

**The Experience of a Family of an Adult who has Re-entered the  
Parental Home Following the Completion of a Local Residential  
Mental Health Rehabilitation Programme**

A Qualitative Study

by

**Rebecca Cassar**

Academic Supervisor

**Mr. Joseph Mangion**

A dissertation submitted in partial fulfilment of the requirements for the  
Masters in Systemic Family Psychotherapy

Institute of Family Therapy- Malta

September 2017

## Declaration of Originality

I hereby declare that this dissertation: *The Experience of a Family of an Adult who has Re-entered the Parental Home Following the Completion of a Local Residential Mental Health Rehabilitation Programme* is my work, carried out under the supervision of Mr. Joseph Mangion.

---

**Rebecca Cassar**

---

**Date**

## Acknowledgements

I would like to start by thanking my research supervisor Mr. Joseph Mangion, for his support, feedback and guidance. Thank you for always reassuring me whenever I was in doubt and for sharing my interest and enthusiasm when listening to my ideas and thoughts.

Words cannot begin to describe my gratitude for the support I have received from fiancé Thom. You have consistently believed in me and in my abilities in moments where it was hard for me to do so. Thank you for your kindness, your care, your patience, and your love.

I also wished to thank my family, for inspiring my drive to learn and for teaching me the value of hard work and being committed to what I choose to do. Last, but definitely not least, I would like to thank my best friend, Lynn, for always being there to remind me to take care of myself in the process of carrying out this study.

## Abstract

This qualitative study explores the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. Three semi-structured interviews were held with the client and her parents. The transcripts of said interviews were analysed using Interpretative Phenomenological Analysis. The following salient findings emerged from this research: The family members were hopeful that the programme would support them in experiencing the desired changes, notwithstanding their past experiences of isolation, blame and anxiety. The three participants discussed their experience of change in the client during the programme; however, the parents also expressed how they wished that they were more actively involved in the process of change. The theme of experiencing and witnessing loss and stress at re-entry also emerged from this study. Finally, the participants shared their experience of mental health stigma in the community and the resulting struggles with maintaining long-term change.

## Table of Contents

Declaration of Originality - ii  
Acknowledgements - iii  
Abstract - iv  
Table of Contents - v

### **Chapter 1 – Introduction - 1**

1.1 Research Question - 2  
1.2 The development of my research interest - 2  
1.3 Significance of the research – 3  
1.4 The Structure of this Dissertation- 4

### **Chapter 2 - Literature Review - 5**

2.1 Introduction - 6  
2.2 The Local Context - 6  
2.2.1 The Maltese Family Unit - 6  
2.2.2 Shame and Stigma in Malta - 7  
2.2.3 A Journey towards the Normalisation of Mental Health Services - 9  
2.3 Current Shifts in Mental Health Services - 11  
2.3.1 Community Based Rehabilitation - 11  
2.3.2 The Family in the Deinstitutionalization Movement - 12  
2.3.3 Collaborating with Families - 14  
2.3.4 Multidisciplinary Interventions - 15  
2.4 Systemic Metatheoretical Framework - 16  
2.4.1 The Structure of the Family and Structural Change - 17  
2.4.2 The Family life cycle - 18  
2.4.3 Bowen’s work on Emotional Fusion and Differentiation of Self - 19  
2.4.4 The Narrative theory and Recovery - 21  
2.4.5 Strength-Based Approaches – 22  
2.5 Conclusion - 23

### **Chapter 3 – Methodology - 24**

3.1 Introduction - 25  
3.2 Research Design - 25  
3.3 Research Tool - 27  
3.4 Sample - 28  
3.5 Reliability and Validity - 31  
3.6 Ethical Issues - 32

3.7 Data Analysis - 33
3.8 Researcher Reflexivity – 34
3.8.1 My experience of working in the field of mental health – 34
3.8.2 Reflecting on the interviewing process – 35
3.9 Conclusion - 36

## **Chapter 4 - Presentation of Findings - 38**

4.1 Introduction - 39
4.2 The research participants - 39
4.3 Table of Themes - 41
4.4. Theme 1
Reasonable Hope for Change - 42
4.4.1 Sub-theme 1:1
The family defining the problem - 42
4.4.2 Sub-theme 1:2
Parents longing for peace of mind - 45
4.4.3 Sub-theme 1:3
Exploring theories around recovery from mental health problems - 46
4.5 Theme 2
Difference in experiencing changing contexts: Home and the Programme - 48
4.5.1 Sub-theme 2:1
Doing things my way - 48
4.5.2 Sub-theme 2:2
Witnessing new stories of resilience - 49
4.5.3 Sub-theme 2:3
Getting to know each other - 50
4.5.4 Sub-theme 2:4
Parents balancing space and involvement during residential programme - 51
4.6 Theme 3
Experiencing and witnessing a struggle for adaptation at re-entry - 53
4.6.1 Sub-theme 3:1
Acknowledging a loss for the client - 53

4.6.2 Sub-theme 3:2	
Linking Happiness and Autonomy -	54
4.7 Theme 4	
Holding on to acquired new experiences -	56
4.7.1 Sub-theme 4:1	
The meaning given to employment -	56
4.7.2 Sub-theme 4:2	
Expecting more -	58
4.8 Conclusion -	59

## **Chapter 5 – Discussion of the findings - 60**

5.1 Introduction -	61
5.2 Salient Findings –	61
5.2.1 The family’s hope that the programme can support them in experiencing the desired changes notwithstanding their experiences of isolation, blame and anxiety -	61
5.2.2 The family members’ experiences of change in the client during the programme, and the parents’ wish to be part of the process of change -	66
5.2.3 The family’s experience of loss and stress at re-entry -	69
5.2.4 The family’s experience of mental health stigma in the community and the resulting struggles with maintaining long-term change –	71
5.3 Conclusion -	73

## **Chapter 6 – Conclusion – 74**

6.1 Introduction –	75
6.2 Summary of Salient Findings –	75
6.3 Limitations of the study –	75
6.4 Implications for practice –	76
6.5 Implications for future research –	79
6.6 Conclusion –	80

## **Reference list - 81**

Appendix A- Semi structured interview guide –	88
Appendix B- Information sheets and consent forms –	91
Appendix C- Sample of Transcript –	95
Appendix D- Original Quotes in Maltese Language –	97



# Chapter 1

---

## Introduction

## 1.1 Research Question

---

This qualitative study was aimed at answering the following research question:

What is the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme?

## 1.2 The development of my research interest

---

My research question was inspired by my past history of being employed in two different residential mental health services, one of which is the mental health rehabilitation programme contextualising this research study. For a total of six years, I occupied both the role of a Mental Health Recovery Officer, and eventually that of a Service Leader in another residence. During this time, I allowed myself to be immersed in the experience of working in the field of mental health and residential services. While I subscribed to most of the philosophies underlying the work I did, as time went by I had started to question other elements of our practice.

The general adopted belief was that clients benefit from being exposed to a different context when moving from home or hospitalisation into the residential facility. This is because as a team, my colleagues and I believed that the exposure to a different structure, context and relationships allowed residents to have the space to develop new skills to support them in becoming more independent. This belief was further reinforced when staff members, residents and family members could assess that clients' independent living skills very often improved during their residence. Some clients opted to live in Supported Housing upon the completion of their stay, but others moved back home to living with their families. We hoped for the clients that when they moved on

from the residential facility, they would take with them their experience of change and the skills they would have acquired, but we were not involved long enough to follow up their experience after the programme.

During my supervised clinical practice at the Institute of Family Therapy, I had the opportunity to work with a family of a son who was previously a client of one of the residences I had worked in. Through this experience of viewing the family as the client and the opportunity to work systemically with this family, I could see a much wider and much more complex picture than the picture I saw when focusing solely on the son in the residential programme. I was also made aware that there were the resources of a whole system to draw from to achieve the change they desired, which, in my opinion, made our work together much richer. It was at that point that I started to wonder, why is it that as a mental health professional I did not know and did not work with this complex picture? What would families say about mental health services and about their experience of the rehabilitation of a family member if their views and experiences were given a voice? These questions ignited my curiosity to explore the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme.

### 1.3 Significance of the research

---

While my own curiosities were central to my research interest, another main motivation was the lack of local qualitative systemic research in the field of mental health rehabilitation and community-based services. Mental health rehabilitation programmes and community-based services are now described as pivotal in achieving the desired shift towards the

deinstitutionalisation of mental health in Malta and in implementing the changes resulting from the enforcement of the new Maltese Mental Health Act (Buttigieg, 2012). Recent studies are also showing that as a result of the deinstitutionalisation movement, which shifted the focus of care from inpatient psychiatric hospitalisation to community-based services (Krieg, 2001), the families caring for relatives with a mental health problem are now becoming more active and present participants in the provision of mental health care (Sholevar and Schwoeri, 2003). These changes place value in giving a voice to families who have first-hand experience of local mental health rehabilitation programmes. This study aims at eliciting the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme.

## 1.4 The Structure of this Dissertation

---

A review of the available literature around the area of interest, and a discussion of my systemic theoretical meta-framework will be presented in the chapter that follows this introduction. The description and discussion of my rationale for my choice of methodology will then be presented. I will then share the findings of this study, and will also discuss the salient findings. Finally, I will share my recommendations for practice and for future research, and I will also discuss the limitations of this study.

# **Chapter 2**

---

## **Literature Review**

## 2.1 Introduction

---

In this chapter I will provide a context for my research through the presentation and discussion of existing literature and research studies. Through the researching and reading of literature, I came to appreciate the complexity of the area of interest, and while I attempted to share this complexity when writing this literature review, deliberate choices were made in order to present a coherent and clear review. In preparation of writing this literature review, I have read existing literature around the following themes; the Maltese family unit, care in the Maltese family, stigma and shame in Malta, local mental health services, the recent shifts in mental health services, and the systemic models and theories that informed my thinking as a researcher. The articles and books chosen were deemed appropriate both for academic robustness, and for their relevance to the research question. Recent studies and original sources of literature were accessed when possible.

## 2.2 The Local Context

---

A review of the available relevant local literature is presented in this section. This was aimed at providing a context to this research within the Maltese history of and culture around mental health.

### 2.2.1 The Maltese Family Unit

---

Malta was described by Abela, Frosh and Dowling (2005) as a face-to-face community, where the family that one comes from is considered as an important determinant in the construction of one's public and private self. The family in Malta is typically nuclear, often a modified extended nuclear family, where a high number of married couples opt to live in the same village as one or both of

their parents, (Abela, Frosh & Dowling, 2005). Traditionally, the men in the family were expected to work, while the wife had her responsibilities at home, caring for the children and the family, including the extended one. Borg Xuereb (2008) explained how this division in roles of husband and wife is no longer as clear as it was traditionally. The recent shift in roles started requiring both females and males to feel obligations to contribute to housework, their children's upbringing, and the care of the family's vulnerable members.

Abela (2016) discussed the theme of caring responsibilities in the Maltese family across time. She explained how, in spite of the changes which the Maltese family structure has experienced throughout the years, ties of affection and the members' obligations of care and support still remain considered as main uniting features. This element of family care was also mentioned in the context of caring for vulnerable family members, such as persons with disabilities and persons with a mental health problem. Abela, Farrugia, Vella and DeGiovanni (2015) discussed how mental health services in Malta rely heavily on this element of family care, while minimally focusing on the effects which this may have on the rest of the family members. In their study, Abela, Farrugia, Vella and DeGiovanni (2015) reported that 47% of caregivers participating in their research claimed to be under pressure, 42% reported being depressed, and 34% claimed that they were receiving help from their general practitioner. It was also reported that only 38% of these caregivers reported receiving help from mental health services.

### 2.2.2 Shame and Stigma in Malta

---

The idea of Malta being described as a face-to-face community, suggests a community where everybody knows everybody (Abela, 2005). Bradford and Clark (2011), stated that people in Malta

meet regularly in everyday life, and often, people know each other by name and can acquire a certain personal knowledge. Clark (2012) discussed how her research participants explained that in Malta, news travels quickly and that it travels easily from one person to another by word of mouth; thus facilitating this accessible pool of knowledge about others.

The culture of honour and shame has been described as more intense in a face-to-face community (Bradford and Clark, 2011). O'Reilly Mizzi (1994) as cited by Bradford and Clark (2011) explained that when a person's behaviour deviates from the culture's norm, in a face-to-face community, one does not have the liberty to move to a different part of the community and start over. This is because reputation follows and catches up with people quickly. Instead, in order to avoid this anticipated shame and stigma, persons who deviate from the norm may feel the need to hide, when possible, the behaviour or feature which deviates from the honourable norm (Clark, 2012).

According to Agius, Falzon Aquilina, Pace and Grech (2016), stigma for mental health problems in Malta was possibly brought about because of the history of treatment and the poor conditions of the original mental health hospitals. In their paper, Agius et al (2016) go through the history of mental health hospitals in Malta; starting with "Ospizio" in the time of the Knights of Malta where patients, who were badly clothed, fed and housed were chained to the walls in small rooms. Most were beaten due to the belief that mental illness is caused by demonic possession (Cassar, 1964, as cited in Agius et al, 2016). In 1725, women were cared for in the Hospital for Incurable Women. Villa Franconi in Floriana was then introduced in the early 19<sup>th</sup> century. Being in a residential area,

persons in Villa Franconi were often teased and instigated by neighbours (Savona-Ventura, 2004). Until this day, ‘Franconi’ is a term that carries with it stigma (Agius et al, 2016).

The ‘Asylum for Imbeciles’ in Attard was opened in 1861, and initially provided care for around 200 persons (Grech, 2016). Over the following thirty years, the hospital catered for over 650 persons. People reported that they felt a shudder when passing through the village of Attard; and that the people who lived in Attard felt stigmatised simply because they lived in the same village as the ‘Asylum for Imbeciles’ (Agius et al, 2016). Relatives of a person with mental health problems would postpone having their relative admitted for care unless the situation offered no alternative; where admissions to the hospital would often still take place at night. Relatives then typically also refused to accept to take their family member back home from hospital because of fear of the need for readmission. The hospital was renamed Mount Carmel Hospital in 1967 (Agius et al, 2016).

### 2.2.3 A Journey Towards the Normalisation of Mental Health

---

The 1981 Mental Health Act introduced the idea of voluntary admissions to Mount Carmel Hospital, open wards and hospital leave for persons admitted to hospital. A Psychiatric Unit was established in the General Hospital, which further enhanced the process of ‘normalisation’ (Agius et al, 2016). Community Psychiatry services then began in 1995, where people who were not admitted to hospital could come into contact with nurses, social workers, and psychologists in the community (Agius et al, 2016).

Grech (2016) explained that following the enforcement of the new Mental Health Act in 2013, Malta started modernizing and improving its Maltese Mental Health Services. The Maltese Mental Health Act (2012), takes a direction towards the reduction of hospital stays, as well as towards emphasizing the importance of mental health rehabilitation and community based services in order to accomplish this reduction. As stated by Buttigieg (2012), the aims of the new Maltese Mental Health Act include giving acute treatment in hospital if necessary and moving towards a community approach. This new law aims to see people with mental health difficulties as full and active members of the society. This suggests that services, such as the residential mental health rehabilitation programme contextualising my research, will be pivotal means towards the achievement of the new local Mental Health Act directives.

Grech (2016) identifies two main challenges which the Maltese Mental Health Services have to address:

- Is the present inpatient mental health facility the best possible set-up for effective and as short as possible inpatient care?
- Do the community mental health services offer the spread and width of care required to prevent admissions, and offer support to decrease the length of such admissions as much as possible when they do happen?

