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Adolescents' Experiences Returning to School after a Mental Health Hospitalization

Pamela Iverson
Minnesota State University, Mankato

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Adolescents' Experiences Returning to School after a Mental Health Hospitalization

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Pamela J. Iverson

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This dissertation has been examined and approved by the following members of the student's

committee on April 7, 2017.

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Walter Roberts, Jr., EdD

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Richard Auger, PhD

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Karin Lindstrom Bremer, PhD

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Abstract

This qualitative study explores how adolescents experience transition when they return to school after an acute mental health hospitalization. For this study, the term transition is used to describe the process of adjusting to the return from an acute mental health hospital to school. Eight adolescents from southern Minnesota, ages 15-17, were interviewed about their transition experience for this study. Each participant had experienced an acute hospitalization within 12 months of their interview. Each participant interview was recorded, transcribed, and analyzed using phenomenological research methods. For each participant, an individual textural description, structural description, and textural/structural description was provided through analysis. After individual analysis was provided for each participant, a composite description was written providing three emergent themes: academic aspects (schoolwork, stress related to schoolwork, school staff support, having a plan, accommodations), social aspects (worried about others, bullying and rumors, peer support), and personal aspects (personal growth and development, positive thoughts and feelings, reflections on mental health, ongoing mental health concerns). In the Conclusion chapter, discussion, significance of study, limitations, implications, and recommendations for future study are provided. This study particularly recognized the impact support from school staff, peers, and family can make on an adolescent's transition to school.

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Chapter 1: Introduction

Introduction

The prevalence of adolescent mental illness has long been established and discussed. Specifically, 20% of adolescents (ages 13-18) experience symptoms related to a mental health disorder in any given year (U.S. Department of Health and Human Services[DHHS], National Institute of Mental Health, Revised 2009) with 10% of adolescents experiencing significant symptoms impacting their daily lives (U.S. Department of Health and Human Services[DHHS], National Institute of Mental Health, Revised 2009). Adolescents hospitalized for mental health needs have also been studied and literature published; much of this focus has been placed on the types of mental illness, length of stay, and cost of illness as compared to other nonmental illnesses (Case, Olfson, Marcus, & Siegel, 2007). Since the 1990s, hospital stays for adolescents for a mental health reason have decreased from nearly a month to a week, which have been attributed to managed health care (Heflinger, Simpkins, & Foster, 2002).

In response to adolescent mental health needs, school personnel have also taken a more active role in providing support to student mental health needs (Hoagwood et al., 2007; Stormont, Reinke, & Herman, 2010; Weissberg, Kumpfer, & Seligman, 2003). Schools are one of the only places all children and adolescents have equal access; hence, a majority of children and adolescents who receive mental health service do so in schools or through school-related connections (Rones & Hoagwood, 2000; U.S. Department of Health & Human Services, 1999).

Another way in which school personnel intersect with a student's mental health is when that student experiences a significant psychiatric illness, needs to be hospitalized, and is absent from school. Although the average length of stay for a mental health hospitalization is only four

days (Blanz & Schmidt, 2000), the student is released from the hospital when stabilization--not

treatment goals--are achieved (King, Hovey, Brand, & Ghaziuddin, 1997). Many adolescents

return to the same environments that may have created the stressors and problems, including

school, without adequate coping strategies, which places the adolescent at high probability of

being readmitted to the hospital (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth,

2001). After a young person is discharged, the return to school can be stressful. However, little

literature and few studies have documented this time of *transition* (Savina, Simon, & Lester,

2014). Current literature and studies have been from the perspective of adults who interact with

young people: caregivers (Rager, 2015), school staff, and hospital professionals (Clemens,

Welfare, & Williams, 2011; Clemens, Welfare, & Williams, 2010; Simon & Savina, 2005;

Simon & Savina, 2010; Tisdale, 2015; White, Langman, & Henderson, 2006).

Relationship to the Topic

As a school counselor, I am often one of the first people at school a student or family

contacts about a student's mental health hospitalization. As I engaged with these young people

leaving and returning to school over the years due to their mental health needs, my awareness of

the topic of what and how adolescents experience transition from the hospital to school

increased.

An adolescent who is experiencing crisis warranting a hospitalization is experiencing a

major upsetting life event. Yet, adolescents have told me they have held off on telling anyone

about their ongoing suicidal thoughts or attempts for fear of being hospitalized, which seemed

scarier than the suicidal thoughts and attempts themselves. As school counselor, I have been

hopeful that the hospitalization would help stabilize the adolescent and provide connections to

aftercare that would facilitate stability and health for the adolescent.

Within the hospitalization process, the transition back to school piqued my interest most.

As a school counselor, I hope to help adolescents connect to school resources, staff, and peers in

a way that may help them feel better about returning to school. Some of the returning students

shared being ready for reentry back to school after a hospitalization, but often students have told

me they were worried or nervous about returning to school. I have shared in their anxiety with

them. I thought about how the student's peers and friends would welcome their return. I

worried about how the teachers would make accommodations for the student's absence as well

as the student's ongoing difficulties adjusting back to school.

I am well into my 20th year as a school counselor, and I have seen a number of students

leave and return to school for a mental health hospitalization. I have worked in a few different

schools, and none of these schools initially had a transition plan for these students. Also, the

hospitals did not seem to have a clear plan or system to help students transition from the hospital

to school either. Conversely, some hospitals gave a detailed stock list of school accommodations

that may not be readily available at the school or fit the returning student. Regardless, the

families many times ended up being disappointed. I felt frustrated, too.

These experiences left me with a deep compassion and care for young people who were

experiencing this time of transition. When I first started investigating this concern, I was

surprised that I could not find a study that asked these young people about their transition

experiences. Regardless of my experience working with children and adolescents, it did not

replace hearing from the adolescents directly. I believe we need to hear their voice, and this study allowed for that to happen.

Need for the Study

The goal of this study was to ascertain a better understanding of how adolescents who have been hospitalized due to an acute mental health concern experience returning to school. Exploring this issue was important for numerous reasons. First, there has been a gap in the literature. There exists little literature currently about the topic of student transition from hospital to schools (Savina et al., 2014). More literature exists regarding the transition of an adolescent from the hospital to school when the adolescent is struggling with an illness not related to mental health than due to an illness related to mental health (Kaffenberger, 2006; Katz,Varni, Rubenstein, Blew, & Hubert, 1992; Prevatt, Heffer, & Lowe et al., 2000; Shaw & McCabe, 2008).

A second, and perhaps more significant gap in the literature is that I could not find a study that asks adolescents about their experience reintegrating into the school environment. To date, I have not found a study or an article referencing a study asking young people how they experience transitioning from the hospital to school. Studies at present focus on the adults' perspective of adolescent transition from hospital to school (Clemens et al., 2010; 2011; Rager, 2015; Simon & Savina, 2005; 2010; Tisdale, 2015; White et al., 2006). I did find one study (Trout et al., 2014) that did ask adolescents and parents questions about discharge and readiness to return to the community prior to discharge from the hospital. However, this study did not follow up with the adolescents or parents after discharge regarding transition.

Students may return to school from hospitalization not ready to engage within the

school's environment (Blanz & Schmidt, 2000). Although school personnel identify that school

is a place to help students with their mental health concerns, often school personnel do not feel

prepared or do not know how to best help students (Reinke, Stormont, Herman, Puri, & Goel,

2011). This includes how best to help adolescents when they return to school after a mental

health hospitalization (Simon & Savina, 2010).

This dissertation has added to the body of literature that specifically addresses the

experience of students transitioning from the hospital to school for mental health issues, uniquely

adding student voices to literature. This dissertation is an asset for school personnel, school

counselors, counselor education programs, as well as to mental health hospital personnel.

Purpose and Scope for the Study

The purpose of this qualitative, phenomenological study was to explore how adolescents

experience returning to school after an acute mental health hospitalization in southern

Minnesota. By using one core research question, which drove the study, I conducted interviews

with participants who had experienced an acute mental health hospitalization sometime within

the last year (12 months). This topic and methodology was specifically chosen for the potential

contributions to school counseling, schools, and counselor education, as well as the mental health

field.

Qualitative research is not directed by hypothesis, but rather guided by a core

(overarching) research question (Creswell, 2007). In addition, qualitative research questions are

open-ended, evolving, and non-directional (Creswell, 2007). Taking this advice, one core

question drove the research: How do adolescents experience transitioning back to school after an

acute mental health hospitalization?

The scope of this study included adolescents (ages 13-18) who had been hospitalized for

an acute mental health stay. An acute mental health hospitalization, also known as acute

psychiatric hospitalization, is usually for people experiencing self-harm or other harm symptoms

and the goal is typically stabilization (Sharfstein, 2009). The average length of stay is four days

and less than fifteen days (Blanz & Schmidt, 2000). Hence, I interviewed adolescents between

the ages of 13-18 who had experienced an acute mental health hospitalization lasting four to

fifteen days. So, that the experience was somewhat easy for the adolescent to remember, I

interviewed adolescents who had experienced the hospitalization within the last year but were

out of the hospital and considered by their primary mental health provider to be stable. For

safety measures, only adolescents who were currently receiving ongoing professional counseling

were included within the study.

Preview of Theoretical Framework

A constructivist worldview guided this study. As recognized by Creswell (2007), there

are four primary, qualitative paradigms or worldviews that shape or guide qualitative studies:

postpositivism, constructivism, advocacy, and pragmatism. In constructivism, each person

creates his or her own meaning about the world based on his or her own unique understanding of

the world garnered through their own experiences. "Truth" is defined not as a tangible object but

rather a shaped object through cultural, social, and linguistic constructs (Patton, 2002).

Constructivism is often the worldview used by researchers who seek to describe their

participants' experiences (Moustakas, 1994). This approach and construct matched the purpose

of this study. I wanted to know how adolescents described in their own words their experience transitioning from the hospital to school. Constructivism strives to "rely as much as possible on the participants' views of the situation" (Creswell, 2007, p. 20). In using phenomenological research methods, I was able to respect the constructivist worldview by interviewing adolescents who had experienced the transition from acute mental health hospitalization to school.

Overview and Rationale of Methodology

This study was performed using qualitative research methods and a phenomenological approach. I made the methodology decision based upon the intent to answer the core question about how young people experience transition after hospitalization. Rather than looking solely to numbers for explanation, qualitative research seeks to understand "the complexity of people's lives by examining individual perspectives in context" (Wang, 2007, p. 256). In order to better understand how adolescents experience transitions, I did not think numbers could sufficiently explain the complex issue of returning to school after hospitalization. Further, the phenomenological approach focuses on the lived experiences of people to help better understand a human phenomenon (Corbin & Strauss, 1990). A qualitative, phenomenological methodology is recommended for research that is not focused on cause but rather to describe the everyday world experienced by participants (Denscombe, 2007).   As such, it was a more effective method to answer the core research question and provided deeper understanding of how adolescents experience return to school after a mental health hospitalization.

Interviews were conducted with a small group of adolescents who had experienced an acute mental health hospitalization. I followed recommended practices found in Creswell (2007; 2009) using the Stevick–Colaizzi–Keen method which is outlined in the Method Chapter of this

dissertation. Open-ended questions were utilized in interviews.   Pertinent literature provided the

basis for the formulation of the questions. Interviews were recorded and then transcribed. The

transcripts were analyzed for themes. Along with transcribing, experiences were recorded in a

reflective field journal. The reflective journal recorded the observations and thoughts of the

researcher about the experience. Bracketing was detailed to allow participants' descriptions of

their experience to be represented clearly and accurately in the study. *Textural* (what the

participant experienced) and *structural* (how the participant experienced) *descriptions* were

provided. Member checking was conducted after the *significant statements* (those statements left

after redundant statements were removed from the transcripts) to ensure validity. Most

important to phenomenological study, I engaged in the process of *epoche* prior to the study and

throughout the study. Epoche is the approach the researcher takes to view the study through new

and fresh vision (Patton, 2002). A detailed description of methodology and epoche can be found

in Chapter 3.

Definition of Terms

        The following operational terms and definitions will be helpful when reading the

literature review and remainder of the study.

        Acute mental health hospitalization: An acute mental health hospitalization or psychiatric

hospitalization happens when there is a crisis, usually a person experiencing thoughts of harm to

self or others that does not last more than 15 days (The American Academy of Child &

Adolescent Psychiatry, 2008).

        Adolescent: An adolescent is a young person between childhood and adulthood

predominantly within the ages 13-18. For this study, all participants will be aged 13-18.

Although the ages assigned to adolescence can differ, I chose 13-18 due to the popularity of

medical and mental health information within studies also using that parameter (Merikangas et

al., 2010).

      School counselor: School counselors are educators who have completed certification or

licensure requirements within their state, usually with a minimum of a master's degree. The role

of the school counselor, as defined by the American School Counselor Association (ASCA), is to

"address all students' academic, personal/social and career development needs" (2012b, Role of

professional school counseling, para.1).

      Transition: Transition is "a movement, development, or evolution from one form,

stage, or style to another" (Transition, n.d.). In this study, transition is used to describe the

process of adjusting to return from an acute mental health hospital to school. Previous literature

describing the transition from the hospital to school include a variety of life aspects for

adolescents that may include: academic, social, and emotional (Clemens et al., 2010).

      Voice: In this study,I use the term voice to describe each participant's perspective, often

in the participant's own words. Mazzei and Jackson (2009) stated that qualitative researchers are

trained to respect the voice of participants. Providing participants a voice in research is an

attempt to help another's perspective to be known to others. Bogdan and Biklen (1998)

described voice as "empowering people to be heard who might otherwise remain silent" (p. 204).

Overview of Remaining Chapters

      This paper includes 13 chapters along with references, and appendices. Chapter 1

provided an introduction to the topic of adolescent transition from mental health hospitalization

to school. Chapter 1 also included a personal introduction, need for the study, purpose and scope

for the study, preview of theoretical framework, overview and rationale of methodology,

definition of terms, and summary and overview of remaining chapters. Chapter 2 introduces

background information about adolescent mental health, adolescent mental health

hospitalization, the school's role in working with students with mental health concerns, and the

school counselor's specific role in working with students with mental health concerns. Most

importantly, Chapter 2 includes a critical literature review of articles specifically about

adolescents' transition from hospital to school. Chapter 3 includes a description of the research

design and methodology. Specifically, qualitative methodology, phenomenology, and

constructivism will be described. Chapters 4 through 11 give data from each participant in the

study. Chapter 12 provides a composite description of all the participants within the study.

Chapter 13 includes the study discussion, significance of the study, research limitations,

implication and recommendations of the study, and the summary. A list of references will

conclude the paper, followed by appendices.

Chapter 2: Literature Review

In phenomenological research, a review of literature is done as a preview to become familiar with the phenomenon being explored and to find where this dissertation study may fit within the existing literature (Creswell, 2007, 2009). The researcher viewed the literature to find in what ways the phenomenon may be better explored and understood (Bloomberg & Volpe, 2012). With this in mind, literature was pulled and reviewed to gain background information. Literature was also reviewed to discover any potential gaps. As recommended when using phenomenological methods, I paused and reflected throughout the literature analysis to consider and identify any presuppositions being formed.

This chapter examines how adolescents experience transitioning back to school after being discharged from a mental health hospitalization. Studies used in the literature review were conducted in the United States unless otherwise identified. ERIC EBSCO and PsycINFO databases were searched using this combination of the terms: *hospital, school,* and *transition* or *reentry*. The results from these searches included few articles specific to transition from mental health hospitalization to school. The reference pages of these articles, however, were helpful in finding additional resources. Many of the articles within the first search also included discussion of transition from hospital to school due to other health issues but not mental health. In addition, the relevant articles yielded authors and articles on the subjects of adolescent mental health and adolescent mental health hospitalization which provided background information for this topic. Additional searches were done on Google Scholar, ERIC ProQuest, and MEDLINE to ensure a thorough search was done. No new relevant resources were produced. Searches were

predominantly performed in August through October, 2015; however, a few small additions to the paper were made after the dissertation proposal in March, 2016.

Inclusion criteria for this paper were any published articles or books prior to October, 2016, that focused upon transition from a mental health or psychiatric hospital to school, were peer reviewed, and available in English. A few recent resources on adolescent mental health and adolescent mental health hospitalization were included for background information. Also, included in this paper were dissertations which are typically reviewed by their university departments. Exclusion criteria for this paper were articles that although related to the transition to school from hospital, were focused on transition due to specific illnesses such as cancer or traumatic brain injury. These articles offered little transferable information to this paper.

I specifically looked for what type of research was done (qualitative or quantitative), location of the study (geographical location), who provided the information (population studied), the instrument or tool used to gather the information, and the findings from each study.

The first section of this literature review provides background information about adolescent mental health, adolescent mental health hospitalization, the school's role in providing support for students with mental health concerns, and with a specific emphasis on the school counselor's role in supporting students with mental health concerns. This background information helps provide context to the more specific issue of transition which is provided in the second section of the literature review. The second section of this literature review provides a review of literature specifically looking at those articles discussing adolescent transition from mental health hospitalization to school.

Schools and Mental Health

The topic of adolescent mental health and the role school personnel play in supporting adolescent mental health has increased in discussion during recent decades (Stafford, 2007). This may be partially in response to world-wide initiatives such as the United Nations Convention on the Rights of the Child (UNCRC) in 1989. This convention, resulting in a 1990 paper, identified children as having the right to an education that helps them develop fully both mentally and physically (UNCRC, 1990, Article 29). Also, the World Health Organization identified schools as logical places to support positive mental health in children and adolescents through education models and curriculums (World Health Organization, 2001). Along with initiatives, studies have indicated that prevalence of childhood and adolescent mental health problems are a global concern (World Health Organization, 2005).

Adolescent mental health overview. Mental health concerns affect a significant population of today's youth with 20% of young people ages 13-18 experiencing symptoms related to a diagnosable mental health disorder in any given year (U.S. Department of Health and Human Services, National Institute of Mental Health, Revised 2009). In addition, an estimated 10% of the adolescent population experience serious emotional and mental disorders that cause significant functional impairment in their daily lives disrupting ability to function socially, academically, and emotionally (National Institute of Mental Health [NIMH], n.d.; U.S. Department of Health and Human Services [DHHS], 1999).

In particular, the Surgeon General's Report on Mental Health established several research initiatives to address the lack of national statistics on mental health in children (Department of Health and Human Services, 1999). One of these initiatives, the National Comorbidity Study—

Adolescent Supplement (NCS—A) provided a national face-to-face survey of 10,123 adolescents aged 13–18 years in the United States (Merikangas et al., 2010). From this survey, valuable information regarding prevalence of types of disorders was ascertained. Anxiety disorders were the most common condition (31.9%), followed by behavior disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%) as experienced by adolescents. In addition, approximately 40% of the youth who met criteria for one disorder also met criteria for another class of lifetime disorder. The overall prevalence of disorders with severe impairment or distress was 22.2%.

Along with prevalence of types of disorders the age of illness has also been studied. The Centers for Disease Control (CDC) researchers published a report on children and adolescent mental health from 2005-2011 and found that rates of mental health concerns increased with childhood age (CDC, 2011). The National Comorbidity Survey Replication study involving 9,000 people in the United States from February 2001 to April 2003 found that in the peak age of onset for any mental health disorder is 14 years old (Kessler et al., 2005). In a study focused on the adolescent brain and mental health, Giedd, Keshavan, and Paus (2008) explained that adolescence is a time for neurobiological and behavioral change. The exact reason for why adolescence is the time during which most are likely to develop and experience a mental health problem for the first time is not known. This period of brain maturation of adolescents is also a time for increased vulnerability to depression, anxiety, and eating disorders, which all may require clinical intervention. Further, these adolescents experience a higher level of social and academic demands, increasing their levels of stress.

Adolescent mental health hospitalization overview. With child and adolescent mental health concerns more prevalent, it has become apparent that hospitalization for some children and adolescents is needed. When a child or adolescent is in danger of harming self or others, an inpatient psychiatric or mental health hospitalization may be necessary. The American Academy of Child & Adolescent Psychiatry (2008) defined such an intervention as a crisis residence or acute care psychiatric program, and most last less than 15 days. Within the last two decades, psychiatric hospitalization has had to respond to managed care and the length of stay has been reduced from close to a month of care to approximately a week (Heflinger et al., 2002). Although hospitalization in the past had been centered more toward treatment issues, crisis or brief hospitalization is now focused on stabilization (ensuring safety; King et al., 1997). Length of stay has become an important issue for child and adolescent mental health hospitalization. On average, children's hospital stays are 29% shorter than those of adults (USDHHS, 2003). The average length of mental health hospitalization for children is four days (Blanz & Schmidt, 2000). Case et al. (2007) analyzed data from the nation's largest community hospital discharge survey from 1990 to 2000. Hospital staff respondents indicated a dramatic reduction in duration of hospital stays for those patients suffering with a mental illness compared to those patients suffering other illnesses. Further, results described the length of stay for mentally ill children has been reduced by almost 75%, with the length of stay averaging to just four days. Also, the children with mental illness being served were described as struggling with more severe illness than in the past. The researcher summarized that severity of illness was being treated through briefer stays of hospitalization (Case et al., 2007).

Perhaps one of the most notable concerns of crisis hospitalization is that it relies heavily upon the client's self-report. When a client no longer indicates that they have intentions of harming self or others, the client may be considered to have reached stabilization and no longer need hospitalization. Self-reports of no longer engaging in self-harming or suicidal behaviors is the threshold also required by third party payers for patient release (Bronfman, 1999). Often times, detailed coping strategies and after care plans are not considered essential to the process of stabilization; therefore, not a part of the crisis hospitalization experience. As a result, adolescents return to the same environment without coping strategies, which places them at high probability to return to high-risk behavior and potentially readmissions to the hospital (Compas et al., 2001).

Blanz and Schmidt (2000) in a review of literature, discussed child and adolescent mental health hospitalization. Specifically, the pressure to release children early, the threshold for readiness for release, and the recommendations for alternatives to inpatient care were reviewed. Due to the financial pressure to release children and adolescents quickly from inpatient care and the concern to have children in the least restrictive environment, Blanz and Schmidt recommended less restrictive and less expensive outpatient services following inpatient care. Bickman, Foster, and Lambert (1996) identified the availability of alternatives to inpatient psychiatric services for children and adolescents significantly reduced the rate of inpatient hospitalization. With children and adolescent hospital stays so short, Blanz and Schmidt (2000) identified a concern that young people may return to school while still experiencing significant symptoms of mental illness.

Along with shorter mental health hospitalization stays, the readmission rates for children

and adolescents are quite high. In a study examining the risk and attributes of rehospitalization

of children and adolescents following their first inpatient psychiatric hospitalization, it was found

that 43% of children experienced rehospitalization within 30 months, with most of those

hospitalizations happening within the first year of discharge (James et al., 2010). These results

were consistent with rates of rehospitalizations from similar studies done by previous researchers

(Arnold et al. (2003); Blader (2004); Fontanella, Zuravin & Burry [2006]). James et al. (2010)

highlighted in their discussion of their findings the unique vulnerability of this population of

young people during the postdischarge period and the critical need for community-based

outpatient services. The authors indicated danger to self or others and the high percentage of

readmissions as reason for additional service for this population. Researchers also discussed the

effectiveness and purpose of today's shorter psychiatric hospitalizations due to managed care

pressure where stabilization and medication are the focus (Sharfstein, 2009).

One response to shorter hospitalization for children and adolescents for mental health

stays has been a rise in studying what could be helpful to these young people during their

inpatient treatment. One example focused on the extent to which a goal attainment model would

predict stabilization for adolescents who were hospitalized in an acute care psychiatric program.

Balkin and Roland (2007) established that problem identification, coping skills and commitment

to follow up upon discharge would predict positive stabilization outcomes for adolescents in an

acute care program. The results to this study surveying adolescents (ages 13-18) indicated a

positive correlation between being able to clearly express problems and symptom relief. The

researchers identified that commitment to follow up after discharge would better be surveyed

after discharge. There was minimal correlation between coping skills and symptom relief. The

researchers hypothesized that the created survey was perhaps not sufficient to capture the

complexity of measuring coping skills.

Moses (2011) interviewed 82 adolescents seven days after discharge, with an average of

seven days of admission, about their experience in the hospital asking about what was helpful,

unhelpful, and harmful. From these interviews, three main helpful themes emerged:

interpersonal support, therapy and psychoeducation, and overall hospital environment. Among

the most popular responses were support from peers, support from staff, and learning cognitive

and behavioral coping strategies. Four main unhelpful or harmful themes also emerged: rigidity

and confinement, lack of treatment responsiveness, and frightening/anxiety provoking

experiences. There was less consensus about what was unhelpful or harmful. Two of the most

frequent responses were too much room time and staff being unhelpful. From the participants'

individual responses, the researcher noted the profound impact peer support had on each

participant. The adolescents rated this as the most helpful part of inpatient hospitalization and

named group as one of the most useful therapeutic components. By being with peers, the

experience was less alienating, and the youth felt supported.

