

A qualitative study exploring adolescents' experiences of peer relationships in an
inpatient CAMHS setting

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Research Summary

Aims: To explore the lived experiences of peer relationships within an adolescent psychiatric inpatient setting and investigate how adolescents perceive peer relationships to influence their psychological wellbeing.

Background: During adolescence peer relationships play an integral role in development, where shifts occur in attachment from parents towards friendships. Complex and relational trauma are highly prevalent in the inpatient population, this influences the formation of relationships with peers which are intensified within the therapeutic milieu. It is well-known that peer relationships in adolescence can impact on mental health. Such relationships are likely to have a profound influence upon recovery, wellbeing and service outcomes. However, little is known about how these peer relationships are experienced by young people and their influence on psychological wellbeing within the inpatient setting.

Methodology: A qualitative methodology was utilized within an interpretivist paradigm. The sample comprised 8 participants; 5 females and 3 males, recruited from a single psychiatric inpatient unit using purposive sampling. Data was gathered from semi-structured interviews and analysed using inductive thematic analysis.

Results: Four main themes, each with a number of subthemes, emerged from the dataset. Peer relationships were fragile and jealousy and distrust were common, fuelled by fears of abandonment and rejection. Dilemmas and difficulties within peer relationships were acknowledged, with participants describing competition for staff attention, bullying and challenges with discharge and maintaining boundaries. For some the inpatient environment was experienced as unsafe and triggering, which influenced patients' recovery and the formation of peer relationships. Relationships

brought a number of benefits including normality, shared experience, acceptance and the sense of being cared for.

Conclusion: Peer relationships are complex and may have positive and negative influences on psychological wellbeing. Findings are discussed in the context of psychological theory and existing literature. Clinical implications are outlined including staff management of relationships and utilization of peer support.

CHAPTER ONE: INTRODUCTION

Chapter overview

This chapter outlines theories and research pertinent to the study aims, including the historical and clinical context of adolescent inpatient units and theories of development in adolescence. The relationship between attachment and mental health difficulties is discussed as well as the theoretical underpinnings of adolescent inpatient units and impact of hospitalization during this key developmental period. The important role of peer relationships in adolescence and the influence of peers both hindering and facilitating mental health recovery are explored. Lastly, research regarding adolescents' general experiences of inpatient units is presented and critiqued as a systematic review, the results of which will provide a rationale for the current research. The chapter concludes by presenting the research questions and aims of the current project.

Nature of Child and Adolescent Inpatient Services

To date, there is little literature exploring adolescents' experiences of peer relationships within psychiatric inpatient units, despite health policies promoting service-user involvement and seeking service-user views to aid the design and development of service delivery (NHS England, 2015). The developmental period of 'adolescence' has long been defined as a distinct stage by society, characterized by exploration, change and volatility (Arnett, 2000), thus necessitating separate mental health services able to meet the specific needs of young people. Adolescents require safeguarding and it is therefore inappropriate to manage them within adult inpatient services. During this developmental period, the incidence of mental health difficulties

increases considerably (Kessler et al, 2005), consequently psychiatric inpatient facilities will always be required, especially for adolescents with complex mental health presentations and needs, who may require services into adulthood (Fisher, 1994). Gaining an understanding of young people's experiences is necessary to support them through this process.

Historical context of psychiatric inpatient units. Over the last century, slow but necessary changes to the provision of mental health services have occurred. In the 1950's, services were required to compulsorily detain patients in asylums for long periods of time. These institutions were dominated by a psychiatric medical model and upheld by the prevailing societal narrative and preoccupation with the mentally unwell deemed as 'dangerous' and 'untreatable', and their conditions poorly understood. Over the last 60 years, attitudes have shifted, with mental health legislation acknowledging the need to discharge individuals once they are well enough (Mental Health Act, 1959). The influential work of Goffman (1968) raised concern regarding the institutionalization of psychiatric inpatients, which prompted socio-political change and led to the gradual demise of asylums over the subsequent 30 years. The government recognized the need to provide resources to enable the delivery of community mental health services in the 1970's (Department of Health, 1975), as there was increasing evidence of poor care, malpractice and ill-treatment of patients within mental health institutions. Government policies such as 'Care in the Community' (Department of Health and Social Security, 1981), supported the focus on professionals supporting service users in the community, which has been demonstrated to lead to better patient quality of life and satisfaction (Killaspy et al., 2006).

Whilst this movement towards community services and patient independence is encouraging, a cohort of individuals with a higher level of need requiring more intensive and specialist inpatient treatment remain. Consequently the reduction in psychiatric inpatient beds, despite persisting need (Dimond & Goldberg, 1999), has led to shortcomings. Concerns exist regarding continuity of care and units containing the most complex and risky patients resulting in volatile inpatient environments that are challenging to work and recover in (Quirk & Lelliott, 2001) and do not provide a therapeutic setting (Sainsbury Centre, 1998 & 2004). Consequently difficulties with staff retention and reliance upon bank and agency nursing staff is commonplace, impacting upon patient care and experiences (Jaffa et al., 2004; Killaspy, 2006). Furthermore there are persistent concerns regarding the psychosocial impact of separating adolescents with acute and severe mental health problems from their families, peer relations and school, by placing them in inpatient care (Edwards et al., 2015).

Adolescent Mental Health Policy. A number of key policy documents have been published outlining guidelines and recommendations for the development and improvement of mental health services in the United Kingdom, thus influencing child and adolescent mental health services (CAMHS) commissioning and delivery. Between 2010-2015, the coalition government committed to improving mental health services for young people, pledging the provision of early intervention and access to psychological services and developed strategies such as “No Health without Mental Health” (DoH and Social Care, 2011) and “Closing the Gap: priorities for essential change in mental health” (DoH, 2014). The 2015-2017 Government vowed to change CAMHS provision in order to advance mental health services by 2020-2021 and

promised additional funding. In 2017 a Green Paper was released (DoH and Social Care, 2017) which proposed key initiatives including schools providing mental health support and a reduction in waiting times for specialist CAMHS services. However, concerns have been raised regarding the strategy's lengthy timeframes and the pressure that the proposals will place on other workforces, including education (House of Commons, 2018). Reviews of CAMHS have identified that young people frequently have inadequate experiences and are unable to access appropriate support in a timely fashion (Care Quality Commission, 2017, p5). Lengthy waiting times can result in adolescents' conditions worsening, possibly escalating into crisis prior to assessment by mental health services. Consequently increased demand is placed on specialist inpatient services, which is more intensive and costly (House of Commons, 2018). It has been proposed that a 'systemic shift' is required to prioritize the needs of young people rather than the needs of the health care system (House of Commons, 2018).

National Provision of Adolescent Inpatient Services. In the UK a four-tier CAMHS framework has been devised, with each increasing tier providing more highly specialist care to young people and their families. Within Tier 4 CAMHS units, four levels of support for adolescents with mental health difficulties or neurodevelopmental disorders exist, dependent on their presenting level of risk. This includes medium secure units accommodating the most complex adolescents, deemed to be the highest level of risk and low secure units managing complex adolescents presenting with lower but still significant risk to others and themselves and requiring high physical security. Psychiatric Intensive Care Units (PICU) accommodate adolescents requiring physical security who demonstrate behavioural disturbance which cannot be managed in a general psychiatric ward environment. General psychiatric units manage adolescents

with severe and complex needs who require intensive, specialist mental health intervention; and who cannot be safely managed within the community.

Tier 4 CAMHS specialist provision usually provides care to young people aged between 12-18 years old and may offer day patient, residential inpatient, community crisis support or outreach multi-agency care, tailored to meet the individuals' needs and may include different levels of specialism. Admission to inpatient CAMHS units should be for the minimum period necessary, with the aim of stabilization of the young person's mental state and prompt discharge to community services (McDougall, Worrall-Davies, Hewson, Richardson & Cotgrove, 2008). Within inpatient units, schooling provision and engagement in communal activities are considered vital components of daily schedules. Adolescent inpatient units typically consist of a multi-disciplinary team of mental health professionals who utilize an integrative and eclectic evidence-based therapeutic approach, including a comprehensive biopsychosocial assessment and formulation of the young peoples' presentation and needs, underpinning intervention. Interventions are often bespoke and tailored to the needs of the individual, with formulations drawing from a number of psychological theories and models (Abeles, Crosbie & Milson, 2015).

In December 2015, there were 1,440 CAMHS NHS inpatient beds in England (House of Commons debate, 2015; NHS England, 2014). Between October and December 2016, 2,434 young people, aged 18 and under, presenting with mental health difficulties were admitted into hospital (NHS England, 2017). The length of admission varies, some stay for a few days whilst others stay for much longer. In 2013 the average length of stay across all units in England was 116 days (NHS England, 2014). Within

England, a geographical disparity exists with regards to the provision of inpatient beds for the adolescent population, with the North East having the greatest provision (House of Commons Written Answer, 2016).

Adolescent Inpatient patient population. Adolescence is a stage with increased vulnerability to the emergence of mental health problems and many serious psychological disorders (Kessler et al., 2007). Worldwide and UK prevalence rates of such conditions in young people have risen significantly over recent years (Pitchforth et al., 2018; Polanczyk, Salum, Sugaya, Caye & Rohde, 2015) and such trends place increasing demands on CAMHS. Prevalence rates vary according to region, 11% of children in London aged between 5-16 years old have a mental health problem, as compared to 7.7% in Thames Valley (NHS England, 2016). Children receiving mental health intervention are a small minority; many remain unknown to services or receive no treatment following referral to CAMHS (Patel, Flisher, Hetrick & McGorry, 2007, Public Health England, 2016, p6). The majority of adolescents with mental health difficulties do not require inpatient admission, however approximately 0.1% of young people diagnosed with a psychiatric disorder will present with deteriorating psychological wellbeing whilst receiving community intervention, require a 24 hour assessment, be deemed to be a significant risk or have mental health problems combined with a challenging relationship with their family making engagement in treatment complex (Cotgrove, 2001; Cotgrove & Gowers, 1999; Gowers & Cotgrove, 2003).

Inpatient services accept adolescents with a diverse range of psychiatric diagnoses, young people within Tier 4 services typically have been diagnosed with two

or more co-morbid mental health conditions. The most common presenting problems are developmental disorders, emotional disorders, eating disorders, autistic spectrum conditions (ASC) and psychotic disorders (NHS England, 2014). Tulloch et al., (2008) identified that 66% of adolescent inpatients were females, most aged between 15 to 17 years old and 20% of patients were from a Black or Minority Ethnic group. Wille, Bettge and Ravens-Sieberer (2008) identified cohorts of young people at increased risk of developing mental health difficulties and found that predictive power increases with number of risk factors. Those at higher risk include young offenders, refugees, children who are in the care of the Local Authority, those who have a parent with mental health difficulties or substance abuse, children who have a learning disability, physical disability, physical illness, sensory impairment or who have been sexually, emotionally or physically abused or living in an adverse family climate (NHS England, 2017). Furthermore, parental separation, low self-confidence, social disadvantage, high levels of conflict within the family, low educational attainment and social relationship difficulties are also associated with increased risk of mental health problems (Boden, Fergusson, Horwood, 2008; Green, McGinnity, Meltzer, Ford & Goodman, 2004; Walker et al., 2007).

Efficacy of adolescent inpatient units. Given the current economic climate, there is pressure to demonstrate the effectiveness of CAMHS inpatient services. However, evaluation is challenging given the diverse and complex interventions offered by a variety of professionals (Green & Jacobs, 1998), with multiple treatments often operating in parallel it is hard to deduce variables that influence recovery. Many studies have methodological weaknesses as a result of scientific demands and ethical considerations which constrain the scope of research design thus reducing validity and

reliability (Epstein, 2004). The literature often has a narrow focus on what constitutes a meaningful change, with outcome studies focusing on symptom reduction and behavioural change as assessed by researchers or staff, neglecting wider systemic or intra-psycho factors. Moreover, studies are often retrospective and utilize heterogeneous samples (e.g. multiple co-morbidities). Ethical dilemmas include randomization to treatment versus control groups due to the acute and severe nature of the adolescents' presentations. It is possible staff may be reluctant to participate in or conduct research, as it may be perceived as a threat to their role and an added responsibility. However, establishing which inpatient interventions are most beneficial to young people informs the development of more effective units (Gavidia-Payne, Litterfield, Hallgren, Jenkins & Coventry, 2003). Given the costliness of such inpatient services, their restrictive nature and the vulnerability of service users, high quality literature evaluating the effectiveness of inpatient care is imperative (Green, 2002).

The research surrounding the effectiveness of adolescent inpatient units reports mixed and frequently contradictory results. A large volume of literature indicates that adolescent inpatient care is effective as assessed by short and long term generic outcomes for a variety of mental health presentations across different countries and cultures (i.e. Jaffa & Stott, 1999; Pfeiffer & Strzelecki, 1990; Curry, 1991; Pottick et al., 1993; Blanz & Schmidt, 2000;); however due to methodological limitations including lack of standardized outcome measures, absence of control groups, inadequate demographic reporting and small sample sizes, results must be interpreted with caution (Gowers & Rowland, 2005). Evidence demonstrating the value of inpatient admissions for specific diagnoses, such as the treatment of eating disorders is mixed (Fonagy et al., 2002), showing minimal benefits of inpatient care compared to

community-based treatment. Interpretation and generalization of these findings are limited as studies were predominately outside the UK and may have had differing treatment standards. Jacobs et al., (2004) and Tulloch et al., (2008) have both successfully argued for the clinical benefits of CAMHS inpatient admission, with those who have longer admissions and more severe needs demonstrating the greatest improvement. Certain features of the ward environment were associated with positive outcomes including engagement in therapeutic activities, positive elements of ward peer-group culture, staff demonstrating an empathic stance and coherence within the clinical team (Tulloch et al., 2008).

Despite the current focus on service user views and involvement within the domain of health and mental health (NHS England Offender Health Collaborative, 2015), studies examining young people's experiences of hospitalization within psychiatric units are limited. Young people admitted to a psychiatric hospital may continue to use services throughout their lives (Fischer, 1994), therefore understanding and supporting them is important to ensure patient satisfaction and efficient service provision. Service-users satisfaction has been measured as their overall experiences of inpatient units, which are generally rated as 'high' (Healthcare Commission, 2004), and in relation to various elements such as medication or staff members. However, despite these encouraging outcomes, Stallard (1996) noted methodological flaws, which weaken the reliability and validity of the studies (i.e. low response rates). Existing literature exploring service users' satisfaction with CAMHS inpatient units frequently draws upon a quantitative paradigm (Brown et al., 2012). Such surveys are subject to methodological flaws including the assumption that satisfaction can be quantified, the focus on parent and carer ratings and the restrictive nature of such

surveys not allowing for detailed exploration of lived experience (Bettmann & Jaspersen, 2009; Moses, 2011; Williams, 1994).

Inpatient units are not always considered the most suitable or effective environments for managing the needs of adolescents with complex mental health difficulties, (O’Herlihy et al., 2001). However due to difficulties with community Tier 3 services, such as retention of specialist staff and an increased number of referrals and complexity of presentations, they are frequently regarded as necessary to support problems which cannot be managed in the community (Kurtz et al., 2006). Although inpatient units can provide relief, respite from stress and a safe environment, there are concerns regarding the negative impact of admission, which can result in delayed discharge and compromised recovery (Offord, Turner, Cooper, 2006). Themes include the inpatient experience being frightening or bewildering, stigmatization and labelling, disruption to their normal life, missed opportunities important for healthy development, exposure to other patients’ self-harming, separation from parents and the risk of institutionalization (Blanz & Schmidt, 2000; Green, 2002; NHS England, 2014), which may have long-term implications.

It is crucial to consider psychological theories of adolescence development, which theoretically underpin CAMHS inpatient units, to provide appropriate services and understand the pertinent developmental issues that complicate treatment and challenges which may delay discharge.

Theoretic Conceptualisations of Adolescent Development

Adolescence has been conceptualized as the critical and distinct developmental period starting as puberty commences and lasting until social independence is reached (Steinberg, 2014), commonly between 11 to 18 years old (APA, 2002). Development can be defined as a complex, multidimensional and intricate process of growth and change throughout the lifespan. From infancy to adolescence, growth and transformation are extensive and multiple cognitive, emotional, physical and social changes occur. This process is described as contextual and multidirectional. A number of key theories drawing upon different paradigms have been developed in an attempt to understand the complexity of human development, which will be discussed.

Psychodynamic links. Siegfried Bernfeld (1923; 1935) suggested that adolescence can be experienced variably, manifesting itself in many different ways including physiological, psychological and sociological elements, thus no one theory can be postulated. However, various schools of thought exist within psychoanalytic theory, providing insight into the developmental process.

Freud (1905) considered adolescence in relation to psychosexual stages and proposed five fixed stages of psychological development; oral, anal, phallic, latency and genital, which have a life-long impact upon behaviour. He suggested that fixation of libido, on varying parts of the body occurs at each stage, which can lead to frustration, pleasure or the experience of conflicting feelings. Freud described libido as the result of built-up energy created by survival and sexual instincts, which when discharged creates feelings of pleasure. He argued that when individuals mature biologically, the accumulation and discharge of sexual energy occurs. He believed that

conflict arises at each psychosexual stage, which requires resolution before progression to the next. He declared that “fixation” arises if resolution is not reached at each stage; consequently an individual may remain stuck until conflict resolution is achieved. The genital stage occurs from the onset of puberty until adulthood, Freud noted that during this phase sexual experimentation and amplified sexual tensions occurs. Freud considered that during adolescence sexual arousal intensifies, driving the individual to disengage and detach from parental objects, to prevent fantasies relating to incest. He argued that if the preceding psychosexual stages have been resolved, the individual will have increased capacity to form healthy sexual relationships.

Freud emphasized the key role that early childhood experiences have on shaping individuals adult relationships and interactions and proposed the existence of different levels of awareness when conceptualizing personality development. Freud (1962) held the belief that the id, the primitive and impulsive component of personality, works according to the ‘pleasure principle’, which operates to fulfil, desires and fantasies. The superego commands moral behaviour, accounting for values that are established in society and functions to control the id’s urges and desire of instant gratification. The ego acts in accordance with the reality principle, mediating and reasoning between the unreasonable id and the world. Adolescence is considered a period of increased vulnerability where changes in psychic structure occur, failure of psychic restructuring is claimed to result in psychopathology. During adolescent disengagement from infantile internalized objects, ego weakness, amplified strength of drives and regression to infantile dependencies occurs; crucial psychic processes that can explain adolescent emotional turmoil (Blos, 1967). Anna Freud (1936) proposed the concept that conflict between the ego and the drives occurs during adolescence, a

strong id and weak ego results in the ego attempting to utilize defences as it is challenged. Consequently the ego experiences oscillation between defence, victory and defeat. Anna Freud (1958) described the state of inner and outer turmoil that occurs in adolescence due to the conflicting ego and drive, which she termed “necessary disharmony”. She noted that this has a progressive purpose which aims to create “new psychic balance”.

Psychosocial Links. Erikson (1959) adopted a different perspective by considering the importance of social contexts adolescents encounter, which support and facilitate their development. He considered that an individual’s ego integrates with the social context and is in a continual state of change due to social interactions and different experiences resulting in an individual dilemma. It is necessary to successfully negotiate these challenges as unresolved issues will resurface later and cause difficulties for the individual. Erikson proposed an eight-stage model of ego growth and considered each stage as a ‘psychosocial crisis’, requiring resolution before young people may proceed into the next phase. Inability to complete a stage may affect the completion of subsequent phases and result in a reduced sense of self.

The first stage, occurring between birth and one year, is termed ‘trust vs. mistrust’ where the infant learns whether the world is a safe, reliable and trusting place. This is dependent upon on the consistency, predictability and quality of caregiving, a sense of mistrust means the infant will perceive the world as a threatening place. Failure to complete this stage may cause anxiety, mistrust in others and the world and feeling less secure about oneself. The second stage, ‘autonomy vs. shame’, occurs between one and three years. This is when the beginning of asserting independence and awareness

of being separate from the caregiver develops. Confidence arises from parents who support this independence. However if parents respond with a lack of patience, or by controlling and shaming behaviours, a lack of confidence in one's own abilities and worth may ensue.

'Initiative vs. guilt' is the third stage, occurring from three to six years old. Children become more autonomous, include others in their activities and assert themselves more readily, at the same time having internalised values from significant adults, transgression may induce feelings of guilt. If the child's initiative is discouraged, excessive guilt may be experienced. Resolution of this dilemma enables the adult to have a sense of vision and purpose. Stage four, 'Industry vs. Inferiority' takes place from six years old to puberty. Children will begin to feel pride in tasks they have completed and develop new skills. If they are supported and encouraged in their endeavours, they will want to achieve goals, if not, a sense of inferiority may develop. During the transition from childhood to adolescence, they enter the next stage of 'identify vs. confusion'. Young people become increasingly independent, begin to consider the future and experiment with risk-taking and values which maybe outside their family norm, and so develop their own identity. This strengthens individuals' internal and external ego processes as the adolescent becomes increasingly able to complete developmental tasks. Erickson proposed that the main requirement for adolescents is to acquire a coherent and integrated sense of identity. In following their peer group, a conflict may arise between conforming and following their own aspirations. Adolescents require boundaries and security from adults but at the same time friendships should not be controlled. The final three stages occur beyond adolescence.

Early adverse life experiences may significantly impact upon the first four psychosocial stages, and are central to understanding the development of childhood mental health problems. Unresolved psychosocial crises influence relational patterns, including a sense of mistrust in others and the world, heightened insecurities and a sense of inadequacy and dependency upon others (Erikson, 1959).

Cognitive Links. Piaget (1936) argued that cognitive development comprises four stages that children advance through, underpinning our understanding of their intellectual and social progress. He explained that the ‘Sensory Motor’ stage occurring from birth until two years of age involves the development of schema, an internal representation of the nature of things and how to understand and respond to them, which begins with movement in infancy. A baby is tasked with understanding sensory information, which it utilizes to explore the world and grasps how to move through the use of muscles which was coined ‘action schemas’. The baby learns the relationship between cause and effect and to conjure up mental representations of objects as well as the concepts of time and space. Next the ‘pre-operations’ stage between ages two and seven where learning how to think and verbal expression develops, however children remain egocentric in their outlook. The ‘concrete operations’ stage follows through seven to eleven years, where thoughts mature and become more logical and flexible and children develop the ability to classify and order. In the last stage, ‘formal operational’, the capacity for abstract thinking and complex problem solving develops in adolescence. The adolescent is also able to grasp the importance and meaning of their prior life experiences.

Systemic Links. A child's first emotional and social encounters occur within the family unit, thus family relations influence their interactions outside the family context (Putallaz & Heflin, 1990). The family life cycle (Carter & McGoldrick, 1989) comprises different intellectual and emotional stages, to pass through these successfully individuals must complete certain tasks. Carter and McGoldrick posit that transitions evoke stress within the family system and reorganization and negotiation is required to establish a new homeostasis. The challenges individuals face at each stage require adjustment and may influence smooth progression to the next stage (Bigner, 1998). If adaptation is not possible, any individual within the family may become 'symptomatic'. This model suggests that during adolescence, the development of independence is a central stage where the principle aim is to separate emotionally from caregivers so that the adolescents become self-sufficient physically and socially, including the development of intimate peer relations, which may be inhibited within the inpatient setting. Steinberg (1998) suggests that adolescents are tasked with attaining an adult identity that is stable whilst relinquishing parental dependence, which often occurs with the formation of intimate or enduring relationships. It is proposed that these developmental tasks are facilitated or hindered by family contexts and relational patterns between the adolescents and their parents.

Attachment theory . The work of Bowlby (1969, 1973, 1980) formed the basis for attachment theory, which posits that infants are pre-programmed to form attachments with caregivers to seek protection, and require a consistent nurturing bond with at least one responsive primary caregiver for healthy social, emotional and cognitive development. It is necessary for the infant's caregiver to maintain a central role in their life for three to five years, the critical period where rapid brain development

occurs. Receiving care from a sensitive and attuned caregiver who recognises, makes sense of and reacts to an infant's cues and needs, is necessary for an individual to develop resilience and meaningful and healthy relationships. Ainsworth (1970) empirically constructed four attachment styles, believed to develop in response to early care giving experiences: secure, insecure-ambivalent, insecure-avoidant and disorganised.

The work of Bowlby and Ainsworth was further developed by Pat Crittenden who proposed the Dynamic Maturational Model (DMM). The DMM proposes patterns of attachment and adaptive strategies which individuals develop over time, serving functional purposes including: self-protection from danger, safety and survival, and following puberty, the need to seek a reproductive partner (Crittenden 1995, 2004). Crittenden (2005) argues that individuals learn these self-protective strategies through their interactions with an attachment figure and their attachment style becomes 'activated' when under threat. The model proposes that the absence of a safe, protective and comforting environment with an optimal amount of stimulation and interpersonal interactions from an attuned caregiver impairs the development of a range of cognitive and affective emotional regulatory strategies which allow an individual to manage life stressors (Briere, 1992). Within this framework, symptoms of mental health problems are conceptualised as functional, and attachment strategies are dependent upon context, thus understanding an individual's attachment strategy and context synergy is central to delivering effective treatment (Crittenden, 2005).

A secure attachment permits development of an internal working model providing a template upon which all subsequent relationships with others are based and

establishes security in the world, enabling safe exploration and learning as the infant senses that their caregivers can meet their emotional and physical needs (Zilberstein, 2006). Caregivers who are attuned to an infant consistently respond to their needs by aligning with the child's internal state, establishing a sense of trust, safety, containment, and interpersonal connection. Consequently, the infant develops a capacity to regulate their emotions, form meaningful interpersonal relationships, and the ability to mentalise (Sroufe, 1990). Caregivers are not always able to correctly anticipate the needs of a child, however a 'repair' process through reconnection allows the child to develop skills in conflict resolution.

Attachment and mental health difficulties. Attachment theory can be drawn upon to understand the complex behavioural and emotional presentations commonly seen within inpatient CAMHS settings, influenced by disrupted attachment experiences such as intermittently responsive or emotionally unavailable caregivers (Allen & Hauser, 1996). The literature suggests that attachment experiences influence infants' development and later behaviour (Bowlby, 1969); individuals with an insecure attachment and those who have experienced social deprivation are at greater risk of developing childhood psychopathology (Harlow, 1961; Sroufe, Carlson, Levy, & Egeland, 1999). Disrupted attachment experiences can lead to emotional dysregulation, poor impulse control, and relationships characterised by high levels of conflict (Fonagy, 1999). Complex trauma, characterised by young people experiencing poly-victimisation and multiple adverse and traumatic experiences can have a long lasting and pervasive impact upon wellbeing and functioning. There is a complicated multi-directional interaction between attachment and complex trauma (Cook et al., 2005). Children may develop an insecure attachment with their caregiver which can lead to

interpersonal insecurities, relational difficulties, difficulty with help-seeking, communication and self-regulation (Green & Myrick, 2014), which puts them at risk for additional trauma exposure and psychological dysfunction (Cook et al., 2005). Those with complex presentations such as severely disrupted attachments may engage in excessive help-seeking behaviours, and or social withdrawal, and may develop a rapid dependency on others (Cook et al., 2005) to assuage core fears. Within inpatient CAMHS units, this affects how adolescents form relationships with staff and patients; they may be distrustful of others, sensitive to rejection and demonstrate hypervigilance towards threat of abandonment, utilizing learnt preventative strategies to avoid rejection. Insecure attachments will impact the adolescents' ability to engage in enjoyable social relationships and to correctly appraise their social interactions (Dozier, 1990). Given the trauma and attachment histories of the typical inpatient population, it is likely that they may experience hostile attribution biases, which makes them more likely to misperceive hostile intent from others even in the absence of threat (Price & Glad, 2003). Furthermore, negative expectations of themselves and others can result in self-fulfilling social interactions (Snyder & Uranowitz, 1978), distorted information processing and high levels of conflict within social relationships. (Dozier, 1990).

It is important to note however, that studies exploring development of the adolescent brain indicate that features of adolescence including self-centeredness, inability to take the perspective of others, and lack of flexibility may be linked with a lack of maturation in specific brain regions involved in self-control (Casey, Getz & Galvan; Steinberg, 2008). Therefore demonstrating a neurobiological underpinning of difficulties with impulse control and failure to mentalize which is not solely trauma-related.

Theoretical underpinnings of inpatient CAMHS

An integral aspect of inpatient care is creating and maintaining a therapeutic milieu, a nurturing and supportive interpersonal atmosphere, where all components of the environment are designed in a therapeutic context to facilitate recovery (Peplau, 1989; World Health Organization, 1953). This involves ensuring physical, procedural and relational security (DoH, 2010), where pathological behaviour is restricted and patients are encouraged to be active participants, take collective responsibility for the ward and develop psychosocial skills by drawing upon all elements of the therapeutic environment (Thomas, Shattell & Martin, 2002). The therapeutic milieu is composed of five aspects: containment, validation, support, structure and involvement (Gunderson, 1978), aiming to improve psychological wellbeing through lessening distress and destructive behaviour. Green and Burke (1998) argue that both the physical ward environment and quality of social relationships within the unit are fundamental to the milieu development and success. Through positive relational experiences a more secure attachment can arise. On the ward there may be a high turnover of patients and frequent staff changes, consequently the milieu can change regularly, requiring close attention by staff.

Attachment and role of professionals. Whilst CAMHS inpatient settings aim to offer treatments and support to manage immediate risks and facilitate prompt transfer back to the care of community services, professionals within these services often encounter attachment-related difficulties, which require careful management. Professionals have two roles within the CAMHS inpatient setting: to help repair disrupted attachments, and support the development of a secure attachment by providing a safe environment with responsive, attuned professionals who are

emotionally available. Such connectedness and positive relational experiences can enable the young person to develop a sense of self and relational trust. The theoretical underpinnings of attachment theory posit that staff must provide a genuine, respectful and healthy relationship with the adolescent, characterized by reliability, consistency and predictability. Clear and established boundaries and communication are vital to prevent the young person feeling rejected, and to facilitate the development of self-confidence, self-control and feeling secure. A positive therapeutic alliance between patients and staff is the most predictive factor in determining successful treatment outcome (Green et al., 2007; Kazdin, Siegal & Bass, 1990). Trusting (Kato et al., 2009) and supportive relationships, which allow the development of an emotional attachment whilst maintaining appropriate distance are central to this (Funakoshi, Tanaka, Hattori & Arima, 2016). The therapeutic relationship is particularly crucial given that the young people might not have initiated their referral or oppose the need for treatment, which can reduce their motivation, sense of agency and engagement (Diguseppe, Linscott, & Robin, 1996; Green, 2006).

Containment. Bion (1962) introduced the concept of ‘Container-Contained’, a notion considered when designing and implementing inpatient care. He drew upon Klein’s idea of projective identification and posited that an infant’s caregiver acts as a container for their emotional experiences, their role is to receive the infants’ projections, process this experience through sense-making and return it to them in a modified and tolerable translated form. He described this as a process of ‘mental digestion’ (Bion, 1962), enabling the infant to develop the capacity to tolerate their emotional experiences and to think. Within the inpatient setting, where adolescents

may not have experienced containment in their early life, professionals are tasked with providing this emotional experience for patients' unprocessed states.

