Volume I
Research Component

DEVELOPMENTAL AND SERVICE TRANSITIONS:

DO PARENTS MATTER?

by

Emma L. Millar

A thesis submitted to

The University of Birmingham

For the Partial Fulfilment for the Degree of

DOCTORATE IN CLINICAL PSYCHOLOGY

Department of Clinical Psychology

School of Psychology

University of Birmingham

Edgbaston

Birmingham

B15 2TT

June 2012

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Thesis overview

This thesis is submitted in partial fulfillment of the requirements for the degree of Doctorate in Clinical Psychology at the University of Birmingham. It comprises of both research and clinical components of the course. Throughout both volumes all names and identifying information have been changed to ensure anonymity is maintained.

Volume I, the research component, comprises of three papers, the literature review, an empirical paper and a public domain briefing document. The literature review examines emerging adulthood and parenting during this stage of development. A systematic review was undertaken on fifteen articles, with the findings being divided into two sections, an overview of the studies including the quality considerations and a summary of the findings. This paper will be edited for submission to the journal *Developmental Review* (Appendix 1).
The empirical paper examines a qualitative research study exploring how parents have made sense of the transitions they have experienced, due to their young adult having mental health difficulties. In particular, focusing on the move from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). This paper will be edited for submission to the journal *BMC Health Service Research* (Appendix 2). The third paper briefly summarises the findings from the literature review and the empirical paper.

Volume II contains five clinical practice reports based on work conducted on clinical placements during training. The first report (psychological models) presents the case of a 57-year-old man with post-traumatic stress disorder formulated from cognitive and psychodynamic perspectives. The second report (service evaluation) investigated the need for the implementation of a ‘self-compassion’ group within the service, to aid the development of

the construct within clients. Report three (single case design) evaluates a cognitive behavioural intervention with a 14-year-old boy, with a moderate learning disability, presenting with sleep difficulties. The fourth report presents a case study of a 72-year-old woman diagnosed with an adjustment disorder with mixed anxiety and depression following health complications after an operation. Finally, the fifth report is an abstract from a case study presentation given orally, which describes the Solihull Approach. This was used to formulate and intervene with a mum and her 18-month-old son who had difficulties with self-regulation, leading to him having difficulties sleeping.

Dedication

To my husband, whose unconditional love, acceptance and encouragement enabled me to keep going.

Thank you for everything.

Acknowledgements

Firstly a huge thank-you to the participants who took the time to share their experiences with me. Your courage and determination to keep going and continue fighting for your child is inspirational. I hope this research goes someway to others hearing your story and for changes to occur.

I would especially like to thank Doug, Aunty Barb, Uncle Rob and 'the girls' for their continued support, love, encouragement and laughter, especially when I felt anxious or lost. I could not have done this without you all.

Thank you to all of my family and friends for your belief in me, urging me to keep going and helping to pass the time on my drive home!

Finally, special thanks to my research supervisors, Michael Larkin and Dr. Cara Redmond who have offered me guidance and reassurance from beginning to end.

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Paper to be edited for submission to Developmental Review

PARENTING AND EMERGING ADULTHOOD:

A REVIEW OF THE LITERATURE

by

EMMA L. MILLAR

School of Psychology

University of Birmingham, UK

Department of Clinical Psychology

The University of Birmingham

Edgbaston

Birmingham

B15 2TT

ABSTRACT

A review was undertaken of fifteen studies investigating parental (maternal and paternal) influences on 'Emerging Adulthood' (Arnett, 2000) and parents' and emerging adults' understanding of this theoretical construct. The findings of this review are divided into two sections, an overview of the studies including relevant quality considerations and a summary of findings. The latter is split into six sub-sections: Parenting styles, parental versus emerging adults' perspective, psychological control, indirect effects, mediators and gender. In line with child and adolescence research, the studies emphasise the importance of the continuing influences and relationships between parents and their emerging adult. However, these influences may be direct or indirect and changes in parenting may become apparent during this stage of development. Theoretical, clinical and research implications are presented along with the limitations of this review. The paper concludes with recommendations for clinicians and services to take into consideration for future practice. These include the advantages of using the term 'emerging adults' to describe individuals within this stage of their life and for services to support the parent/emerging adult relationship, during this often confusing and uncertain stage of development.

Keywords: Parenting, Parenting style, Psychological control, Emerging Adulthood, Emerging Adult, Arnett.

INTRODUCTION

For today's young people, the road to adulthood is lengthier compared to an industralised society fifty years ago (Tanner & Arnett, 2009). Continued education, societal changes, rising house prices and youth unemployment make it more difficult and less attractive for young people to move out of the parental home (Coleman & Brooks, 2009) and start a completely independent life when they reach young adulthood. Most do not marry, become parents or find a long-term job until at least their late twenties, which were all traditional markers for adulthood (Arnett, 1997; 2000; 2004). From their teens to their late twenties they generally explore the possibilities available to them in love and the workplace, before moving gradually towards making lasting choices. Such freedom to explore different options is exciting and this period can be a chance to try a number of experiences. It is also a time of anxiety and uncertainty about the future (Arnett, 2004).

Emerging Adulthood

The term Emerging Adulthood (EA) is used interchangeably and widely throughout the literature, with authors attaching different meanings to it. Arnett (2000) provides a clear definition and understanding of EA, by developing a theoretical, culturally constructed concept regarding this specific stage of development. He states that this life stage occurs between the ages of eighteen to twenty-five and has distinct features that make it different from adolescence and adulthood, which include: *the age of possibilities*; *identity exploration; instability; focus on the self; and feeling in-between* (Arnett, 2000; 2004; 2007; Tanner & Arnett, 2009, p. 39). These subjective and psychological experiences can be seen in the behavioural and socio-emotional changes of Emerging Adults (EAs) (Nelson et al., 2007).

This stage of life is full of possibilities [*age of possibilities*]. EAs have high hopes and great expectations, which can lead individuals to make dramatic changes in their lives, and try new things (Tanner, Arnett & Leis, 2008). It is a time for *identity exploration*, when EAs are trying to figure out who they are and what they want. They may experiment in a number of ways, including trying different vocations and having multiple relationships. These experiences can be mixed, as their experimentation can lead them to engage in risk taking behaviours. These include: Drug use, alcohol use and sexual promiscuity (Arnett, 2005; Padilla-Walker, Nelson, Madsen & Barry, 2008).

The *age of instability* encompasses the above, as well as changes in living arrangements, friendship groups, and subsequent reactions to these events. This makes them self-focused [*focus on self]* because they are faced with decisions about what they want to do, where they want to go, and who they want to be with. Arnett (2000) proposed that the stage of EA is the least structured and the least bound by obligations to others. Individuals however, may feel pressured to get it 'right' and still need guided support and advice, especially from their primary caregivers. This means that EAs may feel as if they are *'in-between'* adolescence and adulthood. Research supports this view, because when asked if they have reached adulthood, most emerging adults respond neither yes nor no but "in some ways yes, in some ways no" (Arnett, 2004, p. 14; Mayseless & Scharf, 2003).

Tanner (2006) contributes to Arnett's theory by stating that EA is not only a distinct stage but also a pivotal period of development. She proposes that *recentering* (Tanner & Arnett, 2009, p. 40) is the process that underlies the shift to adulthood and is the primary psychosocial task of EA, suggesting that recentering is achieved in three stages. At stage one, EAs are still very

much reliant and based within their family of origin. Shifts are occurring in their and others' expectations about self-reliance and self-directedness. The second stage encompasses the description above of 'identity exploration'. Commitments made by the EA are transient and fleeting in nature as they explore a number of options available to them, whilst they continue to work towards independence. At the end of this stage and entering stage 3 of the recentering process, EAs are making lasting decisions and commitments to all aspects of their lives.

Parenting

Considerable research has supported the claims that a secure nurturing parent-child relationship contributes to emotional wellbeing and social competence across the lifespan (Ainsworth, 1989). The research asserts that a strong parent-child relationship is fundamental to all areas of development, and maintains that attachment processes are central to personality functioning from 'cradle to grave' (Bowlby, 1982, p.172).

Research investigating child and adolescence-parent relationships suggests that the type, construct, quality and style of parenting all have an impact on a persons wellbeing, overall functioning and their level of engagement in 'risky behaviours' (Dumas, Lawford, Tieu & Pratt, 2009; Pettit, Laird, Dodge, Bates & Criss, 2001; Stattin & Kerr, 2000). There are a number of ways that parenting has been identified and examined within this literature including parenting styles, psychological control, parental knowledge and overall quality of relationship with their child.

Parenting Styles

Baumrind (1991) suggested three classic styles of parenting: authoritarian, permissive and authoritative, which vary in their levels of demandingness and responsiveness. Authoritarian parenting is characterised by behaviours that are highly restrictive and extremely demanding, (Marsiglia, Walczyk, Buboltz & Griffith-Ross, 2007). Children's independence is restricted, and harsh punishment is a consequence of less desired behaviours. Parents who show this type of parenting style tend to be less responsive to, and accepting of, their child. Permissive parenting is at the other end of the spectrum compared to authoritarian parenting. They are non-restrictive, free from rules, do not punish negative behaviour and are very responsive, but either indulge or neglect their child's needs. Authoritative parenting provides an optimal balance of responsiveness and demandingness. They set boundaries and suitable consequences for inappropriate actions that are understood by all. They promote individuality, responsibility and encourage joint decision-making, whilst scaffolding and encouraging their child through each stage of their development and achievements (Liem, Cavell & Lustig, 2010).

Studies have shown that children brought up in authoritative environments have fewer difficulties in terms of their externalising and internalising behaviours, compared to children from permissive or authoritarian upbringings (Baumrind, 1991; Henderson, Dakof, Schwartz & Liddle, 2006 & McKinney & Renk, 2008). Children raised by permissive parents are more susceptible to antisocial peer pressure and problem behaviours, while they also tend to perform less well at school compared to both authoritarian and authoritative parenting styles. Children from permissive families, however, have better outcomes in terms of their internalising behaviour compared to children from authoritarian environments. Authoritarian

parented children are likely to have low self-esteem and higher levels of depression.

Psychological control and parental knowledge

Barber (1996) stated that parents exert psychological control in a number of ways including: Guilt reduction, pressuring tactics, love withdrawal and anxiety promotion. They define psychological control as a negative and deceptive style of control. Parental knowledge, also termed as parental monitoring, is considered to be an important element of parenting during childhood and adolescence and is linked to psychological control tactics (Steinberg, 2001). The way that psychological control is perceived depends on the family environment. For example, in one lacking warmth, parental monitoring may be seen as controlling, whereas in a positive, warm environment it can be interpreted as genuine concern, (Padilla-Walker et al., 2008). Therefore the closeness of parent-child relationships can be seen as crucial to how parental behaviours are perceived.

Parenting and Emerging Adulthood

In contemporary Western cultures, the relationship between a parent and EAs goes through a transformation during adolescence and into adulthood. At the core of this developmental transition is the recognition that the relationship is moving away from that of parent and child and towards that of two adults (Aquilino, 2006; Arnett, 1997). As cited above, one of the key developmental tasks of this transition is for adolescents to gain autonomy from their parents, with parents either helping or hindering this process, directly or indirectly (Kenyon & Koerner, 2009). Difficulties can arise when parents and EAs have differing perceptions regarding their understanding of this developmental stage and adjusting to this transition period.

Rationale

Research on parent-child relationships in adulthood suggests that relationships between parents and their adult children continue to be important, especially during times of transition (Bartle-Haring, Brucker & Hock, 2002). As cited above, EA is a transition period from adolescence to adulthood and there is a rising interest into the concept of EA and parenting within this developmental stage. This systematic literature review therefore explores the evidence to date investigating these dimensions. The studies will be evaluated methodically; an overall summary of the findings will be presented with suggestions for future areas of research. Theoretical and clinical considerations will be discussed and recommendations for clinical practice will be made based on the evidence. Three key questions were asked of the literature for this review. These were:

1. What are the parenting styles [maternal and paternal] and relationship quality of parents and EAs?
2. What are the perceptions of emerging adulthood from the EAs and/or parents' perspectives?
3. What other maternal and paternal influences are there on the EA?

METHOD

Search Strategy

Computerised searches of four databases were used to conduct the literature search PsycINFO (1987 to date) EMBASE (1996 to date), and MEDLINE (1996 to date) and Web of Science (1996 to date). Keywords used to conduct the search were:

> Emerging adulthood / emerging adult / emerging adult children /emerging adult child AND Parent child relations / parent attachment / parents / single parents / parent relationships / parenting style / parenting /parental control/ authoritarian parenting / authoritative parenting / permissive parenting / parenting skills / parents perception / mothers / fathers.

The searches yielded a total of 1550 references, before an additional limit of peer reviewed journal articles was implemented. This resulted in 261 references remaining, which were examined to identify those relevant to the topic under review. The articles were sorted by hand, the abstract was read through and reference list examined if needed, with the following inclusion and exclusion criteria in mind:

Inclusion Criteria

i. Research studies published in English.

ii. Studies including the term emerging adults (or similar) within the title, abstract or keyword search of the article.

iii. Studies including emerging adults' relationship with their parents. Emerging adults and /or Parents could or could not be involved in the study.

iv. Studies using the term 'Emerging Adulthood' as defined by Jeffery Arnett and author referenced in article.

v. Examining and measuring a form of parenting within the emerging adulthood years.

Exclusion Criteria

i. Did not include the term emerging adult /emerging adulthood / emerging adult-child.
ii. Did not reference Jeffery Arnett in relation to Emerging Adulthood.
iii. Trajectories of parenting from adolescence to emerging adulthood or comparisons of two developmental stages', (e.g. adolescence and emerging adulthood)
iv. Studies exploring situational transition, for example, work, college, home leaving or financial support and the impact this has on the parent-emerging adult relationship.
v. Studies exploring only adoptive parents or step-parents and not including biological parents.
vi. Cultural family expectations / values on emerging adulthood rather than actual parenting.
vii. Parental relationships not being the main focus of the study due to other relationships being included (i.e. peer or romantic partners).

Excluding duplicates these searches gave a total of 14 papers (Appendix 3), 1 extra paper was collected through the reference list of the articles. Key experts were contacted by email for references that could not be obtained via Birmingham University sources, as well as to enquire about other potential references. A total of 15 articles was collected and will be included within this review (Table 1). Appendix 4 gives an example of a full summary of an article. This process was conducted for all of the papers within this literature review.

Table 1: Summary grid of papers reviewed.

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Barry, Padilla-Walker, Madsen & Nelson (2008) USA	EA N = 228 (F = 132 M = 96) Age 18-25 (M = 19.95) Undergraduate Students Parents N= 228 (Mothers) Drawn from larger study (READY)	Self –Report Questionnaires online Quantitative Cross-Sectional	Social Provisions Questionnaire Prosocial Self-Regulation Questionnaire Prosocial Tendencies Measure	Relationship Quality	Not examined	Prosocial Values Pro Social Tendencies
Kenny & Sirin, (2006) USA	EA N = 81 (F = 32 M= 49) Age 22-28 (M = 25.98) Parents N = 92 (Mothers)	Self Report Questionnaires Quantitative Cross Sectional	General self worth scale of the adult self perception profile Centre for Epidemiological Studies Depression Scale Parental Attachment Questionnaire	Relationship quality / attachment Family Cohesion Parent Burden	Self worth	Self worth Depression

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Kenny & Sirin, (2006) Cont.			Mothers – Demographic questionnaire Parent version of Parent Authority Questionnaire Family cohesion subscale of the Family Adaptability and Cohesion Evaluation Scale Parental Burden Scale			
Kloep & Hendry (2010) UK	EA N = 0 (63) Age 18-25 (M=20.59) Parents N = 59 Dyads N = 29 mother/daughter N = 26 mother/son N = 5 father/daughter N = 2 father/son	Semi – Structured Interview Qualitative	None	'Letting go'	Not examined	Letting go or holding on in relationship with EA.

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Luyckx, Soenens, Vansteenkiste, Goossens & Berzonsky (2007) Belgium	EA N = 565 (F = 482 M = 83) Time 1 Age (M = 18.7 EA N = 364 (F = 325 M = 39)	Self report questionnaires Quantitative Longitudinal (5 time points) – Focus on Time 1	Ego Identity Process Questionnaire – Dutch translation Dutch Utrecht-Groningen Identity Development Scale (Commitment and Exploration) Psychological Control Scale – Youth Self-Report	Psychological Control	Not examined	Psychological Control Identity Formation
Marsiglia, Wakczyk, Buboltz & Griffith-Ross (2007) USA	EA N = 334 (F = 169 M = 165) Age 18-25 (M = 18.67) College Freshman -228 Sophomores 65 Juniors 33 Seniors 8 Parents N = 0	Self Report Questionnaires Quantitative Cross Sectional	Parent Authority Questionnaire Measures of Psychosocial Functioning Locus of control scale – Internal External Scale	Parenting styles	Not examined	Psychosocial Functioning Locus of Control

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
McKinney, Milone & Renk (2011) USA	EA N = 526 (F = 363 M = 163) Age 18-22 (M = 19.22) Undergraduate students	Self –Report Questionnaire Quantitative Cross Sectional	Parental Bonding Instrument Parental Authority Questionnaire The Conflicts Tactics Scale: Parent-Child version Rosenberg Self Esteem Inventory Becks Depression Inventory The Manifest Anxiety Scale	Parenting styles Parental bonding – Caring and overprotection	Discipline Gender	Emotional Adjustment – Self Esteem Depression Anxiety
Morgan, Thorne & Zurbriggen (2010) USA	EA N = 30 (F = 17 M = 13) Age (M = 18.2 T1 M = 21.1 T2) Undergraduate Students Parents N = 0	Semi Structured Interviews and Self Report Questionnaires Mixed Methods	60 item questionnaire 4 questions assessed aspects of participants' sexual and dating experience Attitudes toward dating and relationships	Parental Attachment	Not examined	Openness and comfort

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Morgan et al. (2010) Cont.		Longitudinal 1st (T1) and 4th (T2) year college	Measure (Abridged version) Parent subscale of the Inventory of Parent and Peer attachment			
Morton & Markey (2009) USA	EA N = 208 (F = 117 M = 91) Age 18-23 Undergraduate students Parent N = 208 (Mothers = 110 Fathers = 98)	Self report questionnaire Quantitative Cross Sectional	Respondent goal measure Parent child interaction questionnaire revised	Relationship quality and conflict	Not examined	Goals Social relationships Financial control Affect control Academic/occupational Health Independence Moral or religious organisations
Nelson et al. (2007) USA	EA N = 392 (F= 242 M =150) Age 18-25 (M= 19.89) Unmarried College Students Parents N= 590 (Mothers – 319 Fathers 271	Self-report questionnaires via internet or post Quantitative Cross Sectional	Criteria for adulthood questions	Criteria parents and EA have for becoming an adult. Role Transitions Norm Compliance Biological /Age	Not examined	Criteria parents and EA have for becoming an adult Role Transitions Norm Compliance Biological /Age transitions Family Capacities Relational Maturity

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Nelson et al. (2007) Cont.	Drawn from larger study (READY)			transitions Family Capacities Relational Maturity		
Nelson, Padilla-Walker, Christensen, Evan & Carroll (2011) USA	EA N = 403 (Female 62%) Age 18-26 (M= 19.89). Undergraduate students Parents N= 604 (Mothers = 317 Fathers = 287) Drawn from larger study (READY)	Self-report questionnaires via internet Quantitative Cross Sectional	Psychological control Barbers Regulation Scale (Parental Knowledge) Parenting Styles and Dimensions Questionnaire Parental Closeness – Parent-Child Closeness Scale Social Provisions Questionnaire –short version Drinking – 2 items from Add Health Questionnaire Self Perception Profile	Parental Knowledge Psychological Control Parenting Styles and Dimensions Parental Closeness Relationship Quality	None examined (Clusters)	Psychological Control Self Worth Social Acceptance Kindness, Depression, Anxiety Impulsivity

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Nelson et al. (2011) Cont.			(Self worth and Social acceptance) Personal Characteristics Adult Temperament Scale (Subscales related to Kindness, depression, anxiety & impulsivity)			
Padilla-Walker et al. (2008) USA	EA N = 200 (F = 121 M = 78) Age 18-25 (M = 19.59) Undergraduate students Parents = 400 (Mothers = 200 Fathers = 200) Drawn from larger study (READY)	Self Report Questionnaire Quantitative Cross Sectional	Project READY questionnaire Barber's Regulation Scale Parent-Child Closeness Scale Two questions from Add Health Questionnaire Alcohol, Drugs, Sexual risk taking	Parental Knowledge Parental Closeness	Not examined	Risk behaviours – Drinking Drug use Sexual behaviour

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Patock – Peckham & Morgan - Lopez (2009) USA	EA N = 441 (F = 216 M = 225) Age (M = 19.48) Undergraduate students Parents N = 0	Self-Report Questionnaire Quantitative Cross Sectional	Parental Authority Questionnaire Parental Bonding Instrument - 2 out of 4 dimensions used in study Rosenberg Self Esteem Centre for Epidemiological Studies Depression Scale Zung Depression scale Depression Anxiety and Stress Scale – assess 3 emotional states only depression used Alcohol use – quantity frequency measure.	Parenting Style Parental Confidence Parental bonding – Caring and overprotection	Parenting style Parental Confidence Self Esteem Depression Alcohol related problems	Self Esteem Depression
Patock – Peckham, King, Morgan-Lopez, Ulloa & Filson Moses	EA N = 581 (F = 316 M = 265). Age – (M = 20.07) Undergraduate students.	Paper and Pencil Questionnaire Quantitative Cross Sectional	Parental Authority Questionnaire The Parental Monitoring Scale	Parenting style Parenting monitoring Parental regulation	Parenting Style Parenting monitoring	Impulsiveness

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
(2011) USA			Impulsivity Impaired Control Scale Problems with alcohol use		Drinking Control Alcohol related problems Gender	
Soenens, Vansteenkiste & Sierens (2009) Belgium	EA N = 495 (F = 74% M = 24 % Age = 17-25 (M = 19.30) Undergraduate students	Self Report Questionnaires Quantitative Cross Sectional	Psychological Control Scale – Youth Self-Report Promotion of Independence – 8 item scale Promotion of Volitional Functioning -6 item Centre for Epidemiological Studies Depression Scale	Parental Control Autonomy – Promotion of Independence and Promotion of Volitional Functioning (Self Determination Theory)	Not examined	Wellbeing – Self Esteem Depression Adjustment to college –social and academic
Soenens et al. (2009) Cont.			Rosenberg Self Esteem Scale Students Adaption to College Questionnaire – Dutch translation. Academic adjustment & Social Adjustment.			