School's role with student mental health. With the significant prevalence of mental

health concerns for children and adolescents, it makes sense that schools have also increased

their involvement with student mental health within the last few decades. School-based

prevention and intervention strategies have become essential in dealing with and reducing mental

health problems that impact learning and social development for children (Dwyer, 2004). Many

children and adolescents receive mental health services during school or through school

connections (Rones & Hoagwood, 2000; U.S. Department of Health & Human Services, 1999).

Families are more likely to accept mental health support provided at school due to a reduced

sense of stigma and being offered in a familiar environment. School-based individual mental

health support is important too (Fernandez & Vaillancourt, 2013).

As the mental health support needs have increased, research for the use of school-wide

interventions (targeting all students) as well as individual (targeting students at risk) school-

based interventions for mental, emotional, and behavior concerns has grown over the past few

decades (Hoagwood et al., 2007; Stormont, et al., 2010; Weissberg, Kumpfer, & Seligman,

2003). There is an important connection between mental health and academic performance

along with universal contact to children making schools a good setting to provide mental health

services (Greenwood, Kratochwill, & Clements, 2008).

Teachers also agree that schools play a role in student mental health. In 2011, Reinke et

al. (2011) investigated the role teachers perceived they have in regard to students with mental

health needs. From this online survey, 292 elementary teachers completed the survey which

focused on the teachers' perceptions of the school's role meeting mental health needs of children

and the participants' knowledge of evidence-based practice. From the respondents, 89% of

teachers agreed schools should be involved in addressing the mental health needs of children.

Only 34% of teachers, however, reported having skills to support students who have mental

health needs. In addition, teachers reported needing more training in the area of working with

students exhibiting externalizing problems.

Along with individual mental health support, school-wide approaches to promote mental

health and positive behaviors have gained in popularity. Efforts that include yearlong systematic

approaches have shown some efficacy (Wells, Barlow, Stewart & Brown, 2003). Perhaps

motivated by the attention of the World Health Organization, which led the way since the 1990s

focusing on the need for schools to promote and be involved in school-wide mental health

initiatives (Graham, Phelps, Maddison, & Fitzgerald, 2011). One popular approach to school-

based interventions within the past two decades is called the three-tiered approach. In the three-

tiered approach, there are three types of support: primary (all students receive support);

secondary (small groups of potentially at-risk students receive support); and tertiary (individual

student receives support; Walker et al., 1996). The interventions are designed to support

students based upon evidence. Evidence (data) is collected to identify what supports are needed,

where the supports should be implemented, and for whom the support should be placed. The

supports are specifically designed to prevent problems, recognize when and where problems are

occurring, and respond to students who need more intensive interventions. Although each school

has its own specific system to use tiered interventions and its own way use data, one alternative

may be to focus on identifying student mental health needs and student mental health support

with data and tiered interventions (Forman, Olin, Hoagwood, Crowe, & Saka, 2009).

School counselor's role with student mental health. When schools have

comprehensive school counseling programs, school counselors may also provide school-wide

initiatives which focus on mental health for all students within a school. The school counselor's

role is multifaceted. The school counseling profession is guided by the American School

Counselor Association (ASCA) which has developed the ASCA Model to address three

developmental domains of content to assist students: academic (grades, learning concerns, and

postsecondary planning); career (exploration and assessment); and personal/social (interpersonal

and intrapersonal skills; ASCA, 2012a). Within the personal/social domain, developmental

classroom lessons may be beneficial to promote mental healthiness for all students.

Within the school, many professionals (e.g., teachers, school nurses, social workers,

school psychologists) play a role in providing mental health services to students. However,

oftentimes the key advocate of services for students' mental health issues are school counselors

(Foster, Young, & Hermann, 2005). Although sometimes seen as educators more than

counselors, DeKruyf, Auger, and Trice-Black (2013) argued that school counselors should be

seen both as educators and counselors. This places school counselors in a unique position to

provide mental health support and education to students. Cappella, Jackson, Bilal, Hamre and

Soule (2011) conducted a study of 12 mental health professionals located within the school with

master's degrees in one of the following professions: social work, counseling, or psychology.

The focus of the study was evaluating a bridge program among classroom teachers, school

mental health professionals, and community mental health professionals to support students with

behavioral and mental health concerns. As noted within the study, by being located within the

school, the professionals held understandings about schools that other mental health

professionals may not be privy. For example, school counselors have an understanding of

existing relationships with teachers and students. They also know personalities of students and

teachers and understand issues concerning fit within a classroom as well as environmental fit.

This background information is valuable in helping students solve problems.

Since the role of the school counselor is continually evolving, it may make sense that it is

not always clear the part school counselors play in student mental health. Brown, Dahlbeck, and

Sparkman-Barnes (2006) identified discrepancy and overlap between how school counselors

view their roles and how school administrators view them in providing mental health support to

students. In surveying both school counselors and school administrators about the school

counselor's role in regard to mental health, school counselors identified themselves as mental

health providers to a greater extent than did the school administrators. Both groups were in favor

of also including outside mental health providers to support students because caseloads are too

high for school counselors, and some of the school administrators reported that some school

counselors did not have the right training. Both groups also valued the collaborate efforts

between school counselors and outside mental health support. Of the respondents, 75%

indicated that the school counseling position addresses both academic and mental health

concerns. Due to the misunderstandings by administrators and other school staff of the school

counselor's background and training, the authors urged communication and education about it

among staff including administrators. Because all participants identified a significant mental

health concern for young people, the authors also urged continued collaboration among staff as

well as to outside agencies to support students.

Literature continues to emphasize the role schools--particularly school counselors-- play

in collaboration when a student has a mental health need. Along with working with students

directly (whole school or individually), school counselors also collaborate within school and

with others regarding student mental health. School-based mental health counselors and

expanded school mental health professionals (mental health professionals in the community who

have partnerships with the school) are examples where school counselors are actively

collaborating with others for student mental health (Weist, Melissa, & Lewis, 2006). Having

partnerships between community mental health agencies and schools are mutually beneficially

and growing in popularity (Weist et al., 2006). These programs have provided increased access,

improved outreach to students with less observable problems and increased staff productivity

(Center for Health and Health Care in Schools, 2003).

ASCA has identified the collaboration role as being so important to school counseling

that it has identified it as one of four themes within the school counseling profession (ASCA,

2012a). Types of collaboration described by ASCA as being germane to the school counseling

profession include: interprofessional (working within interdisciplinary teams); youth centered

(viewing youth as experts and working with them); parent-centered (viewing parents as resources

and working with them); family-centered (partnering with families for the well-being of youth

and families); intra-organizational (working with people within the school); inter-organizational

(working with groups outside of school such as community agencies); and community (working

with all stakeholders within the area).

When specifically discussing a student's discharge from the hospital, the school is one of

the major postdischarge environments the child or adolescent encounters. Hence, a smooth

reintegration following hospitalization becomes important for the child's postdischarge

adjustment (Savina & Simon, 2014). Reviewing the existing literature and research regarding

reentry becomes crucial for further understanding of this topic which is covered in this next

section.

Transition: Themes in Literature

In reviewing literature pertaining to adolescents' transition from hospital to schools, three

main topics or themes emerged: the perception of others of what happens during the transition

process (Clemens et al., 2010; Rager, 2015; Simon & Savina, 2005; 2010; Tisdale, 2015);

concerns or barriers during the transition process (Rager, 2015; Tisdale, 2015; Simon & Savina, 2005; 2010); and the ideal or success during the transition process (Clemens et al., 2011; Tisdale, 2015; White et al., 2006). Along with predominant themes, certain attributes about the literature and research focusing on transition from mental health hospitalizations to school have become apparent.   Savina, Simon, and Lester (2014) lamented on the lack of literature describing the transition from psychiatric hospitalization to schools in their literature review. They identified Clemens et al. (2010, 2011) as well as Simon and Savina (2005, 2010) as perhaps the only resources on this topic. However, information in this literature review from two recent dissertations (Rager, 2015; Tisdale, 2015) is included, as well as inclusion of a short article provided by White et al., 2006 describing a transition program that also included descriptive statistics on their study's outcome. Along with dearth of literature, another attribute about the literature was the participants within the research have been from the adult perspective: mental health professionals, school personnel, or caregivers. Neither the Savina et al. (2014) literature review nor the other research articles referred to any research done from the perspective of the child, adolescent, or student in regard to the transition from the psychiatric hospital to school.

Perceptions of transitions. Perceptions of what happens during transition as a theme emerged from the literature because many of the articles reported upon how the adults (in hospitals or in school, or caregivers) experienced adolescents' transition from mental health hospitalization to school (Clemens et al., 2010; Rager, 2015; Simon & Savina, 2005; 2010; Tisdale, 2015). The first four studies focus primarily on how adults coordinated transition for the adolescents from the hospital to school (Rager, 2015; Simon & Savina, 2005; 2010; Tisdale, 2015); whereas the last study (Clemens et al., 2010) focuses primarily on professionals'

perspectives of what happens for the adolescent during transition from the hospital to school. In

this section, many of the studies will be introduced for the first time, so a more complete

description of the study will be included in this first section and specific pieces in the other

sections.

In a study designed to investigate how hospital-based therapists help prepare children and

youth transition to schools, Simon and Savina (2005) surveyed 49 mental health therapists

working in with children and adolescents in an inpatient hospital. The study sought to answer

three questions. First, what are the most common methods used by inpatient therapist to

transition children and adolescents from a hospital setting to a regular school setting? Second,

who are the recipients of the transition methods used by inpatient therapists? Third, what content

is and should be discussed between hospital and school personnel within the scope of the

transition process? The survey asked eight questions. The first question asked therapists about

the actions they performed to help children and adolescents transition from hospital. The

therapists indicated meeting face to face with the parent or caregivers as the action most often

performed followed by consulting with school personnel by phone before discharge.   The next

step was phone contact with a parent or caregiver before child's discharge. Regarding

postdischarge practices, 28.6% of therapists provided consultation over the phone with parents,

and 24.5% of therapists with school personnel along with 46.9% of therapists mailing or faxing a

discharge summary to school personnel. When therapists were asked about their perceived

receptivity of parents or caregivers and school personnel, the therapists rated both groups as

being receptive with average scores of 8.04 and 7.98, respectively, with 10 being the most

receptive. The content of consultations with parent/caregiver or school personnel prior to the

discharge from hospital focused on behavior related to the disorder (95.9%), academic

performance (91.9%), and interpersonal relationship with peers (81.6%). Therapists were also

asked about what they thought children would be concerned about prior to the children's

discharge. The therapists identified peer relationships (87.8%) as a topic of concern. Other

highly identified concerns (identified by 60%-70%) were personal coping skills, academic

performance, and relationships with school personnel. The problem most identified by therapists

for children after discharge was anxiety. Another problem identified for children after discharge

by therapists was disruptive behavior, inclusive of manipulation, rule breaking, being withdrawn,

being off-task, aggressive behaviors, argumentativeness, and inattentiveness. In this study, the

therapists rated their hospital transition practices as 7.3 on a 10 point Likert scale with 1 meaning

very dissatisfied and 10 meaning very satisfied.

In a study by Simon and Savina (2010), 329 special education teachers completed a one-

page questionnaire. Of the 329 responses, 210 were used for this study due to the respondents

having direct experience with students who had transitioned from a hospital to school. The

responses indicated that 76% of the special education teachers had contact with a parent prior to

the student returning to school, and 45% had contact with hospital personnel before return to

school. Contact with parents after returning to school was indicated by 91% of teachers, and

37% had contact with hospital personnel after return. Another issue the survey asked about was

knowledge, skills, and resources needed by special education teachers in the transition process.

In particular, special education teachers wanted further information about the child's disorder,

consultation with the hospital personnel, and access to the discharge summary. An additional

issue the survey addressed was behavior returning to school. A large percentage of teachers

(93%) also observed one type of problem behavior from students by children upon returning to

school after hospitalization with off-task behavior being the most observed behavior. A final

issue mentioned from the study, asked special education teachers to indicate when they thought

was the crucial time for children to become reestablished in school after a hospitalization. The

largest group identified the first few days of school to week being the most crucial time to get

reestablished in school.

Tisdale (2015) focused on the hospital-to-school transition from the perspective of

mental health and school mental health professionals involved in the transition process through a

mixed methods study. The study was intended to build upon Simon and Savina's work (2005,

2010) regarding the psychiatric hospital-to-school transition. Participants in the study were

seven mental health staff from two different hospitals and 24 school mental health professionals.

Only nine professionals completed the interview portion of the study. All participants completed

the survey portion of the study. When answering questions about the hospital-to-school

transition process, school mental health staff identified the following information: school staff

were more likely to have contact with parents prior to discharge than hospital personnel; school

staff identified a critical time for transition was within the first week of school after discharge;

school staff identified a concern about anxious or withdrawn behavior of student when return;

school staff requested resources such as hospital discharge plan; and school staff reported

inconsistent contact from hospital personnel. Hospital mental health staff identified the

following information about the hospital to school transition process: hospital staff indicated

always contacting schools prior to discharge; hospital staff indicated being available to meet with

school staff with parental consent, hospital staff identified that school and family contact ceased

after discharge, hospital staff revealed more than half of the participants were willing to reinforce transition plans if school or parent makes contact, and hospital staff noted 57% of hospital staff reported being somewhat satisfied to adequately satisfied with the provided transition process. As noted the perceptions of the school staff and mental health staff of what happens during the hospital-to-school transition in regard to communication differed in regard to communication between hospital staff, school staff, and families. Regardless, both school staff and hospital staff both reported some concern about the transition process.

Rager (2015) explored the caregiver's perspective of the transition students make from a mental health hospitalization to school. Rager conducted a multicase study interviewing three families about their experiences transitioning from the hospital to the school. Rager engaged in member checks, triangulation, and a third-party auditor to ensure validity. The families within Rager's study reported to have had unfavorable transition experiences. Two cases did not involve a multi-disciplinary team approach during discharge from the hospital, and the one case with a team approach did not provide clear explanation of roles of team members. The caregivers found the discharge experience to be unclear and at times received contradictory information. In addition, the caregivers were disappointed how they were treated by some hospital staff and sometimes felt disrespected. The caregivers did not report receiving any coordinating services for their child to transition back to school or significant information how to approach school personnel about re-entering school. There was no postdischarge follow up. Although counseling was recommended for children, the caregivers were not given information how to select an appropriate therapist to continue care after discharge. The caregivers also did not perceive much help with relapse prevention and there was no postdischarge follow-up. In

addition, all three families indicated they had some information about how to support their

student upon return to school, but all three indicated not being aware of more specialized,

accommodation plans such as individualized education plan (IEP), 504, crisis, behavior support,

and transition plans. This information would have been beneficial.

This last study focused on the professionals' perspective of what adolescents experience

returning to school from the hospital after treatment for mental health concerns; whereas, the

other studies described previously focused on how adults coordinate transition. While

investigating the perspectives of professionals (*N*=14) who work with adolescents transitioning

to schools from hospitals, Clemens et al. (2010) interviewed professionals working in inpatient,

outpatient, and school settings. Interviews were transcribed, coded, and formed into domains.

The research team used consensus process to incorporate auditor feedback to word domains and

discrepancies. Three methods were used to ensure trustworthiness: member check, triangulation,

and external auditor. Three major transition themes emerged: academic, social, and emotional.

Almost all participants indicated adolescents experience academic elements to transitioning back

to school. Academic aspects of transitioning to school include effects of absences (missing

work), preexisting academic concerns (academic struggles prior to hospitalization), and readiness

for reentry (ready to leave hospital, but not ready for full-time school). The social aspects of

transitioning to school include social problems that existed prior to hospitalization, concern

about explaining their absence, and friendships impacted by hospitalization. Emotionally, the

adolescents were reported to experience an overall "overwhelmed" feeling after going from

hospitalization (where the adolescent received a high level of care and support) to the school

(where there was more stress and less support). Limitations to the Clemens et al. study were

researcher bias, small sample size, and research topics guided by interview questions based upon

existing literature. Again, this study was from the adult perspective of how adolescents

experienced transition.

Concerns or barriers during transition. Along with the general perception of what is

experienced during transition, another theme found within the literature was concerns or barriers

for adolescents transitioning to school from the hospital (Clemens et al., 2010; Rager, 2015;

Simon & Savina, 2005; 2010; Tisdale, 2015).

In a study designed to investigate how hospital-based therapists help prepare children and youth

transition to schools, Simon and Savina (2005) surveyed 49 mental health therapists working

with children and adolescents in an inpatient hospital. Although the hospital personnel were

overall satisfied with their transition programming, they acknowledged having contacts with

parents and school personnel about worries and concerns regarding transition. These contacts

included the following topics: behavior related to disorder (95.9%), academic performance

(91.9%), and interpersonal relationship with peers (81.6%). Therapists were also asked about the

types of concerns children identified before discharge. Peer relationships (87.8%) rated the

highest child concern prior to discharge about transition. Other highly identified concerns

(identified by 60%-70%) included personal coping skills, academic performance, and

relationships with school personnel. The problem most frequently identified by therapists for

children after discharge was anxiety. Another problem identified for children after discharge by

therapists was disruptive behavior. These behaviors included: manipulation, rule breaking, being

withdrawn, being off-task, aggressive behaviors, argumentativeness, and inattentiveness.

Simon and Savina (2010) surveyed 329 special education teachers who completed a one page questionnaire, and 210 of the responses were used for this study due to the respondents having direct experience with students who had transitioned from a hospital to school. Along with describing how and when the special education teachers had contact with the adolescent's parents and hospital personnel, this survey also asked about concerns the special education teacher had about helping children with mental health concerns transitioning back to school after a hospitalization. Specifically, the survey asked about knowledge, skills and resources needed by special education teachers in the transition process. In particular, special education teachers indicated they wanted further information about the child's disorder, consultation with the hospital personnel, and access to the discharge summary. An additional issue the survey addressed was the adolescent's behavior returning to school. Special education teachers (93%) reported observing one type of problem behavior from students by children upon returning to school after hospitalization, with off-task behavior being the most observed behavior. The study also asked special education teachers when they thought was the crucial time for children to become re-established in school after a hospitalization. The largest group identified the first few days of school to week being the most crucial time to get re-established in school. These last two concerns, off-task behavior and the crucial time of transitioning back to school, could be potential concerns for transitioning back to school depending upon how the student was helped during that timeframe and with those behaviors. Simon and Savina (2010) identified a need for further education for school personnel to best help transitioning students with these potential concerns and barriers.

Tisdale (2015) focused on the hospital-to-school transition from the perspective of

mental health and educational professionals involved in the transition process through a mixed

methods study. The study was intended to build upon Simon and Savina's work (2005, 2010) on

the hospital-to-school transition, postpsychiatric hospitalization. Although Tisdale identified

some positive feedback predominantly from the hospital staff (such as always having contact

with school personnel prior to discharge and being available to meet with school staff with

parental consent) there were a few comments that could be seen as barriers (such as reported to

having no contact with family or school after discharge). Only 57% of staff were somewhat or

adequately satisfied with their transition programming. School personnel identified more

concerns about students being ready to transition back to school.   Specifically, school staff

identified these needs or concerns: critical time for transition was within the first week of school

after discharge, concern about anxious or withdrawn behavior of student when return, requested

resources such as hospital discharge plan, and reported inconsistent contact from hospital

personnel.

Rager (2015) explored the caregiver's perspective of the transition students make from hospital

to school. Rager conducted a multi-case study interviewing three families about their

experiences transitioning from the hospital to the school. All the families within Rager's study

reported having unfavorable transition experiences. Specifically, only one family experienced a

team approach to transition. The caregivers identified discharge was being unclear and

confusing. Additionally, the caregivers felt they were treated by hospital staff at times in a

disrespectful way [manner]. The caregivers also said they did not receive coordinating service to

better transition their child back into the school setting.

While investigating the perspectives of professionals who work with adolescents transitioning to schools from hospitals, Clemens et al. (2010) interviewed professionals working in inpatient, outpatient, and school settings (*N*=14). The study found three major transition themes: academic, social, and emotional. These themes linked to concerns the adolescents had about transitioning back to school. Predominantly, participants experienced academic aspects to transitioning back to school. Academic aspects to transitioning to school include effects of absences (missing work), preexisting academic concerns (academic struggles prior to hospitalization), and readiness for reentry (ready to leave hospital, but not ready for full-time school). The social aspects to transitioning to school include social problems that existed prior to hospitalization, students are concerned about explaining their absence, and friendships are impacted by hospitalization. Emotionally, the adolescents were reported to experience an overall "overwhelmed" feeling from going from hospitalization where the adolescent receives a high level of care and support to the school where there is more stress and less support.

Ideal or successful transition. Along with general perceptions of what happens during transition and concerns and barriers to transitioning, literature also identified aspects of ideal or successful transitioning (Clemens et al., 2011, Tisdale, 2015; White et al., 2006). Two studies are introduced in this section and will be shared in detail. These studies (Clemens et al., 2011; White et al., 2006) were intended to highlight program attributes that were most helpful and successful. The Tisdale (2015) study is again shared highlighting the pieces which were specifically identified as those attributes of transition that were seen as most helpful to transitioning.

Clemens et al. (2011) detailed the elements of the study which discussed successful school reentry. There were five factors identified as having the most impact for successful school reentry: school-based factors, student-based factors, familial factors, mental health care factors, and systemic factors. Within the school-based factors coordination among school personnel, understanding and support in schools, reentry interventions and follow through, stepdown programs, and reentry options were attributes considered as important. Student-based factors included attributes such as investment in recovery and student experience of symptoms. Familial factors included these attributes as important: parental investment in recovery, parents' expectations of treatment and recovery, parents' response to hospitalization and reentry, and parents' understanding of resources. Mental health care factors include these important attributes: continuity of care and attention to school reentry. Within the systemic factor, the main characteristic is communication among all major stakeholders.

In an intensive program designed to support students after transitioning back from the hospital, White et al. (2006) described a program where students receive school-based and care coordination during the first six to ten weeks after discharge from a mental health or chemical health hospitalization. With two master's-level social workers and a classroom aide, the program was located in a classroom or homebase. Each social worker focused on six to eight students at one time. Services provided were: assessment, counseling, family support, case management, care coordination, and educational planning. Students were referred to the program by school counselors and participation was voluntary. The student identified goals throughout the program, and regular class time increased as the student became more ready to fully attend school. Students were also allowed to return to the "homebase" classroom between

classes or for a quick respite if they were stressed or needed help. Referrals to outside agencies

were often also needed. The classroom aide helped organize and prioritize homework with

students. During a two-year span, the program had 99 participants with a median of eight-week

participation. After three months, 88 students were fully back into school and community. Only

11 students required rehospitalization.

Last, Tisdale (2015) also identified some helpful elements during the hospital-to-school

transition from the perspective of mental health and educational professionals involved in the

transition process through a mixed methods study. Aspects from this study that were considered

helpful to adolescent transition from hospital to school were that school staff were likely to have

contact with parents regarding the student's transition from hospital to school. Also, hospital

staff indicated they had some kind of contact with school and were willing to meet with school

with parental consent.

Summary

Chapter 2 provided pertinent information surrounding the topic of adolescents returning

to school after a mental health hospitalization.   The first section of the literature review provided

background information on adolescent mental health and hospitalizations giving a better

understanding of the significant mental illness prevalence among adolescents (U.S. Department

of Health and Human Services, National Institute of Mental Health, Revised 2009). This section

also provided background information regarding concerns for adolescent mental health

hospitalizations such as shortened length of stay (Blanz & Schmidt, 2000), focus of

hospitalization being stabilization not treatment (King et al., 1997), and concerns for

readmissions (James et al., 2010) as well as issues involved with adolescent mental health

hospitalizations (Balkin & Roland, 2007; Moses, 2011).   Schools are playing an increasing role in adolescent mental health (Hoagwood et al., 2007; Stormont et al., 2010; Weissberg et al., 2003).

The second section of the literature review provided a critical review of literature, which focused on the actual transition process adolescents undergo when transitioning from mental health hospitalization to school. A review of this literature yielded broad and encompassing themes: the general perceptions adults have about what happens during the transition process; the perceived concerns or barriers the adults have for children and adolescents as they return to school; and the perceived ideal situation or successful ways the adults have for child or adolescents as they return to school.