Mentalizing and epistemic trust. Attachment figures have multiple functions, providing infants with feelings of safety and security that foster their exploration of the world (Bowlby, 1973) and the context for promoting the capacity to mentalize, the ability to understand one's own and others mental states (Fonagy, Gergely, Jurist, & Target, 2002). Humans have demonstrated a hardwired predisposition to social interaction, a notion supported by neurobiological studies (Frith & Wolpert, 2004) which have identified an innate capacity for mentalization, enabling engagement in relationships, friendship, play and love (Sharp, Fonagy, & Goodyer, 2008). Mentalization depends on parental capacity to understand their own and infant's minds and emotional states without becoming emotionally overwhelmed and shutting down (Slade, 2005). Within a secure attachment relationship, the caregiver can correctly represent the infant's thoughts, feelings and intentions in their mind, consequently the infant is able to safely curiously explore their own and caregivers' minds without emotional overwhelm, thus developing mentalization and affective regulation capacities (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Luyten, 2009). This allows the individual to participate in social interactions effectively through understanding their own and others feelings, thoughts, perceptions and behaviour.

Another key function of attachment relationships is to support the development of epistemic trust, which is understood as trust and authenticity in knowledge that is transmitted interpersonally facilitating social learning (Fonagy & Allison, 2014). Children who have experienced a breakdown of epistemic trust in their attachment

relationships may experience hypervigilance, confusion and uncertainty about the social world, misattributing others' intent as hostile. It is thought that mental health difficulties may arise from epistemic mistrust leading to failed social communication or a complete failure to trust others, rejecting them as a provider of social knowledge. These characteristics are often observed in those who have experienced trauma and developmental adversity, who have adapted to a social world where it was beneficial not to trust, as information provided by caregivers may have been frequently misleading or incongruent with their mental state. Considering an individual's level of epistemic trust and thus openness to social learning within a context of psychotherapeutic intervention is vital. Inpatient settings initially attempt to generate epistemic trust and increase adolescents' capacity for mentalizing when emotionally aroused within the context of an attachment relationship. Difficulties with emotional regulation, self-soothing, empathy, understanding one's own and others' feelings, thoughts and motivations may arise, thus compromising interpersonal relationships.

Psychiatric hospitalization during adolescence

When hospitalized within a psychiatric unit, adolescents face numerous challenges, which can include loss of agency resulting in feelings such as anxiety, helplessness, powerlessness and overdependence (Tiedt, 1972). In adolescence, a key developmental task is for young people to gain control over their life, consequently it is typical for adolescents to oppose and question authority figures. Within the hospital environment, adolescents experience a loss of control over many aspects of their life, many young people find this challenging and may respond with regression or defiance resulting in power struggles and conflict with patients and staff.

Theoretical models, including systemic, developmental, psychodynamic and social psychology will be applied to the inpatient setting to understand the complex relational dynamics that exist within secure units. These models are frequently referred to within the adolescent mental health literature (Brown & Wright, 2010; Rasic, 2010).

The inpatient unit as a system. Bowen (1976) introduced the family systems theory, which conceptualizes the family as a system of interconnected members, thus individuals cannot be understood separately from the unit. Bowen proposed that within systems, each individual adopts roles, and rules exist which must be adhered to. Interactions within a family are dependent upon these roles, consequently interactional patterns develop, wherein each individual's behaviour influences other members' behaviour. Maintenance of predictable relational patterns balances the system, however it can also lead to dysfunction. He argued that families have an emotional system, and patterns develop with the aim of lessening tension and maintaining stability. This theory can be applied to psychiatric inpatient settings, both patients and clinical staff are assigned roles, and regulations exist similar to that of a family (Jaffe & Manis, 1974). A hierarchal structure is present within the system where staff may represent authoritative parental figures offering stability and security, however given the patients' often complex history and family dynamics devoid of adequate parenting, this may be unfamiliar or threatening to the adolescent. Thus, staff who represent caring figures and who offer interpersonal closeness may evoke feelings of ambivalence for the adolescents (Delhaye et al., 2011). Adolescents may desperately wish to be wanted and loved but fear closeness. The adolescent may feel more aligned to the nurses, health care assistants, and their peers who, from an attachment lens may feel like safer relationships, rather than the psychiatric team, who represent authority and power.

Attachment and dependency. When admitted to an inpatient unit, adolescents undergo separation from their primary attachment figures, possibly for a prolonged period (Berry & Drake, 2010). Factors influencing the impact of this separation include: a stressful unit environment, individual experiences within the unit, and availability of a substitute attachment figure (Schuengel & Van Ijzendoorn, 2001). Admission may evoke feelings of insecurity and loss, consequently triggering attachment strategies (Field, 1996). Thus, relationships on the ward may protect against the emotional consequences associated with separation from their primary attachment figure (Schuengel & Van Ijzendoorn, 2001) and the stress associated with the unit. Patients with insecure attachments are more likely to form over-dependant relationships or avoid close connections with others (Furnivall, 2011). In the ward environment, relationships can challenge the adolescents' embedded negative expectations of others (Moses, 2000). Within staff-patient relationships, boundaries are essential to avoid over-involved and dependent connections (Sergeant, 2009), however challenging to achieve (Moses, 2000). Dependant relations may evolve within inpatient units (Sergeant, 2009), resulting in escalation of challenging behaviour, and decline in mental health; particularly when these relationships terminate once young people transition back to the care of community services (Berry & Drake, 2010; Gill, Butler & Pistrang, 2016; Sergeant, 2009).

Transference and Countertransference. Coined by Freud (1920), transference and countertransference are psychodynamic terms. Transference refers to the process by which feelings, expectations, attitudes and reactions are unconsciously redirected from a person of the past, usually childhood relations, to a person in the present, which can underpin relational patterns (Beretta et al., 2007).

Countertransference describes the feelings and associated thoughts experienced as a consequence of unconscious transference communications (Ryle, 1998). Within the unit, transference and counter-transference dynamics exist that are unique to inpatient settings (Stone, 2001). Each patient brings with them their own family dynamics, which are recapitulated on the unit as well as relational issues such as fear of abandonment and rejection, distrust of others and violation of boundaries. Thus, the young people may experience feelings such as extreme anger, hostility, fear, shame, helplessness and despair, directed at both patients and staff. Unknowingly, both staff and patients will participate in the young peoples' internal world of object relations, derived from interpersonal interactions with significant others during infancy. Adolescents may elicit behaviour from others which maintains their unsuccessful, yet adaptive and protective relational patterns. Additionally, adolescents will likely be negotiating and attempting to resolve critical developmental issues (Erikson, 1972, 1974), complicated by residing within an inpatient unit. For example, separating from authority figures, and aligning with their peers, where exploration of sexuality and intimacy may occur.

Social Identity Theory. Tajfel (1979) proposed that social identity, an individual's understanding of who they are, is derived predominantly from membership of groups. Developed by Tajfel and Turner (1986), social identity theory posits that individuals socially categorise and stereotype humans into out-group (them) and in-group (us) members. They proposed that group membership is associated with self-confidence, positive social identity and a sense of pride and belonging. In order to boost self-esteem, humans will place more standing on the groups they belong to, and discriminate against those they do not. They argued that the mental process of categorisation and grouping is normal, but leads to amplification of things which are

similar in the in-group, and difference between the in and out groups. Tajfel and Turner (1986) identified three steps in this process including: categorisation, social identification, and social comparison. Within society, those with mental health diagnoses are often members of a minority group, stigmatized and attributed a low status identity (Link et al., 1997), which may threaten their social identity. Once admitted to the inpatient context, intergroup processes may occur resulting in the development of in and out groups which can play a role in bullying behaviour (Brown, 2000). Patients may wish to identify with a group of adolescents they perceive to be 'superior' to improve their self-esteem, discriminating against out-group members who are deemed to possess less favourable qualities (Gini, 2006; Tajfel & Turner, 1986). Group membership outlines social rules and specific behaviours (Ojala & Nesdale, 2004). Bullying is more likely to occur when members of the out-group are perceived as threatening, and when this behaviour is consistent with the in-group's behavioural norms (Ojala & Nesdale, 2004), this may occur with new admissions, or adolescents who display undesirable characteristics such as aggressive behaviour.

Theoretic Conceptualization of peer relationships

Early on in their development, children form peer affiliations, and subsequently peer groups, which are essential to their psychosocial development and psychological adjustment (Parker & Asher, 1987). Friendships can be understood as a 'close, mutual, dyadic relationship' (Hartup, 1996), and acceptance by peers (Nangle et al., 2003). Given the opportunity, the formation of social bonds begins early on in a child's development, particularly during play. These relationships are characterized by arguments, where the young child masters skills in turn-taking, co-operation and sharing, these social experiences can provide a sense of trust, acceptance, inclusion,

belonging and self-worth. Once at school, relationships become more co-operative. Peer relationships can provide young people with emotional support and the experience of reliable alliances, encouraging the development of self-esteem and skills for conflict resolution, appropriate social interactions, validation and intimacy. Hay, Payne and Chadwick (2004) suggest that harmonious interactions with peers in childhood facilitates the development of skills associated with language, imitation, emotional regulation, and inhibitory control.

Sullivan (1953) suggested that primary interpersonal needs arise at different developmental stages and are met by social relationships. He proposed that from birth to two years of age the infant requires tenderness, and from two to six years old children have a primary need of companionship, both of which are met by parents. As the child develops, friendships play a more integral role in their adjustment, from age six to nine a need for acceptance arises which is addressed by both parents and peers. The major need for intimacy occurs during pre-adolescence between nine to twelve years old, which is predominantly fulfilled by peers, and lastly during adolescence, needs associated with sexuality emerge and are satisfied by peers who also fulfil social needs.

Bingelow and La Gaipa (1980) proposed a model of friendship expectations, which has three established stages. The first stage, 'reward-cost', occurs between the ages of 7-8 years old where friendships are dependent upon engagement in similar activities, living in close proximity and holding expectations that are akin. At age 9-10, the 'Normative stage' arises where common values are of high importance and rules and sanctions established. Finally, the 'empathic stage' arises around age 11-12 years

old, where mutual interests, compassion and understanding, and self-disclosure dominate.

Importance of peer relationships in adolescence. During adolescence peers play a supportive role and are important for building autonomy and emotional and social competence (Furman & Wehner, 1994). A major shift in friendships occurs where more time is spent with peers rather than parents, sub-group formations begin and peers become more influential and socially supportive (Buhrmester, 1992). Additionally, romantic feeling and experiences may occur, which may start as being unreciprocated and internalized as the young person makes sense of the relationship (Carver, Joyner & Udry, 2003). During adolescence, young people may rebel against their parents' value systems, and as the development of personal autonomy is of increased importance, family conflict may arise (Arnett, 1999).

Peer relationships and attachment. Peer relationships provide an opportunity to satisfy attachment and emotional needs, contributing to an individual's quality of life. Ainsworth (1989), and Sroufe and Waters (1977), propose that friendships can be conceptualised within an attachment framework; the attachment style developed in childhood serves as a model for future relationships. During adolescence it has been suggested that changes occur within attachment relationships as they become reciprocal and based on internal beliefs and expectations. The primary attachment figure is often a peer or partner who is sought to provide comfort, minimise distress, or engage in sexual relationships (Allen & Land, 1999). Hazan and Shaver (1994) proposed that during adolescence changes occur within attachment hierarchies, and constructed a model demonstrating how attachment relationships become inclusive of peers and as

children grow up they spend more time with their friends than parents. Childhood peer relationships are typically formed in the context of close physical proximity, however in early adolescence attachment relationships involving peers are thought to focus on security and safety (Sroufe & Waters, 1977). Over time adolescents learn that the peer will be available and responsive in times of distress, resulting in the formation of a secure base. As the capacity for forming and maintaining healthy social relationships are dependent upon developmental and attachment experiences, it is likely that peer relationships within the inpatient unit are complex.

Peer relationships and mental health. Peer relationships influence the wellbeing of adolescents as they fulfil multiple key functions including: supporting positive psychological adjustment and self-worth, validation, companionship and providing a reliable alliance, which enables an individual to feel secure (Furman & Robbins, 1985). Depressive symptoms have been found to be associated with less stable, poorer quality relations and negative friendship experiences (Prinstein, Borelli, Cheah, Simon, & Aikins, 2005; Rudolph, Ladd & Dinella, 2007). Additionally, peer relationship difficulties and negative friendship features, such as conflict, are associated with increased anxiety (Kingery, Erdley, Marshall, Whitaker, & Reuter, 2010; Poirier et al., 2015). Conversely, higher friendship quality is related to reduction in anxiety over time (Vernberg, Abwender, Ewell, & Beery, 1992).

Friendships, particularly good quality relationships provide loyalty and support, which can reduce the likelihood of children experiencing peer victimization (Hodges, Boivin, Vitaro, & Bukowski, 1999). Furthermore, for young people who do experience peer victimisation, friendships can mitigate negative effects through providing security

and help, thus reducing the likelihood of the individual internalizing their distress (Hodges et al.,; You & Bellmore, 2012). Young people who are supported by a social network demonstrate increased resilience to deal with life stressors, including parental separation (Steinmetz, 1999). With regards to school adjustment, peer relationships play a contributory role for adolescents' school engagement, such as improving academic achievement, increasing self-esteem and reducing features of depression (Wentzel, Barry, & Caldwell, 2004).

Peer Support. The literature confirms the value of humans experiencing a sense of belonging and connection to others (Brewer, 1991), which for those with mental health difficulties can facilitate recovery, increase wellbeing and improve social integration (Davidson et al., 1999). The benefits of peer support for adolescents experiencing mental health difficulties is well recognized, being able to access support without fear of stigmatization provides an experience of relating with authentic validation and empathy, through similar lived experiences. This enables the development of equal relationships (Coleman, Sykes & Groom, 2017; Mead & Macneil, 2004). Yalom (1995) proposed key therapeutic factors that occur during group interventions, which account for individual healing and successful outcomes, such as the emergence of hope, universality as they connect with others experiencing similar difficulties, corrective recapitulation resolving past family events, development of social skills, and modelling of new behaviours. This is particularly pertinent during adolescence, where investment in peer relationships is fundamental to development.

Negative impact of peer relations. Evidence has demonstrated that individuals are most susceptible to the influence of their peers during adolescence (Spear, 2000;

Steinberg & Monahan 2007). Peer relationships are not always beneficial; a body of evidence has demonstrated the possible harmful effects of forming friendships with others who engage in offending behaviour or those with mental health difficulties such as depression. When studying boys with a history of offending behaviour, Dishion and colleagues (1996) found that peers were met with a positive response (e.g. laughing) when they discussed criminal or deviant behaviour, which resulted in more conversation regarding rule breaking. They termed this process 'deviancy training', which they found predicted increased use of marijuana, alcohol and tobacco (Dishion, Capaldi, Spraklen, & Li, 1995), arrests by the police and risky sexual behaviour (Patterson, Dishion, & Yoerger, 2000). Deviancy training is more prevalent among males; however females who participate in deviancy training are more likely to engage in antisocial activities (Snyder, Schrepferman, Bullard, McEachern, & Patterson, 2012).

Dishion and Tipsord (2011) investigated the construct of peer contagion in children and adolescents. They describe peer contagion as a reciprocal process between two individuals that may hinder development or cause harm to others, for example aggression or mental health difficulties such as depression. Concern about the effect of peer contagion on child development has given rise to research exploring the possible negative impact of peer relationships. Social mechanisms and peer dynamics have been demonstrated to be influential factors in the development of depression, substance use and bulimia (Stice, Burton, & Shaw, 2004). Suicide and self-harming in adolescents have also appeared susceptible to contagion qualities (Rosen & Walsh 1989). As friendships play a role in supporting adolescents' wellbeing, negative experiences of peer relationships, such as not having friends or victimization, can have adverse

consequences. Rejection by peers can result in loneliness (Asher, Parkhurst, Hymel, & Williams, 1990) and lower quality peer relationships are associated with depression (Preddy & Fite, 2012), although causal inferences cannot be made. Victimization by peers is associated with suicidal ideation and suicide attempts (van Geel, Vedder & Tanilon, 2014) and those who are bullied are at increased risk of lifelong psychological problems (Copeland, Wolke, Angold & Costello, 2013) highlighting the detrimental and long-lasting impact of bullying.

Research has shown that peer-group interventions can have negative consequences due to the influence of the group dynamic, for example increasing adolescent problem behaviour within high-risk youth (Boydell, Gladstone & Crawford, 2002; Dishion, McCord & Poulin, 1999). Furthermore, evidence suggests peer relationships can be both helpful and detrimental to the therapeutic process, wellbeing and recovery of individuals with mental health difficulties (Coatsworth-Puspoky, Forchuk & Ward-Griffin, 2006), suggesting that the impact of adolescents' peer relationships on wellbeing is a worthwhile investigation.

Defining wellbeing

It is essential to explore the concept of wellbeing in the context of inpatient settings as it is integral to patients psychological healing and necessary to demonstrate improved service outcomes. Dodge, Daly, Huyton and Sanders (2012) highlight the difficulties of conceptualising and measuring the multi-faceted construct wellbeing. Definitions differ depending upon how much emphasis is given to physiological, social and psychological aspects and whether the conceptualisation has a more positive or negative emphasis. The World Health Organization (WHO) suggest that wellbeing is

defined as “a state ... in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Ranaweera & Chandra, 2009), a definition that is considered inappropriate for the current study due to the constraints of the adolescents’ situation as inpatients. Furthermore, the utilization of a predetermined definition of wellbeing will be difficult to convey in simple language to the participants within the interview schedule. For the purpose of this research, the focus will be on adolescent’s subjective experience of wellbeing and as an interpretative paradigm will be drawn upon, a particular definition will not be imposed. During the interview participants will be asked what well-being means to them in order to capture their individual understanding of the concept.

Systematic Review

Qualitative literature investigating psychiatric inpatient experiences from the young person’s perspective is scarce and has not yet been synthesised. Therefore, the aim of this review is to examine and consolidate qualitative research exploring young peoples’ lived experiences of psychiatric inpatient units.

Paper Identification

A systematic search of five electronic databases was conducted to identify literature pertinent to the current review. Key words and search expanders and limiters were utilized to identify suitable papers for inclusion (Appendix A). Inclusion and exclusion criteria were established, to evaluate the appropriateness of identified papers. Given the methodology of this thesis, this review includes only qualitative literature.

Due to the limited literature, the search included all research including theses and non peer-reviewed studies, as these were considered likely to contain important findings relevant to the review aim. The search strategy, inclusive of PRISMA diagram, is outlined in Appendix A. Through electronic and manual searching, 8 studies were identified for inclusion within the review (Appendix B).

Quality appraisal

It has been proposed that systematic reviews should only contain methodologically rigorous studies (Slavin, 1987), however conversely others make a case for including all relevant literature (McPherson & Armstrong, 2012). There is no consensus regarding acceptable, or empirically evaluated criteria for excluding research based upon quality (Harden, 2008). Nonetheless it is important to include explicit quality assessment of the studies to prevent the reviewer or reader drawing unreliable conclusions. The Critical Appraisal Skills Programme (CASP) for qualitative research (CASP, 2002) was used to critically evaluate the methodological rigor of articles included within this review. As the area under review is an emerging field, limited studies were available for inclusion, therefore articles were not excluded according to their methodological quality, nonetheless this was critically evaluated (Noyes and Popay, 2007), allowing readers to interpret the results of the review according to these parameters (Schlosser, 2007). The quality assessment identified that the included literature is of good methodological quality, all stated clear aims and employed an appropriate methodology, research design and data collection and completed rigorous data analysis. However some weaknesses were evident which should be borne in mind, such as studies not including adequate contextual information (e.g. regarding recruitment and data collection processes) and without explicit

consideration of the researcher-participant relationship or to the researcher's epistemological stance.

It has been argued that a significant shortcoming of qualitative synthesis is that included research is de-contextualised, and findings established in one context cannot be generalized to other settings (Britten, Campbell, Pope, Donovan, Morgan & Pill, 2002). Part of the role of the reviewer is to ensure that concepts can be validly transferred from one setting to another, highlighting when this is not possible. Providing a summary of the literature included in this review (Appendix C) preserved the studies context and enables individual judgment about the validity of transfer (Thomas & Harden, 2008).

Data Synthesis

Methods for synthesising qualitative literature are diverse and have developed substantially (Barbour & Barbour, 2003), the differing approaches are outlined by Dixon-Woods, Agarwal, Jones, Young and Sutton (2005). It is argued that a fundamental distinction between these approaches relates to epistemological stance (Gough, Thomas, & Oliver, 2012). A systematic review method frequently drawn upon, to synthesise research focusing specifically on participants' perspectives or experiences, is thematic synthesis (Harden et al., 2004).

The findings of the current review will be synthesised utilizing thematic synthesis, following the principles described by Thomas and Harden (2008). This process included three stages, first systematically coding text line by line and developing initial descriptive themes, drawing upon an inductive approach to ensure

proximity to original data. Comparison of codes across datasets was completed so that they could be grouped, and analytical themes developed. Lastly, the results from all the articles were gathered into the themes (Popay et al., 2006), ‘going beyond’ the findings of the included literature (Thorne, Jensen, Kearney, Noblit & Sandelowski, 2004).

A concern regarding qualitative synthesis is what constitutes ‘data’ abstracted from the study findings. Sandelowski and Barroso (2002) discuss the challenges with regard to identifying key concepts, which is complex given differing styles of reporting findings. All text identified as ‘results’ or ‘findings’ present within the included literature, pertinent to the aim of the review, was extracted from each study and used within the data synthesis.

Thematic Synthesis

Theme one: cessation of previous life. Adolescents’ reported disconnection from their previous life. Unable to engage in valued activities impacted their educational and occupational achievements and goals and left adolescents feeling as if they ‘remained stagnant’, with little incentive to progress with their life. The young people experienced distance from their social network and difficulties in maintaining relationships with their peers. They attributed this deterioration to perceived judgment, lack of understanding, prejudice, stigma, stereotyped views of those with mental health difficulties and friends moving on. Some felt this as a loss of support and consequently expressed a need to invest in making new friends. Young people also noted that admission resulted in the loss of their role within the family, being unable to attend events or observe the development of their siblings. However, some spoke positively

of this disconnection from lives that were stressful and pressured, valuing time away, the opportunity to reflect, and acquire new insights and outlooks.

Theme two: desire for sense of normality. The inpatient environment was described as a ‘fake world’ and an ‘alternative reality’, considered strange and abnormal, and vastly different to real life. Some stated that living in close quarters with others who experienced mental health difficulties was empowering and interesting, however for others it provoked fear and uncertainty due to the unpredictable nature of the ward. Experiencing normality within this context was considered important, including opportunities to partake in normal adolescent and everyday activities, fostering independence and connecting with their previous life, recreating a recognizable reality. This was perceived to reduce feelings of difference and resentment of missing out, alleviate boredom, and minimize the impact of hospitalization upon normal adolescent development. The staff and other patients were sometimes viewed as a family system, where young people established familiar roles, to maintain a sense of normality. Staff played a key role in ensuring adolescents felt like ‘normal teenagers’, although some felt that the units encouraged dependence rather than independence.

Theme three: feeling alone and isolated. Some adolescents described their inpatient experience as lonely and isolating, mirroring aspects of their lived experience of mental illness. Unit policies were perceived to engender loneliness, through inflexible visiting times, limited interaction with other patients, and excessive bed-rest; resulting in disconnection from family and friends whilst adolescents were experiencing homesickness and distress due to separation from caregivers. These were

described as frightening experiences, which reduced adolescents' sense of belonging. In contrast, some adolescents reported that inpatient admission afforded them the opportunity to be surrounded by people who they could interact with, which was starkly different to their previous loneliness

Theme four: adjustment to new environment. Adolescents spoke of experiencing difficulties adjusting to the inpatient environment early in their admission. Some experienced it as a non-judgmental place, which provided a sense of safety where they were able to express their true self, however this could be conceptualized as a false sense of security. Others described it as a fragile and threatening environment, which at times felt unsafe. Encountering angry and violent patients created tension for the adolescents, whilst they conceptualized this behaviour from a compassionate stance, it threatened their sense of safety, which was hard to accept. Adolescents spoke of an attachment to the unit and the people within it, which they felt accentuated their dependency on others, decreased their confidence and complicated transitions such as discharge, which were associated with difficult emotions.

Theme five: loss of personal identity. The adolescents emphasized the value of staff and patients perceiving them as a whole person, rather than being defined by their diagnosis. Staff making assumptions, generalizations, accusations, and patronizing behaviour was deemed problematic. Some felt that they were not considered to have unique needs and did not receive individualised care which saw 'the person behind the illness'. Some experienced a reduced sense of self, loss of social identity and belonging leading to low self-esteem.

Theme six: importance of multifaceted intervention. Adolescents expressed the value of addressing their psychological needs as a priority and developing individualised and flexible treatment programmes. Utilizing a multi-disciplinary and systemic approach, such as including patients' families in treatment, and recognizing wider issues, was considered important. Some felt that this had not been achieved, which compounded their illness. They described the inpatient setting as serving the function of a 'holding place', containing behaviour as opposed to offering intervention to facilitate healing. The majority valued the opportunity to engage in therapy and make sense of their frightening experiences and symptoms as coping mechanisms, a process described as an emotional release. Others experienced therapy as unhelpful or anti-therapeutic, feeling pressure to discuss their problems and feeling threatened, uncomfortable and vulnerable when disclosing information, or being exposed to difficult feelings. Fear of professionals misinterpreting or over-analysing the adolescents was voiced. Views on the use of medication were conflicting, for a few young people who considered themselves to be 'ill' medication had a positive effect and enabled them to manage their emotions practically. Others felt that medication was unable to tackle the underlying causes of their distress, resulting in side effects and mistrust of the staff's capability to provide adequate help.

Theme seven: control vs. containment. A sense of powerlessness and lack of freedom was expressed, due both to the physical confinement and unit restrictions imposed. Whilst some experienced this as relieving, others perceived the unit to lack humanity, and felt controlled by staff. This generated feelings of defectiveness, annoyance, vulnerability and inadequacy, which reinforced difficulties. One of the

most difficult aspects of admission was loss of privacy, which for some increased incidents of self-harming. Some adolescents desired more opportunities for collaboration in their treatment and therapeutic decisions, which was perceived to facilitate engagement; exclusion from this evoked distress. Achieving empowerment through increasing autonomy and freedom prior to discharge was desired. Feeling controlled and scrutinized was infantilizing and punitive for some, with care considered to be substituted by monitoring. Some adolescents expressed a desire to rebel against the rules when they felt they were being punished by the imposed restrictions, others experienced the inpatient environment as containing. Routine and structure were valued and understood as improving wellbeing, which adolescents were able to appreciate more throughout their admission. They considered containment to provide a safe environment and a distraction from their difficulties.

Theme eight: navigating relationships with staff. Establishing authentic and meaningful relationships with professionals, where adolescents felt understood, was valued. These relationships developed in the context of openness, reliability and trust, providing patients with a sense of normality and were considered crucial for emotional disclosure. Some adolescents experienced the staff as supportive, validating, and non-judgmental and of having the necessary skills to understand their needs and provide emotional support compared to other adults in their life. Young people valued developing meaningful relationships with staff, which included professionals sharing elements of their own experiences or private life. Permanent staff took on parental roles during admission, thus the adolescents found it difficult to cope when they were absent, and found it hard to establish rapport with agency staff. Some perceived staff as being neglectful, unavailable and unwilling to listen unless distress was evident, mirroring

potential neglectful home environments. For these adolescents, staff were deemed to be inconsistent and emotionally distant, providing monitoring rather than care, leaving patients feeling angry, anxious and disappointed. Relationships with professionals were at times polarized; young people appreciated support but were averse to the risk management component of the staff's role. Some adolescents found it challenging to form trusting relationships and when their needs were not met they experienced disappointment and frustration.

Theme nine: peer relationship dilemmas. Adolescents described their relationships with other patients on the unit as a valued aspect of their experience; helpful, supportive and providing validation and empathy. This facilitated the development of a deep level of acceptance and understanding due to a shared lived experience. Peer relationships provided a sense of belonging, companionship and familiar interactions during admission, which was at times frightening. Adolescents experienced genuine acceptance, as compared to the stigma they encountered in the outside world. Being in the presence of other teenagers brought a sense of normality to the ward, enabling the adolescents to manage the intense inpatient experience and provided motivation and learning opportunities. When staff were unavailable, peer relationships provided support during distress, enhancing adolescents' emotional competency, however some felt burdened by this obligation and ill-equipped to take on the role of a helper and consequently withdrew as self-protection.

Navigating such complex relationships within the inpatient context presented challenges associated with peer pressure and social conformity, provoking dilemmas for the adolescents, such as preserving other's confidentiality, rule-breaking, and

partaking in destructive behaviour; all of which risked rejection and alienation. Witnessing other adolescents in distress, being restrained, or violent and aggressive behaviour, was upsetting, confusing and ‘triggering’ for some, whilst others learnt negative coping strategies from other patients. Concern for causing their fellow patients distress meant some adolescents hid the extent of their self-harm whilst others gained attention through escalating and exaggerating their behaviour, leading to a competitive environment. Physical contact was prohibited; however this was felt to be central to the development of trusting peer relationships.

Theme ten: healing vs. hopelessness. Most adolescents expressed that they developed insight into their difficulties, which increased their confidence and agency, allowing recognition of their vulnerabilities and utilization of positive coping strategies. Having gained a new perspective, adolescents felt hopeful and optimistic for their future. This positive outlook possibly minimised the impact of their admission by defending against difficult emotions. Changes in interpersonal functioning, the ability to form trusting relationships, and self-acceptance were reported. Conflicts with recovery were conveyed, including: readiness to change, disappointing others, and leaving the safe and supportive inpatient environment whilst desiring to return to their previous life. A few adolescents felt their admission had been detrimental to their psychological wellbeing with worsening of their difficulties, creating a sense of hopelessness. They communicated anger at being let down and feeling unsupported by staff and felt vulnerable having divulged information they wished they had suppressed.

Discussion. Adolescent inpatient admission can be an isolating experience, with patients removed from their previous life and support systems. It is important for

adolescents to maintain their sense of identity and connection to the outside world and for some normality to be created within the ward environment such as engagement in age-appropriate activities, and staff encouraging their independence. The environment can be perceived as over-controlling, punitive and restrictive which was considered counter-therapeutic and elicited strong emotional responses. A balance between engaging adolescents in collaborative treatment programmes, and developing their autonomy whilst setting boundaries and providing an environment that is containing is desired. Therapy was greatly valued by most, however safety within the therapeutic relationship was key to exploring distressing emotions without these becoming emotionally overwhelming. Adolescents benefited most from a holistic treatment approach, and a context wherein both their physical and emotional needs were met. Staff were considered central to recovery; adopting the role of temporary attachment figures, consistency and trust within these relationships was key. Peer relationships were experienced as both helpful and detrimental. Positive aspects included offering support within the sometimes hostile ward environment and providing understanding and validation via peer identification and shared experiences. Conformity, peer pressure and competition were challenges for adolescents.

Strengths and limitations. The synthesis was completed by one researcher due to time and resource restraints. With qualitative research, a degree of subjectivity occurs with data interpretation, which can bias findings, methodological rigour and credibility of the approach is therefore imperative. The analysis utilized was systematically outlined, and followed principles described by Thomas and Harden (2008), enabling each step within the process to be understood by others, guaranteeing transparency.

The quality assessment highlighted inadequate contextual information in some included literature, such as the recruitment strategy, research setting and data collection processes and methodological weaknesses were identified. However, these studies were felt to contain rich data pertinent to the review aims. The studies contained small sample sizes from regional inpatient units, each with their own unique philosophy, admission criteria, therapeutic approach and treatment programmes, all of which influence adolescents' experiences, thus limiting the generalisability of the findings. Participants were from a range of mental health settings, including specialist units for particular disorders, it is unknown if these accounts reflect the experiences of individuals within general inpatient services. Many of the studies interviewed adolescents following discharge; therefore, raising the possibility of influence by retrospective bias. The only paper that explicitly explored adolescents' experiences of peer relationships was an unpublished thesis undertaken in 2006. However, since that time there have been significant changes in mental health provision, with a different government, new policies, and increasing strain on adolescent mental health services. Additionally, the social context, including rising prevalence of social media, has evolved resulting in different pressures upon young people. A salient theme present in all papers was the benefits and dilemmas adolescents face in peer relationships within the inpatient setting. Adolescents' perception of staff management of peer relationships, their reactions to staff intervention, factors impacting upon relationship development, and the effect of peer dynamics on the wider unit remain unknown. Further research exploring adolescents' experiences of peer relationships in depth, to gain a more comprehensive understanding given the changing environment described is therefore important.

