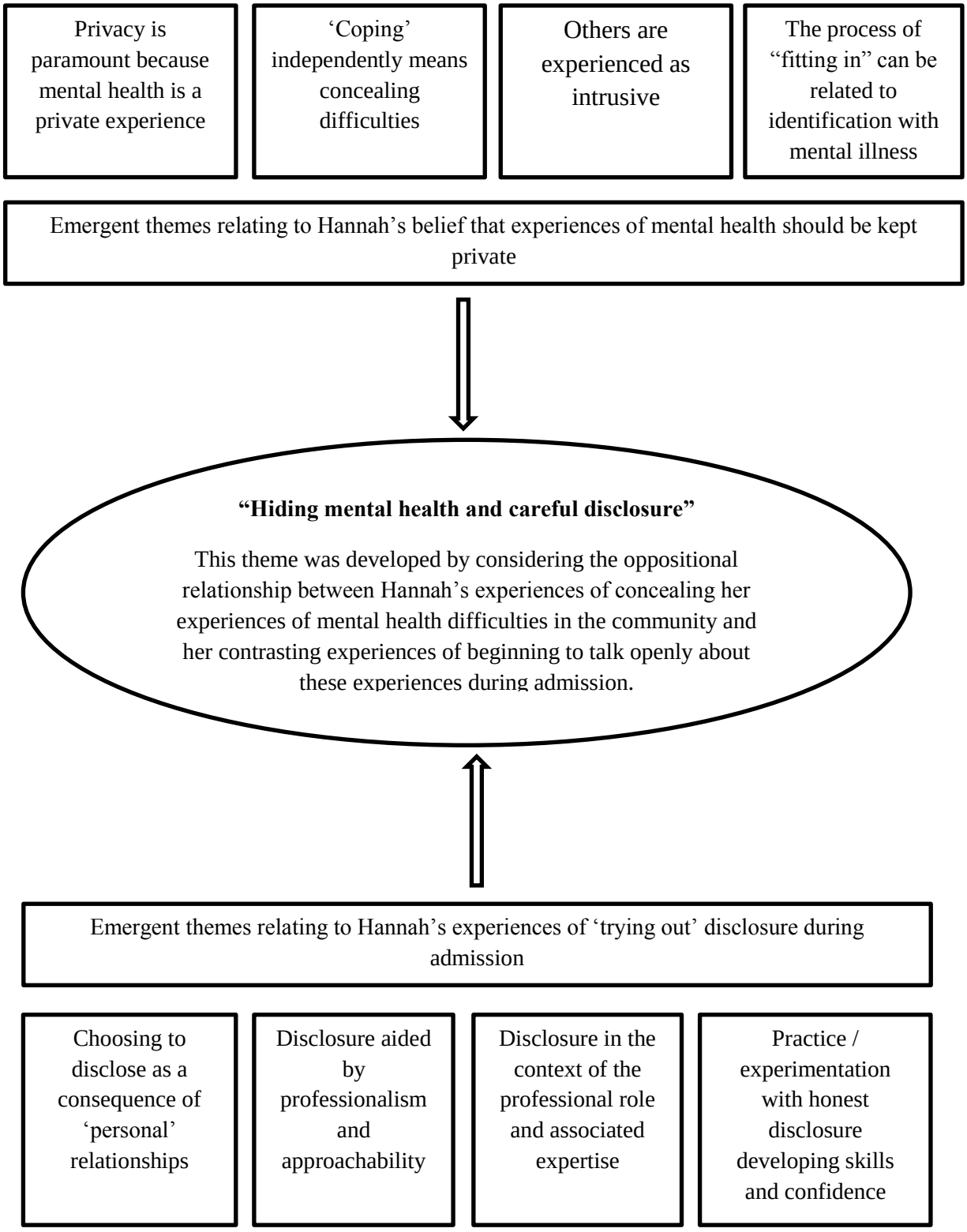

Table 2. Table showing the development of super-ordinate themes for Hannah (step four of analysis)

