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Adolescents Coping with Mood Disorder: A Grounded Theory Study

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ADOLESCENTS COPING WITH MOOD DISORDER:

A GROUNDED THEORY STUDY

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ABSTRACT

ADOLESCENTS COPING WITH MOOD DISORDER:

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A grounded theory methodology was used to explore the phenomenon of coping as experienced by adolescents with a mood disorder. Mood disorders among children and adolescents are more persistent than previously thought and have numerous negative associated features, including further episodes of depression, impaired social, academic, and vocational relationships, use of alcohol and other drugs, and an increased of suicide. Current literature offered little awareness of how adolescents cope with a mood disorder, as well as their perspective of how such an illness impacts their lives.

A substantive theory regarding the process of coping for adolescents with a mood disorder was generated from the data [interviews and two chart reviews] collected from one male and eight female adolescents. Using the coding procedures espoused by Strauss and Corbin (1998), a four-phase coping theory identified by the categories Feeling Different, Cutting off Connections, Facing the Challenge/Reconnecting, and Learning from the Experience was presented in a schematic theoretical model. The core category identified in this research was An Unplanned Journey: Coping Through Connections. Implications identified for nursing practice, research, policy, and education included greater attention on the prevention of adolescent mood disorders and the education of adolescents about the development and enhancement of healthy coping skills.

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DEDICATION

I wish to dedicate this dissertation to my parents, Estell and the late Robert Meadus, Senior who always supported my educational endeavors. Since a young age, my parents had instilled in me the importance of education. My father passed away during the writing of this report and I dedicate the finished product to his memory.

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CHAPTER 1

INTRODUCTION

Introduction

> "But when the melancholy fit shall fall
> Sudden from heaven like a weeping cloud,
> That fosters the droop-headed flowers all,
> And hides the green hill in an April shroud;
> Then glut thy sorrow on a morning rose"
> (John Keats, Ode on Melancholy, 1990, p. 290).

Melancholy or sadness is a common phenomenon that occurs in all age groups. Feeling a certain amount of sadness and emotional pain is a part of life. But there is a point where the feeling of sadness becomes chronic, disabling, and insufferable; it is not a passing mood, but a serious illness, defined as a mood disorder (Gelman, 2000; National Youth Network, 2001). These disorders, referred to as brain disorders, completely disrupt a person's emotional and physical health (United States Department of Health and Human Services [U.S.DHHS], 1999). The World Health Organization (WHO, 2001) predicts that within the next 20 years mood disorders will become "the second cause of the global disease burden" (p. 10). They are among the most prevalent, recurrent, and disabling of all illnesses (Costello et al., 2002) and have been reported for more than 40 centuries. Hippocrates (460-377 BC) was the first to hypothesize that black bile [melancholia], a toxic product of digestion, caused mental illness. This belief is considered to be the first *biological* causal theory of mood disorders (Cornwell, 2003).

Mood disorders in children and teenagers are a significant problem in North America. These disorders are associated with disturbances in psychological, physiological, academic, and social functioning (Brown, 1996; Cornwell, 2003; Frydenberg, 1997). According to Todd and Botteron (2002), the economic, social, and

personal costs to society associated with childhood and adolescent-onset mood disorders are tremendous because the illness occurs during important developmental periods, has frequent recurrences, and persists into adulthood. The purpose of this study was to explore the phenomenon of coping as experienced by adolescents with a mood disorder and to generate a grounded theory of the processes involved as they cope with a psychiatric illness.

Adolescence is a period of human development characterized by a complex set of tasks that pose a unique set of stressors. The presence of a mental illness, such as a mood disorder, during this stage of development adds a major challenge that can interfere with completion of these normal developmental tasks. Researchers have reported that in general certain coping behaviors facilitate illness recovery [thinking positively, seeking social support] whereas other behaviors [avoidance, rumination, use of substances] hinder recovery (Bentov, 2001; Broderick, 1998; Broderick & Korteland, 2002; Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Fields & Prinz, 1997; Hino, Takeuchi, & Yamanouchi, 2002; Losoya, Eisenberg, & Fabes, 1998; Spasojevic & Alloy, 2001). Coping is considered a vital process of concern in nursing. However, in general, there remains little attention to the mental health needs of children and adolescents related to coping by primary health care providers, including nurses (Duffy, 2000; Dulmus & Rapp-Paglicci, 2000; Kools, 1998). Nurses and other health professionals working with this population need to be cognizant of how adolescents cope with psychiatric illness. Such knowledge and understanding about adolescent coping with a mental illness by these professionals will help in the development of supportive

interventions, information, and counseling that will assist to mediate or strengthen development of the adolescents' coping abilities when they have a psychiatric illness.

Definitions/Categories of Mood Disorders

Mood disorders, also called affective disorders, are the most common and least understood psychiatric problems constituting a public health problem in North America (Bland, 1997; Grof, 1997; Health Canada, 2002; Sartorius, 2001). These disorders are leading causes of disability worldwide and impose substantial health and economic burdens on individuals and families, as well as society (Costello, Egger, & Angold, 2005; McGuire, et al., 2002; Sartorius, 2001; Ustun, Ayuso-Mateos, Chatterji, Mathers, & Murray 2004; Wang, Simon, & Kessler, 2003; Wells et al., 2002; Wells, Sturm, Sherbourne, & Meredith, 1996; WHO, 2001). Despite decades of research, there are no universally agreed upon means of defining and classifying mood disorders. They are most commonly classified according to the type of mood disturbance experienced by the client (American Psychiatric Association, 2000, Diagnostic & Statistical Manual of Mental Disorders (DSM-IV-TR). The two main categories of disorders under this classification are bipolar disorders and depressive disorders. They include the following major categories:

1) Bipolar I and Bipolar II Disorders
    (a) Bipolar I Disorder: the person has one or more manic or mixed episodes [meets criteria for both manic and major depressive episodes]. Often individuals have also had one or more major depressive episodes (DSM-IV-TR, 2000). Bipolar II Disorder: this includes major depressive episodes and hypomanic episodes. The person has a history of one or more major depressive episodes or has major

depression at present. The individual has a history of one or more hypomanic episodes or has hypomania now, but has never had a manic or mixed episode (DSM-IV-TR, 2000).