The current study

Problem Statement

Determining the effectiveness of inpatient CAMHS is challenging as important ethical considerations compromise internal and external validity. Research highlights the important role therapeutic alliance serves with engagement and achieving positive psychotherapeutic outcomes for adolescents. Given the importance of peer relationships during adolescence, it is likely that this alliance will be extended from the therapist to other young people on the ward. The development of a milieu adapted to the complex needs of adolescent patients is challenging but considered a vital element of treatment, and an intervention in its own right (Green & Burke, 1998). Alongside other factors, peer relationships are an essential component of the creation of the milieu (Green & Burke, 1998), therefore it is advantageous to understand these complex dynamics and potentially anti-therapeutic features from the adolescents' perspective. As peer relationships are influenced by early attachment strategies, the formation of these relationships within inpatient units are complex, with a high prevalence of severe and complex trauma and young people demonstrating potentially insecure attachment styles. Staff report challenges managing peer affiliations, which have the potential to keep adolescents stuck as recovery may threaten peer group dynamics with some patients feeling a sense of guilt about recovering. When exploring adolescents' general experiences of inpatient units, the value and detrimental impact of peer relationships emerge as pertinent themes. However their impact upon patients' psychological and emotional wellbeing, and their views regarding staff management of these relationships is an under-researched area. As such relationships are likely to have a profound impact upon recovery, wellbeing, and service outcomes this should be explored further from

the patient's perspective to improve understanding, which may support service development. A qualitative approach is utilized to investigate adolescents' perceptions, narratives, and insights of peer relationships within the inpatient unit.

Aims and objectives

The present study will address the following main aims:

1. To explore the lived experiences of peer relationships within an adolescent inpatient setting.
2. To investigate how adolescents within a CAMHS inpatient setting perceive peer relationships to influence their psychological wellbeing.

CHAPTER TWO: METHOD

Chapter Overview

This chapter will detail the rationale for the use of a qualitative approach and chosen method of analysis within the philosophical framework of my epistemological stance. The research procedure will be outlined, including addressing ethical considerations, recruitment, data collection and data analysis. Measures to ensure reliability and methodological rigour are detailed. Research reflexivity is described by explicitly outlining my personal assumptions, beliefs and interests; and the influence of these on the research process.

Philosophical Framework

Outlining my epistemological and ontological position, which is woven throughout this research, is critical as it influences many of the research decisions (Silverman, 2013). Recognising my own personal subjectivity creates an awareness of possible bias that may emerge, increases the credibility of the research and ensuring transparency of the research process and methodological decisions which may influence research outcomes (Frost et al., 2010). Commonly a researcher's ontological stance will influence the epistemological position, which in turn influences research methodology.

Ontology. Ontology can be defined as “the study of being” (Crotty, 1998, p10) and “the nature of reality” (Lincoln & Guba, 1985, p 37). Ontological positions identify the researcher's perception of what constitutes reality: whether or not reality exists independently from human interpretation. A number of different ontological theories

exist which can be conceptualised as positioned along a continuum; at one end sits realism and at the other end relativism. Realism posits that the world including both natural and social components, is separate from human interpretation and thus objective measurement of reality can be made (Blaikie, 2007). Tebes (2005) described this position as a ‘mind-independent truth’. Realism assumes that the application of relevant research techniques can reveal ‘the truth’, of which there is only one version. Thus our observations of the world are considered to be an accurate representation of what exists, termed as ‘a correspondence theory of truth’ (Madill, Jordan & Shirley, 2000:3) which underpins most quantitative research. Conversely, relativism posits there are many different constructed realities rather than a single mind-independent truth (Cromby & Nightingale, 1999). This position states that reality and truth are not universal but vary across time and context. Between the extremes of realism and relativism sit critical realist positions. This also invokes a real and knowable world which can only be revealed in part as it lies beneath the subjective and socially influenced knowledge that a researcher is able to assess (Madill et al., 2000). For this research, I do not consider that an ‘objective truth’ exists, waiting to be ‘revealed’. My understanding is that individuals construct their own reality where multiple potential versions can coexist according to the lenses through which they are viewed and experienced.

Epistemology. Epistemology is a branch of philosophy involving the theory of knowledge, how knowledge is acquired, what is possible to know and the legitimacy of this knowledge (Crotty, 1998). Epistemology mirrors ontology in that different stances exist on a continuum; from objectivism to subjectivism.

Positivism. Positivism, or objectivism, assumes that valid knowledge is obtained through the application of scientific methods, and by these means it is possible to discover the ‘truth’ that exists. This stance is based on a simplistic relationship between the world and how it is perceived, favouring the dualistic belief that there are no influences between researcher and participant (Scotland, 2012).

Constructionist. Other epistemologies reject the concept that knowledge is an objective account of reality. Constructionist or subjectivist epistemologies consider knowledge is constructed through specific social and cultural contexts and that there is not one truth but a number of different knowledges subject to change over time as external contexts change.

Contextualism. This epistemological stance draws from the positions at either end of the spectrum. Like constructionism it does not propose a single reality and regards knowledge as emerging from contexts and reflective of researchers’ positions, however it retains a realist dimension in its interest in understanding the “truth”. Although it acknowledges that no single method can get to the ‘truth’, it asserts that knowledge will be true in certain contexts, a notion which constructionism rejects.

I consider that the participants in this research are likely to have differing interpretations of reality, perceived through the lenses of factors such as gender, race and social class. This reflects the constructionist approach accepting that there are numerous possible ways to create truths and attempts to develop understanding of a researched phenomenon (Denzin & Lincoln, 2005)

Research paradigm

In order to optimise and strengthen the research design it is essential to choose a research paradigm aligned with the researcher's views regarding the nature of reality (Mills, Bonner & Francis, 2006). According to Denzin and Lincoln (2005) a paradigm consists of ontological, epistemological and methodological views held by the researcher. Paradigms are also classified on a spectrum from positivist to interpretivist. The current research is positioned within the interpretivist paradigm, drawing from a relativist ontological stance and constructionist epistemological position.

Within the interpretivist paradigm “objective reality can never be captured. I only know it through representations” (Denzin & Lincoln, 2005, p. 5). I will focus on developing an understanding of how the adolescents perceive their experiences and the meaning they attribute to them. An interpretive paradigm will be used to make sense of how the adolescents perceive and interpret their peer relationships, and from these accounts I will construct and interpret an understanding (Cao Thanh & Le Thanh, 2015). The study aims to elicit adolescent's views of peer relationships in the inpatient setting and attempts to discover their reality based on their experiences and views (Yanow & Schwartz-Shea, 2011). By exploring multiple perspectives of the adolescent's accounts a comprehensive understanding of the particular context will be developed (Willis 2007).

Self-reflexive Statement

“Reflexivity involves an awareness that the researcher and the object of study affect each other mutually and continually in the research process” (Alvesson and Sköldböck, 2000, as cited in Haynes 2012, p73).

When conducting qualitative research within an interpretivist paradigm, it is believed to be impossible to remain objective and outside of the research subject (Palaganas, Sanchez, Molintas & Caricativo, 2017). Reflexivity acknowledges the researcher's influence on the research process, how their beliefs, upbringing, personal experience and interests impact on methodological decisions and their interpretation of participant's accounts. Transparency and research quality is strengthened by the researcher exploring their influence on the co-construction of meaning with participants during the interview process (Lietz et al., 2006).

I identify as a 30-year-old, middle class, white female of British origin. When I was 19 years old I left home to study Psychology at university, where I obtained an upper second-class honours degree. Subsequently I completed an MSc in Health psychology. I then worked for 2 years with children diagnosed with ASC and subsequently in a CAMHS team as an Assistant Psychologist. I commenced the Doctorate in Clinical Psychology aged 27. My clinical experience prior to training was largely with children and adolescents in a community setting. In my clinical work I utilise an integrative approach, drawing from systemic, attachment, third wave Cognitive Behavioural Therapy and psychodynamic theories and approaches. I am drawn to formulating from a psychodynamic and attachment perspective, having been influenced by the approach of my previous supervisors and having attended a doctoral course that provides in-depth psychoanalytic teaching. Within my clinical and research supervision, I have been encouraged to consider how my clients' early childhood experiences influence their development and how unconscious processes manifest within the context of their relationships.

Upon commencing the doctorate, a psychologist from the recruiting unit identified areas of research that the team were keen to explore further. One area of particular interest related to understanding the young people's experiences of peer relationships within the inpatient setting, as the complex dynamics between patients was perceived to be a continual area of challenge for the staff.

This prompted me to reflect on my experiences of working with this client group, and the observations I had made on the impact of admission on these young people. I was curious about factors on the ward that may influence their wellbeing such as complex relationships with other patients. This led me to consider how attachment and relational difficulties may play out in peer relationships in the inpatient setting and the impact upon their progress towards discharge. I also recalled my experiences of running groups within mental health settings and how beneficial peer support can be in providing a deeper level of understanding and empathy from others with lived experience of mental health difficulties. Given the high levels of relational trauma on adolescent inpatient wards and the influence this will have on the development of peer relationships on the unit, I was surprised to learn that little research had been conducted from the adolescent's perspective in this area. I therefore felt compelled give them a voice and to use this project as a means to improve staff's understanding of the young people's experiences.

It is important to acknowledge the frustration I experienced whilst on my community CAMHS placement which will have influenced my position. I perceive that as a result of the current political environment in the NHS, detrimental service changes have been implemented resulting in fragmentation of teams, provision of limited and

short-term therapy, dominance of the CBT model, and loss of clinical expertise within services. Consequently many services, in particular community settings, feel unsafe to work in and are unable to provide the long-term therapeutic input often needed by young people with complex needs. Anecdotally, it appears as though as a result of service shortcomings, some adolescents learn to escalate their behaviour and risks in order to be admitted into inpatient settings where they can receive the specialist care they require.

Prior to commencing the interviews, I thought about how I may be experienced by the young people on the ward as an unfamiliar adult, given their current levels of distress, experiences of mental health services and possible mistrust of others. I recognised that I was an outsider and considered how this would impact upon developing rapport. I thought it important to spend time on the unit in order to understand the patients' routine and management of the ward, as well as becoming a familiar presence on the unit for both patients and staff. I was received very positively by staff, who were keen for the research to be conducted. Being on the ward afforded me the opportunity to engage eligible patients in conversation where I took a curious and unknowing stance and established myself as independent from the clinical team and possibly less threatening thus enabling the young people to openly share their experiences. I reflected on my relatively young age and wondered whether this was beneficial in helping to manage the power imbalance, as patients may have been able to personally identify with me. However, it is possible that some patients held fantasies about my power, such as my ability to bring about change, and used the interview as a means to express their needs.

I reflected on my own role as a researcher and the difficulties being an impartial observer rather than a psychologist. I also thought about how my identity as a trainee clinical psychologist would influence participants' expectations of me and our interactions during the interviews, such as being placed as an expert who provides advice. I often found maintaining the boundary of a researcher with a neutral stance challenging due to my professional training and desire to alleviate mental distress. However, I was mindful throughout the interview process to question participants from a research rather than clinical perspective.

Methodology

The chosen ontological and epistemological stance informs the research methodology. Silverman (1993) differentiates between research methodology; defined as the general strategy adopted to investigate a topic of interest, compared to the method; known as 'a specific research technique'. The ways in which knowledge is discovered differs and the researcher's underlying philosophical paradigm usually influences this. Quantitative methodology is typically grounded in a positivist paradigm and structured approach, such as quantifiable observations or empirical measurement. The research often involves hypothesis testing through a controlled, logical and structured approach (Krauss, 2005), where it is assumed that the researcher is independent from the researched phenomenon (Hudson and Ozanne, 1988) and is evaluated on the basis of validity, reliability and generalisability.

Qualitative methodology is associated with an interpretivist paradigm, wherein it is theorised that multiple realities exist (Hudson and Ozanne, 1988) and that the knowledge obtained is socially constructed (Carson et al., 2001). Interpretivist research

seeks to understand, interpret and capture the meanings attributed to subjective human experiences and participants' perceived realities (Black, 2006; Carson et al., 2001), which are considered to be bound by context and time (Hudson and Ozanne, 1988). The aim of my research was to gain a deeper understanding of adolescents' experiences of peer relationship within CAMHS inpatient settings; a phenomenon where an objective truth cannot be ascertained, or cause and effect relationship established, thus I felt it was most appropriately investigated using qualitative methodology.

Method of data collection. Methods of obtaining data are determined by the research question, so that relevant and useful data are collected to enable understanding of the studied phenomenon. Common methods of data collection are discussed in turn and my choice of in-depth interviews is justified.

Semi-structured interviewing. In qualitative research within the social sciences, this is the most common method of data collection (Briggs, 1986), due to practicality and its compatibility with numerous methods of data analysis. This strategy for obtaining data enables the researcher to gather information about participant's perspectives and experiences through face to face interaction, capturing their language in relation to the researched phenomenon (Rubin and Rubin, 1995). Semi-structured interviews are often guided by a carefully constructed interview schedule, a set of pre-determined open-ended questions, which are flexibly adhered to but which ensure that some control is maintained over the direction of the interview whilst the participants are given the opportunity to provide new insights. This method of data collection has been chosen as it is suited to gathering detailed and rich, data about individuals' sensitive experiences and perspectives, where the researcher can maintain an element

of control over the interview; increasing the probability of generating relevant data. Additionally, it enables flexibility and openness to insights that the researcher may not have anticipated.

Textual data. A less common method, this includes the collection of participant-generated data in the form of written notes on a phenomenon or pre-existing data in written format such as medical notes or online forums. Researcher directed diaries are one method of participant-generated data, where participants record entries over an agreed period of time with some guidance such as the focus and frequency of the documentation. Despite some participants reporting this as an empowering method (Holliday, 1999), it can be problematic as recording a diary can impact upon participants' daily routine, and the quality of the data collected is dependent upon participants' enthusiasm and commitment to the study. Furthermore only those willing to commit to the demands of diary keeping will participate, which may result in a biased sample and high drop-out rates (Breakwell & Wood, 1995). Qualitative surveys are an alternative method, where participants answer a set of open-ended questions, which can be less daunting than interviews and a quick, easy way of gathering plenty of data. However due to its limitations including the exclusion of those with literacy difficulties and being unable to probe participant's answers further, this method of data collection is deemed unsuitable.

Focus groups. As an alternative to semi-structured interviews, focus groups provide the opportunity to gather data on interactions between participants on a topic of interest, where the researcher acts as a moderator by steering the discussions. Participants are required to remark on each other's contributions, challenge comments

and develop thoughts, which provides rich data in a less artificial de-contextualised setting (Wilkinson, 1999), as compared to individual interviews. However the use of a focus group was considered inappropriate for the current research question. Being amongst other patients may inhibit participants from disclosing their views and experiences due to concerns about vulnerability and confidentiality (Leask, Hawe, & Chapman, 2001; Liamputtong, 2011), particularly when discussing more intimate experiences, or those involving other members of the focus group. Furthermore, focus groups do not permit in-depth exploration of individual experiences, which is the focus of the current study.

Justification for Thematic Analysis

As different approaches to analysing qualitative data have been developed, each will be discussed in turn and justification given for choosing thematic analysis as most suitable for the current study. According to Starks and Trinidad (2007), research questions and the goals of the study determine the method of data collection approach to analysis.

Grounded Theory. Developed by Glaser and Strauss (1967), this approach utilizes a systematic method to analyse qualitative data. This involves the researcher focusing on the data to generate concepts and hypotheses through an inductive, and evolving process (Charmaz, 2000), thus it is best suited to exploratory research where theory is derived from data. This process aims to link theory and practice and is accepted in the social sciences (Breckenridge & Jones, 2009). Strengths of this approach include the development of an in-depth and rich understanding of the data and detailed, rigorous theory of complex phenomenon, accounting for the researcher's

perceptions (Bryant, 2002). However, there is a lack of consensus regarding its method (Barbour, 2001) which can result in methodological inaccuracies (Potrata, 2010). I considered this approach unsuitable for addressing the current research questions which focused upon describing young people's experiences rather than constructing a theory to explain them. Furthermore a key characteristic of this approach is theoretical sampling (Jones & Alony, 2011) which requires theoretical saturation to be reached (Brown et al, 2002). I anticipated that this would be difficult to achieve given the complexity of the participants and the in-patient setting which hampers recruitment; for example: patients being transferred or discharged at short notice.

Interpretive Phenomenological Analysis. Developed by Jonathan Smith (Smith,1996), Interpretive Phenomenological Analysis (IPA) aims to establish how individuals perceive and make sense of their experiences by focusing on single cases, or small groups of homogenous individuals, where themes are generated within and across sets of data (Smith et al., 2009). IPA adopts a phenomenological approach, exploring people's subjective experiences, assuming that participants and their social context cannot be meaningfully separated. IPA involves a dual interpretive process, where the participant makes sense of their experiences and the researcher attempts to make sense and interpret the participant's world (Smith et al., 2009). IPA has been criticised for lacking standardisation, being predominately descriptive rather than interpretative and for being ambiguous (Brocki & Wearden, 2006). Thematic analysis was considered preferable as the current research aims to describe participant's experiences, rather than seeking to interpret the meaning of their lived experiences.

Conversation Analysis. Conversation analysis is a highly structured, systematic and detailed approach (Psathas, 1995), which involves describing the structure, patterns and orderliness of conversation, and the process by which identities, and social realities emerge (Braun & Clarke, 2013). Conversation analysis focuses on structural organisation, sequence and turn taking in conversation. As the current research does not focus upon identifying and explaining patterns of interaction, conversation analysis was deemed unsuitable.

Thematic Analysis. Thematic analysis (TA) is an analytic method used extensively (Roulston, 2001) which utilizes a systematic approach to identify, analyse and report themes across a series of datasets from a homogenous sample (Braun & Clark, 2006). Different varieties of TA exist with varying aims and ways of developing themes, including: inductive, theoretical, experimental and constructionist methods. This analytic method is unique due to its flexibility; it does not specify alliance to a particular theoretical framework, data collection method, or ontological and epistemological position, consequently it can be utilized with most research questions and methodologies. Furthermore, researchers do not require specific training in order to use TA. Braun and Clark (2006) have developed guidelines outlining the method, enabling skills including data-handling and coding to be learnt, therefore it is highly accessible for researchers new to qualitative analytic methods, and methodologically sound. Braun and Clark (2006) argue that TA can produce data that is detailed, rich and complex, going beyond description and interpreting certain aspects of the studied phenomenon (Boyatzis, 1998). Research has demonstrated that TA is a useful way of allowing participants' voices to be heard (Joffe, 2011).

Historically TA has been critiqued for being a method where “anything goes” due to the lack of specific guidelines and flexibility (Antaki, Billig, Edwards & Potter, 2002), not permitting claims about participants language (Braun & Clark, 2006) and lacking coherence and consistency when deriving themes from a dataset (Holloway & Todres, 2003). However Holloway and Todres (2003) suggest that when generating themes consistency can be encouraged by the researcher explicitly acknowledging their epistemological stance underpinning the research. Furthermore, many of these limitations are associated with studies that produce unclear descriptions of the analytic method or analyses that are inadequately conducted (Hayes, 2000).

TA was deemed to be an appropriate method of analysis for the current study, it has been commonly used to address topics related to individuals’ experiences and perceptions of a studied phenomenon (Braun & Clarke, 2013, pp. 44–55) and meets the research aims. Comprehensive themes regarding adolescents’ experiences of peer relationships within an inpatient setting can be developed from within an interpretivist framework. Furthermore, a rigorous and clear six-step process of familiarisation with the data, coding and development of themes can be applied to identify patterns within the dataset to address the study aims (Braun & Clark, 2006).

Ethical Considerations

Guidance for conducting ethical human research (The British Psychological Society, 2014; Neill, 2005) was complied with.

Informed Consent. The process of obtaining informed consent from patients was complicated by their complex mental health conditions, particularly as some were

detained because of their perceived inability to make competent decisions (BPS, 2014; Hoop, Smyth & Roberts, 2008) and keep themselves safe. The patients' clinical team confirmed their eligibility to participate in accordance with the study inclusion criteria. For those patients where there was uncertainty about their ability to consent, the principle of 'Gillick competence' was applied if they were under 16 years old or the Mental Capacity Act for those over 16. This ensured that the adolescents had sufficient understanding and intelligence to make reasoned choices and consent to participation after full consideration. Wheeler (2006) made the case for retaining Gillick competence as the prime method to judge capacity in children. For those under the age of 16 years old who wished to participate, consent was sought from the parent or legal guardian in addition to the patient themselves, informing them of the nature of the research and their right to withdraw their child (BPS, 2014).

In order to affirm my independence as a researcher from the service clinical team, I recruited participants by attending weekly community meetings where I introduced myself and outlined the research study. I considered this recruitment strategy to be preferable to service staff identifying possible participants as it reduced the likelihood of patients feeling coerced to participate and obliged to continue to take part. Once patients expressed an interest in participating and were confirmed as being eligible to participate by their clinical team, I arranged to meet with them to discuss the study in greater depth.

The BPS (2014) states that vulnerable populations, including those under the age of 16 years old and those lacking capacity, should be provided with sufficient opportunities to be informed of the study purpose, nature and expected outcomes of

participation. In order to maximise their understanding, techniques to enhance their comprehension were employed. In-depth and careful communication of the research aims and methods was delivered to patients at the initial recruitment stage during the community meeting and in a one-to-one meeting arranged with me to discuss the study in greater detail. Flory & Emanuel (2004) propose a one-to-one meeting as the most effective method in improving research participants' understanding.

As the adolescents understanding of the research depended upon how information was provided, careful consideration was given to the language and information presented. Service users were consulted with regards to the readability and understandability of the information given to patients and parents (Vitiello, 2008). Participants' understanding was assessed by asking them to recall the objectives of the study, study procedure, potential benefits and risks of the research and describe their rationale for participation based on the key components of the Mental Capacity Act (2005).

Participants were given a minimum of 48 hours between their one-to-one meeting and the interviews commencing to allow adequate time for them to decide whether or not to take part, without feeling pressured and to have an opportunity to ask as many questions as they wished. This is in accordance with the guidelines provided by the Health Research Authority Guidance (2017).

Confidentiality. Participants were informed of the limits of confidentiality, and that it would be necessary for me to break this if they disclosed information that raised safeguarding concerns (British Psychological Society, 2014). They were

informed that in this event, I would discuss the disclosure with the responsible Clinical Psychologist on the unit who would pursue these concerns and take appropriate action by following the trust's safeguarding procedures. Participants were required to provide informed consent confirming their acceptance of this and were advised that I would inform them beforehand if I felt that it was necessary to break confidentiality.

Anonymity. As the data being collected is qualitative in nature, direct quotations will be used within the final study write-up, therefore despite measures to protect anonymity there is a risk that participants could be personally identifiable (Larossa et al., 1981). The challenges of maintaining anonymity by removing contextual identifiers whilst preserving the participants' rich and detailed accounts is recognised in the literature (Kaiser, 2009). As the research was conducted within the naturalistic service setting, other patients were aware of those participating. It was possible that participants might have experienced negative consequences from other patients as a result of taking part. To minimise this the interviews took place in a private room. To ensure that patients were aware of these potential issues, they were discussed during the informed consent process and encouraged to disclose any distress that they experienced as a result of participating with a nominated Clinical Psychologist within the team.

Data Storage. Participant interviews were audio-recorded and transferred to a secure University of Essex computer system, located in a secure location on the University premises. The interview data was transcribed and anonymised, after which the audio recordings were destroyed. To ensure anonymity of the data, each participant was allocated a participant number. The research data was stored in a password-

protected document, which only I could access. Paper records, containing personally identifiable information, including consent forms were kept in a locked cabinet in the Academic Supervisor's office. In line with the Data Protection Act (1998), participants were informed of these data storage policies and provided consent for their transcribed data to be retained for 5 years after which it would be destroyed.

Providing Advice. If the participants requested advice during the interview process, they were encouraged to discuss their concerns with a nominated Clinical Psychologist within the team.

Right with withdraw. During the informed consent procedures, participants were informed of their right to withdraw at any stage of the research process without prejudicing their treatment (British Psychological Society, 2014). This was stated within the consent forms to prevent participants from feeling obliged to continue to take part.

Protection from harm and debriefing. It was envisaged that participants might be exposed to questions leading to sensitive discussions, for example situations that have induced feelings of anger resulting in negative mood following participation (Lee & Renzetti, 1990). The sharing of personal, intimate experiences may arouse powerful emotions; however, due to the nature of the unstructured interview participants retained agency over the process (Cassell, 1980). As I am a trainee Clinical Psychologist with experience of working with clients who frequently experience emotional distress, I drew upon my therapeutic skills to minimise this (Corbin & Morse, 2003). This involved monitoring and responding to participants emotional state,

offering breaks, and providing a containing environment whilst being sensitive to any reluctance to discuss difficult experiences (Kavanaugh & Ayres, 1998; McSherry, 1995).

Accounting for ethical protocol (The British Psychological Society, 2014), participants were fully debriefed following their interviews. If during this debrief, any concerns regarding the emotional wellbeing of the adolescents were raised, this was immediately communicated to the clinical team. As the research took place within the inpatient setting, the participant's clinical team were able to monitor their emotional wellbeing following participation.

The balance of benefits to participants must outweigh any possible harm they might experience as a result of taking part. Hutchinson et al. (1994) acknowledged seven potential benefits of qualitative research interviews including providing participants with a sense of purpose, empowerment, validation, enhancing self-awareness promoting healing, being a cathartic experience and enabling the disenfranchised to be heard. Lipson (1994) affirmed this and reported that there appeared to be no long-term harm following research interviews. Following discussions with service staff, it was apparent peer relationships within the unit could be problematic and that there was uncertainty as to the best way of managing these. Investigating peer relations from the perspective of the patients may yield useful insights and improve understanding which could ultimately benefit both staff and patients in terms of well-being and service development which outweighed potential harm caused by sensitive discussions. Participants may acquire benefit from having the opportunity to discuss a topic that is currently under-researched and which will lead

to furthering staff's knowledge on the adolescent's experiences and possible service level changes being implemented.

All participants who expressed an interest in receiving a lay summary of the study findings will be sent a copy via post, as it is anticipated that most, if not all patients would be discharged from the service by this point in time.

Financial remuneration. Offering financial incentives for participation in qualitative research is a factor that should be given ethical consideration (Head, 2009). Giving participants financial payment to demonstrate an appreciation of their contribution and to value their expertise (Goodman et al., 2004) may influence their decisions regarding participation, consent, withdrawal and data validity (Head, 2009). In agreement with national guidance (National Institute for Health Research, 2009) I believe financial remuneration to be important to reduce sample bias by encouraging all to participate, as well as reducing the power imbalance between researcher and interviewee (Goodman, 2004) and expressing gratitude for participant's time and contribution. Following participation, participants were provided with an envelope containing a letter of thanks and a one-off £10 financial gift.

Risk. As I conducted interviews alone with participants, I adhered to local Trust Policy and guidelines around lone working. The responsible Clinical Psychologist identified possible risks prior to the interviews taking place. It was possible that as a result of being exposed to participants' distressing accounts I could experience vicarious traumatisation (Perlman & Saakvitne, 1995). My emotional well-being was contained through supervision with my research supervisors.

Ethical Approval. Full NHS ethical approval was received on the 16th April 2018 (Appendix D). The local NHS trust's Research and Development department reviewed the research proposal and granted ethical approval on the 16th May 2018 (Appendix E). The University of Essex ethics committee gave the study ethical approval on the 15th May 2018 (Appendix F).

Method

Research Design. Exploratory, naturalistic, qualitative methodology was utilized to explore and capture adolescent patients lived experiences of peer relationships within the inpatient setting.

Service Context. All participants were recruited from a Tier 4 NHS inpatient Adolescent Mental Health Unit providing therapeutic support for young people aged between 13-18. Young people admitted to the unit are experiencing severe and/or complex mental health difficulties and deemed to pose a significant risk of harm to themselves, or others, which cannot be safely managed within the community. The service has two wards, in addition to a therapeutic educational department providing patients with specialist education. Patients are either detained under the Mental Health Act (1983;2007) or are informal patients.

Within the service there is a multi-disciplinary therapies team consisting of clinical psychologists, psychotherapists, a cognitive analytic therapist, and family therapist. The service offers a range of psychological therapies including Cognitive Behavioural Therapy, Cognitive Analytic Therapy, Dialectical Behaviour Therapy

skills, psychotherapy and integrative formulation driven work often drawing from an attachment and complex trauma framework. Nurses, health care assistants and Occupational Therapists care for the young people on the wards.

Between October-December 2016, 2,434 young people were admitted to hospital due to mental health difficulties (NHS England, 2017). Owing to the limited number of inpatient units and low numbers of patients, specific service information is not provided to protect participants' anonymity.

Participants and sampling method. Purposive sampling is a frequently used method employed in qualitative research that takes an interpretivist approach (Creswell, 1998). This is commonly used to identify and select participants possessing particular characteristics or knowledge related to the subject of interest (Cresswell & Plano Clark, 2011) who are available and willing to participate (Bernard, 2002; Spradley, 1979).

Inclusion and exclusion criteria were established with the clinical team and all patients admitted to the general psychiatric ward from the recruiting NHS Trust were invited to participate. Once a patient expressed an interest in participating, a nominated Clinical Psychologist from within the service screened their eligibility against inclusion and exclusion criteria accounting for their capacity to consent and mental health status.

Inclusion criteria:

1. Participants who had been admitted to the general psychiatric ward for a minimum for 4 weeks to give them enough time to experience

and form peer relationships

2. Male and female patients
3. Aged between 13-18 years old
4. Informal patients and those detained under the Mental Health Act
5. Native English speakers due to translation costs and the difficulties associated with the use of interpreters in qualitative research including threat to validity (Edwards, 1998).

Exclusion criteria:

1. Patients deemed by their clinical team to be unable to provide informed consent.
2. Patients experiencing acute psychosis because of potential difficulties with communication due to lucid experiences and their reduced capacity to tolerate the interview.
3. Patients currently receiving 1:1 observation and those deemed to pose a significant clinical risk which would prevent the researcher from interviewing them alone.
4. Patients admitted to the Adolescent Intensive Care unit due to the acute nature of their mental health difficulties likely impacting their ability to consent and participate in the research interview.

Sample size. Quantitative research commonly calculates sample size through the use of power analysis which looks at the likelihood of obtaining a statistically significant result with a specific sample size. Sandelowski (1995, p. 179) stated “There are no computations or power analyses that can be done in qualitative research to

determine a priori the minimum number [...] of sampling units required". Sandelowski (1995) argued that sample size requires subjective judgement; it is necessary to have a sample size that is big enough to provide new understandings of experience whilst small enough to be manageable.

A dominant discourse within the literature concerning participant numbers required to ensure validity of qualitative research is data saturation (Mason, 2010). This posits that sampling adequacy is that beyond which no further new themes or perspectives are identified. Issues related to the use of data saturation have been identified, O'Reilly & Parker (2012) stated that as the notion of saturation has derived from grounded theory, it is not always suitable to employ it indiscriminately across all qualitative approaches nor is it a gauge of generic research quality when used alone. Defining a set number of participants required for data saturation is challenging as developing themes can be never-ending (Green & Thorgood, 2004) as each participant shares their own unique experiences, thus there is always new data to discover and saturation may never be reached (Wray, Markovic, & Manderson, 2007). The depth of the data is paramount rather than quantity of participants (Burmeister & Aitken, 2012), fewer rich, in-depth interviews are more desirable than many short interviews (Fusch 2015).