Author(s) Date Location	**Sample (EA N) Age (Mean) Parents N**	**Method of data Collection Type of research Design**	**Measures**	**Type of Parenting**	**Mediators**	**Psychological Construct/ Outcome(s) Measuring**
Urry, Nelson & Padilla-Walker (2011) USA	EA N = 252 (F = 175 M= 77) Age 18-26 (M = 19.89). Undergraduate students Parent (mother) N= 252.	Self Report Questionnaires via Internet Quantitative Cross Sectional	Child disclosure – Parent child closeness scale – 2 items from this. Feelings regarding upbringing –RELATE instrument - 3 items Satisfaction with current relationship- RELATE instrument – 2 items Psychological control scale-Youth self report Maternal Knowledge – adaptation of Barbers Regulation Scale Risk behaviours – scale made up 3 items varying [1]in risky behaviour	Psychological Control Maternal Knowledge/child disclosure Satisfaction with current relationship Feelings about upbringing	Current Relationship Satisfaction Child Disclosure Maternal Knowledge	Risk behaviours Becoming drunk Illicit drugs Drink-driving Psychological Control

[1] All references for the measures used are available in the original articles.

Quality considerations

As is evident from the inclusion and exclusion criteria above, no articles were excluded on the basis of 'poor quality'. This review attempts to present a synthesis of the literature and quality considerations as a whole.

A recent paper systematically reviewing the content of critical appraisal tools (Katrak, Bialocerkowski, Massy-Westropp, Kumar & Grimmer, 2004) concludes that there is no "gold standard" critical appraisal tool for any design study, nor a widely accepted generic research tool that can be applied to a variety of studies. Instead there are an abundance of tools to choose from for quantitative (e.g. CONSORT [Consolidated Standards of Reporting Trials], Altman et al., 2001; Polgar & Thomas, 2000) qualitative (e.g. Elliott, Fischer & Rennie, 1999; Yardley, 2000) and mixed method designs (e.g. Sale & Brazil, 2004), each with their own strengths and limitations.

Based on guidance from the systematic review (Katrak et al., 2004) a critical appraisal tool (Caldwell, Henshaw & Taylor, 2005) was selected on the basis of three criterions. Firstly, the framework addressed both quantitative and qualitative research within one list of questions. Secondly, the authors provided evidence for the empirical basis for the construction of their tool, the validity of items and reliability of interpretation; this was in its limited stages though. Thirdly, it assisted the 'novice' researcher in applying the criteria and quality checklists to the studies within this review.

The questions were expanded on within the framework through peer and supervisor review, using guidance from other sources (Critical Appraisal Skills programme [CASP] 2006;

Elliott, et al., 1999; Sale & Brazil, 2004, table 2 & 3). Examples are given within the appendix section (5 & 6) of the guidelines being applied to the articles within this review.

Rating Scale

The NICE rating system for methodological quality of studies (NICE, 2009) was adapted as no rating system was provided within the framework (Table 4). An overall rating score was not given to each article as the weighting of different elements within the criteria may have led to skewed results and readers' interpretation. For example, a paper with a weak method, but scoring '++' on the majority of questions asked (see Mckinney et al., 2011) may have ranked higher than a paper scoring '--' or '+/-' on certain questions (e.g. rationale of the study design) but rating highly on the methodology and results section (e.g. Barry et al., 2008).

Table 2. Quality checklist for quantitative study.

Quality criteria	Specific questions to consider when rating	Rating
1. Title and Abstract	• Does the title reflect the content • Abstract summarises key components (e.g. Aim, Method, Results) • Overall findings presented (bias of positive results without describing the negative / non significant findings).	
2. Rationale clearly described?	• Does the author(s) describe the current evidence base? • Does the author(s) identify the gaps in the evidence base? • Does the author(s) justify the need for the area of research?	
3. Research aims clearly stated?	• Does the author(s) clearly state what they plan to research? • Are there clearly focused questions / hypotheses identified?	
4. Ethical issues addressed?	• Does the author(s) state that ethical approval was sought? • Does the author(s) demonstrate an awareness of the ethical issues raised by the study (e.g. informed consent, confidentiality, how the effects of the study on participants during and after are handled, withdrawal etc.)?	
5. Methodology appropriate to the research question?	• Is the use of quantitative methodology appropriate to the research aims (e.g. to determine relationships between a number of variables)?	
6. Study design identified and the rationale for choice evident?	• Does the author(s) clearly state the design of the study? • Does the author(s) justify the research design used (e.g. longitudinal, cross sectional, cohort etc.)?	
7. Experimental hypotheses stated?	• Does the author(s) clearly state what they expect to find?	
8. Key variables identified?	• Does the author(s) identify the main variables (e.g. independent, dependent) investigated in the study?	
9. Sample population situated?	• Does the author(s) adequately describe the sample (e.g. gender, age, relationship to care receiver etc.) so that the reader can determine validity of findings? • Is it a representative sample of the population?	

10. Selection of participants adequately described?	• Does the author(s) describe the context of where the samples were recruited from? • Does the author(s) describe the method of recruitment used (e.g. the sampling method, how potential participants were approached to take part etc)? • Does the author(s) identify the inclusion / exclusion criteria?	
11. Method of data collection reliable and valid?	• Does the author(s) use measures appropriate for the population group? • Does the author(s) use measures that reflect the desired constructs? • Do the author(s) use measures with good psychometric properties (e.g. test-retest reliability, inter-rater-reliability, internal reliability (Cronbach's alpha) and internal consistency)? • It the time difference between Time 1 and following up subjects long enough (i.e. longitudinal studies)?	
12. Method of data analysis reliable and valid?	• Does the author(s) state which statistical tests were used? • Does the author(s) use statistical tests that are appropriate to the data properties (e.g. does the data meet the assumptions of the test)? Are power calculations given? • Where the statistical tests used appropriate to the research question? • Does the author(s) consider the impact of extraneous variables and correct / adjust / control for these within the analysis process (i.e. regression)? • Does the author(s) provide evidence of statistical findings (e.g. Data within the text, tables etc.)? • Does the author(s) state the levels of significance?	
13. Findings clearly stated?	• Does the author(s) explicitly state their findings? • Does the author(s) present the statistical data in a clear manner? • Does the author(s) clearly differentiate between significant and non-significant findings?	
14. Comprehensive discussion?	• Does the author(s) summarise the main findings? • Does the author(s) link their findings back to the research aims? • Does the author(s) state the contribution to theory, context and method linking their findings to current literature and / or psychological theory? • Can the findings be generalised?	

15. Strengths and limitations identified?	• Does the author(s) identify the limitations of the research (e.g. Sample size, recruitment strategies, method of data collection, analysis etc)? • Does the author(s) identify the strengths of the research (e.g. its usefulness etc)? • Does the author(s) make recommendations for future research?	
16. Justifiable conclusions made?	• Does the author(s) make conclusions that are supported by their discussions of their findings?	

Table 3: Quality checklist for qualitative study.

Quality criteria	Specific questions to consider when rating	Rating
1. Title and Abstract	• Does the title reflect the content • Abstract summarises key components (e.g. Aim, Method, Results) • Overall findings presented (bias of positive results without describing the negative / non significant findings	
2. Rationale clearly described?	• Does the author(s) give a review of the literature? • Does the author(s) identify the gaps in the literature? • Does the author(s) justify the purpose of research? • Does the author(s) specify where it fits within relevant literature?	
3. Research aims clearly stated?	• Does the author(s) clearly state what they plan to research?	
4. Ethical issues addressed?	• Does the author(s) state that ethical approval was sought? • Does the author(s) demonstrate an awareness of the ethical issues raised by the study (e.g. informed consent, anonymity / confidentiality, how the effects of the study on participants during and after are handled, withdrawal etc)?	
5. Methodology appropriate to the research question?	• Is the use of qualitative methodology appropriate / responsive to the research purpose (e.g. to interpret or illuminate the actions and / or subjective experiences of the participants)?	
6. Philosophical background identified?	• Does the author(s) state their theoretical, methodological and personal orientations? • Use of 1st person rather than objective stance (owning one's perspective).	

	• Does the author(s) highlight personal experience within the area of interest and/or initial bias?	
7. Study design identified and the rationale for choice evident?	• Does the author(s) clearly state the design of the study? • Does the author(s) discuss the reasons for employing qualitative methodology? • Does the author(s) justify the methodology used (e.g. IPA, grounded theory etc)?	
8. Major concepts identified?	• Does the author(s) define the key concepts (e.g. parents emerging adulthood etc.) in the study?	
9. Sample population situated?	• Does the author(s) adequately describe the sample (e.g. Gender, age, ethnicity, size, life circumstances.) so that the reader can determine transferability of findings?	
10. Selection of participants adequately described?	• Does the author(s) describe the context of where the samples were recruited? • Does the author(s) describe the method of recruitment used (e.g. the sampling method, how potential participants were approached to take part etc)? • Does the author(s) identify the inclusion / exclusion criteria?	
11. Method of data collection auditable?	• Does the author(s) describe how the data was collected (e.g. semi-structured interviews, where data collection took place, who collected the data etc)? • Does the author(s) describe the areas covered in the interview and / or provide a copy of the questions asked?	
12. Method of data analysis credible and confirmable?	• Does the author(s) clearly describe the analysis process? • Does the author(s) describe how they addressed the issue of validity during the analysis and/or interpretation stages (e.g. external reviewers, dual coders, triangulation etc)? • Does the author(s) provide specific examples to support their findings? • Does the author(s) provide quotes that appear to be relevant to the themes identified?	
13. Reflectivity considered and described?	• Does the author(s) acknowledge the influence of the research process and the presence of the researcher (including the role of potential biases in analysis and selection of data, assumptions, values, interests and experiences etc) on the data collected? • Does the author(s) describe this in the 1st person?	

14. Findings clearly stated?	• Does the author(s) explicitly state their findings (e.g. themes / sub-themes identified)? • Does the author(s) clearly distinguish themes / sub-themes within the results section? • Are they coherent and resonate with the reader?	
15. Comprehensive discussion?	• Does the author(s) summarise the main findings? • Does the author(s) link their findings back to the research aims? • Does the author(s) state the contribution to theory, context and method linking their findings to current literature and / or psychological theory? • Are the results transferable?	
16. Strengths and limitations identified?	• Does the author(s) identify the limitations of the research (e.g. sample size, recruitment strategies, method of data collection, analysis etc)? • Does the author(s) identify the strengths of the research (e.g. its usefulness etc)? • Does the author(s) make recommendations for future research?	
17. Justifiable conclusions made?	• Does the author(s) make conclusions that are supported by their discussions of their findings?	

Table 4. Rating system (adapted from NICE guidelines manual, 2009).

++	All or most of the criteria have been fulfilled. Where they have not been fulfilled are thought **very unlikely** to impact on the quality or overall conclusions of the study
+/-	Some of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought **unlikely** to impact on the quality or overall conclusions of the study.
--	Few or no criteria fulfilled. They are thought **likely** to have an impact on the quality or overall conclusions of the study.

OVERVIEW AND QUALITY CONSIDERATIONS

The majority of the studies identified for this review employed quantitative methodology (n= 13), one used mixed methods (Morgan et al., 2010) and one stated that it was a qualitative study, although it employed quantitative analysis to compare the four groups identified (Kloep & Hendry, 2010).

Out of the thirteen quantitative studies, twelve were cross sectional correlational designs using self-report questionnaires (Barry et al., 2008; Kenny & Sirin, 2006; Marsiglia et al., 2007; McKinney et al., 2011; Morton & Markey, 2009; Nelson et al, 2007; Nelson et al., 2011; Padilla-Walker et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al., 2011; Soenens et al., 2009; Urry et al., 2011). One employed a longitudinal design using self-report questionnaires (Luyckx et al., 2007). Morgan et al. (2010) also adopted a longitudinal design to their mixed methods approach, distributing self-report questionnaires and conducting a semi-structured interview with their sample. They applied the qualitative methodology of thematic analysis (Braun & Clarke, 2006) to their data. Kloep and Hendry (2010) used principles of grounded theory and cluster analysis.

Twelve studies explored the impact of both parents on the EA (Marsiglia et al., 2007; McKinney et al., 2011; Morton & Markey, 2009; Nelson et al., 2011; Nelson et al., 2007; Padilla-Walker et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al. 2011; Soenens et al., 2009), with four exploring the differences between paternal and maternal parenting on EA. Three studies (Barry et al., 2008; Kenny & Sirin 2006; Urry et al., 2011) explored the influences of maternal parenting on the EA. All three collected data from both the EA and their mothers.

No studies focused exclusively on paternal parenting influences. Kenny & Sirin (2006) gathered data on paternal parenting, however, due to a small sample size the data were excluded from analysis. From the four studies that collected data from both the EA and one or both of their parents, two were unclear regarding how many participants had more than one parent taking part in the study (Nelson et al., 2007; 2011) and one regarding the dyad of parent-EA relationship (Morton & Markey, 2009). Padilla-Walker et al. (2008) used views from both parents, as well as the EAs perspective. It would appear that the paternal role is under-represented in this literature.

In terms of recruiting parents, all of the studies relied on the EAs to email them a request asking to participate in the study, or agreed for their parent(s) to participate. Thirteen EAs in Kenny and Sirin (2006) study did not agree to this and were excluded from the study. It could be assumed that when a request for permission is granted, this alludes to a better relationship between the EA and parent. Studies may therefore have under-represented the effect of relationships between parents and EAs when developed outcomes are less positive.

Seven studies investigated the EAs perception of the parenting construct(s) being measured, (Luyckx et al., 2007; Marsiglia, et al., 2007; McKinney et al., 2011; Morgan et al., 2010; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al., 2011; Soenens et al., 2009). Kloep and Hendry (2010) gathered data from just parents. Research within parenting states that child and parent reports are only weakly correlated (Barker, Bornstein, Putnick, Hendricks & Suwalsky, 2007), requiring the inclusion of various perspectives whenever possible; a recommendation that was only adopted by seven studies within this review.

Nine studies (Barry et al., 2008; Kenny & Sirin, 2006; Marsiglia, et al., 2007; Nelson et al, 2007; Nelson et al., 2011; Padilla-Waker et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al., 2011; Soenens et al., 2009; Urry et al., 2011) scored '- -' on the 'ethical issues addressed' quality guideline (question four). Morton and Markey (2009) and Nelson et al. (2007) scored '+/-' for this quality check. The remaining articles scored '++' for their description of the ethical procedures.

The majority of the studies examined in this review used sample populations from universities. A number were recruited through introductory psychology courses (Luyckx et al., 2007; Marsiglia, et al., 2007; McKinney et al., 2011; Morgan et al., 2010; Padilla-Walker et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Soenens et al., 2009; Urry et al., 2011) and nine studies used incentives (either course credit or monetary gains) to attract participation. This method tended to result in a gender biased sample population, as statistically psychology courses attract a higher ratio of females to males. These factors make it difficult to apply assumptions of representation on the overall population and generalisability of findings.

All the studies bar one (Kenny & Sirin, 2006) limited their age range to EA (eighteen to twenty-five) as stipulated by Arnett (2000). The studies by Kenny and Sirin (2006) as well as Morgan et al. (2010) had mean ages above twenty-one. The rest of the studies had mean ages between eighteen and twenty years (see summary grid of articles reviewed). Higher mean ages may provide different results in terms of where the EAs are within the developmental stage and their relationship with their parents. Eighteen to twenty year olds can be viewed as

being at ‘stage 1’ of this age period (Tanner, 2006). This was again taken into account when rating the articles. Not one article mentioned this as a limitation within their study.

Four studies recruited their sample from a larger sample involved in a study already running called “READY” (Researching Emerging Adults’ Developmental Years). There was little information regarding how these participants were recruited to this larger study; whether the samples recruited for the studies were taken from the same year, or if samples recruited took part in a number of the studies. They were scored ‘+/-’ on their descriptions of the participation selection due to these issues.

Kenny and Sirin (2006) stated the relationship of the mother to their EA (biological). Only two studies explored the possibility of the parent not being their biological one, but did not specify the actual relationship of the parent to the EA (Marsiglia et al., 2007; Morton & Markey, 2009), neither was this considered within their analysis and discussion, therefore was included in this review. It could be suggested that all the other articles assumed that it was the EAs biological parent(s) who were involved in the study.

As reported above, fourteen studies used self-report questionnaires to gather their data. Twelve of these were single points of data collection, with two being longitudinal. Self-report questionnaires have a number of methodological flaws including: Systematic bias; extreme and moderate response styles, especially when rating scales are used (i.e. Likert); their psychometric properties in terms of validity and reliability; missing data through the subject not completing all questions; and the subjective nature of all responses.

All articles reported the internal consistency of their measures by reporting the coefficient alpha (Cronbach, 1951). Five articles gave more detail in terms of studies where the measures have been used before (Barry et al., 2008; Morton & Markey, 2009; Padilla-Walker et al., 2008; Patock-Peckham et al., 2011; Soenens et al., 2009). Six articles also reported on different types of validity (construct and concurrent) in relation to the measures used (Kenny & Sirin, 2006; Luyckx et al. 2007; Marsiglia et al., 2007; McKinney et al. 2011; Nelson et al. 2007; Patock-Peckham & Morgan-Lopez, 2009). A minimum coefficient alpha of 0.7 is recommended in the literature (Cox & Ferguson, 1994), measurements that fell short of that were commented on (Mckinney et al., 2011; Morton & Markey, 2009; Urry et al., 2011), or not commented on (Luyckx et al., 2007; Marsiglia et al., 2007).

Missing data resulted in those participants being excluded from analysis (e.g. Kenny & Sirin, 2006), or controlled and estimated for (e.g. Patock-Peckham & Morgan-Lopez, 2009). Marsiglia et al. (2007) excluded 31 data sets due to equal scoring on two parenting styles. There were a number of self-report questionnaires used within each article (Table 2), with studies using different measures to examine an internalising symptom (i.e. depression). Due to the limited space within this review, a full overview of the strengths and limitations of each of the measures employed cannot be discussed.

Quantitative Analysis

The majority of quantitative articles reviewed used appropriate statistical tests and controlled extraneous variables within the analytic process. Padilla-Walker et al. (2008) actively controlled a number of variables including gender in their regression analyses, due to it being a factor significantly related to the study variables. A number gave clear rationales for doing

certain statistical tests (e.g. Padilla-Walker et al. 2008; Soenens et al., 2009) and clear descriptions of the tests used.

Studies that used Structural Equation Modelling (SEM) used a range of tests to determine the model of fit including root mean square error of approximation (RMSEA), Comparative fit index (CFI) and Model chi-square ($\chi 2$) and discussed the cut off point for a good model of fit. Chi-square should not be used on sample sizes of two-hundred or greater due to its over sensitivity, leading to it rejecting the model (Hooper, Coughlan & Mullen, 2008). McKinney et al. (2011) and Soenens et al. (2009) complied with this recommendation, using a range of other methods to identify 'good-fit'; others did not (Barry et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al. 2011 & Urry et al., 2011).

In McKinney et al. (2011) SEM is particularly confusing for the reader, with it being unclear how it relates to the progression of the model and how the reported findings are ascertained. This model needed a number of indicators removed and re-specifications, hence scoring '+/-' for quality of their results section. Other models were easier to read and did not need re-specification, thus the '++' scoring. Within Nelson et al.'s (2007) study there was an over reported significant finding, which could not be deduced from any of the statistical output or descriptions given (p.670). Additionally, there was a difference in reported findings in the results and discussion sections of their report relating to the importance fathers' placed on norm compliance (p.671).

Although some of the papers were weak in several areas, none scored poorly in all aspects measured. In addition, due to the majority of studies being correlational in nature one should read their conclusions with a certain amount of caution, as causality cannot be assumed.

Qualitative Articles

The review of qualitative articles covers four main areas, reflectivity, credibility, triangulation and transparency (Elliott et al., 1999). For the two papers that used qualitative analysis neither stated their epistemological position, their potential biases or previous experiences and both wrote objectively rather than subjectively. Morgan et al. (2010) commented on the impact of the gender and ethnicity of the interviewers upon certain male participants sharing their experiences of sexual relations, which has led to a rating of +/- for question thirteen. Both studies used dual-coders to cross validate the themes (triangulation) and a number of quotations throughout, to support interpretations and the themes identified (credibility), as well as demonstrating a level of transparency in terms of the nature and content of procedures used. Kloep and Hendry (2010) did not explicitly state in their article that they used a grounded theory approach and instead made reference to it by using procedures recommended by Charmaz (1995). Cluster analysis was then undertaken to integrate their themes, which led to the '+/-' score for methodology.

The reviewer felt that both studies were not 'best practice' examples of qualitative studies and were limited in terms of their transferability of findings.

SUMMARY OF FINDINGS

1. Parenting styles

A number of papers explored the direct impact on the three parenting styles stipulated by Baumrind (1991). Marsiglia et al. (2007) explored the impact on locus of control (either internal or external) and perceptions of parenting styles on the psychosocial success of EAs. In line with previous research, authoritative parenting (both maternal and paternal) was associated with greater psychosocial success compared to authoritarian and permissive styles of parenting. However, maternal authoritative parenting was associated with a greater internal locus of control. This was not supported for paternal parenting influences. However, EAs with authoritarian fathers had higher psychosocial success compared to EAs with permissive fathers.

McKinney et al. (2011); Patock-Peckham et al. (2011) and Patock-Peckham and Morgan-Lopez (2009) also explore parenting styles and EAs adjustment, which support the overall findings of Marsiglia et al. (2007). Authoritarian parenting fosters more positive outcomes on a number of the concepts measured compared to the other two types of parenting. These papers however only investigated the EAs perspective.

Nelson et al.'s (2011) study distinguishes four clear parenting styles: 'uninvolved', (which could be seen as similar to permissive parenting style); 'controlling-indulgent', (an authoritarian style of parenting); 'authoritative' and the fourth cluster labelled as 'inconsistent' for mothers and 'average' for fathers. They found that there were no differences on EA outcomes between authoritative and inconsistent mothers, with both generally having more positive outcomes within the majority of variables assessed. However, controlling-

indulgent mothers had EAs with the most negative outcomes. They had the lowest levels of parent-child closeness and self worth and the highest levels of depression, anxiety and impulsivity. Marsiglia et al. (2007) found no significant effect for authoritarian or permissive styles of maternal parenting.

Nelson et al. (2011) also contributed to the evidence that differing parental styles produce different outcomes. The impact of having an uninvolved mother is often not as detrimental as having a controlling-indulgent mother; nevertheless it is still associated with a number of negative consequences, including attaining lower scores on the constructs examining social acceptance and kindness.

Nelson et al.'s (2011) findings on fathers' parenting styles are consistent with those of Marsiglia et al. (2007) and Patock-Peckham and Morgan-Lopez (2009) studies. EAs with authoritative fathers displayed positive outcomes in terms of closeness, self-worth, social acceptance and kindness and had the lowest levels of depression. Nelson et al. (2011) provided further insight by suggesting that EAs with controlling-indulgent and uninvolved fathers had poorer outcomes compared to average fathers, with controlling-indulgent EAs fairing the worst. Patock-Peckham and Morgan-Lopez (2009) linked this to risk taking behaviour. They suggest that unsupportive, emotionally distant and rule driven fathers can contribute to the internalising symptoms of EAs. Symptoms can include depression and low self-esteem, which can be comorbid with alcohol related problems.