Super-ordinate Themes	Emergent Themes	Exemplar Quotes from Transcript
Attempts to protect her identity as an adult – This theme includes Hannah's experiences of being treated as an adult who is able to have agency over her own life. Her identity is rooted in being seen as mature – this shapes the way that she is perceived by others and the way in which she perceives herself (especially when she compares herself with her peers). In order for professionals to be perceived as helpful they need to acknowledge the importance of this aspect of Hannah's identity. Hannah desires for staff to treat her as an equal and she recognises similarities between her and the staff which enhance this perception of equality. When staff acknowledge how important it is for Hannah to be treated as an equal and an adult she feels more able to seek help. However, the focus on protecting this aspect of her identity serves to distance Hannah from others (e.g. peer group and her Mum).	Valuing experiences of taking responsibility / making shared decisions Professionals are perceived to be most able to help when they treat Hannah as an equal – friendly but professional Able to identify commonalities between Hannah and the staff Juggling maintaining independence whilst asking for help Professionals scaffolding interactions in order to make them feel more acceptable and less intrusive Respect is mutual and earnt – adults treat others with respect Fighting for independence despite families expectations Power imbalances within relationships can be apparent	"Erm … I felt a bit sort of I felt like I was this is going to sound silly I felt like an adult like in a nursery if that makes sense and like and just seeing that a lot of the other girls were dead young or dead immature … it just sort of felt like like that like I was in a nursery" "I've always had to sort of do things myself and deal with it myself so I've not sort of I'm not really used to having someone there who I can like who I can almost say "right I'm struggling. I need you to help me". I was always sort of done it myself and that's sort of worked until now" "Erm I think just personally because they are quite young so we sort of they know how to sort of erm speak to me without patronising me (…) When people sort of meet me initially they speak to me normally because they think I'm older but when they find out my age they sort of start speaking down to me which I hate"

Hiding mental health and careful disclosure – This theme relates to Hannah's perception that, even within the more intimate of relationships, talking about emotional experiences and mental health is not acceptable. Hannah emphasises the importance of maintaining her privacy. This is achieved via a strong identification with the belief that she is a strong, capable adult and partly by the maintenance of a physical distance from her peers. Hannah also suggests that she believes that she has a responsibility to protect others from exposure to her distress. However, Hannah appears to recognise that disclosure can happen in a controlled way with professionals within the inpatient environment. It is possible that admission represents an opportunity for Hannah to develop the skills necessary to communicate more openly about her experiences and ask for help.	Choosing to disclose as a consequence of 'personal' relationships Disclosure aided by professionalism and approachability Privacy is paramount because mental health is a private experience Disclosure in the context of the professional role and associated expertise The process of "fitting in" can be related to identification with mental illness 'Coping' independently means concealing difficulties Others are experienced as intrusive Practice / experimentation with honest disclosure developing skills and confidence	"Erm the relationships are more personal than what you would have say with my teacher. They are a lot more personal than that because I'm sort of like able to speak about the things that are personal to me (…) I'm not sort of restricting what I say to them because I'm worried about that they, I don't know, will tell student support and then I'll end up in a place like here because I am already here!" "I can get sort of another person's insight into sort of and advice into what's happening (…) whilst being completely honest. Yeah, and someone who's got, someone who sort of knows what they are talking about so that's quite good"

Table 3. Table showing how individual emergent themes (step three of analysis) contribute to the development of super-ordinate themes (step four of analysis) for each participant

Participant	Super-ordinate Themes	Emergent Themes
Hannah	Please see Table 2 for Super-ordinate Themes	Please see Table 2 for Emergent Themes
Rebecca	Mental health as a connecting force	Having a connection with others is a protective experience
		Understanding of mental health can only be accessed via direct experience
		Shared experiences act as the key to connection
		Relationships formed on the basis of a shared or implicit recognition of similarities in experience
		Identifying so clearly with a diagnosis of problem that it defines you
	Not being able to come to terms with the imperfect carer	Please see Table 4 for Emergent Themes
	It is undesirable for anyone to express emotion	Expression of emotion is contagious – knock on impact
		Others expression their emotion is undesirable too – a calm environment is preferable
		"Otherness" or undesirability of people with mental health difficulties

		Emotions are a part of you which it is best to deny
		Mental health difficulties are out of your control and they "cause" incidents not you
		Any undesirable emotion should be defended against or avoided
	The perfect carer should protect me from my emotions	Ward perceived as a place of safety
		Professionals perceived as being able to hold emotion
		Professionals need to "manage" situations and take responsibility – they don't always do this
		The responsibility to attend to emotions is located outside of the self
Laura	The variable experience of control and empowerment	Please see Table 4 for Emergent Themes
	Compassion and shared experiences are key to relationships	Engaging in interactions which aren't problem focussed allow insight to other aspects of identity
		Professionals as non-threatening – a shared humanity
		Learning how to be "safe" from others because they understand
		Connections formed as a result of having a common understanding