Accounting for the ethics panel stipulation that a concrete participant number should be stated (Guest, Bunce, & Johnson, 2006), I aimed to recruit a maximum of 15 participants to obtain a representative sample of 'typical' patients within the service (Marshall, 1996). I was unable to obtain a desirable sample size due to the practicality associated with the limited number of patients admitted to the service who meet the

study inclusion criteria and who expressed an interest in participating as well as the time restrictions associated with a doctoral thesis. Guidelines for TA recommend 6-10 participants for interviews (Braun & Clarke, 2013, p. 50), which has been affirmed in published literature (Anderson & Felsenfeld, 2003; Creswell, 1998).

Data Collection. An interview schedule was created specifically for the study in consultation with professionals within the service and research supervisors, designed to address the research objectives and aims. Service users were consulted to establish the understandability of questions and to advise on significant themes that may have been omitted and on any changes that they felt were required (Pontin, 1996). It is thought to be beneficial to consult patients and involve them in the research development process (Williamson, 2001), as they can offer a different perspective (Trivedi and Wykes, 2002).

Lofland and Lofland (1995) outline four key stages to designing a research topic guide including identifying ‘puzzlements’, generating interesting aspects of each of these to further explore, consulting the literature to add what is already known about the area of research and to involve individuals working in the field and contribute to the development of the schedule. Five main areas were explored including; experience of peer relationships, impact on wellbeing, observations of peer relationships, staff management of peer relationships and factors influencing peer relationship development. Each area was divided up into subtopics.

Data was gathered using semi-structured interviews with a guided interview approach (Patton, 1987:113) to obtain a holistic account of the participants’ experience

whilst ensuring that important topics are investigated. The questions were open ended, neutral and used simple language; probes were used when necessary to ensure that in-depth data were collected. Easier questions were placed at the start of the interview and progressed to those exploring more sensitive topics to put participants at ease and facilitate the development of a rapport (Britten, 1995). Due to the complex nature of the participant population, good clinical engagement skills were necessary in order to encourage young people to share their experiences within the interviews, Thompson (2000) emphasises the importance of building a good rapport with participants through the interviewer displaying empathy, understanding, interest and respect.

The interview consisted of six stages as outlined by Legard, Keegan and Ward (2003). Firstly, the authors note that it is crucial for the researcher to be sensitive to the anxiety that the participant may experience and to put them at ease through making conversation. Following this, participants were introduced to the research topic and provided with a copy of the interview schedule so that they were aware of the topics that they would be questioned on. When beginning the interview, important contextual information was gathered which provided an opportunity to judge the participant's engagement and adapt my approach accordingly. During the interview, participants were guided through the research themes, exploring these further through the use of probes in order to develop a deeper understanding (e.g. "can you tell me more about that experience?"). Legard, Keegan and Ward (2003) suggest that the researcher should signal approach the end of the interview approximately five minutes prior to finishing (e.g. "The final topic"). The final stage involved thanking the participant for their contribution, providing reassurance with regards to confidentiality and completing a debrief.

Research Procedure

Stage 1: research promotion. I attended the service's weekly community meeting to promote the study to potential participants. This meeting is chaired by a member of the multi- disciplinary team (MDT) with most patients in attendance, its purpose is to encourage patients to think about the community that they are living in and it gives them an opportunity to voice and address any concerns that they may have. A brief verbal overview of the research project including; aims, requirements of participants, confidentiality and the financial gift of £10 was presented. I made clear that the research was completely independent from patients' treatment to avoid feelings of coercion or obligation to participate.

Study information sheets (Appendix G) were available for those expressing an interest. Patients were required to contact a nominated Clinical Psychologist within the team if they were considering participating. They were informed that once they expressed an interest in participating, and their eligibility was confirmed by a Clinical Psychologist within the team, a meeting for in-depth discussion regarding the study would be arranged with me.

Stage 2: recruitment. Eligible patients expressing an interest in participating contacted a nominated Clinical Psychologist within the service, who in turn notified myself. I arranged convenient times to meet individually with the patients to discuss the research project in more depth. Their decision to take part was discussed whilst emphasizing that participation is voluntary and would not influence their treatment or legal status under the Mental Health Act (1983; 2007) in any way. A period of at least

48 hours between this meeting and the interviews commencing was left to allow patients time to decide whether or not to take part and discuss this decision with others. Following this, I arranged times for participants' interviews to take place with the service Clinical Psychologist, accounting for prior commitments that the patients may have.

I liaised with a Clinical Psychologist within the unit to discuss whether specific young people required Gillick Competency or Capacity Assessments in order to provide informed consent for the research study. Parental consent was obtained for eligible participants under the age of 16 years old (Appendix H). Those who were eligible and aged between 16-18 years who wished to participate and where there were no concerns about potential lack of mental capacity, were permitted to take part. Parental consent was not obtained for patients over the age of 16 years old as there is evidence that there are benefits to giving adolescents this decision-making capacity such as feelings of self-respect (Sanci et al., 2004).

Stage 3: data collection. The recruitment and interviewing of participants occurred between June 2018 and December 2018. Full informed consent was obtained from participants prior to the interviews commencing (Appendix I). Participant's capacity to consent was assessed in accordance with the Mental Capacity Act (2005) guidance, as well as their understanding and retention of the information present on the study information sheet. Those over the age of 16 years old were required to read and sign three copies of a consent form. Parental consent was obtained for participants under the age of 16 years old.

Interviews were conducted in private rooms within the unit to minimize disruptions and to ensure confidentiality. The duration of the interviews was expected to vary depending upon participant engagement and the length of their answers, however it was anticipated that the interviews would last no longer than 60 minutes. Each interview began with the collection of basic demographic data (Appendix J) and then followed the research schedule (Appendix K). The interviews were audio recorded using a Dictaphone.

Following the completion of the interview, a debrief was completed and participants were given a sealed envelope containing a remuneration letter (Appendix L) and their financial gift.

Stage 4: data analysis. The interviews were transcribed and analysed using thematic analysis (Braun and Clarke, 2006), see Appendix M for example coding. In the study write-up any epistemological assumptions that have informed the analysis have been made explicit and a detailed account of the analytical process including justifications of any decisions made are documented (Attride-Stirling, 2001).

Data Analysis

After each interview, I wrote summaries of the interview process and possible areas of bias, which I considered when analysing the data. These were both reflective and descriptive and included my feelings and impressions immediately after each interview. This promoted transparency enabling others to evaluate the extent to which biases will have influenced data collection and analysis, thus improving the quality of

the study.

Transcription of data. The process of transcription is guided by the theoretical underpinnings of the research and the method of data collection utilized. Data in textual format is unable to fully capture all the information available during an interview (Mishler, 1986). When interviews are transcribed, data reduction occurs when it is decided what to include (Miles & Huberman, 1994). Transcription should be completed in a standardised manner, recording verbatim what is said including slang and grammatical errors.

Transcription guidelines allow systematic organisation of data, however it is necessary for the researcher to make decisions about what information is transcribed. Guiding principles for data management and transcription suggested by McLellan, MacQueen and Neidig (2003) were followed. Audio recordings of the interviews were transferred to a computer and manually transcribed using Microsoft Word. Identifiable information such as real names and organisations were substituted. All verbal information such as sighs and laughter were included as well as pauses, however non-linguistic information was omitted.

The researcher transcribed all of the audiotaped interviews, proof-read the transcripts and checked the transcripts against the audiotaped interviews on two occasions to ensure that no errors had been made. This reading also facilitated the process of becoming familiar with and immersing myself in the data (McLellan, MacQueen & Neidig 2003).

Thematic Analysis. As a result of the flexibility of TA, it is necessary to make decisions regarding the research paradigm informing the research, whether an inductive or deductive approach will be utilized and whether interpretative or descriptive meanings will be deduced from the data. As the researcher assumes an active role within the analytic and research process, Braun and Clark (2006) acknowledge the importance of the researcher taking a reflexive position regarding how their knowledge, skills and experience may impact the data and research methodology. It is recognised that the themes developed from the data set are influenced by the interaction of the theoretical framework the research is conducted through and the skills that the researcher possesses (Lyons & Coyle, 2016). The current study will employ an inductive TA method, where analysis is not influenced by established theory but rather themes are generated from the bottom of the data upwards whilst acknowledging that the researcher's views, beliefs, experiences and epistemological stance will influence the analysis. NVivo was used to assist with data coding. TA consisted of six stages based on Braun and Clarke's (2006) guidelines (Appendix N).

Quality Assurance. Positivists have critiqued the trustworthiness of qualitative studies due to the difficulty with applying their notion of reliability and validity (Shenton, 2004). The quantitative notion of rigour proposes that there can be an objective truth or reality (Burr, 2003), this is rejected by the qualitative paradigm adopted in the current research study, rather that the search for multiple truths and meanings is required. Academics have considered ways in which matters regarding the trustworthiness of qualitative research can be addressed (Silverman, 2001). Lincoln and Guba (1985) put forward alternative criteria which they propose should be attended

to, judging the trustworthiness of qualitative research accounting for the underlying philosophical assumptions, which were used to appraise the current study to enhance reliability and validity.

Credibility refers to the notion of ensuring that the study findings are an accurate representation and interpretation of the participants interviews (Lincoln & Guba, 1985). It is suggested that it is only the participants themselves who are able to assess this criterion, since the results are attempting to understand the studied phenomena from their unique perspective. Accounting for the context in which the research is taking place, it was not possible for the themes generated from the analysis to be verified and judged by the participants themselves. Further, the method of member checking to demonstrate validity has been critiqued (Morse, 1994). The technique assumes that there is a truth or an objective reality that can be described and verified by participants which is opposed by an interpretive paradigm. Credibility was promoted by contextualising and grounding interpretations in the data that they were derived from through the use of verbatim quotes from participants' transcripts which can serve to achieve quality (Willig, 2001). I also immersed myself in the entire dataset through the transcribing process which involved listening to the recorded interviews on numerous occasions. I also familiarised myself with the culture of the organisation through discussions with the local collaborator and visits to the unit prior to data collection. Prolonged engagement with the participants, endorsed by Lincoln and Guba (1985) and Erlandson et al. (1993) was not possible due to time constraints and the undue pressure that this would put on the service staff. The use of random sampling to minimise researcher bias in recruitment was not appropriate due to the small pool of suitable participants, or triangulation because of time constraints.

Transferability is concerned with the extent to which the study conclusions can be generalised to a wider population. Erlandson et al (Ibid) state that conventional generalisability as defined in positivist work, cannot be achieved in qualitative research as the findings are specific to the context within which the research took place. Lincoln and Guba (1985) and Firestone suggest that it is the investigator's responsibility to provide adequate contextual information in order to enable others to make decisions about the appropriateness of transferability. In line with Marchionini & Teague (1987) and Shenton (2004), the research setting, research methodology and assumptions that underpinned the research are thoroughly described.

Dependability concerns the accurate representation of data and care with data recording and data analysis (Mason, 2002). This was enhanced by transparency and in-depth descriptions of the research design and procedures, supporting interpretations with verbatim quotes, consistency in the execution of the procedures and using a systematic approach to data analysis (Lewis & Richie, 2003).

Confirmability relates to the concept of objectivity, that the reported findings are experiences and ideas of the participants and not greatly influenced by the researcher's preconceived ideas and biases. I have outlined my predispositions, which Miles and Huberman (1994) state is essential to monitor confirmability, as well as keeping a reflexive commentary throughout the research process. Furthermore, a rationale for the decisions made and chosen approaches are documented to demonstrate my thought processes at each phase of the research.

CHAPTER THREE: FINDINGS

Chapter overview

This chapter outlines the study results. Participants' demographics will be presented, then drawing upon the principles of thematic analysis, themes and subthemes developed from participants' data will be discussed. In order to explain my interpretations during the analytic process and encourage understanding of adolescents' experiences, verbatim extracts will be presented. To ensure participant anonymity, identifiable contextual information is omitted, participants have been assigned pseudonyms and distinguishable turns of phrase have been disguised, as indicated by double asterisks.

Participant Demographics. Sample characteristics are detailed in Table 1. Participants experienced a range of mental health difficulties associated with relational, interpersonal and emotional dysregulation, histories of trauma and abuse, mood disturbances, and unusual perceptual experiences.

Table 1

Participant demographics (N=8).

Interview Order	Participant Pseudonym	Age range	Identified gender	Ethnicity	Length of current inpatient admission	Total number of inpatient admissions
1	Jack	14-17	Male	White-British	5 months	2
2	Georgia	14-17	Female	White-British	2 months	1
3	Anna	14-17	Female	White-British	3 months	1
4	Vicky	14-17	Female	White-British	2 months	1
5	Caroline	14-17	Female	White-British	6 weeks	4
6	Helen	14-17	Female	White-British	1 year	2
7	Jacob	14-17	Male	White-British	11 weeks	1
8	Adam	14-17	Male	White-British	4 months	2

Study sample. The study contained 8 research participants, who all described their ethnicity as White-British. Participants' ages ranged from 14 to 17 years old, 3 identified as male and 5 as female. All participants were receiving support from the recruiting unit at the time of interview, 7 were inpatients and 1 a day patient. Duration of admission to the unit ranged from 6 week to 1 year, with a mean of 4 months, at time of interview.

Interviews. The interviews ranged from 20 minutes to 118 minutes in length, with a mean of 56 minutes.

Analysis. Using thematic analysis (Braun & Clark, 2006), themes and sub-themes were derived from participants' data. These are presented in Table 2.

Table 2

Themes and sub-themes derived from dataset (N=8)

Theme	Subtheme
You kind of don't know who to trust	Oh why don't you love me It's nice to have friends that I can rely on People tend to fall out
Everything falls apart	Why aren't I good enough There's always that one kid who gets picked on You're the one left behind I would never be able to say no
It just didn't feel like a nice environment	Personal reactions can cause a reaction within the whole unit It makes me feel unsafe
It makes being here easier	They care about you A sense of normality You're not the only one

Theme one: You kind of don't know who to trust. The first subtheme, “oh why don't you love me?” explores the fragile nature of the adolescents' relationships, characterised by mistrust and fears of abandonment and rejection. How these fears influence the development of peer relationships on the unit are discussed, as well as the psychological defences participants have developed to ameliorate these core fears. The second subtheme “it's nice to have friends to rely on” captures the value participants place on trust and consequent positive impact trusting relationships have upon wellbeing. Predicaments and consequences associated with breaching trust are described. The third sub-theme “people tend to fall out” examines participants' experiences of peer relationships as intense, volatile, fraught with jealousy, and at times short-lived.

Oh why don't you love me? In discussing peer relationships on the ward, most participants provided accounts indicating the influence of insecure attachment styles. Participants referenced sensitivity towards rejection and/or abandonment and the tendency to self-blame, complicating the formation and maintenance of relationships. For Helen and Vicky, this led to feeling a sense of pressure to remain in relationships, or to moderate their behaviour, so not to reinforce and confirm fears of abandonment or rejection.

There's a girl and she had really bad attachment issues and it'd be at a point where if she was sat next to you and you said like... she said hello to you and you didn't hear it and if you didn't reply she'd be screaming at you, like crying “oh why don't you love me are we not friends anymore?”, and you'd be like I didn't even hear you say hello like I'm sorry. (Helen)

Well its complicated because normally if they get attached to you, you know that if you're not comfortable with that friendship it's difficult to like say that because 1) most people in here are very sensitive and 2) attachment issues make that person's life a lot worse because they can't cope with being left so they're like, "oh no they left me it's the end of the world" like with a break up, that's like that every time you lose someone for someone with an attachment issue, I'm saying issue, I mean disorder. (Vicky)

Participants described various self-protective and functional psychological defence mechanisms which they unconsciously employed to avoid experiencing the emotional pain associated with perceived abandonment and disappointment within peer relationships. These include: emotional numbing, avoidance and isolation, wherein participants cut themselves off from or minimise difficult emotions, and shut off forming emotional connections to avoid experiencing overwhelming feelings.

I'm used to people leaving so it doesn't really affect me. (Vicky)

I have noticed there's been times where I have kind of self-isolated and stuff like that because like relationships have been getting like too close and stuff like that. (Jacob)

Well sometimes they don't want to get attached to new people that have come. Just in case they attached and then they get sad when they leave. (Adam)

I'm quite good at not getting emotionally invested in things except when they're relationships that I'm directly involved in then I don't think they've affected me at all. (Georgia)

For Georgia, she identified that her fear of rejection influenced the development of her relationships within the inpatient setting. She expressed that she learnt to cope

with this fear by only developing relationships with those she was not emotionally connected to, thus protecting herself from the possible threat of rejection from those she cares about.

The thing with me that's a bit strange is that I only seem to make friends with people who I don't like because I'm scared of rejection so I befriend people who I'm not particularly drawn towards so that makes my relationships pretty fake. (Georgia)

Vicky was able to make sense of this fear of abandonment and rejection through making connections to previous experience of loss and abuse, which led to an internalised fear of others and a tendency towards using emotionally distancing strategies to avoid feelings of insecurity. It is likely that the adolescents hold an expectation that others are not dependable through experiences of not having their emotional or physical needs met.

It hurts a little bit but my dad used to walk out on us all the time and like sometimes they come back and sometimes they don't so you just kind of learnt to cope with it after a while...(Vicky)

It's difficult for the people that have had adults abuse them or let them down because then they struggle to open up again. (Vicky)

In discussing what influences peer relationships, Vicky described the impact of adolescents being transferred to different levels of care and how this can confirm expectations that others will leave or reject them. She expressed, "I think it can mess up relationships because it's like the sense of rejection". Further to that, she spoke about how new admissions to the unit also activate the threat of abandonment and how this

can influence the dynamic of the unit. It is possible that violence and anger serve as defences against feelings of vulnerability, or perhaps may be reflective of the significant emotional dysregulation difficulties commonly experienced by participants in the face of perceived stress.

If someone takes a liking to a new admission it can get very tense and very violent because over a sense of rejection again. (Vicky).

Like if there's someone new coming on to the ward, like there's supposed to be a new girl coming but now she isn't, however if there is a new admission normally everyone's like "oh a new admission, new person, new friend" that sort of thing but sometimes that person doesn't even want to talk to us so it's like "oh well fuck you then" and then they end up like starting an argument constantly and then it just becomes hell for everyone because we all have to live here and have to cope with that. (Vicky)

The impact of these complex relational dynamics was significant for the adolescents, who expressed some understanding and compassion for other patients but at the same time appeared conflicted about how best to respond, which created additional stress.

Mm...It's quite stressful, cos you are wondering will they mind if I do this? Are they going to get pissed off? Yeah...(Helen)

Its stressful knowing that actually they're quite nice people but either they're fostered or something along the lines of that and they have really bad attachment issues...(Vicky)

It's nice to have friends that I can rely on. Many of the adolescents spoke about the importance and value of trust within peer relationships. Given that some patients may have experienced relational trauma, the adolescents may hold the belief that others may hurt them or let them down, affecting their ability to form trusting relationships and making trust crucial for developing emotional intimacy. One participant described having to 'suss out' patients on arrival to the unit and expressed "it also kind of makes you realize that you can't trust anyone, why would you trust anyone if they're just going to hurt you? That's what most people in here think." (Vicky). Another described being able to trust peers as a new experience.

it's nice to have friends that I can rely on and trust because I've not really had that before. Things like mealtimes, there was a period when I stopped eating, I had trouble eating but they would sort of try and get me to eat. (Jack)

Interviewer: How would you define peer relationships?

Umm (coughs) trusting, like a lot of trust you have to have in people...umm not to be two-faced and like obviously slag each other off, because like that's not really how relationships work. Just be truthful and honest really. (Caroline)

Participants experienced trusting peer relationships as positively influencing the wellbeing of patients. Establishing trust enabled patients to speak freely to other patients without fear of undesirable ramifications, such as the escalation and sharing of personal information or judgement from staff. While some withdrew from peers and moderated what information they were willing to share through concern of mistrust, articulated by Vicky, "have quite bad trust issues which is why I stay quiet and keep to myself" and Jacob, "it just makes you more cautious about what you say".

I suppose with some staff it's harder to talk to but staff also have to report whatever you say and document it but another young person doesn't do that they just listen so it feels more secure to talk to a young person. (Jack)

Um you can only tell certain people certain things because some of them are really sneaky but that's life. (Vicky)

Most participants acknowledged the challenges associated with maintaining trust within peer relationships and the negative consequences that ensue when trust is perceived to be broken. Participants spoke about more typical adolescent behaviour such as "bitchiness" occurring within the ward environment leading to trust issues, and behaviour related to other peoples' mental health difficulties, such as taking other adolescents personal items to self-harm with, also leading to a sense of mistrust.

You can talk to them but you can't trust them because if you think they're where I am, they're just like me, there are people in here that want to die just as much as me so they'd do anything to hurt themselves. (Vicky)

You kind of don't know who to trust, you kind of think well I can't really say that to this person cos they might go tell someone else and you kind of feel like there's only a few people you can trust. (Jacob)

For some participants, broken trust resulted in feelings of anger and anxiety, and the felt sense of the unit being unsafe, possibly reinforcing their views of the world as an unsafe place and others as untrustworthy. This is encapsulated by Vicky, "well I already knew I couldn't trust anyone but its helped me find that out more, I find that out more virtually every day." The intense environment of an inpatient setting is exacerbated in an intense social world for adolescents.

I got really, really angry and I like dissociated and I went to my therapist and just screamed and cried and so many emotions came out it was unreal because I trusted her enough to do it and then I did and it was broken so it was kind of like I've just hurt myself again fully knowing that it was going to happen, like I walked into that one really. (Vicky)

Dilemmas associated with the boundaries of confidentiality were acknowledged by two participants, including when it is necessary to break trust and the possible consequence of being labelled a “grass”, with some patients “holding grudges” and peer relationships terminating. Vicky encapsulated this idea, “once you grass you get called a grass and then it’s like a whole other thing and it just makes everything worse.’

It can affect them because if you tell them something that they then need to tell a member of staff it can sort of break the trust and friendship. (Jack)

People tend to fall out. Some participants described how patients can misjudge situations easily, leading to the breakdown of peer relationships, pushing others away, conflict and annoyance. It is likely that some patients are hypervigilant to threat, both physical and relational, having experienced situations which have disrupted their sense of safety, and altering the way in which they perceive others. Through being on high alert and continually monitoring their environment, patients might be more likely to draw quick conclusions, thus possibly misreading the intent of others and social situations. This had a significant impact upon participants, including everyone feeling “unsettled”, “horrible” and “frustrated”.

There is someone here that didn't like someone else when they first arrived and then they got close and now they're friends, were friends should I say, but I

don't know they just don't get along any more, one of them said something and the other one took it the wrong way. (Vicky)

Um well some um sometimes other people can take stuff wrong which I say.
(Adam)

I'm not like involved in drama and bitchiness but here people seem to misjudge quite quickly. (Georgia)

For the majority of participants, at times they experienced peer relationships on the unit as volatile.

Yes, things can change really quickly here it's like yes quite amazing but it can be really good or really bad so like I was really, really close friends with someone but then, well I had two friends and both of them were arguing with each other and it meant that I got dragged away from one of them because they automatically think you're taking the other person's side and it can shift really quickly... (Georgia)

Well um so sometimes people you fall out then you get back together and then you fall out and a lot of people are falling out and then getting back together. (Adam)

Georgia partly attributed this volatility to jealousy, which on one occasion led to a patient resorting to extreme behaviours in order to gain her attention. Participants described experiences of patients feeling threatened by their friends developing relationships with other patients, the threat of losing the attention of others may result in feelings of vulnerability. It is possible that this jealousy is exacerbated by patients' feelings of relational mistrust, which leads to disruption in peer relationships. However participants expressed that they experienced these situations as stressful, and unsettled

the ward environment, Georgia articulated that she felt conflicted by such relationships which at times are supportive but also detrimental to her wellbeing.

...She gets jealous if I spend time with other people so like she'll go into her room and say that if I don't kick the door down, they lock the airlocks because she always comes into my room and then they have to restrain her out and we misbehave together in my room really badly so she will say if I don't kick the door down that she's going to drown herself and then I don't know what to do because there's no way of getting a staff member so then I'll hear her drowning herself and then I'll kick down the door and then get like reported for like property damage to the police so that sort of thing's hard, or she keeps taking overdoses and that gets me really stressed out, so there are negative relationships but then equally if I am struggling she is also really lovely. (Georgia)

Some people probably get a bit jealous to be honest to see two people are going round being good friends and stuff but at the same time it does make other patients happier – ooh they're getting on well, that's good. (Helen)

It can be just be like quite difficult when people get jealous of each other, because then people tend to fall out and stuff like that and then that's not really good for anyone, because like... it can make it like everybody just like stressed out. (Jacob)

Theme two: everything falls apart. All participants acknowledged the existence of difficulties and dilemmas associated with peer relationships. The first subtheme, “why aren't I good enough”, captures a sense of envy and rivalry between patients which manifests as competing for the attention of staff. Patients on the unit developed a range of strategies to elicit care from staff members in order to meet their needs. The second subtheme, “there's always the one kid that gets picked on”,

described participants' experiences of bullying between patients, for some replicating previous traumatic events. The third subtheme "you're the one left behind" discusses the ambivalence participants feel towards peers being discharged, which can induce a sense of hope or hopelessness, and the challenges of maintaining relationships. Finally, "I would never be able to say no", encapsulates participants' experiences of establishing and maintaining boundaries within peer relationships which are often fraught with challenges. It also captures the important role adolescents play in supporting other patients, characterised by feelings of responsibility, pressure and stress.

Why aren't I good enough? All participants described patients competing for the attention of staff in order to seek care. This manifested in different ways of acting out, such as: increased severity of attempts to self-harm or to end their life, resulting in a higher observation level and thus contact with staff. This was encapsulated by Jack, "if I was to go and bang my head I would get a member of staff more quickly than if somebody else did because I don't bang my head lightly". This sense of competition and rivalry between patients was understood by some participants as escalating behaviours in an attempt to be the "illest". One participant found the reasons for this difficult to comprehend.

You do get some people in the unit and they're just like they want to be there and they want to be the "illest" person there, it's a bit weird to be honest.
(Helen)

It's like if I was like going in my room and was like crying and I'd throw a battery but the next day someone else would throw three batteries yeah I don't know...but what's the point what's the need for it? (Helen)

Participants also expressed that externalising behaviours were more likely to gain staff attention and quick action, leading to frustration which “shifts the dynamics negatively on the unit” (Vicky). The effects on the other patients were noted, including not having the opportunity to speak to the ward manager, learning that aggression and rudeness results in being heard and is an effective way to draw care from others. They expressed envy and resentment towards patients who commanded staff attention. Those patients who were perceived to internalise their distress were felt to be less held in mind and more likely to be overlooked within the busy and sometimes chaotic ward environment.

Whoever speaks the loudest and kicks up the biggest fuss takes all the time so because this person’s louder and kicks off all the time she’s the one that gets the time to speak about it but I haven’t been able to speak to her yet to get any actual rules put in place. (Vicky)

She used to kick down the doors a lot...and kind of want to get restrained (yawn), she kind of wanted it all. Because other people were getting attention and she wanted it. And that’s kind of how it felt to everyone. She would kick down the door, she would kick off, she would shout, she would scream, it just didn’t, I personally hated it. (Caroline)

Participants described this competition increasing with new admissions, where new behaviours were described as “contagious” and “spreading like a new trend”. It is likely that patients perceived a sense of threat with the arrival of new patients. One participant stated that since being admitted she had started to head bang, which she expressed was a new behaviour, and described feeling bad that others were mimicking her behaviour and felt that this was “dangerous”. Another felt that these behaviours

also occurred before discharge and were not genuine signs of distress, which caused annoyance and arguments amongst patients.

I don't know sometimes you just get someone like a new admission, like they seem nice and then they start doing really weird stuff like they're not upset but they'll have incidents like or like they get told they're going to get discharged or something so they'll start having incidents but like it's not genuine it's quite weird actually...(Helen)

Members of staff being perceived to have favourite patients was discussed by a number of participants. They expressed envy towards these relationships and desire to be special, favoured and cared for, possibly driven by feelings of insecurity and fears or expectations of inadequate care. Perceived favouritism impacted the wellbeing of other patients, including feeling inadequate, on edge, uncomfortable, internalising blame and provoking arguments between patients. Participants coped through the use of psychological defences such as denial and emotional distancing, encapsulated by Vicky, "that's why I'm not close with anyone here because the jealousy between certain people is unreal".

Sometimes you do get a bit of jealousy like a member of staff will give you something and if they don't give someone else something they're like why are they doing that? What have they done that I haven't. (Helen)

It can cause arguments, yeah, so for example um sometimes like between the nurses, if the nurses have got a favourite it can cause arguments between (yawn) the peers. (Adam)

There's always the one kid that gets picked on. Many of the participants discussed experiences of victimisation through bullying or witnessing bullying between other patients. This took various behavioural forms including verbal threats, intimidation, spiteful comments and social exclusion. Interpersonal aggression may serve different functions, however such behaviour may be a defence against feelings of vulnerability and perceived threat, a mechanism by which patients have learned to defend themselves.

Yes, well it wasn't small scale bullying it was a person saying that they were going to kill the other person. (Jack)

She used to kick the doors, she used to kick patient's doors and set their alarms off. And it was just a bit intimidating and nasty really. (Caroline)

There was a boy who was, the boy kept giving my friend apparently dirty looks then she kept on starting on him like a rebuke if you have something to say about me say it to my face and all of that and like fight me and then another boy got involved and was like yes and was saying I'm going to put you in hospital by the end of the day like watch out because I'm going to attack you... (Georgia)

Two participants expressed that some patients had experienced bullying prior to their admission. Incidents of feeling excluded or alienated from friendship groups may mirror previous experiences of bullying. Rather than the ward providing a place of safety, this patient's bullying was re-enacted within the unit.

It wasn't great cos she'd been bullied before in school so...(Adam)

Whilst most acknowledged that bullying occurred within the unit, one participant whose admission had been the longest expressed different experiences. It is probable that her conceptualisation of bullying differed from the other participants, or that she was using emotional avoidance of distressing or negative feelings as a defence to enable her to exist within an occasionally hostile environment. Another participant indicated she had become desensitised to bullying behaviour, mitigating herself against the emotional impact of witnessing such incidents.

Interviewer: And what about, have you ever witnessed bullying or been bullied?

Mmm no, not really. There's sometimes, like they'll be two groups and you'll be arguing with each other but never really bullying. It's just having a go at each other sometimes. (Helen)

I don't really know, I'm kind of used to seeing that sort of thing, so it's like I think everyone is, it's not great but I don't think it has an effect on me. (Vicky)

One participant described an incident of bullying on the ward, where the victim was ridiculed for a neurological difficulty. She attributed other patients lack of understanding regarding the condition as an explanation for why they were victimised.

I've witnessed it, it wasn't like, yes I've just witnessed it really. It was someone with [a neurological condition] and everyone, not everyone actually that was a bit dramatic, but quite a lot of people tend to laugh about it because they don't understand or for whatever reason, I'm not going to justify why they did it but it does get out of control sometimes but everyone's in here for like their own reasons, I'm not like backing them up or anything but because bullying's awful. (Vicky)

Participants described the formation of different groups of patients within the unit where individuals assumed varying roles within instances of bullying including victim, bystander and perpetrator. Establishing in- and out-groups enhanced adolescents' social belonging and self-esteem. Splitting of people into good and bad occurred.