Chapter 3: Methodology

Researchers and reviewers who have investigated the topic of children and adolescents transitioning from the hospital to school for mental health concerns all indicated the need for more research upon this topic (Clemens et al., 2010; 2011; Rager, 2015; Savina et al., 2014; Simon & Savina, 2005; 2010; Tisdale, 2015; White et al., 2006). One gap in the literature has been the absence of the child and adolescent voice regarding transition from mental health hospital back into the school setting. Hence, in an effort to give voice to this population, I specifically chose qualitative, phenomenological methodology to explore how adolescents experience returning to school after an acute mental health hospitalization in southern Minnesota.

In Chapter 3, the theoretical framework, research design, and methodology for this dissertation is explained. Then, a description of choosing participants, collecting and analyzing data as well as ensured for trustworthiness throughout the research is given. In providing these details, I hope to provide clear rationale for methodology selection as well as step by step description of how the study was conducted, making replication possible.

Theoretical Framework

The paradigm from which a researcher views a study is the worldview the researcher brings to the study and further shapes the research (Creswell, 2007). There are four qualitative paradigms identified: *postpositivism*, *constructivism/social constructivism*, *advocacy/participatory*, and *pragmatism* (Creswell, 2007). I chose the constructivist paradigm for this study because it both matches my own worldview as well as the purpose of this study. In this worldview, people construct their own meaning about the world based on the individual's

unique understanding of it as contemplated through their own experiences. Constructivism

strives to "rely as much as possible on the participants' views of the situation" (Creswell, p. 20).

Also, social constructivism is often the paradigm used by researchers who seek to describe their

participants' experiences (Moustakas, 1994). This matched the purpose of the study to bring

forth the voice of the adolescents who have experienced the transition from acute mental health

hospitalization to school. I personally believe that each person constructs his/her own

understanding of the world through his/her own experiences: past, present, and future. In order

to better understand another person's experience, I needed to ask each person about his/her

experience.

To better understand the constructivist's paradigm, I provided a brief overview of the

ontology, epistemology, and methodology of phenomenology. In the constructivist's nature of

reality, also called ontology, "realities are multiple, intangible mental constructs, socially and

experientially based" (Guba & Lincoln, 1994, p.110). A truth or reality may be shared by a

group or culture but not any one "truth" is more absolute. In regard to epistemology or nature of

the relationship between knower and what can be known, this relationship is constantly evolving.

Constructivists describe how an individual creates or constructs meaning through cognitive

processes, and these constructions are influenced from the individual's interaction with the

environment; changes can influence the individual's experience (Reich, 2009). From a

methodological perspective, it is suggested that constructions "can be elicited and refined only

through interaction between and among investigator and respondents" (Guba & Lincoln, 1994,

p.111). The goal of phenomenological methodology is to create a "consensus construction"

(Guba & Lincoln, 1994, p. 111) that is more informed than previous understandings of the phenomenon.

Qualitative Research

In keeping with the constructivist's perspective, I used qualitative research. A qualitative research methodology most appropriately helped answer the core research question for this study, as well as aligned with the theoretical framework. Qualitative analysis was applicable in research for a number of reasons. Qualitative research was appropriate in order to ensure that the voices and experiences of the participants were heard. It also allowed for a better understanding of an issue and understanding the environment in which participants encounter an issue (Creswell, 2007). I was seeking to better understand how adolescents experience transition from an acute mental health hospitalization to school. Qualitative methodology seemed the most appropriate framework for this study to collect thick, rich information from the participants to better understand their experience.

Quantitative research was not considered most appropriate for this study. Mainly, the purpose of quantitative research is to seek numerical data that can used to analyze and explain phenomena (Creswell, 1994). While quantitative data would yield numbers regarding the adolescent transition from hospital to school, it would not fully provide a depth of what participants experience in regard to transition. The key focus of this study was on the experiential world of adolescents and how they experienced transition from acute mental health hospitalization to school. Hearing those voices was critical for meeting the desired goals of this study.

Qualitative research is research that does not quantify a phenomenon nor use statistical procedures to explain it (Strauss & Corbin, 1990). Rather than looking to numbers for explanation, qualitative research seeks to understand "the complexity of people's lives by examining individual perspectives in context" (Wang, 2007, p. 256) through techniques such as interviews, observations, and documents (Creswell, 2007). A qualitative approach to study is "fluid and flexible" (Richards, 2005, p. 34) and open-ended research questions are reshaped after the researcher listens to the participants (Creswell, 2007).

The concept of qualitative research has evolved over time and Creswell (2007, pp. 37-39) has identified common characteristics found in qualitative research. The themes which Creswell has identified which were applied to this research were the following five characteristics: The researcher is the key instrument; I conducted the interviews. Data are analyzed inductively; I looked for emerging patterns or themes. In addition to research methodology, and a theoretical lens is used; I used the theory of constructivism to view this study. The inquiry is interpretive; I made interpretations of the problem being studied while being aware that these were my own understandings and guarded for bias through peer debriefing, reflective notes, and advising. Lastly, qualitative research provides a holistic account; I received multiple accounts of the phenomena in order to provide a broad-based view.

Glesne (2006) summarized qualitative research as aiming "to understand social phenomena from the perspectives of those involved, to contextualize issues in their particular socio-cultural-political milieu, and sometimes to transform or change social positions" (Glesne, 2006, p. 4). That description fits this goal of the study because I tried to better understand the phenomenon through interviewing adolescents.

Phenomenological Research

Creswell (2007) explained five perspectives or approaches to qualitative research: narrative, phenomenological, grounded theory, ethnographic, and case study. I used phenomenological research for this study. The intention of phenomenology is "to produce an exhaustive description of the phenomena of everyday experience, thus arriving at an understanding of the essential structures of the 'thing itself', the phenomenon" (McLeod, 2001, p. 38). In other words, the researcher asks the question and allows the answers or data from participants surrounding the phenomenon to speak for themselves (Osborne, 1990).

Phenomenology has been considered a philosophy, a method, and an approach (Patton, 1990), with Edmund Husserl (1859-1938) being attributed as influencing the phenomenology philosophy the most. Husserl, a German philosopher, explained that phenomenology is the study of how people describe things and experience them through their senses (Patton, 2002). Patton (2002) explains phenomenology through Husserl's well-known quote "we can only know what we experience" (p.105). Two basic premises of qualitative phenomenological research are that what is important to know is what people experience and how they interpret their experiences. This is why qualitative study is most appropriate for methodology for this study, and why conducting in-depth interviews and observations are valuable.

When conducting phenomenological research, the researcher's attitude needs to be one of an open mind with genuine curiosity. Approaching the client with this attitude is as important as the technique the researcher uses. Finlay (2009) described phenomenology and the researcher's attitude:

…it involves both rich description of the lifeworld or lived experience, and where the researcher has adopted a special, open phenomenological attitude which, at least initially, refrains from importing external frameworks and sets aside judgments about the realness of the phenomenon. (Finlay, 2009, p. 8)

Phenomenological research describes a method of inquiry with an aim to explore the *essence* or shared experience from the participants themselves. The focus of the phenomenological study is uncovering and describing the inner cognitions and processing of a common experience as perceived by those immersed within the phenomenon (Patton, 2002). Although the inquiry from the researcher is done with an open mind, there is a systematic processing of the information through phenomenological reduction (Moustakas, 1994). The researcher must first determine if the research problem is appropriate for examination by a phenomenological approach. The type of issue best suited for a phenomenological study is one in which it is important to understand individuals' shared experiences of a phenomenon (Creswell, 2007). In addition, understanding these shared experiences may help others develop practices or policies or to "develop a deeper understanding about the features of the phenomenon" (Creswell, 2007, p.60).

Because I wanted to better understand the shared experience of how adolescents experience transition, I chose to implement a phenomenological study. Specifically, I chose the modified Stevick-Colaizzi-Keen method as described by Moustakas (1994), and recommended by Creswell (2007). Giorgi (2010) acknowledged that one error many social scientists, often dissertation authors, make when selecting phenomenology is not selecting and following through with one specific method of phenomenological research. Although he acknowledged

experimentation in research may be applauded for venturing into new fields, he particularly recommended not creating new or interchanging steps of research. By making changes to research methodology, a researcher can inadvertently influence how the research is done and the outcomes. Rather, it is far better to select and commit to an established methodology. Hence, I took Giorgi's advice and outlined a detailed description of the phenomenological research steps used in this study later in this chapter.

Rationale for Selecting Methodology

I chose a qualitative, phenomenological research method based upon how data inductively emerges from the research and this aligns with the theoretical framework for the study. In addition, the method and design best aligned with the purpose of the study. Qualitative researchers seek to use data to gather thick, rich information rather than numerical data to explain phenomena (Moustakas, 1994), which seemed most appropriate when seeking to best describe how adolescents experience their transition from acute mental health hospitalization to school. Since little research has been done on this topic, an exploration of this topic was first needed; hence, broad, open questions of qualitative inquiry is needed (Creswell, 2007). Data in qualitative research are analyzed inductively, searching for emergent themes. I interviewed multiple participants looking for each one's unique experiences, as well as commonalities, among participants.

A constructivist theoretical framework was used for this study. In constructivism, each person creates his or her own unique meaning about the world based on that individual experience (Creswell, 2007). Constructivism also seeks to explore the "participants' view of the situation" (Creswell, 2007, p. 20) and how the participant interprets reality (Bloomberg & Volpe,

2008). These subjective interpretations or meanings are created through experiences interactions with others (Creswell, 2007). These meanings become the individual's learned reality. The attributes of constructivism align with using a qualitative methodology to explore how adolescents experience returning to school after an acute mental health hospitalization. Similar to constructivism, qualitative research seeks to understand how people's inner thoughts and beliefs are shaped by their cultural experiences (Corbin & Strauss, 2008). Qualitative research values the individual's point of view within their context and acknowledges multiple and subjective realities (Lincoln & Denzin, 2008). In addition, qualitative research produces findings that are not derived from statistical procedures but focuses on the lived experiences of people to help better understand a human phenomenon (Corbin & Strauss, 1990). This dissertation study focuses on participants' words, and places value on how each person within in the study creates his or her own reality.

Regarding a specific research qualitative methodology, I considered all qualitative methodologies, with case study and phenomenology being the two methodologies being most seriously being considered for this study. Although case study also allows for an in-depth investigation into a process or individuals (Stake, 1995) which was attractive for this study, it does not have the same attention to understanding the essence of the phenomenon (Moustakas, 1994).

Through collecting first-person accounts of the phenomenon, phenomenology strives to answer a question rather than test a hypothesis. Moustakas (1994) explained that phenomenology commits itself to descriptions of experiences rather than explanations or analysis. The ultimate purpose of phenomenology is to report clear and "systematic descriptions

of the meanings" (Polkinghorne, 1989, p. 45). Because phenomenology turns to the participants for their own perceptions regarding their experience, I identified it matched the main goal of this research. I had an interest in understanding better what adolescents experience when they transition from an acute hospitalization back to school. Phenomenological researchers often pursue research in an area of interest or want to know about an experience in a deeper level (Moustakas, 1994; Patton, 2002), and this was true for me. I wanted a deeper, more descriptive understanding of the adolescent's perspective of the process from the hospital to school transition.

Population Selection

The first step in my research process was receiving approval to conduct research by both my dissertation committee and the university's institutional review board. Then, I focused on selecting the sample population for the study. Because I asked a mental health center that services southern Minnesota as a resource for referrals, I first provided an information meeting for the counselors at this counseling center. The information meeting happened during an all staff meeting and provided information regarding the purpose of the study, need for the study, methods, data collection, ways to ensure client anonymity, and method to attain parental consent. I also gave the recruitment letter to the counselors to pass along to the clients and the clients' parents. After working with mental health counselors at local counseling centers for referrals, I did not receive an adequate number of participants. So, I returned to the Minnesota State University, Mankato's Institutional Review Board and received approval to include school counselors as a referral resource. I then, reached out to school counselors by meeting informally with them and through giving additional information through email about the research. School

counselors then passed along the recruitment letter to potential participants and participants'

parents. The potential participants then contacted me about being a part of the study. In some

cases, the school counselor asked the parent directly if the school counselor could give me the

parent contact information. In these cases, the school counselor asked the parent for permission

to share contact information after the counselor had already talked with the parent's child, and

the child indicated interest in participating in the study. I then contacted the parent directly to

inquire about participation.

Patton (2002) recommended selecting participants for study who are "information rich"

so that they will be able to offer the best insight into the phenomenon of interest. Rather than

approaching sampling from "empirical generalization" (Patton, 2002, p. 40), sampling can gain

the best insight into the phenomenon of interest. This study used criterion selection as a means

to acquire the sample of the overall population to be studied. This means each participant in the

study experienced the same phenomenon (Creswell, 2007; Moustakas, 1994; Wertz, 2005).

Criteria for this study's participants was:

1.   Adolescents (age 13-18);

2.   Living in southern Minnesota;

3.   Had experienced an acute mental health hospitalization (4-15 days);

4.   The mental health hospitalization had to occur within the last 12 months;

5.   Participants currently participating in on-going counseling.

I ensured confidentiality of the participants throughout the study by not using the

adolescents' names. As mentioned, I worked with mental health centers and school counselors

in southern Minnesota as a resource for referrals for the study. All participants had parental

consent forms signed to participate in the study. The counselors identified which clients met

criteria and gave them an informational letter about the study (See Appendix B) which had

detailed information about the study, as well as my contact information on it.

There were three steps in gaining participants for the study. First, the counselors at the

counseling center or school identified eligible participants and gave them the letter with study

information and my contact information. Second, the potential participants contacted me, and I

verified the participant's eligibility, made plans to get parental consent, and arranged date and

time for interview. As I mentioned, there were times when school counselors, after the potential

participants indicated an interest in the study asked the parent's permission to give me the parent

contact information. Third, I then contacted the parent to inquire about doing the interview with

the adolescent. I gained signed parental consent by driving to the parent's work, home, or in

three cases, the parent came to the interview and signed the form.

Reaching saturation is the goal for participation when conducting qualitative study

(Creswell, 2007). Saturation is reached when redundant statements begin to be made and no new

information seems to arise. Five adolescents were the interview target number. The number

remained flexible to ensure the study had sufficient data to answer the research questions. After

five interviews, overlapping information was obtained; however, saturation was questioned due

to the brevity of two of the interviews. Additional participants were sought, and three additional

participants were interviewed. Overlapping, repeating information continued, and it was

ascertained that saturation was met.

Instrumentation

Interviews are a common method of data collection for phenomenological research and was the instrument for this study. Creswell (2007) and Moustakas (1994) encouraged the use of an interview protocol or guide. When setting up the interviews, I made arrangements for getting parental consent and assent on forms either at the interview or prior to the interview. For example, if the parent was not able to meet at the counseling center or school prior to the interview to sign the consent form, I drove to the parent's home or work to get the signature form signed and to visit about the study. I used a three-phase interview protocol as outlined by Osborne (1990): establishing rapport, sharing of narratives, and appropriate closure. Rapport was often attempting by engaging in nonthreating conversation: talking about the weather, thanking the participant for interviewing, and asking about the participant's day in general. After attempts at rapport, information was shared about the study (essentially reviewing previously written informed consent), including purpose of the study, research questions, interview questions, and consent to participate in the study. These guidelines were on a paper that I had in front of the participant as I talked about it. The explanation stressed that the participation was voluntary, and the participant could stop at any time without consequence. I then also let the participant know that the interview would be taped and transcribed and how this would be protected (electronic through password and hardcopy through lock and key). I also explained that as the participant's words are being shared in the paper, the participant would remain anonymous and be identified by a pseudonym.

Phase two of the interview was the interview itself: the four questions involved in the study. Semi-structured interviews have a prepared interview guide that includes ready questions;

however, the researcher remains open for further inquiry or prompts depending on responses of

participants (Roulston, 2010). The questions should be open-ended (Creswell, 2007; Moustakas,

1994; Roulston, 2010) to generate the most description about the phenomenon including the

"participants' feelings, perceptions and understandings" (Roulston, 2010, p. 16). In addition, the

interview questions are "a narrowing of the central questions" (Creswell, p. 133) in the study. I

placed the four questions in front of each participant during the interview, and gestured to each

question as I asked the question to give the participant a reminder of what was being asked.

The first interview question was designed to be the broadest and elicit a full description

from the participants.   Question one was, "Could you describe for me what your experience was

like transitioning from the hospital to school?" Question two was, "Could you describe any

specific incidents (and those people involved) that may stand out for you that were connected to

your transition?" Question three was, "Could you describe any feelings or emotions that were

generated by your experience?" Question four was, "Is there anything else that you think is

important for others to understand about returning to school from your viewpoint?" The

participants had the sheet of paper with the questions so that they could refer to the questions

visually if necessary. Each question was gestured to so that the participants could follow along

(Appendix C).

The last phase of the interview is the appropriate closure. During this time, I again

thanked the participants for their time. I asked if there were any questions for me. I explained

that I would be making contact at least one more time to check my understanding of the

participant's significant statements after I went through the transcript. I then checked to make

sure the adolescent had a safe plan to get home from the counseling center or school after the interview.

Data Collection

Giorgi (2009) identified that the goal of the phenomenological interview is to provide as "complete a description as possible of the experience that a participant has lived through" (p. 122). The interviews were conducted in person to increase the likelihood of garnering the most information about the adolescents' experiences. Because observation is an important factor in phenomenological interviewing (Creswell, 2007; Wertz, 2005), in-person interviews also included field notes and reflective journal notes describing any details pertinent to the interview such as the details of the setting and the participant's demeanor.

I conducted interviews in a convenient location for the participant that was also allowed for a private interview. Locations for interviews needed to have some privacy for the participant's comfort. A public location was best to help the adolescent feel comfortable meeting the researcher. Privacy was also needed so that the adolescent felt comfortable sharing freely about their experience. The ultimate location would include public yet private elements such as a counseling center office or a school counseling center office. Six interviews were conducted in such locations. However, two interviews were done in the home with the parent or guardian in the yard doing fall yardwork. One interview was done this way because of not wanting to miss school for the interview and needing to ride the bus home (the participant lived in a semi-rural location). The other interview was done in the home due to the participant not feeling comfortable being interviewed at school or a public location. The hospitalization of the participant was kept private, but the family wanted to contribute to the study. I expected the

interviews to last between 45-90 minutes. The whole interview process did take about that long; however, the interviews themselves were shorter, 20-60 minutes.

Prior to the interview questions, I described the purpose of the study, research questions, and specific interview questions, to help each participant feel comfortable with the process. Written consent to participate in the study, and to be recorded, was acquired prior to the interview. As previously noted, the start of the actual interview, verbal informed consent was reviewed again with participants. So, prior to the start of the interview, each participant and the participant's parent or guardian signed informed assent and consent to participate. I then explained that the interview would be recorded and transcribed.

After the interviews, I wrote in a reflective journal about any thoughts and feelings brought up during the interview process. Reflective journaling helped me acknowledge my own personal experiences and separate them from the adolescent's experience. In addition, I wrote descriptive field notes about the experience. The field notes were not about my thoughts and feelings but objective as possible observations during the interview experience. An example of the reflective journal may have included that I felt empathy for a participant or that the participant reminded me of a former student; whereas, an example of field notes may have included a description of the adolescent's dress, walk, or general demeanor. I wrote these notes on a computer which was password protected under two different files to keep the process of writing in each type of journal separate for me. I also tried to take a break between writing in each type of journal, field notes versus reflective journal to help clear my mind between writing.

Data Analysis

After interviewing, I made efforts to set aside any personal biases by engaging in bracketing and made every effort to understand the statements and meanings of participants. Specifically, I used recommended procedures for processing the interviews. The Stevick–Colaizzi–Keen method, which Creswell (2007) identified and modified as the "most practical, useful approach" to analyze data from a phenomenological viewpoint (p. 159), was used for this study. The following is a summary of the steps to the process as provided by Moustakas (1994, p. 121-122) and modified by Creswell (2007, p. 159):

1. A description of the researcher's own experience of the phenomenon is given in an effort to set aside personal bias and focus on the participants' description of the phenomenon.

2. After careful review of the transcripts, the researcher develops a list of significant statements by participants by removing overlapping, redundant statements. Each statement is treated as having equal worth. This process is known as horizontalization.

3. The significant statements are then grouped together to create meaningful themes.

4. A textural description of what the participant experienced regarding the phenomenon is given next.

5. A structural description of how the participant experienced the phenomenon in regard to context and setting follows.

6.   A composite or essence of the experience is described next that combines the

textural and structural descriptions of how the participant experienced the

phenomenon.

The first step in a phenomenology study is to engage in a process is known as epoche

(Moustakas, 1994). A simple explanation of epoche is for the researcher to contemplate on his

or her own beliefs, thoughts, and preconceptions (Moustakas, 1994). Through epoche, the

researcher openly acknowledges personal thoughts that occur before and during the study. The

researcher engages in an ongoing awareness in an effort to freshly encounter the participants in

the study and report the most accurate data (Wertz, 2005). I have also included my own

experiences and biases as a school counselor working with students returning to school after a

mental health hospitalization later in the chapter. Prior to data analysis, my dissertation advisor

performed a transcript audit. The transcript audit checked that I interviewed participants, asked

the four interview questions, and transcribed the audiotapes accordingly.

The second step is performed after transcribing the interview tapes and called

horizontalization. In this step, after several readings of the transcription, I listed all significant

statements as if they have equal weight. This list does not include overlapping or repeating

statements. After listing all significant statements, the statements were grouped together to

create themes. This may also be referred to as *meaning units*. During this process, I removed any

repeating statements. The significant statements were checked by both a peer reviewer and the

participants.

The dissertation committee recommended that I member check after the significant

statements rather than after descriptions due to the age of my participants. So, I brought the

significant statements as well as the transcripts to the students and visited with students a second

time. I explained the process of removing any overlapping and repeating statements from the

transcripts. I asked the students to review the significant statements. We discussed if these

statements represented their transition experience. I also asked if there were any other

statements or thoughts they wanted to add. New data emanating from the member check was

included in the descriptions since this information seemed important to the members. Next, the

textural description of what the participant experienced was written from themes that were

created from the significant statements. The textural descriptions included quotes from the

participants describing what they experienced about the phenomenon. Throughout data

collection and analysis, I sought to bracket assumptions as they arose. I reviewed textural

themes with two school counselors. One of my school counselor peer reviewers was also a

doctoral student in counselor education. I then wrote the textural descriptions and reviewed the

descriptions with one of the school counselor peer reviewers.

The next step was to write the structural description which included providing details

surrounding how the participant experienced the phenomenon. This required me to reflect upon

the setting and context in which the phenomenon was experienced as described by the participant

and observed during the interview. This process is also known as *imaginative variation*. In this

process, "variation is targeted toward meanings and depends on intuition as a way of integrating

structures into essences" (Moustakas, 1994, p. 98). The steps to utilizing imaginative variation

as described by Moustakas (1994) include:

1.   Systematic varying of the possible structural meanings that underlie the textural

     meanings;

2.   Recognizing the underlying themes or contexts that account for the emergence of

the phenomenon;

3.   Considering the universal structures that precipitate feelings and thoughts with

reference to the phenomenon, such as the structure of time, space, bodily

concerns, causality, relation to self, or relation to others;

4.   Searching for exemplifications that vividly illustrate the invariant structural

themes and facilitate the development of a structural description of the

phenomenon. (p. 99)

Following the structural analysis, a textural/structural description was written for each participant

next. This was considered the essence of the participant's experience. This step involved

reviewing all of the material once again and identifying common themes found among the

participants. This was then written within the composite description chapter. These common

themes and later the composite descriptions were peer reviewed by a school counselor. Small

changes were made to the descriptions as feedback was given to me by the peer reviewers.

Along the way, I consulted both my dissertation advisor and another committee member about

the process.

Ensuring Trustworthiness

In qualitative research, Lincoln and Guba (1985) suggested validity and reliability are important

in qualitative research but these concepts are seen in a broader sense by establishing

trustworthiness (Polkinghorne, 1989).   Ensuring trustworthiness is a process the researcher takes

and then describes which seeks to convince the reader the study is worth reading and

acknowledging. Essentially, the researcher should ask, "How can an inquirer persuade his or her

audiences that the research findings of an inquiry are worth paying attention to?" (Lincoln &

Guba, 1985, p. 290). In qualitative research, the researcher establishes "trustworthiness"

(Lincoln & Guba, 1985, p. 290) by taking measures to ensure credibility, transferability,

dependability, and confirmability.