2. Parental versus EA perspective

An interesting finding in all of the papers that explored both the EA and parental perspective was that the EA interpretation of their relationship with their parent was more predictive of the outcomes than that of their parents (Barry et al., 2008; Kenny & Sirin, 2006; Soenens et al., 2009; Urry et al., 2011). For example, in the study conducted by Kenny and Sirin (2006) it was found that the EA perspective on the attachment relationship with the mother was more predictive of the EAs interpretation of self-worth and depressive symptoms than their mother's perspective on their relationship. Soenens et al. (2009) found that whether or not parents were perceived as promoting independence appeared to be less important for emerging adults. However, in some, promotion of independence by parent(s) did seem to help nurture social adjustment. The EA and parent viewed markers regarding quality of relationships differently. Kenny and Sirin (2006) found that mothers' perceptions of attachment were more positively associated with the frequency of communication with their EA, compared to the EAs perspective.

Kloep and Hendry's (2010) paper explored parents' perspective on the transition to emerging adulthood. Their study concentrated on one major theme of 'responses to emerging adulthood' and four main clusters came from this: Happy to let go"; "reluctant to let go"; "holding onto"; and "power fights". The "happy to let go" cluster had fourteen parents in it, demonstrating that parents showed '*deep satisfaction'* and *'pride'* towards their EAs increasing independence. Three stated that they would feel 'relief' to see their EA grow up and leave.

Nineteen parents were in the "reluctant to let go" cluster with them having a sense of difficulty accepting their EAs increasing autonomy, with feelings such as '*losing their role*' and not '*being needed anymore'* (Kloep & Hendry, 2010). These parents had difficulty stating that their EA was a 'full adult' even though they acknowledged that all the signs were there, wishing at times they were not. This could provide an explanation towards the differences that occur in how parents and EAs perceive this developmental stage, (Nelson et al., 2007) and where conflicts arise (Morton & Markey, 2010). Nelson et al. (2007) explored the criteria that EAs and their parents have for adulthood. They found that the criteria differed between EAs and their parents, with levels of importance differing for each group. For example, emerging adults rated 'norm compliance' as less important than fathers and mothers, with fathers rating it less important than mothers. However, there was also some consensus about particular markers for adulthood between all three groups, such as 'relational maturity'.

The third overall cluster from the main subordinate theme of 'responses to emerging adulthood' explored the notion of "holding on". Twenty-three parents were within this group, which included similar items to the second cluster. However, these parents used conscious (i.e. bribery) or unconscious strategies (i.e. doing daily activities for them) to inhibit the development of autonomy and continued to interfere in their EAs lives. Incentives were a common element to this; however, in line with Kenny and Sirin's (2006) findings, these external markers did not indicate the quality of a relationship. Parents often felt blackmailed and disgruntled when their EA only contacted them for money, which promoted negative feelings towards them. These parents could be classified as having a permissive style of parenting (Kloep & Hendry, 2010). A number of parents within this category could see the

links between their style of parenting and the resulting behaviours that their EA was exhibiting.

In line with the findings reported by Nelson et al. (2011) and Patock-Peckham and Morgan-Lopez (2009) parents reported that their EAs were not happy with them interfering and tried to prevent them becoming involved. This "Holding on" stage could also provide support to Nelson et al.'s (2007) study, where they found that parents did not see their children as adolescents, or as adults, but somewhere in-between as did the EA. This could also provide some explanation for why over half of the parents in Kloep and Hendry's (2010) study fell into this cluster due to the uncertainty and confusion within this developmental period.

The final category, "power fights", links into the findings of Soenens et al. (2009) and Morton and Markey (2009). Soenens et al. (2009) differentiated two different types of autonomy; promotion of independence and promotion of volitional functioning (from the self determination theory). This study states that promotion of volitional functioning is incompatible with psychological control, as it demonstrates a lack of attunement to and identification of a child's interests. Kloep and Hendry (2010) found that the parents within this final category saw that EAs were making the 'right choice' if they agreed with their parents without being told to do so, therefore could be deemed as high on the spectrum of psychological control and not promoting volitional functioning. Morton and Markey (2009) demonstrated that higher levels of conflict resulted in lower goal agreement between the EA and parent, linking into this idea about "power fights" and conflicts.

3a. Psychological control

Conceptually related constructs relating to psychological control including overprotection, parental knowledge and parental monitoring were explored within a number of papers reviewed. Padilla-Walker et al. (2008) investigated the impact of parental knowledge, linking this to several positive outcomes for the EA, including a decrease in risky behaviour with the presence of parental knowledge for both young men and women, even when controlling for parental closeness.

Soenens et al. (2009) found that promotion of independence can occur in either a controlling or non-controlling fashion. However, Luyckx et al. (2007) explored parental control and identity formation within four dimensions: Commitment making, exploration in breadth, identification and exploration in depth. Exploration in breadth refers to EAs considering different identity options, while exploration in depth refers to the gathering of further information to make a decision in terms of commitments already in place. They found that the perception of parental psychological control impacted on the EAs ability to make committed choices. EAs who felt subjected to high levels of parental psychological control were less capable of decision-making, struggled to empathise, or make choices with any certainty. In addition, there was a decrease in exploration in breadth as psychological control increased over time. Soenens et al. (2009) supported this in terms of suggesting that parents can be perceived as using controlling tactics, forcing EAs to make rash or undesired decisions, which causes even less certainty regarding decisions. There was a non-significant effect on exploration in depth. An explanation for this could be due to no committed decisions being made or feeling uncertain for these options to be fully explored due to the level of parental control.

Morgan et al. (2010) suggested that patterns in conversations changed over the course of their research, with more open, varied and detailed conversations occurring between parent and EA regarding sexual relationships. They found that once the dyad had one conversation about a topic relating to sexual relationships and dating, then these conversations became part of the routine of interactions. This study firstly demonstrates the positive implications of conducting longitudinal research compared to taking a snapshot of the relationship, as is the case with cross sectional studies. In addition, it supports the premise that changes take place between the EA and their parent over the course of this developmental stage, with a more reciprocal relationship occurring.

Nelson et al. (2011) gave support to this, by suggesting that parenting during EA is most productive and effective when they talk to their children and form new boundaries, including promoting autonomy, which in turn creates a more balanced adult-adult relationship. Urry et al. (2011) expanded on this by proposing that child disclosures in terms of open and comfortable discussions is a prominent indicator in terms of maternal knowledge, which can be linked to satisfaction with the current relationship.

3b. Indirect effects

The focus of EAs upon independence, identity exploration behaviours and socio-emotional development, may result in parenting that does not relate directly to child outcomes (Arnett, 2000). Instead, parenting may relate indirectly through influence on EAs personal characteristics, for example, beliefs and values or how they perceive their parents (Barry et al., 2008). Parenting is still believed to matter to EAs, but may best be explained through indirect relations rather than direct ones.

A number of studies supported the notion of indirect rather than direct parenting effects. Padilla-Walker et al. (2008) demonstrated that the way EAs perceived their fathers' knowledge of their activities led them to engage in less risky behaviours, such as reductions in drug use and sexual activity. However, this study could not determine the key factors behind the reduction and how it could be interpreted.

Kenny and Sirin's (2006) study suggested that parental attachment was indirectly linked to lower depressive symptoms and higher levels of self-esteem. Barry et al. (2008) demonstrated that high quality maternal relationships are positively related to EAs internal regulation of prosocial values and negatively related to external regulation of prosocial values. A number of studies explored the indirect influences of parental behaviours and style on the prevalence of and type of risky behaviours, including alcohol related problems and impulsivity (Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al., 2011; Urry et al., 2011). More positive, adaptive, styles of parenting (i.e. warmth, less psychological control and appropriate responsiveness) led to lower engagement with risky behaviours. These could also be perceived as being typical of mediators, which will be discussed below.

3c. Mediators

Mediators "*explain how external physical events take on internal psychological significance*" (Baron & Kenny, 1986 p.1176). "*Mediation is established when a) the independent variable significantly predicts the dependent variable b) the independent variable significantly predicts the mediator variable c) the effect of the independent variable on the dependent variable is diminished when the mediator variable is controlled for*" (Kenny & Sirin, 2006 p. 66).

A number of studies explored the impact of mediators within different parental constructs and psychological well-being (Kenny & Sirin, 2006; Marsiglia et al., 2007; Padilla- Walker et al., 2008; Patock-Peckham & Morgan-Lopez, 2009; Patock-Peckham et al., 2011; Urry et al., 2011). Padilla-Walker et al. (2008) explored the mediating effects of parental closeness on parental knowledge and child outcomes demonstrating that closeness mediated how this parental knowledge was perceived. Specifically, they reported that maternal knowledge and less risky behaviour (lower alcohol and drug use) were strongest when maternal closeness was high. Fathering with an element of warmth was found to be protective against depression for both genders in Patock-Peckham and Morgan-Lopez (2009) study. Kenny and Sirin, (2006) proposed that self worth acted as a strong mediator between parental attachment and depressive symptoms, with higher levels of self worth decreasing the number of symptoms associated with depression.

3d. Gender

The evidence regarding gender differences of parent-child dyads has demonstrated that it varies by the gender of the parent and of the child. For example, mother-child communication is more frequent than father child communication (Dilorio, Pluhar & Belcher, 2003) or the role of care giving is general seen as a mother's role (Crouter, Helms-Erikson, Updegraff & McHale, 1999). Certain studies have focused on this, as discussed above in parenting styles whereas others have observed the different dyads with a number of variables. Morgan et al. (2010) demonstrated that both males and female participants were more likely to report more open and comfortable conversations with their mothers then their fathers at both time points observed. However, openness and comfortableness did increase over time with both parents. They also reported gender differences between daughters and sons with restrictive sexual

messages being experienced by daughters, and positive sex messages being experienced and aimed more at sons. It was not explored whether this was related to the gender of the parent. Restrictive sexual messages significantly decreased overtime, which suggests a more open form of communication, promotion of autonomy and trust in the developing EA and parent relationship.

Patock-Peckham and Morgan-Lopez (2009) also gave support in relation to difference in parenting styles towards males and females, with females perceiving their fathers to be significantly more overprotective than did males. However, overprotective fathers increased the level of depression and reduced levels of self-esteem, which increased the prevalence of alcohol related problems in men. Additionally, authoritarian mothering led to a reduction in self-esteem and to increases in the level of depression in men. No effect was found for females in relation to their mothers' style of parenting. Other studies found no gender differences in preliminary analysis hence were not considered in further analyses (Kenny & Sirin, 2006).

DISCUSSION

This literature review aimed to provide a systematic summary of research exploring the impact of parenting on emerging adults. From the results, the most apparent conclusion that can be drawn is that parenting, whether as a direct or indirect influence, still plays a crucial role in the psychological and social functioning of EAs, giving support to the importance of this relationship beyond the adolescent years.

In the papers that explored parenting styles, authoritative parenting demonstrated more favourable outcomes in terms of their child's internalising and externalising behaviours, psychosocial success and emotional adjustment. This is in line with the research conducted with children and adolescents (Dumas et al., 2009; McKinney & Renk, 2008). However, Nelson et al. (2011) suggested that although parenting styles were similar to those found in childhood and adolescence, new approaches are used during EA, terming them 'uninvolved', 'controlling-indulgent', and 'authoritative'. They also termed a fourth group as 'inconsistent' for mothers and 'average' for fathers. These new categories could be due to the unique challenges that parents face as their EA tries to gain autonomy whilst still, at times being dependent. In addition, it gives evidence to the confusion this stage of development can bring to both parents and EAs, therefore parents adjust their styles accordingly to try and adapt to this stage, (Arnett, 2001; Nelson et al., 2007; Kloep & Hendry, 2010).

As discussed during the main body of this review, due to the majority of papers on this subject being cross-sectional, causality cannot be assumed; ultimately meaning the application of these conclusions to other populations is limited. However, the findings do

raise interesting questions that we as clinicians, researchers and the services overall, need to contemplate. All of these will be discussed further in the forthcoming sections.

Theoretical Implications

The developmental stages of adolescence, young adulthood and emerging adulthood pose difficulties in their conceptualisations, meanings and age distinctions. Firstly, late adolescence and young adulthood are used interchangeable due to the lack of clarity and a clear definition being present, of what age, a person is deemed to be in these stages of development, (Gaudet, 2007). Eighteen year olds who have a number of legal rights do not see themselves as adolescents but they would not classify themselves as young adults either (Arnett, 2004). Emerging adulthood, although clearly defined by Arnett (2000, 2001, 2004) is also commonly referred to in the literature without at times the authors providing transparency of their definition or understanding of this term.

The concept of emerging adulthood as defined by Arnett (2000) has come under criticism from a number of researchers arguing that the term does not add to our understanding of the complexities, interactive processes and mechanisms that are involved in human development, (Bynner, 2005; Hendry & Kloep, 2007a). It does not capture the variations that exist within individuals and across cultures (Hendry & Kloep, 2010; Nelson, Badger & Wu, 2004). Therefore the ability to make generalisations is called into question and is accused of being nothing more than a cultural construct. Finally, they argue that structuralist stage theories of development are becoming more and more obsolete, (Hendry & Kloep, 2007b). They propose a phased approach to lifecycle transitions, encompassing the characteristics of an EA as being just one significant feature (Bynner, 2005; Cote & Bynner, 2008).

On the other hand, others have welcomed this theoretical contribution (Gibbons & Ashdown, 2006; Bundick, 2011). Although the majority of arguments supporting the concept derive from Arnett (2000) and Tanner (2006), an abundance of literature uses the term EA within their studies, providing a clear definition to distinguish the stages of development between adolescence and young adulthood. This can be seen in research, in addition to the studies included within this review, exploring a variety of concepts in relation to EA, including significant transitions within their life, (e.g. Buhl, 2007) and identity formation (e.g. Schwartz et al., 2011).

Arnett and Tanner (2009) suggest that there are a number of important developmental features that distinguish adolescence from EA encompassing cognitive, behavioural and emotional elements to reveal underlying neurological and physiological development. This is supported by the current literature in brain development (Giedd et al., 1999; Bennett & Baird, 2006) demonstrating specific regional changes in the brain structure, especially during times of life transitions, and research exploring the associated risks for mental health difficulties within this age period, (Tanner et al., 2007).

Clinical and Research Implications

One important factor as evidenced by the research, is that positive parental relationships can act as mediators towards EAs engaging in risk type behaviours, including drug use, alcohol use and sexual promiscuity (Padilla-Walker et al., 2008). There is a growing body of literature suggesting that experimentation and risk taking behaviours are particularly prominent during

adolescence and emerging adulthood (Arnett, 2005; Dodgson & Ross, 2011). This can lead to comorbid mental health issues arising during these stages of development.

Evidence supports the claim of certain difficulties becoming more prevalent during EA for both males and females, which can impact on the transgression though this developmental stage and into adulthood, (Kessler, Foster, Saunders & Stang, 1995 & Kessler et al., 2005; Tanner et al., 2007). These include: Anxiety disorders, mood disorders and substance use disorders. Alternatively, this stage can be seen as a "*sensitive period*" (Tanner & Arnett, 2009, p. 42) for changing the trajectories of early mental health difficulties to more salutary ones. This reinforces the need for services to have targeted treatment programmes and policies to address the mental health needs of emerging adults (Howard, Galambos & Krahn, 2010; Kuwabara, Van Voorhees, Gollan & Alexander, 2007).

It can also be suggested from the literature that parental knowledge may serve as a protective factor during this *age of instability* (Arnett, 2000; Padilla-Walker et al., 2008). This includes reducing the risk of engaging in certain behaviours, which can lead to the mental health difficulties cited above. However, a number of services (e.g. adult mental health services) are structured in such a way that the inclusion of parents within sessions is generally non-existent, leading to them feeling alienated from, and lacking knowledge of, their EAs care, (Por et al., 2004; Singh, 2009). This could lead to tensions occurring between the EA and parent that could be avoided with acknowledgement of the importance of the continuation of this relationship and inclusion of parents in their EAs care. Services should view this stage as a distinct and sensitive period of development and support both the EA and their supporting systems through it.

Gender variables were also explored in terms of both maternal and paternal influences on their sons and daughters. As earlier research has highlighted, both males and females felt closer and more open to having conversations about particular taboo topics with their mothers rather than their fathers, (Dilorio et al., 2003; Morgan et al., 2010). The research also highlighted different outcomes for the different dyads illustrating an occasional parent-offspring gender mismatch (Patock-Peckham & Morgan-Lopez, 2009). This emphasises the importance of exploring gender dyads of parents and their offspring in research and clinical practice. In addition, studying the impact of parents, in particular paternal factors, separately rather than amalgamating them together as 'parent' influences.

Although limited within this review the longitudinal studies suggested that relationships between parents and EAs change over the course of this developmental period. This includes a more open mutual relationship forming, where communication between both parties increases over time and a sharing of information occurs (Morgan et al., 2010). In addition, parents can struggle to let go and adapt to this transition stage. These are important factors to consider when reflecting on the development and maintenance of the parent/EA relationship, subsequently practitioners and service structures should hold these in mind when working with this age group.

Future Research

The direction of future research should include the suggestions made above as well as exploring the relationship between parents (maternal and paternal) and EAs in clinical populations. A limitation of all of the studies exploring EAs perspective was that the samples

were recruited from university populations. These are samples of convenience and an abundance of studies undertake research using this sub sample. Generalisability is however difficult due to a number of factors. Firstly, attending university assumes a level of independence and behaviour that may not reflect the abilities of those suffering with physical and/or mental health difficulties. Secondly, recruiting from a university sample leads to huge skews in data in terms of social economic status, educational attainment, financial stability and previous and future employment transitions. Finally, the majority of people attending university live away from home, especially during term-time. Research has shown that a parent-emerging adult relationship can become strained when the EA is still living at home, regardless of other difficulties being present (Seiffe-Krenke, 2006). Consequently impacting on the parent-EA relationship that may not be as evident when observing the relationship with university samples.

Further research is needed to explore the proposals made by Nelson et al. (2011) of new parenting styles being present and unique to this developmental stage. In addition, more emphasis is needed to understand how both make sense of this stage of development and how this impacts on the progression of their relationship. Finally, how parents adjust to this stage of development and how this impacts on their own life course transitions, especially when factors are involved, which may hinder their EA progressing. Longitudinal and qualitative research will only aid to our understanding within these areas; both of which are sparse within the theoretical construct of EA.

Limitations of review

This review considered the impact of parenting on EA, whilst limiting the concept of 'EAs' to that defined by Arnett, (2000) and to that author being referenced in every article included within this review. This excluded a number of articles that explored parent/child relationships but did not reference Arnett or did not use the term 'emerging adulthood'. Articles were also excluded if their main focus was not on the parental relationship but explored other concepts instead. For example: leaving home, financial and familial obligations. This review therefore did not cover all areas of research that might contribute to our broader understanding of parental influences during this developmental stage.

Another consideration to make is the challenge of systematically evaluating and synthesising quantitative and qualitative research. Whilst objectivity and rigor have been attempted, one's own interpretations and biases come into play, especially when conducting the quality checklists to the studies. This may lead to variations in scores from reader to reader. Therefore before drawing any conclusions from this review, the reader should consider these confounding factors.

In addition, some of the studies' findings were not discussed because they were not common to the set of papers as a whole, but this does not mean these results are unimportant or cannot further add to our understanding of parental influences on EAs.

Recommendations

Taking into consideration the limitations highlighted above, a number of recommendations can be made from this review for both practitioners and services' when working with EAs and their supporting systems.

1. Using the term 'emerging adulthood' to define individuals between the ages of eighteen to twenty-five, rather than the confusion that prevails in today's society of terming them, young adults, late adolescence, adult-child etcetera, (Gaudet, 2007). This will lead to all systems having a common understanding and a shared language about the developmental stage of individuals and their overall needs.
2. The importance of the continuation of the parent/EA relationship. This is particularly pertinent to services (e.g. adult mental health) where family involvement is not part of everyday practice and the importance of this is not reinforced. Thus clinicians and services should be nurturing and scaffolding this relationship by including parents within sessions and overall treatment plans.
3. Practitioners and services recognising both the needs of the EA and parent(s), including the influence of the gender dyads and how these needs will manifest and change over the course of this developmental stage. These factors could have both positive and negative implications for treatment adherence and outcomes.

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Paper to be edited for submission to BMC Health Service Research

HOW DO PARENTS OF YOUNG ADULTS MAKE SENSE OF THE TRANSITION BETWEEN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES AND ADULT MENTAL HEALTH SERVICES?

by

EMMA L. MILLAR

School of Psychology

University of Birmingham, UK

Department of Clinical Psychology

The University of Birmingham

Edgbaston

Birmingham

B15 2TT

ABSTRACT

Background

The transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) is a crucial aspect of care provision, however there is a paucity of literature exploring this event. In particular, in depth research investigating the parents' experiences of this process. This study aims to gain a better understanding from the parents' perspective, of their journey within mental health services.

Method

Using a qualitative design, semi-structured interviews were conducted with six mothers of young adults who had experienced the transition from CAMHS to AMHS. The interviews were analysed using Interpretative Phenomenological Analysis.

Results

Five super-ordinate distinct, but interacting themes were identified: (1) the fight; (2) hooks; (3) the scaffold; (4) readiness for transition and (5) what support should look like. The themes as a whole described the parents' journey throughout their young adults life in relation to their mental health difficulties, encompassing the struggles and the positive aspects of this.

Conclusions

This study provides further insight into a relatively unexplored area. In line with previous research, parents felt excluded and lost within the transition process and tried to find alternative strategies to help them cope with their young adults' presenting difficulties. It also provides new evidence regarding the impact on parents' identity and their own life course

transitions of having a child with mental health difficulties. The clinical implications of the findings are discussed in relation to service provision and providers, with recommendations for an integrated holistic approach and a 'shared language' being implemented and for services to work towards 'optimal transitions' for everyone involved in the process.

Keywords: Parents, Child and Adolescent Mental Health Services (CAMHS), Adult Mental Health Services (AMHS), Transition, Young Adults, Emerging Adults, Qualitative.

INTRODUCTION

Adolescence is a time of rapid change and transition for young people and their families. It is a time for physical maturation, psychological growth and the development of life plans, which can lead to excitement and uncertainty for both adolescents and caregivers, as they adapt to this new stage of development. Whilst adolescents are trying to assert their autonomy as they begin to adopt adult roles and responsibilities, parents are learning to accommodate and adjust to these changes. Within the description of developmental transition there is an explicit acknowledgment of the significance of the developmental age of the young person (Singh et al., 2010). This can be very different from the chronological age stipulated by policies and guidelines at the service level (Davidson, Cappelli & Vloet, 2011), presenting issues for an age based 'administrative event' between services.