I either love someone or I hate them I don't really have any other emotion it's one or the other really, yes its really strange. (Vicky)

Well basically there was like a group, it kind of all split in half it was like kind of three and three and I really wasn't involved in the drama but because I'm friends with the people who are I got accused of it. (Georgia)

I think it's ...it's just similar to school I think when you go to school there's people you just get along with and people you don't...like obviously there's people from all parts of like, different like groups in school. There's like the popular one's that you're all just shoved together there's people like you'd never talk to in the outside world, yeah. (Helen)

Participants who stated they had been victims of bullying described feeling depressed and anxious, through projective identification they unconsciously identify with the projected feelings. Those who witnessed bullying expressed that this had a "severe impact" on the unit and their emotional wellbeing, including feeling sad and depressed for the victims. Participants described different responses to being victimised including surrendering to negative views of themselves, avoidance through social isolation and withdrawal and overcompensating, attempting to be liked by other patients by "giving themselves" to others.

I think it made me like a bit withdrawn and, like a lot of people commented on the fact that I wasn't really interacting with other people and made me feel kind of just really bad. (Jacob)

Well it's...it's like they give up and they just basically want to give you everything possible so they can try, hopefully have mates.... Well they just give up in everything so...they basically give themselves to you...(Adam)

Two participants reflected on the ward being a closed environment, thus patients were unable to escape from bullying which left them feeling trapped and powerless. This creates an oppressive atmosphere and a context which makes healing more challenging.

Well it was horrible because like because when people are being horrible to you it's bad enough when you're at home and you can get away from it by going home but like when you're stuck here and you can't get off the ward and you're literally surrounded by it all day and then you can't even get away from it except for when you go to your room at night, it just makes things really hard. (Jacob)

You're the one left behind. Participants expressed ambivalence towards peers being discharged. They described feeling sad at the loss of an important source of support and companionship, whilst feeling happy that their peer's mental health had improved and they were able to progress with their life. During adolescence, peers become integral in meeting attachment needs, so the loss of such key figures is significant, particularly for those patients who do not have support networks outside the unit.

It's sad but at the same time you're happy for them because you know they're moving on and that's important. Yes it's nice to know that they're moving on. (Jack)

It is quite hard to always leave people behind. There's been loads of times I've been on the unit my friend will get, leave or get transferred and we'd all be like sitting we don't want to leave...crying our eyes out waah. (Helen)

Well sometimes it can be hard to say goodbye...I got quite a good bond with them and I done quite a bit for them and they've done quite a bit for me so. It'll just mean I'll miss them when I, when they go. (Adam)

Some participants expressed envy and resentment towards patients who were discharged and able to return to their previous life. These feelings influenced participants' behaviour in a variety of ways. For some this acted as a focus and motivated them towards their goal of discharge. Whilst for others, these comparisons led to self-criticism and the internalisation of the belief that they had not made enough progress or worked hard enough, inducing a sense of hopelessness, encapsulated by Helen, "Yeah I guess so, you could get really, instead of like, instead of kicking you to get better you could be like I'm never going to get well, I hate my life."

Um that makes it trickier because although obviously I'm happy for them but it's harder when you're the one left behind because you're still in this environment and you've still got to pass the time and you know that, I don't know, you know that you could be out in the real world spending time with people and enjoying things...(Georgia)

Yeah it's quite hard, yeah. You.. Especially when you think that they're worse than you as well and they're leaving, you're sitting there like why have you left and I haven't. Yeah. (Helen)

It's like sometimes when you hear people talking about like the fact that they're getting discharged the next week can be like make you like really jealous and like nobody likes to admit that but like everybody kind of gets a bit like...'I wish I was being discharged' like, stuff like that. (Jacob)

Concern was expressed regarding forming close bonds with other patients due to the sense of abandonment upon discharge. This loss of support left some participants feeling annoyed and miserable and facing the conundrum of whether or not to form close relationships with other patients. Whilst valuing the support these relationships bring, at the same time they recognised the pain of separation at discharge possibly leading to deterioration of their mental health.

...it also makes it quite challenging because if I leave or they leave then we're going to end up back at square one, not knowing anyone and being on our own. (Vicky)

I know in a way I could make their life better but I could also make it worse because if I did have to be discharged or was discharged when we'd built a bond they would feel really crap about it because they'll think well she just left me why should I do that. (Vicky)

That can be really hard because you can get close to someone and rely on them a lot and then for them to just suddenly go, it can be really difficult. (Jacob)

Two participants discussed particular difficulties arising from the fact that the unit accepts referrals nationally, which presents potential difficulties in terms of future contact with inpatient peer support networks. The loss is heightened by these relationships being intense as a result of close physical proximity over a potentially

long period of time. Rather than acknowledging the painful feelings associated with this loss, Helen uses the defence of rationalization.

You got quite a few people from everywhere around, like Norfolk, Suffolk, Wales, I dunno and then you like make friends with them there and that and they leave and it's not like they're just leaving, like you literally don't know if you'll ever see them again cos they live like 500 miles away from you so it kind of makes it a lot more intense. (Helen)

They're people you've spent literally every day with and you never see them again. Mm that's life. (Helen)

The fear for others upon discharge was a particular concern for Vicky who expressed her worry that without continuing adequate support in the community, there is a high risk of relapse. She drew upon her own traumatic experience of a friend ending their life shortly after discharge, although she had made known her intentions, Vicky felt that these were not taken seriously by staff due to her history of seeking care through escalation. She expresses a low expectation of care and of the professionals being able to meet her needs.

I feel glad because sometimes they get better but equally they're going to go down the same road again, more than likely anyway but knowing that they could have done more, like the NHS could have done more to help is so annoying especially when you watch people go through it and then go through it yourself and have people tell you to go on this medication because this will get rid of it but it doesn't and just knowing that they're going to go back out in the world and feel like a complete loser again is awful. (Vicky)

Whilst acknowledging the benefits of continued contact, participants also expressed concerns which left them feeling conflicted. Seeing others enjoying a life outside of the unit helped participants to stay connected to their previous life and gave hope for the future. Also receiving ongoing support from individuals who have the same lived experience was felt to be beneficial.

It makes you feel quite positive. I still talk to somebody who's been discharged and it's nice to know that they're doing well and that there is a place outside of here and that you can enjoy it. (Jack)

Yeah cos you can always talk to them if you're upset because they'll like understand. (Helen)

On the other hand, participants expressed a wish to compartmentalise their inpatient stay and move on with their life. Seeing ex-patients living in the outside world can elicit negative feelings as can being aware of any deterioration in their mental health. There were difficulties acknowledged with maintaining relationships when peers had moved on, specifically in relation to meeting each other's differing needs. Participants described a number of self-protective strategies to deal with possible breakdowns in relationships, including: emotional distance, denial and repression of painful feelings, and pre-emptively rejecting peers to avoid themselves being rejected.

I want to stay in contact with them but I know that with some people the past is the past and you leave everything there and that's how some people feel about it, so if they don't want to stay in contact, if they want to keep in touch then that's up to them I'll let them come to me because I don't want to be a burden on them but I always leave it down to them, sometimes they contact you sometimes they don't but that's up to them really. (Vicky)

I think I'd stay in contact with some of them but at the same time it would be quite nice to sort of move on from this place, I don't really know, it's quite a hard decision really because you want to move on but you've made friends so you don't want to just leave them behind because you've been discharged so some of them I would definitely stay in contact with. (Jack)

I don't see them as being long-term and it's not that I wouldn't want to keep in contact it's just that I know from experience that it takes two people to maintain a relationship and that's not really one of my skills. (Georgia)

I would never be able to say no. All the participants described difficulties with establishing and maintaining boundaries within peer relationships. Some described intense relationships with blurred boundaries. This caused confusion as to where the dividing line between themselves and others existed, resulting in a lack of distinction between the self and others, and individuals losing their identify within peer relationships. Through internalising the message that asserting one's own needs is bad and shameful, the adolescents described difficulties expressing their own needs, possibly through a desire to please others and a fear of rejection. When they were unable to voice their own needs, patients required staff intervention to assert boundaries.

I had er a situation where I was in a relationship with another patient and um that was really bad because of the fact that we, because we had feelings for each other, we didn't want to be separated and then it became very like, we wouldn't talk to anybody else. It would just be we'd talk to each other and staff were getting concerned about how close we were and all that. (Jacob)

I've got people who I appear to be the most close with, like really close friends with, or everyone calls us like Siamese twins and best friends because we're always together. (Georgia)

Well one relationship in particular kind of just reinforces the feeling that I'm like pretty much a pushover and I'm pathetic because I just become a shadow of someone and like do whatever they say to the point that I was like making them drinks every time they asked at the drop of a, I would just do anything for them so it makes you feel a bit, it makes you feel you're stupid and weak because I'm really easily controlled...(Georgia)

I do know of a relationship of a boy and a girl, it was just a friendship but she was really uncomfortable with it because he was kind of following her around everywhere and like she couldn't spend time with anyone else because he would always be right there over her shoulder and he was beginning to creep her out a bit and she asked the staff like, because it was really affecting her, so she said could some boundaries please be put in place. (Georgia)

This intense emotional closeness had a negative impact. Participants reported experiencing low mood and anxiety and at times feeling "awkward". Participants detailed the contagiousness of affect within the intense inpatient environment, and of feeling each other's emotions. When one patient became emotionally overwhelmed, this created an emotional ripple effect around the unit, causing distress in other adolescents. Participants were unable to separate their own emotional experiences and became emotionally overinvolved within peer relationships. Participants described losing their emotional identity.

I kind of, if someone else is happy I kind of like get happy myself, if someone else is sad I get a bit sad...(Helen)

They can also be a negative impact like say someone's just come, been admitted and they're like really ill and you're like becoming friends with them, they like can like bring you down a bit because, like they're, like struggling themselves, but if you've got someone who's near discharge and like really positive and stuff like that you can kind of get some of their positivity and like, kind of think more positive yourself. (Jacob)

Participants expressed that they were observant and sensitive to the needs of other patients and described feeling responsible for their emotional wellbeing. This inflated sense of responsibility resulted in participants feeling guilt and self-sacrificing their own needs. Participants were vulnerable towards adopting a position of 'the helper' and incorporated this within their identity, losing themselves in other patients. This role of supporting other patients was detrimental to the wellbeing of participants, leaving them feeling overwhelmed, stressed, inadequate and pressured to fulfil the role. One participant acknowledged that being needed felt "good and nice", however helping others when your mental health is suffering can have a detrimental impact on recovery.

The fact that sometimes when they're struggling you really wanna like help them but you don't know what to do and like staff can tell you like not help and then you feel bad or you.. like you, you get down yourself because your friend's struggling and you can't help them. (Jacob)

well one of them affected people because of the anger that one person had, so when one person was struggling the other person would get annoyed because they felt that it was their fault... (Jack)

I can't recover as well myself cos I'm looking out there, helping out other people. (Adam)

Three adolescents described a more destructive element within peer relationships, where patients encouraged and facilitated self-harming behaviours in others thus inhibiting their recovery. Patients experience envy at others recovery, a feeling which may be considered unacceptable, resulting in an unconscious wish to sabotage and derail others. One participant expressed that she was drawn towards forming unhelpful peer relationships as she was easily influenced and unable to express her own needs, she stated that staff are helpful in maintaining boundaries. Others stated that they found this dynamic “creepy” and it made them feel angry.

...I'm really quite close with somebody who always gives me leggings and lace and blades and things like that so that's kind of where our relationship is I want to get close to them because they've been giving me loads of harmful things...(Georgia)

With some people it ends badly because some others here are sociopaths and they encourage people to hurt themselves and with the people that are easily influenced, that's not good. (Vicky)

At the time I was happy I was like woo I've got good friends there I can harm myself and I'm like why let me do that in front of you? It's a bit weird. (Helen)

Most participants expressed how common it was for patients to form romantic relationships with others patients, which were discouraged by staff. Within the intense and volatile ward environment such romantic relationships were fraught with difficulties and threatened patient safety. These included the emotional-wellbeing of one patient significantly impacting the other partner, experiences of aggression which disrupts the ward environment and affects self-esteem, threatening recovery. Staff managed these difficulties by transferring patients to a different ward, one participant

discussed the artificial environment of the inpatient setting and how this management strategy does not reflect circumstances in the real world.

I do think sometimes if you get too close to someone in hospital like romantic with someone it sometimes... you're here to recover do you know what I mean, it's not like a dating place. Some people just go and get with someone instantly and, and then they'll break up later on and they'll both starting having incidents again.... so sometimes I feel like when you get too close to someone and then you like fall out with them it's not going to help your recovery. (Helen)

I think it's quite artificial because there are going to be relationships in the real world and you can't just pluck someone and put them on the other side of the country so I'm not sure. I guess it's good because you don't want to, quite often if you get romantically involved there's going to be heartbreak at this stage when you're in this environment you don't want any setbacks but I'm not sure. (Georgia)

Many participants discussed the “no touching rule” that was implemented on the ward, they emphasised the importance of touch in both the development of peer relationships and the supportive role this can play. Georgia expressed that “a hug goes a long way”. Participants expressed how peers met their psychological need for physical affection following separation from caregivers Physical contact served a number of purposes, such as providing comfort, reassurance feelings of connection, trust and intimacy and alleviating loneliness. For one participant, the ward provided him the opportunity to have a different experience of peer relationships, where rather than being bullied they provided physical comfort through hugging. For him touch was an important means by which he could express his gratitude to others.

Well not being able to show how much you thank them and how much you love 'em for what they've done for you. (Adam)

Well I just think that if you're struggling sometimes it's quite nice to give a hug to that person. (Jack)

They just sit there and hold their hand through it all. (Caroline)

There's also some really supportive people here who if they see you sitting alone will come up and ask if you're ok and if you like need anything. Like when I was crying the other day one of the girls came over and said do you need a hug and I was like, yeah and then I felt a lot better afterwards.... You just know someone cared, and that someone wants you to be alright and that they're not there because they're paid to be there they're there because they want to be there. (Jacob)

Participants acknowledged the function of the rule as providing safety for the patients, however they expressed how they "ignore staff" or that the presence of such a rule encourages the behaviour. Such rules allow adolescents to push boundaries and assert their independence and control. One participant described the wider impact on the unit of rule breaking which she considered "unfair" when the rule is amplified.

Yes but if you are then there is supposed to be a no contact rule, so patients aren't really supposed to hug each other but I suppose it is for the safety of both people but it sort of sometimes gets overlooked which is a good thing. (Jack)

I feel like when people get told to not do something in here, they'll deliberately do it even worse or whatever, so yeah. (Helen)

Another participant commented on how staff assert this rule and the importance of the language they use, which can induce memories of past traumas.

They kind of just say “ahh stop touching her up” and stuff like that. I kind of just said well considering my past I would never ever, ever touch up another patient ever in my life. So you can’t sit there any say that what I’m going to do that. Because I’m not. (Caroline)

Theme 3: It just didn’t feel like a nice environment. The first subtheme, “personal reactions can cause a reaction within the whole unit”, encompasses participants’ experiences of the ward as a changeable and triggering environment, which for some exacerbates their mental health difficulties. How the environment impedes recovery and affects the development of peer relationships is discussed. The second subtheme “it makes me feel unsafe” explores participants’ experiences of the environment as unsafe and lacking privacy and how residing in a high threat environment influences attachment strategies.

Personal reactions can cause a reaction within the whole unit. The adolescents described the inpatient environment as being volatile, and frequently characterised by violence towards staff, patients and the physical environment. The impact of living in such an environment varied for participants. It caused upset, distress and annoyance for some, whilst others perceived it as “normal”, possibly due to desensitisation following admission, emotional numbing caused by psychological factors, the impact of medication or previous exposure to a high threat and changeable environments.

As you can hear she is very loud to say the least and struggles to keep her impulses intact so she's, yes, kicking doors and stuff currently but for some people that's really distressing and for others its normal. (Vicky)

They would take it out on objects so that caused upset and its quite annoying because things get broken that didn't really need to get broken...(Jack)

Three patients conceptualised a clear distinction between patients' presentations; those having 'behavioural' issues, versus mental health problems. Internalising behaviours such as being withdrawn and depressed were understood as genuine signs of distress and thus responded to with compassion from the peer group. Externalising behaviour manifesting in physical and verbal aggression towards others and the environment was perceived as having various ulterior motives, such as 'attention seeking', provocative and a result of boredom, of which participants were less tolerant and understanding. Participants found externalising behaviours hard to manage within the ward, as such behaviour created a tense and 'triggering' environment.

There's a line between behavioural issues and mental health problems that is often hard for people to see so for example, kicking through a door, some people do that when they're very distressed and having mental health problems and some people do that for fun to try and wind up staff, that kind of thing. So people get quite upset seeing people trigger other people through noises and stuff just because they're bored and they want to act up so we really don't like people in general who do that because it's really upsetting for people and, yes, we all understand when people have incidents prompted by mental health but behavioural stuff does tend to annoy. (Anna)

...The difference between behavioural and mental health issues because sometimes some people have lots of behavioural issues so they'll throw chairs

about and flip the tables, bang on doors and yell and scream and that can be quite upsetting for other people so it just makes the ward quite unsettled because you've got one person who's not really....this person doesn't really do it for a mental health reason they do it because they're not getting their own way. (Jack)

It is possible that judging other patients' behaviour as disingenuous enabled some participants to keep an emotional distance from those perceived to be disruptive, and contributing to the creation of a violent, uncertain, stressful and triggering environment which re-enacts patient's past trauma. Others, possibly those who find tolerating conflict challenging, appeared more forgiving of this externalising behaviour.

...even the girl with behavioural issues, people are nice to her when she's struggling even though most of us do have quite a lot of dislike, people aren't too direct about it because we all know we've got to live here. (Anna)

It's fine because afterwards they come and apologise. At first it was something that was really nice, they'd come and say sorry for what they had done but now it's so regular it's sort of becoming like just a word that they say. (Jack)

Many participants spoke about the impact of the inpatient environment on mental health, this included exposure to trauma related triggers such as loud noises, shouting, anger and aggression; leading to patients re-experiencing distressing memories of previous experiences. One participant acknowledged that although these triggers are present in the community setting, they feel more intense and "extreme" within the ward environment. This triggering led to patients experiencing "meltdowns", flash-backs and engaging in self-harm to cope with their distress.

So a lot of us have kind of associated traumas and triggers that include things like shouting, banging so the kind of things you've seen and there's a lot of kicking doors at the moment and yelling at staff and most of us don't cope well sensory with loud noises so it will set the rest of us off, a lot of us do things like bang our heads against the walls when we're stressed so it will just kind of increase around more noise. (Anna)

I've been like doing quite well and been incident free for a week but then my friend will have an incident which can sometimes trigger it. (Helen)

Incidents occurring within the ward tend not to be spoken about by patients, creating an "awkward atmosphere", which one adolescent likened to an "elephant in the room", possibly due to difficulties understanding their own and others' states of mind. Finding it challenging to express and tolerate feelings, fear of being overwhelmed by emotions, viewing conflict as dangerous, and attempting to avoid emotional pain may result in avoiding such discussions.

The difficulties associated with forming peer relationships with young people within the inpatient environment, who may have certain sensitivities, was discussed by participants. Adolescents expressed fear of triggering other patients and guilt when this occurred. For some, their mental health difficulties were triggered by their relationships with other patients, which led to one patient feeling sad and subsequently self-harming after being rejected.

Rape that's a really touchy subject...death...you're just having a genuine conversation with someone and you just say the wrong word, someone gets upset...most people are quite good now though, everyone seem to say what triggers them so you can be like careful to not say that thing round them. (Helen)

...that set loads of people off and that makes you feel guilty and it obviously makes other people feel bad. (Georgia)

So sometimes my (mental health condition) comes on from relation, from bonds in the er hospital. (Adam)

Participants reflected on the different needs of patients within the inpatient setting and the disruptive and at times counter-therapeutic atmosphere of the ward which they perceived as hindering their recovery.

I like to be quite quiet when I feel down and she likes to be the complete opposite and she'll go crazy and kick doors so that's not a good thing. (Vicky)

Not great really, cos when you're trying to recover you just want it to be calm and peaceful. (Adam)

It makes me feel unsafe. Participants experienced elements of the inpatient environment as being unsafe. This included fear and anticipation of aggression, to which participants appeared hypervigilant, and staff who they perceived as being unable to keep them safe from harm. It is likely that this is fuelled by the adolescents' internal working model where they perceive themselves as vulnerable, others as being unsafe and unavailable in times of distress and the world as unsafe and unpredictable. Participants' stress reactivity systems were highly attuned to perceive threat and thus they are vigilant to danger, easily leading to overwhelming feelings.

It makes me feel unsafe knowing that the staff are supposed to be checking and they could have checked on her but they didn't...(Vicky)

It can be a bit unsettling because like even if you're not the one being threatened you can still be like, oh but that person's threatening that person so if I do something wrong then they can be doing that to me. (Jacob)

this is the one place you should feel safe because it's got to the point where you need to be here, it's kind of.. not feeling safe here has a really negative impact on like how you feel...it kind of makes you feel like you can't cope cos like you feel like everything's like out of control and you can't stop it. (Jacob)

Several participants acknowledged the lack of privacy within the ward, including the unit design such as open plan social space and the impact of rules on their privacy, for example patients not being allowed in their rooms during the day. Noise resonating throughout the unit also added to this feeling of the environment being pressured. Georgia articulated; "whatever one person is doing really affects everyone else". Environmental restrictions meant that the adolescents were unable to escape distressing situations, felt "trapped", possibly creating a sense of powerlessness and exacerbating their feelings of fear. For one participant, lack of privacy resulted in her having an incident in front of other patients, which was exposing and possibly induced feelings of shame. Loud noises at night were described by many participants, it is possible that night time is a period of increased vulnerability for some, adding to the feelings of a lack of safety on the unit.

There's no way of being on your own because we're not allowed in our bed spaces during the day so there's pressure because we're in the same place, we're all in the social area in the same room so you're not allowed to go anywhere else. (Georgia)

When doors are being banged and shaken, the whole ward shakes really. (Jack)

I knew I was going to have an incident and I really didn't want it to be in public because I know how it affects everyone else on the ward so I kept asking to go to my room but they wouldn't let me so then I had an incident on the ward. (Georgia)

Within the high threat environment of the inpatient ward, adolescents' attachment strategies were activated, which influenced how they related to their peers including their ability to empathise, how they seek support, regulate their emotions, and interpret social information. Under threat some participants emotionally detached themselves from other patients, suppressed negative affect and demonstrated reliance upon cognitive strategies, "well I just got used to it. It didn't really bother me." (Caroline). In contrast, other patients responded to the arousal of their attachment systems with angry and threatening behaviours which were exaggerated to get their needs met.

I know that some people are sort of.. like because of what happened to them or whatever are like really scared, get really upset but it's just the same as the outside world really, things are gonna upset you.. gotta get over it. (Helen)

If someone comes in with kind of violence, aggression, behavioural issues, they can over react to other people and get violent. (Anna)

We don't react in the normal sense, we'll get upset and throw things, or hit things or attack people or hurt ourselves... I've learnt to detach over time. (Anna)

Theme 4: it makes being here easier. The benefits of peer relationships on the inpatient unit are explored in the final theme. Participants sense of being cared for by other patients is outlined in the subtheme, “they care about you.” This encompasses the difference between the care offered by patients and staff, and discusses adolescents’ challenging relationships with authority figures. The second subtheme, “a sense of normality” outlines the sense of normality peer relationships provide within inpatient settings, including engaging in typical adolescent behaviours and conversations. “You’re not the only one” details the value of forming relationships with individuals who have shared lived experiences, and provide a sense of feeling understood and accepted.

They care about you. Feeling cared for by other patients was identified by all participants as a benefit on the unit. Participants expressed that they were observant and attuned to each other’s needs and provided care and support to facilitate recovery through a variety of means including: distraction, empathetic listening, availability, responsiveness when staff were absent, and sharing coping strategies. These positive experiences of care were internalised by the adolescents, providing them with a reparative emotional experience of compassionate and attentive responses. This support was described as reciprocal in nature and particularly valued in times of distress, preventing escalation into an incident.

...You feel kind of left out of it you kind of just sit on the beanbag in the corner not really joining in much, but there’s also some really supportive people here who if they see you sitting alone will come up and ask if you’re ok and if you like need anything. Like when I was crying the other day one of the girls came over and said do you need a hug and I was like, yeah and then I felt a lot better afterwards. (Jacob)

It's just nice to talk to people and be there when the other person's struggling because you know that they will be there for you and it sort of.. it helps more. Sometimes staff are busy so they won't...for instance if you're headbanging staff might not instantly go and help you whereas peers will. (Jack)

Sometimes you'll literally just sit next to them and just talk shit, you don't need to do anything that special...(Helen)

Adolescents played a key role in welcoming new patients the unit. On arrival, participants expressed they had felt scared and fearful about being disliked by others. Participants valued being approached by their peers, engaging in conversation, and invited to play a game, which provided reassurance and made them feel cared for.

Well like when I first came in to the er (identifiable information) I knew nobody on the ward and I was like really scared and it wasn't until two people approached me and said like Hi and started chatting with me that I actually thought, you know what I'm going to be ok here. (Jacob)

For some participants, peers offered support through the use of humour as a distraction or a defence, enabling them to cope with painful emotions associated with their traumatic experiences, and the challenging inpatient environment.

I go to someone else who I know makes me laugh quite a lot...well they say make you laugh making you laugh would get rid of stuff...is a form of happiness. (Adam)

Humour, I love humour...I just have to make jokes out of all like this shit stuff so it's nice to have someone to make jokes out of bad stuff with. (Helen)

The care received from other patients was perceived to differ to that from staff. Participants expressed that patients were more consistent with their responding and emotional availability, consequently they could rely on them to “be there for you” when staff were otherwise occupied. Several participants felt that they were ignored by staff when they were in distress, and that they only responded to situations involving risk, such as self-harm. Participants questioned the staff’s motivation for their role, suggesting their prime motive as money rather than genuine desire to help and care, possibly due to their expectation that adults are not a source of support and love and their belief that they are not worthy of care. Conversely, they perceived patients to take their emotional pain seriously and have a desire for them to recover.

Well for friends it’s, I don’t know, it’s something that makes you know that they care about you but staff are doing it because it’s their job... (Jack)

You just know someone cared, and that someone wants you to be alright and that they’re not there because they’re paid to be there they’re there because they want to be there. (Jacob)

Participants expressed that they felt misunderstood and at times uncared for by staff, this led to a sense of hopelessness and distrust as they were unsure about who would provide support. A paradox was evident, participants wanted to receive care from staff but were possibly afraid to seek this, viewing adults as unresponsive and rejecting. However, seeking and receiving care from their peers, where there was less of a power imbalance, was not as threatening. Within the inpatient setting a power differential between patients and staff is clearly evident, staff have a professional title and/or a uniform, physically restrain patients when necessary and are not restricted in their movement, amplifying this authority.

Sometimes you get members, like members of staff who really care and then sometimes you get staff members who just sit there and watch and make sure nothing's going on but they don't really care about how you're actually getting on. (Jacob)

In particular, participants experienced difficulties with agency staff, which they experienced as frustrating. Participants were sensitive to changes in their attachment figures, and found the multiple attachment disruptions challenging. Relationship continuity and receiving consistent care from familiar members of staff was valued, affording patients the opportunity to learn that staff could be sources of security and comfort.

The staff have been supportive...obviously you get the agency that aren't so nice that don't really understand you or take you seriously but you do get some really nice members of staff who do care and do listen. (Caroline)

A sense of normality. There was a strong sense amongst participants that peer relationships helped to provide a sense of normality within the unit, on occasion allowing patients to have fun with their peers. Participants were able to pursue typical adolescent interests and behaviours, including watching television. For some, these relationships provided a distraction from the abnormal environment, therefore helping time to pass more quickly. It was also acknowledged that peer relationships created a sense of belonging, mitigating against feelings of loneliness. Young people were encouraged by their peers to engage in group activities, for those where this was difficult it was felt to be helpful for staff to facilitate this.

We were all really close, we pushed the tables together at dinner, we all ate together, we got each other drinks, we all went into the courtyard together we moved around as a group and we were always chatting, playing games and it was like an actual community. (Georgia)

Sitting together at meal times, watching films together, playing games together they're nice things to do. (Jack)

It was important for the young people to engage in discourse that was not centred around their mental health issues, thus away from dominant problem saturated narratives. Through talking about "random things" participants connected with their pre-admission teenage identity, which created a more relaxed atmosphere and instilled a sense of hope for the future.

...also helps a lot because then we don't just have to talk about mental health we can also talk about stuff that's just normal teenage stuff. (Jacob)

...Then when you just have a chat about like things that aren't like mental health related it's kind of makes you more relaxed. (Vicky)

It makes me feel like.. like a sense of normality, that like just because I've got mental health problems doesn't mean that has to ruin my whole life. (Jacob)

Although most valued time spent with those who had similar interests, one participant reflected on the benefits of forming relationships with others who would normally be outside their social circle. This included the opportunity to be introduced to new interests and to learn skills that may not have been developed in childhood, such as acceptance of those who are different.

It's quite nice actually because I've met quite a few people, like people I'd never hang around with on the outside but they've like...yeah taught me stuff I didn't know like computer leagues ...Yeah it's nice to be around loads of different people cos you get to know quite a lot of stuff. (Helen)

Actually I've just learned not to make assumptions about people and stuff cos obviously you're in here that's all the people I've met in here are like if I'd met them in the outside world I'd think, oh you're a bitch I don't like you I'd be really quite horrible to them but like you meet them under these circumstances and I dunno you realise yeah that they might be a bitch but they're not the biggest bitch in the world. (Helen)

You're not the only one. A common experience vocalised by participants was the advantage of meeting others who had lived with similar mental health difficulties. They described the comfort of no longer feeling alone or different, having similar experiences to their peers. Patients who were nearing discharge modelled the ideal of hope and recovery, allowing them to consider their future. Participants voiced the lack of understanding they encountered prior to admission, and experiencing radical empathy within their peer relationships on the unit. They were able to share similar frustrations, including barriers to accessing support from mental health services, which also facilitated their connection. Meeting others with issues more severe than their own, helped participants to gain perspective which they found reassuring.

It's nice to hear that other people have got similar problems to you with (mental health condition) and it's nice to hear that you're not the only one and that there are other people that struggle. (Jack)

Knowing that someone else has the same stuff as you is quite comforting so it's nice to know that there's someone else there that relates sort of in their own way. (Vicky)

Well I always thought that I was just weird and I was the only one suffering from all these different things but I realized I'm not and there are more people like that that are worse and yes, I feel a bit lucky in a way because I don't know, it's just easier knowing someone else has had the same thing happen and they've got better which kind of makes you feel like you're going to get better... (Vicky)

In a normal peer relationship because schools and students aren't aware of this sort of thing until they've been through it or seen someone go through it or helped someone go through it, they never fully understand. (Vicky)

The experience of being accepted and understood by other patients was recognised as a benefit of peer relationships on the ward. Participants reported that this alleviated feared judgement by others which positively impacted their self-esteem and confidence and provided a safe and supportive environment. Peers were understanding of others' emotional distress and behaviour, therefore patients were able to "be themselves" and did not feel compelled to repeatedly recall their stories. This deep level of understanding meant that at times peers were attuned to each other's needs, thus responding in helpful ways such as walking away rather than retaliating.

Well it's just like if I, um I'm having a bad day and I'm not really feeling that chatty, then like she always um, tends to understand that like it's not cos I'm in a bad mood with her, it's just that I'm struggling myself. (Jacob)

We understand that, like I hate people touching me so she won't go and touch me or hug me whereas most friends are like oh why and hug you. We understand that if each other goes silent then we either need to get someone or keep an eye on them because it usually means that they'll try and hurt themselves. (Vicky)

...Being surrounded by people your age who understand, and you can do things that are slightly weird and nobody will bat an eyelid...(Jacob)

A number of participants had had negative experiences of peer relationships in the past which contrasted with their current friendships who were considered to be less of a threat. For one participant, spending time with others who were understanding of her difficulties enabled her to develop a positive experience of building peer relationships, which challenged her previously held negative beliefs about herself, thus providing a reparative experience and improving her wellbeing.