Credibility is establishing the study as believable. The researcher's responsibility is to

provide a database of thick description including details from the participants' voices (Lincoln &

Guba, 1985). In Chapters 4-12, I have included detailed descriptions of the discussions that take

place throughout the study from participants' words in this study. As often as possible, I have

included direct quotes from the participants. Transferability is not necessarily the responsibility

of the researcher (Lincoln & Guba, 1985). In fact, Lincoln and Guba did not believe it is the

responsibility of the qualitative researcher to ensure transferability. Rather, it is the

responsibility of the reader to identify if the study is reasonable to apply to other situations. The

researcher's responsibility is to provide a database of thick description from participants' voices.

I provided detailed, often verbatim, descriptions of the discussions that take place throughout the

study by using as many of the participants' words as feasible in this study.   Lincoln and

Guba (1985) suggested one way to ensure dependability for the study was to "overlap methods"

(p. 317), known as triangulation. In this study, I triangulated the research by using multiple

participants, member checking, peer review, and keeping a reflective journal. Another way

triangulation was used in this study is through the review of literature. The literature was used as

another data source. Because each researcher brings his or her own perspective to qualitative

research, researchers should seek to confirm findings with others (Lincoln & Guba, 1985). To

reduce bias and increase the confirmability of the study, member checks were conducted after

interviewing by having each participant approve their significant statements. I conducted these

member checks face-to-face when possible so the adolescent can see the statements in person,

and I could answer any questions in person about the statements. This process increased the

likelihood that condensation of the data accurately represented participants' perceptions.

Role of the Researcher

The role of the researcher extends beyond the interactions with participants during the

interview. The researcher influences the entire research process (Moustakas, 1990) beginning

with choosing the research topic. Moustakas (1994) stated, "In phenomenological research, the

question grows out of an intense interest in a particular problem or topic" (p. 104). The

researcher's background invariably affects choices such as the research questions and design.

Because phenomenological researchers have a personal and social interest in the topic,

recommended practice is for the researcher to openly recognize their personal experience with

the topic of study.

When the researcher acknowledges the closeness of the topic, the researcher keeps the

research focused on the participants' experience and helps ensure the most reliable data is

collected (Finlay, 2009; Wertz, 2005). The terms epoche and bracketing are central to

phenomenological study. These terms are often used interchangeably; however, they are not the

same (Bednall, 2006). Epoche is an ongoing approach and process the researcher takes from the

beginning of the study in an effort to newly view a phenomenon. Bracketing is the individual act

of acknowledging preconceptions (Patton, 1990). Structurally, bracketing is a part of a larger

concept, epoche (Bednall, 2006). Whereas the researcher engages in epoche throughout the

study, bracketing occurs at those "interpretative moments when a researcher holds each of the identified phenomena up for serious inspection" (Bednall, 2006, p. 127).

Through self-reflection, the researcher examines his or her own experiences and then seeks to understand the participants' experience. Although there is a personal interest in the topic, the researcher also has a larger or social interest in the topic to be studied (Moustakas, 1994). With this in mind, the researcher acknowledges how he or she influences the totality of the study while truly seeking to better understand the experience of the participants in the study. Later in the chapter, I detail my own experiences with the phenomenon which provides a context for the reader to view the study.

Epoche

Considered at the heart of phenomenological research is what Husserl called epoche. Moustakas identified how people view everyday life through preconceptions and apply these preconceptions as a part of reality or knowledge. The epoche requires the researcher to look at things in a new way. In this new view, the researcher first uses self-reflection to become aware of personal biases and preconceptions. Through this self-reflection, the researcher is able to gain insight. With better understanding of one's self, the researcher can then explore the phenomenon with a fresh view (Moustakas, 1994). Although biases should be acknowledged and understood, Bednall (2006) suggests that epoche allows for connection and empathy. Bednall (2006) described the process of the researcher having a better understanding of his or her preconceptions but is not eliminating or substituting preconceptions. By acknowledging assumptions, researchers set aside their assumptions and judgments about the phenomena to be able to view the phenomenon with a new or fresh view (Wang, 2007). Phenomenological researchers not

only acknowledge their preconceptions to themselves but also describe their experiences and

biases within the study. For this reason, I am also sharing my own experiences including

personal assumptions and biases.

Researcher's Personal Experience

I was born and grew up in a midsized, isolated town in South Dakota that was surrounded

by prairie. Although the town's population was about 13,000, all other towns within an hour

radius were considered rural. My ancestry is predominantly Norwegian and Irish. I have been a

school counselor for 19 years, including experiences in rural and suburban areas, working K-12,

elementary, and secondary schools. While growing up, I did not experience a mental health

hospitalization, nor did I have family members that have experienced mental health

hospitalizations. I did have one friend who was hospitalized during high school for an eating

disorder. I remember being baffled about what happened, but was compassionate enough to

know that something big in her life had occurred. We remained friends after she returned, but I

did not feel comfortable asking her about the experience. I do remember being paired in classes

with her when she returned and feeling like I wanted to help because I thought it must be hard to

return after being gone so long. Personally, when I experienced my own feelings of upset,

sadness, or frustration during adolescence, my family was present; however, I felt I was given

the message that I needed to figure it out, tough it out, and solve my own problems. I also

perceived the message that I was more fortunate that others. So, I should not complain.

I have encountered a number of students as a school counselor who have had absences

due to a mental health hospitalization for a variety of lengths of stay. Some students who have

identified themselves as suicidal to me or parents are assessed at the local hospital but are not

admitted because the hospital says "there isn't a bed available" at the hospital. The family is given a choice to go a longer distance for a hospital or try to manage through outpatient counseling services. Some students are admitted for a few days to two weeks, and yet others are admitted locally and then referred to other facilities for longer stays.

Before being admitted to the hospital, sometimes I know the student is struggling with a mental health concern. Other times nobody at the school knows. Regardless, I have experienced a mix of thoughts and feelings when I know a student has been admitted to the hospital for a mental health concern. First and foremost, I am hopeful that the adolescent will be able to get help. Often times the hospitalization will be a catalyst for tough conversations within a family about mental health and family problems. Theoretically, the hospital is a safe place for the young person to bring these topics up to professionals and family members, sometimes for the first time. When I hear about or am instrumental in helping a student go to the hospital for their acute needs, I am very aware that my first instinct is to be hopeful and even excited that this may be the intervention that may help the student.

My second and lesser response is one of skepticism and worry. After seeing so many students return quickly and without an adequate aftercare plan, I worry that the student who is going to the hospital this time will return only to struggle with the same problems. Oftentimes as a school counselor when I meet with students and families after a hospitalization, they explain that medication or counseling has been recommended; yet, a solid plan for aftercare has not been made. There are also times when the student and family are very committed to an aftercare plan, and both are interested in putting together a school reentry plan with me.

Likewise, when students are about to go to the hospital they have shared with me their ambivalent and fearful feelings. They may want to feel better, and they may be hopeful that going to the hospital can help. Some young people also share though that they are scared or that they may be hesitant that going to the hospital will actually help.

I am also aware that I have a feeling of guilt regarding this topic. When I first became a counselor, these situations did not happen frequently at the schools where I was working. I did my best when students returned after hospitalization, but I did not know for sure what to do. Now, as a more experienced counselor, I am seeing more hospitalizations each year at my current school. Although I have more skills and ideas than when I was a novice, I am still not sure how best to help these students. I have felt many times that I have not helped a student returning to school from the hospital enough or even adequately.

These are all experiences that I bring with me to this study. I am aware that they have contributed to some preconceived beliefs which in turn may influenced this research. My experiences may have influenced my tone of voice, how I asked a question, how I responded to their words, and even which interview questions in which I offered more encouragers. Having engaged in prolonged reflection upon my biases regarding adolescent mental health hospitalizations, these are the assumptions I brought with me: (a) most adolescents are not ready to fully return to school when they are released from an acute mental health hospitalization; (b) most students have troublesome experiences transitioning back to school after an acute mental health hospitalization; (c) most students do encounter a few experiences during transition back to school after an acute mental health hospitalization that are helpful; (d) most schools do not do an adequate or good job helping adolescents transition back to school (e) most school counselors

and school staff intend to help students but may not know what to do to help students in this

situation. With the awareness of these preconceptions, I worked to bracket out the biases during

the research process.

Ethical Considerations

Before beginning research on the proposed study, I received approval from the Minnesota

State University, Mankato Institutional Review Board and my dissertation committee. Most

importantly, I worked to treat participants with dignity and respect throughout the study.

Pseudonyms were used to protect the anonymity of participants. Each participant and their

parent were read and signed a consent form prior to beginning the interview. As recommended

by Creswell (2007), participants were informed about the central purpose of the study,

procedures to be used to collect data, policies regarding confidentiality of the participants, risks

associated with participation in the study, and expected benefits to participants from the study.

In addition, participants were informed about their right to ask questions and withdraw from the

study at any time. Participants were also given information about how to obtain a copy of the

study when it is finished. The taped interviews, consent form, transcripts, journal, and field

notes will be kept in a locked filing cabinet for up to three years after the study is completed and

approved. Materials will then be destroyed. Electronic files with confidential information were

kept on a password-protected computer, and the files will be destroyed three years after the study

is completed and approved.

Summary

This chapter was divided into eight sections: method, sample population, instrumentation,

data collection, data analysis, role of the researcher, ethical considerations, and summary. In

Chapter 3, I described the details of the methodology in which I conducted this research. This research sought answers to a core research question by conducting a phenomenological, qualitative study using semi-structured interviews. The interviews were conducted face-to-face, recorded, and then transcribed. A reflective journal and field notes were kept to supplement the data. Significant statements and emergent themes were identified. The researcher acknowledges her role and the need to set aside personal biases. Also outlined were ethical considerations of performing the research and storing data.

In future chapters, the findings and results from the data analysis, reflective journal, and field notes are described. Participants' experiences are shared through textural and structural data, as well as the essence provided by a combination of both.

Chapter 4: Participant One

Ann (all names in this dissertation have been changed to protect participant anonymity) was a 16-year-old female who is from an urban community in southern Minnesota. At the time of the interview, as well as at the time of her hospitalization, she attended a large urban high school. She was a freshman at the time of her hospitalization, and was interviewed in the summer prior to her sophomore year of high school.

Textural Analysis

Help. When Ann talked about her experience returning to school after being hospitalized, she commented often about getting help or not getting help from others. She referred to getting help from teachers, administrators, social workers, her mental health counselor that she met soon after being hospitalized, and from friends. For the most part, she related not getting much help or direction from teachers at school. She felt like, "Teachers didn't really help you a lot." This feeling left her confused and not knowing how to do her homework. Ann said, "I had to make a plan myself." Despite having been told while in the hospital not to worry so much about school, she felt as if, "We [the treatment team] got this covered." She also perceived the message, "We got a plan."

Ann shared that she did not feel alone in her frustration with not getting help or support from teachers after coming back from her hospitalization. She talked about a girl who was a year older than her who had also been hospitalized. When they would see each other in the halls, they would ask how each other were doing. The older girl also said she was worried about not graduating and felt like the teachers did not help her when she got out of the hospital.

Ann did explain that there was a lot of talking with teachers when she first got out of the hospital, but it felt more like "everybody just pushing me to do good in school" and "I had to do everything." She implemented a plan herself which included staying after school and going to Saturday School. Ann was appreciative of one teacher who she thought was really helpful. She identified that "once he knew what happened and why I went to the hospital for, he pulled me aside after class and talking [*sic*] with me about it." She recounted how he was "there for her" and tried to make a plan for her and even asked other teachers to understand. He also asked her how she was doing. She got a feeling that he "kinda' had my back."

When Ann had been given medication, plans for counseling, and had been told the school would have a plan for catching up in school in the hospital, she felt determined when she was first discharged from the hospital to do well in school. She acknowledged though, "that when you first get out even though you may feel determined, you will need a lot of help." She also thinks: "Teachers need to help more, like they need to get more involved." Ann advised: that if teachers know what is going on, teachers should "check in" and the teachers should "make sure you're doing fine."

Confusion. Ann depicted a strong sense of confusion and unknowing during the weeks following her transition back to school after her hospitalization. When asked about how she would describe her transition, her first words were, "It was confusing, and I felt like lost." She described her confusion stemming from not knowing about what to do with her academics and also from perceived mixed messages she was receiving from adults. One thing she was confused about was whether or not she should "start with all the assignments when I left, or like, start doing the stuff they were doing now." She felt a need to catch up. Yet, she didn't know how to

"catch up and get all my homework in the way they wanted me to."   When she was pulled aside

and got more help from her math teacher, she was able to "catch up better" in that class.

Academically, this helped the confusion about work in math class.   She described how she is a

quick learner, and how she could go in and "learn something one day," review the next day, and

then take a test or quiz the following day.

Along with academic confusion, Ann explained confusion about her attendance and

homework plan from adults. When she was in the hospital, she worried about missing school

and catching up on homework. The adults during her hospitalization told her not to worry about

schoolwork because there would be a plan for her to catch up when she was out of the hospital.

However, she felt like when she did return to school, she was told: "You have to do it. You have

to do your own plan." Another way she experienced confusion was regarding her attendance.

Ann had struggled with attendance in her pas, including issues with truancy. So when she was

gone for the week in the hospital, she worried about being out of school for so long. She

reflected that adults acknowledged that what was happening and going to the hospital was "a big

deal" and knew why she had missed school. Yet, when she got out, "They were making it seem

like I missed those days on purpose, like I could have came [*sic*] to school."

Positive thoughts. Although Ann had some discouraging experiences when she returned

from school after her hospitalization, she also held positive thoughts and hope throughout the

experience as well. Overall, Ann wanted to do well in high school. She was looking forward to

high school as a fresh start. Since it was her first year of high school she was "planning to do

really good." When Ann was discharged from the hospital, she was still focused on doing well.

She thought, "I am going to get all my homework done." She was preparing to do "really good

when I got out." She also felt encouragement from being prescribed medication and having

started counseling. She said she was, "kinda', like, happy and determined" when she got out of

the hospital. Despite not feeling as if the teachers "didn't really help," she did develop a plan for

herself. She contacted her teachers, attended Saturday School, and stayed after school to work

on assignments. She also identified feeling encouragement from her math teacher who would

check in with her. She also found the teacher's help academically helpful. Ann also reflected

that she thought her transition was perhaps better than some other students who had gone to the

hospital. She had seen other students either at the hospital during her stay or just knew of the

students having gone to the hospital, and it seemed like her situation was better. Ann then

narrated a story about a girl who is a year older than her and how that student was worried about

graduating and did not feel like she was getting help from teachers.

Structural Analysis

    Feeling let down. The process of returning to school for Ann was fraught with feelings

of frustration, disappointment, and in general, an overall feeling of being let down by others,

primarily adults. One context in which Ann experienced returning to school after her mental

health hospitalization was through a lens of feeling let down and disappointed by others. Ann sat

poised and stayed focused on the topic of her school transition as she described how she returned

to school after her hospitalization. As she answered each of the interview questions, a new layer

of how she felt let down by an adult was revealed. She did not seem prone to embellishment.

She detailed her experience with a matter of fact, calm voice.

    When Ann returned to school, she identified feeling "lost" and "it was confusing" when

she discussed the schoolwork she was required to make up. She also identified she was not

given much direction about how she was supposed to make up the work. She did not know if she was supposed to work on current work or the work that was done while she was gone. She specifically identified that, although she met with teachers, few teachers actually gave her instructions or help about how to make up the work. She stated, "My counselors and social workers and stuff would talk with them, but, um, they didn't really do anything."

Another way Ann seemed to feel let down was in the area of attendance. She had a history of attendance issues in 8th grade. It was important to her to improve her attendance during high school. Even when school staff knew why she had gone from school and "they said it was a big deal," she said that when she returned to school, she felt like they accused her of missing school on purpose or that she could have prevented the absences. She then perceived that she needed to start at the beginning with all of the missed work. Her reaction was, "I don't know why they would do that?" She also explained, "I know how to have good patience and tolerance and stuff. So I kind of like, took it, but I know some other students that it make them [*sic*] worse." Ann perceived that the adults in the building sent her mixed messages that while going to the hospital was important, in some way her missing school could perhaps have been avoided or was her fault. She then felt like she needed to do all of the work from all of her classes that she missed. Hence, she felt misled and let down by the adults at school.

Another facet to her experience of feeling let down during her return was the idea of having a plan when she returned. Prior to being hospitalized, Ann was worried about school and her absences. Her impression from adults was, "we got it covered" and "we got a plan." While in the hospital, the medical team asked about a return to school plan, and her social worker indicated that the school would have a plan. She felt encouraged that she would do well when

she returned to school. When she was released, however, she didn't think they had a "plan or anything." Her viewpoint was that she had to do it herself and had to create her own plan. She stated, "I had to make a plan myself." Ann experienced disappointment that she was supposed to have a plan but it did not happen. At first, she was "happy and determined" when she first got out of the hospital thinking that things were ready for her at school, but she was frustrated that there was so little was actually planned for her. She was the one who had to go to the teachers and ask about work, attend Saturday School, and make her own plan.

The message Ann seemed to receive upon returning to school was that, with the exception of her math teacher, she couldn't depend upon the adults at school. She felt let down that there wasn't a plan or support for her to get her work done despite being told that there would be help and a plan. Despite being admitted to the hospital for crisis care, she felt questioned by adults when she returned to school about her attendance and not supported about being absent. Although there was a meeting with teachers, she thought, "they didn't really do anything." Ann made several comments like, "the teachers didn't really help you a lot" and "the teachers need to help more, like they need to get involved more." In essence, the lack of school staff support contributed to Ann's feeling let down when she returned to school. With Ann's calm demeanor and quiet strength, she explained how she got the impression she needed to rely on herself at school when transitioned back to school.

Textural/Structural Analysis

Ann is a well-spoken, calm young woman, who spoke directly about the topic of returning to school after her brief mental health hospitalization during the previous school year when she was a freshman. She spoke without embellishment or diverting onto tangents.

When combining textural and structural descriptions of Ann's experience, the essence of the experience emerges that ties together what Ann experienced and how she experienced it. The textural themes of help and confusion describe what happened during Ann's return to school and how this contributed to Ann's structural theme of feeling let down which describes how she experienced her return to school.

As Ann clearly described her experiences returning to school, a sense that she felt let down by the adults at school emerged. Although she felt let down, she did not seem to be bitter or unable to see some of the good things that came out of her seeking help at the hospital. Rather, Ann was able to share the struggles, as well as some of the good things, that came from her experience returning to school after her hospitalization. Ann did have some positive experiences returning to school, and this was described in the textural theme called, positive thoughts.

Ann experienced frustrations with the lack of support and help when she returned to school. She was frustrated that although she was expecting to have a plan for getting homework done, there wasn't one. Also, although there was a meeting with teachers, she felt as if the teachers didn't really provide help. She perceived that she was left to make her own plan. In addition, she held feelings of confusion regarding how to make up schoolwork and mixed messages regarding attendance and having a plan for work. She felt there were strong indications prior to hospitalization and at discharge that support would be provided at school when she returned, and this led her to be disappointed when she returned to school. However, this feeling of being let down did not prevent Ann from creating her own plan, contacting teachers, finishing the school year, and working outside of school on her mental health. When

she described creating her own plan, she seemed proud of this. Ann was also able to recognize

the positive factors after hospitalization. Ann was able to continue to recognize the importance

of the help and support of one teacher, and one social worker, as well as the hope medication and

counseling gave her. She was also able to depend upon herself to continue with school. Her

advice for teachers who know about a student's hospitalization is to "check in and ask" the

student and "make sure" they are "doing fine" similar to the teacher who helped her when she

returned to school.

Chapter 5: Participant Two

Beth was a 16-year-old female who lives in a rural community with a grandparent and attends a small high school in southern Minnesota. She had been hospitalized more than once for mental health and chemical health concerns. This interview primarily focused on a brief mental health hospitalization that happened during the previous school year. However, she also referred to a very recent hospitalization that occurred a few months prior to before this interview, during that took place in the summer, a few weeks prior to school resuming in the fall. At the time of the main hospitalization discussed here, she lived in a different rural community with a step-parent and attended a small high school in that community.

Textural Analysis

Before and after hospitalization difficulty. Beth expressed that her life prior to hospitalization was strongly impacted her life after hospitalization, and her life had many difficulties. She also explained that the time of transition amplified some of those difficulties for her. Although Beth may have liked taking time away from some of the stressors of home during her hospitalization, she did not like being disconnected from the one good friend and her grandma she wanted to talk to. While she identified having anxiety and depression, she fervently stated that her environment was contributing to her anxiety and depression. In her words, "Taking you out of the situation and closing you off, I don't think it does any good. I think that if something is not right in the place you are at, you have to figure something out."

Beth discussed how angry she was when she was discharged from the hospital. After working with nurses and hospital staff during her hospitalization, she had hopes that things could get better: "Somehow in my mind the nurses put it in there that being in here [the hospital] would make me feel better". She had anger because "everything was still crappy." When she returned to her home and school after her hospitalization, she felt that nothing had changed, and she was "walking into the same situation you were before." Along with her environment not changing, she still felt the same emotions as well. "I still had all of those mental things going on even after I got out. So, the transition was really difficult because I still had so much going on." She talked about having anxiety and depression before, during, and after hospitalization. She described how she was cutting before she went into the hospital and the day she got out of the hospital because "nothing was different." During the time of transition for Beth, she experienced many of the same emotions and situations prior to hospitalizations, but things were perhaps even more difficult because during transition, she had to readjust to home life, catching back up with schoolwork, and explaining her absence. In her words, "The transition was hard because I had to get used to the same things." She also said, "getting used to it again is definitely a process." She then discussed how school and explaining "why you weren't at school" added to stress of transition process.

Pressure. Throughout the interview, Beth made it clear that she experienced stress and pressure. The stress and pressure came from both home and school. At home, she was experiencing her stepmom asking her to do chores and tasks. After getting a break from homework at the hospital, when she returned to school, Beth was overwhelmed with the amount of homework she had to make up. She reflected that it seemed like, "If you're in high school

…you have to jump right in and they expect you to keep up like you were never gone." As she

returned to school, she perceived the adults were telling her she needed to do more and more.

She felt that "the second I got out" she was being asked to watch her younger siblings and that

she had a "bunch of assignments on day one." She portrayed her experience as people telling her

"you got to do more," "you aren't doing enough," and "you aren't good enough." All of this

pressure made her feel as if it "pushes you farther into a hole and makes it harder to get back

out." Instead of feeling encouraged during her transition, she didn't want to do anything and

didn't want to get up in the morning.

When Beth was feeling anxious like this, she explained she needed her space, not people

pushing her: "When I am anxious, you can't touch me. You can't be near me. I have to have my

bubble." During the transition, she expressed that things seemed more difficult because so much

was going on and people seemed to be saying, "chop, chop, chop" to get things done. This only

amplified her anxiety, and would make her more prone to have her "trigger" more easily tripped.

She felt as if she needed space during this time so that she could adjust to returning to school and

home. Another pressure was that she had few friends at school, and she was also getting bullied.

She thought the bullying got worse when she was discharged from the hospital. Her stepmom

had told people about her hospitalization and some of the harassing focused on her illness and

hospitalization. She said, "Transitions are really [an] anxious and nerve-wrecking time because

you have people finding out, about people knowing, and getting made fun of for it."

Beth did find ways to deal with some of this pressure both through help from her new

school as well as through her own growth. She learned that she feels better when she can take

breaks and talk through things. This can be with a friend or with an adult. She has learned that

"Counseling works for me." She also found that music was a stress-releaser for her. When she is feeling anxious, she listens to music. This participant talked at length about her new school's district accommodation plan (a school plan which allowed her accommodations based upon her struggles) and how she was given options for when she is feeling stressed. Taking a break, taking her tests in a separate room with extra time, and having one earbud in to listen to music are three of her most used accommodations. Having these school options seemed to allow her the space she needed to feel less stress. She also learned to take care of the stress "in little pieces and [not to] let it build." When referring to stress, she thought that now she has most of the skills and options she needs to "work piece by piece to keep levels of everything down."

She acknowledged the strength it takes to get through mental health issues and commented, "Some of the strongest people I was in the psych unit with are the strongest people I have ever met." She also acknowledged, "and I know I am one of them."