Adolescence and mental health

The research exploring the prevalence and onset of mental health difficulties highlights that most adult mental health problems emerge during adolescence (Kessler et al., 2005). Although there is no clear consensus regarding the underlying causes of problems occurring between the ages of twelve to twenty-five (McGorry, 2007), it has been suggested that a number of factors are involved (Dodgson & Ross, 2011). These include adapting to this stage of development, identity formation and an increase in risk taking behaviour including substance misuse and sexual promiscuity (Arnett, 2005; Dodgson & Ross, 2011). However, under twenty-fives are underrepresented in the Adult Mental Health Services (AMHS) population (Dodgson & Ross, 2011). This poses the questions: What is the reason for this underrepresentation and who is supporting them if they are not involved in professional care?

Set age boundaries for categorising people into different stages of development offer confusion, as there is no clear distinction regarding what age range constitutes adolescence and/or adulthood. The World Health Organisation (WHO, 2012) defines adolescence as between the ages of 10 to 19; others use the term as a working definition stipulating the age of adolescence ranges between 12-25 (McGorry, 2007). Services on the other hand define adulthood at 18 leading to transitions occurring from child-orientated services to adult focused services.

Throughout literature on the subject, interchanging terminology is used to refer to individuals within this stage of developmental transition, for example, late adolescence, early adulthood, adult-child or young adult, with no clear definition given (Gaudet, 2007). There is a growing body of literature regarding this developmental stage being a distinct period of lifespan known as 'Emerging Adulthood', which lasts from eighteen to twenty-five (Arnett, 2000; 2004; 2007; Tanner, 2006). A number of studies have explored the impact of parenting within this developmental stage, (Kloep & Hendry, 2010; Nelson et al., 2007), which conclude that the relationship between parents and their emerging adult continues to be important, especially during times of transition (Bartle-Haring, Brucker & Hock, 2002). This research will focus on the age range of between 18-25 to aid clarity and due to service transitions occurring once the young adult reaches 18. The concept of emerging adulthood will also be considered and explored further within the discussion section of this report.

Transition

Blum et al. (1993) refer to transition as *"the purposeful planned movement of adolescents with chronic physical and mental conditions from child-centered to adult-oriented health care systems"* (p. 570). The goal of transition planning is to provide inclusive proficient services

that are *"seamless, coordinated, developmentally appropriate, and psychosocially sound"* (Sawin, Cox, & Metzger, 2004 p. 144). Optimal transition should scaffold the young person and surrounding systems and be a collaborative process with a beginning, middle and end (Gorter, Stewart & Woodbury-Smith, 2011).

The literature on transition identifies three simultaneous but potentially conflicting elements that can impact on the transition process defined above: *Developmental, institutional and multiple transition factors* (p. 14, Davidson, Cappelli & Vloet, 2011). The institutional or systems level transition involves policies and guidelines that direct service provision and delivery. The implementation of these policies at an institutional level can be seen as an administrative event (Vostanis, 2005) requiring an arbitrary response, meaning the complex needs and requirements of individual service users and supporting systems (e.g. parents / carers) are not specifically addressed. Aging out of a Child and Adolescent Mental Health Service (CAMHS) can be viewed as a system level transition, hence reaching eighteen involves leaving CAMHS and either being referred into another service, for example, AMHS or support being terminated.

Transition and Mental Health

Developmental and service transitions become more complex when the young person has challenges in one or more areas. These can include physical, emotional, behavioural or mental difficulties, which can lead to multiple transitions occurring all at once (Hovish, Weaver, Islam, Moli & Singh, 2012; Kirk, 2008). Studies exploring developmental and service transitions of individuals with a disability from paediatric to adult health care, have explored opinions and the perspectives of family members as well as professionals (see Chambers, Hughes & Carter, 2004; Hewitt-Taylor, 2009; Peter, Forke, Ginsburg & Schwarz, 2009).

Within mental health services, research exploring the impact of transitions has been relatively sparse, with even fewer exploring family perspectives. Studies that have explored parents' experiences of mental health difficulties include transitions within learning disabilities (Tarleton & Ward, 2005) and generic mental health settings (Harden, 2005; Jivanjee, Kruzich & Gordon, 2009; Pejlert, 2001). Other research has focused on reviewing policies, practices and the perspectives of health professionals (Birleson, Luk & Mileshkin, 2001; Richards & Vostanis, 2004). A great proportion of existing research has been conducted in America, Canada and Australasia, in contrast to the United Kingdom (UK), where research has been limited.

Transition in the UK between CAMHS and AMHS has been a fundamental care provision and 'hot topic' in government legislation and services nationwide for a number of years (Lamb, Hall, Kelvin & Van Beinum, 2008, Department of Health [DOH], 2004; 2011). The current government strategy, 'No Health without Mental Health' (DOH, 2011), emphasises the importance of a number of issues when discussing the transition between CAMHS and AMHS. These include: Early planning, providing appropriate and accessible information and promoting flexible services based on development needs. It also acknowledges the importance of inclusion of all systems stating that *"families and carers, including children, have detailed knowledge and insight and are often best placed to advise health and social care professionals about what may help or hinder the recovery of the person for whom they are caring"* (DOH, 2011, p. 33).

There has been a long-standing concern that young people and their families are getting 'lost in transition', in their move from CAMHS to AMHS (Arcelus, Bouman & Morgan, 2008; Davis, 2003; Singh, 2005; 2009; Singh, Moli, Ford, Kramer & Weaver, 2008; Singh et al.,

2010). A recent national review of CAMHS provision in the UK (Singh et al., 2008; 2010) found that the transition from CAMHS to AMHS caused major concern to service users, carers and practitioners. The main issues were around not receiving the required care during transition, having a rigid cut off point with age, different perspectives on treatment goals and not reaching the threshold for AMHS. This was particularly significant for young people with neurodevelopment disorders, for example, Attention Deficit Hyperactivity Disorder (ADHD) or Autistic Spectrum Disorder (ASD), and emotional and/or behavioural related difficulties.

Transition and Parental Involvement

A growing body of literature supports the view that parents need to be involved and supported through the transition process from child orientated to adult orientated services (Brookman-Frazee, Baker-Ericzen, Stadnick & Taylor, 2011; Kingsnorth, Gall, Beayni, & Rigby, 2011; McConachie, Hoole & Le Couteur, 2011; McDonagh, 2004). Firstly, there is evidence emphasising the importance of the parent-child relationship throughout the lifespan (Bowlby, 1982; Bartle-Haring et al., 2002). Secondly, an individual's disengagement with the CAMHS/AMHS transition process maybe significantly reduced by the inclusion of family (Dixon, Adam & Luckstead, 2000). Finally, having a child with mental health difficulties can have a substantial impact on the parents and extended family (Brookman-Frazee et al., 2011; Hovish et al., 2005; Milkie, Norris & Bierman, 2011; Pillemer & Suitor, 1991). There is a dearth of literature investigating the latter point, it is therefore unclear regarding what the implications are and the 'resources' parents have or develop, when faced with these difficulties.

The coping mechanisms which parents adopt may aid our understanding of these 'resources' and their ability to 'bounce back' to act as a protective factor for their child, throughout their mental health journey, particularly during transitions (Davydov, Stewart, Ritchie & Chaudieu, 2010). These mechanisms can be grouped under the term resilience, which is defined as "*the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma ..."* (Windle, 2011 p. 152).

The support that is offered needs to recognise that service users and their families should have the ability to have choice and control in their own care and treatment (DOH, 2008; 2010; Laugharne & Priebe, 2006; Worrall-Davies, 2008). This obviously raises challenges when conflicting views are at play between service users, parents, practitioners and service providers (Day, 2008; Hovish et al., 2012). The tensions between CAMHS and AMHS broadly relate to both structural and procedural difficulties arising from the interface of the two services or cultural differences. This leads to CAMHS working from a more holistically-orientated model where as AMHS takes an individual-focused approach (Appleton & Pugh, 2011). Although the literature cited above supports the need for parental involvement during the transition process and beyond, the evidence which has explored this has found that parents may be less involved than they were in CAMHS, feel "*in the dark"* (Hovish et al., 2012 p. 255) and experience difficulties adjusting, once their child had transferred over to AMHS (Hovish et al., 2012; Singh et al., 2008; 2010).

The TRACK study (Singh et al., 2008; 2010) is the first large-scale study to explore the impact of the transition process from CAMHS to AMHS for service users, parents and clinicians. A number of published studies have come from the TRACK study, however this

has meant that the data collected may be three or four years old by the time the report is available for public dissemination (e.g. Hovish et al., 2012). In addition, the sample in Hovish et al. (2012) study only included young people and potentially their parents who had transitioned to AMHS and who were still engaged with them, three months after transition. Therefore the sample was under-representative of young people and parents who had dropped out within this three-month period, nor did it gain a full picture of their experiences after this time-frame. Finally, there was minimal in-depth qualitative exploration into the full impact of this transition for individuals, particularly parents, as the studies explored multiple perspectives, using the 'Framework Approach' described by Ritchie and Spencer (1994).

Rationale

Transition is an inevitable part of every person's life, with certain stages being critical for the continuing development and wellbeing of an individual. Adolescence can be seen as a particularly critical point in an individual's life, because experiences and events at this juncture can shape one's ability to progress through this stage of development into the next. There is an increased vulnerability when other factors are interplaying, for example mental health concerns, which can lead to multiple transitions occurring simultaneously within this stage of development. If handled well, individuals will be able to progress and adapt to these transitions despite their difficulties. Research suggests, however, that if this process is not handled well, it can have adverse consequences on individuals and their supporting systems; leading to them feeling lost in the transition process, excluded, and with reduced support from services (Hovish et al., 2012; Singh et al., 2008; 2010).

As cited above, the evidence demonstrates that everyone involved within the transition journey needs to be taken into consideration, particularly parents. Research exploring the impact of transitions on parents, specifically from CAMHS to AMHS, is scarce, with an even smaller number of in depth qualitative studies being conducted within this area. There is a general consensus with professionals that transitions are difficult and anxiety provoking, with very few following the guidelines for 'best practice'. However, the focus on these transitions is generally on the young adult, therefore at times the parents get 'forgotten' within this process. Small scale studies therefore need to be undertaken to gain rich, detailed accounts of parents 'lived experiences' of these events, to fully understand how they have found this process. This will help to minimise the assumptions made about how they may find it and guide future service provision.

This research therefore sets out to build on findings from Singh and his colleagues (2008; 2009; 2010; 2012) and contribute to the paucity of literature within this area. It aims to explore how parents of young adults have made sense of the transition their child has gone through between CAMHS and AMHS from a phenomenological perspective, particularly focusing on the process, outcome and experience of transition for the parent(s) of the young adult (Singh, 2009).

METHOD

Context

The study took place within the CAMHS teams working in the West Midlands. The policy regarding the transition from CAMHS to AMHS was devised with commissioners and joint commissioners of children and adult services. It highlighted the need to start the transition process at seventeen years six months, with a three-month period of joint working with the young person and their family, particularly with complex cases.

Design

This study adopted a design of one-off semi-structured interviews with parents of young adults. The aim was to explore how they had made sense of the transition between CAMHS and AMHS, focusing on the process, outcome and experience of the transition. The qualitative methodology of Interpretative Phenomenological Analysis (IPA; Smith, 2003) was chosen as the most appropriate method of analysis, as the intention of IPA is to explore in detail how participants make sense of their world. In particular, the main focus is on the meanings people give to particular experiences and/or events, such as transition (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009).

Ethics

Ethical approval was sought from the the West Midlands Ethics Committee (Appendix 7). Worcestershire Health and Care NHS Trust Research and Development department approved for the study to be carried out over sites within the Worcestershire region. (Appendix 8)

Recruitment

Participants were recruited from two CAMHS teams. The teams were presented with a summary of the study (plus two sister projects that were taking part in the same services) and the rationale for the research (Appendix 9). Potential participants were identified by the lead practitioner of the case and were offered to sign a consent slip at the point of discharge of their young adult who was being transitioned over to AMHS (Appendix 10). This was to find out more information about the study from the researcher. A number of steps were followed to ensure that consent and opportunities to withdraw were avaliable to each participant up until data analysis, (Appendix 11).

Participants

Six particpants took part in the study, a small sample of this size is considered appropriate for IPA to facilitate in-depth analysis (Smith & Osborn, 2003). The participants were mothers whose children had been involved with CAMHS and had been referred to AMHS. The participants were recruited based on the inclusion and exclusion criteria summaried in Table 1.

Table 1: Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
• Parent (s) of young people who have experienced the transition from CAMHS to AMHS and the young adult is still involved with AMHS. • Parent (s) of young people who have experienced the transition from CAMHS to AMHS but the young adult is no longer involved with the AMHS service. • One or two parents of the young adult can be interviewed; this will be done separately. • Young People will be 17 or 18 at the time of transition. • They will have good verbal and written communication in the English language.	• Only one young adult will be discussed with parent (s) who have experienced the transition process with two or more of their dependants. • Parent (s) of young people who have been referred onto other services i.e. Relate, sexual health, and speech and language therapy. • Carers of looked-after young adults who have been transitioned • Grandparents of young adults who have been transitioned • Individuals with little or no basic understanding of written or verbal communication in the English language.

Procedure

The primary procedure was to follow the steps of informing and gaining consent described above. After the initial contact, participants were sent 'Participant Information Sheet' (Appendix 12) and two consent forms, for both themselves and their young adult to sign (Appendix 13 & 14). The importance of their young adult agreeing for them to take part was highlighed as further participation could not be considered without this consent. They were contacted again a week later to answer any questions and an interview was arranged at a time convenient to both interviewer and interviewee. Four out of the six participants had a young adult taking part in a similar study exploring their experiences of the transition process from

CAMHS to AMHS, conducted by another trainee clinical psychologist (Jefferies, 2012) within the researcher's cohort. This meant that the two interviews were conducted seperately but simultaneously to minimise potential disruption to the families' lives.

Data Collection

Interviews

Semi-structured interviews were conducted in a therapy room at CAMHS or at the participants' house. The interviews were digitally tape-recorded and lasted between 48 and 127 minutes. The interview schedule (Appendix 15) was developed in-line with questions asked within previous research (Singh et al., 2008) and in collaboration with the researcher's supervisors. The following topic areas were explored with participants:

- how they became involved with CAMHS;
- their understanding and experiences of the transition process;
- their impression of AMHS and how it differed from CAMHS; and
- what they believed had been helpful/unhelpful.

They were also invited to add anything else and comment on questions asked/not asked. This high-level structure was flexible, meaning changes could occur during the interview process.

During the first two interviews it became apparent that the participants struggled to provide insight into the transition process for various reasons (i.e. lack of involvement or a 'transition' not really occuring), therefore this experience was not in their 'frame of reference.' In discussion with research supervisors, future interviews were broadened out to gain a narrative account of their experiences of transitions before, during and after CAMHS, including the transition to AMHS. This revised approach still focused on the process, outcome and

experience of these transitions. This seemed a logical format to follow, as it was important to understand how participants made sense of the transition process by the time they reached adult services.

In the later interviews, participants were asked questions regarding whether they viewed their son/daughter as an adult and their feelings towards their readiness to transition. These were prominent themes in the first two interviews conducted, which indicated their importance and the need to explore them with future participants. This is in line with IPA interviewing, as when different themes or ideas become apparent within previous interviews, the researcher can incorporate and explore these within future interviews (Smith et al., 2009).

Participants were debriefed and offered information for further avenues of support if required. These included: Improving Access to Psychological Therapies (IAPT), RELATE and carers' support groups. The interviews were then transcribed verbatim, with all personally identifying information removed and line numbers added to aid analysis. All participants were given a number and pseudonym and these were used to identify the participant, ensuring anonymity (Table 2).

The anonymised transcripts were sent to the participants to ensure accuracy and for them to have the chance to omit anything they did not want to be included within the research document. This also gave a final opportunity to confirm continued participation within the study.

Data Analysis

IPA is concerned with the subjective personal perception that an individual has regarding an event, rather than trying to make objective links and statements about the event itself. Table 3 gives a step-by step account of the process of data analysis used in this study, with steps one to four being repeated for each participant. To ensure the validity (triangulation) of themes, codes and emerging themes were cross-referenced with my research supervisor who has in-depth experience and knowledge about IPA. A number of quotations are used within the results section of this report to support interpretations and themes identified, demonstrating credibility (Elliot, Fisher & Rennie, 1999; Yardley, 2000).

The researcher's own ideas and formulations however, do come into play during the process. Therefore whilst the participants are trying to make sense of their experiences, the researcher is trying to make sense of how the participants are trying to understand their experience from a psychological perspective, known as a double hermeneutic (Shaw, 2010; Smith et al., 2009). It is therefore important in terms of validity to understand and show sensitivity to the epistemological position of the researcher and the 'person in context'.

Epistemological position and person in context

I am a thirty-one year old white British middle-class female trainee clinical psychologist. Participants were made aware of my trainee status and understood that the research was a partial requirement of my Doctoral studies. I have experienced the tensions between young people and adult services in relation to transition with not very positive results. It caused a great deal of anxiety, frustration and confusion for all concerned and only a small number had an optimal transition process. This was before starting my clinical training and these

experiences were the driving force behind my interest for this research. I felt that it was a chance to explore whether changes had occurred within the transition process from CAMHS to AMHS.

In addition, at times I have felt powerless as a practitioner raising my concerns in supervision and allowing me to explore my feelings around this topic. I was, however, left wondering how it had truly impacted on the service users and their parents and where they could go. Therefore, to be able to conduct this study and 'give voice' (Larkin, Watts & Clifton, 2006) to parents' experiences and views was a privilege and appealed to me intuitively.

Undertaking this research, I expected to hear stories of transitions that had not gone to plan, I wondered whether parents felt excluded from the process and the impact this had on them and their relationship with their child and wider systems. I was aware of my own potential biases and experiences, tried to remain neutral and focus on asking open questions. I was also aware that this could potentially be an emotional and distressing subject matter. This was discussed with both my research and clinical supervisors regarding ways to manage these situations appropriately and professionally. Packs were made up with information regarding services available for further support for the participants. In addition, space to seek support after the interviews was available for me if needed.

Table 2. Participant Summary

No	Pseudonym Parent-Child	Son/daughter of participants Gender & Age (at point of interview)	Relevant Contextual Information Young Person	 Parent
1	Linda – Janet	Female, 19	Transitioned to Early Intervention (EI) after hospital admission, in the process of transitioning over to AMHS and has had contact with AMHS for 4 months at time of the interview. Janet had an inpatient admission whilst involved with CAMHS. Diagnosed with semantic-pragmatic disorder, ADHD, schizoid affective disorder and depression with psychotic elements. At the time of interview EI and AMHS were disputing these diagnoses.	Linda is a single parent; she has a partner who does not live with them. Works flexible hours due to Janet's difficulties. She has an elder daughter whom has a learning disability who no longer lives in the family home.
2	Tina – Paul	Male, 19.	Transitioned to AMHS at 18, has been under their care for just under 2 years but he has had only one appointment in that time. No inpatient admission whilst involved in CAMHS. Diagnosed with Asperger's	Tina is a single parent, with no partner. Paul is her only child. She works in a school, and has flexible hours due to Paul's difficulties

			syndrome and dyspraxia, bouts of depression and has self harmed in the past.	
3	Amanda – Billy	Male, 19	Transitioned to AMHS just after 18th birthday just over a year ago. He has had one appointment with AMHS. No inpatient admission whilst involved with CAMHS. Diagnosed with ADHD. Billy took an overdose, which led to the transition to AMHS.	Amanda is married to Billy's father. She is currently the only one working in the household. She has an elder daughter who moved out due to Billy's behaviour.
4	Debbie – Tom	Male, 19	Transitioned to AMHS at 18, over a year ago. He has had one appointment with AMHS, after waiting 3 months at the point of being discharged from CAMHS. No further support offered. No inpatient admission whilst involved with CAMHS. Diagnosed with ADHD.	Debbie has a partner [Jason]. She works in a school supporting children with emotional and behavioural difficulties. Debbie works flexible hours due to Tom's difficulties and has an older daughter, who moved out of the family home due to Tom's behaviour
5	Patricia - Toby	Male, 19	Transitioned to AMHS at 18 so has been involved with them for just over a year. He has had two appointments with AMHS, at the time of interview. These were very	Patricia is married to Toby's father. She has three children, all of whom have mental health difficulties and have been involved with CAMHS at

			spaced out with no consistency. No Inpatient admission whilst involved with CAMHS. Diagnosed with ADHD. AMHS are exploring a diagnosis of ASD.	some point in their lives. She works in a nursing home specialising in Dementia care.
6	Sally – Ben	Male, 18	Transitioned to AMHS at 18 and has been with them for 4 months He has had two appointments at the time of interview the timings of these have not been consistent. Ben had an inpatient admission whilst involved with CAMHS. Diagnosed with Atypical Depression.	Sally is married to Ben's father. She works as a health visitor and has an older daughter who is away at University.

Table 3: Stages of Data Analysis

Stage	Process & procedure	Credibility and Reflexivity checks
1	Tape recordings of the interviews were listened to and then a 'free association' of the transcripts was conducted, documenting any thoughts, feelings, assumptions, questions and concerns that came to mind whilst reading the text. This was then placed to one side and I tried to 'bracket off' my thoughts, values and existing theoretical assertions to complete stage 2.	At the end of each interview and when listening to the interviews at the initial stages of analysis; my thoughts, feelings and overall impressions of the process were noted in a reflexive journal, (Appendix 16). Other checking systems included: - Regular discussions with academic and clinical supervisor - Peer support (attended an IPA support group)
2	A second copy of the transcript was used to systematically code the data line-by-line. This followed the steps set out by Smith et al. (2009) of descriptive, linguistic and conceptual coding. Further readings followed to ensure full analysis and capture of the participants' complete experience. These were noted on the left-hand side of the page (Appendix 17).	
3	Emergent patterns of commonality were noted in the right-hand margin. (Appendix 17).	
4	Emerging themes were written on post-it notes for each participant and stuck to an A3 piece of paper, (Appendix 18). Connections across emerging themes were identified, exploring the convergence and divergence of themes for each participant.	

5	Patterns of themes were identified across individual transcripts and drawn together to create a super-ordinate theme. Themes that were not relevant were excluded.	

RESULTS

Five main sub-ordinate themes were derived from the in-depth analysis, with eleven emerging sub-themes, which are presented below. Not all participants contributed to every sub-theme, as providing evidence of convergence and divergence within the participants' accounts is part of the essence of the IPA process (Smith et al., 2009). The final themes were chosen for their frequency and the emphasis that participants attributed to them within their accounts.