Being here it's nice to know that the friends you make here aren't going to hurt you. (Jack)

I didn't really have many relationships outside so being bullied but in here (inaudible) this is my first sort of friends really. (Adam)

My relationships have built up my self-esteem and my confidence quite a lot because I didn't think that I was capable of actually forming relationships. (Georgia)

Peer relationships enabled participants to internalise a sense of acceptance and challenge dominant attitudes regarding mental health, breaking down stigma and enabling them to view their inpatient experience more positively, and work towards self-acceptance. Peers validated patients' emotional experiences, for example by "believing them".

You think you're crazy so having someone that's like trying to calm you down and tell you something else rather than its not there...because I know

from hearing voices, when someone is telling you they're not there it's not helping you. (Vicky)

...We all kind of accept that everybody has, everybody's different and that half the time that's the reason why they're here because other people haven't accepted that so you need to be as accepting as you can to other people to make sure that they feel comfortable. (Jacob)

For participants who struggled to verbalise their emotional experiences, peers helped to facilitate communication via other means that were perceived as safer and less threatening.

Well we both struggle to communicate when we're struggling but she's like my next door neighbour so we devised like a knocking sequence so on a series of knocks we can ask how each other is. (Georgia)

Well it's just sometimes they don't want to speak so they just want to write down so it's just easier for them to do. (Adam)

CHAPTER FOUR: DISCUSSION

Chapter Overview

This chapter will summarise and discuss the study findings in relation to existing research and psychological literature. A critique of the study strengths and limitations will be presented. Recommendations regarding clinical practice and child and adolescent mental health policy will be outlined, and areas for future research offered. In conclusion, a personal reflective account will be presented.

Adolescents spoke eloquently and in great depth, demonstrating insight into the complex processes influencing peer relationships within the inpatient setting, and how these affect psychological wellbeing. Young people discussed both positive and negative aspects of these complex relationships. Whilst there were clearly many benefits, as evidenced by the therapeutic processes they described, there were also substantial negative components, resulting in conflicts and dilemmas. For some, peer relationships were anti-therapeutic with a significantly detrimental impact upon mental health. The challenging aspects of these relationships were intensified because of the milieu, and adolescent development; which is fraught with a heightened emotional state.

Therapeutic component of peer relationships. The therapeutic nature of adolescents' peer relationships is evident within participants narratives, such relations were characterised by important personal qualities, such as caring, empathy and good listening skills. Participants described how therapeutic processes occurred within these relationships including acceptance, feeling understood, a sense of belonging, validation

and instilling hope. Peers were interim attachment figures for patients and provided containment (Ainsworth, 1989; Bion, 1962), conditions necessary for improvement in patients' psychological wellbeing and emotional literacy. This finding supports the literature exploring adolescents' experiences of inpatient care, where patients valued peer relationships as a source of support, enabling their emotional competency to develop (Colton & Pistrang, 2004; Gill, Butler & Pistrang, 2016; Moses, 2011; Offord, Turner and Cooper, 2006; Reavey et al., 2017; Sischy 2006). Such characteristics have been identified as important therapist attributes fundamental for the development of a positive therapeutic alliance (Ackerman & Hilsenroth, 2003, Feller & Cottone, 2012) and as favourable qualities of 'helping professionals' (Freake, Barley & Kent, 2007; Gilbert, Rose & Slade, 2008). Carl Rogers (1957) proposed core conditions including empathy, congruence and unconditional positive regard are the foundation of therapeutic relationships and enable change. This allows individuals to develop openness, feel valued, respected and understood, build trusting relationships and experience acceptance. These interpersonal processes were consistent with adolescents' accounts of the helpful components of their peer relationships on the ward. Suggesting these elements may be vital aspects of generally supportive relationships, not just therapeutic relationships and that some participants peers took on 'therapist' roles for young people.

Within adolescent inpatient settings, there is a high prevalence of Post-Traumatic Stress Disorder (PTSD) and complex trauma (Belivanaki, Ropi, Kanari, Tsiantis & Kolaitis, 2017). Many patients have experienced trauma within the context of attachment relationships (Keeshin et al., 2014). Experiencing relational trauma, or abusive, deficient or intrusive parenting, has a profound effect on the development of

subsequent relationships, and such individuals frequently find it challenging to form and maintain healthy connections to others (Pearlman & Courtois, 2005). Study findings suggested that for some, peer relationships enabled adolescents to reconnect with others, which had a reparative and healing effect, where they learnt to trust and rely on others for their emotional needs, much like the patient-therapist relationship (Clarkson, 1995; Cooper, 2008; Ryle & Kerr, 2002). Some adolescents experienced their peers as attuned and attentive to their psychological and emotional needs, which provided relational healing through internalising new attachment experiences.

The findings suggest that many adolescents found it easier to establish supportive relationships with their peers, compared to staff. Research supports the notion that young people frequently seek support from their peers when facing difficulties (Department of Health, 2015) and that adolescent inpatients often have ambivalent experiences of staff (Colton & Pistrang, 2004; Delhaye et al., 2011; Haynes, Eivors & Crossley, 2011). Some reported experiencing staff as “uncaring” and “neglectful” and motivated by money rather than compassion, a finding supported by adult inpatient research (Reavey et al., 2017; Wood & Pistrang, 2004). Experiences of relational trauma with adults is typical within the inpatient population, consequently adolescents may have developed adaptive and protective strategies in the context of such abuse and inconsistent or unavailable parental figures (Crittenden, 1999), including distrust of those in authority. The adolescents’ relationship to helping professionals can be conceptualised as a repetition of formative relationships with caregivers (Reder & Fredman, 1996), where the belief that adults cannot be relied upon is established. Fuelled by fear, expectations of rejection and abandonment, and prior negative experiences of help-seeking, patients may be hesitant to develop interpersonal

relationships with staff who assume the role of the carer within the inpatient system (Bowen, 1976). The power differential between patients and staff is clearly evident; staff have a professional title and/or a uniform, physically restrain patients when necessary, and are not restricted in their movement, amplifying this authority. This power-discrepancy between young people and staff may further inhibit care seeking (Boyd, 1996), which is consequently redressed with peers. Some may hold negative expectations about being cared for, feeling undeserving or unworthy of care. Additionally, during adolescence shifts in attachment focus occur from parental figures towards peer groups to meet emotional needs, which was evident from their accounts (Brown, Eicher & Petrie, 1986; Buhrmester, 1992; Erikson, 1968; Hazan and Shaver 1994; Zimmer-Gembeck & Collins, 2006).

Benefits and dilemmas of peer support. Adolescents' peers played an integral role during inpatient admission, providing support, building emotional and social competence (Furman & Wehner, 1994), and enabling them to develop independence and emotional separation from caregivers (Carter & McGoldrick, 1989). A unique feature of these relationships was the shared lived experience of mental health difficulties and associated challenges, such as stigma, a feeling of difference and resulting loneliness. Being understood and accepted by peers who were experiencing similar struggles, led to many adolescents being able to express their true self without fear of rejection, creating an authentic connection. The stigma associated with mental health problems can lead to experiences of shame, isolation and low self-esteem (Kaushik, Kostaki & Kyriakopoulos, 2016; Moses, 2010), normalisation and validation provided by peer support can facilitate self-acceptance. This was demonstrated by the study findings; adolescents expressed a sense of belonging, meeting others in similar

situations provided reassurance that they were not alone, helping to ameliorate their loneliness. They experienced radical empathy, rooted in their own personal lived experiences (Repper & Carter, 2011) and felt able to self-disclose within these relationships, deepening relational bonds. Further, peer support encouraged self-expression, where adolescents were better able to understand and express their experiences, finding a language to voice this within a supportive setting (Reavey et al., 2017). This supports Bigelow and La Gaipa's (1980) model of friendship expectations, where during adolescence self-disclosure, understanding and empathy characterise peer relationships.

Peer relationships encouraged participation in the unit programme and provided a sense of normality by allowing young people to engage in typical teenage behaviour, which provided distraction from their difficulties and helped pass time. This facilitated escape from the problem-saturated narrative they had become embedded within, and drew attention to subjugated stories inclusive of their strengths and hope, which may have been overshadowed and overlooked (Anderson, Goolishian and Winderman, 1986; White, 1989) and development of a more positive sense of identity (Repper, 2013). Admission to an inpatient unit may suspend or threaten patients' identity development, a central task of adolescence (Erikson, 1968). Remaining connected with their pre-admission identity through the process of establishing peer relationships with young people on the unit, and ensuring that the inpatient context has features of adolescent's normal life is essential (Haynes, Eivors & Crossley, 2011).

Patients' peer groups provided opportunities to learn adaptive coping strategies to deal with distress more effectively (Colton & Pistrang, 2004). Additionally,

observing the improvement of peers' mental wellbeing, and subsequent discharge, gave a sense of hope for their own futures, and provided role models for recovery (Mayor, 2018), findings consistent with the literature concerning the benefits of peer support for adolescents experiencing mental health problems. The research encompasses peer support programmes which are operationalised in a variety of ways (Foster, Lewis & McCloughen 2014; Tower Hamlets CCG, 2013; Weare & Nind, 2011) and is also in line with services for adults in some parts of the country (e.g. Recovery College) using peer support workers to help with individuals' recovery. The findings also concur with the literature on the supportive and protective role of social support in mental health (Auerbach, Bigda, Eberhart, Webb & Ho, 1986; Wentzel, Barry, & Caldwell, 2004) and the increase in self-confidence providing peer support can bring (Houlston & Smith, 2009; Parsons et al., 2008).

Participants frequently adopted the position of 'helper' within the inpatient system (Bowen, 1976) and incorporated this within their identity, losing themselves in other patients. Despite the value of peer support, adolescents spoke about the detrimental impact of assuming this role, including feeling burdened by others' problems, emotionally overwhelmed, sacrificing their own needs, pressure to fulfil this role whilst experiencing their own struggles, and conflicts regarding confidentiality, supporting the findings of Sischy, (2006). Participants' accounts suggested that they found it challenging to implement and maintain healthy personal boundaries, common amongst those who have experienced abuse involving violation of their personal limits (Harper, 2006). Unresolved resolution of 'autonomy vs. shame' may lead to difficulties separating from peers and dependency may ensue (Erickson, 1968). Further, seeking out opportunities to support others may be an attempt to mitigate against feelings of

stress (Raposa, Laws & Ansell, 2015), a means by which adolescents can avoid their own emotional pain. The care-giving role may be familiar to those who have experienced parentification, as a sole supporter of their parent whilst suppressing their own needs, resulting in negative outcomes (Hooper, 2007). This presents a challenge for inpatient staff, who must balance empowering the adolescents to utilize peer support whilst ensuring that the environment is safe, and healthy peer relationships develop.

The fragile nature of trust. Participants described peer relations as intense. Establishing trust was challenging due to powerful fears of abandonment and rejection, and epistemic mistrust (Fonagy & Allison, 2014). With repeated exposure to neglectful or abusive caregivers, the development of a ‘secure base’ and consequently relational trust in the world is inhibited (Bowlby, 1988) as the psychosocial stage of ‘trust vs. mistrust’ is unresolved (Erickson, 1963). The adolescents portrayed internal working models where others are framed as abandoning, unreliable, unpredictable and hurtful, resulting in continual fear of persecution, deeply rooted in adverse childhood experiences (Bowlby, 1973) common in the inpatient setting. These core fears were frequently triggered within the ward by threats including patients being stepped up to more intensive services, discharged to community teams and new admissions resulting in a loss of peer support and feelings of abandonment. The adolescents described defence mechanisms, such as avoiding emotional connection and emotional numbing, to protect themselves against the pain associated with threats to attachments.

Adolescents expressed sensitivity and hyper-vigilance towards rejection threats within peer relationships. For many, having developed in the context of high threat environments, increased vigilance towards the environment and others may be a self-

protective strategy (Hostinar, Stellern, Schaefer, Carlson, & Gunnar, 2012). Threats were conceptualised as physical and interpersonal in nature, some patients appeared alert and continually analysed the behaviour of others leading some adolescents to modify behaviour to avoid triggering sensitive peers. Participants' accounts highlighted their feelings of worthlessness, where each negative experience within their peer relations reinforced relational distrust, and their belief that others may abandon them (Schimmenti, 2012).

Typical developmental trajectories observed during adolescence encompass intense relationships and instability of affect, however this was heightened within the inpatient population. Developmental trauma adversely impacts the regulation of affect and understanding and articulating internal states (Schimmenti & Caretti, 2010). Within the context of complex trauma and PTSD, perceived threats to attachments were described as quickly activating high levels of emotional dysregulation, leading to automatic responses including fight, flight and freeze (Shaver & Mikulincer, 2007). It is likely that adolescent inpatients have a lower threshold for arousal of their attachment system, activated in stressful inter-personal interactions (Fonagy & Luyten, 2009). Participants responded to threats of abandonment with aggression, withdrawal or emotional numbing, which can be understood as functional threat responses.

The fragility and volatility of peer relationships was described by participants, where behaviour and the intent of others was misjudged resulting in relationship breakdown. This finding supports the notion of dysfunction in mentalizing, where individuals have difficulties in understanding their own and others mental states and linking these to behaviour (Bateman & Fonagy, 2004); suggested to occur as a result

of insecure early attachment relationships (Fonagy & Luyten, 2009). Disruption in mentalizing abilities leads to challenges maintaining healthy relationships, emotional dysregulation, distress (Levy et al., 1999) and difficulties appraising social information (Bateman & Fonagy, 2003), evident in participants' accounts. Hyper-mentalizing was also apparent, a strategy wherein patients were acutely vigilant towards emotional cues from others, leading to over-attribution and over-interpretation of their state of mind, commonly resulting in misinterpretation (Dziobek et al., 2006) of harmful or malevolent intent (Fonagy & Luyten, 2009).

The use of professional language. It was evident from adolescents' accounts that many had absorbed the language of professionals, using terms such as “attachment problems” and “dissociation” and categorising symptoms as psychiatric disorders. It is possible that throughout their admission they internalised the care of professionals, thus building their emotional intelligence and developing a sense of security in themselves.

Adolescents use of such language can also be conceptualised as the defence of intellectualization (Freud, 1915, 1949), perhaps enabling young people to cope with overwhelming affect by transforming intensely emotional experiences into non-emotional ones through overreliance on thought. Such rational explanations may serve to alleviate vulnerability, and preserve emotional homeostasis. In these circumstances, emotion is often absent and acting-out behaviour still occurs, demonstrating a lack of development within their emotional intelligence. This pseudo-mentalizing occurs when the young person appears to understand their difficulties at a cognitive level, however connections to their own experience, including affect are absent. During the psychosocial stage of ‘Identity vs. Role Confusion’, adolescents are tasked with

developing and defining their individual identity through personal exploration, attempting to fit in with their peers whilst establishing their own unique identity (Erickson, 1968). In order to resolve this developmental crisis and in an attempt to seek security, the development of an illness identity may arise (Estroff, 1989; Goffman, 1961). Such an 'illness identity' may enable the adolescent to feel more secure through integration of aspects of the self into a coherent sense of self, regarding relationships, roles and social engagement, rather than contending with a fragmented, uncertain and unstable sense of self and consequent identity distress. Adolescents may reject their earlier identity and goals in an attempt to achieve a sense of belonging to the inpatient peer group (Gill, butler & Pistrang, 2016). As illness identity influences recovery (Yanos, Roe & Lysaker, 2010), it is important to consider how this can be channelled in a healthy way to empower the young people.

Destructive peer relationships. Participants reported complex interpersonal dynamics between patients, including competition for staff attention. This competition, rivalry and jealousy resulted in patients attempting to become the "illest patient" on the ward, increasing the severity of their risk-taking behaviours and acting-out through externalising behaviours, in order to seek care. This is mirrored in studies investigating adolescents' experiences of inpatient admission for anorexia nervosa (Colton & Pistrang, 2004; Offord, Turner and Cooper, 2006) but is a novel finding for general psychiatric wards. The experience of rivalry is an important component of normal childhood development, often occurring within the context of sibling relationships and motivated by competition for parental love and attention, common belongings and living space, and manifests as hostile impulses towards siblings (Freud, 1916-17). However, the emergence of such rivalry within the ward environment became

problematic when patients responded to such feelings with destructive behaviours when in pursuit of care from staff. Many adolescents perceived other patients receiving care as threatening, triggering fears of abandonment, feelings of inadequacy and vulnerability to losing attention and care from staff. These feelings were exacerbated by their histories of emotional abandonment, relational distrust, shame and inadequate parenting. The adolescents responded to attachment threats with functional, self-protective strategies to get their emotional and physical needs met, elicit protection, and ensure proximity to attachment figures (Crittenden, 1995).

Bullying was reported within the inpatient context with patients assuming different roles mirroring dynamics described within the Karpman 'drama triangle' (Karpman, 1968), which illustrates destructive human interactions during conflict. The roles participants described encompassed that of the victim, rescuer and persecutor. Individuals have a habitual role, but these are changeable during interactions. The victim feels helpless, powerless and oppressed whilst the rescuer is an enabler who rescues to alleviate feelings of guilt, however in so doing establishes a dependant relationship with the victim, allowing them to avoid their own difficulties through tending to the needs of others. The persecutor attributes blame to the victim, demonstrating controlling, critical, rigid, angry and authoritative behaviour. Interpersonal aggression may serve different functions, such behaviour may be a defence against feelings of vulnerability and perceived threat. Each individual assumes roles based on their own, often unconscious, psychological needs, which are met through the interactions. The rescuers self-esteem is enhanced and they gain from creating a co-dependent relationship with the victim, who benefits from the care.

When discussing bullying on the ward, one adolescent described how a patient with a neurological condition was categorised as a member of the -out-group (Tajfel, 1979) and adopted the victim role. The adolescent attributed others' ignorance regarding the condition as an explanation for why they were victimised. Within the inpatient context, adolescents may identify with patients they perceive to be 'superior' to increase self-esteem, and discriminate against out-group members who they deem to possess undesirable characteristics (Gini, 2006; Tajfel & Turner, 1986). The inpatient setting is fraught with high emotion. Patients experience a range of conscious and unconscious feelings and consequently utilise psychological defences, namely splitting and projection, to manage the difficult feelings they experience. Adolescents may split other patients into dichotomous "good" or "bad" categories based on positive or negative attributes. Splitting strengthens the adolescents' sense of self as being good whilst vilifying those who differ. Patients may harbour fears regarding their self-worth and vulnerability and experience rivalry and envy, leading to unbearable feelings of anger and anxiety which they wish to eliminate. In an attempt to protect themselves against these internal conflicts, patients split their emotions into different components. Through projection, difficult feelings are placed in other patients and in this way idealisation may result.

Establishing and maintaining boundaries within peer relationships was a challenge. Through internalising the message that asserting one's own needs is bad and shameful, adolescents described difficulty expressing their needs, possibly from a desire to please others and fears of rejection. Participants were unable to separate their own emotional experiences and became emotionally over-involved within peer

relationships, describing losing their emotional identity. When unable to voice their own needs, patients required staff intervention to assert boundaries.

Young people are highly influenced by their peers during adolescence (Spear, 2000; Steinberg & Monahan 2007), which can increase problem behaviour through peer contagion (Dishion and Tipsord, 2011). Anti-therapeutic aspects of peer relationships were reported, including learning new destructive behaviours and facilitating self-harm in other patients which corroborates existing literature exploring adolescents' experiences of inpatient units (Colton & Pistrang, 2004). It is possible that this behaviour is a response to patients' fear of others moving on and leaving them though the process of recovery and discharge. Patients may experience envy at others' recovery, a feeling which may be considered unacceptable, resulting in an unconscious wish to sabotage and derail other young people. Patients may project unwanted parts of themselves into other adolescents so that their 'badness' becomes located in the other. Consequently, the patient encouraging harmful behaviours is left feeling okay whilst the adolescent who has engaged in self-harm suffers. These findings support the work of Dishion, McCord & Poulin (1999) who investigated peer aggregation with groups of adolescents. During adolescent development, deviant behaviour is expected and often occurs as a consequence of group affiliation and peer pressure (Weisz & Hawley, 2002). It is possible that within the inpatient context this is exacerbated, and that young people conform in order to gain acceptance and develop a group identity, intensified by previous experiences of rejection.

Unsafe environment. Participants described the inpatient environment as a frequently changeable, volatile and triggering atmosphere, which negatively affects

patients' psychological wellbeing. For some, this anti-therapeutic environment felt unsafe and hindered their recovery through experiencing re-enactments of past trauma. These findings are consistent with research investigating adolescents' experiences of psychiatric inpatient environments, described as lacking privacy, artificial and pressurised containers where patients were expected to unpack distressing emotions, which at times was felt to be unsafe (Colton & Pistrang, 2004; Gill, butler & Pistrang, 2016; Reavey et al., 2017). In contrast, research also highlights how some adolescents perceive the structure and care provided within inpatient wards to be containing, providing safety from stressors in the outside world (Gill, butler & Pistrang, 2016; Moses, 2011; Offord, Turner and Cooper, 2006).

Within the inpatient context, triggers were experienced as more intense and extreme, due to the fragile emotional environment and contagious affect from which patients cannot escape (Reavey et al., 2017). To minimise the adverse impact of admission, patients utilized a variety of management strategies and defences such as: rationalisation, withdrawal, avoidance and normalising, which provided protection from unbearable inner affect (Gill, Butler & Pistrang, 2016; Lemma, 2003). The high threat and stressful environment elicited feelings of vulnerability, fear and stress activating patients' attachment systems, which influenced their behaviour and interpersonal interactions with their peers (Bowlby, 1969, 1973, 1980). To manage such threats, patients suppressed this affect, avoided intimacy through distancing strategies, or amplified their distress to gain proximity to others. At times, adolescents' attachment insecurity destabilised their relationships (Simpson & Rholes, 2017). The unsafe environment threatens the safety of the milieu and compromises the therapeutic essence of the inpatient setting.

Limitations. Recruitment occurred whilst participants were current inpatients, which may have influenced the information they chose to disclose. It is possible that participants were concerned about confidentiality and feared repercussions from their peers, such as ostracisation and bullying, therefore omitting more negative aspects from their narrative. Furthermore, when in the midst of complex relational dynamics and in the grip of the intensely emotional environment, participants' accounts might be either heightened or the more painful aspects of their reality denied. If interviews had been conducted post-discharge, it is possible that the responses elicited might have differed as a result of distance from their experiences. However, in order to capture participants' lived experiences and the immediacy of this, it was deemed preferable to interview participants during their inpatient admission to avoid retrospective bias influencing their accounts.

Constrained by ethical requirements, only patients who were considered sufficiently stable, and who were deemed to have mental capacity, were included in the study, possibly excluding those with greater relational difficulties, more intense emotional dysregulation, or higher levels of risk. The sample was self-selecting and comprised patients who volunteered to participate, so were possibly more engaged within the therapeutic programme. Whilst these accounts are undeniably of great value, the sample may not have been truly representative of typical patients within the service. However, rather than generalising findings, interpretivism aims to provide in-depth meaningful descriptions.

Recruiting the young people to take part in the study was challenging. Often adolescents were on leave, had been stepped up or down to different services or were

unavailable due to competing requirements of the unit programme. Whilst the sample size of the current study is within the suggested guidelines for thematic analysis (Flick 2008; Fugard & Potts, 2015), it would have been preferable to increase this further. The eight accounts provided in this study represented one third of the usual inpatient population within the recruiting unit at any one time. During the period of recruitment inpatient numbers were unusually low, and service issues such as cuts leading to a reduction in staff numbers were occurring, further complicating this process. It may have been beneficial to meet with staff again part way through the recruitment process to remind them of the research and discuss possible strategies to improve recruitment given these limitations.

My assumptions during the research process need to be considered as a potential source of bias. I assumed that adolescents would classify their social interactions with other patients as a relationship, that their relationships would influence their wellbeing, and that certain factors would impact their relationship development. Despite enhancing transparency through reflective accounts, it is likely that these assumptions will have affected participants' responses during interviews, and data analysis. However, I bore my assumptions in mind, continually and consciously viewed each participant's account as unique, and was mindful not to fit the evidence to confirm my own beliefs. The reader can draw their own conclusions from the data presented in the knowledge of my stated assumptions.

Within qualitative research, it is important to consider the unique relationship between the researcher and participants, where a power differential exists (Richards & Schwartz, 2002), thus posing ethical risks such as participants feeling unable to express

their wish to withdraw or feeling obliged to respond to questions (Mishna, Antle, & Regehr, 2004). To reduce the possibility of participant coercion, the adolescents were repeatedly informed of the voluntary nature of the research, encouraged to seek clarification and reassured about their right to withdraw without adverse consequences.

A key limitation of the study was the underrepresentation of minority ethnic groups despite the fact that the service provides care for adolescents across the country from a diverse range of ethnic backgrounds. Concern regarding the ethnic mix present in research samples not representing the cultural diversity in the general population, has been raised in the literature (Allmark, 2004). It is essential to challenge the often implicit assumption that little variation of experiences and perceptions exists across different populations and not to prioritise the views of more dominant populations. Cultural difference brings unique and diverse perspectives; thus findings cannot be generalised to different populations (Henrich, Heine, & Norenzayan, 2010). Difficulties associated with representing participant diversity in research is acknowledged (Allmark, 2004). Nonetheless, whilst research indicates BME groups tend to be disproportionately represented within inpatient services, it is understood that this is not typical within the examined service. The vast majority of admissions to the service are for those identifying as 'White British', meaning that whilst lacking in ethnic diversity, the accounts provided are representative of the typical inpatient population.

A psychodynamic approach was taken to interpreting some of the participants' experiences. Criticism of psychodynamic theory includes its subjectivity, abstract nature and difficulties with rigorous empirical testing. Thus, within the current study,

another researcher may have deduced different findings (Silberzahn et al., 2018). Despite this, such concepts are applied tentatively within the current study and provide a valuable framework for making sense of participants' experiences. Further, since multiple truths and perspectives are accommodated within an interpretive paradigm such interpretations provide one way of understanding participants' accounts.

Credibility checks to certify that generated themes are an accurate representation of the data were not completed and testimonial validity was not carried out with participants to ensure that themes truly reflected their experiences (Elliott, Fischer, & Rennie, 1990). Therefore, a degree of researcher subjectivity is inevitable within the study findings. However, themes were developed alongside supervisors through discussions and within an interpretivist paradigm, where each participant is perceived to have their own social reality and subjective experience therefore this was not deemed necessary (Angen, 2000; Birt, Scott, Cavers, Campbell & Walter, 2016; Morse, 1994; Sandelowski, 1993). Testimonial validity checks, which assume the existence of a fixed reality identified by the researcher and verified by participants' would have contradicted the epistemological position of the study.

Strengths. Recruitment for the current study focused exclusively upon one inpatient unit, thereby reducing heterogeneity between participants and preserving their unique experiences and challenges faced within that particular service context. Since inpatient units vary in terms of treatment approaches, bed and staff numbers, the physical environment, admission requirements and philosophy (Crowhurst & Bowers, 2002), sample homogeneity was ensured (Smith & Osborn, 2003).

To date, literature exploring the experiences and views of adolescent inpatient populations is scant, particularly in relation to peer relationships. The value of recognising the voices of service users and the knowledge that they hold, rather than regarding patients as passive recipients of care, is becoming more widely recognised. The current study provides novel insights, enhances professionals' understanding of peer relationships within the inpatient environment and challenges dominant staff narratives, therefore providing opportunities for service improvement to meet the needs of young people.

Researchers have an ethical responsibility to consult with individuals who have expertise in the area under investigation (APA, 1992), particularly in the phase of project development and planning. For the current study, I received joint supervision from a Clinical Psychologist with vast clinical expertise within the studied population who ensured that ethical principles were adhered to. Before the commencement of the study, I met with a service-user to discuss the research idea, methods of recruitment and check understandability of the research schedule and information sheets and consent form, which proved very informative and allowed me to challenge and modify preconceived biases and assumptions; and ensure the project appeared relevant to the population.

My status as an outsider influenced how I related to participants' experiences. This was advantageous as it enabled a degree of analytic detachment and distance to be maintained (Denzin, 2003), which was particularly beneficial during the interview process where I could adopt a curious stance when questioning participants with regard to their assumptions. The use of face-to-face interviews allowed the researcher and

participants to develop a rapport, therefore allowing them to reveal sensitive information (Rice & Ezzy, 1999).

The current study employed suitable methods to address research objectives which were systematic and transparent,. Techniques were used to enhance the research credibility, transferability, dependability and conformability (Lincoln & Guba, 1985). These include prolonged engagement with the service and participants, thick descriptions of participants' accounts, inquiry audit and a reflexive journal documenting the research process and reflective account, allowing the reader to judge the credibility of the research.

Clinical Implications and Recommendations. This study suggests that the therapeutic relationships that adolescents form within the inpatient setting extend beyond those with professionals and that significant therapeutic processes occur within the context of peer relationships. The therapeutic benefit of peer relationships in facilitating recovery should be recognised, including the internalisation of care providing a new relational model for patients. Consequently, the ward environment should be structured to encourage the formation of relationships, for example providing opportunities for patients to engage in activities and when necessary these relationships should be promoted by staff. This suggests that rather than primarily drawing upon individualistic models of treatment, intervention that considers the multi-level systems that patients exist within is beneficial. This supports guidelines recommending the provision of therapeutic groups within inpatient CAMHS (NHS England, 2018). Further, utilizing adolescent peer support workers whose role includes in-reach work in inpatient settings should be considered.

Experiencing a sense of trust, feeling cared for, being welcomed within the unit, humour, emotional attunement and availability were aspects of peer relationships valued by participants. Members of staff can draw upon these components and values when building therapeutic alliances with patients to improve engagement and relationship quality. Recognising the power imbalance between patients and staff, and adolescents' previous experiences of adult authority figures should be considered in the development of therapeutic relationships with young people on the ward. Some adolescents found it challenging to engage with and receive support from multiple members of staff, in particular with those who were less familiar such as agency staff. Where possible, consistency of professionals and providing adolescents with the opportunity to regularly spend time with staff with whom they have an established connection should be prioritised.

Nursing staff and patients attending community meetings held at the end of each day would provide an opportunity for the dynamics on the ward to be discussed and addressed, support conversations between patients and encourage expression and containment of difficult feelings (1962), providing a safe holding environment (Winnicott, 1960) which may facilitate healthy emotional development of the young people.

Given the critical role of peer relationships during the developmental stage of adolescence, it is important for adolescents to be admitted to psychiatric inpatient services in close proximity to where they live. This would enable a graded discharge, maintaining contact with inpatient peer relationships post discharge and visits from family and pre-existing peer relationships during admission. Although this is not

always possible within current services due to a significant bed shortage, it is important to consider how parts of the CAMHS system is counter-therapeutic and perhaps contributes towards deterioration in young peoples' mental health by reinforcing attachment problems, and creating systems which promote endings characterised by loss and pain.

Although peer relationships are often a significant source of support, they also have the potential to cause harm, with patients facilitating risky behaviours and hindering the recovery of others. It is important for staff to have awareness of the complexity of these relationships, and utilise clinical supervision to help formulate such behaviours. Further, group dynamics should be considered when completing risk and management plans (NHS England, 2018); rather than relying upon individualistic approaches to the assessment of risk. Many found it challenging to establish safe boundaries within peer relationships, resulting in them assuming unhelpful roles which adversely affected their own psychological wellbeing. It is therefore necessary for staff to have awareness of this potential, and to model and support the development of healthy boundaries within relationships.