Home life. Throughout talking with Beth, she expounded on how her home life affected her mental health and transition. She began with detailing how when she was living with her stepmom, she had many responsibilities taking care of younger siblings, which required her to often miss school. She described it as, "I was always watching the kids." This made it hard for her to have many friends or peer interactions because she was often needed at home. When she returned from the hospital, she indicated, "when I got out, it was the same." The expectations for her at home seemed to overwhelm her as she was released from the hospital: "The second I got out I had everybody on my back again and watching the kids all the time again." She simply stated, "I think another thing that so many people don't realize [is] that how much your home life can affect you." When she was at school and explained that something was going on at home,

someone would tell her to put it out of her mind or "off to the side." She stated, "It isn't that simple." Beth recognized that many teens do not get along with their parents, but she indicated that her situation was more involved, "There is so much people don't see."

Another way her home life affected her transition was that she was certain her stepmom told people about her hospitalization. This led to her being bullied by peers about the hospitalization. Beth felt judged and intimidated by her peers in her small community. Although she tried to ignore the comments, it did lead to her "having doubts about yourself [*sic*] too."

Beth explained that she had recently moved to live with her grandma. Because she trusts her grandma much more than her stepmom, things have been less stressful for her. Although she was recently hospitalized for a suicidal expression, she said that she did not truly feel suicidal and this time her transition home and the start of the school year has been much easier. She also detailed how "Transition definitely can be easier or more difficult depending upon which way it goes depending upon the person you are released with." Because she now lives with someone she trusts and feels safe with, she thought her transition was "definitely easier." She talked about how her depression is much less than last year and that "It is amazing how much your emotions can change when you're with somebody else."

Along with less pressure of caring for her siblings, fewer chores, and being with somebody she trusted, she also talked about the benefits of having a regular schedule and routines. Beth elaborated on how stress affected her physically, mostly her eating habits and weight. Since living with her grandma, she "eats regularly" and "keep myself at a healthy weight."

Structural Analysis

Feeling frustrated. When talking with Beth, it was clear she had felt a strong element of frustration and, at times, anger throughout her main transition experiences prior to her recent move. This pervasive frustration and anger was experienced primarily during her hospitalization when she lived with her stepmom and experienced within the context of home and at her previous school where she did not feel support. Beth is an expressive speaker who uses her voice and body language to punctuate her feelings, and she used both to mark her strong feelings about transitioning from the hospital to school and home. When she returned home from the hospital, she felt as if things returned to how they were before she went into the hospital. Perhaps her biggest frustration was her return to home. She described it as, "the second I got out" she was being asked to watch her younger siblings and do housework. At times, she would be late for school or missed school because she needed to watch a 6-month-old sibling. While trying to deal with her own mental health issues, she was also trying to help her siblings, often being left alone with them. Beth identified anxiety and needing to stay at home all the time as two main reasons why she was unable to have any time with friends or why she had so few friends. She also perceived that her stepmom told others about Beth's hospitalization. Since they lived in a small town, she felt like most people knew about it, and she was teased and bullied for it. Beth shared that her stepmom abused alcohol. From her perspective, her stepmom spent her time drinking, working, or sleeping. This led to Beth being responsible for the small siblings much of the time. Feeling responsible to keep things together for everyone when she returned from the hospital added to her frustration. A complicating factor to her relationship with her stepmom were the unresolved feelings about her father's suicide. Shortly before Beth's

hospitalization, her father committed suicide the same night she disclosed he had been abusing

her. He admitted the abuse and then later that night committed suicide. Beth perceived that her

stepmom and others blamed her for his suicide because she had told adults about the abuse. In

her words, "it was like it was my fault because I told that he was abusing me." This added to the

mistrust between Beth and her stepmom and the frustration of not having anyone with whom to

talk.

One of the main frustrations Beth held was the expectation of feeling better when she got

out of the hospital. She held hope that she would feel better and she experienced this expectation

by others as well. She stated, "A lot of people just look at it as you were in the hospital, and you

got out. So, you should be better than you were before you went in, and that isn't necessarily

true." When she got out of the hospital, she was angry that things "weren't better". She felt like

the nurses in the hospital were telling her that things would get better, and for her she thought

"everything was still crappy."

Upon returning to her new school after her most recent hospitalization school,

Beth identified that her previous school did not make many accommodations for her when she

returned. She said school personnel did not really understand what she was going through, and

"yelled" at her for such things as having her sweatshirt hood up when things were hard for her.

However, placing her hood up was one way she was dealing with her diagnosed post-traumatic

stress disorder. Another frustrating issue at school was when she was having a tough time at

home and would tell teachers, she said the teachers would not acknowledge the concern. For

example, the teacher might say something like, "put it off to the side" and for her she said, "It

isn't that simple."   She would have all these thoughts going on in her head and nobody at school or at home to talk with about them.

When Beth returned to school, students knew about the hospitalization and some of the students said things to her about it. She felt bullied when she returned to school. To further her frustration, she felt disadvantaged compared to the students who were bullying her because they had more money, friends, and resources in the town and school. Although she did not think of herself as popular and had some peer conflict prior to her hospitalization, it got worse when she returned from the hospital. During transition, she was dealing with the adjustment of getting back to school, with all the questions of why she was gone, with all the homework, and returning home. Having to deal with students saying things to her about having been in the hospital made her transition even harder. She basically felt, "People targeted me when I already felt like a target." After several of these verbal encounters, Beth perceived she tried to stand up for herself. Things at times became physical. She got so frustrated with being "picked on" that she wanted to physically fight back. She stated, "If anybody got in my way, I just hit them."

Feeling supported. Another underlying theme that permeated the interview was Beth's appreciation for support she now feels since moving in with her grandma and starting a new school. After Beth moved to live with her grandma, there was a recent hospitalization right before school started. She identified that this transition to home and the start of the school year went much smoother because she felt like she was supported by both her grandma and the school district. When Beth spoke about her most recent transition from her hospitalization, her entire demeanor shifted. This was the hospitalization that occurred in the summer a few weeks before

the start of school. She sat a little further back in her chair, she leaned further back in her chair, and her presence seemed more relaxed.

At the heart of Beth's message about transition was her observation that, "Transition definitely can be easier or more difficult depending upon which way it goes depending upon the person you are released with." When she was discharged from her most recent hospitalization shortly before being interviewed, she reflected that instead of watching young siblings and having so many responsibilities, she only had her regular chores and then was provided the opportunity to focus on her own mental health. Because of Beth's diagnosed post-traumatic stress disorder, anxiety, and depression, she has difficulty with people crowding her physically as well as verbally. It was easier at her grandma's home when she was discharged because her environment was less demanding both physically and verbally. Beth also identified her grandma as someone with whom she felt safe, and who she could talk and share her feelings with. Her grandma has been her "main support from day one." This allowed her to open up about what she was thinking and feeling when she got out. This helped her deal with what was happening when she was discharged recently.

Although there was one friend she counted on for support in her old school, she did not recount any other support people from her previous school or home. Also, due to missing school and not being able to do things outside of school, Beth didn't feel she was able to develop many friendships at her old school. In her new school, while living with her grandma, she made a few close friends. After the interview, she talked about having an active leadership role with a small church youth group outside of school. At her new school, she talked freely about her "options" through her district's accommodation plan and the school counselor who helped her with the

plan, as well as allows her to take breaks when needed. Beth identified that telling her what to

do or "pushing" her to do better did not work for her. She indicated that giving her options or

choices to handle her anxiety and depression worked for her. For her, "[giving] somebody their

space" is the best way to go. She explained her district accommodation plan with eagerness and

almost a sense of relief. Her plan includes options such as being able to use an earbud in one ear

to listen to music while in class, taking tests in the counseling office, going to the counseling

office for a break, putting her hood up if it is an intense day, and being allowed extra time on a

test. Due to high anxiety and post-traumatic stress disorder, she also has the option to use notes

on her tests, but she reported that she does not use this option often because she explained that it

would be cheating unless she absolutely had to. These accommodations helped her feel

supported and helped keep "stress levels down for school." Transitioning with support was a big

difference for Beth. She reported, "you gotta' know that you have people there to support you

and you have options to keep yourself mellowed out."

Textural/Structural Analysis

Beth was a self-identified "strong" young woman who had been hospitalized multiple

times. Transition was experienced for her through frustration and, at times, anger when she lived

with her stepmom and attended her old school. She experienced the same difficulties as before

the hospitalization. Although she received messages from the nurses at the hospital; that things

would be better when she was discharged, she identified that things were "still crappy" when she

returned home. She still had many of the same emotions and struggles that she had prior to the

hospitalization and her environment, including people within the environment who did not

change while she was hospitalized. A feeling of being upset permeated into her return to school because Beth had strong thoughts that her transition was greatly impacted by her home life.

Frustration also emerged from the pressures she experienced during her transition. Beth was responsible for watching her young siblings, doing chores, and had a great deal of homework to make up when she returned to school. Due to anxiety and caring for her siblings, Beth felt isolated and not able to build many friendships. She became frustrated that she was unable to process her feelings very often, and talking is something that worked for her. She stated she needed "some sort of communication" with others. Beth also experienced frustration from the pressures of peer conflict. She felt bullied by students in her previous school, and it got worse when students found out she had been hospitalized. At times intimidation led to physical altercations.

For Beth, home life may have been the strongest source of concern. She often mentioned the impact of her home life on transitioning from the hospital to school. Due to her father's suicide, which occurred shortly before her hospitalization, she took on more child care duties. This included being late or even missing school. When she was at school during transition, she talked about "zoning out" when she was thinking about home concerns. She also had fewer opportunities to spend time with friends or to build friendships which kept her less involved in school or feelings of involvement in school. Beth did not trust her stepmom. She observed her stepmom's increased alcohol abuse and sleeping when she wasn't working rather than taking care of the children. Beth grew frustrated with her growing roles of child care and housework.

After moving to live with her grandma and attending a new school, she experienced a smoother transition to school from a recent hospitalization. Her lens of transition shifted to one

of feeling more support from both her home and school. Beth then felt she was living with the person who was her "main support" and the person she trusted most. She also credited her new school with providing her the "space" through options within the district accommodation plan and the school counselor in providing support that she needed to work through things "piece by piece."

Beth experienced multiple hospitalizations from different home and school environments or contexts. These environments were highly important to how she experienced transition from feeling primarily frustration to feeling primarily support. Throughout her transition experiences, she has been able to see herself and others who have experienced hospitalization as strong individuals even when others may not be able to see it: "They don't realize how much it takes guts to get through it." She also added that, "Some of the people I was in the psych unit with are the strongest people I have ever met, and I know I am one of them."

Chapter 6: Participant Three

Carl was a 15-year-old adolescent in the 10th grade who had been hospitalized roughly six months prior to this interview. He explained that he was given a pass during his hospitalization to return to school. This return did not go well. He then later tried to return to school again. He could not remember exactly if something happened during the first trial return to school or the second trial, or how many days passed between efforts to return to school. He referred to these efforts to return to school and then the return to the hospital as two hospitalizations. However, it was during the same main time period and under two weeks of total hospitalization. He was currently attending the same midsized suburban high school he attended while being hospitalized the previous school year.

Textural Analysis

Having people and communicating. An important aspect of Carl's transition was having people to talk with and communicating about what was involved in the transition back to school. He explained how his first attempt to return to school on a school pass was "really stinky and not good." He described feelings of being behind in school projects and that his routine "resumed as normal" even though he was "really behind." It wasn't until later, when his family and school staff set up a meeting and created a plan that things improved for him. He indicated that having supportive people at his meeting and creating a plan for school made him feel more at ease, "My parents came in and we all met with the principal, the guidance counselor, and so that was a lot better."

Carl also explained that his school counselor was someone who was helpful to him by just checking in and asking him how things were going. He further advised that if a student gets

hospitalized, the student should seek out the school counselor: "[You should] really come up with a plan with your guidance counselors, principals, and all that about what you are going to do to make it all up."

He identified that having a peer or friend to talk with was helpful. When he first came back, he said he felt "sad" because "socially" it was hard with friends. He perceived his friends did not understand why he was gone. He experienced some sadness that he was not able to connect with his regular friends. He did, however, appreciate that he related to a girl at school who had also been hospitalized in the past. He found her to be "pretty helpful" because "she knew what it was like, so to speak, and helped me get back and stuff." He could talk with her about "serious stuff." He later expanded on the idea of having a friend or peer to talk to. He explained that the peer did not need to have gone to the hospital to be helpful, but "just having someone to talk to about things is useful and helpful."

Carl also named his parents as being helpful during this transition. Although he indicated it was "really weird" to go home after being gone for more than a week, he named his parents multiple times during the interview as being there for him. When we discussed his meetings, he stated that his parents had come to school to be there for the meeting to make a plan. Also, when we talked about what was helpful, he identified it as "my parents were in there."

Things got better. As Carl first started to talk about his transition experience, he quickly and clearly related his first "terrible" experience of "jumping into class like normal." He described being behind on a project and other classwork. After having opportunities to meet with people to create a plan and get support, things seemed to change for him. Carl imparted a more positive outlook on his transition experience. When his parents came in and they all met

with the principal and the guidance counselor, he acknowledged that it "was a lot better." After

this meeting, he was able to view school as "pretty much normal," saying it was a "normal week

going to school." Things were not perfect since he had so much homework and it was "right at

the end of the term so that kinda' sucked," but he was able to see that things were looking up.

Structural Analysis

      Feeling insecure. Carl talked nervously when he met me, chatting about a variety of

topics prior to the interview. When I started the audiotaping and the actual interview, Carl

became more hesitant in his speech and discussion. As he described his transition experience,

his feelings of nervousness and insecurity during the transition emerged.

      Initially, Carl had a bad transition back to school because he did not know what to do or

expect when he returned. He felt like he needed to jump back into things and was expected to

resume as normal, but he was really behind, which made him unsure and nervous about his

return. On a following day, he met with a group which included his parents, guidance counselor,

and principal, and he felt less anxious. In his words, after they met, "That was a lot better." He

felt like he knew what he needed to do. More importantly, he seemed to feel reassured after

meeting with others about his return to school. He also met with his counselor regularly about

how he was doing and how things were going. This contact with his school counselor seemed to

help.

      Socially, Carl felt insecure about his transition. He did not seem to want to elaborate, but

he was sad that at first "it seemed like nobody noticed I was gone." When his friends did notice,

they made comments like, "Oh, you're back." He understood these comments to have a negative

connotation. He felt like his transition back to school from a social perspective was first, not

noticed, and then when it was noticed, it had a negative feeling from his friends. He described

that he felt "sad" about this, and when he described this during the interview, he was hesitant to

talk about it and did not want to elaborate on the details. He appreciated one person who he later

told me was not a close friend but an acquaintance who had also been hospitalized. He explained

that she talked with him a few times about returning to school, having been hospitalized herself,

and "just that she was there for me." When we went through significant statements and talked

about his experience, he clarified that this girl was not a close friend and that it was more

important to just have someone to talk with during transition. It seemed important to him to have

someone to talk with. Yet again, he seemed anxious or unsure about categorizing that girl as a

close friend or talking about his other friends.

Carl seemed to experience insecurity during his transition and had some hesitancy talking

about aspects of his transition. He seemed more talkative prior to the actual start of audiotaping,

which may indicate general feelings of anxiety. His feelings of insecurity, unsureness, or

nervousness seemed to be calmed when he had contact and communication with others. The

people who were most important to soothe his insecurity were school staff, a peer, and his

parents.

Textural/Structural Analysis

Carl was a 15-year-old young man who experienced transition through anxiousness and

insecurity. Communication with school staff, peers, and parents helped him feel some assurance

and this helped him feel like things got "a lot better."

Carl struggled with anxiety. This influenced his transition experience as it added to his

unsureness of how to transition. He was behind in his schoolwork and seemed to feel

overwhelmed and unsure how to proceed with how to get caught up, but after he had a team meeting with his counselor, principal, and parents, he felt much better about his chances of success. The meeting helped him with direction regarding his homework.

Carl also experienced transition through a lens of insecurity in a social sense. He perceived his friends first didn't notice his absence, and then assumed remarks his friends made were negative in nature. However, he did welcome conversations with a peer who also experienced a mental health hospitalization. He stated that having a peer to talk with would be important for anyone transitioning back to school.

For Carl, feelings of insecurity, unsureness, or nervousness, during school, seemed to be calmed when he had contact and communication with others. The people who were most important to reduce his insecurity were school staff, a peer, and his parents. After he had meetings and contact with others, he was able to feel assured and his transition got better.

Chapter 7: Participant Four

Deb was a 16-year-old female adolescent who was a junior in high school at the time of the interview. She was hospitalized toward the end of her sophomore year of high school. She currently lives in a suburban community that is a short drive from the small rural high school she attends. Deb currently attends the same small high school she was attending while being hospitalized last year. Her hospitalization was for about one week, and then shortly after she had a day skills program that was about two weeks in length to help her cope before returning to school.

Textural Analysis

      Difficulty returning to regular homework. Deb was quite concerned about her

academics while being in the hospital as well as when she was discharged because she is "really

academically focused." The first few weeks back to school were the most difficult for her in

regard to schoolwork because "it was really stressful" to get "caught back up with things and

going back to the everyday school schedule." In particular, she was nervous the night before her

return to school and "stressed about the homework and getting back on track." Because Deb was

in accelerated classes, she found it hard to keep up upon returning since she had fallen behind on

her assignments during her hospitalization. Her teachers did "star" some assignments so that she

did not have to complete those assignments and that did help, but she still needed to work her

"butt off" and come in early in the mornings, and stay up late to do homework to "get all caught

up." She estimated that it took about three weeks to get caught up. She would do the current

day's homework and then would try to do at least one day of homework that she missed. She

was used to staying up late to do homework because she is also active in athletics and other

school activities. During the time of transition, she would sometimes be up as late as 3:00 a.m.

doing homework. This contributed to her sense of exhaustion and having difficulties with sleep

during her transition time. Deb's desire to get things back to normal pushed her to get

homework done despite the late hours: "I am normally up until midnight anyway, so it was just, I

just wanted to get it done, just get back to how it used to be before I left."

      Support. Throughout the conversation, Deb conveyed the importance of support when

struggling and during the time of transition. She outlined how school adults were supportive to

her. She said the teachers collected homework for her while she was in the hospital, and there

were times when she had access to do some of it. She also identified that her school counselor

was really helpful by asking her what she needed, and making sure teachers did not dock points

while she was gone. The school counselor also did daily check-ins to see how she was doing

with friends and schoolwork as she transitioned back to school. Her teachers also exempted

some work while she was gone. Beth depicted her teachers as helpers by pulling her aside and

working one-to-one with her to make sure she understood the material. She really liked that "I

had a school that worked with me." The teachers let her know that she could leave class to take

a break, but she found that she did not need to use that accommodation when she transitioned

back. Rather, if she needed a break because she was feeling stressed, she used her earbuds to

listen to music. This was a way for her to take a break without leaving class.

Deb believed that her transition was better than other people who experience transition

partially due to support. She said that she has always liked school and was glad to be back to the

"constant" of school. She stated, "The thing is, I missed school a lot, and I missed my friends."

Although she talked highly of the support provided by her school staff, she was perhaps even

more appreciative of her friends. She reported, "My friends are my everything." Her friends

decorated her locker on her first day returning to school from the hospital, and that was an event

that stood out for her. She relayed that her friends were "basically just with me 24/7." Her

advice to support other students when they transition is "being there and letting them talk, and

listening and letting them do it at their own pace." In general, she said, "It is good to have the

support, not just from your friends but from the staff, the teachers and just everyone." Deb

believes that "support is huge or else you will just end up back where you were."

Nervousness. Deb expressed her trepidation about returning to school from the hospital: "I was nervous going back that first day." Some of the nervousness was about "trying to get everything back on track" for her homework. However, most of it was about what to say about her absence: "The hardest part about coming back was probably telling people why you were gone or why I was gone." Fearing that people would not understand her situation, she "didn't tell anyone why I was leaving or why I was going to be gone." She had seen others be bullied or "think there is something wrong with them" when they were recognized as having been in the hospital for mental health reasons. She didn't know if "anyone had found out so I was really nervous, I guess." Deb chose to hide her hospitalization and tell others that she was gone due to "family issues." She explained that this was not a lie, but rather it was only one part of what was going on for her and that very few people knew she had been in the hospital.

She realized her teachers knew that she had been gone for mental health reasons, but was unsure if they knew she had been hospitalized or any details about her situation. Nobody else was told that she had been hospitalized or that she was struggling with "mental health issues."

Structural Analysis

Perception of mental health. Deb experienced her transition through a cloak of being gone for "family reasons." Although she explained that this was not a lie, she only disclosed that she was hospitalized due to mental health concerns to a select few. Because of her desire to keep her hospitalization private, Deb felt most comfortable being interviewed in her home, not at school or in a community location. She also quickly let me know that she was "academically focused" and was in "all accel classes" and now in "college classes." She also indicated that she "always enjoyed school" and was involved in sports and activities. Her discussion of academics,

athletics, activities, and school in general did not take on a bragging tone, but rather it seemed to be a part of how she sees herself.

In contrast, Deb did not discuss her mental health concerns. She did make several comments about being nervous that people would find out why she was gone even though she and her family did not tell people why she was gone. However, when she did return, "no one… really questioned" why she was gone. Deb said it was her choice not to tell people why she was gone. Her perception was that because she had friends, did well in school, was involved, and had a job, she was not someone "who was never known as a person who needed mental days or go to the mental health hospital." She also thought people would think that having a mental health issue would not fit who she was, and would say things like, "that is not you" and "I never thought that would happen to you." So, it was easier to not deal with having to explain everything to people, and just say she had "family stuff."

It became apparent that Deb was much more comfortable with her identity as a student, athlete, and worker than as someone who needed a mental health hospitalization and support. In addition, it seemed that Deb held some biased perceptions of mental health and how people with mental health concerns are viewed. Primarily, she thought that most people who need mental health support would not also be strong students, be involved in school activities, have lots of friends, or hold jobs.

It also seemed important for her to identify that her transition was "pretty easy" and compare her experience to others by saying "I know some people have problems with it, but mine was pretty easy, all my friends were there." She pointed out that nobody bullied her or "treated me down." She acknowledged that while others she knew who had been hospitalized

had a tougher time returning to school, she knew that some people do not like school and did not want to return.

Deb seemed to have a strong desire to get caught up and have things return to normal quickly. As she transitioned, she worked late into the night to catch up on homework as quickly as possible. She wanted to have things get "back to normal." She also stated that it was important to focus on the fact that she was back and that was "all that mattered."

Deb also chose those accommodations that were the least intrusive, such as using music on her earbuds to take a break rather than leaving the classroom to do so. Because Deb is so academically focused, it is hard to know if her not leaving class was due to her not wanting to miss content or fearing that she would be seen as different.

Textural/Structural Analysis

Deb was a 16-year-old female who self-identified strongly as a good student who liked school, had many friends, and was involved in many activities. Deb did not share information about her hospitalization to anyone but close family, and she was nervous that others would discover the reason she was gone. A part of Deb's transition experience was her discomfort in discussing her mental health hospitalization, as well as her perceptions about mental health and people who have had a mental health hospitalization. This view about mental health saturated her transition experience.

Although grades and academic performance were important for Deb, it was also important for her to get the work done as quickly as possible to be able get things back to "normal." Deb had to stay up late for weeks to keep up with current work, as well as make up missed work.

Throughout Deb's transition, she identified support as being important. She recognized that her friends and school staff were supportive to her. She shared limited information about her hospitalization with her closest friends, and those friends in turn were protective of her. They welcomed her back to school and decorated her locker on her first day back. When she returned, she also stated that her friends stayed with her "24/7" and were not going to "leave my side." She appreciated their support, truly valued their friendship and reported that "My friends are my everything." Deb also felt supported at school and identified that her school counselor and teachers were helpful. She said her school counselor was probably the most helpful by checking in with her daily during the early days of her transition.

Deb felt nervous returning to school. She was worried people would know why she was gone. She was also worried about the amount of work she needed to make up. Also, Deb was not comfortable discussing her mental health hospitalization, and she held some perceptions about people who have mental health concerns that did not fit how she generally saw herself, which was as a good student with lots of friends and who was involved in school. Considering the discomfort she had discussing her mental health hospitalization, it made sense that she was nervous about returning to school. Although Deb seemed to push herself fairly hard to get assignments done quickly with few accommodations, she perhaps felt other adolescents did not need to have the same pressures. Her advice to school staff indicated these thoughts, "being there and letting them talk, and listening and letting them do it at their own pace."

Chapter 8: Participant Five

Emma was a 17-year-old female who had been hospitalized multiple times over the past two years. She described the hospitalization that happened during the previous school year at her previous school when she was a sophomore in a small suburban high school. At the time of the interview, Emma was a junior attending a midsized suburban high school. At times, she referred to a very recent hospitalization that occurred during the summer shortly before school started.