(b) Cyclothymic Disorder: this involves alternating hypomania and depressive episodes. Cyclothymia entails cycling between highs and lows, but the illness never reaches full mania or major depression (DSM-IV-TR, 2000).

2) Depressive Disorders

(a) Major depressive disorder: this disorder is considered the most severe type of depression, without any hypomanic and manic episodes. It is often called unipolar depression.

(b) Dysthymic disorder: the essential feature is a chronically depressed mood that occurs for at least two years. If the chronic depressive symptoms include a major depressive episode during the initial two years, then the diagnosis is major depressive disorder, chronic [if full criteria for a major depressive episode are met]. After the initial two years of the dysthymic disorder, major depressive episodes may be superimposed on the dysthymic disorder. In this case, the person may be diagnosed as having both dysthymic disorder and major depressive disorder [double depression], at the same time, if the criteria are met (DSM-IV-TR, 2000).

In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder [Type 1] (De Santis & Eekegren, 2003; U.S.DHHS, 1999). Among the most severe of the mood disorders in adolescents are major depressive disorder and bipolar disorder (Watkins, 1999). Major

depressive disorder is the most prevalent mental health problem for this population (Albright, 1999; Birmaher et al., 1996; Greist & Korn, 2001; Kools, 1998; Martin & Cohen, 2000). During adolescence, females are twice as likely to experience this disorder compared with males (Cyranowski, Frank, Young, & Shear, 2000; Lewinsohn, Clarke, Seeley, & Rohde, 1994). In a recent national survey in the United States, over 1400 high school mental health professionals serving adolescents reported depression to be a serious problem, even more serious than violence. More than two-thirds of these professionals surveyed "identified depression as a great (14%) or moderate (54%) problem in their schools" (The Annenberg Public Policy Center, University of Pennsylvania, 2004, p. 1). Mood disorders in young people often co-occur with other mental disorders, such as anxiety, disruptive behavior [conduct disorder, attention-deficit/hyperactivity disorder (ADHD)], or substance abuse and personality disorders (Axelson & Birmaher, 2001; Kessler, Avenevoli, & Merikangas, 2001; Nixon, 1999; Son & Kirchner, 2000). This factor may contribute to the failure to early recognize mood disorders in children and adolescents.

Scope and Significance of the Problem

Lefkowitz and Burton (1978) proposed that the clinical syndrome of depression was a malady to which children were not susceptible. It was considered “normal” for adolescents to be depressed as it was seen as a part of being a teenager. Although this was the prominent view among many mental health professionals for much of the 20th century, Lamarine (1995) contended that in recent years this belief has given way to an understanding that child and adolescent depression does exist. The recognition that mood disorders can occur in children and adolescents is a recent phenomenon, dating back to

the last 10 to 20 years. It wasn't until the 1980s that mood disorders in children and adolescents became a category of diagnosed psychiatric disorders (Brown, 1996). Mood disorders in this age group are recognized as insidious and serious psychiatric conditions that demand timely intervention (Duffy, 2000; Kools, 1998; Lamarine, 1995). According to the WHO (2001), mental disorders are becoming more common world wide, often beginning in the adolescent years. Data compiled by the WHO suggests that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50% internationally, contributing to the global burden of disease and disability. The mental health problems affecting children and adolescents are considered to be a crisis of the 21st century (U.S.DHHS, 2000).

Mood disorders were once thought to occur rarely in youth, but approximately 20 to 30 percent of all adult bipolar patients had their first identified episode during adolescence, with a peak age of onset between 15 years and 19 years of age (Brown, 1996; McClellan & Werry, 1997). Affective disorders among children and adolescents are more persistent than previously thought and have numerous negative associated features, including further episodes of depression, impaired social and academic relationships, nicotine dependence, abuse of alcohol and other substances, risky sexual behavior, teenage childbearing, early marriage, and an increased risk of suicide (Birmaher et al., 1996; Brown, 1996; Fergusson & Woodward, 2002; Gotlib, Lewinsohn, & Seeley, 1998; Kandel & Davies, 1986; Kashani & McNaul, 1997; Kessler, Berglund, Foster, Saunders, Stang, & Walters, 1997; Kovacs & Goldston, 1991; Ramrakha, Caspi, Dickson, Moffitt, & Paul, 2000; Rao, Daley, & Hammen, 2000; Reinherz, Giaconia, Hauf, Wasserman, & Silverman, 1999; Vander Stoep, Weiss, McKnight, Beresford, &

Cohen, 2002). Several authors report that more than 90% of young people who commit suicide have an associated psychiatric illness, most commonly a mood disorder, especially major depressive disorder (Esposito & Clum, 2002; Flisher, 1999; Houston, Hawton, & Shepperd, 2001; Kashani & McNaul, 1997; Langlois, & Morrison, 2002; Pfeffer, 2002; Shaffer et al., 1996). Suicide is the third leading cause of death in the United States among adolescents and young adults 15 to 24 years of age (Pfeffer, 2002). It is the leading cause of death among the adolescent population in Canada (Langlois & Morrison, 2002).

Mood disorders in children and adolescents are difficult to assess. Thus, the exact incidence continues to be underdiagnosed, misdiagnosed, and undertreated (Geller & Luby, 1997; Scahill, 2001). Duffy (2000) suggested these problems have hindered development of a knowledge base required to treat or to prevent mental disorders in children and adolescents. While the seriousness of the problem has been well researched, there has been little research on effective interventions to assist adolescents dealing with mood disorders. There is a need to explore the phenomenon from the adolescents' perspective in order to develop more effective approaches to assist this vulnerable population.