Many perceived the inpatient environment as unsafe and triggering. Therefore, curtailing the amplification of dysregulation in response to triggering events would be desirable for patients. It is necessary to prioritise the use of psychological formulation to understand patients' behaviour within the context of their experiences and provide person-centred care in order to contain their emotional responses. Guidelines should be devised to help staff manage incidents on the ward to avoid other patients becoming re-traumatised, including removing uninvolved young people to places of safety and

allocating staff to tend to their emotional wellbeing during incidents. Furthermore, when developing inpatient services, priority should be given to creating a safe therapeutic environment, including a designated space to which patients can retreat when wishing to seek privacy or a calming space (Department of health, 2017).

Participants avoided conversations following disputes, often contributing to hostile and difficult atmospheres. Following such events, patients should be offered an informal or formal debriefing space for conversations facilitated by a familiar member of staff which would afford them the opportunity to reflect on the impact of the incident, offer emotional containment and encourage conversations between patients. Staff can model skills associated with mentalization, thus supporting the young people to understand and reflect on their own and others' state of mind and to repair relational ruptures.

Participants discussed core fears of rejection and abandonment. Consequently, attention needs to be given to the detrimental impact of peer discharge, and conceptualise this as a loss of an attachment figure, affecting other individuals and the wider unit. Professionals should be attentive towards patients' needs following peer discharge, and formulate changes in their behaviour or psychological wellbeing within the context of their attachment histories, and as a period of increased vulnerability where fears may manifest as internalisation, acting out or regression. Support should be given to enable the adolescents to make sense of their triggers and patterns, and their intense automatic fear of abandonment and develop strategies to manage this.

Greater therapeutic consideration should be given to managing these relational endings, so that the termination of peer relationships is not re-traumatising. This should be included within discharge planning, which policy states should begin before or at the point of admission (NHS England, 2018). Staff should sensitively support the young people to process upcoming endings, giving warning where possible and eliciting their emotional responses. Strengthening patients' coping and self-regulatory skills should be a priority, as well as drawing upon other safe attachment figures within the adolescents' life. The use of transitional objects and goodbye letters may be beneficial (Greiner, 2010). If appropriately managed, the adolescents can develop a new model for handling endings, which is not characterised by intense trauma.

Given the integral role peers play throughout adolescents' inpatient admissions, the loss of such peer relationships as well as a sense of belonging, acceptance and community, should be considered in risk assessments upon discharge. Peer support may be protective and mitigate against risk factors, however the loss of a peer support network may increase vulnerability and the likelihood of negative outcomes. Additionally, it is important to recognise that the experience of positive peer relationships may result in patients becoming invested in staying on the unit, unnecessarily fostering dependency upon inpatient care (NICE, 2014). Therefore, discharge planning should include fostering young peoples' relationships within the community, particularly those with lived experience of mental health difficulties possibly through peer support programmes, providing opportunities for adolescents' emotional needs to be met once discharged. Effective discharge planning should incorporate consideration of peer social support, particularly as risk of suicide may elevate three months post discharge (NICE, 2016). Further, throughout admission,

connections to adolescents' pre-existing peer networks should be maintained where appropriate. Home leave is recommended to enable adolescents to uphold community links and to support the transition to community-based services (NHS England, 2018).

Peer relationships within the inpatient setting allowed adolescents to remain connected to aspects of their pre-admission identity and retain a sense of teenage normality, through conversations and spending time engaging in valued activities. This helped the adolescents to cope with the negative aspects of their sometimes lengthy admissions. Policy states that inpatient CAMHS must provide recreational activities as part of their structured programme (NHS England, 2018). The study findings suggest that to help mitigate against the distressing environment, it is important to allow young people to participate in typical adolescent pursuits. This also allowed the young people to distance themselves from their illness identity and instil a sense of hope.

Jealousy and envy emerged as significant features of the adolescents' inpatient experience, often manifesting as competition for staff attention. Adolescents who externalised their distress were perceived as receiving more care compared to those who internalised their distress. Policy states that each patient should be allocated a named nurse, care co-ordinator and Responsible Clinician (NHS England, 2018), however many reported that contact with professionals and receiving care was increased through externalising behaviours such as violence and aggression towards property. It was felt that this response reinforced acting out, whereas those abiding by the unit rules felt they went unheard. Hence, sufficient staffing numbers and opportunities for quieter patients to receive care from staff and to have a space to voice their needs and opinions are required.

Further Research. Considering the findings from the current study, it would be of value to compare adolescents' experiences of peer relationships across different inpatient services, including general and specialist psychiatric units, to understand how patients' lived experiences are similar or differ. Exploring staff accounts of adolescents' peer relationships and the social processes that occur within the inpatient setting, including the dilemmas they encounter, may also be beneficial. As some participants spoke at length about their relationships with staff, and as they are an essential component of the milieu, it would be useful to explore patients' lived experiences of their therapeutic relationships with staff during their inpatient stay, to obtain more of an in-depth understanding about how these facilitate or hinder recovery and wellbeing. It may be beneficial to investigate adolescents' experiences of peer relationships within the inpatient unit once they have been discharged which would enable participants to speak from a position of distance about their experiences and possibly be less inhibited by fears related to peer relationships following disclosure of certain information. Finally, it may be beneficial to explore how peer relationships and attachment issues within these relationships differ according to young peoples' particular experiences of relational trauma and abuse.

Personal Reflections. Within the domain of psychology, an exhaustive and sometimes overwhelming range of therapeutic approaches and methods exist. The current study has emphasised the fundamental role of establishing a therapeutic alliance with clients, based on human connection, empathy, genuineness and sensitivity, where individuals feel listened to, heard, valued and understood. A relationship built on trust and attunement, where clients can explore their relational attachments, enables healing to occur within the safety of the therapeutic relationship, which may have a deeper

impact than other therapeutic interventions. Furthermore, the importance of peer support is indicated, including the value of shared personal experience and experiencing a sense of belonging and acceptance. Consequently, I recognised what might differ in the patient-therapist relationship and considered the power differential that exists, where therapists can be construed as powerful authority figures in the minds of clients. Thus, it is important to consider patients' relationship with authority and how power has operated in their lives.

Throughout the research process and analysis, it became apparent that a conflict existed between my chosen constructionist epistemological stance and a critical realist approach. Critical realism assumes that not one truth exists however it suggests that in attempting to make sense of these multiple perspectives, an intrinsic subjectivity in constructing our knowledge exists. My own position and psychological knowledge was drawn upon when understanding participants' experiences and my analysis was influenced by critical realist ideas and concepts. Critical realism postulates that in particular contexts, knowledge will be true, a viewpoint rejected by constructionism. Therefore a critical realist approach could have been used in the current study.

I encountered challenges when attempting to establish engagement with the participants. I considered this difficulty prior to commencing interviewing (Green, 2006), due to patients being potentially wary of unfamiliar adults and mistrusting others,. I spent time on the unit building a rapport with patients and staff to maximize my chances of success with recruitment, however due to time and practical limitations, this was restricted. If I were to conduct this research again, I would prioritise this component of the research process to ensure that the young people felt safe and

comfortable. Although the current study drew upon service-user involvement to give advice on areas of the research at the beginning of process, it would have been valuable to have consulted an advisory group throughout the duration of the research.

Experience of conducting the interviews

Many of the young people appeared to feel comfortable talking about their peer relationships and spoke articulately and eloquently about both their positive and negative experiences on the unit. It is possible that this was the first space that the young people had to think about and express how meaningful yet complex their peer relationships were and they therefore engaged in rich discussions. Often participants spoke at length and consequently as the interview progressed they appeared tired and struggled to engage with the latter half. As I adjusted to the role of a researcher and the interview process I was able to better manage timings and the limitations associated with participants' levels of concentration, often impacted by medication or their mental health difficulties. At times I felt overwhelmed by participants lengthy and detailed accounts, particularly for those who reported feeling emotionally neglected by staff, who I felt possibly valued the validating interview space. Participants often presented as helpless and vulnerable and on occasion I was aware of the pull I felt to rescue and protect them and the inadequacy I felt at being unable to do this and how this at times led me to overcompensate.

Others found it challenging to speak about the more difficult aspects of their relationships. It is possible that these young people employed strategies such as emotional numbing and avoidance or denial to cope with the significant emotional impact of the inpatient environment, or that they experienced emotional blunting as a

result of psychiatric medication which impacted their subjective experiences. One participant appeared reluctant to engage in the interview and appeared to withhold, I reflected on their motivation for participating and wondered whether this was driven by the financial remuneration rather than a desire to share their experiences. I also thought about what I represented to the participants, the power dynamics that existed between us and their relational mistrust and how this will have influenced the experiences they shared. I relied on my clinical skills to elicit information from these participants, encouraging them to talk and engage with the interview topic through the development of a rapport. I noticed that participant's stage of progress through their admission influenced their accounts. Those who had experienced multiple admissions or who had an imminent discharge used more professional language, appeared more socialised to the system and appeared to have "seen it all".

Striking a balance between adhering to the interview schedule to elicit information I perceived relevant to the study objectives and encouraging adolescents to speak freely about what they considered to be significant was a challenge. Further, my joint role as a researcher and Trainee Clinical Psychologist influenced the way in which I responded to participants' distress. Maintaining the neutral, objective stance of a researcher whilst demonstrating empathy and validation for participants' difficult accounts was challenging. However, with this complex participant group, I perceived a degree empathetic listening was essential in order to facilitate engagement and to ensure that the interview process was not distressing in itself. During one interview, an issue of risk was disclosed leading to a safeguarding concern. As a clinician, I experienced a sense of powerlessness and helplessness in response to this, possibly mirroring the patients' experiences within the inpatient setting, an environment that

restricts their freedom. My supervisors were integral in enabling me to reflect on this and how it may influence my interactions. This safeguarding concern was highlighted to the Clinical Psychologist within the unit, who followed due Safeguarding Processes; no further action was taken following this.

I encountered practical difficulties associated with interviewing the young people within the ward environment. Due to the disruptive nature of the inpatient setting, the interviews were frequently interrupted by members of staff, and noise caused by other patients. I noticed how this impacted upon participants' engagement during the interview, and how at times they commented on the unfolding incidents occurring on the ward. It is possible that this influenced how safe patients felt within the interview context, thus potentially affecting their narrative.

The young people who participated in the current study reported the value of having the opportunity to express their views and perceptions. Unique insights have been gained into how peer relationships influence patients' lived experience of inpatient admission and participants were able to reflect on complex psychological processes which may enable the unit staff to improve the quality of care and therapeutic outcomes, and allow patients to feel empowered and develop their confidence. This highlights the importance of meaningful service-user involvement and co-produced research as an intrinsic aspect of developing adolescent-led services, mental health policy and service delivery (Thornicroft & Tansella, 2005). The lengthy process of obtaining ethical approval to conduct research within the National Health Service with such a vulnerable patient group was frustrating. Whilst safeguarding this population is

important, the potential negative consequences of limited research in this area should not be overlooked.

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Appendix A

Systematic Review Search Strategy: Young Peoples Experiences of Psychiatric inpatient units

Search strategy

Five major electronic databases were searched in December 2018. Search expanders and limiters include: English language, journal articles, apply related words and search within title. The search terms that were utilized were:

1. Adolescen* OR teenager* OR youth* OR young person OR youngster* OR juvenile* OR teen* OR young adult* OR child* OR children* OR male OR female OR girl OR boy OR young people*
AND
2. Experience* OR encounter* OR perception* OR insight* OR understanding* OR view* OR lived experience* OR feedback OR opinions OR thoughts OR awareness
AND
3. "CAMHS inpatient" OR "CAMHS inpatient unit*" OR "CAMHS inpatient ward" OR "CAMHS inpatient facility" OR "CAMHS inpatient service" OR "inpatient child and adolescent mental health service" OR "inpatient child and adolescent mental health ward" OR "inpatient child and adolescent mental health facility" OR inpatient OR "tier 4" OR "tier four" OR "psychiatric inpatient unit" OR "psychiatric inpatient ward" OR "psychiatric inpatient service" OR "psychiatric intensive care" OR PICU OR "psychiatric ward" OR

"psychiatric unit" OR "psychiatric service" OR "psychiatric hospital" OR
 "psychiatric facility" OR "inpatient unit" OR "psychiatric inpatient treatment"

Inclusion Criteria	Justification
1. Qualitative methodology	1. Attain rich in-depth accounts
2. Adolescent inpatient unit	2. Review focus
3. Focus on young people's inpatient experiences	3. Review focus
4. Young people population (aged 8-23 years old)	4. CAMHS and adult services utilise different therapeutic approaches ¹
5. Child and adolescent psychiatric inpatient context	5. To capture the uniqueness of this lived experience
6. Primary data (focus group or interview)	6. Anecdotal account
7. Papers published in English	7. To allow reading and critique of paper as translation unavailable
8. Papers accessible at full text	9. To allow reading and critique of
10. Published and unpublished literature	11. Emerging field with limited literature
Exclusion Criteria	Justification
1. Sample including staff or parental views	1. Not applicable to the review aims

¹ Winston, Paul & Juanola-Borrat (2011)

A total of 342 articles were identified by the search. Of these, 277 were excluded at title, including duplicates, as they did not meet the inclusion criteria. An additional 54 articles were screened out at abstract. Thirteen papers were deemed appropriate for

full-text screening. A total of 6 papers did not fulfil the inclusion criteria and were screened out; 2 as they were review articles (Goldfarb, 2010; Nielson, 2018), as the sample consisted of adults (Begley, 1998; Määttä, 2009), one as the sample contained staff (Ramjan & Gill, 2012) and one as the sample consisted of young children prior to adolescence (Sorsa, Ranta, Hartikainen & Paavilainen, 2006). A Google scholar and citation search identified two further papers (Moses, 2011; Sischy, 2006) and a hand-search of the included article references located one paper fulfilling the inclusion criteria (Hepper, Weaver & Rose, 2005). *Figure 1* outlines the process of journal selection.

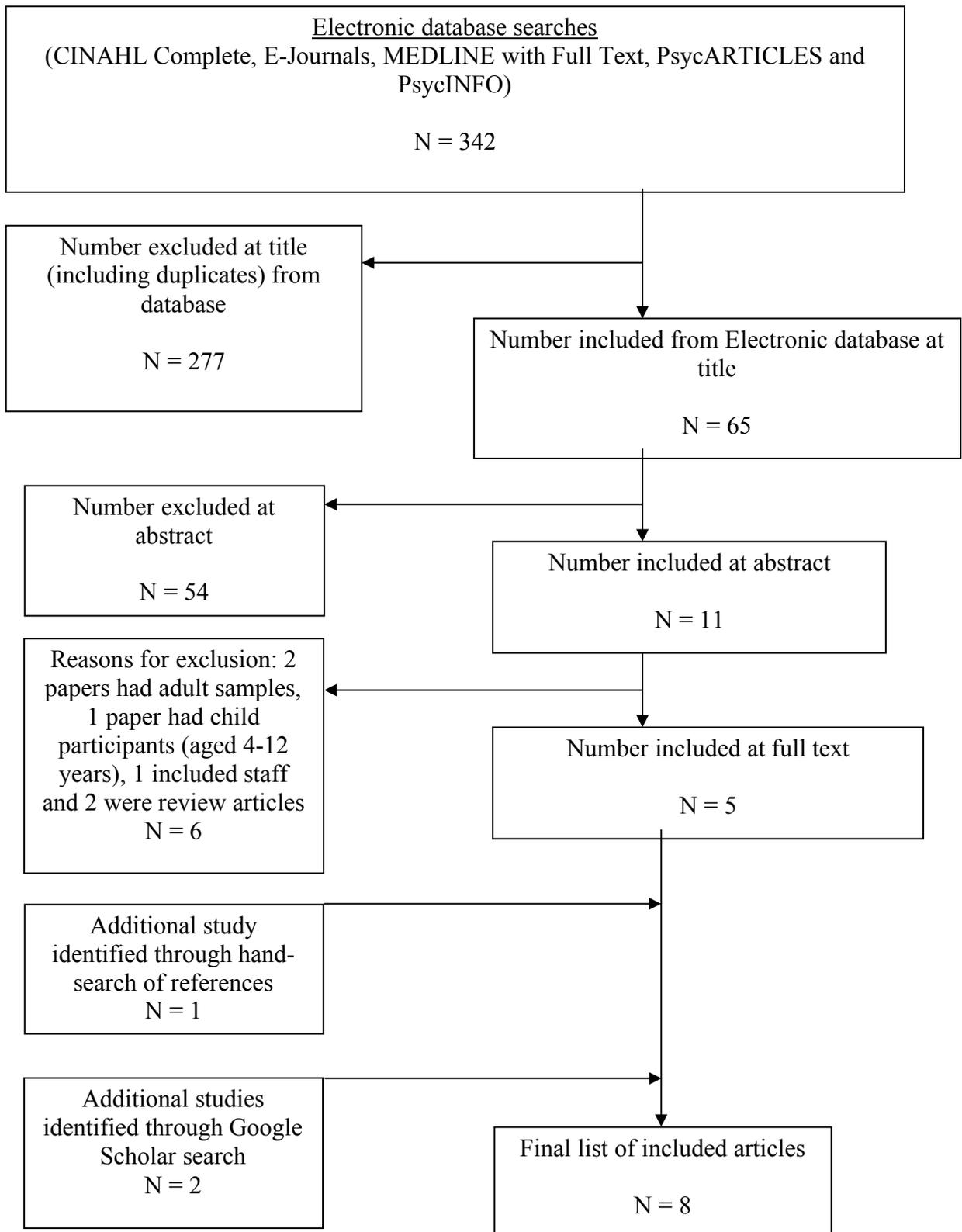


Figure 1. PRISMA diagram outlining the search strategy

Appendix B

Articles Included in Systematic Review

Overview of studies included in the review

Table 1

Author, date and location	Aims	Number, age and gender of participants	Recruitment	Methods	Summary of findings
Colton & Pistrang (2004) UK	Investigate how adolescents with eating disorders experience their inpatient treatment	19 participants Age: 15.4 All female	2 inpatient eating disorder units.	Semi-structured interviews	Participants struggled to understand their illness. They expressed ambivalence about recovery. They experienced other patients as a source of support and distress. They compared themselves with

					others resulting in a competitive environment. They felt they lost their identity and were not viewed as individuals by staff. Collaboration in treatment was considered important.
Gill, Butler & Pistrang, 2016 UK	Explore the advantages and disadvantages of inpatient care	12 participants Age: 16.3 2 male 10 male	3 adolescent inpatient units	Semi-structured interviews	Participants described the unit as a fake world. They found it hard to witness other patients' distressing behaviour. Supportive relationships and feeling understood were benefits. Patients and staff created a substitute family. Adolescents expressed fears of becoming dependant and attached to the unit. They valued routine and consistency and felt

					better able to manage their difficulties. Adolescents desired normality.
Haynes, Eivors & Crossley, 2011 UK	Explore adolescent inpatient care from the young people's perspective	10 participants Age: 16.7 4 male 6 female	2 inpatient units	Semi-structured interviews	Admission elicited strong emotional responses and impacted self-esteem and identity. Adolescents felt restricted and disconnected from their previous lives. They described polarised relationships with staff. Adolescents valued establishing new supportive relationships.
Hepper, Weaver & Rose, 2005 UK	How do young peoples make sense of their admission to a psychiatric inpatient unit?	18 participants Age: 8-13 11 males 7 females	Psychiatric inpatient unit	Semi-structured interviews	The young people valued the experience of containment and increasing their sense of agency. Learning strategies to manage their emotions was particularly helpful.

					The young people desired more collaboration in goal setting.
Moses, 2011 USA	Evaluating adolescents' experiences of psychiatric hospitalisation – what are helpful and unhelpful aspects	80 participants Aged: 15.3 61% female 39% male	Non-profit community hospital, psychiatric inpatient unit	Semi-structured interviews	Helpful aspects included interpersonal support, normalisation of experiences, feeling understood, and therapy. Unhelpful experiences related to feeling confined, witnessing frightening experiences, intrusive or uncaring staff and developmental needs not being met.
Offord, Turner & Cooper, 2006 UK	Investigate adolescents' experiences of inpatient admission for anorexia nervosa and discharge	14 participants Age: 16-23 All female	General inpatient units, outpatient clinics or recruited from past inpatient treatment records.	Semi-structured interviews	Adolescents felt disconnected from normality. They expressed that their developmental needs were not always met. Staff utilizing an authoritarian

			All had been discharged for 2-5 years prior to participation.		approach increased feelings of worthlessness and isolation.
Reavey et al., 2017 UK	How do adolescents experience inpatient admission from a social and emotional perspective?	20 participants Age: 16.8 8 male 12 female	Discharge group and treatment as usual group	Semi-structured interviews	Participants felt that they were under surveillance rather than being cared for. Valued peer and staff relationships and opportunity to develop trusting, open relationships. Medication played a key role in managing emotions. Some felt safe by the containment; others perceived the ward to have aspects of a punitive environment.

Sischy 2006 UK	Young people's experiences of peer and staff relationships within inpatient units	13 participants Age: 16 3 male 10 female	3 adolescent units	Semi-structured interviews	Relationships providing an opportunity to feel normal in the inpatient context, to feel understood accepted and supported through this difficult period and being able to have honest conversations about their feelings. Adolescents expressed difficulties in living with others with poor mental health, and how this may negatively influence them. They described experiences of not getting their needs met by staff, and feelings of despair and hope.
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Appendix C

Systematic Review: Quality Appraisal of Literature

Table 2

CASP Critical Appraisal for Qualitative studies included in the review (CASP, 2018)

	Appraisal Criterion									
	Clear aim?	Methodology appropriate?	Appropriate research design?	Appropriate recruitment strategy?	Appropriate data collection?	Considered researcher-participant relationship	Considered ethic issues?	Rigorous data analysis?	Clear findings?	
Journal Article										
Colton & Pistrang (2004)	2	2	2	2	2	1	1	2	2	
Gill, Butler & Pistrang, 2016	2	2	2	2	2	1	2	2	2	

Haynes, Eivors &	2	2	2	2	2	2	1	2	2	2
Crossley, 2011										
Hepper, Weaver &	2	2	2	2	2	2	1	2	2	1
Rose, 2005										
Moses, 2011	2	2	2	2	2	2	1	2	2	1
Offord, Turner &	2	2	2	2	2	2	1	2	2	2
Cooper, 2006										
Reavey et al., 2017	2	2	2	2	2	2	1	1	2	2
Sischy 2006	2	2	2	2	2	1	2	2	2	2

Note. 2 = yes, 1 = can't tell, 0 = no; * identification of future research, discussion of findings in relation to current literature, policy or practice and acknowledgement of transferability of results.

Appendix D

NHS Ethical Approval Letter



Miss Lucy Dalzell

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

16 April 2018

Dear Miss Dalzell

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

Study title: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient Child and Adolescent Mental Health Service (CAMHS)
IRAS project ID: 229179
REC reference: 18/LO/0294
Sponsor: University of Essex

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

How should I continue to work with participating NHS organisations in England and Wales?

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

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

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

IRAS project ID	229179
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You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

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

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

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

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

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

How should I work with participating non-NHS organisations?

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

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

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

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

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

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

The sponsor contact for this application is as follows:

Name: Lucy Dalzell



Who should I contact for further information?

IRAS project ID	229179
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Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **229179**. Please quote this on all correspondence.

Yours sincerely,



Copy to:



IRAS project ID	229179
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List of Documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance letter]		15 July 2017
HRA Schedule of Events	1	13 February 2018
HRA Statement of Activities	1	13 February 2018
Interview schedules or topic guides for participants [Interview schedule]	1	03 October 2017
IRAS Application Form [IRAS_Form_30012018]		30 January 2018
Letter from sponsor [Sponsor letter]		09 January 2018
Non-validated questionnaire [Demographics questionnaire]	1	03 October 2017
Other [Additional notes on PIS and decision to not obtain parental consent for over 16's]	1	03 December 2017
Other [Remuneration letter]	1	22 August 2017
Other [Proposal feedback]	1	28 April 2017
Other [Public liability]	2	10 April 2018
Other [Evidence of conditions being met]	2	10 April 2018
Other [Parent PIS]	2	20 March 2018
Other [PIS 13-15 year olds]	2	20 March 2018
Other [PIS 16-18]	2	20 March 2018
Participant consent form [Assent form 13-15 year olds]	1	21 November 2017
Participant consent form [Participant consent form 16-18 year olds]	1	21 November 2017
Participant consent form [Parental consent form]	1	22 August 2017
Research protocol or project proposal [Project proposal]	1	04 April 2017
Summary CV for Chief Investigator (CI) [Chief investigator CV]	1	03 October 2017
Summary CV for supervisor (student research) [Supervisor cv]	1	04 June 2017

IRAS project ID	229179
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Summary of assessment

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

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	This is a non-commercial, single site study taking place in the NHS. A Statement of Activities has been submitted. This will act as the agreement between sponsor and participating NHS organisations. No other agreements are expected.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	Sponsor is not providing funding to participating NHS organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	
5.3	Compliance with any	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	applicable laws or regulations		
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	
6.3	Devices – MHRA notice of no objection received	Not Applicable	
6.4	Other regulatory approvals and authorisations received	Not Applicable	

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a non-commercial, single site study. There is one site-type involved in the research. Activities and procedures as detailed in the protocol will take place at participating NHS organisations.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If Chief Investigators, sponsors or Principal Investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the Chief Investigator, sponsor or Principal Investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator (PI) is expected at participating NHS organisations. Sponsor does not expect research staff to undertake any specific or additional training for the research.

IRAS project ID	229179
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GCP training is not a generic training expectation, in line with the [HRA/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

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

No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

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

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

Appendix E

Trust Approval Letter

13th June 2018

Miss Lucy Dalzell

Dear Lucy

Research Project Title: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient Child and Adolescent Mental Health Service (CAMHS)

IRAS Project ID: 229179
REC Reference: 18/LO/0294
Sponsor: University of Essex

Further to my e-mail of 16th May 2018 confirming capacity and capability on behalf of [REDACTED] for your project to proceed please accept this letter as approval and support for your project on behalf of the Trust.

As your project is in receipt of Health Research Authority (HRA) approval and NHS Research Ethics approval you are bound by their terms and conditions which [REDACTED] accepts and follows the same. Please note that any information sheets/consent forms etc. used for participants recruited from [REDACTED] should be provided to individuals on [REDACTED] letter headed paper. Furthermore as a participating site you should keep us informed via HRA and REC of any changes to the approved documents and/or conduct of the study together with providing progress updates and a copy of the final outcomes report should be sent to me within 3 months of its completion.

I would also like to take this opportunity of advising that any external publication of the outcome findings must be submitted to me for review by the relevant [REDACTED] Research senior management team before sending to a publisher. Additionally I would ask that you supply a summary or abstract of the project that would be suitable for dissemination within the Trust.

Finally as a reminder you must report any adverse events/serious untoward incidents relating to this project to me as soon as practicable, I can be contacted by telephone on [REDACTED] or via e-mail. In addition, you must complete one of the Trust's adverse incident forms and follow the requirements as set out in the Trust's adverse incident reporting policy. A copy of this form must be submitted to **me** as soon as possible. A copy of the Trust's adverse incident reporting policy can be located on the Trust's intranet or alternatively, please contact me and I will be happy to supply you with a copy.

I wish you all the best and look forward to hearing the outcomes of the project in due course.

Please do not hesitate to contact me further for any assistance.

Kind regards

Yours sincerely



cc. by e-mail:



Appendix F

University of Essex Ethical Approval

15 October 2019

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Dear Lucy,

Re: Ethical Approval Application (Ref 17037)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

[REDACTED]

Ethics Administrator

School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Appendix G
Participant Information Sheets

Participant Information Sheet for 16-18 year olds

Title of the project: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting

Name of Chief Investigator: Lucy Dalzell, Trainee Clinical Psychologist

Supervised by: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Introduction

You are invited to take part in a research project. Before deciding whether to take part, it is important for you to understand the purpose of the research and what it will involve. Please carefully read this information sheet. If you have any questions about the research, please contact [REDACTED]. If you decided to take part in the research, Lucy will go through this sheet with you and answer any questions that you may have.

Thank you for taking the time to read this information sheet.

Part one: Information to help you decide if you would like to take part.

1. Why is this research being conducted?

This research project is being completed as part of a Doctorate in Clinical Psychology course being completed by Lucy at the University of Essex. The study aims to explore adolescent experiences of peer relationships within the inpatient setting and the impact that these may have on well-being. In this study peer relationships can be defined as relationships, both positive and negative, with other young people on the unit. There is currently very little research investigating adolescent inpatients experiences of peer relationships on inpatient units. Examining and understanding patient's experiences may allow child and adolescent mental health services to think about how to best manage relationships on the unit and how to support patients.

2. Why have I been invited?

You have been invited to participate as Lucy is interested in hearing about the experiences of adolescent who are currently admitted as inpatients at the [REDACTED]

██████ She hopes to interview between 15-20 adolescents. You may be suitable to participate in the research and may like to share your experiences.

3. Who can participate?

You may be able to participate if you:

- Have been admitted to ██████████ a minimum for 4 weeks
- Are aged between 13-18 years old
- Are a detained or informal patient
- Are an English speaker

4. Do I have to take part?

No, you do not have to take part in the project. Participation is entirely voluntary. If you decide not to take part, this will not affect the treatment that you receive, your length of admission or your legal status under the Mental Health Act. If you decide that you would like to take part, Lucy will meet with you to discuss the study in more detail. You will be asked to sign a consent form before taking part. If you start the study but change your mind at any point, you can ask to stop without giving any reason.

5. What will happen if I decide to take part?

If you decide to take part in the research project, please inform ████████ who will arrange a time for Lucy to meet with you to discuss the study in more detail and answer any questions that you may have. Lucy will check that you understand what taking part will involve and that you are happy to participate. You will then have a minimum of 2 days to think about taking part. Following this time, Lucy will meet with you again to establish if you are happy to participate. After this, you will be asked to sign a consent form. Once you have signed the consent form, you will take part in an interview with Lucy. This interview will last approximately 1 hour. There will be 10 minutes at the end of the interview to have some time to think about how you found taking part in the study and to ask any questions you might have.

The interview will take place at ██████████ in a private room. The interview will be recorded using a digital audio recorder. During the interview, you will be asked to share your experiences of peer relationships on the unit. No patient names should be used during the interview. At the end of the interview, Lucy will ask you if you are still happy to participate and how you feel about the information that you have given. If you are unhappy with any of the information that you have shared being presented in the findings, this can be removed. Once the interview is over, you will not meet with Lucy again.

You are free to withdraw from the study at any time, without having to give a reason and without it affecting your treatment. Taking part in this research will not affect the treatment that you receive at ██████████ in any way.

6. Will I get paid to take part?

If you decide to take part in the study, you will be given a one-off gift of £10. This gift is an appreciation for you giving you time to participate and sharing your experiences. Lucy will provide you with an envelope containing this financial gift once you have finished participating.

7. Are there any disadvantages to participating?

Some people may find that discussing their experiences causes distress. During the interview, you do not have to talk about anything that you do not wish to. If you feel uncomfortable when talking, let Lucy know and you will not be asked to discuss it further. If following the interview, you feel upset about the things that you have discussed, please contact [REDACTED] who will be available to talk about this further.

As the interview will take place at [REDACTED], other patients and members of staff will be aware that you are taking part in the study. They will not be told about your specific experiences or about the content of your interview. When the research is written up, the information that you provide will be disguised, as much as it can be, so that you cannot be directly linked to the results. However direct quotes will be written up in the results, it is possible that you may be identifiable from the experiences that you share. Please inform [REDACTED] if you experience any negative consequences as a result of taking part in the study.