		There is value in seeing the perspective of others
		Communal living can be challenging because they are all "human"
Sarah	Shared experience and a focus on mental health bolsters relationships	The environment is accepting because difficulties can't be denied
		Communication is expected and accepted because professionals have expertise
		Shared experiences "sure" up friendships
		Being aware that others are experiencing difficulties too
		Putting everything "out in the open" aids communication
		A shared language because of shared experiences
		The value of feeling understood by others – unspoken support
	An unavoidable focus on mental health and emotions	The unit is a constant reminder that you have mental health difficulties
		Admission means that difficulties can't be avoided
		The obvious presence of difficulties mean that they must be discussed
Tom	Staff balancing being alongside young people whilst still being seen as helping professionals	Please see Table 4 for Emergent Themes
	"Like brothers"	There's something unseen about the ways in which relationship develop,

		it's "magical"
		Relationships develop in way that you can't explain
		Relationships should be valued and defended
		Appreciating the ability of people to be two things – annoying and nice
		Experiencing an instant connection
		Finding people to fit in the role of family
Louise	When others distress becomes your own	Having insight taps into your own feelings
		Witnessing others emotional distress has an impact on you because you are friends with them
		Emotional connection = empathy
		Mental health problems can make you (and others) more difficult to live with
		Empathy can be burdensome because you understand how others feel
	Staff foster a belief that young people are worthy of their time	Please see Table 4 for Emergent Themes

	Experiencing mental health problems allows you access to an exclusive in-group	Living in close proximity forges friendships
		You need friends to get through the experience
		Friendships “just happen”
		Friendships are unconscious and effortless
		Some problems convey access to the group more readily than others
		Group membership is powerful when you have experienced isolation
		The shared experience of mental health difficulties is bonding
Amy	The role of acceptance	Non-judgemental environments help you to relax
		Accepting others even if they are difficult to live with
		Others who have similar experiences are more accepting of you
		Non-judgemental staff are more approachable (but those who judge keep you safe because of fear)
		The presence of others can be comforting
		Finding alternative ways of communicating to “get around” difficulties
		Staff are consistently present and can bear to witness distress
	Conflicts related to giving and receiving help	Feeling under increased amounts of pressure can cause you to withdraw

	Others difficulties mean you have to tread carefully
	Accepting help because staff have expertise
	There is ambivalence about getting help because she doesn't want to change
	Asking other young people for help is easier – they understand and young people support each other
	The desire to help others can occur at the same time as wanting to be helped
	You can't manage difficulties on your own and others need to "reach out"
	Professionals need to recognise she is trying to make changes
	Others reluctance to get help can contribute to her own ambivalence
	You want to help but don't know how
	There are different "levels" of care (robotic care and genuine care)
	Staff need to work hard to keep young people in mind
	Others can take responsibility for safety
A temporary solution	Physical distance between you and things that might hurt you
	Distance improves relationships with family – appreciating them more fully
	Friendships can be maintained if they are real

		Seeing others move on and being left behind
		A place removed from the expectations of peers
		Getting back “home”
Rob	United against adversity	“Illness” conceptualised as something that takes over – out of your control
		Mental health takes you to a ‘bad place’
		Mental health can result in people judging you but you are accepted on the unit
		Judged for something that is out of your control
		Relationships developed quickly because there is a shared struggle
		Refraining from judgement is central to Robs perception of group identity
		Mental health conveys rejection by others in the wider society
		Belonging and feeling accepted is central
		“Group therapy” is protective
		Acceptance of others difficulties – setting this aside
		Perceptions influenced by public perceptions of mental health and admission

		Mental health is out of control of young people – brought here by fate
	Taking on others troubles – An accumulation of distress	Worry about others contributes to own distress
		The demands of holding someone else in mind
		Concerns about a genuine threat to life (self and others)
		Rather than reducing distress, admission enhances it
		Emotional contagion – copying behaviour
Paul	Seeing experiences on the unit as being a temporary respite that won't resolve difficulties in the longer term	There's an accumulation of stress outside which is unmanageable
		Overwhelming emotions which are out of your control – therefore, you aren't accountable
		Isolated from difficulties – will the improvements made translate?
	The unit is a safe place that can contain emotions which are usually perceived as uncontrollable in nature	Metaphorical and actual "open arms"
		Experiences of being treated as an adult – relationships with staff are reciprocal
		The unit as a place of safety – shelter from stress
		Professionals should protect you from external pressure
		Admission providing perspective