In spite of the value that Grech (2016) placed on answering these questions effectively, he stated that studies which are Maltese population based and which generate data on the rate and diversities of mental health problems in Malta, and on the service use and service need do not exist.

While Agius, Falzon Aquilina, Pace and Grech (2016) acknowledge a shift in Maltese Society and the attitudes of Maltese people in regards to acceptance of mental health problems, and thus a movement towards the aforementioned normalisation, the authors also note that issues about how people relate to mental illness among their friends and families are still present. The impression is that Maltese people still typically avoid to talk about and own up to the presence of mental health issues in the family.

## 2.3 Current Shifts in Mental Health Services

---

Ample literature discusses the deinstitutionalization movement, where more persons with mental health problems are being discharged from psychiatric hospitals and provided care in the community. Deinstitutionalization has been defined by Krieg (2001) as the “shift in the care of mentally ill persons from long-term psychiatric hospitalization to more independent living environments.” (pp. 367).

### 2.3.1 Community Based Rehabilitation

---

Salem, Seidman and Rappaport (1988) claimed that deinstitutionalization works when alternatives to hospitalization are in place in the community. Alternative community based rehabilitation programmes were described to lead to levels of community living skills, social adjustment and a quality of life which is as good, or better, to hospitalizations. However, once persons lose contact with the programme, their gains often disappear (Salem, Seidman and Rappaport, 1988). Successful community based rehabilitation programmes must, according to Salem, Seidman and

Rappaport (1988), provide ongoing and long-term support as well as individually tailored programmes. There must also be a balance between care that is assertive to reach clients who typically fall between the system cracks and care that is flexible to allow persons to develop their own resources.

Traditionally, mental health services were shaped mainly by the medical model, where the focus involved the treatment and controlling the symptoms of mental illnesses (Xie, 2013). Pratt, Gill, Barrett and Roberts (2014) spoke about the distinction between treatment and rehabilitation. Treatment is defined as any action designed to cure a disease or reduce its symptoms. On the other hand, rehabilitation is defined as any action which is intended to reduce the negative effects of the disease on the person's everyday life. Rehabilitation programmes aim at doing the latter. The rehabilitation of a person with mental health problems generally aims at supporting the individual to learn skills and receive support, to enhance their independence, integrate into normal community life, obtain the highest level of functioning possible, live free of symptoms as possible and lead a meaningful life which offers personal satisfaction and self-efficacy (Lieberman, 2008).

### 2.3.2 The Family in the Deinstitutionalization Movement

---

When institutionalization was the main model of intervention, mental health professionals were perceived as the experts who determined the symptomatology, and devised the interventions and treatment plans. The families typically assumed the position of the relatively passive support system (Sholevar and Schwoeri, 2003). Baronet (1999) claims that one of the outcomes of deinstitutionalization is the increased responsibility on the family in managing their relative's

mental health problem and providing care. The family started observing the entire range of their relative's behaviour, determining which behaviours were most problematic, and asking for assistance of the mental health professionals when the family feels overwhelmed by the symptoms of their relative's mental health problem (Sholevar and Schwoeri, 2003).

Smith (2012) researched the experiences of older women parenting an adult child with mental health problems, and explained how even in their later years, these women were still in continuous negotiation with themselves and their adult child with regards to how and when their role as caregivers can end. Smith's (2012) participants expressed how they wished for more time for themselves in their later years and how they wished to not have to be tied down to constant caregiving. However, the same participants also explained how they were still committed to supporting and protecting their adult child a little longer, with the hope that their adult child will be ready to be less dependent on them in the near future.

Leith and Stein (2012) found that healthy or well siblings of persons who were diagnosed with a mental health problem explained a personal loss of the future; which the authors interpreted as being in anticipation of the time when they will be recruited to provide assistance and care to their sibling diagnosed with a mental health problem. According to Leith and Stein's (2012) findings, although well siblings did not necessarily describe themselves as the primary care givers to their sibling who has a diagnosis of mental health problems, they still reported strong intentions to provide care to their sibling in the future. Both Smith's (2012) as well as Leith and Stein's (2012) findings confirm the family's important role in caring for their relative with a mental health problem.

### 2.3.3 Collaborating with Families

---

The new nature of the family's contribution in the care of their relative with a mental health problem has made it a necessity to develop new and collaborative models by which mental health professionals and families can work together as two major resources (Sholevar and Schwoeri, 2003).

Stanbridge and Burbach (2007) stated the importance of working in partnership with families when their relative is participating in a community based programme. They believe that this partnership is more effective than simply adding on separate services for carers. As described in a report prepared by the Centre for Addiction and Mental Health (2004), there are two main philosophies of working with families. The first is described as family-focused work, where the clients' needs are met within the context of the family. The second philosophy for working with families is described as family-centred care. This, by contrast to family-focused care, focuses on meeting the needs of both clients and families. Family-centred care has been described as an evidence-based best practice. According to Centre for Addiction and Mental Health (2004), research demonstrates that involving families through family-centred care results in a faster client recovery from mental illness, lessens the risk of mortality, reduces dependence on health care services, decreases the rate of rehospitalization and relapse, enhances treatment compliance, and strengthens client interpersonal functioning and family relationships. Family-centred care improves the quality of health care and both health care professionals and clients experience this collaborative approach as resulting in greater satisfaction with health care.

Bellmore (2013) explained that a client's re-entry in the parental home following rehabilitative residential programmes can be experienced as a struggle in situations where progress was not encouraged or acknowledged by relatives, and where the home or community environment was not supportive of the changes made by the client. In such environments, clients risk reverting to old-patterns (Bellmore, 2013). Gillum (2007) described how family members may also feel concerned that the change that their relative experienced would not be sustained after the residential programme and that their life would revert to being the same as it was before. Hendrickson (2017) emphasized the need for treatment providers and clinicians to embrace the family system during the recovery process. In her chapter, Hendrickson (2017) recommended that the families of people in community residential programmes and the clients go through a parallel process. She explained how this parallel process begins when a client enters residential treatment and the family members also start their own treatment process. While encouraging family members to participate fully during the residential programme, home-based family therapy can also be offered to support the family system with developing a re-entry plan for when their relative returns home (Hendrickson, 2017).

### 2.3.4 Multidisciplinary Interventions

---

According to Sholevar and Schwoeri (2003), the multidisciplinary nature of contemporary interventions began to develop as a reaction to the fragmented system of health care. This approach has brought up the need for application of biological, psychological, and family therapies in an integrated fashion. A multidisciplinary approach to care has been described as most effective in utilising the different skills and experiences of professionals with the aim of improving the health status of clients (Pritchard & Ryan, 2004).

However, Pritchard and Ryan (2004) also highlight how a multidisciplinary team would typically not function in an effective way by simply bringing together a varied group of professionals who are not professionally aligned. A multidisciplinary approach requires expanded consultation skills, refined communication and psychoeducational skills from all caring professionals, all aimed at ensuring that professionals provide accurate information to clients and their families (Sholevar & Schwoeri, 2003). This could be attained through adopting a systemic approach to teamwork; where each element of the system compliments the other, and in total would be able to meet the needs of their clients (Pritchard & Ryan, 2004).

## 2.4 Systemic metatheoretical framework

---

In this section I shall discuss the systemic theories which informed my thinking. Ideas were borrowed from different approaches with the aim of looking at this research eclectically. This approach fits within the post-modern shift in thinking, where as a researcher, I did not wish to hold one truth, but instead attempted to look at this research through multiple truths and lenses.

### 2.4.1 The Structure of the Family and Structural Change

---

Structural Family Therapy was developed by Salvador Minuchin and colleagues during the 1960s, and operates under the premise that families are organized by a set of invisible rules which govern relationships and interactions between family members (Vetere, 2001; Colapinto, 1982). The structure of a family can be observed through repeated transactions that happen within the family, and between the family and other external systems. Colapinto (1982) described 'homeostasis' in

the family as patterns of transactions which assure stability in the system and the maintenance of the family's basic properties. The homeostatic process keeps the status quo in the family.

Systemic change is described by Colapinto (1982) as a reaccommodation of the system in order for it to adjust to a different environmental circumstance or to an intrinsic developmental need. The example of a couple having children is described in Colapinto's (1982) paper, where the spouse subsystem now needs to coexist with the parent-child subsystem, eventually introduce a potential sibling subsystem, as well as negotiate a new set of boundaries. Such boundaries would define who participates in what, and which family members are excluded from specific situations. When the family system is faced by situations which require it to change and meet new needs, the system experiences stress and disequilibrium. Vetere (2001) described that families and family members are exposed to inner stressors coming from developmental changes in its own members and subsystems. There are also outer pressures coming from the demands to accommodate to significant social institutions that influence family members. The strength of the system relies on the abilities of family members to develop different patterns when internal or external conditions demand restructuring of the system, as well as to balance between emotional connectedness and the development of autonomy as family members mature and live through the family life cycle (Vetere, 2001). Boszormeny-Nagy and Spark (1973) described how during these transition points of family restructuring, family members may feel disloyal to their family. Others may feel a pressure to go back to old roles and patterns instead of bearing the uncertainty of change.

Lappin (1988), explained the belief that problems result from present relationships, past relationships or both; thus problems are contextualised within a system. If a professional holds the

belief that the source of psychopathology, for instance, is genetic, predisposed and historic, then the interventions are designed to address these sources possibly through attempting to resolve intrapsychic conflicts or through the prescription of medication. While a systems position does not ignore the individuals in the system, their history or the need for medication; it puts these issues in a wider, non-blaming therapeutic context which is inclusive of all opportunities for change (Lappin, 1988).

## 2.4.2 The Family life cycle

---

Mederer and Hill (1983) stated that families typically move through predictable changes; termed as the family life cycle. The traditional perspective as held by Mederer and Hill (1983) divides the family life cycle into eight different stages:

1. Establishment Stage (childless, newly married)
2. First Parenthood (infant to 3 years of age)
3. Family with Preschool Child (oldest 3-6 years)
4. Family with School Child (oldest 6-12 years)
5. Family with Adolescents (oldest 13-20 years)
6. Family as Launching Center (leave taking of children)
7. Family in Middle Years (empty nest)
8. Family in Retirement (breadwinner 65 and over)

Walsh (2003), however, revisits the traditional definition of a family, and argued that different families may experience, at different points, additional stages in their life cycle. She mentions divorce, single parenting and remarriage as examples which reflect the reality of some families in

the present. DeMarle and Le Roux (2001) stated that although families of children with physical disabilities or mental health problems go through life cycle stages, some stages may be elongated, shortened, or never experienced.

According to Jivanjee, Kruzich and Gordon (2009), adolescents with mental health difficulties may struggle with attaining certain skills which allow the transition of young people to adulthood. Accepting responsibility for oneself, making independent decisions, becoming financially independent, and establishing relationships with the parents as equal adults were mentioned in Jivanjee, Kruzich and Gordon's (2009) paper as signs of this transition. Parents are also typically going through complimentary transitions; allowing their children more space in order to develop an adult-to-adult relationship with their parents (Jivanjee, Kruzich & Gordon, 2009). Hitchings et al. (1999) as cited in Jivanjee, Kruzich and Gordon (2009) stated that the transition from adolescence to adulthood is a challenging period for all families; however, these challenges are likely to be more intense for families of children with mental health difficulties.

### 2.4.3 Bowen's work on Emotional Fusion and Differentiation of Self

---

Central to Bowen's work around Fusion and Differentiation of the Self, was his belief that the driving force that underlies all human behaviour comes from the simultaneous push and pull between family members to obtain both distance and togetherness. Bowen proposes the presence of an instinctive life force in humans, that drives the developing child to grow up into becoming an emotionally separate person, as well as to be able to think, feel, and act as an individual. At the

same time, Bowen also assumes the presence of a corresponding life force, also instinctively rooted, that drives the child and family to preserve their emotional connectedness. The balancing of these two forces is, according to Bowen, the core issue for all humans (Goldenberg & Goldenberg, 2013).

Bowen (1978) as cited in Skowron and Friedlander (1998) explained that on an intrapsychic level, differentiation of the self refers to the person's ability to balance emotional and intellectual functioning, and thus, to choose between being guided by one's intellect or one's emotions. On an interpersonal level, it refers to the ability to experience levels of intimacy and independence from others. Fusion, by contrast, is where the individual's choices are set aside with the aim of achieving harmony within the system. Fusion can be expressed as a sense of intense responsibility for other's reactions, but it can also be expressed as emotional cut-off from the strain within a relationship. For persons who are fused, self-esteem is typically based on the approval of others and generally conform to those around them.

According Sholevar and Schworer, (2003), Bowen explained that pathology in an individual is viewed as a symptom of an imbalance in the family's emotional system. Symptoms can be categorised as either: physical, emotional and social dysfunction; each of which can be conceptualised as symptoms of the emotional process in the family through the family's unconscious ways of regulating anxiety. Pathology can improve if: 1) a family becomes less anxious, 2) the family shifts focus of anxiety off the person with the symptom, or 3) the person with the symptom reduces the degree to which he or she absorbs family anxiety.

## 2.4.4 The Narrative theory and Recovery

---

Walther and Carey (2009) stated that a problem-focused understanding of people's identities, offers an invitation for professionals to focus on what the authors refer to as the 'what is'. For instance, a professional would question what is the matter with the client, their family, the community? How is the situation viewed in terms of normality? These normative expectations and discourses can be maintained and thickened in the professionals' assessments of clients, reports, outcome measurements and advice giving. According to Walther and Carrey (2009), the risk of this is that such speculations about the clients' lives and identities may become the truth of how clients define their identities. It was argued by Walther and Carrey (2009) that the effects of this could be that the clients' options available to choose from in their lives and experiences become limited into the set ideas which subscribe to the judgements made and conclusions reached.

White and Epston (1990) discussed the perception of problems according to the Narrative Theory as entities which survive and progress within the lives of families through the way that the members organise their lives around particular problems. In her book about Narrative psychiatry, Hamkins (2014) stated that "Patients who consult with psychiatrists and psychotherapists are often mired in stories of despair and failure". Hamkins (2014) described the value of deconstructing the dominant narratives that are harmful to the person receiving treatment and their families, and of discovering lost or subjugated stories of strength and meaning. As stated by Roberts (2000), the recent shift in focus on rehabilitation and recovery in the field of mental health is resulting in changes in the narratives of people around mental health to ones of hope, agency, and self-determination. According to the Commonwealth of Australia (2013), "the lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented

culture.” The focus of recovery allows persons with mental health difficulties to describe their experiences and journeys while affirming that they have a personal identity beyond the restrictions posed by their diagnoses. The recovery approach challenges the traditional ideas of professional power and expertise, and respects everyone for their experience, expertise of their experience and the personal strengths which they contribute.

In their article, Kondrat and Teater (2009), discussed the evaluation of the language used as a critical element in empowering persons with mental health problems. They argue that the choice of the language used can either result in empowerment and depathologising or in contributing to further stigmatisation. Konradt and Teater (2009) mentioned how instead of the use of the phrase ‘helping’ persons with mental health difficulties, practitioners can instead ‘collaborate’ with the clients. The phrase ‘treating persons who suffer’ could be altered to ‘working collaboratively with persons in recovery’. As stated by Konradt and Teater (2009), the use of language in the latter phrase represents a view of persons with mental health problems that is hopeful, and that inspires a narrative where individuals can live a satisfying, hopeful and productive life.