According to Erikson (1963), adolescence has been described as a critical transition period between childhood and adulthood. This period marks the onset of puberty characterized by biological, cognitive, and developmental changes. Erikson (1963) referred to these changes in psychosocial development as the stage of identity versus role confusion. During this time, the young person encounters challenges of entering adulthood, including sexual maturity, vocational decisions, acquiring

independence from parents, a growing interdependence on peers and friends, and development of a greater sense of self. It is also the period when youth are developing psychosocial competence, including strategies for coping with life stressors (Byrne, 2000). In addition to the normal stresses of adolescence, the added stress of having a mood disorder exerts an extreme level of disruption on normal development and accomplishment of developmental tasks that are necessary for entering adulthood (Albright, 1999; U.S.DHHS, 2000). Dealing with mood disorders during a period when adolescents are building coping strategies complicates the adolescents' completion of such tasks. Managing these challenges may be more difficult for an adolescent impacted by a mental illness.

The number and kind of changes and challenges occurring concurrently during adolescence may determine how effectively the individual can cope or adapt (Plancherel & Bolognini, 1995). Allen and Hiebert (1991) and Patterson and McCubbin (1987) suggested that when the stresses and demands associated with a major life event are superimposed on normal everyday hassles, the adolescent may not have the coping resources necessary to adapt. How adolescents meet these challenges depends in part upon their perception of family as a relatively secure haven (Grossman & Rowat, 1995). Several investigators have found that depressed children and adolescents perceive their families to be less communicative, less supportive, and more authoritative and critical, compared to the perceptions of unaffected control adolescents regarding their families (Garrison, Waller, Cuffe, McKeown, Addy, & Jackson, 1997; Shiner & Marmorstein, 1998).

Prevalence

Interpretation of the epidemiology of child and adolescent mental health disorders is difficult. The annual prevalence of mood disorders in children and adolescents is not as well documented as that for adults (U.S.DHHS, 1999). Problems in definition, measurement, and sampling among studies make it difficult to report accurate disorder prevalence. Although there are variations across studies, the lifetime prevalence of major depressive disorder among adolescents appears to be between 15% and 20% (Birmaher et al., 1996; Kessler & Walters, 1998). Lewinsohn, Rohde, Klein, and Seeley (1999) found that individuals who had experienced an episode of major depressive disorder by the age of 19 were at a significantly elevated risk for future major depressive disorder, compared to participants with adolescent-onset adjustment, anxiety, substance use and disruptive behavior disorders, and adolescents with no disorder. Depression in childhood or adolescence has a 60-70% risk of continuing into adulthood (Weller & Weller, 2000).

Although no national epidemiological studies have been undertaken concerning adolescent mood disorder, an estimated 7.5 million children in the United States are reported to have been plagued with mental disorders, nearly half of which lead to serious disability. About 1/3 of these children and adolescents receive care (Scahill, 2001). Families of children and adolescents who have access to mental health care speak of barriers to obtaining appropriate quality mental health services. Parents and caregivers of psychiatrically ill children report that health professionals involved in the care of their children and adolescents lack sufficient training and expertise (Scahill, 2001; Stephenson, 2000). Jordan, Excell, and Waggoner (1999) suggested that changes in health care spending and overburdened government programs were obstacles that have prevented

many health care professionals from adequately responding to the needs of mentally ill children and adolescents, and their families.

Researchers have reported that approximately 18% to 20% of, or 1.5 million children and youth in Canada, were at specific risk for mental health problems (Health Canada, Childhood & Youth Division, 1998). Some authors have argued that the prevalence of mood disorders among children and adolescents are much higher than what epidemiologic studies have suggested (Geller & Luby, 1997; Roberts, Attkisson, & Rosenblatt, 1998). Despite these findings, mood disorders have received little attention, are poorly understood, and services for children and young people with mental illness have lagged behind those programs developed for adults (Health Canada, Childhood & Youth Division, 1998; Puskar, Tusaie-Mumford, Sereika, & Lamb, 1999). In addition, few empirical efforts have focused on prevention in young people (Beardslee, Salt, Versage, Gladstone, Wright, & Rothberg, 1997; Dulmus & Rapp-Paglicci, 2000; Hammen, Rudolph, Weisz, Rao, & Burge, 1999).

Strikingly, there has been a substantial increase in the use of psychotropic medications for treatment of children and adolescents with mood disorders (Conrad, 2004; Zito et al., 2002; Zito et al., 2003). Complicating matters further, evidence is lacking into the safety and effectiveness for many of the current psychopharmacological treatments specific to this population (Ambrosini, 2000; Emslie & Mayes, 2001; Green, 2004; Harrington, Whittaker, & Shoebridge, 1998; Jureidini, Doecke, Mansfield, Haby, Menkes, & Tonkin, 2004; Michael & Crowley, 2002; Milin, Walker, & Chow, 2003; Nardi & Barrett, 2005; Waddell, Offord, Shepherd, Hua, & McEwan, 2002; Wells, Kataoka, & Asarnow, 2001; Whittington, Kendall, Fonagy, Cottrell, Cotgrove, &

Boddington, 2004; Whittington, Kendall, & Pilling, 2005; Zito et al., 2002). Recently the United States Food and Drug Administration (FDA) advisory committee endorsed a recommendation that a "black-box" warning label be attached to antidepressant drugs, specifically selective serotonin reuptake inhibitors (SSRIs) prescribed for children and adolescents. This initiative was proposed based upon evidence that the use of these drugs may lead to increased suicidality in this population (Lock, Walker, Rickert, & Katzman, 2005; Newman, 2004; Olfson, Shaffer, Marcus, & Greenberg, 2003).