	The emotional costs and benefits of friendship	The cost of supporting peers
		Physical and emotional proximity makes you vulnerable
		Letting people in can be dangerous
		Inclusion – being part of something
		The exchange of mutual support
		Immediate connection (in contrast to previous rejection)
		Others can be experienced as intrusive – demanding he shares information
Heather	Emotions overwhelm you and others	Mental health difficulties will cause you to be rejected
		Emotional experiences are dangerous and should be guarded against
		Hiding emotions (what you see isn't reality)
		It's more acceptable to provide others with "polished" version
		Mental health difficulties can be central (to the individual and the family)
		Mental health blocks future plans
		Loss of relationships and identity because of mental health
		Emotions are overwhelming and multiple
		Mental health comes and goes and has a huge impact

	You battle against difficulties to be “ok”
	Emotions aren’t easily understood by others
	Daily battle with burdensome past experiences
	Emotions are uncontrollable and overwhelming
Feeling forced into a position of powerlessness	Please see Table 4 for Emergent Themes

Table 4. Table demonstrating how individual emergent themes (step three of analysis) and super-ordinate themes for each participant (step four of analysis) contribute to the development of "Theme One: The complexity of the professional role – The incorporation of friendship and expertise (step six of analysis)

Individual Super-ordinate Themes Contributing to Theme One	Emergent Themes Contributing to Super-ordinate Themes for Each Participant	Exemplar Quotes from Transcripts
Tom *Staff balancing being alongside young people whilst still being seen as helping professionals*	Reciprocity – professionals giving something of themselves "Banter" or convivial joking creates a sense of balance between professionals and young people Interacting on a human level "Banter" as the social glue – predictable, implicit rules regarding interactions put you at ease Humour can be the antidote at the time of upset Professionalism is the added extra Meaningful conversations can happen "alongside" staff Staff trusting you is important and can help you mitigate feelings of powerlessness Young people deserve to be treated with equity / respect Reciprocity is "bonding"	"If you are having banter with the staff you get good relationships with them (…) they can understand you better" "The reason why I've bonded with (member of staff) is basically he's been through the same thing that me and my ex have been through" "He explained his ex-relationship and it was basically the same and we could relate to each other, like what we had been through, and I've got to be really honest with you it really did help me" "I was still feeling like I needed to talk to someone more professional if you know what I mean (…) so I walked over to (Member of staff)"

Louise *Staff foster a belief that young people are worthy of their time*	People convey they care by "being there" It is meaningful when professionals make sacrifices for me Professionals going beyond expectations Being 'supported' means feeling able to ask for help Professionals are perceived as being physically and emotionally present Being noticed Being heard enhances her willingness to seek help Staff are capable of absorbing and containing young people's emotion Professionals as friends	"Like they give you support when you need it and stuff … erm … and like sometimes when they have got a break sometimes they won't go on a break and they will support you instead" "I remember the first the first time I was in here and (Member of staff) was on shift and I was sat my room (…) and (Member of staff) came in and sat with me for ages and cheered me up" "The staff actually do bend over backwards for us all. If someone is upset they are always there for you and stuff."
Laura *The variable experience of control and empowerment*	The necessity for admission is perceived as a failure or personal shortcoming Your coping mechanisms are inhibited as a function of the environment Feeling overwhelmed by dominant characters enhances sense of loss of control Feeling "trapped" Acceptable of a undesirable situation in the interests of	"Erm, I don't know I was quite conflicted (…) I knew it would be the safest place for me at the time" "I still feel like it's the safest and most secure place I've been ever. But I also still feel like I'd like to leave. Erm its done a lot for me though" "Little things can escalate if you are all trapped in the same place"