### 2.4.5 Strength-Based Approaches

---

Strength-based approaches in services fit within the shift away from focusing solely on pathology, problems and failures that come with a mental health diagnosis. These approaches encourage mental health professionals to acknowledge the clients’ “personal qualities, virtues and traits; what the person has learnt about themselves, others and the world; what people know about the world around them from education or life experience; the talents people have; cultural and personal stories, informal networks, institutions or professional entities.” (Xie, 2013). Ample recent

evidence suggests that strength-based approaches are central to mental health services, including residential programs (Nickerson et al. 2004). According to Nickerson et al. (2004), the implementation of a strength-based approach in residential rehabilitation programs, is even more effective when the whole family's strengths and resources to support these strengths are taken into account.

Walsh (2006) defined resilience as the ability to withstand and rebound challenges that disrupt. Implementing a family resilience approach, according to Walsh (2006) is beneficial when working with vulnerable and multistressed families. Problem focused conversations tends to replicate the families' problem-saturated experiences, while empowerment, supporting coping efforts and building resources are effective in stress reduction and can break cycles which are not working for the family (Walsh 2006).

## 2.5 Conclusion

---

This chapter was aimed at establishing a systemic metatheoretical framework for this study, as well as at reviewing existing studies and literature about the area of interest. Through this review I also aimed at providing a cultural context, taking into consideration that the study was carried out in Malta, as well as a temporal context, taking into consideration the recent shifts and philosophies around the field of mental health and residential mental health rehabilitation services. In the next chapter I will discuss my rationale for the methodology which was chosen to carry out this study.

# Chapter 3

---

## Methodology

## 3.1 Introduction

---

The design and process utilized to carry out this study will be illustrated throughout this chapter. The research tool and method used in data collection will be discussed together with the features of the selected sample, the method of data analysis, the ethical considerations as well as researcher reflexivity.

## 3.2 Research Design

---

The aim of this study is to elicit the lived experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. The choice of the most rationally appropriate methodological approach was considered an essential step in meeting the aim of the study.

The debate between qualitative and quantitative research as explained by Newman and Benz (1998) is based on different assumptions about what reality is and whether or not one can measure reality. It is also based on different opinions about how knowledge is understood; whether through objective or subjective means. Most quantitative research approaches emphasize that there is a common truth on which people can agree (Newman and Benz, 1998). Quantitative research approaches knowledge empirically in such a way that claims can be made about an object of study if one takes accurate measurements (Langdridge, 2004).

On the other hand, qualitative research:

- a) is mainly concerned with the qualities of the particular phenomena rather than its quantification
- b) focuses on meaning

- c) aims at identifying processes, thus discards the natural science model
- d) does not attempt to control extraneous variables but embraces differences in lived-experiences as an asset to the richness of findings (Langdrige, 2004)

Since this study aims at eliciting the research participants' experiences, a qualitative research design was deemed as more appropriate.

One of the methodologies considered was the application of grounded theory. The reason for this is that grounded theory aims at interpreting case based field studies which deal with social contexts (Hughes & Jones, 2003) and eliciting participants' experiences in the given social context (Lyons & Coyle, 2007). Nonetheless, the aim of the study was not to develop a new theory or to challenge existing theories about the phenomena of interest (Lyons & Coyle, 2007). Therefore, other methodologies were considered.

Secondly, the application of phenomenology was considered. Phenomenological approaches aim at exploring, describing and analysing the meaning which individuals give to their lived experience. It is mainly concerned with the first-person accounts, which provides the researcher with access to a concrete description of the participants' lived experiences (Langdrige, 2004). However, the focal aim of this research involved the achievement of deeper understanding of the participants' lived experiences rather than the description on its own. It was for this reason that it was ultimately decided that interpretative phenomenological analysis (IPA) was most appropriate.

IPA is the blend of two philosophical traditions: Phenomenology and the Hermeneutics tradition. The Phenomenological aspect is concerned with experience. Smith, Flowers and Larkin (2009) draw a distinction between what is part of the everyday flow of unselfconscious experience and ‘an experience’ which we are aware of. IPA is used to study the latter, and those experiences which have a greater and more significant impact on the person’s life. According to Smith, Flowers and Larkin (2009), when engaged with ‘an experience’, people begin to reflect on what is happening. IPA research aims to engage with these reflections. The second major theoretical axis of IPA is Hermeneutics, which is the theory of interpretation. IPA pays particular attention to the interpretative process involved in analysis, when people are studying people (Shaw, 2008). Smith, Flowers and Larkin (2009) describe IPA as a double Hermeneutic process, where the research participant is trying to make sense of the participant trying to make sense of their experience.

The aim of IPA is for researchers to interpret the way by which the participants make sense of their experiences. The researcher cannot obtain objective knowledge of others and the researcher’s individual natural attitudes and biases are taken into account. The researcher is also invited to become aware of beliefs, ideas and judgements, and that through this awareness, the researcher attempts to remain open towards the participants’ experiences (Langdridge, 2004).

### 3.3 Research Tool

---

In order to collect data for this research, three semi-structured interviews were carried out with a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. As stated by Lyons and Coyle (2007), semi-structured interviews are guided by a schedule, but not dictated by it. For this reason, semi-

structured interviews allow the exploration of respondents' in-depth experience, perceptions and opinions regarding complex issues (Barriball & While, 1994). Interviewees have the opportunity to elaborate and ask for further clarifications. As a consequence, the possibility of misinterpretation of the interviewer's question is greatly reduced (Galletta, 2012). Smith (2008) also recommends the conduction of a semi-structured interview in IPA, while highlighting that the interview guide is suggestive but not prescriptive.

The research tool, which in this case was a semi-structured interview guide (presented in Appendix A), was developed after a thorough literature exploration and review. Participants were given the choice to answer either in Maltese or English depending on their personal preference. The interviews were held at the family's home as this arrangement was most convenient to the family.

### 3.4 Sample

---

The interviewing process was divided into three sessions with one family. For the purpose of this study, all family members were invited to the three-session interview, including but not restricted to the parents, siblings and the client. This open invitation was aimed at giving consideration to the participants' ideas around who forms part of their family. Through this open invitation, I also attempted to elicit a more complete and complex exploration of the phenomena being researched as experienced by the whole system, including both the dominant stories of this system around the experience, but also the subjugated stories. Through giving voice to all family members, observing the family dynamics at play while interviewing and exploring relationships in the family I hoped to gain a richer understanding of this family's experience of an adult who has re-entered the

parental home following the completion of a local residential mental health rehabilitation programme. While I invited the whole family for the interview, the mother, father and the daughter (the client) participated in the interview. The client's older brother and sister, opted to not participate in the process.

The following information regarding the mental health rehabilitation programme was compiled through my knowledge about the programme, which was also discussed with professionals who worked at the residence during the time of accessing research participants. This programme is one of the services offered by a local non-governmental and non-profit organization. Persons who can benefit from the residential mental health rehabilitation programme contextualizing my research include people who have a mental health problem, persons who are willing to use the service, persons who are able to understand the philosophy of a therapeutic community and are willing and able to participate and contribute to the community. The programme that is offered is one year long; and a successful termination is achieved when the clients have actively worked on goals included in their care plans and whose programmes were not terminated prematurely. Clients are often provided with the option of visiting their families during restricted times during week days, and also to spend weekends at home. The clients' visitors are also welcome to visit during the same time slots.

I proposed that a one year minimum and a two-year maximum will need to have passed from the termination from the residential mental health rehabilitation programme. Iyer, Rothmann, Vogler, and Spaulding (2005) explained how most quantitative studies evaluate the outcomes of mental health rehabilitation programmes using a pre-programme and post-programme design. This involves assessments at the beginning and termination of the programme. This approach was

critiqued by the authors for not covering longer time periods and for not measuring change over time after the programme. This qualitative study does not aim at measuring change, but rather to explore the experience of the family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. Nonetheless, I wished to leave a gap of one to two years between the termination from the programme to the interviewing process, in order to leave space for the family to discuss their experience of life after the programme. Considering my past employment in this same programme, I chose to exclude the persons that I had directly worked with myself, as I wished to ensure loyalty to the participants' experience and I feared that this would have been more difficult if I was also directly involved in the experience of the phenomenon being researched.

The participants were chosen using a convenience sampling technique, which, according to Marshall (1996), involves the selection of the most accessible subjects. Participants were recruited through the residential mental health rehabilitation service which contextualised my research. A meeting was held with the service Operations Manager, where I had expressed my interest in conducting this research at this specific organization. I was granted both verbal and written consent from the Operations Manager, with whom I offered to share the results of my study. Members of staff were then informed of my research following the acceptance of my research proposal and once I was granted permission by the Institute of Family Therapy Malta Ethics Approval Board to carry out my research. Families who fit the criteria and who were interested in participating in the study were referred to me by the staff members working at the residential mental health rehabilitation programme. One family was randomly chosen and contacted, but declined the proposal. Another family was then randomly selected and the members agreed to participate.

### 3.5 Reliability and Validity

Lyons and Coyle (2007) state that quantitative psychological research is often assessed according to its reliability, as well as its internal and external validity. These criteria assume objectivity in order to limit researcher bias which acts as a deviation from facts. As discussed earlier on, qualitative research does not perceive researcher bias as inappropriate. Nonetheless, Yardley (2000) as cited in Lyons and Coyle (2007), states that elements of ‘sensitivity to context’, ‘commitment and rigour’, ‘transparency and coherence’ and ‘impact and importance’ (pp. 22) contribute to good qualitative research. I have tried, to my best of abilities, to ensure the presentation of a good qualitative research by following these guidelines.

<b>Elements of good qualitative research</b>	<b>Explanation</b>
Sensitivity to context	The clarification of the context in which the study was carried out, such as the historical and socio-cultural influences
Commitment	The researcher’s extended engagement with the topic being researched
Rigour	The demonstration of completeness in data collection and analysis
Transparency	The researcher’s disclosure and discussion of the research process
Coherence	The relationship between the research question and the methods of collection and analysis of the data
Impact and Importance	The study’s theoretical, practical and socio-cultural influence

**Table 1 Elements of good qualitative research, Yardley (2000) as cited in Lyons and Coyle (2007)**

## 3.6 Ethical Issues

---

Participation in my research was voluntary, informed and unpaid. In the unlikely eventuality that research participants would have required support following my interviewing process, they were offered the possibility to receive follow-up support by a Systemic Therapist at the Institute of Family Therapy Malta.

Informed consent was obtained in writing by means of a consent form which I provided every research participant. The participants were also provided with an Information Sheet, where they could find the contact number of the Institute of Family Therapy Malta in case they needed to pass on any feedback or complaints. A sample of the consent forms and information sheets, both in Maltese and English language can be found in Appendix B. I was insured against professional negligence claims by The Institute of Family Therapy.

The interviews were voice recorded and then transcribed. The research participants were fully informed with regards to this process and I obtained a written consent from each participant granting me permission to do so. Every research participant was informed of their rights to anonymity and confidentiality. One of my main concerns was that in Malta we have a limited number of residential mental health rehabilitation services, and thus I was more careful with handling the data in such a way that safeguards the anonymity and confidentiality of my participants.

The voice recordings and transcripts were stored in a password locked folder where only I had access to them. The research participants had ultimate ownership of the data. The recordings were disposed of once the data was transcribed. Names and any information which may make my

research participants identifiable were changed in order to eliminate this risk. One example of how this was done was by changing the names of the participants in the transcripts to fictitious ones. Parts of the transcript which shared the parents' or daughter's current employment details were also intentionally not selected in the quotes which were presented in the Results Chapter.

### 3.7 Data Analysis

---

The model of Interpretative Phenomenological Analysis as suggested by Smith, Flowers and Larkin (2009) was applied in this study. The voice recordings containing the semi-structured interviews were initially transcribed in the Maltese language as this was the participants' language of choice while interviewed. Once the transcription was complete, I attempted to immerse myself in data by reading the transcripts thoroughly. In order to begin the process of entering the research participants' world, Smith, Flowers and Larkin (2009) urged the researcher to actively engage with the data. Linguistic comments and Conceptual comments were then noted down. The next step involved the establishing of themes that emerged. These were then organized according to patterns and connections which started to emerge. The subthemes which emerged were organized under four superordinate themes. My interpretation and discussion of these four superordinate themes and the subsequent subthemes can be found in the findings and discussion chapters. A sample of the analysed transcript can be found in Appendix C.

## 3.8 Researcher Reflexivity

---

I wished to dedicate this section to making my own experiences, biases and judgements around the subject being researched known by those reading my study. This wish came from the belief that in a qualitative study such as this, my self and my voice will inherently come out in the way I interview my participants, and just as importantly, in the way I interpret and present data. I also wished to share my personal reflections on the research process.

### 3.8.1 My experience of working in the field of mental health

---

As I explained in depth in the Introduction chapter, I carry with me my experience of having worked in residential mental health services in the past. While providing me with the inspiration to carry out this research, my experience of working in this field has also provided me the opportunity to form my opinions and beliefs around the subject. Throughout my employment, I learnt to hold an appreciation for the clients as unique individuals. The applicants' referrals to the residential services where I worked, were aimed at gathering information about the clients' mental health diagnoses, signs of relapse and psychiatric history. I believe that such information has its value.

However, through getting to know clients in a residential setting, where people form part of a community that highlights strengths as resources utilised towards the recovery of the community, I learnt to see that there is so much more to people than their diagnosis. In this study, I believe that I carried with me this appreciation for uniqueness of experiences and the interest in a picture that

is wider than one which solely focuses on pathology. While embracing my enthusiasm to learn about the research participants' narrative of their unique experiences and my interest in exploring a wide systemic view of the phenomenon, I also wished to pace myself during the interviews and to stay with the stories that the participants share. I also wished to be aware of this during the analysis of my findings, and their discussion.

### 3.8.2 Reflecting on the interviewing process

---

The interviews were held in the participants' home on their request. Since I had made arrangements for interviews to be held either in the therapy room at the Institute of Family Therapy or in the counselling room of the organization that referred the participants, I initially offered these two options to the family. The family explained that their wish to hold the interviews at their home was based on two reasons. Firstly, the location of the Institute of Family Therapy was out of their way, and considering that I was meeting the same family three times, they preferred somewhere which was more convenient. They also stated that they did not feel comfortable with having the interviews in the residential facility as they would have been recognized by staff members working there. Due to my wish for the participants to feel comfortable and to make this process as least of an inconvenience for them as possible, I accepted to hold the interviews in their home. Since I currently work in a service offering Home Based Therapy, there was an element of familiarity for me too in meeting people in their homes. I have also come to appreciate how in my work, some clients have expressed feeling safer and more contained when meeting in their home, and I hoped that accepting the research participants' request might possibly leave them with a similar experience.

Prior to this dissertation, I had two other experiences of carrying out semi-structured interviews. The interviews that had been carried out in my previous researches were one-to-one where I could focus on the experience of one participant at a time; while in this study I aimed to have multiple family members participating in my interviews. While I wished that the siblings were also participating in the study, I still had three family members present; the mother, father and daughter. I found myself drawing from the professional skills learnt during my Family Therapy studies; which were very useful both for my confidence while interviewing a group of people, as well as for asking questions that elicited not only the content of the participants' experience but also the processes which the family went through. Another skill which I heavily relied on was my curiosity. I believe that while I carried with me my experience of working in the field of mental health, I have learnt to remain curious and open to learn about the participants' experience.

The family seemed at ease during the interviewing process. The participants claimed that through being given a voice in this research, they hoped to support other families going through experiences which resonate with theirs. In my opinion, I believe that their desire motivated them in being very honest and open in discussing their experiences. It also gave the family the freedom to voice their criticisms and suggest what can be done differently with families.

## 3.9 Conclusion

---

This chapter provided a detailed description of the methodology used in this study, and my rationale for my choice of methodology. The next chapter will present the findings that emerged from the application of this methodology aimed at eliciting the experience of a family of an adult who has

re-entered the parental home following the completion of a local residential mental health rehabilitation programme.