In summary, mood disorders in adolescents carry with them many burdens putting the adolescent's mental and physical health at risk. Adolescents, suffering with the symptoms of mood disorders, experience disruption of developmentally appropriate social and cognitive functioning. Adolescent depression is often manifest in academic failure (Kovacs & Goldston, 1991; Shoaf, Emslie, & Mayes, 2001). It has been reported that these disorders impact social development and emotional well being, interfering with the formation of friendships and other peer relationships (Frydenberg, 1997). During adolescence, problem-solving capacities are developed, but development of these abilities is impaired by affective illness (Riley, Ensminger, Green, & Kang, 1998; Williamson et al., 1998). Young people, suffering from mood disorders, have problems completing school and college, resulting in decreased future earnings and unemployment (Berndt et al., 2000; Fergusson & Woodward, 2002; Kessler, Foster, Saunders, & Stang, 1995). These disorders often persist into adulthood and have a variety of adverse psychiatric and psychosocial consequences (Aalto-Setala, Marttunen, Tuulio-Henriksson, Poikolainen, & Lonnqvist, 2002; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2000).

There is a positive relationship between coping processes and illness outcomes. Therefore, it is important to examine and understand the ways that adolescents cope with illness-related stressors (Ryan-Wenger, 1996). Nurses, physicians, and other health care professionals caring for adolescents with psychiatric disorders need to be knowledgeable about how these adolescents cope with and experience mood disorders in order to provide the best interventions. Nursing, as a practice discipline, lacks a conceptual base for understanding how adolescents cope with mood disorders. The combination of experiencing the maturational crisis of adolescence and the situational crisis of an affective disorder will impact coping. Currently, theoretical models about adolescents' coping abilities related to processes of dealing with mood disorders have not been documented in the literature.

Problem Statement

Nursing, as a practice discipline, is concerned with persons as being-in-the-world and the uniqueness of their experiences in health and illness (Munhall & Oiler, 1986). There is no nursing theory based on how adolescents with mood disorder cope with their illness. This lack of theory hinders nurses' abilities to practice from a theoretical framework. The problem addressed by this study is to provide descriptions of adolescent coping and to build nursing theory. An understanding of the coping processes of adolescents experiencing mood disorder will address the needs of adolescents and is expected to contribute to the theoretical knowledge base of nursing science.

Empirical studies have been conducted which identified the factors that contribute to child and adolescent vulnerability for mood disorder. However, there is an absence of literature concerned with how these young people cope with such disorders (Albright,

1999; Beardslee, Versage, & Gladstone, 1998; Beardslee et al., 1996; Kools, 1998; Lewinsohn, Rohde, & Seeley, 1998). Current literature offers little awareness of how adolescents cope with affective illness, as well as their perception of how it impacts upon their lives.

Nursing as a humanistic discipline is concerned with the understanding of human experience. A theoretical base of how adolescents cope with the experience of a mood disorder can help mental health professionals better assist adolescents with the stresses of a mood disorder. The discovery and understanding of coping experienced by an adolescent's adaptation with an affective disorder will aid in the development of a conceptual model. A theoretical base will enable nurses, physicians, and other health care providers to provide supportive interventions, information and counseling. Such efforts will help to promote successful coping and recovery in youth living with a mood disorder.

Purpose of the Study

The purpose of this study was to explore the phenomenon of coping as experienced by adolescents with a mood disorder and to generate a grounded theory of the processes involved as they cope with a psychiatric illness. Given the lack of information on the coping experience of youth with mood disorders, research illuminating how adolescents cope with mental illness is needed. Ultimately, exploring how adolescents cope with the stress of a mood disorder may provide a theory which will aid in the development of a nursing model for caring for adolescents with mood disorders. The theory will enable nurses to develop and implement more effective nursing interventions to guide practice. Information about the processes of coping from the

perspective of youth experiencing a psychiatric illness will contribute to the base of nursing knowledge and theory. The research will add a new perspective to the existing knowledge about coping and those youths living with a chronic mental illness.

Research Questions

This study concentrated on the coping processes of adolescents who have a mood disorder. The phenomenon of concern was addressed through the following research question:

How do adolescents experiencing a mood disorder cope?

A sub-question of interest for the study was:

What other persons and things influence coping?

According to Speziale and Carpenter (2003) and Strauss and Corbin (1998), the investigator of a grounded theory study must begin with a question that is very broad, but provides focus to the study. These authors suggest that the question becomes more narrowed and more focused during the research process. As data collection and analysis proceed, the question (s) becomes refined, giving the emerging theory.

Research Paradigm

The research paradigm or worldview used by the investigator is constructivist, originally termed "naturalistic inquiry" by Lincoln and Guba (1985). They propose their paradigm as a replacement for the scientific or positivist paradigm of inquiry, which has dominated natural science investigation in the Western world. Guba and Lincoln (1998) define paradigm as a set of basic beliefs used to guide inquiry, based upon ontological, epistemological, and methodological assumptions that can be summarized according to the responses to three fundamental questions. (1) The ontological question: What is the

form and nature of reality, and moreover, what is there that can be known about it? (2) The epistemological question: What is the nature of the relationship between the inquirer and what can be known? The concern is with the origin and structure of knowledge. (3) The methodological question: How should the inquirer go about investigating knowledge to answer the research question?

The constructivist mode of inquiry is concerned with the understanding and reconstruction of the constructions [realities] that people hold. The aim is consensus construction through interpretation. This requires the investigator to adopt an emic perspective, which is different from the positivist's etic viewpoint. Accordingly, the researcher acts as a human instrument within the investigation in order to discover and elucidate meaning from the constructions that are embedded in the language and action of the respondents. Knowledge of the world results from individual construction of meaning; thus, "discovered" reality arises from the interactive process between the researcher [viewer] and the participants [viewed], and its temporal, cultural, and structural contexts (Charmaz, 2000).

Development of an understanding of the phenomenon, adolescents coping with mood disorders, is constructed from individual experience. Supporting this process, the researcher acts as a collaborator, interacting with study participants throughout the research process to access the multiple views of reality that may exist. In this research paradigm, the informants play a more active and egalitarian role (Appleton & King, 1997; Guba & Lincoln, 1998).