1. **The fight**
    a. Within self
    b. Within the family
    c. With services
2. **Hooks**
    a. Fear
    b. Life on hold
3. **The scaffold**
    a. Positive support means being included
    b. Maintaining communication within the family
    c. [The mothers'] Resilience
    d. Staying hopeful
4. **Readiness for transition**
    a. What to call our young person?
    b. Transition, what's that?
5. **What support should look like**

All of these themes are interrelated, reflecting the participants' subjective accounts of their journey. However, their relationship with each other should not be underestimated in aiding our understanding of the complexities and at times distressing experiences of the participants.

Theme 1: The fight

The theme of 'the fight' explores how all mothers feel that their journey to get to and/or when in mental health services has been a battle. What also came from the interviews was a sense of fighting within themselves and fights happening within the family due to these experiences.

a. Within self

All six mothers described in some way the journey that they had been on in coming to terms with their young adult's mental health difficulties. Some mothers struggled to face the truth about these difficulties. This was summarised by Debbie who stated that she was "*too frightened to name it."* Amanda commented on Billy being *"naughty, we thought he was just a naughty lad […] I suppose you don't want to believe that your kid's like that. So I just left it and left it."* Linda described her experiences as *"mind-blowing."* These accounts are tremendously powerful and provide a sense of fragmentation and the problems participants had in comprehending their experiences.

Sally described Ben's difficulties being like a bolt from the blue "*a complete shock"* and something she could not make sense of, "*it was bizarre".* For her, life was normal until he turned 16 and became unwell. This experience was in contrast with that of the other mothers, whose difficulties with their young adults had been present for a number of years. The mothers who had experienced more gradual transitions in their young persons' presentations had more time to move from a position of denial into one of acceptance.

In trying to understand why they did not want to seek support it was important to grasp the meaning they attached to support. For some, it appeared to be a feeling of fear; that services would confirm what they already believed; they had done something wrong and were to blame for their young persons difficulties. In some instances they appeared to have put up with the behaviour of their young person, and the resulting impact on themselves and the wider family, as a form of punishment. Comments such as *"I thought no, it's got to be something I've done wrong"* **(Debbie)** or *"you blame yourself"***(Linda)** were common throughout the interviews.

> *"It made you think about what your life was about and what you were doing and to think oh no not another child, because obviously we had gone through that with John, we though oh no not with Toby. It was really difficult, to be honest. We kept asking ourselves, what had we done, is there something we didn't do when he was younger or in the womb, you know or something."* **(Patricia)**

This fear became more apparent when their young adults were struggling to cope, leaving parents feeling helpless and to blame:

> *"It has been hard, really hard, especially for Tom more so, cause he's got tired over it and sometimes he's cried and said he don't know what's the matter with him and it's not fair on him and that's why sometimes I blame myself."* **(Debbie)**

> *"It was really difficult, because sending Toby to school when I knew he wouldn't deal with it. I mean even his school photographs, when he has had a group photograph, they are all nicely in a group and he is on his own. It used to be heartbreaking because Toby used to be at school with no mates at all and he used to have his lunch on his own sat in the playground that was awful. Many a times we would just drive past to see if we could see him to what he was like because we just felt awful that he would be sitting there without anybody. It was just really difficult."* **(Patricia)**

Debbie's acceptance for seeking help seemed to come from her not being able to cope anymore:

> *"I weren't happy at first, but I need it, I was going to end up having a nervous breakdown if I didn't get the help, because of things that were going on at home. "* **(Debbie)**

However, for Patricia, she was still on her journey to accepting certain aspects of her son's care:

> *"Because they have given him medication that's another issue that I need to try and sort out in my head, because I didn't want him to go down the medication route because of the problems with John. But if he says it's helping him them I've got to accept that's what he is doing".* **(Patricia)**

For all mothers there was a sense that they battled with the feelings of guilt and regret. This was due to a number of factors including their reluctance to seek help at first and leaving their young person alone when they were unwell. This was particularly prominent when their dependant was having thoughts of suicide or self-harm. In addition, these feelings were aroused due to not pushing for further care or seeking clarification.

> *"So there are a lot of things where, I wish I would have done it a hell of a lot sooner you know […] I should have done it years ago, I just didn't want a label and probably I made a mistake myself for putting up with that and not doing things sooner"* **(Debbie)**

> *"Sometimes when Ben wasn't good I felt guilty about going to work, wondering if I was doing the right thing, that's why we checked on him, making sure he was o.k. [...] I am angry at myself for not pushing harder, I keep questioning should I have done more, should I have been more pushy."* **(Sally)**

All participants clearly had a sense of preoccupation about their young adult when they were not with them, feeling on-edge and in a constant state of fear about what they could potentially do. This anxiety will be explored in more depth within theme two, '**hooks'**. This pre-occupation also impacted on other areas of their life, including work.

With all of the mothers there was a real sense of feeling lost, alone and unsure of themselves. Descriptions such as "*immaterial"* **(Tina)** and *"sometimes I just feel like a robot"* **(Patricia)** were dotted throughout the discussions:

> *"No, sometimes I don't even know myself sometimes, don't know who I am anymore sometimes, cause it's always been this"* **(Debbie)**

Both Linda and Tina commented a number of times on their own levels of intelligence. This seemed to be a re-occurring theme within their life, in terms of how they viewed themselves and their understanding for the reasons why people did not listen or believe them. Linda stated, *"because I am not that intelligent they did not take any notice of me"* and *"I am not that intelligent, I could not put into words or make people listen to my concerns."* Tina referred to herself as "*being thick"* and *"I can't get things to work for us, I can't do it"*.

In trying to understand Tina's position and her experience of her "fight" it seemed that Tina had not expected her life to be like this, which had left her feeling very *"bitter"*. The continuous fighting that she has had to do throughout Paul's life has left her struggling to see reasons for continuing to fight, or for remaining positive about the future:

> *"I don't know what to do for the best for him that's the trouble now just don't know what, and often I don't know what to say to him either because when things seem hopeless I think well yeah they do[…] I can't see a light at the end of the tunnel, you know, I just can't. I'm not good at putting a good light on things either, I can't make*

the best of things because I've done it all my life I am not doing it anymore, I've had enough now. I am fed up with it now." **(Tina)**

All participants stated they had experienced conflict within themselves, these included: Feeling lost, guilty, insignificant and unsure of who they were, and at times what they were fighting for. There is a sense this left them feeling drained, alone and riddled with worry and regret. However, as well as trying to deal with these, had to put up with other fights within the family and services, both of which will be discussed next.

b. Within the family

Tina, Amanda, Linda, Patricia and Debbie all discussed how family life had been tense, and at times distressing, within their recollection of their journey. The conflict between mothers and their young persons will be explored in more depth in theme 2, **Hooks.** Conflict in the wider family could be with a partner/ex partner, between siblings or within the extended family systems including grandparents:

"Billy and my daughter never got on. It did cause a lot of arguments between us all. It's as bad; it's still bad now. It did cause a lot of arguments. I suppose because both of them are jealous of each other. They think that the one is getting more attention than the other. I suppose the way Billy has been, he does get a bit more attention. You are trying to balance everything, have time for everyone but you just can't do it." **(Amanda)**

Debbie gave insight into how her son's mental health difficulties had impacted on her whole family. This also included her and her partner's parents. She felt embarrassed by this, as it did not sit comfortably with her own *"respect your elders"* code of conduct:

"He'd tell his grandad to 'f' off and I didn't want that with his grandad and his Nan they're going to get older and you respect your elders. I was brought up like that […]

> *It's just been an absolute nightmare for me and the family not just for me, Jason and Sarah, it's been for Jason's mom and Dad Jason brother the nephews, its affected all the family, everybody."* **(Debbie)**

For Linda, the fight within the family was trying to make her partner understand why Janet could not, and still cannot, do certain things. This gives a sense of constantly having to justify and be an advocate for her daughter even within the family home:

> *"Well her stepdad finds it hard to come to terms with because I have got another daughter with disabilities, so it is quite stressful and he just thinks, he's like in denial. He doesn't understand it even if the support worker has sat him down and said look this is how it is, he's still in denial. Why can't she do this? Why can't she go to the shop?"* **(Linda)**

There is a sense that the mothers never experience harmony or tranquillity anywhere within their home and/or extended environment. This only adds to feelings of exhaustion and intensifies their sense of responsibility. There is also little surprise that there is a sense that there is a loss of self-identity. The mothers reported that they have little time for themselves due to constantly having to deal with the conflicts that arise within the family and dealing with different services.

c. With services

The fight with services varied from participant to participant, however the commonality with all of their accounts was their poor experiences of AMHS.

For Tina, Linda and Amanda the fight began when they were trying to access CAMHS. Other professionals, especially within school, did not believe them, did not listen to them, blamed them, or on occasion questioned their parenting skills. This was expressed by Tina, *"I've had*

to fight, fight, fight all the time," giving a particular example of when school questioned her parenting abilities:

> *"They kept having me in and actually I lost my temper with them because one of the teachers insinuated that I was sat at home on my bum watching the telly and smoking. I said I go to work, I said I have jobs that Paul could so that he's not in care, he is with me all the time and I've had to carry on doing that because I'm very aware that at the drop of a hat I've got to be pulled out to go and see to him."***(Tina)**

All the participants at some point in their journey stated that they felt "*in the dark*" and *"excluded"* from the care of their young person. In trying to understand this, notions of hopelessness, being rejected, powerless and of feeling de-valued and unskilled became apparent. These experiences made them question, at times, their own parental abilities, perpetuating the cycle of regret, blame and guilt discussed in the fight *within them*.

Sally, Patricia and Linda all discussed the lack of support they received from the community CAMH services. Sally and Patricia talked of incidences where they were excluded from sessions:

> *"I would drive him to the appointments and then drive him home again. I would just sit in the waiting room, professional would come out and I would sit in hope and then she would call Ben and then they would come back out and we would go home. [Demonstrated how she would sit up and show interest so they may ask her something.] Sometimes I just thought why would they not ask us?"* **(Sally)**

In the end this led Patricia to give up fighting with CAMHS due to feeling unheard, insignificant and like a number on a list:

> *"It was really frustrating; because I know they kept saying oh we only have one person on the whole of Hereford and Worcestershire and I kept saying I know you have but Toby needs to be seen. He is at that point where I need some help and they*

said we will get you the next available appointment and that never came through. Then I would ring them up again, look we are still waiting, this would probably be a gap of months, we are still waiting. They would say sorry, the lady who you want an appointment with was off sick then she would be off on annual leave. So I just thought, we can't do this anymore we are just going to have to manage on our own and that's what we did." **(Patricia)**

This could provide some explanation to why families discharge themselves from services or are under-represented within services. This will be discussed in more detail within the discussion section of this report.

Linda discussed an incident with the support worker. In trying to make sense of this interaction between Linda and the professional, the importance she placed upon it and the meaning behind it, needs to be taken into account. Potentially due to the professional questioning her interpretation of her daughter's difficulties, Linda felt that the professional was insinuating that she was making them up. This left her feeling judged and again, having to justify her position and the concerns she has for her daughter:

"When I was talking to the support worker she said that she heard voices and I said I'm sorry I don't hear voices, I don't think it's normal. The things that she was saying to me well, I don't hear voices, I don't see things or hear things, so what is she trying to say." **(Linda)**

Tina very much felt that she and her son were excluded and treated differently from services due to where they lived. There was a real sense of injustice about this, feeling that others from more affluent areas were treated with more care and consideration and felt like she was being *"trampled on*". This was a common theme that ran throughout her interview and something she was not prepared to accept:

"Somebody who was exactly the same as Paul in his class at school even he was on the top rate of mental of Asperger's exactly the same, but he got away with everything because he was from [place]. To the point that they told Paul that he could not mix with his friends but it was alright for the other one to and I said well can you tell me what the difference is apart from postal codes and there was no answer. So I have proved this from the bottom, I know it's postal coded and I don't care and I even told the parents this as well. I said I might be on a council estate but that does not give your son the right, in my eyes and I don't care what the school says for him to get away with everything." **(Tina)**

There seemed to be a sense of confusion for all of the mums regarding what support AMHS could offer. When asked what they knew about AMHS, no one could give a definite answer, comments like *"I don't know if they can offer much really"* **(Tina)** or *"I really do not know what to expect"* **(Linda)** were given. Their understanding of the transition process will be explored further in theme 4: **Readiness for transition.**

Debbie provided an account of the battle she had to firstly get her son to go the AMHS appointment, *"so it took at hell of a lot for me […] eventually I did get him there,"* and the experience of when they were there:

"We went there, waited quite a while which he was very agitated because he was seeing people he didn't like and it upset him […] What worried Tom as well was when we came out there was all locks on the doors and everything, so it was more like an institution really. They didn't ask me to go through with him, they asked Tom to go with him and they needed to talk to him for half an hour. Tom didn't really like that, because I've always supported Tom and been there for him. As he walked through the door, I could see his face and I thought he's either going to go, which he never and I was really proud of him. They must have been in there 35-40 minutes talking to him. Then they asked me to go through um and this lady said, she went out for a minute to

speak to a doctor and Tom said she asked me some weird questions […] She came back, she sat down and she says what do you expect us to do at this place for Tom? And I said well really we came so Tom could talk to someone every so often and that he could come himself if he brings it upon himself that he could do that eventually, with his age and I said about his medication because his medication is a prescribed drug and we do make sure he needs it. And she said well there's nothing, I've been and spoke to somebody and I don't think there's anything we can do here. I said so what am I going to do, meaning 'well what am I going to do, I don't know, I don't know what I'm going to do.' She did not say anything, so I said could you please write to the Doctor so I can keep getting his medication. As you know Tom's here, he needs his medication." **(Debbie)**

She described this experience, as being "*absolutely disgusting" and "horrendous."* When asked if she would think about returning to AMHS for further support, she categorically stated that she wouldn't. This was understood to be due to many reasons including: Not being prepared to put her son or herself in that situation again where they were not treated appropriately; not having the strength to deal with the consequences; if the appointment goes wrong (i.e. her son's reaction) and losing faith with them as a service. This 'loss of faith' was an underlying theme within most of the other mothers' experiences too.

Amanda was not involved at all in the discussions about Billy going to AMHS. Not only did she have to deal with her son taking an overdose, but her feelings of being excluded, devalued and deskilled as a parent were all coming into play as seen by the quote below:

"They just don't want to listen to us, they just wanted Billy. But since March, that's when he did it. He has only been to the adults once. And it's like he took an overdose, he had to go a couple of months after that to see the adults and that's it nothing else. Well I think it's disgusting. A kid at that age taking an overdose and only been seen

once. Where is the help? I know he is 19 now but at the time he was 18, he's got no help […] No, they were honestly a load of rubbish." **(Amanda)**

Tina described her son having his first appointment with AMHS nearly two years ago and has been waiting ever since to receive a second appointment:

"So he'll be twenty in February. He has not really had any proper counselling since we transferred over to adult services and we have had to ring them in between because he does get very depressed […] He's had absolutely nothing and I find that a bit hard really, almost two years and he has not seen anybody since then." **(Tina)**

Every mother recalled accounts of experiencing a poor service from AMHS, these ranged from no support, to being involved in one appointment, to AMHS disputing the diagnoses given from child services. There was a sense that the whole process was a waiting game, a common theme throughout all the participants' accounts: Ringing up, requesting help, which never comes, and so trying again and again. Feelings of powerlessness, frustration, being rejected and loss all came into play when they were discussing these experiences.

Theme 2: Hooks

This theme encompasses fear and life being on hold. Fear experienced by the parents' is two-fold; firstly, living in fear of their young adult trying to harm themselves and living with violence or aggression; each will be discussed in turn.

a. Fear

All of the mothers who took part in the study have experienced their child self-harming, suicidal ideation, or trying to commit suicide at some point in their lives. This feeling of living on *"tender hooks"* was described by Amanda:

> *"Tender hooks, that is all I can say. Did not want to leave him on his own. It happened in the March and I was going away abroad in May with my mum. So it was like my husband had to keep an eye on him. My husband didn't come. So he had to keep an eye on Billy and make sure he was alright. If he was late home we didn't know if he had done anything. When he has a drink, he can't hold his drink, then he gets very depressed when he has had a drink. You are then wondering, you phone him, he will argue with you saying leave him alone, I'm old enough to look after myself. He doesn't come home. Or it's his friend, he's friends coming round, Billy's done a runner we don't know where he is. We are then out all night looking for him."*
> **(Amanda)**

Linda felt powerless and deskilled as a parent during these periods "*I don't know what to say to her or how to cope when she is very upset or self-harming, I find it very difficult."* This was also coupled with not receiving enough support, or the support being inadequate due to the intensity and the distressing nature of the incidents For example, one piece of advice given to Janet was to *"give your mum a hug or keep busy 24/7,"* which Linda did not feel helped with the severity of the situation. These feelings link in with theme 1: **The fight**.

The second part to the emerging theme of fear is living with violence or aggression. This involves them being unsure about what they may face when they walk through the door, '*walking on eggshells'* and at times being scared to be in their home with their young adult, linking into the notion of *"tender hooks"* described above. Amanda, Debbie and Tina have all experienced some form of violence towards them and/or another member of their family. These included: Knives being held to siblings' throats, furniture being thrown and broken, and dents in appliances. These were always during times of minimal support, especially from mental health services. During her interview Amanda stated that she was having a really difficult time with her son due to the lack of support AMHS were offering him:

> *"It is, it's awful. Sometimes I don't want to come home from work. Sometimes I can utter one word to Billy and he is down my throat or he punches a wall. It is hard. I hate it sometimes coming home […] When I come home, stupid things, like I'll say to Billy, turn your telly down because I am going to bed, this is 9 o'clock at night sometimes 10 o'clock and he just starts effing and blinding to me. I say I have to go to work Billy. It is alright for everybody else, you can have a lie in. I can't. It just ends up in a big argument. It is very hard again at the moment."* **(Amanda)**

Others describe the reactions of their children when things happen, that to some may seem as being inconsequential, but have lasting and stressful outcomes for the young person, mother and the wider family:

> *"He used to build models in his room out of Lego and he, one day I went in there to clean it and accidentally knocked it over and he just went ballistic, really bad, because he just could not cope with the fact this model had been broken."* **(Patricia)**

Trying to make sense or even begin to understand the strength these mothers have and continue to demonstrate throughout all of their experiences is astounding. This will be explored in more depth within the next sub-ordinate theme, '**the scaffold'**.

b. Life on hold

A clear consequence of the fear described above is a sense of stagnation that the mothers' personal lives have been stalled due to the mental health difficulties of their young person. Sally described this feeling in some detail:

> *"I feel like life has been put on hold. For example, I am just painting the hall as for the last 2/3 years we have done nothing; it has just been making sure that Ben is okay. and not changing too many things. So life has been on hold. Things are good at the moment, Ben is good but I know it won't last we are just waiting for it to change. Ben is doing his exams this year, exams are always a difficult time for us so we know this is going to be tough but we are just going to have to get through it."* **(Sally)**

This also links into the reflection of being on "*tender hooks"* and even though life is good at the moment because Ben is good, Sally is just waiting for it all to change. There is a sense that living like this must be draining and confusing for all parties, with no long-term goals and no sense of progression. The parents were all unsure about how long good behaviour was going to last and what issues would arise in the future.

Linda described her life being on hold but she was also worried about the future, especially as she gets older and may not be able to look after Janet. There seemed to be a sense of her not wanting to transition to different stages within her life because her daughter is 'stuck' and not able to transition through life due to her difficulties:

> *"That's a very big worry, a very big worry. I mean I'm young enough at the minute but as time gets on and you get older or anything should happen to me."* **(Linda)**

Debbie described her life at the moment as *"in a bubble"* until she could go back to the GP and discuss Tom's medication options. This seemed to be another hurdle she had to face and one that she would be glad to overcome.

Theme 3: The scaffold

This theme includes elements that have supported and helped both the parent and the young adult, providing a form of scaffold for them both. These include experiences of positive support, communication between them both, the roles parents have adopted to scaffold their young person and the hope they have for the future for their young adult.

a. *Positive support means being included*

Tina, Amanda and Debbie all found the support they received at CAMHS helpful. To some extent they all felt their opinions and experiences were listened to and believed, as well as being included in the care process. Amanda just thought they were *"fantastic*"

> *"To start with Billy had an assessment here. Then he had counselling and umm they also let us go as well and they talked to us as well. So we were going to counselling, all of us."* **(Amanda)**

Linda and Sally did not have a positive experience within community CAMHS, however found the support and treatment from the inpatient CAMHS team really helpful. This was due to being included in discussions, feeling valued and diagnoses explained to them:

> *"For someone to listen and believe what you're saying is the truth. You're not after attention or anything like that, you just want a diagnosis and to understand."* **(Linda)**

> *"Yes definitely, they [inpatient CAMHS] explained things, asked our opinion, they would talk to us about what was going on, we went to the discharge-planning meeting and discussed things with us and CAMHS. With atypical depression, which is what Ben has, he does not get angry, Ben has never got angry. They said that was Ben's problem that he never got angry he just held everything in. When they asked me at [place] that, I had never thought about it, I just thought he was a calm child. But when they asked me I though yes, he never gets angry."* **(Sally)**

For all, this sense of feeling included differed greatly to how they felt in the summary of the fight *'with services,'* where they were left feeling lost, deskilled and excluded. It seemed that Sally understood Tom's difficulties more when there were conversations and questions posed to her about what could be contributing to his issues. For all of the mothers, having a sense of understanding and awareness about their young persons difficulties helped them to find practical strategies and the strength to continue moving forward.