# **Chapter 4**

---

## **Presentation of Findings**

## 4.1 Introduction

---

The research participants generously shared unique and detailed aspects of their experience as a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. This chapter aims at presenting the different views shared by the participants.

The chapter will start with a brief description of the participants. I will then proceed to presenting an illustration of each super-ordinate theme and the related sub-themes which have been elicited from the analysis of the detailed and rich transcript originating from the interviews held with the participants. Each theme will be presented in Table 2.

Following this, each theme will be described in detail and substantiated with excerpts from the original transcripts. Pseudonyms are used throughout this study to protect the participants' confidentiality. Personal information that could lead to the identification of any of the family members was either altered or left out to ensure anonymity.

## 4.2 The research participants

---

The following legend and genogram present basic information about the family participating in this study:

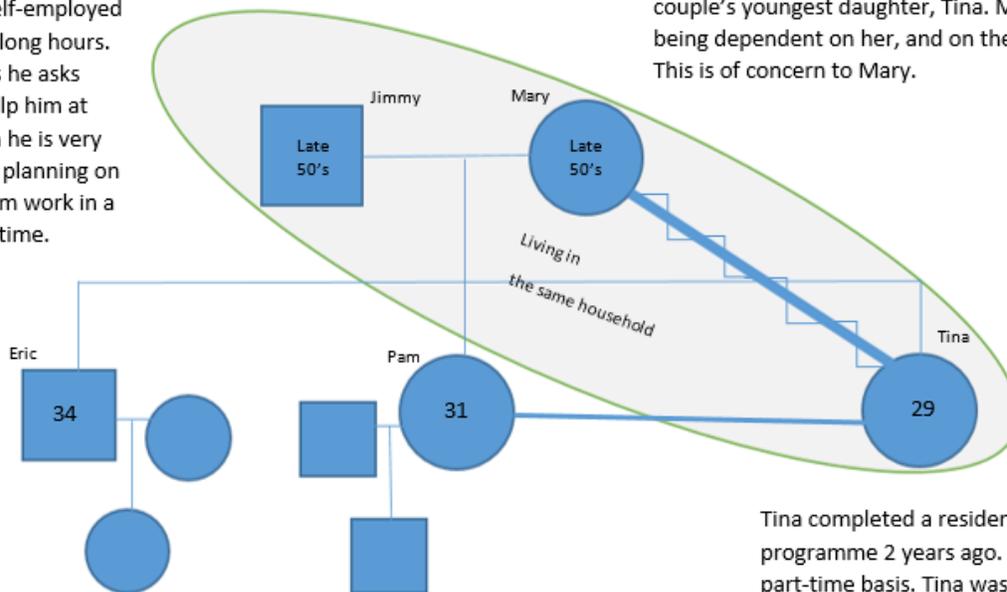
**Legend 1**

Pseudonym	Role
Tina (present in all 3 interviews)	Client, Youngest of siblings
Jimmy (present in all 3 interviews)	Father
Mary (present in all 3 interviews)	Mother
Eric (not present in interviews)	Son, Eldest of siblings
Pam (not present in interviews)	Daughter, Middle child

**Genogram 1**

Jimmy is self-employed and works long hours. Sometimes he asks Mary to help him at work when he is very busy. He is planning on retiring from work in a few years' time.

Mary is a homemaker. She is the main carer of the couple's youngest daughter, Tina. Mary views Tina as being dependent on her, and on their relationship. This is of concern to Mary.



Eric is described by the family as reserved and distant. He is married and has a daughter.

Pam is married and lives with her husband, with whom she has recently had a baby boy. She has a close relationship with Tina, and she was described by other members as someone that takes sides with her sister in family arguments.

Tina completed a residential mental health rehabilitation programme 2 years ago. She is presently employed on a part-time basis. Tina was diagnosed with a mood disorder and experiences symptoms of depression. She describes strain in her relationship with Mary.

## 4.3 Table of Themes

---

Table 2 illustrates the super-ordinate themes along with the sub-themes. This list of themes has been elected from the original transcript of the three participants. A sample of the transcript can be found in Appendix C.

**Table 2**

<b>Super-ordinate themes</b>	<b>Sub-themes</b>
4.4 Reasonable Hope for Change	4.4.1 The family defining the problem
	4.4.2 Parents longing for peace of mind
	4.4.3 Exploring theories around recovery from mental health problems
4.5 Difference in experiencing changing contexts: Home and the Programme	4.5.1 Doing things my way
	4.5.2 Witnessing new stories of resilience
	4.5.3 Getting to know each other
	4.5.4 Parents balancing space and involvement during residential programme
4.6 Experiencing and witnessing a struggle for adaptation at re-entry	4.6.1 Acknowledging a loss for the client
	4.6.2 Linking Happiness and Autonomy
4.7 Holding on to acquired new experiences	4.7.1 The meaning given to employment
	4.7.2 Expecting more

## 4.4 Theme 1

### Reasonable Hope for Change

---

The participants explained their perception of the family's situation prior to Tina's application for the residential mental health rehabilitation programme. The conversations related to this part of the participants' experience were problem-focused and brought forward stories around dependence, and the associated frustration, blame and judgements, isolation and anxiety. Different ideas around what was perpetuating the level of dependence in relationships in the family were explored. In between the lines of the participants' problem-saturated narratives around the period prior to the programme, the family explained that they still held reasonable hope that the residential rehabilitation programme could support them in their wish to change.

#### 4.4.1 Sub-theme 1:1

##### The family defining the problem

---

A conversation between the family was held around their definition of the problem. The participants explained that this was important for them to share, as it was through their definition and experience of the problem that they could identify their expectations for Tina's mental health rehabilitation programme. Every family member discussed their idea of dependence in the family, and recognized this dependence as a main concern. Mary explained her wish for her daughter to form friendships and relationships with persons outside the family. She expressed that Tina relied solely on her mother for company, which she believed, restricted Tina from building and investing in relationships with others.

*“I used to think “My God, she does not have anyone to go out with. She spends all her time with her mother.” That’s what I say to her... would a man approach her if he had to always see her with her mummy” (Mary L.873-874)*

Jimmy discussed his perception of the closeness between Mary and Tina prior to the programme, and how he experienced his wife as struggling with adjusting to Tina leaving home to start the residential programme. While Jimmy also explained that he viewed Tina as being dependent on her mother, he expressed that the dependence between Tina and Mary was not one sided, but rather that he viewed a certain element of interdependence in the relationship between Tina and Mary.

*“I think that they were both too close, it was like the only thing in her [Mary] life is Tina.... Just her.... And I can understand that... because our daughter needs so much from us. But I think that my wife used to focus so much on our daughter...” (Jimmy L. 219-223)*

Tina explained this dependence in terms of her not having the space and freedom to choose. These perceived restrictions were expressed as strain in the relationship with both parents but mostly with her mother.

*“I should be allowed to choose. There is no need for my mother to choose my own clothes; I am not a child. And when I used to try, she would still not approve and she would complain. That’s what we were like. We argued all the time.” (Tina L.183-185)*

Mary, who was presented by the family as Tina’s main carer, spoke about her experience of blame. She explained that she experienced the strain in the relationship with Tina as messages of blame

for the daughter's difficulties. This blame was interpreted not only through the strain in the relationship between Mary and her daughter, but also through blaming messages received from other family members. This blame, according to Mary, placed her in a position where she felt judged, isolated and unsupported by the system.

*“She [Tina] had told her sister [Pam] “I am fed up.” And her sister would tell me “That’s why she [Tina] wants to leave home! Because of you. Because you cannot leave her alone and give her some space.”... Instead of supporting me in my point, they would blame me... And I would feel lonely.” (Mary L. 737-740)*

Mary also spoke about perceiving that she does not have the space or permission to share her responsibility with her husband, which also adds to feelings of isolation and lack of support.

*“If I lose control and I start to shout, she [Tina] would say “Shut up or he [Jimmy] will hear you”. It doesn’t matter that I’d be feeling angry, as long as her dad does not hear us and he’d have to shout too.” (Mary L. 808- 810)*

Mary explained that she hoped that during Tina's programme, the professionals would validate her position in her relationship with Tina rather than take a blaming stance. She expressed a wish to be acknowledged for doing the best she can as a mother.

*“I wanted them to repeat what I did with Tina.... So that maybe through the year she would have spent there... she would start to think “They say the same things my mother says, which means that my mother was right if they are saying the same thing. My mother was right.”” (Mary L.595-596)*

## 4.4.2 Sub-theme 1:2 Parents longing for peace of mind

---

Both Mary and Jimmy disclosed their wish to know that their daughter would be able to cope and survive without their support. They both explained that they were becoming more aware of their vulnerabilities and of their mortality, and felt the need to explain this to Tina every so often with the hope that this would further motivate Tina to work on herself and her skills.

Both Mary and Jimmy expressed that they hoped that the residential programme would support Tina in building her Independent Living Skills, and that this would in turn, lessen their anxiety around their daughter's quality of life in the future.

*"...that she does not need us as much. I believe that we all need each other... in different ways. Her [Tina's] siblings need us. And we need our children. But I wish to have peace of mind that if we are not in a position to give her what we are giving now... (Pause)... That she will be ok as well... that she would be ok without us." (Jimmy L.357-360)*

*"I have another daughter, one year older than her. I can see the difference. That her sister can do so much by herself. But Tina always needs help. Do you know what I mean? And I wished that in some ways... well I am not eternal.... If I had to pass away, I want her to be capable to do things and I want for her to not depend on her siblings like she depends on us." (Mary L.331-333)*

Jimmy spoke about his employment, and how he is working hard to save-up money for Tina's future. This offers him some reassurance and comfort in knowing that his daughter will have financial stability even when the parents are no longer present to provide her with money.

*“Sometimes people just stay there [at Jimmy’s place of work], and I can’t leave. I get annoyed at times, but I can’t just pack up and go home. But then... I’m working for her [Tina]. That’s why I work. Not for us. For her to have enough for her future.” (Jimmy L. 558-561)*

### 4.4.3 Sub-theme 1:3

## Exploring theories around recovery from mental health problems

---

The research participants spoke about their theories of what supports the recovery from mental health problems. They spoke about how Tina had successfully completed a Day User programme at the same residence when she was ten years younger, and also discussed what their experience had taught them about change and mental health problems.

The participants claimed that they all held the same views around psychoactive medication. Despite agreeing that medication helps in the stabilization of symptoms of mental health problems, they also shared the belief that there are other means that support the recovery from mental health problems.

*“We always thought that there were different kinds of help, not just medication. There were other things like the programme that could help her.” (Mary L.81-83)*

*“Even our discipline. We would say when something was out of line. That’s it. That’s what we thought and still think that she needs. You see people on medication... their whole life on medication. They start and never stop.” (Jimmy L.85-88)*

The family explained that through Tina's first programme, they had also learnt about the importance of Tina having a meaningful routine. They explained how the Day User programme gave Tina a purpose to get out of bed in the morning and motivation to go out. Mary explained that she had asked the mental health professionals to extend the Day User programme as she was appreciative of Tina's progress, but procedure required that the programme was terminated after a year. Upon the termination of the programme, the family explained that Tina lost her meaningful routine, and with it, the progress that Tina had made. The participants explained their belief that a residential programme can bring about long-term change.

*“She fell back into her old routine. While she was still there she was changing and improving... so much! That's why I had asked for them to keep her. When she came back home, I mean, when she had nowhere to go, it all started again. Being lazy, she was not doing anything, and then the irritability and sadness started.” (Mary L.111-114)*

The parents also shared that they held the belief that for their daughter to recover and learn, she would need to surround herself by those who are considered as better than her.

*“We always wanted her to be around those who are better than her so that maybe she learns from them and gets better.” (Jimmy L.286-288)*

## 4.5 Theme 2

### Difference in experiencing changing contexts: Home and the Programme

---

The participants compared their experience of Tina being at home to Tina being at the residential facility. They reflected on the difference between home as a context and the residential programme, and how they viewed this difference in context as being linked to changes which they had started witnessing in Tina and experiencing in their relationships.

#### 4.5.1 Subtheme 2:1 Doing things my way

---

Both Mary and Jimmy reflected on how they believed that their concern towards Tina and her wellbeing restricted Tina's space to risk, choose and develop her own way of doing things. They both observed that she had more space to do so during the residential programme when compared to the space she had at home prior to the programme.

*“When I got married and left home I did not remain the same as I was at my mother’s. I was more relaxed since I did not have anyone chasing me to do what they expected of me... my mum used to push me to do things her way. When I left home I did things my way. So I was more relaxed” ... “At the programme she could make her own choices like the adult that she is.” (Jimmy L. 648-654)*

Tina spoke about how she also experienced that she had more opportunities to make choices and have a voice while she was following the programme. She explained how she experienced the programme's routine as structured, but also as one which allowed the space for choices to be made.

*“There we had a structure and a time. There was a time for everything there. Groups, meetings, cleaning, cooking... we had a time table. But then there were other things which I could choose. We chose what we ate, what we discussed in groups, I could go out, have free time with friends, shower when I wanted. So you start to feel good. Like... oh...it's different here!” (Tina L.661-665)*

## 4.5.2 Sub-theme 2:2

### Witnessing new stories of resilience

---

While Tina experienced more space to choose and develop, Jimmy explained how he felt restricted in how well he could protect his daughter while she was following the residential programme.

*“It was hard... really. I used to get into bed at night, that's really the worse time, after a whole day. And I would think to myself, I wonder how our daughter is. I wonder what she did today. I wonder if she went to bed as well.” (Jimmy L. 779-781)*

However, Jimmy also explained that while he could not offer Tina the same protection he used to offer while she was still living at home prior to the residential programme, he also started to appreciate Tina's ability to take care of herself and cope even during challenging times.

*“There were times where bad things happened while Tina was there. Sometimes other residents fought, and she would tell us. I wished she was home and safe. Sometimes I wanted to go and bring her back home. But she managed to cope well even during times of crisis. I mean, she is tough. I know we try to protect her, but she is really tough.” (Jimmy L.786-790)*

### 4.5.3 Sub-theme 2:3 Getting to know each other

---

The family discussed their experiences of other changes which happened in their relationships while Tina was still following the residential programme.

Mary disclosed that during Tina’s programme, she started to realize that she could begin to see aspects of her daughter’s personality which she could not see before. She described how the change in context brought out these differences in her daughter, and also explained that she felt as though she was just getting to know who her daughter is.

*“She had a lot of friends there. Everyone used to comment to me about how much she laughs. They used to say her personality lights the place up. It’s like her personality could shine.” ... “She completely changed. I used to say to myself... this is Tina. This is who Tina really is.” (Mary L. 439-442)*

Tina explained that this discovery was mutual. She claimed that she started having different conversations with her mother while she was following the residential programme, which widened Tina’s perception of her relationship with her mother.

*“I saw that we got along better when I was there. I would really be eagerly waiting for her to come, and I used to like having her [at the programme]. There I used to have a lot more to say to her, because we weren’t together all the time. We spoke about different things. At home we always spoke about the same things. At home it’s about clothes, and how I look. While I was there it was about my week, how things are going, about the people I spend my time with. I enjoyed that.” (Tina L. 757-763)*

#### 4.5.4 Sub-theme 2:4

### Parents balancing space and involvement during residential programme

---

Both Jimmy and Mary disclosed that they experienced a struggle with striking a balance between wishing to give their daughter the space for her to continue progressing during her programme but also remaining involved in the process of change at the same time. They explained that finding this balance was important to them, especially due to their belief that this balance was key to the continuation of Tina’s progress after the termination of the residential programme. Mary explained that she experienced a push for the parents to not get involved in their daughter’s progress while she was still a resident. She argued against this logic and claimed that this worked against the aim of the programme when one thinks in terms of maintaining the progress made in the long term.