Using the constructivist paradigm to guide this inquiry, my intent, as researcher, was to develop a grounded theory that will aid nurses and other health professionals to

better understand adolescents' perspectives of coping with a mood disorder. According to Lincoln and Guba (1985), the naturalist "prefers to have the guiding substantive theory emerge from (be grounded in) the data because no a priori theory could possibly encompass the multiple realities that are likely to be encountered" (p. 41). The phenomenon of concern, adolescents coping with a mood disorder, has no existing theory to test. Although there is a plethora of literature on coping in children and adolescents, there has been limited investigation of coping by adolescents with mood disorders. Grounded theory is a correct approach in exploring nursing phenomena that has a limited knowledge base. This methodology is suited to address this gap in knowledge because of its focus on the richness and diversity of the human experience and generation of theory (Charmaz, 2000; Chenitz & Swanson, 1986; Speziale & Carpenter, 2003).

Summary

In this chapter, I have introduced the topic of investigation, defined the terms, definitions, and categories of mood disorders, the scope and significance of the problem, the prevalence, problem statement, and purpose of the study, the research question and research approach to the study. In the next chapter, I will highlight the consequences of having such a disorder on adolescents. As well, I will discuss the current state of knowledge related to coping in normal adolescents.

CHAPTER II

THE LITERATURE REVIEW

Prior to undertaking this inquiry, a selective sampling of the literature was performed in order to provide background to the study. There are different viewpoints espoused on whether or not a literature review is performed prior to undertaking a grounded theory study. Stern (1980) argued that a literature review prior to undertaking a grounded theory study may be detrimental as it leads to prejudgments and affects premature closure of ideas. Similarly, Strauss and Corbin (1998) advocated reviewing some but not all of the literature in a field before undertaking a grounded theory study, as it may constrain or stifle the investigator. As a professional Registered Nurse, my clinical experience and previous knowledge related to adolescents with mood disorders influenced how I undertook the literature review prior to beginning this study.

Nevertheless, other researchers recommend a literature review before commencing data collection for the purposes of examining the literature for explicit and implicit assumptions, determining biases in measurement and unsubstantiated conclusions, and identifying gaps or biases in existing knowledge (Chenitz & Swanson, 1986; Creswell, 1998; Morse & Field, 1995; Strauss & Corbin, 1998; Speziale & Carpenter, 2003). These researchers identify the literature review as a valuable component of the inquiry process for the grounded theory investigator in providing the study background, purpose, significance of the study, and as a starting point for the development of new knowledge and theory.

I agree with the views for undertaking a literature review as expressed by these researchers [Chenitz & Swanson, Morse & Field, Strauss & Corbin, Speziale &

Carpenter] for the purposes of providing background to the study. Consequently, a general review of the literature was undertaken prior to conducting the study to provide background for the topic. That preliminary literature review is presented in this section. The major component of the literature review undertaken during and following the data collection and analysis process to support the emerging theory will be discussed in the findings section in Chapter IV. Also in a discussion of my implications in Chapter V, I will discuss how my theory is similar or dissimilar to existing coping theories.

Although empirical studies have been conducted which examine the adverse effects of adolescent mood disorder, there is a paucity of data regarding adolescents' experience of coping with such a psychiatric illness. The literature review is presented in two sections. The first section reviews the literature related to the consequences of mood disorder diagnosed during adolescence. The second section is focused on an overview of coping and studies that have investigated coping in normal adolescents. Gaps in the research are also identified throughout both sections.

Consequences of Mood Disorders during Adolescence

Depressive disorders are identified as a key example of a consequence of stress and the coping process. Numerous authors have reported on the associated long-term social, emotional, and occupational impairment of mood disorders during adolescence (Birmaher et al., 1996; Fergusson & Woodward, 2002; Glied & Pine, 2002; Gotlib et al., 1998; Ramrakha et al., 2000; Rao et al., 2000; Shoaf et al., 2001). It is paramount that nurses and other health professionals be aware of the influence of the long-term stressors of the illness trajectory and how adolescents use appropriate coping strategies when struggling with such an illness. How do adolescents deal with these serious consequences

in an adaptive way? The literature documenting these negative consequences connected with adolescent mood disorders has been devoted to depression, specifically major depressive disorder. One of the serious consequences associated with mood disorders in this vulnerable population is suicide and suicide attempts (WHO, 2000).

Researchers have examined adolescents who attempt or commit suicide, reporting that high numbers suffer depressive disorders (Agerbo, Nordentoft, & Mortensen, 2002; Beautrais, 2003; Fleischmann, Beautrais, Bertolote, & Belfer, 2005; Marttunen, Aro, Henriksson, & Lonnqvist, 1991; Marttunen & Pelkonen, 2000; Pfeffer, 2001; Sanchez & Le, 2001; Shaffer et al., 1996). Researchers have also conducted psychological autopsies and have identified that the majority of youth who committed suicide had a mood disorder (Brent et al., 1993; Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Hawton et al., 1998; Houston et al., 2001; Runeson, 1989; Shafii, Carrigan, Whittinghill, & Derrick, 1985). Researchers who have used this psychological autopsy method gather data from a variety of sources, including interviews with surviving family members, friends or other informants such as teachers, employers and reviews of health and police documents (Litman, Curphey, Shneidman, Farberow, & Tabachnick, 1963). The purpose of the psychological autopsy is to ascertain a deeper understanding of the etiology of suicidal behavior. Since the 1980's, this approach has been used specifically on adolescent suicide victims to determine factors associated with youth suicide. The validity and reliability of this procedure in determining psychiatric diagnosis and identifying factors influencing youth suicide has been demonstrated (Brent et al., 1993; Kelly & Mann, 1996).

The psychological autopsy approach has a long history beginning during the late 1950's in studies undertaken to examine suicidality among adults, retrospectively (Litman et al., 1963). Suicidality is defined as suicidal thoughts and behavior including ideation, suicide attempts and completion (Judge & Billick, 2004).