Textural Analysis

School social environment. As Emma discussed her previous hospitalizations, she provided a portrayal of a general school environment including students, teachers, and counselors. This school environment description was primarily unsatisfactory to Emma; however, she did have a few supports. Emma stated that she was not satisfied by how school staff treated her when she transitioned back to school from her hospitalization. Although "staff people knew about it," she felt like they "just threw me back instead of [talking] to me about it." "Getting caught up on work" was difficult because "the teachers didn't really help out in that school." She indicated that some of her teachers did show understanding and allowed extra time on turning in homework. She also did not feel supported by her high school counselor. So, she did not "talk with her about anything because she was kinda' rude." As an alternative, she did find support from her previous middle school counselor. This led Emma to state: "I think teachers need to be more considerate about things."

Emma also reported concerns about students in her previous school. She disclosed, "Most kids think it is like a joke. That is annoying because it is already hard trying to get back to

school." She also expressed a concern about having to answer why she was gone: "On top of that you've got people that, if they find out, spread rumors and everything."

Emma recounted one positive aspect of her previous school culture: a best friend. When she returned to school, her best friend at the time "knew about stuff so she was helpful." In her current school, Emma recounted much more support. She appreciated her current school and how the students and teachers are more supportive at the new school. She considered it "better, I think [at] this school. They all help out. Yeah, everyone is nice here." She gave examples of students asking her if she wants to talk, the staff being "really good" and the school counselor as "amazing." This helped her because she still struggled with depression and had a recent hospitalization in the summer, and although she did not miss any school, she felt like she was still adjusting to the transition from the hospital.

Academic difficulty. Emma was concerned about her schoolwork when she transitioned back to her previous school. She thought it was hard "getting caught up on work." She thought it was made more difficult because her teachers "didn't really help out in that school." Emma recounted that she had to study and do homework every night after school until she went to bed to get caught up from being gone for the first few weeks after she returned. She felt academic pressure to do "the homework you are doing now and then the homework you are doing last week." She felt it was particularly challenging to get caught up in science. The teacher had set a very short timeline to turn in all the assignments from when she was absent. She did get some academic relief by having her friends help her with her homework when she returned to school. Some of her other teachers were more understanding and gave more time to turn in work.

Structural Analysis

Feeling overwhelmed. As Emma recounted her transition narrative, the feeling she was overwhelmed during her transition seemed evident, particularly during the transitions prior to moving to her current school. Emma's disposition was serious and quiet. She was overwhelmed by both the people within the school, as well as the make-up schoolwork.

Emma described returning to school as "hard." She described worrying about what students say when she returned to school and worrying about homework. She also worried about questions which might arise while being off of social media. She reported being often disappointed by how little support some of her teachers gave her to make up her missed work. Emma also did not trust or feel supported by her high school counselor. The words she used to describe the homework assigned by teachers were that they "load you up on homework," and this depicted that she was overwhelmed. She also used the words "stress and anxiety all together." She explained that she felt as if most students feel like hospitalization "is like a joke." Her perception of how other students view hospitalization worried and frustrated Emma and added to her over all feelings of being overwhelmed. She discussed that things had gotten so difficult and overwhelming with her mental health, her transition after her hospitalization, and her difficulties at her previous school that she was looking at an alternative placement which included a day treatment school. However, things had gotten better for her at the new school, and she thought she would be able to remain in a regular high school.

Her most recent hospitalization was just prior to the start of school at her current site. She felt like things were much better at this school, felt more supported by both peers and staff,

and even smiled when she talked about how things were more positive. This seemed to help with her most recent transition.

Textural/Structural Analysis

Emma was a 17-year-old young female who had multiple hospitalizations. When she talked about her transitions, she seemed overwhelmed during the transition period while at her previous school. She spoke with a quiet voice and used little expression. When she talked about her previous school, her face held an almost flat affect. A small smile appeared when she talked about her new school.

Emma's transition experiences were dominated by a sense of being overwhelmed. Her school social environment was not conducive for her return. She did not have many friends who supported her return, only one close friend. She also felt like her peers at her previous school would joke about people who needed to be hospitalized. She was asked questions about why she was gone and why she had disappeared from social media. She did not feel supported by peers or by adults in the school. She indicated that "teachers didn't really help out in that school." She felt like even though the staff knew why she was gone, she was thrown back into school without discussion of potential assistance. She did not talk with her high school counselor because she thought she was "rude" and felt "blamed" for her hospitalization by her; however, she did talk with her middle school counselor with whom she felt more comfortable. She had one teacher that she thought required a workload that did not allow adequate amount of time to complete.

Emma also felt overwhelmed with the transition due to academic difficulties. She had a hard time catching up with her homework and felt like she had little help from school staff. When a few friends helped her, that helped her feel better about schoolwork. She reported she

needed to do homework every night until she went to bed to get caught up. She also felt as if she

was "thrown back" to her academics because she did not have discussions with her teachers

about what she needed to do as she returned.

Emma's transition experience changed at her new school. She had a hospitalization

shortly before school started, a few months prior to the interview. She seemed much less

stressed about school when she talked about the school environment at her current school. Due

to her mental health, she indicated that there was some discussion about a longer hospitalization

or perhaps a different school placement; however, she reported that her new school was

accommodating, and she was doing much better. Her new school's social environment, peers

and adults, were perceived to be more supportive to her. She stated, "They all help out." She

indicated that both the counselor and the teachers were "good". They worked with her one on

one or allowed her to take a break if she needed one. She also indicated that students at her new

school were open to talk and did not make fun of her for having problems. It was the "total

opposite" of her previous school.

Chapter 9: Participant Six

Frank was a 17-year-old adolescent male. He attended a small alternative school within a suburban community in southern Minnesota at the time of the hospitalization, lived in the same community with his father and was attending that same school at the time of the interview. The participant had two brief hospitalizations in the spring prior to the interview. The first hospitalization focused primarily on his mental health. After his mental health hospitalization, he then chose to attend a hospitalization that focused on both mental health and chemical health. The second hospitalization took him out of school for roughly two weeks. Both of these treatments happened during his junior year of school. When the participant answered questions about being hospitalized, he answered about both hospitalizations. He was not discerning between the two absences.

Textural Analysis

Personal growth. An overwhelming aspect of transition for Frank was his personal growth and change. He stated about the time since his hospitalization, "a lot has changed with me since, like, emotionally and mentally." Frank disclosed that since being discharged from the hospital his "thoughts and feelings have changed," and he was "a lot more accepting of myself" or "at least I have been trying to be." He shared that he had been working with a therapist and a doctor. Antidepressants and sleeping pills helped him with his depression and to "get the rest I need every night." He also shared that being hospitalized and working with the therapist had helped him "accept myself and stuff, you know. I still haven't accepted myself, yet, but I am working on it." During his transition, he was "in his head a lot thinking about everything I learned" and wanted to "essentially fix myself and try to put the pieces back together." One

piece that may have complicated things for Frank was his memory loss due to drug use. He explained that it "was definitely stressful to understand myself." He tried to remember things from his childhood, but he could not. He also experienced "warped memories." This all affected his transition experience. Transition was a stressful time for him because while he was trying to transition back to school he was also trying to work on his understanding of himself, his mental health, and his sobriety.

Academic aspects. Frank expressed concern about returning to school and getting caught up on any missed work and credits. Along with getting his mental health in order, he wanted to get his academic life on track. He was "behind in my schoolwork because I was gone for so long," but he indicated that it wasn't so different than what he was doing for school at the time of the interview, because he chose to participate in an independent study option at his school. This allowed him to choose which courses to work on, and then he could also work at school and from home at his own pace to get his work done. He also participated in summer school to get work done. Because he had in-school education provided during his two hospital treatments, he was able to build some school hours and his school accepted those hours for some credit when he was gone. However, he admitted that he did not earn full credit for the classes he was enrolled in at his regular school while he was at the hospital.

When he returned, he met with his principal who was "really supportive for me to come back and get credit." The two met and talked about the coursework and created a plan to return to school. He signed up to take three classes through this independent study program and get those done with the remaining weeks of school. He confessed he got distracted and procrastinated and did not finish the three classes.

Social life. Frank also shared a bit about the social aspect of transitioning back to school. He confided when a serious relationship with a girlfriend ended, he tried to kill himself. That is when he went into the hospital. He had abused drugs more heavily and chose to get further help for chemical use. He indicated that "it was all my own choice." When he returned to school, he was concerned about seeing his ex-girlfriend, which he described as "nervous about seeing her again." Also, he was trying to stay away from drugs: "I felt lonely because I had to get rid of all of my old friends because they were using friends. So, I felt very alone." The school he was attending was a small school, and he was in regular contact with both his ex-girlfriend and his friends who used chemicals. He felt isolated, particularly when he was adjusting to the first days of his transition.

Structural Analysis

Dedicated to personal growth. Frank's focus on personal growth permeated his transition experience. Although he had a desire to catch up on missed schoolwork and earn credit, his main goal was personal growth and change. When he discussed his return to school, Frank continually described how he evolved during and after his hospitalization. With this personal transformation being his primary concern, it did not seem plausible to be on his personal journey and making up the schoolwork at the same time. When talking about his personal growth, Frank smiled and appeared proud about his new viewpoint on his life.

This personal growth took a primary focus during his transition. He explained, "a lot has changed with me since, like emotionally and mentally, you know." He also stated, "My thoughts and feelings have changed." He recounted a regiment of therapy, antidepressants, sleeping medication, and emotional/mental growth after the hospital. This regiment helped him

get the rest he needed and improve his mood. The therapy helped him work on accepting

himself. This was a lonely personal journey since he could no longer spend time with the friends

he had before hospitalization because they still used drugs.

This statement perhaps explained best how Frank's personal journey overwhelmed his

transition: "I was in my head a lot thinking about everything I learned and experienced, figuring

myself out."

Textural/Structural Analysis

Frank was a 17-year-old male who had experienced a hospitalization and then

volunteered for a chemical treatment program. He entered the hospital due to intense emotions

he was feeling after a break-up with a girlfriend. After his brief mental health hospitalization, he

learned that he needed chemical health support along with mental health support to enter a

personal growth journey to help him become healthy. When he returned to school, Frank needed

to focus on the elements of his regiment that helped to keep him healthy. When he was

interviewed about his transition back to school, his answers returned to the personal journey.

People at his school welcomed him back, and he felt supported by his school counselor

and principal. Yet, he felt lonely. He had to separate from his friends at school because they

were involved in drugs, and he wanted to stay away from drugs. By participating in the school

independent study program, he was able to have flexibility in both academics and in the

schedule. This flexibility allowed him to earn credit at his own pace, but he did not earn much

credit during the last few weeks after his return to school at the end of the year. Due to his focus

being on personal growth, and his mind at times "stuck" thinking about things, he procrastinated

and did not earn much academic credit during that time. He was more focused at that time on trying to, "understand myself and essentially fix myself and try to put the pieces back together."

Frank seemed to take pride in the fact that it was his choice to get treatment and that he volunteered for chemical help. After the interview, he also indicated that he did not use chemicals for several months outside of one relapse. Along with being proud of these accomplishments, it seemed important for him to express his responsibility during the interview for not catching up on academics when he returned to school. He needed to state that the flexible independent study program allowed for earning more credit, but that it was his procrastination that led to him not earning very much credit.

Chapter 10: Participant Seven

Greta was a 17-year-old female who attended a small alternative school in a suburban community in southern Minnesota. She currently lived with a foster family within the same suburban community as the school. She indicated multiple hospitalizations throughout high school with the most recent hospitalization being roughly two months prior to the interview during the first week of her junior year of high school. The information provided predominantly focused on the most recent hospitalization, but there are a few times when she referred to previous hospitalizations.

Textural Analysis

Social worries. Having been hospitalized multiple times, Greta elaborated how she became more reluctant in explaining to peers upon her return to school about her absence due to hospitalization. She stated, "Eventually, going multiple times, I became more nervous and I didn't want them to ask where I was." She even admitted, "At that point, I was lying about it because I didn't want them to worry about me or anything." She further explained that along with not wanting her classmates worrying about her, she was worried about being away from everyone at the start of the school year. She also indicated that she did not want people to ask where she was. When talking about returning to school, she expressed her primary concern was "mostly social, honestly." Greta then added that it worried her that since she had missed the start of school, "I had lost contact with lots of people over summer, so I thought it would be harder for me to come back." This nervousness was tempered with some excitement: "I was a little scared, but I was also excited because it was forever since I hadn't seen everyone because of summer." Greta also acknowledged that some people were not supportive to her even if she felt she got

along with most: "Some people were socially not supportive." Greta then added, "It may be harder for others because I do get along with most people."

Homework. Greta considered schoolwork along with the social aspects to returning to school after her hospitalization. She reasoned that although focusing on mental health during hospitalization was "good," it "stresses you out when you have to go back to reality." She stated that, "you miss a lot of work" while you are in the hospital, and it is "hard to make it all up" and to "keep your grades up." She worked with her teacher, principal, and counselor when she returned to school. Although she had difficulty giving exact details, she thought the school staff were "really understanding." When she considered how other suicide survivors could be helped, Greta argued that there "should be some kind of plan for make-up work and stuff." She also gave the example of bringing work to the hospital to help get caught up with schoolwork.

Structural Analysis

Feeling anxious. Greta had anxiety, and this was demonstrated during her interview, as well as during her transition. When interviewing Greta, she was bundled up in a blanket, and offered that she was tired. She answered with a quiet voice, and did not provide long answers. When going over the study details and getting consent forms signed by her foster mother, Greta's foster mother commented that Greta would be interested in the research but would likely be a little shy or hesitant when she would be interviewed. Greta's demeanor during the interview suggested she was using her blanket for security. She wrapped up in the blanket and scrunched her legs toward her so that her feet were on the chair and her knees were underneath her chin. By stating that she was "tired," it also gave an out from the interview if she did not want to

answer or felt uncomfortable. Another example was when she said, "I don't know. I am really tired."

After multiple hospitalizations and transitions, she became more hesitant and less trusting about what to say to peers about her absences. She started lying about reasons for her absence rather than having to answer questions about why she was gone. During her most recent transition, Greta experienced anxiety over returning to school after the school year started. She had difficulty trusting that her relationships would remain intact and would be the same after not seeing people over summer, and then getting a late start to the school year. She was also anxious about schoolwork after being hospitalized because she had focused on just mental health and now had"to go back to reality."

Textural/Structural Analysis

Greta was a 17-year-old female who had experienced multiple hospitalizations. Throughout her transition and the interview, she demonstrated anxiety and difficulty trusting. Having had multiple hospitalizations and transitions back to school, she knew what to expect, and she had grown hesitant to share information about her hospitalizations with others when she returned. Although she indicated that she got along with peers and felt supported by the school staff, she still felt anxious about returning to school.

Anxiety played a role in her transition, in both a social aspect as well as an academic aspect. She identified that she was "mostly social" and worried about returning to school. Because she had not connected with peers over summer and she was delayed in starting school, she was anxious about how it would all go when she did start school again.

She also experienced some anxiety regarding academics. Although it was good to focus on mental health during the hospitalization, it "kinda' stresses you out when you go back to reality." She was scared there would "be lots to make up." Coupled with the anxiety, though, was some excitement about being back at school and being able see everyone again after summer.

Chapter 11: Participant Eight

Hank was a 17-year-old adolescent male in his junior year of high school attending a small alternative high school. He was hospitalized in the spring of the previous school year. He was attending the same small alternative high school located in the suburban community in southern Minnesota when he was hospitalized. He lived in a different suburban community in southern Minnesota roughly 25 minutes from the school in which he attends. He was hospitalized for about one week. This was the only hospitalization he has ever had.

Textural Description

Worried and depressed feelings. When Hank returned from the hospital, he was first concerned about what others would say to him. Right before entering the hospital, the participant posted some emotional comments on social media. He said, "I was kinda' wondering what everyone was going to think because before [hospitalization] I posted some bad stuff. Stuff I shouldn't have [posted] on facebook." He was anticipating that people would comment on the posts, and he was concerned about what they would say and how he should respond to them. He stated that he was, "kinda' nervous about what people would say."

He labeled a breakup with a girlfriend as an event as part of the reason he went into the hospital. The breakup wasn't good, and ended "on a fight and [we] never talked again." This was upsetting to Hank, and he was having a hard time dealing with these emotions before, during, and after his hospitalization. He still "had those thoughts in my head from before" and they were "overwhelming" to him. Those thoughts and emotions were more pervasive than other thoughts and feelings he had while he was dealing with his transition.

Due to the stress about what others would say, he felt like, "I don't want to go back to school." When he did return back to school, his mood was down and he had difficulty focusing on his schoolwork: "I was just focused more on sitting there and not really doing my work." He focused on his mental health, not academics. He listened to music to help with his mood.

Personal development. When he went to the hospital and then returned, he had the feeling that maybe things would change, he used the phrase, "a new opportunity feeling" and "I could fix something here kinda' feeling." By "leaving and being in a place for a while", it allowed Hank to have new thoughts and new opportunities. For him, he decided he needed to focus less on what others thought and more on what he wanted. He also explained that his transition was intended for a balance of mental health and academics even though he didn't feel like focusing on academics. He needed to "focus on myself, academically, socially, all of that, try to balance things out."

Structural Analysis

Being a loner. Throughout the interview, Hank characterized his transition through a lens of being independent. He also seemed to experience loneliness with his independence. When he returned to school after his hospitalization, he was worried what people would say because he had posted some personal sentiments on social media, but "Nobody said anything too bad." However, he did get few social media or face-to-face responses when he returned. He said a few friends asked him where he was and then, "They kinda' of just talked to me and then turned to their friends and talked to them."

The positive to being on his own was that few people worried about him being gone, and fewer people focused on why he was gone and asked difficult questions when he returned. As he

phrased it, "You have all those people who are going to wonder where you were and such."

Since he was a bit of a loner, not very many people may have "even notice."

Hank had experienced the dissolution of a relationship right before his hospitalization,

and he had only been at his current school for a year. He felt like he was "still on my own here."

He had difficulty that there was no contact with his ex-girlfriend even after his hospitalization.

Part of his independence that was starting to develop during his transition was an emerging focus

on himself rather than his being a "people pleaser." He also worked on not relying on friends to

cheer him up, but, "I kind of rely on myself now."

Overall Hank framed his new reliance on himself as a positive thing. He did come across

as a little lonely when he said it was difficult that there was no contact from his ex-girlfriend. He

also acknowledged that not many people even noticed that he was gone. In addition, when he

said his friends asked him about his absence, but then turned to talk with each other, it seemed

this may have hurt him. He stated, "that if you are someone who doesn't have much [*sic*]

friends, um, I probably not worry too much because people might not even notice." He then

quickly said, "not to say that in a bad way." Hank's self-identified term of loner further

portrayed his personal journey.

Textural/Structural Analysis

Hank was a 17-year-old young male who had experienced one brief hospitalization and

transition to school in the previous school year. He was hospitalized shortly after a break up

with a girlfriend, and return to school feeling both independent and alone. His transition

experience was a journey of personal development with ongoing feelings of depression and

worry.

Hank viewed himself as a "loner" and he didn't see this as all bad. Through his hospitalization and transition, he was able to experience personal development that helped him become more self-reliant and independent. He seemed to be proud of this new view of himself. His hospitalization helped him become more self-reliant and see things differently, and have feelings of "new opportunity." The experience helped him become less of a people pleaser and make decisions more for himself. He seemed glad about this change. During his transition, he was focused more on himself as a whole rather than just pleasing others such as just doing academics. Rather, he tried to focus on himself more as a whole to "balance things out."

Hank struggled with feelings of depression when he returned from the hospital. These feelings were not new to him, but he confirmed that these were intensified during his transition back to school. He also suffered heightened feelings of nervousness during his transition because he was worried about what his peers would say about what he posted on social media right before he was hospitalized. He also experienced a tough "breakup" with a girlfriend right before his hospitalization. He did not have any contact with this ex-girlfriend during his hospitalization or during his transition. When Hank returned to school, he did not have any negative peer responses. However, he didn't receive much acknowledgement from others about his absence. In some ways, this allowed Hank to focus on himself and gain independence and self-reliance, but also left him with some loneliness he had difficulty directly acknowledging. Regardless, Hank seemed to consider his hospitalization and transition as an opportunity, and he was able to do things differently. Hank's main sentiment from his hospital experience was, "I do my own thing now."

Chapter 12: Composite Description

This chapter provides the composite description. The composite description of how adolescents experience returning to school after an acute mental health hospitalization can be written only after the textural and structural descriptions have been analyzed for each participant. This composite description provides "the 'essence' of the experience and represents the culminating aspect of a phenomenological study" (Moustakas, 2007, p.159). In this step of data analysis, the researcher analyzes the data for universal and shared experiences among participants. The researcher then writes the composite description which represents the shared experience of the phenomenon of all of the participants.

Each participant's transition journey should be appreciated for the individual's voice and his or her unique experience. As school and mental health professionals read and learn from each participant's transition experience, they can also learn from understanding how the participants' transition experiences held similarities. Through studying both these unique and common experiences, school and mental health professionals can gain a better understanding of what adolescents experience during transition from a mental health hospitalization. Three major areas of transitioning emerged as themes experienced by most participants: academic aspects, social aspects, and personal aspects. Within these themes, subthemes with more details provide a clearer description.

Academic Aspects

Every participant in this study referenced academic aspects to their transition. Some participants ($n=7$) were more focused on academics during their transition than others. When discussing academic content, participants most often discussed the following topics: schoolwork

($n=6$), a plan for return ($n=5$), school staff support ($n=7$), stress related to return ($n=8$), and accommodations ($n=4$).

Schoolwork. Every participant referenced schoolwork during their interview, however, not every participant had schoolwork as the primary focus of their transition. The main issue was the concern about getting caught up with all the schoolwork. This sentiment was referenced by Ann, Beth, Carl, Deb, Emma, and Greta. When discussing schoolwork, participants used phrases, such as Ann said, "I just like had to catch up." Beth talked about the tall stack of work she had when she was hospitalized. Carl stated he was "really behind" in work. Only Hank didn't really talk about the amount of schoolwork he needed to make up. In fact, he openly discussed that academics were not important to him when he returned to school. He stated, "No I didn't have my mind on anything academic." Although others referenced having difficulty focusing on schoolwork during transition, none of the other participants discussed academics not being very important to them during transition.

A common concern about the homework was how to make up the missed work. Some of the participants were unsure how to make up the work they missed. Ann shared, "I didn't know how to catch up." She also said, "I didn't know if I should start with all the assignments when I left, or like, start doing the stuff they were doing now." Beth struggled in school. She stated that she was "never that good at doing my assignments or doing good on tests." With this background, it was frustrating to know how to make up the schoolwork. Emma also talked about having difficulty navigating the complexity of having both "the homework you are doing now and then the homework you are doing last week." Carl struggled prior to his planning meeting

when he went to school and things had "resumed as normal." He felt really behind and didn't know what to do.

Stress related to schoolwork. Participants indicated a sense of pressure or stress when they discussed their schoolwork. Having a break from the schoolwork to focus on mental health was welcomed by the participants, but as Greta explained, then when students return to school "it is hard to make it all up to keep your grades up," and the return was difficult because the student must "go back to reality." This was a sentiment shared by others. Beth called it a "mini-summer vacation." They acknowledged that being in the hospital was a nice break from all of the stressors both at home and school. It was also good to focus on mental health, but when they returned, there was so much to do all at once and this added to the stress of the transition.

One of the ways the participants were stressed was the immediacy of returning to school. There was a feeling of expectation that the students needed to start right away. Emma indicated she was, "thrown back into it." Carl felt as if he had to "jump back in" when he first returned. This feeling and knowing that he was behind in work had him feeling "really stinky and not good." It also added to the urgency to get the work done for him that his absence occurred at an end of the term, so he felt pressure to finish his work to earn grades for the term. Beth felt pressure having all of her work to do and completed quickly when she returned to school. She felt like everyone was telling her "chop, chop, chop" and she had to get everything done when everything was still "hectic" in her head. Deb's transition was primarily focused on academics. She was a strong student in accelerated classes and wanted to make up the schoolwork as quickly as possible because she wanted everything to return as quickly as possible to "normal."

Along with trying to get things done quickly, participants often felt the pressure to stay up late to get work done which added to their stress levels. Although Deb identified that she had a good transition, she felt it "was really stressful the first few weeks just getting caught back with things." She stayed up late most nights, and even until 3:00 a.m. some days. Emma also shared she would go to school and then stay up to do homework at night. She described the pressure as "stress and anxiety all together." She said they would "load up on more homework" when she returned and didn't feel supported or have meetings or support to finish her work.