*“Sometimes they forget that we are part of our children’s lives and that when they come back home, they come back to living with us. So we need to be part of it in some way. If we’re not, it’s just no use.” (Mary L.851-853)*

Jimmy also explained his belief that even if persons following the programme manage to change and progress in their recovery from their mental health problem, there would be a risk for the progress to not be upheld if their lives and routines outside the programme remain the same. Similarly to Mary, he also explained that he wished that as Tina's parents, they were provided with the space to be part of their daughter's process of change.

*"I'm not sure. Because it's true... it's like they need space to grow and learn. But then they come back home and everything is still the same... same old routine, saying the same things, everything the same. I don't know, it's not easy. But everything needs to change for change."*  
**(Jimmy L.859-862)**

While both parents' critiqued the level of family involvement in the programme, Mary identified the monthly Multifamily Group held at the residence as a beneficial space to show her daughter that she is interested in being part of her life during the residential programme.

*"I think that she [Tina] enjoyed having me there. She wouldn't really say it. But I think she saw that I showed an interest and wanted to be part of what she was doing. So that small space... I enjoyed it and I think she could see that I wanted to support her and that I had not forgotten about her."* **(Mary L.863-842)**

Mary also explained that through her involvement in this group, she felt that her position and struggles as a mother were validated by other parents who attended the group.

*"It helped me see that I am not alone. Kind of. There was a period where I felt as though I was having a break down. Because I didn't know... you start wondering if I'm alone. If it's just me. Then when you talk to others, you understand it's not just you."* **(Mary L. 818-821)**

## 4.6 Theme 3

### Experiencing and witnessing a struggle for adaptation at re-entry

---

The family spoke about their experience of Tina's return back home at the completion of the residential programme. Each participant expressed how this period was a struggle to them in different ways.

#### 4.6.1 Sub-theme 3:1

##### Acknowledging a loss for the client

---

Tina explained that it was a struggle for her to adjust to returning back home at the completion of her residential programme. Although she claimed that she looked forward to being back home, she still explained that she had adjusted well into the routine of the programme and to being part of the community there. She acknowledged the loss of what she had to leave behind upon the completion of her programme and explained how she wished to remain connected to her experience of the programme.

*"I used to keep myself busy there. And we always had things to do. The day used to pass really quickly. I wished to come back home, really, I wanted to. But we used to have a good time there." (Tina L.234-236)*

*"I had gotten used to being with other people there and it was hard to leave. I wanted to know what was still going on there even after leaving." (Tina L. 204-205)*

## 4.6.2 Sub-theme 3:2 Linking Happiness and Autonomy

---

Both Mary and Jimmy explained how they started to experience their daughter as being less happy following her return home. According to Jimmy, the programme gave Tina the possibility to be autonomous when making choices and taking responsibility for these choices. Jimmy believed that this sense of autonomy was linked to Tina's increase in happiness while she was still a resident, and that her subsequent unhappiness reflected her loss of autonomy upon the completion of the programme.

*“She was used to having more freedom there. That she could try new things and take responsibility for her own things.” ... “At times I think that that’s why we saw a different side to her there. It’s like when she had more freedom, she was happier. I think that’s why.” (Jimmy L.628-632)*

Mary spoke about how she experienced added strain in the relationship between her and her daughter following the completion of the residential programme. While she acknowledged that prior to the programme, her and Tina used to argue often, she noticed that they argued more or differently upon the completion of the programme.

Mary explained how in her opinion, Tina became accustomed to having more freedom while she was away from home. On her return, Tina's experience of being in a space where she was perceived as being more autonomous and Mary's ideas around priorities and maintaining structure started to clash.

*“I used to give importance to certain things, but there she was given more freedom. And when she came back home, I started to get on her nerves. I annoyed her because there she used to get away with certain things. I became the devil to her. Because I give importance to certain things. I do not want her to go out and look scruffy. People would laugh at her if she did. But why is it that I have to be the one pointing out certain things?” (Mary L. 598-603)*

Mary explained her struggle with understanding Tina’s sadness. She explained how she started reacting to her daughter’s sadness by worrying more about her, and doing everything for her daughter to be happy.

*“I don’t know why... I cannot understand why this girl has to be so moody and sad. Even when I try to do everything for her. She has no reason to be unhappy. I really don’t know why.” (Mary L.827-830)*

*“There’s nothing that I haven’t given her to try and make her happy... but... I don’t know what else I can do.” (Mary L.508-509)*

## 4.7 Theme 4

### Holding on to acquired new experiences

---

The participants spoke about how significant their experience of change during the residential programme was to them and about how they hoped to hold on to this change even at the completion of the residential programme. The family members' experience of the long-term impact of the programme on the family was discussed.

#### 4.7.1 Sub-theme 4:1

##### The meaning given to employment

---

The family explained that Tina was employed for the first time shortly after her return home. Mary spoke about how prior to this, she had started to fear that the progress experienced during Tina's programme would not be maintained long-term. Nonetheless, through Tina's employment, Mary observed that her daughter managed to give structure and routine to her life and explained how this gave Mary hope that there was space for more progress.

*“They [professionals] had told her in my presence. To keep doing the things she learnt there... but I don't know. I think I expected things to go back to how they were before when she came back home. But then she started working, and I thought, at least maybe things will keep progressing after all. Even if it's just for her to make friends.” (Mary L.707-710)*

Mary explained how in the past, the family members did not experience the desired long term change following Tina's first Day User programme. In her opinion, this experience positioned her and her husband in giving even further importance to the possibility that progress can be maintained through Tina's employment following this residential programme.

*“We already had that experience when she did her programme at 16. I know what she went through, and when it ended [the programme] everything collapsed again... She does not need to go to work... kind of... but if she stops having contact with people, she would go back to spending all her time here with us. She'd be sleeping till noon, waking up, eating and then going back to sleep... what sort of life is that? Wouldn't that be monotonous?” (Mary L.310-315)*

Tina, however, expressed feeling unhappy at her place of work due to her employer and colleagues taking advantage of her kind nature. The participants agreed on their view that fear is typically the most obvious sign of stigma, and that Tina was generally not feared by others. Nonetheless, she was still treated differently to how her colleagues were treated because she came across as vulnerable. Each participant explained their disappointment and hurt in perceiving that this employment did not provide Tina the same happiness and confidence that she experienced during the programme.

*“And I need to do everything myself, even when I'm not meant to. They do not ask anyone else to do it... just me. So I'm not happy with that. And I want to say to them... I would want to say something, but I'm scared.” (Tina L.511-513)*

Both parents reported being concerned for their daughter's unhappiness at work. They explained that while they wished for Tina to be happy, they still felt the need to hold on to the changes in the family's routine by supporting Tina with remaining employed.

*“To a certain extent, I do not want her to stop working, because if she does we would go back to square one. Back... to our old routine. So it's best to keep going to work. But at the same time I do not want her to be unhappy. I want her to go to work and be happy that she went to work. I want her to come home and say “We had such a laugh today”.”*  
**(Jimmy L.427-430)**

## 4.7.2 Sub-theme 4:2

### Expecting more

---

Mary explained that there were other skills gained and utilized throughout the course of Tina's residential programme which were not carried back home following re-entry.

*“She made her own bed, cooked and helping with the cooking [during the programme]. But here she does absolutely nothing. Nothing at all. So much so that up to this day I have to keep asking “Have you brushed your teeth?” Did you wash your face?” “Go wash your hair.” Do I really have to ask? Come on... she is 29 now... she is not a little girl.”*  
**(Mary L.193-197)**

Mary claimed that Tina's older brother, Eric, interpreted this discrepancy as Tina lacking the motivation and interest to practice her skills. Mary, who used to believe that Tina was not capable

of performing certain tasks such as cooking and cleaning prior to the programme, started to subscribe to her son's view after having witnessed that Tina was in fact capable.

*“I think her older brother [Eric] is right.... I think her older brother is quietest one, but then when he says something he is usually right. He told me “Mum, it’s not that she doesn’t know how. It’s just that she doesn’t want to.” And it’s true.” (Mary L. 747-750)*

*“I think that she [Tina] did learn a lot from there [the programme]. But when she came back home... nothing. Really nothing at all. She doesn’t even try.” (Mary L.239-241)*

## 4.8 Conclusion

---

The findings of this study, which were presented in this chapter, will be discussed in light of elected literature that discusses the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. The original Maltese quotes can be found in the Appendices section. This discussion will be presented in the following chapter.

# Chapter 5

---

## Discussion of Findings

## 5.1 Introduction

---

This exploratory study was designed to shed light on the in-depth experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. The outcomes that emerged from the contributions shared by the three participants that were interviewed indicate a variety of perspectives about this experience. The aim of this chapter is to discuss the salient findings based on the elicited themes and to give meaning to the participants' reflections substantiated by literature on their unique and particular experience.

## 5.2 Salient findings

---

### 5.2.1 The family's hope that the programme can support them in experiencing the desired changes, notwithstanding their experiences of isolation, blame and anxiety

---

During their description of life prior to the programme, the research participants discussed at length their experience and interpretations of dependence in the family. This was explained by the participants in terms of space, where they shared their wish for change in the family through the renegotiation of boundaries. The participants hoped that this would reduce dependence and increase independence in the family relationships. Systemic change as described by Colapinto

(1982) is a reaccommodation of the system in order for it to adjust to a different need. Each research participant explained their motivation for this renegotiation of boundaries in the family.

Firstly, the daughter's wishes to have the space to become more autonomous were explained. According to Bowen's theory on individuation, the family's index patient is typically the least differentiated member of the family through having had the least opportunity to separate emotions and feelings from those of the larger family (Bowen, 2004). The daughter expressed that she experienced restrictions in her choices, and limited space for her to make decisions. These perceived restrictions were, according to the three participants, expressed as strain in the relationship between the daughter with both parents but mostly with her mother.

The mother experienced this strain in the relationship with her daughter as messages of blame for the daughter's difficulties and dependence. This blame was interpreted not only through this strain, but also through blaming messages received from other family members. These messages left the mother feeling isolated and unsupported in the position that she occupied in the system, and this were further exacerbated through perceiving a lack of opportunity to share her responsibility with her husband. The theme of caring responsibility in Maltese family is strong, where family members typically feel obliged to care and support one another (Abela, 2016). Borg Xuereb (2008) explained that traditionally, Maltese wives are responsible for caring for the children and the family, and thus these obligations of care are typically experienced as stronger by the females in the family. Darmanin Kissaun (2016) also explained that traditionally, Maltese women are expected to selflessly prioritise the family, and to be available to care for the needs of family members. While the roles of the wife and the husband in the Maltese family have recently started

to shift, this description of the traditional role of a wife and the expectations from the mother in the Maltese family, possibly resonate with this mother's interpretation of messages from other family members as being told that the daughter's difficulties are her responsibility.

This gives rise to the second motivation for the described need for a shift in closeness and distance. The mother expressed how she wished to move away from the position which she occupied in the system. She believed that if during her daughter's programme, professionals were to validate and support her position in the system, then the family would acknowledge that she is doing the best she can as a mother rather than blame her, and that a new and possibly wider understanding of the family's struggles would bring her closer to members in the system.

Expectations from men in the Maltese family, are traditionally different to those of women. Men are traditionally expected to work and support the family from a financial aspect (Borg Xuereb, 2008). The father participating in this study, explained that he experiences an even greater responsibility in providing financial stability to his family as he also wishes to provide for his daughter's future. To the father, this means that he has to spend longer hours at work, which could possibly leave his wife in a position where she needs to continue taking responsibility for care in the family.

The parents shared their anxieties when thinking about growing older. Smith (2012) explained that his research participants reported that as mothers of adult children with a mental health problem, they experienced anxiety in their older age resulting from the continuous negotiation with themselves and their adult child regarding how and when their role of caregivers can end. Both the

mother and father participating in this study explained how their main concerns revolved around their daughter's future when the inevitable time comes that their daughter cannot rely solely on her relationship with her parents. The parents explained how they wished to have the peace of mind knowing that their daughter will be happy and will cope in the world when they are not there to support her. This wish became more pertinent to the parents as they grew older.

As an interviewer, I sensed heaviness in the research participants' narration of stories around the family's experience prior to the residential programme. This feeling was sustained through the participants' problem-saturated description of this part of their experience, bringing forward stories around dependence and the associated perceptions of frustration, blame and judgement, isolation and anxiety. In my opinion, it is important to consider the philosophy of the local culture around mental health when contextualising the stories narrated by families in receipt of mental health services. Hamkins (2014) observed that the stories of persons with mental health problems and their families are often heavy and reflect despair and failure at the point when they engage and consult with mental health professionals. Xie (2013) discusses how traditionally, the mental health systems adopted a view of mental health problems based on pathology, problems and failures, which could have further exacerbated and fed into the heaviness which families, such as the one being interviewed in this study, found themselves experiencing.

Community Mental Health Services in Malta started being offered in 1995, and the new Maltese Mental Health Act, which aims towards building a culture of recovery and rehabilitation of persons with mental health difficulties, started being implemented in 2013. One could argue that the movement away from the traditional mental health systems, which as described by Xie (2013)

perpetuate a focus on narratives of problems and failures, started relatively recently in the Maltese system and culture. According to Mizzi (1997) change in Malta happens at a very slow pace due to the size of the island, and the loyalty to traditional, religious and conservative values. As Grech (2016) explained, there are still concerns with regards to whether the local mental health services offered at present are equipped to cater for this shift to happen both on a philosophical level as well as on a practical level.

In between the lines of the participants' problem-saturated narratives around the period prior to the residential programme, the family explained that they still held reasonable hope that the residential rehabilitation programme could support them in their wish to change. Reasonable hope is defined by Weingarten (2010) as hope that is sensible and moderate, and which directs attention to goals which are within reach rather than those that are desired but unattainable. Reasonable hope is differentiated from general hope through its emphasis on working rather than waiting for and anticipating things to change. The participants believed that the residential mental health rehabilitation programme could provide the daughter with the space to make her own choices, the mother with support through empathy and validation from mental health professionals, and both parents with the peace of mind that their daughter can cope with less support from their end. The family's expectations from the programme seem to fit within the description that literature gives to the aims of rehabilitation. Liberman (2008) states that the rehabilitation of a person with mental health problems generally aims at supporting the individual with learning skills, enhancing their independence, integrating into the community, obtaining the highest level of functioning possible, living free of symptoms as possible and leading a meaningful life which offers personal satisfaction and self-efficacy.

The participants' reasonable hope in the residential programme was based on four beliefs:

- The belief in the benefits of pairing treatment through psychoactive medication and rehabilitation through the programme
- The belief that rehabilitation could provide the daughter with a meaningful routine
- The belief that the daughter will have the opportunity to learn from the success stories of other people in the programme
- The belief that a residential programme will be more intensive than a day programme, in a way that it will provide long-term change rather than temporary and short-term change

### 5.2.2 The family members' experiences of change in the client during the programme, and the parents' wish to be part of the process of change

---

The research participants all spoke at length about their perceptions, understanding and experiences of change and difference during the residential programme. Each family member participating in the study agreed that during the programme, the daughter experienced a difference in the opportunities and space available for her to make her own choices. While the father explained that the distance between him and his daughter during the programme left him experiencing new restrictions in how much he could be present to protect his daughter, he explained that he was reassured by how happy and confident he perceived his daughter during this journey. Both parents also spoke about witnessing their daughter's strengths and resilience to cope in situations for which they would have typically felt the need to take responsibility. This served as further reassurance.