In a case-control psychological autopsy study of child and adolescent suicide, Shaffer et al. (1996) reported that over 90% of the subjects (n = 120) suffered from at least one DSM-III psychiatric disorder. Mood disorders were the most common psychiatric diagnoses. Sixty-one percent of the subjects who committed suicide met the criteria for those disorders. Two-thirds of the subjects who completed suicide had one of three risk factors: previous attempt, mood or substance abuse disorder. Seventy percent of the subjects who committed suicide had a comorbid diagnoses, mood disorder in combination with a disruptive or substance abuse disorder. Marttunen et al. (1991) conducted a similar study involving adolescent suicide victims (n = 53) ranging in age from 13 to 19 years living in Finland. Over 90% of the subjects met the criteria for a DSM-III-R diagnosis with depressive disorders being the most common (51%).

In a later case-control study, Brent et al. (1999) used the psychological autopsy approach to compare age and sex-related factors for suicide among 140 adolescent victims with 131 community controls. In comparing older and younger suicide victims, over 89% of the older versus 60% of the younger subjects met criteria for a psychiatric disorder which were mood disorders alone or in combination with a disruptive and/or substance abuse disorder. Suicide risk factors such as mood disorder, past suicide attempt, and handgun in the home were found to be more common in females (71%) than males (43%) who completed suicide.

Other researchers using the psychological autopsy procedure have corroborated that depressive disorders are significant risk factors for completed suicide among youth. In a case-control study of suicide in young people aged 15-24 years (n = 24), Houston et al. (2001), using the psychological autopsy approach, reported that over 70% of the subjects had a psychiatric disorder, most commonly a depressive disorder (55.5%).

Two reviews have been completed on the role of psychiatric disorders and their association with suicide. Arsenault-Lapierre, Kim, and Turecki (2004) completed a meta-analysis of studies related to suicide using the psychological autopsy procedure. Twenty-seven studies that included adult and adolescent subjects (n = 3275) comprised the meta-analysis, and 52% of these were case-control studies. A high number of suicide completers had been diagnosed with a psychiatric diagnosis (87.3%) prior to their death. Over 43% of the victims were diagnosed with an affective disorder. The two single most common diagnostic categories among all suicide completers were affective disorders and substance related disorders. No differences were reported between the adolescent and adult completers. Gender differences were noted in that most female completers had an affective disorder in comparison to the male completers who had substance-related disorders and personality disorders.

Cavanagh et al. (2002) completed a systematic review of 154 studies of suicide that used a psychological autopsy approach. Twenty-two of these were case-control studies using both adult and adolescent suicide cases. A psychiatric disorder (91%) was found to be the most common variable associated with suicide. These were affective disorders alone or combined with other psychiatric and substance related disorders.

According to researchers, these results are consistent with the strong link between mood disorders and suicide in children and adolescents reported in the suicide literature.

Psychiatric problems, particularly mood disorders, as reported by psychological autopsy of suicide completers, are also reported among studies of teens that either attempted suicide or experienced suicidal ideation. Frequently, depressive disorders have been found to be associated with suicidality in clinically referred and nonclinical samples of youths with suicidal ideation or suicide attempt (Andrews & Lewinsohn, 1992; Beautrais, Joyce, & Mulder, 1996; De Man, 1999; Dilsaver, Benazzi, Rihmer, Akiskal, & Akiskal, 2005; Esposito & Clum, 2002; Esposito, Spirito, Boergers, & Donaldson, 2003; Goldston, Daniel, Reboussin, Kelley, & Frazier, 1998; Groholt, Ekeberg, Wichstrom, & Haldorsen, 2000; Reinherz et al., 1995; Wang, Hughes, Murphy, Rigby, & Langille, 2003; Wild, Flisher, & Lombard, 2004).

Using a cross-sectional design, Wang et al. (2003) investigated factors associated with suicidal behavior and health seeking among high school students (n = 2372) in a province in Canada. Depression was identified as the critical risk factor for suicidal behaviors in both female and male students. Although findings indicated that most youths who were suicidal fail to seek help for emotional problems, girls who were suicidal were more likely to seek help than boys. The family doctor was the health professional most commonly contacted by adolescents experiencing suicidality.

In a study of 73 high-risk high school adolescents, Esposito and Clum (2002) used semi-structured diagnostic interviews and standardized clinical assessment tools to examine psychiatric symptoms and their relationship to suicidal ideation. Seventy-four percent of the study's adolescents met the diagnostic criteria for psychiatric diagnoses,

with major-depressive disorder being the most prevalent (40%). The findings indicated a significant relationship between the presence of a psychiatric disorder and suicidal ideation. The symptoms associated with mood disorders were most strongly linked with suicidality in adolescents.

Although most were based on a small sample size, several studies have identified suicidal ideation and behavior as characteristics common among clinically referred samples of adolescents with major depressive disorder (Esposito et al., 2003; Goldston et al., 1998; Ivarsson, Larsson, & Gillberg, 1998; Kovacs, Goldston, & Gatsonis, 1993; Larsson & Ivarsson, 1998; Schoff D'Eramo, Prinstein, Freeman, Grapentine, & Spirito, 2004). For example, Groholt, Ekeberg, and Haldorsen (2000) used semi-structured interviews and DSM-IV criteria, and a variety of psychometric scales to compare two subgroups of adolescent psychiatric inpatients (n = 91) on factors influencing their intent to die or not to die when attempting suicide. The "intent to die" adolescents were significantly more depressed, more hopeless, less disruptive and infrequently abused substances. The "not to die" adolescent group reported more externalizing disruptive behavior [conduct and substance use] disorders and had higher rates of impulsiveness. This above study supports the findings described by Apter et al. (1995) who hypothetically espoused two different kinds of adolescent suicidal behavior each associated with a particular phenomena, depression and aggression. These authors reexamined the correlation between suicidal and violent behavior, and depressive symptomatology within a variety of diagnostic categories of 163 adolescent inpatients. Findings demonstrated two types of suicidal behavior: one associated with depression [a

wish to die] and another associated with impulse control [a wish to not be here for a time] affiliated with a disruptive behavior disorder.