In contrast to the experiences of all other participants, Patricia was positive regarding the support they received from Toby's school:

> *"All through his school he used to have shut downs quite often and he and at one point they gave him cards if he knew he wouldn't interact or just wanted to go off, he would do that…school were very supportive."* **(Patricia)**

This experience of good practice stands in clear contrast with that of the other mothers who felt let down and fought with their respective schools to get professional care for their young person.

b. Maintaining communication with the family

For all of the mothers, even when their personal situations were challenging, they held onto the fact that their young adult communicated with them. Each one stated they had a close and open relationship with their young adult, feeling that they could and did discuss anything with them:

> *"Yeah, very close, she can tell me absolutely anything and I talk a lot to her because there's no point. I've never had to shout at her or smack her because there's no need, you just talk to her, and that's what I told the school. Don't bother shouting at her or you know people do get frustrated I suppose with her but if you talk to her you'll learn*

at lot more than if you shout at her. It's just going to make you have a bad day and her have a bad day too." **(Linda)**

A number of the mothers stated that communication became easier with their young person when they were receiving positive support:

"Yeah much better and just talking about where we're going and who we're going to see and did you mind going and 'no I need it mom' it was more open and a bit more one on one." **(Debbie)**

Sally discussed how open communication had always been an important element of how they functioned as a family and how she feels this played an important role in helping them to get through the last two years:

"Luckily me and my husband have a strong relationship and have supported each other through this. We are a very open family who communicate a lot, all of us, especially with Ben so that has helped." **(Sally)**

c. *[The mothers'] Resilience*

For each mother, their journey has shown a tremendous amount of strength and resilience to keep going. Debbie described it as *"you've just got to shake yourself down and just start again"* when referring to incidents of aggression and violence that she has experienced. She concluded that *"I have to be strong, I have to be, because if I let go Tom's going to fall so I need to be strong for him."* Therefore their strength comes from the knowledge that without them being there, their young adults would not cope and in a sense fall apart. Amanda also commented on this *"I suppose I just try and hold it together for everybody else […] I suppose I am getting stronger and stronger."*

Tina demonstrated this strength and resilience. At the beginning of her interview, Tina discussed in great depth the battles that occurred with mental health services over the years, leaving her feeling very angry, hopeless and ready to give up. Towards the end of the interview she had a sense of hope and a continuation to keep going and fighting for the sake of her son:

> *"One day I'll sit down and think well no I'm not having it and I'll keep blooming ringing because otherwise other people get it so why shouldn't we? Then once I'm on a roll I don't give in, then I'm like a dog with a bone and I just keep on [....] I am fighting for Paul, I am always fighting for Paul really."* **(Tina)**

The mothers also demonstrated ways of how they re-skilled themselves to help their young person. This may have been researching the diagnoses to aid their understanding, or re-naming certain behaviours so the family shared a common language about the presenting difficulties. Patricia shared the notion of *"shut downs"* to describe episodes of Toby shutting himself away and dis-engaging from the family and outside world. Sally discussed using the Internet to find information, as well as talking to her partner. She was the only participant to state that her son's mental health difficulties have brought her and her husband closer together rather than causing fights between them:

> *"I talk to friends and Clive and I talk about this a lot it has made us stronger. We have just been doing what we thought was right asking Ben what he wanted us to do and looking on the internet. Clive and I would have a lot of conversations on the phone or text when one of us had spoken to Ben so we were not hounding him. We told Ben that we would be calling him and asked him not to get pissed off with us, but we needed to do it."* **(Sally)**

This theme also encompasses the roles and routines that the mothers have had to undertake to try and keep familial relationships as 'normal' as possible, whilst maintaining a sense of

"balance" and calmness. They discussed a trial and error approach, finding things that did work for their young person and having to deal with the consequences when this did not work.

> *"He would only eat certain foods; we would have to go to certain towns to get certain foods he liked. Certain drinks he wouldn't drink we would have to drive miles just to, it was our way for Toby coping with it. Some people said yes but you have given into him but it wasn't giving into him it was what Toby needed at that point in time and it was the only way to get him through each day if I were honest. I would have gone to the end of the earth if it meant that Toby could get through his day."* **(Patricia).**

> *"Ironing, I put the stuff away he's got his drawers and it has to be in set places, or he else he goes mad. Just structure, like I say its structure. He says he's not leaving home till he's 30-40 so I ain't bothered he said no-one would know me like you."* **(Debbie)**

> *"How on earth he could live on his own in this point in time, I don't know how he would cope. Because his, even his bedroom is like a bomb's hit it. I know most teenage boys but this is beyond. It is really bad upstairs. We don't go in his room as he gets quite cross if we did so we have learnt to leave It, but things like that he obviously does not cope well with."* **(Patricia)**

It also highlights how stages of development in terms of transitions through life can be delayed when an individual has certain struggles.

d. Staying hopeful

Within this sub-theme each mother had hope that things would eventually improve and that their young adult would be able to function somewhat independently. There was a sense that this was due to their levels of resilience, driving them to keep going and previous episodes of positive support and 'normality':

"To see her more settled to eventually be able to go outside the house without me to be able to work and to have relationship because she hasn't been able to have a relationship because she doesn't trust people. They said that with the Semantic Pragmatic Disorder that she'd have trouble making friends and having relationships, so it's quite a lonely world for her." **(Linda)**

"I hope that he can get a job really and that he could get some independence." **(Patricia)**

Theme 4: Readiness for transition

This theme encompasses two sub themes within it: *What to call our young person?* and *Transition - what's that?* These reflect the difficulties the parents have with a young adult over the age of 18, but being unsure about what to call them and how they view the transition process.

a. *What to call our young person?*

Throughout all of the interviews the mothers used interchangeable words to describe their sons or daughter, including adult, child, kid and infant. This demonstrated confusion about firstly what to call them, but also the perplexity that this stage of development can bring, especially when there are complications in terms of a person's overall mental health and well-being. No mother stated that she thought their young adult had reached adult status, concluding that their chronological age may suggest they have, but developmentally they had not:

"No not mentally he was still a child […] It's sometimes like having an infant still about […] I know he's an adult. I know at that age he's an adult but mentally he isn't an adult and most of these children whose got ADHD, autism, dyslexia whatever, they are still not adults. I don't care they're not, they're not adults." **(Debbie)**

"They are still kids at 20, Billy is still too immature." **(Amanda)**

"Although Toby is 19 in age he is not in mind if you see what I mean he is quite immature." **(Patricia)**

"Really devastated really because I want to know now she's an adult I want to know what's going on because she's not capable of making her own mind up, that's a big worry, that's a big worry in case she signs for something, they might say do you understand and she might say yes but she doesn't really." **(Linda)**

For Amanda and Sally, they could not view their sons as an adult, due to them not believing that they would constantly tell the truth or talk to professionals within the mental health services. This led to them feeling frustrated at both their sons and at the professionals for excluding them from sessions and not taking their view point into consideration:

"Sometime Billy wouldn't come out with the truth […] we found out that he wasn't telling them [professionals] the truth […] saying he was alright when he wasn't." **(Amanda)**

"*When I knew Ben was going but didn't really feel like saying anything. He is really articulate and does talk but sometimes he would say that he couldn't be bothered to go and talk for an hour, he just wanted to forget it and get on with things. I then just thought, which is really bad, what a waste of an appointment, why couldn't they ask us and we could have told them what was going on as sometimes Ben wouldn't."* **(Sally)**

None of the mothers felt that their young person were ready to transition over to AMHS from CAMHS and wished they could have stayed with them longer:

"Yeah yeah and that's what I'm saying where they do come here or wherever and it should stay here till an older age." (**Debbie)**

This can be understood in terms of them not feeling that they were an adult, as considered above, and secondly the mothers not having a sense of what the transition process was about.

b. *Transition, what's that?*

It became clear from the interview process that all participants had a minimal understanding about the transition process. This lack of understanding was due to a number of factors, including exclusion from the decision-making process, as well as preconceptions regarding AMHS.

As discussed in theme 1, several of the parents had been excluded from discussions regarding transition, hearing of it second-hand from their young adult. Secondly, if they were included in their young persons care, there were minimal discussions regarding the transition process, *"no, they did not tell me what would happen."* **(Linda)** Finally, all of the participants felt that they had not had enough of an experience from AMHS, to fully grasp the significance of the transition process. Therefore, trying to make sense of the process was difficult to understand and discuss. Sally summed up her understanding of the transition process as follows:

> *"Well in our experience it just seems that it means papers are transferred from one service to another and we get a letter telling us that has happened. That's it. I wonder how people view transition or really know what it means. That is how transition was for us."* **(Sally)**

All participants had expectations of what they thought AMHS would be like. This was based on their previous experiences within CAMHS. For some this was a hope that it would be a positive experience:

> *"I just thought it would probably be a bit like [professional], but thought that it would be intervention meetings with a group of people with the same sort of thing like ADHD or dyslexia or anything. Just so they'd sit down in a group and how they felt especially with them being young people, young adult people and if they felt they needed the family there, they was asked and the family would have been there, say if Tom wanted to take his Nan, he took his Nan or I don't know his granddad, his sister whatever."* **(Debbie)**

For others, they had heard opinions regarding AMHS prior to their own experience. These opinions led them to hold a negative view regarding AMHS prior to any personal experience:

> *"Well we knew we would be less involved than we are now, so we wouldn't be involved at all."* **(Sally)**

Theme 5: What support should look like

All six participants offered suggestions regarding what they would like support to be like in AMHS. These could be viewed as being simple recommendations, *"a simple wish list"* **(Tina)**, of inclusion, support, practical advice and help for parents to gain an understanding of their young adults difficulties. These suggestions all focused on providing them with support tailored to their personal circumstances, whether through support groups or professionals:

> *"Advice, Support, Education, Information, to know we are doing the right thing. We would travel anywhere to get it but I think it needs to come from someone who knows Ben, who is working with him so having that joint working and those joint conversations."* **(Sally)**

> *"Like I say, I'd like to be able to meet other people, you know and be able to say, because I wouldn't feel so stressed would I if I knew somebody else's child had got similar problems and they could say well why don't you try this or try that, because they've actually been through it."* **(Linda)**

"If there was a session that they would let me go with Toby, I would definitely go. I think it would help, cause I know Toby says things what he's, it's just little bits, he doesn't tell me everything. Oh he says he has given me some tablets and that would be it, he wouldn't elaborate on what else has been said. Not that I would want to know everything because obviously some things Toby needs to keep private. But yeah it would be good to see what line they are going down and how we as a family can support him in that." **(Patricia)**

Implementing some of these proposals could help to reduce many of the issues highlighted in theme 1 **"The Fight"**:

"I want to be there for Toby and I don't feel I am being because I don't know what's going on, you're in the dark really aren't you? So it does feel very odd. It would be good to be more involved in it, definitely." **(Patricia)**

Throughout all of the interviews, it seemed that this was the first time any of the participants had sat down and really thought about their experiences and how these had led to the current situation. All stated they had found it beneficial talking about their journey and their personal experiences of caring for a young adult with mental health problems. It helped to attribute some meaning to their experiences, both good and bad, and to explore ways to move forward.

DISCUSSION

The aim of this research was to explore how parents' of young adults have made sense of the transition their child has gone through between CAMHS and AMHS. What came from the research was that, to understand how these parents experienced the transition from CAMHS to AMHS, one must first have an understanding and make sense of the journey that the parents have been through at the point of reaching this transition stage. 'Transition' is a concept which maybe more meaningful to professionals than it is to carers who experienced this stage of their journey less as a 'move' (from one service to another) and more as an 'amplification' of their difficult circumstances. Five main over arching themes emerged from the interviews conducted, these were 'The Fight', 'Hooks', 'The scaffold', 'Readiness for transition' and 'What support should look like.'

Parents' accounts of 'the fight' they experienced with services, in particular AMHS, were consistent with past findings (Hovish et al., 2012; Singh et al., 2008; 2010). This left them feeling excluded, lost, worried, in the dark and frustrated during the transition from CAMHS to AMHS. Limited discussions were had about the transition process, all felt that their young adult was not developmentally ready to be transitioned over to AMHS, and they proposed a number of recommendations to improve this. The research also supports the impression of individuals with neurodevelopmental disorders being more likely to fall through the gap between CAMHS and AMHS (Singh et al., 2010). This is an alarming finding considering that individuals with ASD are at increased risk of developing mental health difficulties (McConachie et al., 2011).

The notion of the *'the fight - within themselves'* during the process of their young adult having a mental health difficulty are consistent with previous findings (Harden, 2005; Pejlert, 2001). Parents felt they were somehow responsible and to blame for their child's difficulties, and expressed feelings of guilt and regret in the ways they reacted and coped with these struggles.

This study also provided further insight into the parents' experiences of having a child with mental health difficulties and the implications this has for them, their extended families and their own transitions through life. All stated that they had 'lost themselves' throughout the whole process and were unsure of who they were at the time of the interview. They stated that they lived in fear of their young adult potentially harming themselves or others, and touched upon how having a young adult who was struggling with their stages of development could potentially impact on their own life course transitions.

The generic research that has focused on the impact for parents have all suggested a number of negative consequences this can have on them. Pillemer and Suitor (1991) investigated the effects of adult children's problems (i.e. physical health or mental and emotional difficulties) on elderly parents psychological distress, concluding that an increase in problems led to greater reported levels of depression. Milkie et al. (2011) provided further support for this, demonstrating that an individual's psychological well being in late life was related to their earlier parenting experiences. Brookman-Frazee et al. (2011) explored the impact on parents of having a child with ASD, concluding that significant stress and adverse consequences manifested in psychological and financial strain. There is however, a paucity of literature exploring the impact of having a child with mental health difficulties on parents' self-identity and life course transitions, due to their continuing roles and responsibilities. These issues of

carer identity are a key contribution of this study, and they need further consideration and investigation.

A study by Harden (2005) suggested that parents may find alternative strategies to cope with feelings of helplessness and rejection, by re-skilling themselves in terms of acquiring knowledge and renegotiating the parental caregiving role. These ideas could be supported by the current study, as parents found ways to try and understand their young adults' difficulties by researching it on the Internet or seeking further clarification. In addition, they adopted different roles and responsibilities to provide support for their young adult. This was through keeping structure and routine in the family home or re-naming certain difficulties so families had a shared understanding about them. The resilience which parents demonstrated enabled them to continue fighting and 'bounce back' from significant adversity (Windle, 2011). This may also have provided them with a sense of hope for the future for their young adult.

These all offer plausible answers to the questions posed at the beginning of this research regarding why under twenty-fives are underrepresented in AMHS and who is supporting them if they are not involved in professional care**.** The fight that all mothers experienced with CAMHS, AMHS or other services led to some 'giving up the fight'. For example, not ringing up for another appointment. This suggests that it may have been too hard for the parents' to continually be 'rejected' from services and them making false promises to ring back. For some parents', there was a sense that they were apprehensive about going back to AMHS due to their previous experiences, and the resulting consequences that had to face and cope with, from their young adult. This left the young adult being reluctant to go back because of how they were treated. Services may view this as the individual not wanting to engage and

therefore discharge them. In addition, due to the parents' not being persistent and ringing for an appointment, they get forgotten and 'lost' within the process. Finally, by AMHS stating that they did not know what they could do for their young adult or limited support being available the parents' 'lost faith' with them. Therefore, eighteen to twenty-five year olds are underrepresented within AMHS not because of the lack of need, but due to them not matching the needs that service users' and their families are presenting with.

This leaves parents having to cope on their own without any support from services. Research shows that creating a reciprocal 'safe' environment using the principles of 'containment' (Bion, 1959) and 'reciprocity' (Brazilton & Cramer, 1991) can lead to a reduction in both the parents and the child's internalising and externalising behaviours (Bateson, Delaney, & Pybus, 2008; Milford, Kleve, Lea & Greenwood, 2006). The importance of 'being heard', (Myers, 2000) cannot be underestimated, as it leaves individuals with the emotional capacity to continue dealing with difficult situations without becoming overwhelmed by them.

Clinical Implications

This study demonstrated that the transition between CAMHS and AMHS is still an 'administrative event' rather than a purposeful process of change, taking into account the developmental and social needs of the young adult and family members. It needs substantial further consideration, development and a more rapid response to recommendations made by the parents and others involved in the process, in how to manage this service level transition efficiently and effectively. This is of particular necessity, considering that adolescence and emerging adulthood is a vulnerable period for the materialisation of mental health concerns and risk-taking behaviour (Kessler et al., 2005; Dodgson & Ross, 2011).

The policy for the CAMH services seemed to be fruitless, as all participants confirmed that no joint conversations or meetings took place between CAMHS and AMHS that they were involved with. This needs further deliberation and investigation for both services to ensure this policy is adhered to and the importance of why these recommendations are in place. The transition from CAMHS to AMHS is a crucial aspect of care provision and needs to be treated as this, rather than being a paper exercise. The emphasis therefore should be on integrated working (CISP, 2005). Unfortunately, cultural, professional, financial and the fragmentations of organisations, thwart a joined up care approach from being implemented. These include: Poor communication, varying service ethoses and lack of organisational stability (Cameron & Lart, 2003).

The literature on emerging adulthood (Arnett, 2000; 2004; 2007; Tanner, 2006) could provide clarity for providers and families regarding the confusion that prevails in relation to this stage of development. It offers a 'shared language' to describe the age period from eighteen to twenty-five, aiding communication between all. In addition, due to this period being a time of instability and uncertainty, and with research demonstrating that direct or indirect parental influences, aid the emerging adult's progression through this stage of development, it highlights the importance of the continuation of the parent/emerging adult relationship (Millar, 2012). This may assist in moving services towards an inclusive working model and reduce the anxieties that exist, regarding an individuals' readiness for transition. Furthermore, it would enable providers to tailor the support required, and services to be more developmentally focused rather than chronologically needs-led.

This research has strengthened the argument to consider specialist youth mental health models for individuals aged twelve to twenty-five (McGorry, 2007). The development of Early Intervention (EI) services lends support to the success of this notion. This provision straddles the CAMHS and AMHS divide, providing support for individuals and their families between the ages of fourteen to thirty-five with early onset psychosis. This specialist model of care recognises that this age period is a crucial developmental stage, focusing on being person-centred, family-focused, responsive and engaging, whilst normalising their experiences to produce optimal outcomes, clinically and financially, (Bird et al., 2010).

Irrespective of the ethos of the service, a gradual transition, tailored and paced to the needs of the young adult and their family, with a flexible structure and approach, is essential. Thus allowing the experience to be as positive as possible, at such an unpredictable and vulnerable time. Munoz-Solomando, Townley & Williams (2010) present a new definition of transition which is *"A person's journey between services that should be shaped by awareness of the narratives of their past history, evolving needs, values and preferences, and present circumstances as well as services that are involved recognising the culture, capabilities and capacities that are required of them"* (p. 316). This defines transition as a continuous process that runs in parallel with providing parental involvement and support.

Adult-orientated services therefore need to consider the whole system surrounding the emerging adult, and to be more holistic in their approach rather than individually focused. The tendency of such services to see the adult as a discrete and independent individual is potentially harmful in emerging adulthood. Parents at this stage are still parenting, and so they voiced requested '*advice, support, education and information'* to enable them to feel

confident enough to support their emerging adult through their difficulties. The majority of mothers felt they had received this sort of support, at some point from services, in particular generic or inpatient CAMHS but not from AMHS. What cannot be underestimated is the impact that having a family member with mental health difficulties has on the parents and the extended family and that services have a 'duty of care' to recognise and support them through this process.

Limitations of study

IPA is concerned with the detailed consideration of personal lived experience, thus small sample sizes are permitted to allow time for each experience to be analysed in depth, with the aim that something will be identified for each participant (Smith, 2011). Some key findings here are clearly consistent with the outcomes of less in-depth larger-scale studies. However this study offers insight into the carers' own identity and development are new, and merit further research. Recruitment was difficult for this study and I hypothesised why this could be, however a participant summarised the potential possibility of this at the end of our interview together, "*sometimes people do not want to take part in the study or talk about it when things are good as they don't want to think about it, they just want to keep everything on an even balance.*" I made sense of this in terms of linking it back to the themes described above, in particular keeping structure and routine within the family environment. Therefore they may not have wanted to do anything that could have upset this 'balance'.

A second limitation of this research was the underrepresentation of fathers and daughters accounts. Where fathers were fully involved in their child's life and wanted to contribute, both volunteered the mothers to be interviewed first, stating that they would be able to provide a more detailed account, due to them being more 'involved' in their child's care. The

fathers then felt that there was no need to be interviewed separately, even when encouraged to do so. A minimum number (N=1) of parent-daughter dyads offered to take part in the study with those declining citing a number of different reasons for this. Research indicates that fathers maybe more involved with sons than daughters (Bronte-Tinkew, Morre, Capps & Zaff, 2006), and highlights the importance of the relationship between parents and their offspring especially during the emerging adult years (Nelson, Padilla-Walker, Christensen, Evans, & Carroll, 2011). In particular, different outcomes are evident when exploring the relationship between same gender dyads (i.e. mother and daughter), opposite gender dyads (i.e. father and daughter) and a parent-offspring gender mismatch, (father and son, Patock-Peckham & Morgan-Lopez, 2009). This therefore needs further consideration and exploration to gain a fuller picture of the transition process for all involved.

IPA requires the researcher to engage in a process of sense making and interpretation, therefore one's own position and interpretation of the data lends itself to potential biases and hypotheses of the participants' accounts. Although this was accounted for through cross checking analyses with my research supervisor, it cannot guarantee for total elimination of presuppositions nor can it control for these interplaying in the interviews. In addition, my status as a trainee clinical psychologist and what this may or may not have implied regarding my own levels of intelligence, being a psychologist and the potential power differentials exhibited between the participants and myself, could have led to some 'holding back' on certain points during the interview. I felt this was particular pertinent to two of the participants, who struggled with their own levels of 'intelligence' and with previous experiences with psychologists.

Future Research

Research into the implications of service transitions is sparse, and a continuation building on qualitative and quantitative studies within this area, as well as more dialogue encompassing both, within mixed methodologies, is needed. From the research, it was highlighted that due to their young adults having difficulties transitioning through their own developmental stages, this could have implications for the parents life course, complicating their adaption to their own transitions, which include, aging, retirement and menopause. Minimal research has been conducted exploring how parents have been and are affected with the on-going mental health difficulties of their offspring thus future research should concentrate on this, encompassing a more systemic perspective of the transitions process.

As cited above, fathers were underrepresented within this sample; this is a limitation within the vast majority of research observing child-parent relationships. Future research should focus on the influences and involvement of fathers within all aspects of the emerging adults lives, in particular within developmental and institutional transitions. This includes exploring the longer-term influences and changes within these relationships, through longitudinal studies.

This study only explored the view of maternal parents and as previous research has shown, young adults, clinicians as well as parents, all have differing views of the transition process, (Hovish et al., 2012). It is therefore crucial to get the perspectives of all involved and future research will need to consider these factors. By linking into the sister project undertaken by Jefferies (2012) we will be able to provide the young adults views of their transitional experience in comparison to four of the mothers who took part in this study.

Conclusion

This research has demonstrated that services have a long way to go before they can state, with confidence, that optimal transitions occur between CAMHS and AMHS, and that parents are involved with this process, as recommended by DOH (2011). The importance of this occurring cannot be underestimated, as the knock-on effect for emerging adults and parents lives appears to be very substantial.

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PUBLIC DOMAIN BRIEFING DOCUMENT

Parenting and Emerging Adulthood: A review of the literature

&

How do parents' of young adults make sense of the transition between child and adolescent mental health services and adult mental health services?

by

EMMA L. MILLAR

School of Psychology

University of Birmingham, UK

Department of Clinical Psychology

The University of Birmingham

Edgbaston

Birmingham

B15 2TT

PUBLIC DOMAIN BREIFING DOCUMENT

This thesis was submitted as partial fulfillment of the requirements of a Doctorate in Clinical Psychology. The document describes both sections of Volume I, which includes a literature review exploring the relationship between parents and their emerging adults' and a qualitative study exploring parents' experiences of transitions with their young adult, who has mental health difficulties. In particular focusing on the move from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS).