All but one participant commented on school support. Several shared how the level of school support impacted their stress level. For example, Emma said it was hard getting caught up with all the schoolwork because she perceived she received very little school support at her old school. She was surprised that at her old school she was "thrown back into it" without much support and explained how hard this was. The impact of school support stress will be discussed later in the chapter under the school staff support, accommodations, and having a plan sections.

School staff support. When discussing school staff support, there were varying responses about the amount of support participants received. The overall sentiment was that adolescents do need and want some degree of support from school staff when they return to school from a mental health hospitalization. Ann, Beth, Carl, Deb, Emma, Frank, and Greta. The only one not indicating such was Hank.

Ann experienced a transition with primarily unsupportive school staff while Carl, Deb, Frank, and Greta experienced transitions with supportive school staff. Due to multiple transitions in two different schools, Beth and Emma experienced both supportive and unsupportive school staff environments. Most of Emma's interview focused on her experience at

her previous school which was considered unsupportive by her. She had multiple hospitalizations at this school. Beth discussed both schools.

When describing the level of school staff support, the participants typically talked about the level of school staff involvement and demonstrations of understanding of the participant's situation during transition. Overall, Ann was frustrated with the level of support she received from her school. She said, "The teachers didn't really help you a lot." At Beth's old school, she felt the teachers were not very accommodating about her mental health problems and when she transitioned. She felt like they were telling her to "put it off to the side" when she was going through something hard, and it wasn't that simple. Emma was frustrated at her old school when she returned from hospitalizations that her teachers didn't really "help out in that school." She recounted that one particular teacher gave a lot of work while she was gone and expected it to be turned in right away. She also didn't think her high school counselor was very nice, and felt like the counselor "blamed" her for the hospitalization and absence.

Other participants had more positive experiences during transition. Carl felt supported by his school counselor. He met with her regularly and talked about "stuff." He identified her as someone who was significant during his transition. Deb felt supported by her school, too. She indicated that her school counselor checked in with her often, and that her teachers "were really good with helping me with the homework." Greta shared that her teachers, counselor, and principal were all "really understanding" about her absence and hospitalization and helped her transition. They helped her make a plan and helped make it "easier for me" to return.

Participants recognized that they encountered mixed experiences either with different teachers or within different school environments. Although Ann had an overall negative school

staff support experience, she did identify one staff member with a strong positive impact. That

teacher checked in with her, and talked with other teachers about helping her get caught up. She

used the phrase, "he kinda' had my back." This teacher worked with her to learn the missed

material as well as asked about how she was doing. This made a big difference for her. Beth

had a very different experience at her new school compared to her past school. At her new

school, she felt like the transition was easier because she was released to her grandmother who

was her main support person. Also, she felt like her school staff cared. She said that knowing

her options helped her feel like she didn't have to go through the "hassle and stress" of her old

school. A further description of how powerful these options were on her will be described in the

accommodations section. Emma also had varying experiences. Although she gave a bleak

description of her previous school, she did find solace by talking with her middle school

counselor when she was in high school. She also found her new school to be much more

accepting of her. She had very recently transferred to her new school, and had been attending for

a few months. At her new school, she was encouraged that her school counselor was very

supportive. She described her as "amazing." She also indicated her new teachers were really

good too.

As the participants were interviewed, they shared some advice about school staff support.

Beth indicated the importance of teachers knowing what is going on with students and their

mental health particularly during their transition to help them. She said that it would help

explain at times when she "zoned out into blank space." She said that giving students some

space is important. Carl gave advice that students should definitely meet with their school

counselor when they first come back to school after being hospitalized. Deb gave the advice that

each student may need to work on their own "pace." Frank thought it was important for school

staff to know that when he returned he was "in his head a lot." Due to drug use, he had memory

problems. This affected his schoolwork because he had a lot of stress trying to cope, and the

memory problems remained as a barrier to his learning.

Having a plan. Having a plan to address schoolwork was a topic that came up with a

few of the participants. Some had a plan and two were frustrated that they did not have a plan.

When talking about a transition plan, there wasn't a definite idea of what such plans needed to

be, but rather the importance that the participant left with a sense that he or she had a plan that

would assist them in their return.

Prior to leaving for the hospital and while at the hospital, Ann was given the impression

she would have a plan and help when she returned to school after her hospitalization. Ann did

have meetings with her social worker and an administrator when she returned, but she got the

understanding she needed to create her own plan: "I had to make a plan myself." This included

talking to teachers on her own, going to Saturday School, and staying after school to complete

late assignments.

Emma didn't view her situation as not having a plan, but rather described that she didn't

have any arrangements for her return. Specifically, she stated, "I was kinda' like just thrown

back into it. I didn't talk to anyone when I got there like the staff people know about it, but they

like just threw me back in instead of talk to me about everything."

Having a meeting and creating a plan with the student to return to school seemed to help

the participants feel better about their return. Carl returned to school and thought it was

"terrible" due to being behind in work and not knowing what to do. However, when he, along

with his parents, had a chance to meet with his school counselor and principal, things got better. They set up a plan for him to meet with his counselor regularly, have a period each day to catch up on work, and a general plan to tackle his missed work.

Frank met with his school principal and talked over his options for school and created a plan where he would attend independent study which allowed him some flexibility. He felt supported by his teachers, counselor and principal during his transition. Greta had a similar experience to Frank. Greta suggested that all students returning to school after a hospitalization should have some sort of plan for "makeup work and stuff." She added it would be good if some of the work could have been brought to the hospital to avoid having so much when she got back.

Deb did have some collaboration between the hospital and her school. She said that although she kept her hospitalization private from most people, the hospital collaborated with her school counselor and made recommendations and a plan about being able to take breaks and things. The school counselor then sent out some ideas to the teachers with just a little information. She wasn't exactly sure how these arrangements were made, but it was helpful that there was a plan before she returned to school.

Accommodations. Oftentimes school support and school plans come with accommodations that fit each student's needs when they returned to school after their hospitalization. A few participants talked about how these accommodations were helpful to them during transition. For example, Beth indicated that her new school was much more accommodating to her mental health needs, and she had a district accommodation plan. She mentioned the plan several times throughout the interview. She identified "options" as an important part of her plan. She was relieved to have music she could listen to privately through

earbuds, taking breaks in the counseling office, taking longer time for tests, using notes on tests when needed as accommodations that she used. She also said that she knows students who use "doodlepads" (a notebook to draw and write) as an accommodation to draw as a way to cope and that was good too. She doesn't use the "doodlepad" as often as music. The support from these accommodations helped her feel like she had everything to "work piece by piece to keep levels" manageable.

Carl mentioned one accommodation that was particularly helpful for him which was having a period a day to work on his homework. This really helped him catch up on his missed schoolwork. He also appreciated regular check-ins from his school counselor.

Deb also discussed how when she returned that the teachers would allow her extra time on current work when she had sporting activities to reduce her workload and stress. She was also given permission to leave class to take a break, as well as listen to music through earbuds when needed. Similarly, Emma said that when she got to her new school she was happy that they let her take breaks and worked with her one to one when she needed it.

Frank met with his school principal when he returned to school and made a plan to work on three courses. These three classes would be done through an independent study program. This accommodation allowed him to be self-paced and gave him "the freedom to do the work and not get distracted."

In the end, participants benefitted from meeting with one or more school staff and coming up with a plan with accommodations that met their individual needs upon their return to school. The accommodations were organically brought up by participants within the interview as significant incidents and helpful to their transition.

Social Aspects

Participants reported social aspects to transitioning. Most participants experienced the following issues within the social aspects theme: worried about others (*n=8*), bullying and rumors (*n=5*), and peer support (*n=8*). Every participant indicated some aspect of social concern when returning to school.

Worried about others. Every participant mentioned something about what others would say or knew about their hospitalization. Ann was a little worried about returning because, "I was kinda' scared when I first got out of the hospital 'cause I didn't know if people knew." She was okay with her friends knowing about her going to the hospital, but she was worried about adults and peers who were not her friends finding out.

Deb was also quite concerned about people discovering why she was gone, and she was nervous upon her return about what people knew: "I didn't know if anyone had found out so I was really nervous, I guess." She told most people that she was absent due to "family issues" and didn't tell them that she had been in the hospital. A few close family and friends knew some information about her absence. She did not feel comfortable talking about her "mental health issues."

For Emma, she was nervous about returning due to the questions she thought she would get, "People are going to ask questions." She just didn't want to have to deal with the questions and conversations that may come up.

Frank had experienced a breakup right before his hospitalization, and he was nervous about returning to school because his ex-girlfriend attended the same school. This was a really important person to him, and he no longer had her in his life. He also felt lonely because when

he returned to school he needed to disconnect from his friends who used drugs. He felt "very alone." He was worried about how things would go when he returned.

Greta had experienced multiple hospitalizations. She talked more openly about her first hospitalizations, but she became more hesitant to talk about more recent hospitalization. She knew people would ask her "where I was." This created more attention to her return than she wanted. So, she stated, "At that point, I was lying about it." She didn't want to talk about it, and she didn't "want them to worry about me or anything."

Another way Greta was worried about how others would receive her return was in her relationship to them. She was "really overly anxious" about her return to school because she was hospitalized in early September and hadn't seen her classmates over summer. She was worried about how her relationships would renew after being gone and then reconnecting after not being there to start the school year. She identified the social piece of transition as being more worrisome than any other aspect.

Hank was "kinda' nervous about what people would say" due to posting personal things on social media just before his hospitalization. He was then gone for a week, and he didn't know what people would think or say about it. He didn't really want to go back to school because of these concerns.

Participants experienced worry about how others would respond to their return to school. The biggest worry was about what others knew about their absence, and if people would say anything negative about it. However, there was also a worry about the relationships that would be impacted by the hospitalization and return.

Bullying and rumors. As mentioned previously, the participants were concerned about how others would receive their return to school. Some of the participants were concerned about potential bullying and rumors, and others actually did experience both. Beth experienced increased bullying and rumors when she returned to school after her hospitalization. She didn't have "strong friendships," and it was hard to cope with people knowing why she was gone. She said she was teased about her hospitalization. She felt like she was targeted when she was already a target. She started to stand up for herself and her one good friend at her old school. This at times became physical. Beth said she would rather be known for being tough than getting bullied.

Emma did experience some rumors and jokes from peers. She said that in her experience most "Kids think it is, like, a joke." She said that they spread rumors, and came up to her and said "stupid things" and jokes.

Deb made a point to say that she had not been bullied or mistreated during her transition, but she did comment that she knew other students who had this experience after being hospitalized. This may have been part of the reason she did not want anyone to know she had been hospitalized.

Peer support. Participants also talked about the level of peer support they received when they returned to school. Some participants received a great deal of support from their friends when they returned to school from one participant declaring her friends are her "everything" (Deb) to one participant not having "strong friendships" (Beth).

One way peers were particularly helpful was when other students who had experienced mental health concerns or hospitalizations reached out to the participant. Ann had a peer who

was older who had been hospitalized that she talked with about her transition and being stressed out about school. Ann seemed to appreciate this connection with this older girl even though she felt the older student's experience was more difficult than her own.

Carl also appreciated a school peer who reached out who had experienced a hospitalization. He felt supported by a girl in his school who had been hospitalized and talked with him some about more serious topics. She "knew what it was like." This was especially helpful to Carl because he felt socially sad about his transition. He felt like his friends didn't really notice his absence, and when they did, they negatively joked about it.

When peers knew a little about the hospitalization it gave them an opportunity to be supportive. Deb had told a few of her closest friends a little about her absence, and they were very supportive. Those friends decorated her locker when she returned to school, and she said they were with her "24/7." She said that basically, "People were just supportive all around" and nobody said anything to her about being gone.

At her previous school, Emma felt she didn't have much support at school, but Emma had one best friend who knew about her hospitalization. She could talk with her about what was going on, and Emma thought her best friend was "helpful." She also had some friends who helped her with homework and that helped her to feel "relieved" about homework. Emma was surprised that at her new school some students she didn't know well offered to talk with her if she needed. She felt like the students were nicer to her at her new school. This contributed to her feeling like she could remain at the school rather than going to a different placement.

Frank had little peer support during his transition. Some of this was his choice so that he could focus on his mental health and chemical health recovery. He had just experienced a

breakup with a girlfriend who attended his school right before going into the hospital. When he

returned to school, he no longer had that close relationship. Also, his closest friends used drugs.

While being hospitalized, he identified that, to become mentally healthy, he also needed to

become chemically healthy. To remain clean, he needed to stay away from his friends at school.

He was "lonely."

Greta didn't talk about peer support as much as her fear that not starting the school year

with her peers would somehow impact her relationships with them. She said she was more

worried about things "socially." She hadn't seen her peers much over summer, and she didn't

know how things would go once everyone returned to school, and she wasn't there to start school

with them. She was "overly anxious" about it. It didn't take long though after her return for her

to reconnect and for her to feel "content." She thought her transition may be better than some

because she gets along with her peers.

Hank felt like a loner, but he did have one female peer who had been hospitalized before

talk to him a bit about his experience, and he felt she understood what it was like. This seemed

to be something he noticed and was important to him. When he returned, he stated, "Nobody

said anything too bad." Yet, nobody really said much to him about his hospitalization and

absence, at all. He mentioned that people asked him about it, and then just went on with their

own friends. He recognized this as a possible good thing in the sense that this meant fewer

people were worried about him. He also had an experience that when he was in the hospital, a

classmate was also admitted into the hospital at the same time. This allowed him to get to know

that classmate more.

Participants experienced different levels of peer support. Participants who talked with another student who had been hospitalized seemed to feel connected and supported by their shared experience. Participants also shared how they were supported by close friends when they shared information about their absence. Other participants experienced little support sometimes by choice.

Personal Aspects

Along with academic and social aspects, there were topics that came up that seemed to be personal or intrapersonal in nature to the participants. These topics focused on areas such as personal growth and development (*n=3*), positive thoughts and feelings (*n=8*), perceptions of mental health (*n=4*), and ongoing mental health concerns (*n=6*).

Personal growth and development. Three of the participants discussed how they grew personally after their hospitalization, and how transition was a time to focus on personal development. One participant focused more on finding ways that worked for her to cope with her problems. Two others learned about themselves during their hospitalization and transition was a time to focus on further personal exploration.

Beth said that she did not like being in the hospital and admitted she did what it took to get out of there early. She stated that it was helpful to "do whatever the nurses want you to do to get out of there and act like you are all happy and fine." She realized, though, she needed to find ways that actually worked for her. Beth knew talking helped. She got connected to a counselor during her hospitalization, and she said, "Counseling works for me."

Frank referenced his personal journey throughout his transition several times. He said, "a lot has changed with me since like emotionally and mentally." Frank had learned about himself

during his hospitalization. When he was discharged, he knew he had personal work to do. He

worked on accepting himself with the help of medication and therapy. His transition was a time

spent focused in his head trying to figure himself out, "just thinking all the time." Although he

cared about school and earning his credits, his mental and chemical health was his primary

concern.

Similarly, Hank learned about himself during his hospitalization, and when he returned to

school he was focused on his personal development. He acknowledged that he wasn't really

focused on academics. Rather, he identified that he needed to rely on himself more. He needed

to make decisions for himself and be less of a "people pleaser." He seemed proud of his

development and this transition as "new opportunity."

Positive thoughts and feelings. All of the participants expressed a small element of

positive experience during their transition. Some participants had good staff and peer support

during their transition. Also, participants were offered accommodations to help them during

their transition and afterward. Participants also experienced positive personal thoughts and

feelings during their transitions.

Although Ann was disappointed that she did not receive more support with her

homework, at first, she felt "happy and determined" when she got out. She had hope that she

was going to get all caught up on her homework, she had created a predischarge plan at the

hospital, and she had positive expectations about her return to school. She also started

medication and therapy to support her mental health. Despite her perceived lack of school staff

support, she followed through with creating her own plan which included going to Saturday

School, and staying after school to complete assignments. She followed through on her feeling

"determined." Ann was also able to express her feelings of gratitude toward one specific teacher who she described "had my back." So regardless of her pervasive frustrated feelings, she was still able to express her feelings of being "happy and determined," and how she was hopeful that things would get better. She was also able to be thankful for the teacher who helped her.

Deb felt really excited to return to school. She had always really liked school, and she expressed that she wanted to return to school. When she returned to school, she had positive friend and school staff interactions which supported her positive feelings about returning to school. Her friends decorated her locker, and her teachers were "happy to see me." She reported it was overall a pretty "nice day to go back," and she was happy to be back at school. She had a good transition experience and her friends and school staff were supportive. She was glad to see her friends again, and be "back in the routine."

Hank was less expressive about his positive feelings, but he did indicate he was proud that he was more independent. He also liked that he now had "new opportunities." He said that it shouldn't be looked at as a bad thing to be gone for a while and return. This is what allowed him to have this new perspective.

Similar to Deb, Greta was "excited" to see people when she returned to school. Although she was nervous about how the relationships would rejoin after her absence since she missed the start of school, she was excited about seeing her school friends.

Perceptions of mental health. As participants talked about their transitions, participants reflected upon how others viewed mental health. One way participants reflected on mental health was how they thought others viewed it. The participants also added their own thoughts

about how people should view mental health. The underlying concern was that people do not

really understand mental health.

Ann commented on mental health problems as a serious condition. She remarked that

people "don't see that there is something physically wrong so they assume it's not that serious."

She then went on to explain that it may be more difficult and take longer than physical illness to

recover from mental illness.

Beth thought people see those who need to go to a psychiatric hospital as "weak." She

further said, that people think, "That [they] are broken down and nuts." She then gave her own

feelings about people who are going through mental health struggles: "Some of the people I was

in the psych unit with are the strongest people I have ever met." She then added, "I know I am

one of them."

Deb was uncomfortable having people know that she had been hospitalized, and she

perceived that people would not expect for her to struggle with mental health issues because she

was good at school and was active in school events. She used the words, "So, no one really

would expect it, so it was never really a question for me that that was where I was."

Emma made a point that going to the hospital is a serious thing. She felt that a person

needs to be evaluated in order to be admitted. She wanted people to understand the seriousness

of mental health concerns as well as the difficulty of transitioning. She wanted students and

teachers to understand this so that they could be more understanding and considerate to those

students who need to have a mental health hospitalization and then transition.

As Greta visited about why people should provide support to students who are

transitioning back to school, she emphasized that people need to understand there is a reason

why students are hospitalized. She stated, "There has got to be some sort of reason why, you know." To emphasize the seriousness, she even said that some people transitioning may want to give up. She commented, "When you get back, you might want to give up. I know I do. I just want to give up."

Ongoing mental health concerns. When participants returned to school after being hospitalized, they were still working through their mental health issues. During the interview, most of the participants referenced some ongoing mental health concern or need for ongoing mental health focus. Transition is often the time when participants start counseling therapy and medication for the first time as aftercare to their mental health hospitalization.

Although Ann did not talk at length about her mental health concern, she did comment about her ongoing care. She started medication during her hospitalization, and then started therapy during her transition from the hospital. These supports did give her hope that things would get better.

Beth experienced both anxiety and depression during her transition, mostly anxiety heightened when she returned from the hospital. In her words, "It's not like it just went away." She said that she "was cutting when I went in, and the day I got out I was cutting again because nothing was different." In fact, she indicated her anxiety was worse during her transition and her depression was about the same. In addition, her anger level was worse because she was hoping that the hospitalization would help and she felt like it didn't. She did say that she was supported by counseling after her hospitalization and that was something that worked for her.

Emma didn't go into much detail, but she also reported that when she returned she was anxious about the transition. She also said that she still had to deal with her ongoing depression. This made her transition more difficult.

When Frank returned from the hospital, he needed to focus on his mental and chemical health. He started antidepressants and worked with his therapist. Although he didn't use it as an excuse, he was so focused on his mental and chemical health, it may have been difficult to focus on school. He was "in my head a lot thinking about everything." He indicated that his therapist was helping him deal with everything.

When Hank returned from the hospital, his mind was not on academics, instead he focused on his mental health. He said before the hospital, people were pushing him to focus on academics and pushing him to get work done, but he was feeling and "getting worse." When he got out of the hospital, he needed to balance his attention on other aspects of his life, and this included his mental health. He said people seemed to push him less on just academics when he returned from the hospital.

Summary

Phenomenological research methods were used for this study. The aim of phenomenological research is to better understand a shared lived experience through gathering qualitative data from the participants experiencing the same phenomena. This composite description provided insight into those aspects of how adolescents' transition back to school from an acute mental health hospital that were shared experiences by the participants. Commonalities described by the participants during this study were analyzed and shared within this composite description. Three emergent themes were described along with detailed

subthemes: academic aspects (schoolwork, stress related to schoolwork, school staff support, having a plan, accommodations), social aspects (worried about others, bullying and rumors, peer support), and personal aspects (personal growth and development, positive thoughts and feelings, reflections on mental health, ongoing mental health concerns).

Chapter 13: Conclusion

The primary goal of this study was to acquire a better understanding of how adolescents experience transition back into the school environment after a brief mental health hospitalization. Qualitative, phenomenological research methods were used to answer the core question of the research question, "How do adolescents experience transitioning back to school after an acute mental health hospitalization?" The research was conducted through the lens of constructivism which seeks to explore the "participants' view of the situation" (Creswell, 2007, p. 20) and how the participant interprets reality (Bloomberg & Volpe, 2008). To provide background knowledge about this topic, a literature review was provided in Chapter 2. The literature review was followed by a step-by-step description of methodology in Chapter 3. Chapters 4-11 provided an individual description of each individual's transition experience. For each participant, a textural, structural, and textural/structural description was provided. After all individual experiences were expressed in each chapter, common or shared experiences were described within the composite description chapter, Chapter 12. In the Chapter 13, the last details of the study are provided: the discussion of findings, significance of findings in light of current literature, research limitations, implications of research, future research, and the summary.

Discussion

Eight participants were interviewed for this study. Five participants were female and three were males. Although the age parameter for this study was adolescents 13-18 years old, volunteers who became participants ranged in age from 15-17 years old: one participant was 15, four participants were 16, and three participants were 17. All eight participants were from southern Minnesota and had experienced an acute mental health hospitalization within the past

12 months. Four participants had experienced one mental health hospitalization, and five had

experienced more than one mental health hospitalizations. One participant came from a large,

urban high school. Two participants came from midsized suburban high schools. One

participant came from a small, rural high school. Three participants came from a small,

suburban alternative high school.

In Chapters 4-11, individual participant's descriptions were shared. Each

participant has a chapter with a textural description, structural description, and a

textural/structural description. The individual textural descriptions provided insight to each

participant's experience in regard to what they experience. Individual structural descriptions

provided insight into the participant's experience from a different viewpoint that includes

imaginative variation (e.g. experience combined with intuition) from both me as well as the peer

reviewer. The individual composite description provided an intertwined description of both

textural and structural description that is the essence of the participant's experience.

There were two to three textural themes found for each participant, and one to two

structural themes for each participant. The titles of the themes were selected to describe the

material found within the theme description and often used words from the participants. Ann's

textural themes were help, confusion and positive thoughts. Her structural theme was feeling let

down. Beth's textural themes were before and after hospitalization difficulty, pressure, and

home life. Her structural themes were feeling frustrated and feeling supported. Carl's textural

themes were having people and communicating and things got better. His structural theme was

feeling insecure. Deb's textural themes were difficulty returning to regular homework, support,

and nervousnous. Her structural theme was perception of mental health. Emma's textural

themes were school social environment and academic difficulty. Her structural theme was feeling overwhelmed. Frank's textural themes were personal growth, social life, and academic aspect. His structural theme was dedicated to personal growth. Greta's textural themes were social worries and homework. Her structural theme was feeling anxious. Hank's textural themes were worried and depressed feelings and personal development. His structural theme was being a loner.

After individual participant analysis was done, the composite description was written. The composite description depicts the essence of how the group of participants experienced transition to school after an acute mention health hospitalization. This is not to simplify or to remove importance from an individual's experience or voice but rather to allow people to understand the phenomenon better as a whole. Three large themes emerged within the composite description: academic aspects, social aspects, and personal aspects. Within each large theme, subthemes emerged. Under academic aspects, the sub-themes of schoolwork, stress related to schoolwork, school staff support, having a plan, and accommodations emerged. Three subthemes emerged under social aspects: worried about others, bullying and rumors, and peer support. Within the personal aspects theme, four subthemes were present: personal growth and development, positive thoughts and feelings, reflections on mental health, and ongoing mental health concerns.