Several studies supported the notion that adolescents were more likely to attempt and complete suicide if they were experiencing depression. For example, in a controlled study, Goldston et al. (1998) used semi-structured interviews and standardized assessment scales to compare psychiatric diagnoses among psychiatric hospitalized suicidal adolescents (n = 110) with nonsuicidal youths (n = 159). Mood disorders, specifically major depression, were found to be more prevalent among both the repeat and previous adolescent attempters than among nonsuicidal youths. In comparison to nonsuicidal youths, adjustment disorders were noted to be more frequent among first-time attempters.

In a study using a cross-sectional design, Esposito et al. (2003) explored the affective, behavioral, and cognitive capacity of adolescents with suicidality. Forty-seven adolescents who had a history of multiple suicide attempts were compared to 74 single suicide attempters on diagnosis, symptomatology, self-harm, substance use and feelings of hopelessness. Using diagnostic structured interview criteria and a battery of standardized psychometric assessment scales, these researchers found that the multiple attempters had a greater severity of depressive symptoms, anger and self-mutilation, higher levels of mood disorder and affect dysregulation, in comparison to the single suicide attempters.

Similarly, Nock and Kazdin (2002) examined the affective, cognitive, and behavioral functioning related to suicidal outcomes [ideation, attempts, and intent] in child in child and young adolescent (n = 175) psychiatric inpatients. Following separate

interviews with participants and their guardians, diagnosis was assigned based upon DSM-III criteria. The most common diagnoses included major depression and conduct disorder. All participants completed a variety of standardized psychological assessment scales. Suicidal outcomes of the participants were significantly related to depressed mood, negative thoughts, hopelessness and anhedonia. Youth who were suicidal [ideators and attempters] reported higher scores on depressed mood, negative thoughts, and hopelessness in comparison to the nonsuicidal inpatients. Two significant risk factors found among subjects who attempted suicide in comparison to youth who were not attempters, were more anhedonia and a greater number of previous suicide attempts.

The same risk factor evident in psychological autopsy studies, mood disorders, has been identified by researchers using a longitudinal design, as a predictive factor for post-hospitalization suicidal behavior among previously hospitalized suicidal adolescents (Goldston, Daniel, Reboussin, Reboussin, Frazier, & Kelley, 1999; King et al., 1995; Kovacs et al., 1993; Rao, Weissman, Martin, & Hammond, 1993). Most studies had small sample sizes and follow-up periods from six months to ten years. In follow-up, most suicides occurred in late adolescence or early adulthood. For example, in a prospective 5-year follow-up study of psychiatrically-ill discharged adolescents (n = 180) Goldston et al. (1999) used semi-structured interviews and self-report questionnaires to assess post-hospitalization suicidal behavior over time. Seven percent of adolescents attempted suicide 6 months post-discharge, 12% attempted one year after discharge, and 25% of teens attempted suicide five years after hospitalization. Adolescents with a history of past suicide attempts and those with mood disorders were at increased risk for post-hospitalization suicidality. King et al. (1995) reported similar findings in a prospective

study of adolescent (n = 100) suicidal behavior during a six-month post-discharge follow-up period. Eighteen percent of adolescents reported suicidal behavior during the follow-up period. Adolescents who demonstrated suicidality were found to have greater levels of family dysfunction and had been diagnosed with dysthymia than were nonsuicidal youth.

Although suicidality is recognized as one of the most serious consequences or risk factors associated with the development of mood disorders during adolescence, there is also evidence that these disorders negatively impact the cognitive, emotional, social, and occupational functioning during this phase of development. Much has been written about suicidality as an associated risk factor for youth with mood disorders, but there is a paucity of data regarding the long-term outcomes of hospitalized adolescent psychiatric patients, specifically related to academic achievement.

One of the negative consequences related to adolescents who have a mood disorder is the effect on their educational attainment. Academic problems identified for these adolescents with mood disorders include poor school performance, absenteeism, failure to complete high school, college, and graduate school (Berndt et al., 2000; Best, Hauser, Gralinski-Bakker, Allen, & Crowell, 2004; DeSocio & Hootman, 2004; Fergusson & Woodward, 2002; Glied & Pine, 2002; Kessler et al., 1995; Lagace, Kutcher, & Robertson, 2003; Puig-Antich et al., 1993; Vander Stoep et al., 2002). These educational intrusions negatively impact personhood, making it difficult to obtain work, limiting occupational opportunities, and restricting income potential. These factors affect the person's security and overall health.

One of the shortcomings of previous research has been scant knowledge reported about the consequences of adolescent mood disorders on academic attainment. Some of the studies have used different mixed samples, children, adolescents, and adults (Costello et al., 1996; Kessler et al., 1995), but did not report separate information for adolescents. Thus, it is difficult to generalize findings to the adolescent population. Several researchers examined a variety of adverse outcomes related to adolescent mood disorder, but only a few had specifically concentrated on educational outcomes (Best et al., 2004; Kessler et al., 1995; Lagace et al., 2003). For example, in an longitudinal study, Best et al. (2004) used a variety of assessment tools to explore differences in mortality, emotional distress, school completion and educational achievement in a cohort of psychiatrically hospitalized adolescents (n = 70) and a comparable group of high school students (n = 76). Subjects were assessed at three time junctures: recruitment, 11-year, and 20-year follow-up. Hospitalized youth were less likely to complete high school than the nonhospital group. The hospitalized adolescents were also less likely to complete college or graduate school than the high school cohort. This knowledge supports the importance for nurses and other health professionals to assess youth who may have a mood disorder. Timely intervention may help to prevent educational difficulties for adolescents who experience a mood disorder.