Study 1: Literature Review

Arnett (2000) proposes the notion of 'Emerging Adulthood' as a theoretical culturally constructed concept, which is used to define a specific stage of development. This occurs between the ages of eighteen to twenty-five. He suggested that they are distinct features apparent in emerging adults' that differ from the life stages of adolescence and adulthood. These include: *The age of possibilities*; *identity exploration; instability; focus on the self; and feeling in-between.* Research exploring the parental influences on children and adolescents have highlighted the importance of the parent-child relationship on an individuals overall well-being. However, interest is growing in the importance of this relationship throughout the life span, particularly during the emerging adulthood years.

A systematic review was undertaken exploring the parental (maternal and paternal) influences on emerging adults and their (parents and emerging adults') understanding of this stage of development. Fifteen articles were included within this review, which was divided into two sections, an overview of the studies including quality considerations and a summary of the

main findings. Theoretical, clinical and research implications are discussed in line with the findings; direct or indirect parenting still plays a significant role in the lives of emerging adults'. This can however be a very confusing stage of development as both parents and the emerging adult feel they are "in-between" adolescence and adulthood. The limitations of the review are presented and it concludes with recommendations for clinicians, researchers and services overall to consider in their future practice.

Study 2: Empirical paper

There is a lack of evidence investigating parents' perceptions of transitions within mental health services, particularly the transition from CAMHS to AMHS. This in depth qualitative study aimed to explore how parents' have made sense of their experiences. Interviews were conducted with six mothers whose young adult had transitioned from CAMHS to AMHS. The data was analysed using a qualitative method called Interpretative Phenomenological Analysis (IPA). Five over arching themes emerged, encompassing eleven sub themes. Participants gave accounts of *'the fight'* they had experienced *within themselves, within their families* and *with services*, the consequences of not receiving support ('*Hooks'; fear* and *life on hold*) and what helped them along the way ('*the scaffold'; positive support means being included, maintaining communication with the family [the mothers'] resilience* and *staying hopeful*). In addition, how parents understood the transition process and their feelings towards their young adults being ready to transition to AMHS, taking into account their developmental stage *(Readiness for Transition'*: *What to call our young person? Transition what's that?*) Parents then offered some suggestions for '*what support should look like'* for parents and young adults engaged and to maintain engagement, within mental health services, in particular AMHS.

These findings are discussed in relation to the studies conducted in this area by Singh and his colleagues (2008; 2010; 2012) and Harden (2005). The participant's accounts highlight some troubling aspects of the transition process between CAMHS and AMHS and the disparity of the adult services model, to the needs of the service users and their families. In addition, it demonstrates that government and service level policies are not being adhered to. Transition between the two services is still seen as an 'administration event' rather than being a crucial aspect of care provision. This leads to parents' feeling lost, frustrated, excluded and *"in the dark"* about their young adults care. In addition, they are left to deal with their young adult and their resultant behaviour with little or no support. One of the main contributions of this paper is highlighting the impact that having a child with mental health difficulties has on the parents' self identity and adjusting to their own life transitions.

All of the parents' discussed periods of positive support, these were when they were engaged with generic or inpatient CAMHS. However, all suggested a few key areas where improvements could be made in terms of the support offered. These included: Being provided with consistent support, advice, education and information about their young adults presenting difficulties.

Clinical implications and recommendations

A number of clinical implications and recommendations result from the findings of these studies. Firstly, the importance of taking a family orientated approach when thinking about any form of transition whether this is developmentally or service led. Secondly, to begin to understand this period of development a common term is needed, such as 'emerging adult' so

everyone is clear about what to call individuals within this stage of their life. Thirdly, encompassing the whole systems approach, clinicians and services need to be aware of the importance of the parent-child relationship throughout the life span, therefore supporting and encouraging this relationship. In addition, not underestimating the support that parents and the extended family need in helping them to cope with their young adults mental health difficulties.

Future directions

There are a number of directions that future research should take; in particular study two highlighted a general dearth of literature exploring the transition process from CAMHS to AMHS. Gaining accounts from all involved, particularly fathers' reports, through quantitative, qualitative and mixed methodologies will only aid our understanding of this event.

The literature would also benefit from exploring the impact of having a child with mental health difficulties, has on their parents', specifically investigating parents identity and the implications on their own transitions though life (i.e. aging, retirement). This is a relatively unexplored area, but one that could have serious and lasting consequences for any parent in this situation.

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Appendices

Appendix 1 - Omitted

Appendix 2 – Omitted

Appendix 3

The deductive process of gaining articles for the review

Search Engine	Web of science	PsycINFO	Embase	Medline
Total number from Search	1064	289	110	87
Remaining after face value / inclusion of only peer reviewed articles.	81	87	44	49
Removed – No mention of EA	19	6	1	4
Did not reference Arnett	5	12	2	4
Trajectories or comparisons	16	23	17	19
Transition/Financial	12	13	8	4
Biological parents – not included	1	4	2	2
Cultural/Family values	7	3	3	5
Other relationships considered.	5	8	3	3
Not in English	2	4	0	0
Total articles meeting inclusion criteria	14	14	8	8
Duplicates	Same papers appeared in all searches (i.e. 8 papers found in Embase were the same as those found in the PsycINFO search). Total number of papers = 14.			

Appendix 4

Example of a summary table

Summary of Aims/purpose. Type of research *Urry et al. (2011)* ***USA*** *Quantitative*	**Sample**	**Method of data collection**	**Measures**	**Analysis/power Confirmable**	**Findings/Quality issues**	**Clinical Applications**
A) Aspects of mother-child relationships (childs feelings re upbringing, satisfaction with current relationship & psychological control) were related to child disclosure B) Child disclosures related to maternal knowledge C) Whether child disclosure and maternal knowledge were related to childs involvement in risk behaviour Built upon findings of Padilla-Walker 2008 study	252 undergraduate students (77 males 175 females) 18-26 years old Mean age 19.89 Ethnic mix stated – majority European American Parental marriage status identified Home status and religious status all commented on Education level of parent – mothers – age range 40-64 mean age 48.88) – age have any sig on	Recruited from 4 universities across the USA Online data Offered course credit or extra credit and offered small monetary compensation for parents participation Emerging adult – 450 items exploring a number of elements Similar survey for parents 280 items Again email invitation to	Child disclosure – Parent child closeness scale (Buchanan et al) -2 items from this Feelings regarding upbringing -RELATE instrument (Busby et al. 2001) 3 items Satisfaction with current relationship – RELATE instrument – 2 items Psychological control – Psychological control scale-Youth self report (Barber 96) Maternal Knowledge – adaptation of Barbers Regulation Scale	Chronbachs alpha reported -.86 Chronbachs alpha reported -.77 Chronbachs alpha reported -.92 Chronbachs alpha reported -.84	Paths that did not meet significance eliminated from overall model – Child disclosures salient indicator of maternal knowledge during emerging adulthood Age as a factor not explored – does this change over the stage of emerging adulthood i.e. 18 relationship different to 23 year old – implications this has for closeness, risky behaviour, disclosures Confounding factors i.e. argument with mum that day –	Importance of this in terms of information given to emerging adults - closeness of relationship will they pass it onto mum/parent – implications for services MH, GP, employment etc. Why having to use psychological control – not investigated – if kept in loop less use = better relationship Aim of services to model appropriate transition of relationship from reliance to autonomous – does not happen straight away

	results?	parents – emerging adult choose to do this – already implies close relationship with mother?	Risk behaviours – scale made up 3 items varying in risky behaviour	Used in previous studies with same author – chronbachs alpha not reported for the adapted version For this .67 & .71 Chronbachs alpha reported - .59 (emerging adult) .57 (parent) low values commented on	snapshot of life with parent – anything could have happened – where they are at the start of their journey at uni – freshers week minimal contact/ experimentation to more support throughout the years Ethnicity not accounted for – Arnett's cultural approach SES – evidence for this	

Appendix 5

Quality Checklist Example (Quantitative) - McKinney et al. (2011) Parenting and late adolescent emotional adjustment: Mediating affects of gender and discipline.

Quality criteria	Specific questions to consider when rating	Comments from Article	Rating
1. Title and Abstract	• Does the title reflect the content • Abstract summarises key components (E.g. Aim, Method, Results) • Overall findings presented (Bias of positive results without describing the negative/non significant findings	• Yes, although use the term emerging adult more throughout article so would have been better to use this in title. • Good overall abstract – 3 key areas for study stated • Did state significant and non significant findings	++
2. Rationale clearly described?	• Does the author(s) describe the current evidence base? • Does the author(s) identify the gaps in the evidence base? • Does the author(s) justify the need for the area of research?	• Good clear overview of evidence base, separating with titles. Nice funnel effect leading to rationale of study with parts doted in summary after each sub section	++
3. Research aims clearly stated?	• Does the author(s) clearly state what they plan to research? • Are there clearly focused questions/hypotheses identified?	• Clear research and rationale with three hyps clearing stated. The current study focuses on the relationships between perceived parenting styles, disciplinary strategies and emerging adult emotional adjustment in context of cross gender model.	++
4. Ethical issues addressed?	• Does the author(s) state that ethical approval was sought? • Does the author(s) demonstrate an awareness of the ethical issues	• Clear ethical consent discussed, institutional review board • Reviewed and signed consent sheet • Clear instructions	++

	raised by the study? (E.g. informed consent, confidentiality, how the effects of the study on participants during and after are handled, withdrawal etc.).	• Debriefed • Incentives given • Treated with the Ethical Principles of Psychologists and Code of Conduct - GREAT • No information about withdrawal, further support or emotional content • BEST Ethics so far	
5. Methodology appropriate to the research question?	• Is the use of quantitative methodology appropriate to the research aims? (E.g. to determine relationships between a number of variables).	• Yes – large sample size and IV and DV identified	++
6. Study design identified and the rationale for choice evident?	• Does the author(s) clearly state the design of the study? • Does the author(s) justify the research design used? (E.g. longitudinal, cross sectional, cohort etc.).	• Did not state type of study – but it is a cross sectional survey • Did not justify – but needed for the large sample	_ _
7. Experimental hypotheses stated?	• Does the author(s) clearly state what they expect to find?	• Yes three clear hypotheses made pg. 467	++
8. Key variables identified?	• Does the author(s) identify the main variables (e.g. independent, dependent) investigated in the study?	• Yes Perceived parenting styles perceived discipline strategies and emerging adulthood emotional adjustment – mediating affects of gender of both parent and EA	++
9. Sample population situated?	• Does the author(s) adequately describe the sample (E.g. Gender, age, relationship to care receiver	• Break down of gender, mean age 19.22 • Parents Information re: income etc given collected in demographic questionnaire	+/-

	etc.) so that the reader can determine validity of findings? • Is it a representative sample of the population?	• Ethnicity broken down • Not representative of pop – Psychology course	
10. Selection of participants adequately described?	• Does the author(s) describe the context of where the samples were recruited from? • Does the author(s) describe the method of recruitment used? (E.g. the sampling method, how potential participants were approached to take part etc.) • Does the author(s) identify the inclusion/exclusion criteria?	• Introductory psychology course • Inclusion and exclusion criteria • Does not state how asked to take part – just attended a data collection session	++
11. Method of data collection reliable and valid?	• Does the author(s) use measures appropriate for the population group? • Does the author(s) use measures that reflect the desired constructs? • Do the author(s) use measures with good psychometric properties? (E.g. test-retest reliability, inter-rater-reliability, internal reliability (Cronbach's alpha) and internal consistency). • It the time difference between Time 1 and following up subjects long enough (i.e. longitudinal studies)?	• Subjectively and objectively yes – Stated has been used with other samples in studies giving references • All concepts investigated had measurements – detailed with discussions about inter-rater reliability, validity, concurrent validity, Cronbach's alpha and internal consistency pg. 468-469.	++
12. Method of data analysis reliable and valid?	• Does the author(s) state which statistic tests were used?	• All stats clearly stated i.e. paired t test, independent –samples t test, correlations.	+/-

	• Does the author(s) use statistical tests that are appropriate to the data properties? (E.g. Does the data meet the assumptions of the test). Are power calculations given? • Where the statistical tests used appropriate to the research question? • Does the author(s) consider the impact of extraneous variables and correct/adjust/control for these within the analysis process (i.e. regression)? • Does the author(s) provide evidence of statistical findings? (E.g. Data within the text, tables etc.). • Does the author(s) state the levels of significance?	• Means SD and significant differences highlighted in tables • Rationale given for using tests • SEM – two stage modeling approach – structural analysis – control for variance • Power calculations given for Sample size 163 considered fair (males) and 363 considered good (females) • Large results section giving overall findings • Sig stated • Very confusing methods –the SEM model is not easy to read nor can you follow the logic and progression of how they came to their results – correlational table – SEM conducted as an afterthought? • Good rationale for using different model of fit data – RMSEA, CFI & PFI – stated what the cut off point for good model was and reasons for not using the Chi-square • Model needed re-specification and certain indicators removed • Actual scores for model of fit not stated	
13. Findings clearly stated?	• Does the author(s) explicitly state their findings? • Does the author(s) present the statistical data in a clear manner? • Does the author(s) clearly differentiate between significant and non-significant findings?	• Yes, findings explicitly stated, although slightly long winded and complicated – not clear how they got their results from the • Sig and non sig data recorded and reported on • Also variable removed in model and rationale behind this	+/-

14. Comprehensive discussion?	• Does the author(s) summarise the main findings? • Does the author(s) link their findings back to the research aims? • Does the author(s) state the contribution to theory, context and method linking their findings to current literature and/or psychological theory?	• Good discussion, again split into sub sections and giving an overall summary linking back to aims • Great research practice links – ESPECIALLY applying this to clinical settings	++
15. Strengths and limitations identified?	• Does the author(s) identify the limitations of the research? (E.g. Sample size, recruitment strategies, method of data collection, analysis etc.) • Does the author(s) identify the strengths of the research? (E.g. Its usefulness etc.) • Does the author(s) make recommendations for future research?	• Sub section with limitations clearly laid out strengths and weaknesses of study • Unable to generalise • Future research highlighted • Although commented on college sample did not state gender balance in terms of accessing a psychology course renowned for being dominated by women.	++
16. Justifiable conclusions made?	• Does the author(s) make conclusions that are supported by their discussions of their findings?	• Clear concise conclusion	++

Appendix 6

Quality Checklist Example (Qualitative) - Kloep & Hendry (2010) Letting go or holding on? Parents' perceptions of their relationships with their children during emerging adulthood.

Quality criteria	Specific questions to consider when rating	Comments from Article	Rating
1. Title and Abstract	• Does the title reflect the content • Abstract summarises key components (E.g. Aim, Method, Results) • Overall findings presented (Bias of positive results without describing the negative/non significant findings	• Title good overall reflection on article • Abstract minimal in terms of key clusters and themes identified. Did state qualitative interview study. Did not state data analysis in abstract	+/-
2. Rationale clearly described?	• Does the author(s) give a review of the literature? • Does the author(s) identify the gaps in the literature? • Does the author(s) justify the purpose of research? • Does the author(s) specify where it fits within relevant lit?	• Good overview of literature in terms of parents and their life course/transition • Arnett –emerging adult concept explored • Good stats on modern day living taking into account cultural differences • Parental viewpoint limited within lit – none for emerging adulthood – qualitative Good rationale for this study • Good funnel effect with introduction	++
3. Research aims clearly stated?	• Does the author(s) clearly state what they plan to research?	• 3 research questions clearly stated • Stating exploratory study	++
4. Ethical issues addressed?	• Does the author(s) state that ethical approval was sought? • Does the author(s) demonstrate an awareness of the ethical issues raised by the study? (E.g. informed consent, anonymity/confidentiality, how the	• Informed consent • Voluntary and anonymous • Audiotaped • Interviews and data treated confidentially • Choice of place for interview – home or	++

	effects of the study on participants during and after are handled, withdrawal etc.).	uni • Conducted by trained fieldworkers – little information about these • Stated length of time for interview	
5. Methodology appropriate to the research question?	• Is the use of qualitative methodology appropriate/responsive to the research purpose? (E.g. to interpret or illuminate the actions and/or subjective experiences of the participants).	• Gained to understand the experience of the period of emerging adulthood by parents. Focus on the parents viewpoint – Yes.	++
6. Philosophical background identified?	• Does the author(s) state their theoretical, methodological and personal orientations? • Use of 1st person rather than objective stance (owning one's perspective • Does the author(s) highlight personal experience within the area of interest and/or initial bias.	• No nor of the trained fieldworkers. No information was given regarding age, sex, theoretical orientation • No statement of interest or initial bias • Wrote objectively rather than subjectively	- -
7. Study design identified and the rationale for choice evident?	• Does the author(s) clearly state the design of the study? • Does the author(s) discuss the reasons for employing qualitative methodology? • Does the author(s) justify the methodology used? (E.g. IPA, grounded theory etc.).	• States qualitative interview, exploratory study • Does not give reason for why qualitative methodology used over quantitative • Only when get to results section do you realize that they have conducted certain stats on the data. • Does not state what methodology he/she used throughout the article. Referenced the procedure recommended by Charmaz (1995) Assumption grounded theory	- -

		• Qualitative 'cluster analysis' done	
8. Major concepts identified?	• Does the author(s) define the key concepts (E.g. parents emerging adulthood etc.) in the study?	• Family relationship in emerging adulthood • Emerging adulthood through eyes of parents – defines key concepts	++
9. Sample population situated?	• Does the author(s) adequately describe the sample (E.g. Gender, age, ethnicity, size, life circumstances.) so that the reader can determine transferability of findings?	• Ethnicity not stated except British • Age of parents and Emerging Adults (EA) stated • No. of participants and no. of EA • Dyads i.e. mum and son and N in each • EA – occupational backgrounds stated and living arrangements • Parents SES stated	++
10. Selection of participants adequately described?	• Does the author(s) describe the context of where the samples were recruited? • Does the author(s) describe the method of recruitment used? (E.g. the sampling method, how potential participants were approached to take part etc.) • Does the author(s) identify the inclusion/exclusion criteria?	• Opportunity sample created by field workers – unsure where came from or how recruited • Purposive sample - Homogeneous sampling exploring particular characteristics that best enable to answer research Q. • Exclusion criteria highlighted in discussion section i.e. dependent on child due to disability no parents with children with special needs	+/-
11. Method of data collection auditable?	• Does the author(s) describe how the data was collected? (E.g. semi-structured interviews, where data collection took place, who collected the data etc.) • Does the author(s) describe the areas covered in the interview and/or provide a copy of the questions asked?	• Semi structured interviews • Length of time • Audio taped • Uni or at home – Choice of participant • Stated how interview started giving the Q asked and other example • No copy of questions asked	++

12. Method of data analysis credible and confirmable?	• Does the author(s) clearly describe the analysis process? • Does the author(s) describe how they addressed the issue of validity during the analysis and/or interpretation stages? (E.g. external reviewers, dual coders, triangulation etc.). • Does the author(s) provide specific examples to support their findings? • Does the author(s) provide quotes that appear to be relevant to the themes identified?	• Stated tapes were transcribed verbatim with non-verbal sounds • Dual coding was used throughout to cross validate the themes/clusters • Uses a number of quotes and examples to give support to the four key clusters and subordinate themes. Highlighting the subordinate themes in italic to make it easier to digest and credible • Quantitative analysis of variables i.e. no. of males and age – not stated which test used assumption from sign $\chi 2$ = Pearson's correlation co-efficient and F value = ANOVA.	+/-
13. Reflectivity considered and described?	• Does the author(s) acknowledge the influence of the research process and the presence of the researcher (including the role of potential biases in analysis and selection of data, assumptions, values, interests and experiences etc.) on the data collected? • Does the author(s) describe this is the 1st person	• No nor of the trained fieldworkers. No information was given regarding age, sex, theoretical orientation • No statement of interest or initial bias • Wrote objectively rather than subjectively	- -
14. Findings clearly stated?	• Does the author(s) explicitly state their findings? (E.g. Themes/subthemes identified). • Does the author(s) clearly distinguish themes/subthemes within the results section?	• Gives a diagrammatical picture of this – easy to read and refer back to • Four key clusters identified the no. of participants within each cluster given and detail are within a table – clearly stated and separated with headings	++

	• Are they Coherent and resonate with the reader?	• Cluster and subordinate themes clearly distinguished • Good overall summary of findings and good use of quotes	
15. Comprehensive discussion?	• Does the author(s) summarise the main findings? • Does the author(s) link their findings back to the research aims? • Does the author(s) state the contribution to theory, context and method linking their findings to current literature and/or psychological theory?	• Good summary of main findings linking in back to Arnett's theory of emerging adulthood • Links back to main research questions posed at start • Highlights implications for parents and emerging adults in light of findings • Contradicts previous findings by other authors	++
16. Strengths and limitations identified?	• Does the author(s) identify the limitations of the research? (E.g. Sample size, recruitment strategies, method of data collection, analysis etc.) • Does the author(s) identify the strengths of the research? (E.g. Its usefulness etc.) • Does the author(s) make recommendations for future research?	• Number of recommendations for future research • Exploratory study – limited to transferable • Limitations identified i.e. only interviewed once – narratives influenced by emotional frame of mind • Highlighted could be influenced by structural factors i.e. social class, gender, ethnicity. • Did look at age as a factor in ANOVA – although never stated in paper that qualitative stats were conducted	++
17. Justifiable conclusions made?	• Does the author(s) make conclusions that are supported by their discussions of their findings?	• No clear conclusion section – made throughout in terms of implications for emerging adults and parents	+/-

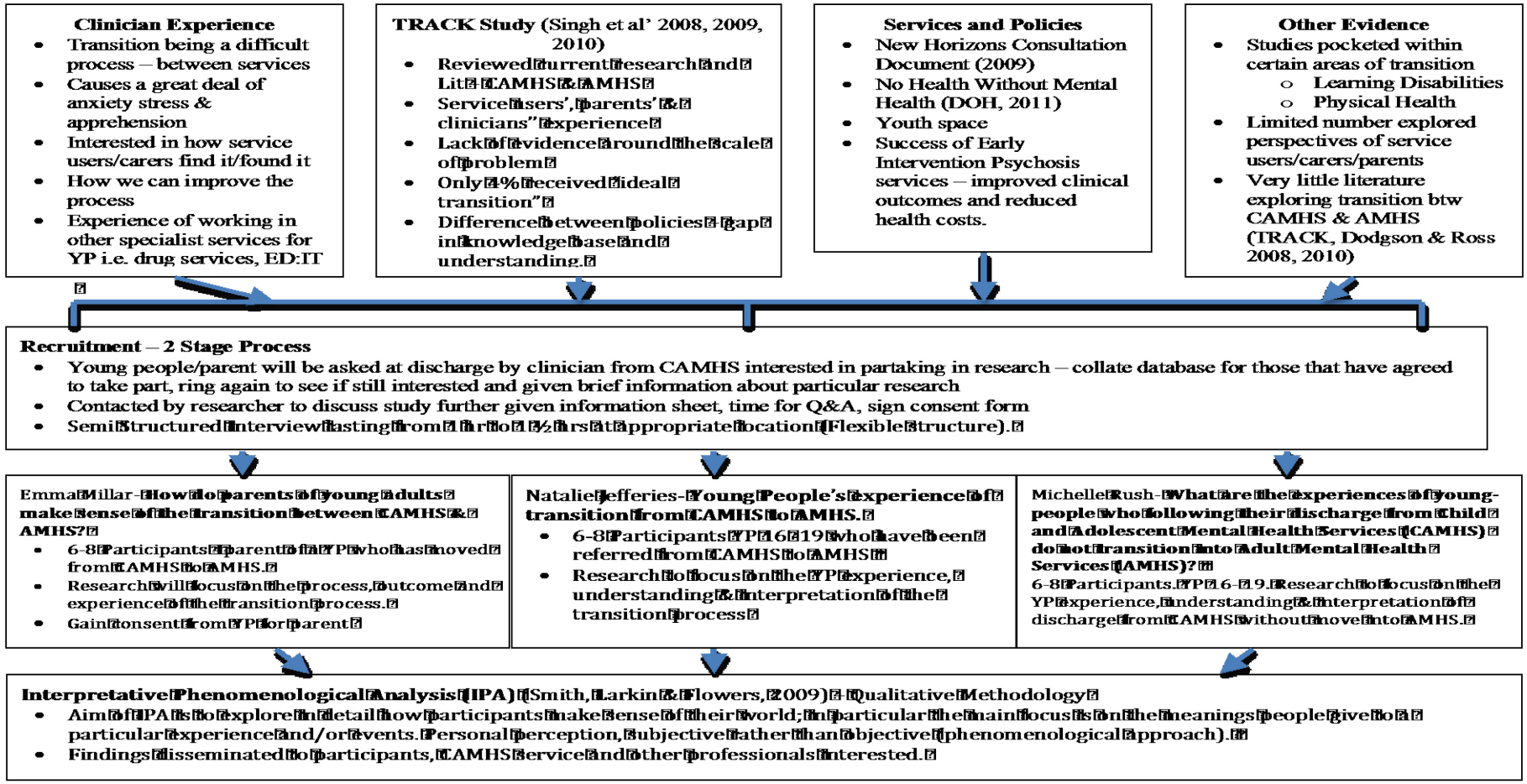
Appendix 7

Ethics approval - Omitted

Appendix 8

Research and development approval - Omitted

Appendix 9
Summary and rationale for study



Appendix 10

Consent Slip

UNIVERSITY OF BIRMINGHAM

School of Psychology
The University of Birmingham
Edgbaston
Birmingham
B15 2TT

Version 2.0 Letter to Participants 10 May 2011

Dear Sir/Madam,

Re: Participation in research on transition from CAMHS

I am writing to inform you about a research project that is taking place to explore young people and their carers' perspectives on leaving Child and Adolescent Mental Health Services (CAMHS). It is hoped this research will enhance professional's understanding of how this transition is experienced, by both young people and their families, to help improve things in the future. To gain this understanding we are hoping to speak to young people and their carers who have recently been discharged from Worcestershire CAMHS. We wish to contact people within the next year to discuss this research in more detail and decide if you want to take part. By showing interest in the research, it in no way commits you to participate in any research. If you **would like** to be contacted about this research, then please return the slip below to your therapist.