8. Are there any advantages to participating in the study?

We cannot guarantee that the research will directly be of advantage to you. It is possible that you will find it interesting and helpful to have a chance to share your experiences. We hope that the results from this study will benefit adolescent inpatients at [REDACTED] by helping staff to understand about patient's experiences and their needs. You will also be offered £10 in cash to say thank you for giving up your time to participate

9. What will happen after the study finishes?

When the research finishes, all participants who have expressed an interest in receiving the results, will be given a summary of the findings which will be sent via post. The study findings will also be presented to the service staff at [REDACTED]

Personal information which may identify you, for example your name, will be disguised so that you are not obviously identifiable within the study findings. However, you may still be identifiable by the information that you provide, as direct quotes will be used in the results.

The project will be submitted to the University of Essex as part of a Doctorate Course in Clinical Psychology. The findings will be written up and submitted to

academic journals and presented as national conferences. A summary of the finding will be provided to policy makers, service providers and academic researchers.

10. Will the information that I provide be kept confidential?

Lucy will not have access to your medical records. If you agree to participate, your interview will be kept anonymously by removing any personally identifiable information, such as your name, from the results. The interviews will be audio recorded, so that Lucy has an accurate account of your interview, however this will only be listened to by Lucy and her supervisor and then deleted from the recording device. Lucy will transcribe the interview and a written account stored on a secure drive at Essex University that only Lucy and her supervisors can access. The research team, including Lucy's supervisors, will have access to the anonymous data.

Lucy will follow legal guidelines and therefore all information will be kept confidentially, except where:

- Your safety is at risk
- There are concerns about the safety of others

If Lucy believes that there is a potential risk to either yourself, or others, she will share this information with the staff team at [REDACTED]. The other information that you have disclosed within your interview will not be divulged. This information may be shared with other services, outside of [REDACTED] (e.g. the police or social services). Lucy will let you know before this information is shared. If during the course of the interview, you disclose information which suggests professional misconduct by a member of staff, Lucy will have a duty to share this information. She will inform you if this information is shared.

11. What will happen to the information that I provide?

Interviews will be audio-recorded and only available for Lucy and her supervisor to listen to. The interview will be written out by Lucy and the audio-recording destroyed once Lucy's supervisor has checked that the written account is the same as what was recorded. Personal information will be disguised (e.g. your name and the name of the service) and the written account will be protected with a password and stored on a computer kept on a secure drive at the University of Essex. The written accounts will be kept by the University of Essex School of Health and Human Sciences for up to 5 years so that articles can be written.

Only Lucy will have access to your identifiable data and it will not be transferred outside of the United Kingdom. Your data will not be used in any future research project, other than the one that you have consented to take part in. The Data Protection Act (1998) will be fully adhered to.

12. What happened if I decide that I no longer wish to continue with the research?

If you decide that you would no longer like to carry on with the research and wish to withdraw, either during the interview or afterwards, please let [REDACTED] know. [REDACTED] will contact Lucy and the information that you have already provided will be used within the study, but no further information will be gathered from you.

13. What can I do if I am unhappy with the research?

If you are unhappy with an aspect of the project, please contact [REDACTED] who will be happy to address your concerns. If you still feel that the problem was not resolved and wish to make a formal complaint you can contact [REDACTED]

sarahm@essex.ac.uk

Independent Advice

If you would like independent advice about taking part in research, please ask a member of staff to help you to contact the Patient Advice and Liaison Service.

14. Who is funding and organising the research?

The project is sponsored by the University of Essex and is being completed by Lucy as part of a Doctorate qualification in Clinical Psychology. The staff at [REDACTED] [REDACTED] are not being paid or receiving any incentive for you taking part in the study.

15. What has reviewed the study?

Research conducted in the National Health Service is reviewed by the Research Ethics Committee, an independent group of individuals who protect the interests of patients. The research has been given approval by [REDACTED] [REDACTED] and by the managerial team at [REDACTED].

What happens now?

If you decide that you would like to participate in the research or have any questions, please contact [REDACTED]. You can either approach [REDACTED] directly on the ward, or ask a member of the nursing staff to arrange for you to meet with her. [REDACTED] will contact Lucy to let her know that you are interested in taking part. Lucy will arrange to meet with you to discuss the study further and to answer any questions that you might have.

Thank you for taking the time to read this information.

Participant Information Sheet for 13-15 year olds

Title of the project: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting

Name of Chief Investigator: Lucy Dalzell, Trainee Clinical Psychologist

Supervised by: [REDACTED]
[REDACTED]
[REDACTED]

Introduction

Lucy would like you to help her with her research project. Before deciding whether to take part, please carefully read this information and talk with your mum, dad or carer. If you have any questions about the research, please talk to [REDACTED]. If you decided to take part in the research, Lucy will go through this sheet with you and answer any questions that you may have. Take your time to decide if you would like to participate. It is completely up to you if you would like to take part. It is fine if you don't, you'll be looked after in the unit just the same.

Thank you for taking the time to read this information sheet.

Information about the research project

16. Why are we doing this research?

This research project is being completed as part of a Doctorate in Clinical Psychology course being completed by Lucy at the University of Essex. Lucy wants to find out more about adolescent's experiences of peer relationships in the inpatient unit and the impact that these may have on well-being. In this study peer relationships can be defined as relationships, both positive and negative, with other young people on the unit. Understanding adolescent's experiences may help the team to think about how to support patients.

17. Why have I been asked to take part?

You have been asked to take part because you are currently an inpatient [REDACTED]. You may be suitable to take part in the research and may like to share your experiences. The staff at [REDACTED] will decide if you are suitable to take part. Your parents/carer also need to agree for you to take part. Lucy hopes to interview between 15-20 adolescents.

18. Do I have to take part?

No, you do not have to take part in the research. It is entirely up to you. If you decide not to take part, this will not impact your treatment at [REDACTED] in any way.

If you decide to take part:

- Lucy will ask your parent/carer to give their permission for you to take part in the research.

- If your parents say “yes”, Lucy will meet with you to discuss the study in more detail.
- You will be asked to sign a form to say that you agree to take part (an assent form).

If your parents say “yes” but you don’t want to take part, you don’t have to participate. Taking part in this study is up to you and no one will be upset if you don’t want to do this.

You are free to stop taking part at any point during the research. You do not have to give a reason for this decision. If you decide to stop, this will not affect the care that you receive at [REDACTED] in any way.

19. What will happen to me if I decide to take part?

If you decide to take part in the research project, please tell [REDACTED] will contact your parent/carer and ask for their permission for you to take part. If they agree, Lucy will meet with you to discuss the study in more detail and answer any questions that you may have. Lucy will check that you understand what taking part will involve and that you are happy to participate.

You will then have at least of 2 days to think about taking part. After this, Lucy will meet with you again to check if you are happy to take part. You will be asked to sign a form to say that you agree to take part. Once you have signed this form, you will take part in an interview with Lucy. This interview will last about 1 hour. There will be 10 minutes at the end of the interview to ask any questions you might have.

20. What will I be asked to do?

The interview will take place at [REDACTED] in a private room. So that Lucy remembers the interview correctly, it will be recorded using an audio recorder. During the interview, you will be asked to share your experiences of peer relationships on the unit. No patient names should be used during the interview. At the end of the interview, Lucy will ask you if you are still happy to participate and how you feel about the information that you have given. If you are unhappy with any of the information that you have shared, this can be removed. Once the interview is over, you will not meet with Lucy again.

21. Will I get paid to take part?

If you decide to take part in the study, you will be given a one-off gift of £10. This gift is a thank you for you giving you time to participate and sharing your experiences. Lucy will provide you with an envelope containing this gift once you have finished participating.

22. Are there any disadvantages to participating?

Some people may find that talking about their experiences makes them upset. During the interview, you do not have to talk about anything that you do not want to. If you feel uncomfortable when talking, let Lucy know. If after the interview you feel upset about the things that you have talked about, please tell [REDACTED] who will be available to talk about this.

As the interview will take place at [REDACTED], other patients and members of staff may be aware that you are taking part in the study. They will not be told about what you say during your interview.

The study will be written up and quotes will be included in the results. All personal information will not be included, but it is possible that people may know who you are from the experiences that you share. Please inform [REDACTED] if you experience any distress as a result of taking part in the study.

23. Will the study help me?

We cannot be sure that the study will help you. It is possible that you will find it interesting and helpful to have a chance to share your experiences. We hope that the results from this study will benefit adolescent at [REDACTED] by helping staff to understand about patients experiences and their needs. You will also be offered £10 in cash to say thank you for giving up your time to take part.

24. What if I don't want to do the research anymore?

Just tell, Lucy, [REDACTED] or your parents/carer. No one will be cross with you. You will still have the same care at [REDACTED].

25. What will happen when the research study stops?

When the research stops, all participants who would like to, will be given a summary of the findings which will be sent by post. The study findings will also be presented to the staff at [REDACTED].

The project will be given to the University of Essex as part of Lucy's Doctorate in Clinical Psychology. The results may be put in psychology magazines and papers that people working in mental health read.

26. Will the information that I provide be kept confidential?

Lucy will not have access to your medical records. If you agree to take part, all personal information, such as your name, will be removed from your interview. The results will be anonymous, which means that you should not be able to be identified from them.

The interviews will be audio recorded, so that Lucy has a correct account of your interview. This will only be listened to by Lucy so that she can write up your interview. It will then be deleted. Lucy's supervisors will have access to your written interview once personal information has been taken out.

All information will be confidential, except where:

- Your safety is at risk
- There are concerns about the safety of others

If Lucy thinks that there is a possible risk to either yourself, or others, she will share this information with the staff team at [REDACTED]. This information may be shared with services outside of [REDACTED] (e.g. the police or social services). Lucy will let you know before this information is shared. If you

share information about a member of staff's behaviour that worries Lucy, she will have to share this information. She will tell you if this information is shared.

27. What if there is a problem?

If there is a problem you can tell Lucy or [REDACTED] and they will try to sort it out straight away. Your or your parents or carer can contact [REDACTED] or if you would like to make a complaint or the Research Governance and Planning Manager:



28. Independent Advice

If you would like advice from outside of [REDACTED] about taking part in the research, please ask a member of staff to help you to contact the Patient Advice and Liaison Service.

29. Who is funding and organising the research?

The project is sponsored by the University of Essex and is being completed by Lucy as part of a Doctorate course in Clinical Psychology. The staff at [REDACTED] [REDACTED] are not being paid for you taking part in the study.

30. Who has checked the study?

Before research goes ahead in the National Health Service (NHS), it is checked by a Research Ethics Committee. This is a group of people who make sure that the research is okay to do. The managers at [REDACTED] [REDACTED] have also said that the study can go ahead.

What happens now?

If you decide that you would like to participate in the research or have any questions, please contact [REDACTED]. You can either approach [REDACTED] directly on the ward, or ask a member of the nursing staff to arrange for you to meet with her. [REDACTED] will contact Lucy to let her know that you are interested in taking part. Lucy will arrange to meet with you to discuss the study further and to answer any questions that you might have.

Thank you for taking the time to read this information.

Parent/Guardian Information Sheet

Title of the project: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting

Name of Chief Investigator: Lucy Dalzell, Trainee Clinical Psychologist

Supervised by: [REDACTED]
[REDACTED]
[REDACTED]

Introduction

Your child/child for whom you are a legal guardian for, are invited to take part in a research project. Before deciding whether or not they can to take part, it is important for you to understand the purpose of the research and what it will involve. Please carefully read this information sheet. If you have any questions about the research, please contact [REDACTED] and she can arrange a time for you to meet with Lucy to discuss the study in more depth. If you consent to the young person taking part in the research, Lucy will go through an information sheet with them and answer any questions that they might have.

Thank you for taking the time to read this information sheet.

31. Why is this research being conducted?

This research project is being completed as part of a Doctorate in Clinical Psychology course being completed by Lucy at the University of Essex. The study aims to explore adolescent experiences of peer relationships within the inpatient setting and the impact that these may have on well-being. In the current study peer relationships can be defined as relationships, both positive and negative, with other young people on the unit. There is currently very little research investigating adolescent inpatients experiences of peer relationships on the unit. Examining and understanding patient's experiences may allow child and adolescent mental health services to think about how to best manage relationships on the unit and how to support patients.

32. Why have they been invited to participate?

They have been invited to participate as Lucy is interested in hearing about the experiences of adolescent who are currently admitted as inpatients at [REDACTED]. She hopes to interview between 15-20 adolescents. Your child/child for whom you are a legal guardian for may be suitable to participate in the research and may like to share their experiences.

33. Who can participate?

Adolescents are eligible to participate if they:

- Have been admitted [REDACTED] for a minimum for 4 weeks
- Are aged between 13-18 years old
- Are a detained or informal patient

- Are an English speaker

34. Do they have to take part?

No, they do not have to take part in the project. Participation is entirely voluntary. If the young person does take part, this will not affect the treatment that they receive, their length of admission or their legal status under the Mental Health Act. If you decide that they can take part, Lucy will meet with the young person to discuss the study in more detail. You will be asked to sign a consent form and they will be asked to sign an assent form before they can take part. If they start the study but change their mind at any point, they can ask to stop without giving any reason.

35. What will happen if I consent to them taking part?

If you decide that they can take part in the research project, please inform [REDACTED]. You will be required to sign a consent form. Following this, [REDACTED] will arrange a time for Lucy to meet with the young person to discuss the study in more detail and answer any questions that they may have. Lucy will check that they understand what taking part will involve and that they are happy to participate. They will then have a minimum of 2 days to think about taking part. Following this time, Lucy will meet with them again to establish if they are happy to participate. They will be asked to sign an assent form, confirming that they are happy to participate. Once they have signed the assent form, they will take part in an interview with Lucy. This interview will last approximately 1 hour. There will be 10 minutes at the end of the interview to have some time to think about how they found taking part in the study and to ask any questions that they might have.

The interview will take place at [REDACTED] in a private room. The interview will be recorded using a digital audio recorder. During the interview, the young person will be asked to share their experiences of peer relationships on the unit. The names of other young people on the unit must not be used during the interview. At the end of the interview, Lucy will ask if they are still happy to participate and how they feel about the information that they have given. If they are unhappy with any of the information that they have shared being presented in the findings, this can be removed. Once the interview is over, they will not meet with Lucy again.

The young person is free to withdraw from the study at any time, without having to give a reason and without it affecting their treatment. Taking part in this research will not affect the treatment that they receive at [REDACTED] in any way.

36. Will they get paid to take part?

If the young person does take part in the study, they will be given a one-off gift of £10. This gift is an appreciation for them giving their time to participate and sharing their experiences. Lucy will provide the young person with an envelope containing this financial gift once they have finished participating.

37. Are there any disadvantages to participating?

Some people may find that discussing their experiences causes distress. During the interview, the young person does not have to talk about anything that they do not wish to. If they feel uncomfortable when talking, they have been informed to let Lucy know and they will not be asked to discuss this further. If following the

interview, they feel upset about the things that they have discussed, they are asked to contact [REDACTED] who will be available to talk about this further.

As the interview will take place at [REDACTED], other patients and members of staff may be aware that the young person is taking part in the study. They will not be told about their specific experiences or the content of the interview. The information that the young person provides will be disguised, as much as it can be, so that they cannot be directly linked to the results. However direct quotes will be written up in the results, it is possible that they may be identifiable from the experiences that they share. They have been asked to inform [REDACTED] if they experience any negative consequences as a result of taking part in the study.

38. Are there any advantages to participating in the study?

We cannot guarantee that the research will directly be of advantage to the young person. It is possible that they will find it interesting and helpful to have a chance to share their experiences. We hope that the results from this study will benefit adolescent inpatients at [REDACTED] by helping staff to understand about patient's experiences and their needs. They will also be offered £10 in cash to say thank you for giving up their time to participate.

39. What will happen after the study finishes?

When the research finishes, all participants who have expressed an interest in receiving the results, will be given a summary of the findings which will be sent via post. The study findings will also be presented to the service staff at [REDACTED]

Personal information, which may identify the young person, for example their name, will be disguised so that they are not obviously identifiable within the study findings. However, they may still be identifiable by the information that they provide, as direct quotes will be used in the results.

The project will be submitted to the University of Essex as part of a Doctorate Course in Clinical Psychology. The findings will be written up and submitted to academic journals and presented at national conferences. A summary of the findings will be provided to policy makers, service providers and academic researchers.

40. Will the information provided be kept confidential?

Lucy will not have access to the young person's medical records. The young person's interview will be kept anonymously by removing any personally identifiable information, such as their name, from the results. The interviews will be audio recorded, so that Lucy has an accurate account of the interview, however this will only be listened to by Lucy and her supervisor, before it is deleted from the recording device. The interview will be transcribed by Lucy and the written account will be stored on a secure drive at Essex University that only Lucy and her supervisor can access. The research team, including Lucy's supervisors, will have access to the anonymous data.

Lucy will follow legal guidelines and therefore all information will be kept confidentially, except where:

- The young person's safety is at risk

- There are concerns about the safety of others

If Lucy believes that there is a potential risk to either the young person, or others, she will share this information with the staff team at [REDACTED]. The other information that is disclosed within the interview will not be divulged. This information may be shared with other services, outside of [REDACTED] (e.g. the police or social services). Lucy will let the young person know before this information is shared. If during the course of the interview, they disclose information which suggests professional misconduct by a member of staff, Lucy will have a duty to share this information. She will inform the young person if this is the case.

41. What will happen to the information that is provided?

Interviews will be audio-recorded and only available for Lucy and her supervisor to listen to. The interview will be written out by Lucy and the audio-recording destroyed once Lucy's supervisor has checked that the written account is the same as what was recorded. Personal information will be disguised (e.g. names and the name of the service) and the written account will be protected with a password and stored on a computer kept on a secure drive at the University of Essex. The written accounts will be kept by the University of Essex School of Health and human Sciences for up to 5 years so that articles can be written.

Only Lucy will have access to the young person's identifiable data and it will not be transferred outside of the United Kingdom. The data will not be used in any future research project, other than the once that you have consented for the young person to take part in. The Data Protection Act (1998) will be fully adhered to.

42. What happened if the young person decides that they no longer wish to continue with the research?

If they decide that they would no longer like to carry on with the research and wish to withdraw, either during the interview or afterwards, they have been asked to let [REDACTED] know. [REDACTED] will contact Lucy and the information that the young person has already provided will be used within the study, but no further information will be gathered.

43. What if the young person or I are unhappy with the research?

If you or the young person are unhappy with an aspect of the project, please contact [REDACTED] who will be happy to address your concerns. If you still feel that the problem is not resolved and wish to make a formal complaint you can contact [REDACTED]

44. Independent Advice

If you or the young person would like independent advice about taking part in research, please contact the Patient Advice and Liaison Service.

45. Who is funding and organising the research?

The project is sponsored by the University of Essex and is being completed by Lucy as part of a Doctorate qualification in Clinical Psychology. The staff at [REDACTED]

██████████ are not being paid or receiving any incentive for the young person taking part in the study.

46. What has reviewed the study?

Research conducted in the National Health Service is reviewed by the Research Ethics Committee, an independent group of individuals who protect the interests of patients. The research has been given approval by ██████████ and by the managerial team at ██████████

What happens now?

If you have any questions or decide that you are happy for your child/child for whom you are a legal guardian to participate in the research, please contact ██████ at the ██████████ You will be required to sign a consent form. If you would like to discuss the study in more depth, ██████ will arrange a time for you to meet with Lucy. If you consent to the young person taking part, Lucy will arrange to meet with them to discuss the study further and to answer any questions that they might have.

Thank you for taking the time to read this information.

Appendix H

Parental Consent Form

Project title: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting

Name of researcher: Lucy Dalzell (Trainee Clinical Psychologist)

I have read the participant information sheet and have had the opportunity to ask questions about the above research project, which have been answered satisfactorily and I understand what the participant's role in it will be.

I understand that participation in this research project is entirely voluntary and that participants are free to withdraw at point in time without giving an explanation and that this will not affect their treatment.

I understand that participating in this research project will not affect the participant's mental health treatment or their legal status under the Mental Health Act.

I understand that participant's do not have to discuss any topics that they do not wish to talk about.

I understand that participant's role in the research will involve an interview with the researcher which will be digitally audio-recorded and that a disguised written account of their interview to be stored for up to 5 years by the University of Essex.

I consent to direct quotes from the participant's interview being used within; academic reports, conference papers, research articles, policy makers and service-providers. I understand that their personal details and information will be disguised so that they cannot be easily identified. However, there is a risk that they could be identified in the report where direct quotes from their interview are used.

I understand that the information that the participant provides in their interview will be treated confidentially except in instances where; they or someone else is at risk or if they share information suggesting professional misconduct by a member of staff. If Lucy is concerned about risk or safeguarding, she has a duty to share this information with the clinical team.

I agree for my child/child for whom I am a legal guardian for, to take part in the above research project.

I understand that if Lucy is concerned during the course of the interview, that the participant no longer appears to have capacity to consent to participate in the study, the interview will be terminated.



Parent/guardian name
parent/guardian

Relationship to young person

Signature of

Name of person taking consent

Date

Signature

Appendix I

Participant Consent Form

Project title: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting

Name of researcher: Lucy Dalzell (Trainee Clinical Psychologist)

I have read and understood the research information sheet for the above research project.

I have had the opportunity to ask questions about the above research project, which have been answered satisfactorily and I understand what my role in it will be.

I understand that my participation in this research project is entirely voluntary and I am free to withdraw at point in time without giving an explanation and that this will not affect my treatment.

I understand that participating in this research project will not affect my mental health treatment or my legal status under the Mental Health Act.

I understand that I do not have to discuss any topics that I do not wish to talk about.

I understand that my role in the research will involve an interview with the researcher which will be digitally audio-recorded and that a disguised written account of my interview to be stored for up to 5 years by the University of Essex.

I consent to direct quotes from my interview being used within; academic reports, conference papers, research articles, policy makers and service-providers. I understand that personal details and information will be disguised so that I cannot be easily identified. However, there is a risk that I could be identified in the report where direct quotes from my interview are used.

I understand that the information that I provide in my interview will be treated confidentially except in instances where; I or someone else is at risk or if I share information suggesting professional misconduct by a member of staff. If Lucy is concerned about risk or safeguarding, she has a duty to share this information with the clinical team.

I agree to take part in the above research project.

I understand that if Lucy is concerned during the course of the interview, that I no longer appear to have capacity to consent to participate in the study, the interview will be terminated.

I understand that data collected during the study may be looked at by individuals from the University of Essex, from regulatory authorities or from the NHS Trust. Where it is relevant to my taking part in this research I give permission for these individuals to have access to my data.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

Assent to Participate in Research Form: 13-15 year olds

Title of the project: A qualitative study exploring adolescents lived experiences of peer relationships in an inpatient CAMHS setting.

Name of researcher: Lucy Dalzell, Trainee Clinical Psychologist.

Please tick in the boxes if you agree with the following statements:

I have read and understand the information about the study

I have asked all the questions about the study that I want to

All of my questions about the study have been answered

I have been told everything that I want to know about taking part

I know that I can stop taking part in the study at any time, for any reason and that this will not affect my treatment in any way

I agree to take part in the study

If you have not ticked all the boxes or you do not want to take part, do NOT sign your name.

If you do want to take part in the study, please sign your name below:

Name of participant

Date

Signature of participant

The researcher who explained this research to you also needs to sign below:

Name of researcher

Date

Signature of researcher

Appendix J

Demographic Questionnaire

Participant Demographic Information Questionnaire

1. Age Group (please circle): 11-13 14-17 18-24

2. Gender:

3. Ethnicity: _____

4. Mental health diagnosis:

.....
.....

5. Previous treatment:

Hospital admissions (please circle one) 0 1 2 3 4 5+

Average length of stay in hospital (if appropriate).....

6. Current treatment:

Length of current stay.....

Appendix K

Interview Schedule

1. Interview Introduction (once consent form has been signed)
2. Participant Introduction To gather relevant background information and to establish rapport a. Reasons for participating b. Length of stay on unit c. Age of participant d. Ethnicity of participant e. Gender that the participant identifies with f. Progress since admission g. Experiences of being on the unit – positive and negative
3. Area 1: Experience of peer relationships a. “If you think about your relationship with a young person you’re closest to on the unit.... Prompts • What works well in this relationship • What is difficult about this relationship • How does it affect your time on the unit? • Impact upon you getting better • Purpose of relationships • Quality of relationships • What peer relationships mean to the participant • Value of peer relationships
4. Area 2: Impact of peer relationships on wellbeing b. “Can you tell me about the effect that friendships in the unit have on your wellbeing?” Prompts • Impact on wellbeing • What wellbeing means to the participant • Effect on the wider unit • How they make you feel in general/about self • Support from staff • Being discharged from the unit and leaving friends behind • Friends being discharged from the unit • Impact of seeing others who do not have friends on the unit • Witnessing bullying/ being bullied

<ul style="list-style-type: none"> • Staying in contact with patients who have been discharged from the unit
<p>5. Area 3: Observations of peer relationships</p> <p>c. “Can you tell me about relationships that you have observed on the unit?”</p> <p>Prompts</p> <ul style="list-style-type: none"> • How would they describe these peer relationships (positive/negative) • Impact on the unit and on other patients • Personal impact
<p>6. Area 4: Staff management of relationships</p> <p>d. “Can you tell me about how staff manage relationships and friendships between young people on the unit?”</p> <p>Prompts</p> <ul style="list-style-type: none"> • Can you think of a time when staff intervened in young peoples’ relationships? • Is this generalizable • Response from staff • Reactions from other patients to staff intervention • Changes to management that they feel would be beneficial
<p>7. Area 5: Factors influencing relationship development</p> <p>e. “Can you tell me which things you feel influence friendships on the unit?”</p> <p>Prompt</p> <ul style="list-style-type: none"> • Influence of their stage of journey e.g. close to admission/discharge • Influence of peers/themselves being stepped up/stepped down from units • Influence of new admissions • Influence of different behaviours e.g. violence, verbal aggression • Influence of disputes/disagreements between patients • Influence of staff • Examples
<p>8. Area 6: Participant comments</p> <p>f. “Is there anything else that you would like to say?”</p>
<p>Ending of the interview</p>

Appendix L

Remuneration Letter

Dear Participant,

Thank you for taking part in the research study “A Qualitative Study Exploring Adolescents Experiences of Peer Relationships in an Inpatient CAMHS Setting”.

As an appreciation of your contribution and of your time and effort taken to share your experiences with me here at [REDACTED] please accept this once-off £10 cash token.

If you have any further questions about the research study, please speak to [REDACTED] [REDACTED] Clinical Psychologist.

Best wishes,

Lucy Dalzell
Trainee Clinical Psychologist

Appendix M

Example of Transcript Coding

L: Uhm, so if you, ...can you tell me what peer relationships mean to you?	Microsoft Office User Contact with patients
J: Like, kind of who you come into contact with on the ward that's also like a patient and I think though like having relationships with like other peers is good because of the fact that like it's better to have friends here than like not have friend's cos like it makes the experience a lot nicer	Microsoft Office User Positive impact Microsoft Office User Friendships Microsoft Office User Improves inpatient experience
L: Can you tell me more about that?	Microsoft Office User Fearful on admission
J: Well like when I first came in to the err (identifiable service information) I knew nobody on the ward and I was like really scared and it wasn't until two people approached me and said like Hi and started chatting with me that I actually thought, you know what I'm going to be ok here	Microsoft Office User Alleviate anxiety Microsoft Office User Talking Microsoft Office User Importance of welcome
L: Uhm	Microsoft Office User Fearful of rejection
J: Cos I was really scared that everybody was going to hate me or everybody was going to be so ill that I'd just get triggered by them and stuff like that.	Microsoft Office User Fear of re-traumatisation
L: Uhm ok, and so you said that two people approached you from the ward and started talking to you. Can you tell me more about that?	Microsoft Office User Feeling cared for by peers
J: Ok, errr well two girls approached me and were just like are you ok? and I was just like yeah and then they were like 'have you come from another unit? And I was just like yeah and then we started speaking about why I got moved and then they asked me if I wanted to play a game with them and then I said yes and we started talking .	Microsoft Office User Sharing difficulties Microsoft Office User Distraction Microsoft Office User Talking
L: And how did that make you feel?	Microsoft Office User Internalising care from peers
J: It kind of made me feel like, people actually cared and that like...they knew what, kind of knew what I was going through, cos they'd been in the same boat as me .	Microsoft Office User Shared lived experience
L: Mm and what impact did that have on you knowing that?	

<p>J: It had a positive impact, ...like it was just if I, I think if I hadn't, they hadn't come over and said Hi and everything it would have been a lot different cos I don't think I would have approached anybody myself.</p>	<p>Microsoft Office User Positive impact of peers</p> <p>Microsoft Office User Importance of welcome</p> <p>Microsoft Office User Hesitation of initiation of contact on admission</p>
<p>L: So if you think about a relationship with a young person that you're closest to on the unit, what works well in that relationship?</p>	<p>Microsoft Office User Feeling heard</p>
<p>J: That we all feel like we can listen to each other and that if one of us is struggling the other ones understanding of the fact that we may not always be ourselves.</p>	<p>Microsoft Office User Peer support</p> <p>Microsoft Office User Understanding</p>
<p>L: Uhm, can you tell me more about that understanding?</p>	<p>Microsoft Office User Show true self</p>
<p>J: Well it's just like if I, um I'm having a bad day and I'm not really feeling that chatty, then like she always um, tends to understand that like it's not cos I'm in a bad mood with her, it's just that I'm struggling myself.</p>	<p>Microsoft Office User Feeling understood</p> <p>Microsoft Office User Accepting of difficulties</p>
<p>L: Uhm....is there anything else that works well in that relationship?</p>	<p>Microsoft Office User Similar age</p>
<p>J: Um I think the fact that a lot of them are also a similar age um and we've got similar interests outside of here also helps a lot because then we don't just have to talk about mental health we can also talk about stuff that's just normal teenage stuff.</p>	<p>Microsoft Office User Shared interests</p> <p>Microsoft Office User Distance from difficulties</p> <p>Microsoft Office User Talking</p>
<p>L: Mm....and how does that make you feel?</p>	<p>Microsoft Office User Connection to teenage identity</p>
<p>J: It makes me feel like...like a sense of normality that like just because I've got mental health problems doesn't mean that has to ruin my whole life.</p>	<p>Microsoft Office User Sense of normality</p> <p>Microsoft Office User Hope</p>

Appendix N

Thematic Analysis Process

Braun and Clarke's (2006) six stage approach to thematic analysis was followed.

TA Phase	Process
1. Familiarization of the dataset	The data was were transcribed into written form with a verbatim description. The transcribed interviews were then read repeatedly and notes on any patterns and ideas for coding written down.
2. Generation of initial codes	Initial codes were generated using NVivo, which captured passages that were pertinent to the research. This involved organizing the data into meaningful sets by looking for patterns.
3. Searching for themes	The initial codes were sorted into possible themes by establishing similarities, relationships and overarching themes using mind-maps. Themes corresponded to broad patterns of meaning within the data, which were built up of codes. It was ensured that each theme was distinctive, however they also related to other themes to build a coherent narrative.
4. Review themes	The themes were reviewed, establishing if there was adequate supporting data. During this phase the themes were refined by discarding those that were not sufficiently supported, merging similar themes or by separating those that can be further broken down. The generation of sub-themes also occurred at this stage, these highlighted an aspect of a concept from within a main theme. The data set was re-read to ensure that generated themes were valid.

5. Define and name themes
Themes were defined, named and further refined if necessary. Detailed analysis of the extracts of data within each theme was completed. Themes were considered in relation to the research aims.
 6. Produce report
Quotes were selected and included in the findings to support the identified themes and illustrate interpretations. The analysis was written up as a narrative, going beyond descriptions of the data and including quotes as evidence.
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