Walsh (2011) discussed how a shift of focus from problems to the resilience and empowerment of families that are vulnerable and multistressed, typically enhances positive interactions and supports coping efforts. This shift also helps in building confidence in the family that its members have resources that are effective in reducing stress (Walsh, 2011). The daughter explained that during the programme, she was being provided with the opportunity to go through the process of being empowered to discover her personal resources. Nonetheless, the parents interpreted that mental health professionals gave them messages to minimise their involvement during the programme. This led to the parents' dilemma when balancing space and involvement.

The participants started to interpret the change in the daughter as being the result of the new distance between Tina and her family. Opposing the mother's aforementioned wishes for her role as a mother to be understood and validated by professionals, the participants' interpretation of what led to the desired change could have possibly further increased the parents' feelings of guilt and responsibility for their daughter's difficulties. As their interviewer, I observed an element of divide between the family and mental health professionals in the language used by the participants; where the relationship between professionals and the family was depicted in terms of 'us and them'. While the parents wished to respect the push for them to remain peripheral during the programme out of love for their daughter, they also argued that they wished the family to be part of the process of change in order for this change to be maintained following the completion of Tina's programme. They argued that if change remained associated with the context of the programme, rather than a change occurring in wider family relationships and routines, then they feared that things will go back to the way they were prior to the programme when the service user re-enters the parental home. Gillum (2007) also found that family members participating in his

study felt concerned that the change experienced by their relative would not be sustained after the residential program and that their life would revert to being the same as it was before.

Ample studies and literature highlight the importance of the collaboration between mental health professionals and the families of persons with mental health problems. Sholevar and Schwoeri (2003) urge the need for the development of collaborative models where mental health professionals and families can work together as two major resources. When the pool of varied available resources belonging to the family, the service user, and the professionals is utilized, client recovery from mental illness is faster, dependence on health care services is reduced, the rates of rehospitalization and relapse decrease, treatment compliance is enhanced, and client interpersonal functioning and family relationships are strengthened (Centre for Addiction and Mental Health, 2004). Hendrickson (2017) suggests that family members should not only be encouraged to participate fully during their loved-one's residential programme, but that the programme also needs to cater for the family and client to go through a parallel process of change. Even though research argues strongly in favour of its importance, the family participating in this study explained how they did not experience this element of collaboration between the mental health professionals and the family members.

Although the participants perceived that they were not provided with the explicit space to go through a parallel process of change as a family, they still explained that the changes in the daughter while she was still a resident, implicitly brought changes in the relationships in the family. The family described a process of getting to know each other in a different light; which I interpreted as the process of the family's subjugated stories being given the space to grow into

stronger and more dominant narratives. Roberts (2000), stated that narratives around mental health shift to ones of hope, agency and self-determination in a space that emphasizes the culture of recovery and rehabilitation. The mother also explained that she chose to attend a family support group held monthly at the residence. This experience helped her connect to the experiences of other families, which helped her feel validated and which lessened her feelings of isolation within the system.

### 5.2.3 The family's experiences of loss and stress at re-entry

---

The third supra-theme that emerged from this study describes the participants' experience and witnessing of struggles to adapt to the re-entry of the daughter into the parental home. The participants explained their experience of loss of what the residential programme meant to the different family members.

The process of re-entry was primarily explained as a loss by the daughter. The daughter disclosed two main experienced losses; that of her sense of belonging achieved through being part of a community during her residence, as well as a loss of the structure and routine that the programme offered her. The parents on the other hand, explained the loss of their daughter as they had started to experience her during her programme. They explained how at re-entry, they no longer perceived their daughter as happy and confident. Based on the parents' interpretation of what made the daughter happy during the programme, they both concluded their daughter was missing the

freedom and space which she had and that she was finding it difficult to shift back to structure and demands of her family at home.

Bellmore (2013) explained that a clients' re-entry in the parental home can be experienced as a struggle when progress was not encouraged or acknowledged by the clients' relatives, and when the home environment does not support the changes made by the client. Colapinto (1982) explained that when the family system is faced by situations which require it to change and meet new needs, the system experiences stress and disequilibrium. While the family in my study explained that maintenance of change was desired and encouraged, the absence of a parallel process of change in the client and family as described by Hendrickson (2017), could have possibly meant that the family system was still not prepared and supported to sustain the change that happened.

Boszormeny-Nagy and Spark (1973) describe how during points of family restructuring and change, family members may feel disloyal to their family. Pressure from the system could push individuals who experienced a change to go back to old roles and patterns instead of bearing the uncertainty of change. In the family participating in this study, one could note that as a reaction to the daughter's sadness, which according to the parents was the reaction to the adjustment to a reduction in freedom, the parents' worry increased. The parents reacted to this worry by doing everything they can to make their daughter happy. The daughter possibly withdraws further in order manage space from her parents; which in turn may increase her parents' anxiety and worry. Engaging in this demand-withdraw pattern could have possibly continued to subjugate the stories about the daughter being resilient and strong in the way she coped with difficult moments, and

brought back to dominance the stories of the daughter being dependent on her parents for happiness. Such experiences fit within the parents' prophecy, mentioned in the previous section, that unless the process of change happens in within family relationships, dynamics and routines during the programme, then other changes in the client will not be maintained.

#### 5.2.4 The family's experience of mental health stigma in the community and the resulting struggles with maintaining long-term change

---

The research participants spoke about the daughter finding her first gainful employment following her re-entry into the parental home at the completion of her programme. According to the family, while most daily living skills acquired through the programme, such as cooking and cleaning, were never practiced at home, the participants spoke about the value they attributed to the daughter's employment as the main long-lasting change that emerged from this journey.

The parents shared their reflections around their view of employment as a means for their daughter to maintain the meaningful routine she had during her programme. The family explained similarities between the residential programme's routine and the routine of an employee; which consisted of having a reason to get out of bed in the morning and get dressed, meeting and socialising with people at work, as well as spending time outside the house. According to both parents, their daughter would have not had the opportunity to do any of these if she was not employed.

Each participant, nonetheless, explained their disappointment and hurt in perceiving that this employment has not been providing the same happiness and confidence that the daughter experienced during the programme. The family spoke about how the vulnerabilities and kind nature of the daughter were being taken advantage of by her employer when being asked to perform tasks that were not her responsibility and that were not asked of other colleagues. The participants agreed in their view that fear is typically the most obvious sign of stigma, and that Tina was generally not feared by others. Nonetheless, she was still treated differently to how her colleagues were treated because she came across as vulnerable. Maltese studies and literature described the intensity of the culture of shame and stigma in Malta. Gossip travels quickly in a face-to-face community such as the Maltese community; and as a consequence, persons who are considered to deviate from the cultural norm may feel the need to hide in order to avoid the anticipated shame and stigma (Clark, 2012). Despite of the participants' stories around the pain experienced through this incident and other past incidences of perceived stigma, the parents explained that they are still not willing to let go of the belief that their daughter is leading a more meaningful life through her employment.

In previous sections, I discussed that in light of my findings and the findings of other studies, there are numerous benefits in mental health services making a shift from supporting change in the individual to supporting a larger change in the family. The research participants' stories and other local researches around stigma also raise a concern around a bigger and wider change that might possibly still need to happen in Malta for community-based mental health services to function in supporting recovery and rehabilitation; that is, a shift in local culture and mentality.

## 5.3 Conclusion

---

The findings discussed in this chapter seem to indicate the multifaceted experiences of family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. The experiences that emerged were compared with existing literature presented in the literature review, whilst also introducing new literature that could enhance further understanding.

In the next chapter I will outline the limitations of this study and will put forward suggestions for future research. Finally, I will discuss the implications of the study and its relevance for the field of family therapy.

# Chapter 6

---

## Conclusion

## 6.1 Introduction

---

This chapter will outline the concluding remarks for this study. It will present a summary of the main findings together with the limitations that have been identified along this research process. Recommendations for future research as well as the implications for practice in systemic family therapy will then follow.

## 6.2 Summary of salient findings

---

The following salient findings emerged from this qualitative research:

- The family members participating in this study were hopeful that the programme would support them in experiencing the desired changes, notwithstanding their past experiences of isolation, blame and anxiety.
- The family experienced and witnessed change in the client during the programme; however, the parents expressed how they wished that they were more actively involved in the process of change.
- The participants experienced and witnessed loss and stress at re-entry.
- The interviewees spoke about their experience of mental health stigma in the community and the resulting struggles with maintaining long-term change.

## 6.3 Limitations of the study

---

- One main limitation of this study involved the absence of family members as research participants who could have possibly contributed more richness and complexity to the results of this study. Although the parents' two older adult children declined the invitation

to participate in the interviews due to other commitments, the use of Circular Questioning techniques were made use of during the interviews. These techniques enabled me to introduce the missing members' presence in the process nonetheless through the reflections and answers of those who were present.

- Another limitation of this study involved my limited experience as a researcher. Better expertise of the different steps involved in carrying out this study, most particularly while analysing data, could have led to deeper understanding, and a more advanced interpretation and refined presentation and discussion of results.
- During the interviewing process, I realised that information about the experience of the Mary and Jimmy as a couple was missing. While I asked questions around how they lived this experience as a couple, Mary and Jimmy answered these questions by talking about their role as parents. I could hypothesise that their role as parents caring for their adult daughter became their dominant story, while accessing and reflecting on stories about how they lived this experience as a couple became more of a challenge. I could also hypothesise that maybe they were not comfortable sharing their experience as a couple in front of their daughter; thus I wonder whether it would have been different to ask questions about this in the absence of the daughter.

## 6.4 Implications for Practice

---

The implications for practice which were derived from the participants' experiences and the literature reviewed shall be discussed in this section.

- Similar to findings in other studies and literature about the recent shifts in the field of mental health, the participants in this qualitative study highlighted the need for the implementation of a family-focused approach in local mental health services. This shift towards family-focused services could initially involve a thorough evaluation of the present local mental health services on a philosophical level, thus revisiting the culture of local services around themes of mental health, recovery and the role of families within the system. An evaluation of the infrastructure and the policies of service delivery could then also prove beneficial in the implementation of family-focused services.
- Embracing and giving a voice to the family system from the assessment stage, thus from the mental health professionals' first contact with the service user, could be one way of implementing a family-centred approach in services. This would allow the professionals to learn about the family dynamics and patterns, the family's past experiences of services, their hopes and wishes for the outcome of the service, as well as the resources and strengths of the family which would support them in reaching their goals.
- In the case of residential services, offering home-based family therapy during the programme could possibly support the family and client in order for them to move in a parallel process of change and growth. Home-based family therapy could serve as a therapeutic space for contact between families, the clients and involved mental health professionals in the family's home environment; thus ensuring not only the aforementioned parallel process, but also providing the space for collaboration between families, clients and professionals. Home-based family therapy could also support the link in merging of

the context of the residential programme and the context of the family home; especially when family members also participate in family support groups and activities held at the residence.

- The continuation of home-based family therapy could possibly also support the system in maintaining the changes that happened during the programme if offered for a period of time following the completion of the programme. Instead of assessing change at the termination of the programme, contact with clients for a period of time following the programme could also provide professionals working in the residence a more realistic assessment of the effectivity of the programme through long term change.
- The research participants shared powerful problem-focused stories around mental health problems and around the transactional patterns in the system which kept the problem alive for the family. A systemic approach applied in the field of mental health, could provide valid contributions such as through identifying and supporting the alteration of systemic patterns, deconstructing problem-focused dominant stories and discovering subjugated ones, and focusing on agency and resources of clients. In the push for a shift towards family-centred care and recovery in the field of mental health, I would question the lack of involvement of systemic therapists in both local government mental health services as well as in the leading in non-governmental mental health service providers.

## 6.5 Implications for Future Research

---

The implications for future research which were derived from the participants' experiences and the literature reviewed shall be discussed in this section.

- Following the numerous themes and the depth that emerged from my interviews with one family, I would be curious to learn about the findings of a larger scale qualitative study researching the same phenomena. This could possibly maintain the depth and the uniqueness of experiences as appreciated in a qualitative study, but also add width through the identification of stronger themes which emerge more commonly across experiences.
- In this study, I decided to include all the family members available in each interview. The interviewing of a different subsystem per interview could have possibly provided a different narrative than the once elicited in this study.
- Local quantitative research measuring and connecting themes such as family resources, family involvement and satisfaction with outcome of services is also lacking in the field of mental health. Such studies could support in the evaluation of present services and in the successful implementation of the new Maltese Mental Health Act.

## 6.6 Conclusion

---

This qualitative study was aimed at answering the following research question:

What is the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme?

I would like to conclude this study by expressing my gratitude and appreciation for the research participants who have so generously shared their experience with me and the readers of this study.

While hoping that the findings of this study were valid contributions to the field of interest, the participants' experience has also reminded me of its complexity. A complexity which has still left me feeling hopeful when looking forward towards a vision of the change and progress to come.

---

# Reference List

## Reference List

- Abela, A. (2016). *Family Life*. Retrieved from [www.academia.edu/32363279/Family\\_Life.pdf](http://www.academia.edu/32363279/Family_Life.pdf)
- Abela, A., Farrugia, R., Vella, A. M., & DeGiovanni, K. (2016). Familialistic countries need a family-inclusive service when caring for people with mental health problems – the case of Malta. *Families, Relationships and Societies*, 5(2), 313-331.
- Abela, A., Frosh, S., & Dowling, E. (2005). Uncovering beliefs embedded in the culture and its implications for practice: the case of Maltese married couples. *Journal of Family Therapy*, 27(1), 3-23.
- Agius, M., Falzon Aquilina, F., Pace, C., & Grech, A. (2016). *Stigma in Malta; A Mediterranean Perspective*. *Psychiatria Danubina*, 28(1), 75-78.
- Baronet, A. (1999). Factors associated with caregiver burden in mental illness: A critical review of the research literature. *Clinical Psychology Review*, 19(7), 819–841.
- Barriball, K. and While, A. (1994). Collecting data using a semi-structured interview: a discussion paper.
- Bellmore, S. (2013). *The reentry of young offenders: a look at reintegration*.
- Boszormenyi-Nagy, I., & Spark, G. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy*. Hagerstown, MD: Harper & Row.
- Bradford, S., & Clark, M. (2011). Stigma Narratives: LGBT Transitions and Identities in Malta. *International Journal of Adolescence and Youth*, 16(2), 179-200.
- Buttigieg, G. (2012). *The New Mental Health Act 2012*. Retrieved from [https://deputyprimeminister.gov.mt/en/commmentalhealth/documents/write\\_up\\_for\\_independent.pdf](https://deputyprimeminister.gov.mt/en/commmentalhealth/documents/write_up_for_independent.pdf)
- Cassar, P. (1964). *Medical History of Malta Welcome Trust*.

## Reference List

- Centre for Addiction and Mental Health. (2004). *Putting Family-Centered Care Philosophy into Practice*.
- Clark, M. (2012). Negotiating Stigmatized Identities and Overcoming Barriers to Inclusion in The Transition to Adulthood. *Inclusive Communities*, 85-102.
- Colapinto, J. (1982). Structural Family Therapy. *The SAGE Encyclopedia of Theory in Counseling and Psychotherapy*.
- Commonwealth of Australia, (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.
- Darmanin Kissaun, G. (2016). Malta's great mother archetype, individuation and separation in psychotherapy. In C.Cefai, & L.Lagana (Eds.), *Psychology and the Arts: Perceptions and perspectives*. Malta: University of Malta Publishing House.
- DeMarle, J., & Pieter le Roux, D. (2001). The life cycle and disability: experiences of discontinuity in child and family development. *Journal of Loss and Trauma*, 6(1), 29-43.
- E. Lyons, & A. Coyle (Eds.), *Analysing qualitative data in psychology*. (pp. 65-86). London: Sage.
- Galletta A. (2012) *Mastering the Semi-structured Interview and Beyond: From Research Design to Analysis and Publication*. New York University Press, New York.
- Gillum, M. (2007). *A qualitative study of parents' experiences of having had an adolescent son in a residential substance abuse treatment program*.
- Goldenberg, I., & Goldenberg, H. (2004). *Family therapy: An overview*. Pacific Grove, CA: Brooks/Cole-Thomson Learning.