Kind regards

Natalie Jefferies
Trainee Clinical Psychologist

Emma Millar
Trainee Clinical Psychologist

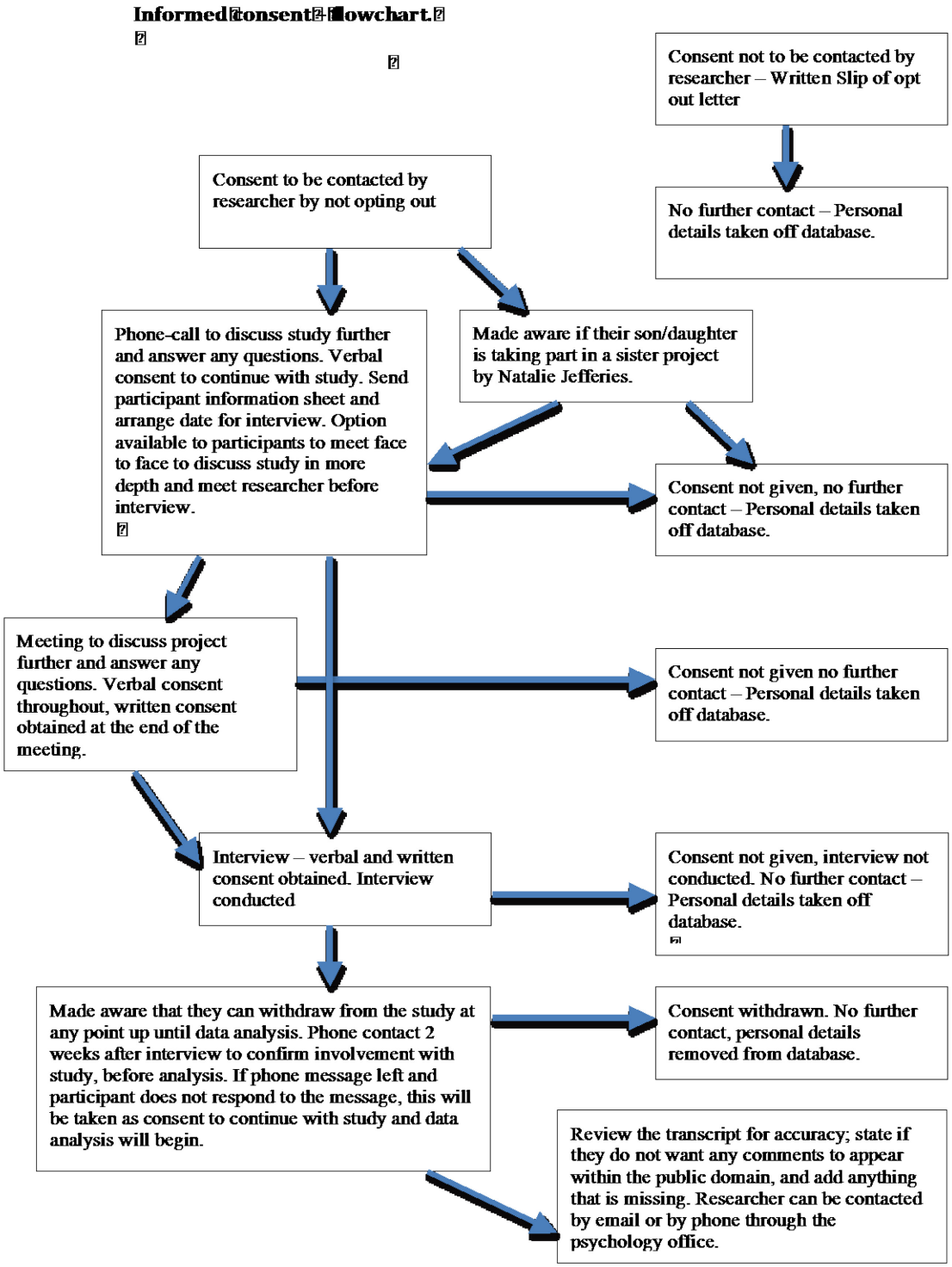
Michelle Rush
Trainee Clinical Psychologist

I **would like** to be contacted about participating in research relating to my or my son/daughters therapy.

Please print your name _____

Sign _____ Date _____

Appendix 11
Informed consent flowchart



UNIVERSITY OF BIRMINGHAM

Appendix 12

Participant information sheet

Emma Millar
Trainee Clinical Psychologist
School of Psychology
The University of Birmingham
Edgbaston
Birmingham
B15 2TT

Version 2.0 10 May 2011

Participant Information Sheet

Study Title: How do parents' of young adults make sense of the transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS)?

Dear

Thank you for expressing an interest in my research. My name is Emma Millar and I am a Trainee Clinical Psychologist. I am doing this research as part of my Doctorate qualification in Clinical Psychology.

Before you decide if you would like to take part in this study here is some information that may help answer any of the questions you may have about my research. Please read this information sheet carefully.

Why have I been invited to take part?

You have been asked to take part because your son/daughter has recently finished contact with Child and Adolescent Mental Health Services and have gone on to access Adult Mental Health Services. I would like to ask you some questions about your experiences of this move to understand how parents of young adults who have moved from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) have found this transition process. Our conversation will help us understand the transition process from the

point of view of parents of young adults, who have just made that move. We hope that this will help other people in the future.

What do I mean by transition?

Transition here means moving from Child and Adolescent Mental Health services (CAMHS) to Adult Mental Health Services (AMHS). Child and Adolescent Mental Health Services (CAMHS) see young people up to the age of 18 after which they are considered adults and make the move to AMHS.

Why is this research important?

So far, there have only been a few studies of transition between CAHMS and AMHS, and none have focused on parents' experiences of the transition process. If we understand more about your experiences, it may be possible to improve what happens in the future for others.

Do I have to take part?

It is entirely up to you to decide whether you wish to take part. If you decide not to take part this will not affect the support you or you loved ones receive now or in the future.

Permission from your son/daughter

Written consent from your son or daughter to access their records and for you to take part in the study, will also need to be obtained. Although this research is looking at your experiences of the transition process and not how you feel your son or daughter found the transition process, it is important that they are made aware of your participation within this project.

What happens next?

If you decide you may want to take part and your son or daughter gives their permission, I will contact you to discuss the project and I will answer any questions or concerns that you may have. You can then take some time following this meeting to decide whether you would like to be involved in the study.

What will happen if I agree to take part?

If after the short initial discussion you are still happy to take part, we can arrange another time to meet and have a longer discussion. This may last between 1-$1^{1/2}$ hours but this will be

flexible depending on how you feel at the time. In some cases it may be useful to meet for a second occasion. With your consent I will record the session(s) using a digital voice recorder. Before I start recording I will show you the equipment and how it works. You may stop the recording at any time during the interview.

When you meet with me for the interview I will ask you some questions about how you found the move of your son/daughter from CAMHS to AMHS and what has happened since. There are no right or wrong answers. I am interested in hearing about how you found this move.

After the research has been written up you will be sent a summary sheet of the results from the study. There will be an opportunity to ask me questions about the findings if you wish.

Does my interview need to be recorded?

Yes. It is important that I can listen to your interview and type it out after we have met. This will help me to develop a good understanding of your experiences and our discussion. The recording of your interview will not be listened to by anyone else.

Will anyone know what we talked about?

Everybody taking part in the research will be given a code name so only I will know which interview is yours. During the analysis of the data I may discuss parts of what we talked about with other members of the research team, however only your code name will be used. It may also be that I use your words (a quote from your interview) to describe particular experiences when I am writing up the study. Again, only your code name will be used so only I know if particular quotes came from you.

If you informed me of a risk that you may harm yourself or another person I would need to discuss this with your GP. I would always tell you if I needed to do this. I would not do this without your knowledge.

What happens if I get upset when we are talking or if I have any concerns afterwards?

People get upset for many different reasons. If you find yourself getting upset at any time during the interview just let me know and we will be able to take a break or stop the interview

if you prefer. I will also provide you with a list of organisations, for example Patient Advice Liaison Service (PALS), which you can take away with you to contact if you feel you need any further support following the interview.

Are there any benefits to taking part?

Some people find it helpful to talk about their experiences but other than that there are no immediate benefits to you taking part.

What will happen if I did not want to carry on with the study?

You have the right to withdraw from the research at any time up until the data analysis begins. I will contact you two weeks after our interview to make sure that you are still happy to be involved in the study. If you do not want to take part anymore, you do not have to tell me the reason why and withdrawing will not affect your or your loved ones support that you receive now or in the future.

Expenses and payments

You will not be paid to take part in this research but your travel expenses will be reimbursed if you provide a valid travel ticket.

Who has reviewed the study?

The University of Birmingham is involved in the organisation and funding of this study. The study has been reviewed by the School of Psychology to ensure that it meets standards of scientific research and by West Midlands NHS Ethics Committee to ensure that it meets important standards of ethical conduct.

Thank you for reading this information. If you are happy to participate or if you have any questions please ring 0121 414 7124 or contact me on my email exj963@bham.ac.uk.
I look forward to meeting with you to discuss the research further.

Yours sincerely
Emma Millar
Trainee Clinical Psychologist

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Appendix 13

Consent Form for Parent

Emma Millar
Trainee Clinical Psychologist
School of Psychology
The University of Birmingham
Edgbaston
Birmingham
B15 2TT

Version 1.1 Consent Form. 22 February 2011

Research site:
Study Number:
Participant Identification Number:

CONSENT FORM

Title of Project*:* How do parents of young adults make sense of the transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Heath Services (AMHS)?

Researcher*:* Emma Millar

Please initial box

1. I confirm that I have understood the information sheet dated May 2011 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview and up until data analysis, without giving any reason, without my own or my loved one's support being affected. ☐

3. I understand that the research interview will be audio-recorded ☐

4. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the NHS team responsible for me or my family member's care but only if any previously undisclosed issues of risk to me or my family member's safety should be disclosed. ☐

5. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments. ☐

6. I agree to take part in the above study. ☐

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

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Appendix 14

Consent Form for young adult

Emma Millar
Trainee Clinical Psychologist
School of Psychology
The University of Birmingham
Edgbaston
Birmingham
B15 2TT

Version 1.1 Consent Form – Young Adult. 10 May 2011

Research site:
Study Number:
Participant Identification Number:

CONSENT FORM

Title of Project*:* How do parents of young adults make sense of the transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Heath Services (AMHS)?

Researcher*:* Emma Millar

Please initial box

1. I confirm that I have read and understood the information sheet dated 10 May 2011 (version 2.0) for the above study. I agree for the named researcher (Emma Millar) to access my records to enable her to interview my mum or dad. ☐
2. I confirm that I understand that the focus of the interview is about how my mum or dad found the transition process and <u>not</u> how they thought I found the transition process. ☐
3. I agree for my mum or dad to take part in the study ☐
4. I would like to receive a summary of the research when it is completed. ☐

.....	.....	.....
Name of Young Adult	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

Appendix 15

Interview Schedule

Proposed Questions for semi structured interview, focus will be on the process, outcome and experience for the parent.

1. How did your family get involved with CAMHS? Prompts - what was going on at the time, Who helped, describe your child's difficulties, what did the service do, support guidance
2. How did you feel about their input? Prompts – In relation to Support, Guidance, who you saw
3. At what stage was the transition process discussed with you and the young adult? Prompts- How did you feel, did you feel the YA was ready to be transitioned over to AMHS – development vs. situational
4. Can you tell me about the transition process? Prompts- How involved did you feel throughout the process, what would you have liked done differently, worked well/not so well, how did you feel about the process
5. What was going on for you and your family at the time of the transition? Prompts- How did your son/daughter react at this time, how did you feel about the change in services
6. What changes were there in your relationship with your son/daughter over this period?
7. Where are you all now within the process? Prompts - Parent, young adult, in service. not in a service,
8. How have you found the adult service overall?
9. What do you think are the main differences between CAMHS and AMHS?
10. Thinking back, is there anything that would have been more helpful in preparing you and your young adult for the move?
11. Would you like to say anything else, were there any questions that you thought I was going to ask but did not? Are there any questions that you feel I should have asked?

Appendix 16

Extract from Reflexive Journal

I felt a great deal of anger when I left the interview, she was very angry and this transference stayed with me. (added and for a number of days afterwards). I thought I would not be surprised to hear their story about how transition had not been as successful as hoped. However, I was not only surprised but saddened that this parent had to fight and continues to fight due to their child having a mental health difficulty. One that I feel we all struggle with to diagnose, work with and contain, This then continues through adulthood and within mental health services.

It warmed me that having space, time and someone to talk to really helps both the young person and their parent. It was also highlighted that not having this leaves a gapping hole that no parent can fill and young people find it difficult to communicate and manage their emotions. This leads to volatile situations at home or finding alternative strategies to cope, some which are not helpful.

I felt that I needed to help this lady and so stated that I would write a letter to her doctor so she could receive support. However, when I was told that I couldn't do this again I felt like the system were letting her down and saying that they couldn't do anything for / not appropriate to do that for. This angered me further and I delayed ringing her and telling her this as I didn't want to again let her down or that I couldn't help her as so many have in the past. [Ghost of services.]

I really found it difficult changing hats from researcher to therapist and really wanted to spend the time discussing ways that we could think about how to move forward or spend time thinking about how she was really coping. It left me feeling uneasy and wondering without support what would life be like for her and how long she could keep on fighting for.

Appendix 17

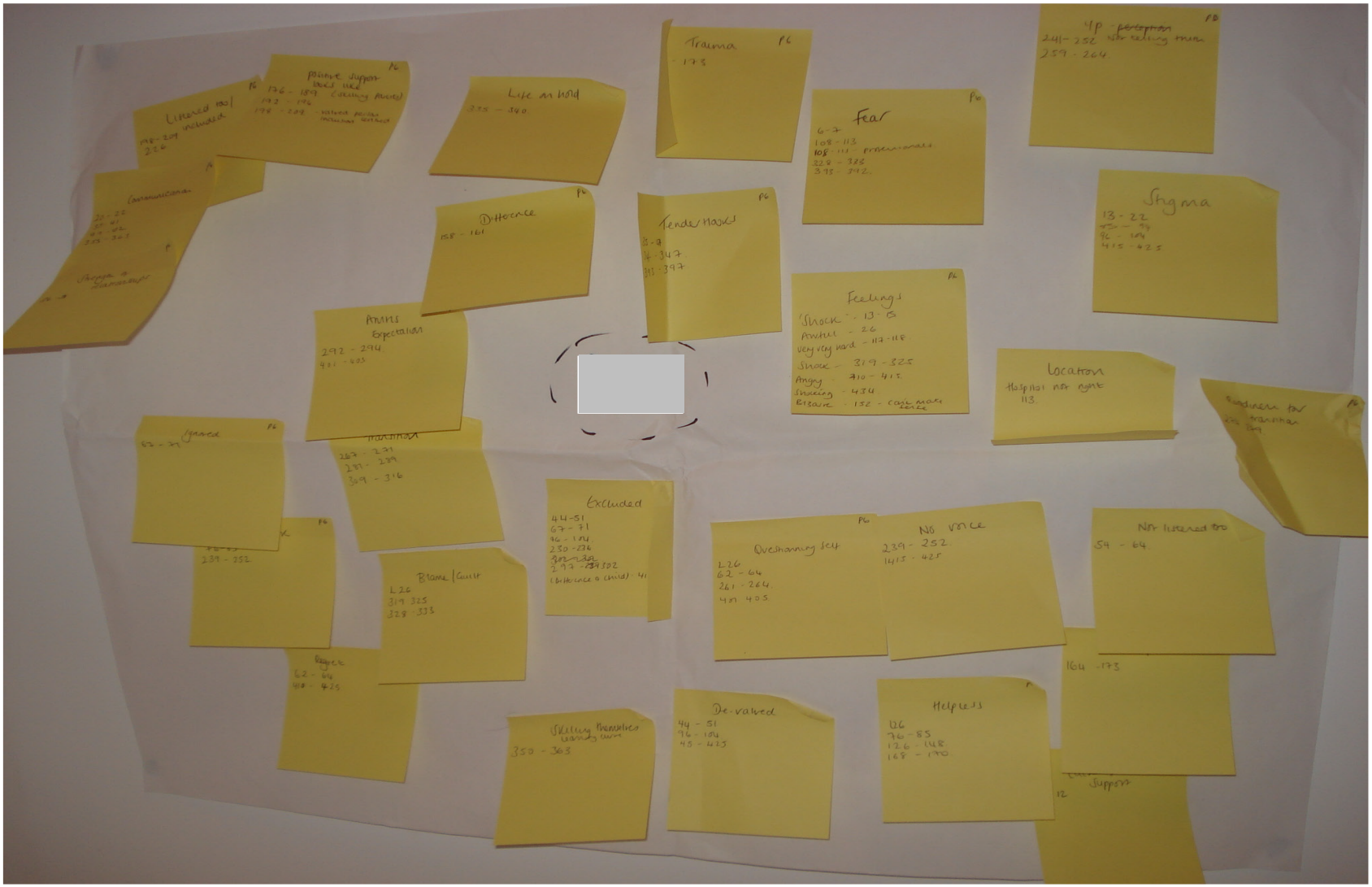
Example of stages 2 and 3 of data analysis

Object of Concern	Transcript	Emerging Theme
7-12 – long time in between just to 'cope' hearing voices – I wonder what sense she made of this – needed this level of illness to get her referred to CAMHs however – not believed again – discharged Home life difficult – eldest daughter – LD Stigma – worried (Janet) Although referred – no support – 'didn't really see her that much' until admission – admitted for 8 months – along time for nothing to be wrong with her – Numerous diagnoses. Family hx – of mental health illness What she has to face – how must she have	biological dad has bi polar and both bi polar and schizoid affective can be hereditary. She also started self-harming in hospital. I think she might have learnt it from others, however Janet stated that she had done it before them but had not wanted to tell me as she knew it would upset me. I really do not know how to deal with the self-harm. I find it very difficult. E: It is really difficult to deal with. E: How was school through this time before Janet was hospitalised? M: high school was bad. I went into school to discuss Janet's difficulties beforehand and they said they never give up on a child. Well she was there for 5 minutes and they basically gave up on her. She barely went to	Fight? – with partner Lost/ questioning parenting skills/Fear - I really do not know how to deal with self harm, I find it very difficult Not listened too – (school) went into school to discuss – services questioning parenting skills Excluded (from School) well she was there 5 minutes and they gave up on her

felt having a child whom self harms. – stating that she does not know what to do – lost How parents cope with self harm? Gave up on her – excluded. Rejected, pushed out Don't want to focus on me – focus on daughter – none of my life has been about me – Don't want to think about it – rejection?	high school they just did not know how to handle her behaviour. E: How did that make you feel? R: Really bad for her as they just gave up on her. She did go to a PRU for a while, which was good as they are more one on one with the children and do more work experience with them. She worked at a hotel for 6 months or so and did really well. However they asked if they would employ her after school and they said no so she left. Janet left school at 16. E: How was the support from the Pear Tree Centre during this time? M: We didn't really see anyone from the Pear Tree Centre as they were waiting for her to go into hospital. We were on our own really, trying to cope with it	Different – don't know how to handle her Rejected – gave up on her Rejected – Would not offer her a job No belief in Janet Lack of support (from CAMHS) before inpatient admission Left Trying – questioning self / own abilities Waiting game – waiting for admission

Appendix 18

Examples of stage 4 of data analysis


Trauma
Fear
Stigma
Tender Hooks
Difference
Feelings
Location
Excluded
No voice
Not listened too
Helpless
De-valued
Blame/Guilt
Ignored
Communication
Life on hold
Listened too/ included
Positive support
Ambits Expectation
Questioning self
Support