	"what's best" There are limits to the care that adults can provide Receiving care can be overwhelming – staff being "professional" can be protective	"It's a different type of caring … it's ok because it's a professional type"
Hannah *Attempts to protect her identity as an adult*	Valuing experiences of taking responsibility / making shared decisions Professionals are perceived to be most able to help when they treat Hannah as an equal – friendly but professional Able to identify commonalities between Hannah and the staff Juggling maintaining independence whilst asking for help Professionals scaffolding interactions in order to make them feel more acceptable and less intrusive Respect is mutual and earnt – adults treat others with respect Fighting for independence despite families expectations Power imbalances within relationships can be apparent	Please see Table 2 for Exemplar Quotes.
Rebecca *Not being able to come to terms with the imperfect carer*	The boundaries of the carer – imposition of rules or inability to fulfil all desired roles or expectations can impact adversity Unable to tolerate the range within staff identity – either one role or the other	"There was a staff like right in the room with us watching us and knowing there was gonna, something was going to happen (…) staff didn't do anything and erm I got really upset about it (…) I was

	Creating dependency on the "unit" – a safe place which can deskill you because it's not like this at home	really angry for the staff not doing anything (…) That could have been prevented, it could have prevented me from being upset. Like a domino effect"
	Feelings of disappointment when staff don't meet expectations	"If I wanted to go out today, like now, and they were like "No, you can't. We don't have enough staff". You do kind of get angry and a bit frustrated because it's not your fault"
	Limitations of care result in frustration	
	Experiences of staff setting boundaries can influence her perception of them	"At that time I was just really angry at the staff because erm like after I had an incident (…) they'd yell and have a go. Or be really strict in a horrible way (…) There's no need to be like that. I understand if someone was at risk but (…) There's a nicer way of going about it"
Heather *Feeling forced into a position of powerlessness*	Usual coping mechanisms can't be accessed – the environment is a barrier	"I feel like since I've come in the system I've been trapped and it's hindering me now. I need to move on but I can't move on"
	Relationships are functional – an attempt to take back control	
	Feeling unable to make people understand	"When I was in my Section Two I served my sentence but I got released on bail. Misled, misplaced, mistreated, misunderstood and bounced back to where I am. Fighting these daily battles over and over again"
	Feeling out of control in relation to interpersonal stressors – inevitable conflict that staff don't intervene in	
	Experience of loss which are multiple and in different areas of her life	"For the night I thought. I was brought

	People aren’t trustworthy	here under false pretences. I was sent home under false pretences”
	People disregard your needs	“Then I wrote that (reads) “why does everyone have to leave me?” and then my key nurse says I’ve got attachment issues. She says to me when I was throwing up, “Well whose fault is that?” Well obviously it’s my fucking fault you tight cow.”
	Other people can do things to you against your will	
	People manipulate you even when you trust them	
	Others actions experienced as abusive	

Table 5. Table demonstrating how individual super-ordinate themes for each transcript (step four of analysis) contribute to the development of super-ordinate themes for the entire dataset (step four of analysis)

Super-ordinate Themes for Entire Dataset	Participant	Individual Super-ordinate Themes Contributing to Super-ordinate Themes for the Entire Dataset
Theme One: The complexity of the professional role – The incorporation of friendship and expertise	Tom	Staff balancing 'being alongside' young people whilst still being seen as helping professionals
	Louise	Staff foster a belief that young people are worthy of their time
	Laura	The variable experience of control and empowerment
	Hannah	Attempts to protect her identity as an adult
	Rebecca	Not being able to come to terms with the imperfect carer
	Heather	Feeling forced into a position of powerlessness
	Rob	United against adversity
Theme Two: Experiencing acceptance through the creation of new group norms	Louise	Experiencing mental health problems allows you access to an exclusive in-group
	Laura	Compassion and shared experiences are key to relationships
	Rebecca	Mental health as a connecting force
	Sarah	Shared experience and a focus on mental health bolsters relationships
	Paul	The emotional costs and benefits of friendship
	Amy	The role of acceptance

	Rob	United against adversity
	Hannah	Hiding mental health and careful disclosure
	Heather	Emotions overwhelm you and others
Theme Three: Intense relationships can result in vulnerability	Louise	When others distress becomes your own
	Rebecca	Mental health as a connecting force / It is undesirable for anyone to express emotion
	Paul	The emotional costs and benefits of friendship
	Tom	Like brothers
	Rob	United against adversity / Taking on others troubles – An accumulation of distress
	Amy	Conflicts related to giving and receiving help
Theme Four: The unit as a temporary safe-haven	Paul	Seeing experiences on the unit as being a temporary respite that won't resolve difficulties in the longer term / The unit is a safe place that can contain emotions which are usually perceived as uncontrollable in nature
	Amy	A temporary solution
	Tom	Being like brothers
	Rebecca	The perfect carer should protect me from my emotions
	Laura	The variable experience of control and empowerment