## Reference List

- Grech, A. (2016). Epidemiology of serious mental illness in Malta – Consequences for developing a new psychiatric hospital and community psychiatry. *Psychiatria Danubina*; 28(1), 108-110.
- Hamkins, S. E. (2014). *The art of narrative psychiatry*. Oxford: Oxford University Press.
- Hendrickson H. (2017) A Parallel Process: Home Therapy While the Adolescent or Young Adult is in Residential Care. In: Christenson J., Merritts A. (eds) *Family Therapy with Adolescents in Residential Treatment*. Focused Issues in Family Therapy. Springer.
- Hitchings, W. E., Natelle, B., & Ristow, R. (1999). Parents, professionals, and the transition process. In P. Retish & S. Reiter (Eds.), *Adults with disabilities: International perspectives in the community* (pp. 77–102). Mahwah, NJ: Lawrence Erlbaum Associates.
- Hughes, J., & Jones, S. (2003). Reflections on the Use of Grounded Theory in Interpretive Information Systems Research. *ECIS 2003 Proceedings*. 62.
- Iyer, S. N., Rothmann, T. L., Vogler, J. E., & Spaulding, W. D. (2005). Evaluating outcomes of rehabilitation for severe mental illness. *Rehabilitation Psychology*, 50(1), 43-55.
- Jivanjee, P., Kruzich, J., & Gordon, L. J. (2009). The age of uncertainty: Parent perspectives on the transitions of young people with mental health difficulties into adulthood. *Journal of Child and Family Studies*, 18, 435–446.
- Kondrat, D. C., & Teater, B. (2009). AN ANTI-STIGMA APPROACH TO WORKING WITH PERSONS WITH SEVERE MENTAL DISABILITY: SEEKING REAL CHANGE THROUGH NARRATIVE CHANGE. *Journal of Social Work Practice*, 23(1), 35-47.
- Krieg, R. G. (2001). An interdisciplinary look at the deinstitutionalization of the mentally ill. *The Social Science Journal*, 38(3), 367-380.

## Reference List

- Langdrige, D. (2004). *Introduction to research methods and data analysis in psychology*. Harlow: Pearson.
- Lappin, J. (1988). Family therapy: A structural approach. In R. Dorfman (Ed.), *Paradigms of Clinical Social Work*. New York: Brunner/Mazel.
- Leith, J. E., & Stein, C. H. (2012). The Role of Personal Loss in the Caregiving Experiences of Well Siblings of Adults with Serious Mental Illness. *Journal of Clinical Psychology*, 68(10), 1075-1088.
- Lieberman, R.P. (2008) *Recovery from disability: Manual of psychiatric rehabilitation*. American Psychiatric Publishing, Washington, DC.
- Mederer, H., & Hill, R. (1983). Critical Transitions Over the Family Life Span. *Marriage & Family Review*, 6(1-2), 39-60.
- Mizzi, S. (1997) *Senglea revisited: 1972–1992*. Paper presented at the International Conference ‘Mediterranean Women: Concepts, Processes and Images’ Organized by The Mediterranean Institute of the University of Malta, April.
- Newman, I., & Benz, C. R. (1998). *Qualitative-quantitative research methodology: Exploring the interactive continuum*. Carbondale: University of Illinois Press.
- Nickerson, A. B., Salamone, F. J., Brooks, J. L., & Colby, S. A. (2004). Promising Approaches to Engaging Families and Building Strengths in Residential Treatment. *Residential Treatment For Children & Youth*, 22(1), 1-18.
- O'Reilly Mizzi, S. (1994). *Gossip: A Means of Social Control*. In *Maltese Society: a sociological inquiry*. (R. Sultana and G. Baldacchino eds). Msida: Mireva.

## Reference List

- Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2014). *Psychiatric rehabilitation*. (3rd ed). San Diego, CA: Elsevier Inc.
- Roberts, G. A. (2000). Narrative and severe mental illness: what place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, 6(6), 432-441.
- Ryan, T., & Pritchard, J. (2004). *Good practice in adult mental health*. London: Jessica Kingsley Publishers.
- Salem, D. A., Seidman, E., Rappaport, J. (1988). Community treatment of the mentally ill: The promise of mutual help organizations. *Social Work*, 33, 403-408.
- Savona-Ventura, C. (2004). *Mental disease in Malta*. Association for the Study of Maltese Medical History.
- Sholevar, G. P., & Schworer, L. (2003). *Textbook of family and couples therapy: Clinical applications*. Washington: American Psychiatric Publishing.
- Skowron, E.A. and Friedlander, M.L. (1998) The differentiation of self inventory: Development and initial validation. *Journal of Counseling Psychology*, 45, 235-246.
- Smith, J. A (Ed.). (2008). *Qualitative psychology: a practice guide to research methods*. Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis*. London: Sage Publications.
- Smith, J. R. (2012). Listening to Older Adult Parents of Adult Children With Mental Illness. *Journal of Family Social Work*, 15(2), 126-140.
- Stanbridge, R., & Burbach, F. (2004). Enhancing Working Partnerships with Carers and Families: A Strategy and Associated Training Programme. *Mental Health Review Journal*, 9(4), 32-37.

## Reference List

- The Maltese Mental Health Act. (2012). Retrieved from <http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=11962&l=1>
- Vetere, A. (2001). Structural Family Therapy. *Child Psychology and Psychiatry Review*, 6(03).
- Walsh, F. (2006). *Strengthening Family Resilience* (2nd ed.). New York: Guilford Publications.
- Walsh, F. (2003). *Normal Family Processes, Third Edition: Growing Diversity and Complexity. Guilford family therapy series.*
- Walther, S., & Carey, M. (2009). Narrative therapy, difference and possibility: Inviting new becomings. *Context*, 105, 3–8.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Xie, H. (2013) Strengths-Based Approach for Mental Health Recovery. *Iranian Journal of Psychiatry and Behavioral Sciences*, 7, 5-10.

## Appendix A: Semi-structured Interview Guide

---

The lived experience of a family of an adult who has re-entered the parental home following a local residential mental health rehabilitation programme

### **Interview 1:**

#### **Generating a conversation around the context of the family's lived experience (before the programme)**

I am very interested in your experience as a family before A moved into the residential rehab programme.

*What was your family life like before A applied for the service?*

*What were your expectations for A and you as a family that A was accepted to follow a residential programme?*

*What were your ideas and understanding on the residential programme and how does this fit with your needs and A's needs of A?*

*Who was in favour or against it?*

*What are your ideas about mental wellbeing or mental illness?*

*In hindsight what would you suggest that could have been done before for a better outcome of this programme?*

*What worked or not worked before A moved out?*

*What type of relationships did you have with A and A with you?*

*How did you prepare yourself for this transition?*

*How did you imagine life would be like for your family while A was following the residential program?*

## Appendices

*How did you imagine life would be like for your family when A returned back home following the residential program?*

*What were your hopes and expectations?*

### **Interview 2:**

#### **Generating a conversation about their experience during the time when A became a resident? What was this like for them and for A as well**

*What were things like at home while A was a resident?(how did the family experience this distance?)*

*What was your family's experience of A being away from home? (changes in family routine & rituals, experience of communicating family matters to A)*

*How did you manage your family relationships during this period?*

*What was the family's relationship with the service? (staff members, other residents, other relatives, the physical environment where service was offered)*

*What was your experience of the process of mental health rehabilitation? What meaning did A's rehabilitation have for you all?*

*What meaning did you give to the idea that the program is time-bound and that it would have ended in a year?*

*What were your ideas on how A was doing?*

*How hopeful were you that A was improving and behaving differently?*

#### **Generating a conversation around the transition of A from the residential program to the parental home**

*Could you tell me about your experience of the period when A was transitioning from the residential program back home?*

*What were your expectations for this period?*

*How did you experience preparing for A being back home?*

*How did you experience making space in your family and family life for the changes brought about through the process of rehabilitation?*

## Appendices

*What were relationships in the family like during this period?*

*How did you experience the termination of the service being offered? (friendships made, support received, any other services offered)*

*What did you find useful and helpful during this period from professionals, from each member of the family; etc...*

*What did not work during this transition period?*

### **Interview 3: Generating a conversation around the family's experience following the termination of the transition period**

*How did you experience the results of the process you went through? (day to day life, any meaningful moments in relation to this)*

*What were relationships in the family like after all of this?*

*Did you learn anything about your family and each other from going through this process?*

*What is your experience of mental health and mental health rehabilitation programs after going through this process?*

*Do you recommend it to others?*

*What could be improved or suggested?*

*What meaning do you give to independence/ dependence / interdependence now that you went through this process?*

*Has the meaning changed for you as a result of this process?*

## Appendix B: Information Sheets & Consent Forms

---

### **Information Sheet and Consent Form**

#### **English Version**

Dear Participant,

I am currently following a Masters in Systemic Psychotherapy Course at the Institute of Family Therapy Malta. As part of my studies, I have to submit a dissertation by the end of my course.

I have chosen to study the experience of a family of an adult who has re-entered the parental home following the completion of a local residential mental health rehabilitation programme. The methodology chosen involves three semi-structured interview with one family. I would like to invite you to participate in this study by accepting to be interviewed by myself about your experiences.

Data will be collected in accordance to the Data Protection Act (Act XXXV1 of 2001). Issues of confidentiality, autonomy and privacy will be strictly adhered to. Participation is voluntary and those who wish to withdraw from the interview can do so at any time during this study. Each interview, which should be approximately one hour long, will be voice recorded, transcribed and coded. Audio recordings will not be made available to anyone else apart from myself and my supervisor. Names and personal details will not be revealed at any point in order to ensure the protection of the respondents' identity. All tapes and material used will be kept in a safe place and destroyed as after I graduate.

Although none of the interview questions address sensitive issues, the Institute of Family Therapy offer their professional support in the case where you might feel some emotional distress as a result of being interviewed.

## Appendices

If any questions or concerns regarding participation arise, one is free to contact on:

Telephone:  
Email Address:

I take this opportunity to thank you for your time.

Yours truly,

---

Rebecca Cassar

---

I have understood my involvement and agree to participate in this study.

---

Name and Surname

---

Signature

---

Date

**Information Sheet and Consent Form**

**Maltese Version**

Ghaziz pareticpant/a,

Jiena qiegħda nagħmel kors għall-Masters fil-Psikoterapija Sistemika, ma' l-Institute of Family Therapy Malta. Bhala parti mil-kors tiegħi irrid niprezenta tezi fl-ahħar ta' dan il-kors.

Fir-ricerka tiegħi se nistudja l-esperjenza ta' familja b'membru li dahal 'l ura d-dar tal-genituri tiegħu wara t-tlestija ta' programm lokali residenzjali u rehabilitattiv għal persuni li għandhom problema ta' sahħa mentali. Nixtieq nistiednek biex tieħu sehem f'din ir-ricerka billi tigi intervistat/a minni rigward l-esperjenzi tiegħek bhala membru tal-familja. L-intervista' għandha tkun maqsuma f'tliet partjiet.

Nassigurak li r-ricerka ser issir skond id-Data Protection Act (Act XXXV1 ta' 2001). Il-konfidenzjalita', awtonomija, u privatezza tiegħek ser jigu imħarsa l-hin kollu. Il-partecipazzjoni tiegħek f'dan l-istudju hija volotarja, u jekk f'xi hin thoss li trid tieqaf milli tippartecita', tista' tagħmel dan bil-liberta' kollha. Kull intervista' mistennija tkun madwar siegħa, u ser tigi irrekordjata għall-uzu tar-ricerka. Jien u s-supervisor tiegħi biss se jkollna access għall-intervista' migbura. L-ebda informazzjoni personali dwar il-participanti m'hija se tigi mogħtija lil terzi persuni, u l-materjali fejn ser ikun hemm kopja ta' l-intervista' għandha tigi mizmuma f' post sigur u mhassra hekk kif nigradwa.

Għalkemm nassigurak li l-ebda mistoqsija ma tindirizza informazzjoni ta' natura sensittiva, l-Institute of Family Therapy Malta offra s-servizzi professjonali tiegħu f'kaz li thossok kommiss jew emozzjonat bhala rizultat ta' din l-intervista.

## Appendices

Jekk ghandek xi mistoqsija rigward ir-ricerka tista tikkuntattjani fuq:

Telephone:

Email:

Nitieq niehu l-opportunita' biex niringrazzjak.

Dejjem tieghek,

---

Rebecca Cassar

---

Jien fhimt u naccetta li niehu sehem f'din ir-ricerka.

---

Isem u Kunjom

---

Firma

---

Data

## Appendix C: Sample of Transcript

---

Transcript Sample	Notes and reflections	Ideas for themes/Sub themes
<p>Mary- ...I don't know...but I don't want her to be unhappy either... because I want her to be happy when going to work. I thought maybe she'll start making friends at work, as a continuation to the changes she made during the programme and to see more change. But we saw no change since she started working. Actually she is unhappier since she started working.</p>	<p>The parents wish for their daughter's happiness... but what does the daughter need to be happy? Are the parents struggling with understanding what the daughter needs? Maybe different understanding of what leads to happiness?</p>	<p>Parents' dilemma- Wishing their daughter to be happy but also wanting her to remain employed</p>
<p>Rebecca- So if I'm understanding correctly you saw work as the next step for Tina following her programme?</p>	<p>Happiness linked to relationships and friendships/ parents wishing their daughter to have a meaningful routine</p>	<p>Having a meaningful routine: The programme and work routine</p>
<p>Tina- Yes, because it's something to do after the programme. I had somewhere to go to and time would go in quickly like it did during the programme.</p>	<p>Having a meaningful routine after the completion of programme/ keeping busy</p>	<p>Having a meaningful routine: The programme and work routine</p>
<p>Jim- To a certain extent, I do not want her to stop working, because if she does we would go back to square one. Back... to our old routine. So it's best to keep going to work. But at the same time I do not want her to be unhappy. I want her to go to work and be happy that she went to work. I want her to come home and say "We had such a laugh today". There are times where she comes and tells me we laughed today because the supervisor was there. But not when the boss is there... she is quite vicious. But she likes her supervisor. Right?</p>	<p>Seeing employment as the only way, the only change, what is keeping hope alive for the parents</p> <p>Wanting their daughter to be happy; the parents' wishes/ peace of mind</p> <p>Comment related to previous explanation of discrimination at work</p>	<p>Employment/ Hope</p> <p>Parents' dilemma- Wishing their daughter to be happy but also wanting her to remain employed</p>
<p>Maria- But till she goes [to work] it's a struggle...</p>	<p>Parents' struggles</p>	<p>Parents' struggles</p>
<p>Tina- During the programme I was better. I had friends there and I used to enjoy it.</p>	<p>Missing being at the programme? Happiness and relationships/friendships</p>	<p>Loss for the client</p> <p>Happiness and relationships</p>