Additionally, when reviewing the participants' descriptions, it may be worth noting that participants viewed the process of transitioning back to school as a mix of external and internal factors. Hence, although the participants were undergoing a personal journey, they explained that factors outside of themselves did impact their transition experience. This can be observed

through the descriptive subthemes. Subthemes that could be considered primarily external

factors to transitioning would be the following: school staff support, having a plan,

accommodations, bullying and rumors, and peer support. Subthemes that could be considered

primarily internal factors to transitioning would be the following: worried about others, positive

thoughts and feelings, personal growth and development, and ongoing mental health concerns.

When reading the transcripts from the participants, the following subthemes had a mix of

internal and external considerations: schoolwork, and stress related to schoolwork.

A unique development of this study was that some of the participants offered advice or

suggestions during their interviews for helping adolescents transition back to school. Some of

the suggestions may not have correlated directly to an individual participant's theme or to a

common theme within the composite description.

It is important to the goal of this study to bring voice to those adolescents who have

experienced transition. Ann thought teachers should be more involved, and "if a teacher knows

what is going on, they should check in and ask." Beth felt pressured when she was told to do

things over and over, rather, she would have preferred school personnel to encourage her: "So, I

just think that you should let me know that they have a higher potential," and "can do better."

She thought it would be helpful if teachers knew what was going on because then they would be

more understanding. Carl gave advice that, "You should really come up with a plan with your

guidance counselors, principals and all that about what you are going to do to make it all up."

Deb said her transition was fairly smooth, but sympathized that it may not be that way for others.

She acknowledged that each transition is different, and gave this advice, "[school personnel]

should just being there, and [let] them talk and [listen] and [let] them do it at their own pace

because everyone has their own way of doing it and coming back." Emma wanted more empathy from her teachers, "So, I think teachers need to be more considerate about things." Greta felt overwhelmed when she returned, and suggested, "There should be some kind of plan for makeup work and stuff if you know they are going to be gone."

The topic of support resonated throughout the participant data and found placement within two subthemes: school staff support and peer support. Some participants spoke at length about the support they received from school staff and peers such as Deb who identified that her transition went smoothly and had significant support. Perhaps more interesting is those participants who felt minimal support during their transition also acknowledged the support when it did occur either through peer or adult support. For example, Ann, although feeling let down by the adults during her transition, strongly appreciated her one supporting math teacher. Another example would be Emma who experienced an overwhelming transition in her old school yet was able to remember and acknowledge the efforts of her one good friend and her middle school counselor for their help. Beth also felt quite frustrated during her transition when she lived with her stepmom and went to her old school, but was able to recognize her good friend's help during transition. These examples may help adolescents, as well as school and mental health professionals understand that one person can impact an adolescent's transition to school from an acute mental health hospitalization.

Significance of the Study

This section compares findings of this study with current literature available on the phenomenon of adolescents transitioning to school after an acute mental health hospitalization. There were similarities from previous research on transition and this current study which

confirmed aspects of the previous findings. However, it was difficult to make direct

comparisons since there were no studies found that interviewed adolescents about a return to

school from a mental health hospitalization. The results from this study can also expand upon

previous literature.

Few studies were found about transitioning back to school after a mental health

hospitalization. Existing studies focused heavily on adult (professionals in hospitals or in

schools, or caregivers) perception of transition (Clemens et al., 2010; Rager, 2015; Simon &

Savina, 2005; 2010; Tisdale, 2015). Four studies focus primarily on how adults coordinated

transition for the adolescents from the hospital to school (Rager, 2015; Simon & Savina, 2005;

2010; Tisdale, 2015), and only one study (Clemens et al., 2010) focused primarily on

professionals' perspectives of what happens for the adolescent during transition from the hospital

to school. Another article discussed the results from offering a tiered-support transition program

(White et al., 2006).

Regardless of the different perspectives, the participants from this dissertation study did

indicate some of the same aspects from previous research. This dissertation study's findings

were most closely aligned with the results from Clemens et al. (2010) which asked adults their

perceptions about adolescent transition from hospital to school.

Clemens et al. (2010) identified three major transition themes: academic, social and

emotional. The results from the dissertation study found the major themes: academic, social, and

personal. To understand how the studies compare, it is important to look at the descriptions or

subthemes within each theme. The professionals interviewed in Clemens et al. (2010) perceived

these concerns within the academic theme: missing work, preexisting academic concerns, and

readiness for reentry. This dissertation study academic theme found: schoolwork, stress related to schoolwork, school staff support, having a plan, and accommodations. The Clemens et al. (2010) perceived these topics as pertaining to the social aspect of transitioning: social problems that existed prior to hospitalization, students are concerned about explaining their absence, and friendships are impacted by hospitalization. This dissertation study identified these items as pertaining to the social aspects theme: worried about others, bullying and rumors, and peer support. The Clemens et al. (2010) study identified an emotional theme where students seemed to experience an overall overwhelmed feeling when transitioning back to school. This dissertation study found the participants engaged in personal aspects to transitioning where the following topics were experienced: personal growth and development, positive thoughts and feelings, reflections on mental health, and ongoing mental health concerns. Ultimately, there are some similar attributes within themes.

A few of the studies focused on transition from the perspective of how stakeholders (hospital, family, and school) coordinate communication during transition (Rager, 2015; Simon & Savina, 2005; 2010; Tisdale, 2015). It is difficult to compare these studies with this dissertation study because the main focus of the study is different. Also, adolescents who were the participants in this study may not be aware of stakeholder communication due to their age. However, it is worth noting that two participants from this dissertation study commented on communication between hospital and school. Ann discussed how before she left the hospital, they (hospital staff) asked her to create a plan: "They help you, ask you questions" about how she would handle leaving the hospital. She referenced this discussion as we talked about returning to school. Her hospital transition plan included coping skills, medication, and therapy.

She had been working with a social worker prior to her hospitalization, and Ann depended upon her for communication of the plan to the school. Previous studies indicated varying levels of direct communication between hospital to school communication, from always (Tisdale, 2015) when interviewing a small group of hospital-based mental health professionals, to 37% (Simon & Savina, 2010) when interviewing a large group of special education teachers about after discharge communication. When Deb was at the hospital, she "came up with a list" and then it was sent to the school counselor. She isn't sure how the teachers knew and how it all worked, but she said that the teachers gave her the support she needed. She knew she could take breaks or do the things she needed. In previous research, hospital-based therapist identified face-to-face communication as the best way to communicate with parents, and they would send discharge plans via mail or fax to schools (Simon & Savina, 2005).

Participants from this dissertation study stated benefitting from plans when they returned to school. Some of these plans were formal, others were not formal. Beth referenced her "district accommodation plan" several times throughout her interview and commented on how it allowed her "options" that gave her the "space" to "keep stress levels down." Similarly, Rager (2015) interviewed families regarding their perception of how their student's needs were met during transition. Rager found the families indicated a need for more information from the school about specific information regarding plans such as individualized educational plans (IEPs), 504s (specialized plans for students with disabilities), crisis, behavior support, and transition. The students in this dissertation study who did not receive school staff support through follow-up plans did indicate a need for more support. For example, Ann commented, "I had to make a plan myself."

As described in detail in Chapter 12, the three major thematic aspects of transition for these participants were: academics (schoolwork, stress related to schoolwork, school staff support, having a plan, and accommodations), social (worried about others, bullying and rumors, peer support), and personal (personal growth and development, positive thoughts and feelings, reflections on mental health, ongoing mental health concerns). Clemens et al. (2011), in a small mixed-methods study with hospital and school professionals, perceived these five elements of transition as being the most impactful for students as they transition from hospital to school: school-based factors (how the school supports the student), student-based factors (student experience of symptoms), familial factors (parent involvement), mental health care factors (follow through of care), and systemic factors (communication of stakeholders). When reviewing the two lists, there are overlapping key aspects to transition made within each study: school support, individual student factors, importance of general support, mental health support, and the importance of communication.

Research Limitations

Limitations exist within this dissertation study which may impacts its generalizability and transferability. Qualitative, phenomenological studies are designed to provide an in-depth description of a phenomenon rather than a broad picture of the phenomenon (Creswell, 2007). Hence, the reader should be cautioned when attempting to generalize this dissertation's results to expanded populations. Although there are key, common aspects of transitioning that occur for most of the participants within the study and help us understand the phenomenon of transition better, it is important to understand that returning to school after an acute mental health hospitalization is a personal journey for each adolescent. Although I made an effort to recruit a

diverse adolescent population (age 13-18) from southern Minnesota, only adolescents 15-17

responded. In addition, only one participant identified as African American, and all other

participants identified as Caucasian. One participant came from a large, urban high school. Two

participants came from midsized suburban high schools. Two participants came from small,

rural high schools. Three participants came from a small, suburban alternative high school.

Although multiple types of schools were represented, alternative schools were likely over-

represented which may be considered a limitation of this study. Alternative learning center

schools serve students who are at risk of not graduating due to a number of qualifying factors

(e.g. chemical use, behind credits for grade level, pregnancy, experiencing personal difficulties).

Another study limitation may be the affiliation between the referral source and the

participants. Participants were referred through mental health counselors or school counselors.

One participant was referred by a mental health counselor, and seven participants were referred

by school counselors. Although school counselors referred participants within the parameters of

the study, they may have felt most comfortable referring those students with whom they had

established relationships. By referring participants with one school staff relationship, those

participants may have reported more favorable transition experiences than those without an

established school staff relationship.

A limitation may also be the length of some of the interviews being shorter than

anticipated. Interview length varied greatly, from 20 minutes to 60 minutes. It is difficult to

know the reason behind the brevity of some of the interviews. It may be due to the age and

maturity of a few of the participants. Having a long conversation to a new person may be

considered awkward to an adolescent. It may have also been that two of the participants seemed

more guarded about going into details about their thoughts and feelings. Despite encouragers

and asking again the questions, a few participants gave few details about some aspects of

transition. It is important to recognize that all participants had been acutely hospitalized within

the past twelve months and may still be struggling with mental health concerns, and it may be

difficult for the participants to trust or discuss any topic. A follow-up with each participant did

occur regarding their significant statements and an understanding of their transition experience.

These follow-ups were done face-to-face with the exception of three participants who were

unable to make their schedules work to allow in-person interviews. Those follow-ups were done

via phone. The follow-ups did allow for the participants to make a few additions to their initial

interviews and allowed an additional opportunity for each participant to have input regarding

their thoughts about transitioning back to school.

Implications and Recommendations

Counselor education. Counselor education programs are helping counselors-in-training

to prepare to face the challenges of the growing mental health demands of children and

adolescents in both the community and at schools. Those helping professionals working in

mental health hospitals, community counseling agencies, and schools typically have a strong

background in diagnosis and treatment of mental illness, but should also have a basic

understanding of what happens before, during, and after a mental health hospitalization to best

help children and adolescents during this highly stressful time. This understanding begins with

the helping professionals' education and training during counselor education. Because all

counselors need a working understanding of the process, it may be best to offer the information

during a core counselor education course. Due to high academic demands for counseling

curriculum, the material could be introduced in one or more of four ways: sharing a personal narrative, sharing transition plans, reading and discussing an article, or taking a hospital field trip.

School personnel. Perhaps the greatest implications this study has is for counselors who work directly with adolescents both in and out of schools. This study helps school personnel better understand how adolescents experience transition after an acute mental health hospitalization. The three large themes and subthemes raise awareness to those common aspects of transition for adolescents: academic aspects, social aspects, and personal aspects. With this awareness, school practitioners can work on a school-wide level as well as on an individual level, to prepare for returning adolescents. On a school-wide level, counselors can provide staff education opportunities regarding mental health as well as a better understanding of what adolescents encounter during hospitalization. This increased knowledge of common mental health issues such as anxiety and depression can help increase understanding as well as empathy toward what the adolescents are going through. This study also uncovered some perceived mental health stigma, misconceptions, and fears among the adolescent population. Continued efforts to educate students about mental health, as well as acceptance and respect programs, should be encouraged as some school-wide initiatives.

Two participants in this dissertation study experienced very different school environments (one not supportive and one supportive) in regard to mental health support from both staff and peers. It is unknown how the schools involved educated their students and staff abut mental health and if any of the schools involved have bully prevention or respect initiatives.

However, it is possible school-wide education and programming could contribute to better social

support for adolescents struggling with mental illness.

Several of the participants in this dissertation study indicated a high level of stress when

returning to school. Small group programs within schools offered to students to handle stress

and anxiety may be helpful to these adolescents transitioning back to school. Also, when

students return, the adolescent and family can be given information and options on educational

programs and plans, both formal and informal that may help the adolescent return to school with

adequate support. Specifically, schools can utilize a transition plan form where students can pick

and choose the most helpful accommodations during their transition.

When returning to school from the hospital, adolescents are still struggling with their

mental health issues. It is important for them to continue treatment recommendations from the

hospital as well as be aware of any other concerns not addressed at the hospital. School staff

should encourage open communication with adolescents and their families regarding follow-up

care from the hospital, and share any concerns they are seeing at school. In utilizing these

recommendations, the practitioner respects the adolescent's individual needs as well as

recognizes some of the common needs which occur during transition.

Future research. Because there is little research about adolescents transitioning back to

school after a mental health hospitalization, more research in this area is encouraged. This

dissertation study was designed to contribute to the body of qualitative literature describing how

adolescents experience transition from an acute mental health hospitalization to school within

southern Minnesota. However, a gap in literature related to this topic exists, and to conduct

further research in this area from different approaches and with larger populations to allow for further generalization of findings seems to be a logical step (Rager, 2015).

Also, since many of the studies were from the adult perspective and were focused on stakeholder communication, a shift in research focus to child and adolescent needs during transition would be logical (Rager, 2015). The participants in this study indicated needs in the area of how schoolwork is addressed in regard to school staff support, having a plan, stress related to schoolwork, and accommodations. Similarly, Tisdale (2015) recommended expanding research in the area of hospital to school transition plans. Ultimately, research that focuses on what helps students transition more smoothly should be the focus. Future research may also be useful exploring which individuals who are involved in hospital to school transitions, the information needed to provide successful transitions, and which interventions that are the most helpful to children and adolescents (Simon & Savina, 2010).

Summary

The number of acute mental health hospitalizations for adolescents from longer hospital stays are increasing due to managed health care (Heflinger, Simpkins, & Foster, 2002). This requires adolescents to return to school just days after being admitted to the hospital for crisis care. For this study, the term "transition" was used to describe the process of adjusting to return from an acute mental health hospital to school for this study. Despite the prevalence of this concern, hospital and school professionals have not thoroughly researched how adolescents experience transition from acute mental health hospitalization nor how to best help adolescents make this transition. The brave and earnest participants in this study experienced both support and challenges along their transition journey while experiencing personal growth and strength.

Three overarching themes of transition were found: academic aspects, social aspects, and personal aspects. The importance of both external factors such as peers, school staff, family, and mental health support and the internal factors such as the personal stress, growth and development, and mental health concerns were all important during transition. Future research exploring this topic is needed and could focus on the adolescents' needs during transition.

In closing, I greatly respect and appreciate the participants in this study, as well as other students I have known who have gone through hospitalization and transition. To quote Beth, "They are some of the strongest people I have ever met."

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Appendix A

Appendix A: Consent Form

Name of Parent or Guardian: _____

I am the legal guardian of_____ . I consent for her or him to

participate in a research project on adolescents' experiences returning to school after a

mental health hospitalization. I understand that Pam Iverson, licensed school counselor

and doctorate-level graduate student, from the Counseling and Student Personnel

Department at Minnesota State University Mankato (MSU) is the primary student

researcher of this study, and that she is being supervised by Walter Roberts, Ed.D,

professor at MSU, Mankato.

As explained to me and described in this consent form, I understand that participation in

this study includes the following for my child and me:

1) Both my child and I have read this form.
2) My signature indicates that I have read this document and asked questions to Ms. Iverson
   if I was unclear about any part of the study.

   3) My child will participate in an interview about his or her thoughts, feelings, behaviors,

   and experiences related to returning to school after his or her mental health hospitalization

   (about 45 minutes). My child will also participate in a second meeting in a few weeks after

   the first meeting to check for understanding of his/her answers (takes about 20 minutes).

<u>Procedures</u>

I understand that my child will be asked questions about his or her thoughts, feelings,

behavior, and experiences. The researcher will take notes and the interview will be

audiotaped. The notes and audiorecordings will be kept locked and the device password

protected.   I can contact the student researcher, Pam Iverson at 507-533-1617 or

pamela.iverson@mnsu.edu or the faculty researcher, Walter Roberts, Ed.D at

walters.roberts@mnsu.edu or 507-389-5659 about any concerns I have about this project.

I also may contact the MSU Institutional Review Board Administrator, Dr. Barry Ries, at

389-1242 with any questions about research with human participants at MSU.

I also understand that my child will receive a $10 Kwik Trip gift card to help with the cost

of travel for his/her participation.

_____Initial this page has been read.

Confidentiality

All information obtained in this project will be kept private by the staff of this research

project. All information will be stored in a locked file cabinet at Minnesota State University,

Mankato. It can be viewed only by authorized research staff members. I understand that no

information about my child will be released and no names will be recorded other than the

consent forms. By law, the only times when information would not be kept confidential is if

my child or I state that one of us were in imminent danger of harming ourselves or others,

or in suspected cases of child abuse.

Risks and Benefits

I understand that my child may have an emotional risk when talking about returning to

school after hospitalization. This interview could bring up an emotional time and topic for

your child.   To help minimize the risk involved, your child will guide the interview. The

interview questions are fairly open, and your child will decide how in-depth and in which

direction he/she would like to take the interview. The researcher will treat your child with

respect and will only talk about those topics regarding transitioning back to school your

child wants to discuss. The researcher will also stop the interview if your child wants to

stop the interview. Your child's safety and well-being are most important. I understand

that I can request a copy of the study's results, which, if requested, would be mailed to me

after the end of the study; and that participating in this study may help the researchers

better understand adolescents' transition from a mental health hospital to school.

Right to Refuse Participation

I understand that participation in this project is voluntary and my child and I have the right

to stop at any time. My child can choose to skip any questions she or he does not want to

answer, and that he/she/we can stop participating by saying we do not want to be in the

study any more. My decision whether to participate will not affect my relationship with

Minnesota State University, Mankato.

Signed: _____

Date: _____

With my signature, I state that I am at least 18 years of age and I have received a copy of the

consent form to keep.

MSU IRBnet ID#: 883168

Date of MSU IRB approval:

____Initial this page has been read.

Appendix B

Appendix B: Assent Form

Participant's Name _____

Thank you very much for helping me in this study.

You are being asked to be part of a research project that will help everyone better

understand how adolescents experience transition from a mental health hospital

experience back into school.   *Transition* is the process or journey you went through coming

back to school after you were discharged from the hospital. You will be asked to answer

questions about your experience with transition.

I am a student from Minnesota State University, Mankato and I will ask you questions about

your experience in hopes to better understand this type of transition better. There are no

right or wrong answers. Your answers are your opinions based on your actual experience.

They will be kept confidential and anonymous. Identifying information will be removed

such as your name or the name of your school. Your answers will be tape recorded to make

sure that I have written down the answers correctly. College teachers and other school

counselors will use the information to help understand how adolescents experience

returning to school after a mental health hospitalization. It is my hope that this study will

help adults make better decisions.

Your parent or guardian said that it is okay for you to participate in this interview, but you

are not required. Talking about transitioning back to school after your hospitalization may

be difficult. It may bring up emotions. The researcher will treat you with respect and let

you guide the direction of the interview. So, you get to decide how in-depth you want to

answer a question or in what direction you want to take the interview.   You also get to

decide if you want to stop the interview.   How long it will take for the interview will

depend upon how much detail you would like to include in your answers. Typically, an

interview will take between 30-60 minutes.   Participating in this interview is voluntary.

After we are finished with the questions, I will thank you and make sure you have a ride

home. In a few weeks, I will call you and ask to connect one more time to check that I have

understood your answers.

_____   _____

Signature   Date

MSU IRBNet ID# 883168

Date of MSU IRB approval: 4/17/16

Appendix C

Appendix C: 18-Year-Old Consent

Name of Participant: _____

I am 18 years of age or older. I am consenting to participate in a research project on

adolescents' experiences returning to school after a mental health hospitalization. I

understand that Pam Iverson, licensed school counselor and doctorate-level graduate

student, from the Counseling and Student Personnel Department at Minnesota State

University Mankato (MSU) is the primary student researcher of this study, and that she is

being supervised by Walter Roberts, Ed.D, professor at MSU, Mankato.

As explained to me and described in this consent form, I understand that participation in

this study includes the following for me:

1) I have read this form.
2) My signature indicates that I have read this document and asked questions to Ms. Iverson
   if I was unclear about any part of the study.

   3) I will participate in an interview about my thoughts, feelings, behaviors, and experiences

   related to returning to school after my mental health hospitalization (about 45 minutes). I

   will also participate in a second meeting in a few weeks after the first meeting to check for

   understanding of my answers (takes about 20 minutes).

<u>Procedures</u>

I understand that I will be asked questions about my thoughts, feelings, behavior, and

experiences. The researcher will take notes and the interview will be audiotaped. The

notes and audiorecordings will be kept locked and the device password protected. I can

contact the student researcher, Pam Iverson at 507-533-1617 or

<u>pamela.iverson@mnsu.edu or the faculty researcher, Walter Roberts, Ed.D at</u>

walters.roberts@mnsu.edu or 507-389-5659 about any concerns I have about this project.

I also may contact the MSU Institutional Review Board Administrator, Dr. Barry Ries, at

389-1242 with any questions about research with human participants at MSU.

I also understand that I will receive a $10 Kwik Trip gift card to help with the cost of travel

for my participation.

_____Initial this page has been read.

Confidentiality

All information obtained in this project will be kept private by the staff of this research

project. All information will be stored in a locked file cabinet at Minnesota State University,

Mankato. It can be viewed only by authorized research staff members. I understand that no

information about me will be released and no names will be recorded other than the

consent forms. By law, the only times when information would not be kept confidential is if

I state that I am in imminent danger of harming myself or others, or in suspected cases of

child abuse.

Risks and Benefits

I understand that I may have an emotional risk when talking about returning to school after

hospitalization. This interview could bring up an emotional time and topic for me. To help

minimize the risk involved, I will guide the interview. The interview questions are fairly

open, and I will decide how in-depth and in which direction I would like to take the

interview. The researcher will treat you with respect and will only talk about those topics

regarding transitioning back to school you want to discuss. The researcher will also stop

the interview if you want to stop the interview. Your safety and well-being are most

important. I understand that I can request a copy of the study's results, which, if requested,

would be mailed to me after the end of the study; and that participating in this study may

help the researchers better understand adolescents' transition from a mental health

hospital to school.

<u>Right to Refuse Participation</u>

I understand that participation in this project is voluntary and I have the right to stop at

any time. I can choose to skip any question I do not want to answer, and that I can stop

participating by saying I do not want to be in the study any more. My decision whether to

participate will not affect my relationship with Minnesota State University, Mankato.

Signed: _____

Date: _____

With my signature, I state that I am at least 18 years of age and I have received a copy of the

consent form to keep.

MSU IRBnet ID#: 883168

Date of MSU IRB approval: 4/27/16

____Initial this page has been read.

Appendix D

Appendix D: Recruitment Letter

Dear Potential Participant,

My name is Pam Iverson. I am a school counselor and a doctorate-level graduate student at Minnesota State University, Mankato. I would like to interview teens about their experiences returning to school after a mental health hospitalization. At present there have not been any studies done that have asked teens about their experiences returning to school after a mental health hospitalization. I think it is really important to better understand what students experience when they return to school after a mental health hospitalization. It is also really important to understand this better by hearing from the teens directly!

If you decide to participate in this study, your name and identifying information will not be released. You will need to have parent or guardian permission to participate in this study unless you are 18 years old. Participation in the study includes participating in an interview and then later visiting with me about my understanding of important points from the interview.

During the study, you will be treated with respect, and your participation will be completely voluntary!

Thank you for considering participation in this study!

Sincerely,

Pam Iverson

MSU IRBnet ID#: 883168

Date of MSU IRB approval: 4/27/16

Appendix E

Appendix E: Interview Questions

1.   Could you describe for me what your experience has been like returning to school after

     your mental health hospitalization?

2.   Could you describe any specific incidents (and those people involved) that may stand out

     for you that were connected to your transition*?

3.   Could you describe any feelings or emotions that were generated by your experience?

4.   Is there anything else that you think is important for others to understand about returning to

     school from your viewpoint?

*Transition - In this study, transition is used to describe the process of adjusting to return from

     an acute mental health hospital to school.