Transcript Sample	Notes and reflections	Ideas for themes/Sub themes
<p>Mary- ...Ma nafx... imma ma rridiex tkun imdejqa aqqas... ghax ix-xoghol ghandha tmur happy. Jien ghidt forsi taghmel il-hbieb ix-xoghol, qisu biex inkomplu bid-differenza li ghamlet [il-programm] u naraw differenza ohra. Imma ma rajniex differenza kemm ilha li marret ix-xoghol. Pjuttost qed tigi iktar imdejqa kemm ilha tahdem.</p>	<p>The parents wish for their daughter's happiness... but what does the daughter need to be happy? Are the parents struggling with understanding what the daughter needs? Maybe different understanding of what leads to happiness?</p>	<p>Parents' dilemma- Wishing their daughter to be happy but also wanting her to remain employed</p>
<p>Rebecca- Qisni qed nifhmek tghid li rajtu li x-xoghol kien ikun qisu the next step ghal Tina wara l-programm?</p>	<p>Happiness linked to relationships and friendships/ parents wishing their daughter to have a meaningful routine</p>	<p>Having a meaningful routine: The programme and work routine</p>
<p>Tina- Ija ghax kont insib x' naghmel wara [l-programm]. Kien ikolli fejn immur u jghaddi malajr l-hin bhal [programm].</p>	<p>Having a meaningful routine after the completion of programme/ keeping busy</p>	<p>Having a meaningful routine: The programme and work routine</p>
<p>Jim- U sa certu punt ma nixtieqix tieqaf mix-xoghol, ghax jekk tieqaf mix-xoghol ha nergghu nigu back to square one. Bil-... bir-rutina ta' qabel. Allura ahjar tmur ix-xoghol hux. Imma fl-istess hin ma nixtieqix tiddejjaq. Jien nixtieqa tmur ix-xoghol u tkun happy li marret ix-xoghol. Nixtieqha tigi d-dar u toqghod tghidli "Kemm dhaqna." Gieli giet u tghidli kemm dhaqna ghax ikun hemm is-supervisor. Mhux il-kbira imma... ghax dik naqa feroci. Mas-supervisor taqbel imma. Hux?</p>	<p>Seeing employment as the only way, the only change, what is keeping hope alive for the parents</p> <p>Parents' dilemma</p> <p>Wanting their daughter to be happy; the parents' wishes/ peace of mind</p> <p>Comment related to previous explanation of discrimination at work</p>	<p>Employment/ Hope</p> <p>Parents' dilemma- Wishing their daughter to be happy but also wanting her to remain employed</p>
<p>Maria- Sakemm tmur imma kbira e...</p>	<p>Parents' struggles</p>	<p>Parents' struggles</p>
<p>Tina- Ara meta kont [il-programm] kont ahjar. Kelli l-hbieb hemm u kont nghaddiha.</p>	<p>Missing being at the programme? Happiness and relationships/friendships</p>	<p>Loss for the client</p> <p>Happiness and relationships</p>

## Appendix D: Original quotes in Maltese language

---

“Kont ngħid “Iwa Mulej, qas għandha hadd ma min tohrog. Il-hin kollu mal-mummy.” Hekk kont ngħidilha... mela guvni ha jfittxek jekk jarak dejjem mal-mummy?” (Mary L.873-874)

“Nahseb kienu t-tnejn, hekk close jien... għaliha kien qisu Tina kienet biss f’ħajjitha... lilha biss... U nista nifhem ta... għax it-tifla għandha bzonn tagħna hafna. Imma l-mara nahseb kienet wisq hekk iffukata fuqha...” (Jimmy L. 219-223)

“Jien għandi nkun nista nagħzel. M’għandix bzonn lil ommi tagħzel il-hwejjeg tiegħi hux; minix tifla. U meta provajt, xorta qas kienet tghidli tajjeb u toqghod tgorr. Hekk konna hi ahna. Niggieldu il-hin kollu.” (Tina L.183-185)

“Hi qaltilha lil oħtha “Kif xbqajt.” U oħtha imbghad tghidli “Dik għalhekk trid titlaq mid-dar! Habba fik. Għax ma thallijex naqra bi kwietha u thallilha naqra spazju.” Flok jissapportjawni fil-punt, jghidulek li għandek tort... U kont inhossha hux wahdi.” (Mary L. 737-740)

“Jekk nitlef kontroll u naqbad ngħajjat, hi tigi tghidli “Aqtagħha għax ha jisimghak.” Bla kaz għax jien irrabjata, l-aqwa li missierha ma jismax għax inkella kien jgħajjat ukoll.” (Mary L. 808- 810)

“Jien ridthom jirrepetu li għamilt jien ma Tina... Biex forsi wara dik is-sena li għamlet hem... tibda tahseb “Dawn qed jgħidu l-istess bħall-mummy, jigifieri l-mummy sewwa tghid jekk jgħidu l-istess. Ommi kellha ragun.” ” (Mary L.595-596)

“Dik... li ma jkollix bzonn lilna daqshekk. Nemmen li kulhadd ikollu bzonn lil hadd iehor ta... b’modi differenti. Hutha jkollhom bzonn lilna ukoll. U ahna jkollna bzonn lit-tfal tagħna. Imma li nserrah mohhi li jekk ma nistawx nagħtuha kif intuha issa... (Pause)... Hekk li tkun ok ukoll... li tkun ok mingħajrna. (Jimmy L.357-360)

“Jien għandi tifla oħra, sena iktar minnha l-oħra. Tarahha d-differenza. Li l-oħra tagħmel hafna affarjiet wehidha. Tina trid qisha dejjem l-għajnuna. Qed tifhem? U xtaqtha li certu affarjiet... jiena minix eternal... heq nigi nieqsa jien irridha tkun kapaci tagħmel u ma tiddependix fuq hutha kif tagħmel bina.” (Mary L.331-333)

## Appendices

“Gieli jibqghulek hemm, u qas inkun nista nitlaq. Gieli nixba hemm, imma mhux kemm tippakkja u titlaq d-dar hux. Imma imbghad... nahdem ghalha jien hux. Ghalhekk nahdem jien. Mhux ghalina. Ha jkollha ghal futur.” **(Jimmy L. 558-561)**

“Dejjem hsibna li kien hemm tipi ta’ ghajnuna differenti, mhux pirmlu biss. Affarjiet ohra bhal programm li seta jghinha.” **(Mary L.81-83)**

“Anke d-dixxiplina taghna ta. Konna nghidulha meta taqbez il-lina. Hekk. Hekk hsibna ahna u ghadna nahsbu li ghandha bzonn. Tara nies bil-pirmlu... hajja shiha bil-pirmlu. Jibdewhom u qatt ma jieqfu.” **(Jimmy L.85-88)**

“Dahlet fir-rutina tas-soltu ta’ qabel. Kemm damet hemm imbiddlet u progressat... hafna ukoll! Ghalhekk kont saqsejt biex izommuha. Meta giet ‘l ura d-dar, fis-sens, meta ma kelliex fej tmur, rega beda kollox. Titghazzen, ma taghmel xejn, imbghad taqbzilha u beda d-dwejjjaq.” **(Mary L.111-114)**

“Ahna dejjem ridniha tkun ma dawk li huma ahjar minnha forsi titghallem minnhom u tmur ghal ahjar.” **(Jimmy L.286-288)**

“Heq jien nghid ghalija meta izzewwiget u tlaqt mid-dar ma kontx l-istess bhal meta kont ghand ommi. Kont iktar relaxed ghax ma kelliex lil min jghaggilni biex naghmel l-affarjiet kif jidrilhom huma, bhal ommi kienet tghafasni biex naghmel kif jidirli hi. Meta tlaqt kont naghmel kif jidirli jien. Allura kont iktar relaxed... Issa fil-programm setghet taghzel hi ta’ kbira li hi.” **(Jimmy L. 648-654)**

“Hemm kellna struttura u hin. Ghax hemm kollox fil-hin kien isir hemm. Gruppi u laqghat u tindif u ikel... kollox fil-hin b’time table. Imma kien hemm affarjiet ohra li kont naghzilhom jien imbghad. Konna nghazlu x’nieklu, fuq xiex ha naghmlu l-gruppi, nistghu nohorgu, ikollna free time ma’ hbieb, ninhasel x’hin jidirli jien. Allura thossok tajba hux. Hekk... istra... hekk differenti hawn! **(Tina L.661-665)**

“Kienet iebisa ta... veru. Ghax kont nidhol fis-sodda filghaxija, dak l-aghar hin, wara gurnata shiha. U kont nghid bejni u bejn ruhi, minjaf it-tifla. Minjaf x’ghamlet illum? Tghid dahlet torqod ukoll?” **(Jimmy L. 779-781)**

“Kien hemm drabi inqalghu affarjiet koroh meta kienet ghadha hemm Tina. Gieli kienu jiggieldu residenti ohra, u kienet tghidilna imbghad. U kont nixtieq li qieghda d-dar safe minflok. Kulltant kont nixtieq immur u ngibha ‘l ura d-dar. Imma kienet tkampa anki f’dawn... hekk krizi. Jigifieri, kienet tough hi ta. Ahna naf li niproteguha, imma hi tough ta veru imbghad.” **(Jimmy L.786-790)**

## Appendices

“Hi ghamlet hafna hbieb hemm. U kullhadd kien jikkummentali fuq kemm tidhaq. Jghiduli li l-karattru taghha kien jixghelu post. Qisu l-karattru taghha kien veru jispikka.”... “Hi kompletament imbiddlet. Kont nghid bejni u bejn ruhi... din hi Tina. Din hi verament Tina.” (Mary L. 439-442)

“Kont narana immorru ahna jien meta kont hemm. Kont veru nistenniha gejjja tarani, u kont niehu gost biha. Kien ikolli hafna iktar x’nghidilha hem, ghax ma konniex il-hin kollu ma xulxin. Konna nparlaw fuq affarjiet differenti. Id-dar dejjem fuq l-istess. Dejjem fuq il-hwejjeg u kif nidher. Hemm ghal inqas fuq il-gimgha tieghi, u kif sejrin, u fuq in-nies li nkun magghom. Kont niehu gost hux.” (Tina L. 757-763)

“Kultant jinsewk huma ta li inti parti mil-hajja tat-tfal taghna u li meta jigu ‘l ura d-dar, gejjin ‘l ura maghna dawn. Mela irridu inkunu parti minnu b’xi mod. Jekk le, ghal xejn heq.” (Mary L.851-853)

“Qas jien cert. Ghax hu veru... qishom ikollom bzonna dak l-ispazju ha jikbru u jitghalmu. Imma wara jigu d-dar u kollox imur ‘l ura l-istess... rutina antika, nirrepetu l-istess paroli, kollox l-istess. Heq ma nafx ta’, ghax mhux facli. Imma kollox irid jinbdel biex issir xi bidla.” (Jimmy L.859-862)

“Nahseb kienet tiehu gost tarani hemm. Ma kienet tghidli xejn ta. Imma nahseb kienet tarani niehu interess u hekk, qisni parti minn dak li qed taghmel. Dak in-naqra cans... kont niehu gost u nahseb kienet tarani ridt nissapportjahha u li ma nsejtx biha.” (Mary L.863-842)

“Ija ghinitni ghax rajtni mhux wahdi. Tipo. Kien hemm zmien hassejtni ha jaqbadni break down. Ghax qas kont naf... qisu tibda tghid imma jien wahdi? Jekk hux jien biss. Imma titkellem ma had iehor, u tifhem li mhux int biss.” (Mary L. 818-821)

“Kont inkun busy hemm jien. U dejjem ghandna x’naghmlu. Il-gurnata konna nghadduha hux, malajr tghaddi. Kont nixtieq nigi d-dar, mhux le, ridt. Imma konna nghadduha hemm.” (Tina L.234-236)

“Drajt li nkun ma l-ohrajn hemm u kienet iebsa meta tlaqt. Ridt noqghod inkun naf x’kien qieghed jigri hem anki meta spiccajt.” (Tina L. 204-205)

“Hemm kella l-liberta’ hi hux iktar minn hawn. Li tista tipprova affarjiet mhux tas-soltu u tiehu responsabbilta’ ta’ l-affarjiet taghha.”... “Kultant nahseb ghalhekk konna narawha hekk qisha

## Appendices

differenti hem. Li kellha iktar libierta', kienet iktar ferhana. Nahseb ghalhekk jien.” (Jimmy L.628-632)

“Mela jien kont naghmel enfasi fuq certi affarjiet, imbghad hemm kienu ituha liberta biex taghmel hi. U meta giet l-ura bdiet tara lili veru kerha. Bdejt indejjaqha imbghad ghax hemm ma kienux jghidulha l-istess haga. Lili qed tarani dimonju, fis-sens tal-kelma. Ghax il-hin kollu nibbaza fuq dawk l-affarjiet. Ghax jiena ma rridiex tohrog barra u tkun tidher... imharbta. U jidhqu biha n-nies. Ghax ghandi nghidilha jien imma?”(Mary L. 598-603)

“Ma nafx jiena ta'... ma nistax nifhem ghala dit-tifla tkun bin-nervi u dwejjaq. Anka meta nipprova naghmel kollox ghaliha. M'ghandiex ghalfejn tkun imdejjaq. Veru ma nafx ghala.” (Mary L.827-830)

“M'hemmx oggett li ma tajtiex biex nikkuntentahha... imma... ma nafx izjed x'nista naghmel.” (Mary L.508-509)

“... lilha qalulha quddiemi biex tibqa taghmel l-affarjiet li tghalmet hemm... imma ma nafx. Kont nistenna li la kienet se tigi d-dar konna ha nigu l-istess. Imma imbghad gie x-xoghol u ghidt ejja, forsi mix-xoghol tirranka. Anki biex taqbad hbieb forsi.” (Mary L.707-710)

“Ahna ga ghaddejna minn dik l-esperjenza meta ghamlitu l-programm ta' 16. Jien naf minn xiex ghaddiet, u meta spicca kollox waqa rega'... Hi mhux ghax ghandha bzonn tahdem... tipo... imma jekk ma jkolliex kuntatt man-nies, terga tibda toqghod maghna hawn biss. Tibda torqod sa nofsinhar, tmur, tiekol, u terga imbghad tmur torqodlok... dik x'hajja hi? Mhux monotona hekk?” (Mary L.310-315)

“Kollox jien irrid naghmel wahdi, anka li mhux sippost naghmel jien. Ara lil had iehor ma jsaqsuhx... lili biss. Mhux kuntenta jien biha dik. U nkun irrid nghidilhom ta'... nghidilhom xi haga, imma nibza.” (Tina L.511-513)

“U sa certu punt ma nixtieqix tieqaf mix-xoghol, ghax jekk tieqaf mix-xoghol ha nergghu nigu back to square one. Bil-... bir-rutina ta' qabel. Allura ahjar tmur ix-xoghol hux. Imma fl-istess hin ma nixtieqix tiddejjaq. Jien nixtieqa tmur ix-xoghol u tkun happy li marret ix-xoghol. Nixtieqha tigi d-dar u toqghod tghidli “Kemmm dhaqna.”” (Jimmy L.427-430)

“Taghmel is-sodda taghha, taghmel u tghin fit-tisjir. Assolutament xejn ma taghmel hawn. Assolutament xejn. Li ghadni sal-llum jien.... “Hsilthom snienek?” “Hsiltu wiccek?” “Ahsel xgharek”. Ghaliex ghandi nsaqsi jien...? U wejja... 29 issa... mhux tifla zghira.”(Mary L.193-197)

## Appendices

“Jien nahseb huha il-kbir sewwa jghid... jiena nahseb huha l-kbir ma jitkellem xejn u ma jghid xejn, imma jghid wahda u jghidha sew. Ghax jghidli “Ma, dik mhux ma tafx. Dik ma tridx.” U veru.” (Mary L. 747-750)

“Tghallmet hafna hi minn hemm. Imma meta giet l-ura d-dar xejn. Veru xejn affattu. Aqqas biss tipprova.” (Mary L.239-241)