In a similar seminal longitudinal study, Kandel and Davies (1986) assessed the continuity of depressive mood among a group (n = 1333) of adolescents who were examined at ages 15 and 16 in high school and followed-up as adults (n = 1004) nine years later. Adults who were depressed as adolescents were more likely to complete fewer years of schooling and drop out than those adolescents who were not depressed.

Female adolescents with depression were more likely to drop out of school compared to the male adolescents who were depressed.

Using a longitudinal design, Fergusson and Woodward (2002) identified the emotional, social, and educational outcomes of a group of adolescents (n = 964) who were assessed during different developmental intervals: birth, 4 months, one year, annually to age 16 years and followed-up at young adulthood. Data were gathered using a variety of diagnostic interview scales, and educational and psychometric assessment tools. Adolescents with depression reported more school failure and were less likely to enter a university. Subjects who were depressed as adolescents in young adulthood had higher rates of unemployment and early parenthood.

Similarly, using a variety of educational and psychological assessment tools, Lagace et al. (2003) in a controlled study explored the academic difficulties related to mathematical ability among adolescents. Forty-four subjects with bipolar I disorder were compared to adolescents (n = 30) with major depressive disorder and a group (n = 45) of teens with no psychiatric disorder. In comparison to the other two youth groups, adolescents with bipolar I disorder had poorer mathematics scores. No significant differences between groups were reported in reading and spelling achievement test scores.

Given the limited state of knowledge related to adolescent academic impairments associated with mood disorders, it can be argued that future studies are needed to determine the continuity of educational difficulties. Research on appropriate interventions for educational problems for affectively ill adolescents is also essential. Such knowledge may help to promote the stability of academic achievements during adolescence.

Another risk associated with youth who have a mood disorder is the use of drugs. Several researchers have highlighted substance use, specifically nicotine dependence as a negative consequence associated with adolescent mood disorders (Boys et al., 2003; Brook, Cohen, & Brook, 1998; Brook, Brook, Zhang, Cohen, & Whiteman, 2002; Danielson, Overholser, & Butt, 2003; Fergusson, Goodwin, & Horwood, 2003; Fergusson, Lynskey, & Horwood, 1996; Giaconia, Reinherz, Paradis, Hauf, & Stashwick, 2001; Rao et al., 2000; Rao et al.1999; Reinherz, Giaconia, Hauf, Wasserman, & Paradis, 2000; Shrier, Harris, Sternberg, & Beardslee, 2001; Wilens et al., 2004; Wu et al., 2004). This information is important for nurses who can target interventions for these populations know to be at high risk.

This connection between major depressive disorder and smoking has been identified in both clinical and non-clinical samples of adolescents (Alvarado & Breslau, 2005; Breslau, Kilbey, & Andreski, 1991; Brown, Lewinsohn, Seeley, & Wagner, 1996; Chang, Sherritt, & Knight, 2005; Escobedo, Reddy, & Giovino, 1998; Fergusson et al., 1996; Kandel et al., 1997; Killen et al., 2004; Koval, Pederson, Mills, McGrady, & Carvajal, 2000; Paperwalla, Levin, Weiner, & Saravay, 2004). Depression has been suggested to increase the risk for smoking. For instance, in a 16-year longitudinal study, Fergusson et al. (1996) used structured diagnostic interviews and standardized clinical assessment tools to explore the relationship between depression and nicotine dependence in a group of children (n = 947). These subjects were assessed during specific developmental periods: birth, 4 months, one year, and annually to age 16 years. Findings supported a strong association between depression and nicotine dependence. The 16 year old male and female teens with depression had odds of nicotine dependence that were

more than 4.5 times the odds for teens without psychiatric disorders. In a 9-year longitudinal study of adolescents (n = 1004) with depressive symptoms, Kandel and Davies (1986) reported higher rates of lifetime and current smoking in young adults who were depressed as adolescents. Fifty-seven percent of the males and 50% of the females who were depressed described smoking cigarettes daily compared to 30% of the males and 34% of the females who were not depressed. These findings are consistent with those of Boys et al. (2003) study completed in the United Kingdom. Boys et al. (2003) found that teens classified as regular smokers were 4 to 5 times more likely to have a depressive disorder compared to non-smokers. Adolescents who had a depressive disorder were over 5 times more likely to be a regular smoker than individuals with no psychiatric diagnosis.

In a prospective, cohort study Escobebo et al. (1998) assessed the smoking practices of a group of teens (n = 7885) aged 12 to 18 years over four years. A moderate association between depression and smoking initiation was noted. Depressed adolescents were more likely to start smoking compared to the non-depressed adolescents. Similarly, Dierker, Avenevoli, Merikangas, Flaherty, and Stolar (2001) conducted a longitudinal study over a four-year period to determine the comorbidity of psychiatric disorders and tobacco use among a community sample of high-and low-risk youths with a history of parental substance use. Nicotine dependence was associated with the onset of affective disorders. Patton et al. (1996) used a questionnaire to examine the association with depression and anxiety in a sample (n = 2525) of youth attending secondary school in Australia. A strong relationship was found between smoking and depression. Even after controlling for a variety of factors [sex, substance use, and parental smoking] youth smokers reported higher levels of depression and anxiety than non-smokers.

Similarly, Vogel, Hurford, Smith, and Cole (2003) explored the connection between smoking, depression, and a number of demographic and psychosocial variables among a group of high school and college students (n = 98). All subjects completed a self-reported depression assessment tool and a demographic questionnaire. Higher depression scores were associated with adolescents who smoked or had intention to smoke. Two variables within the depression inventory were significantly correlated: instrumental helplessness and social introversion were associated with smoking. In a longitudinal study of adolescents (n = 1123), Tercyak, Goldman, Smith, and Audrain (2002) reported a strong correlation with depressive symptoms and smoking in adolescent youth.

Although depression has been identified as a risk factor for smoking initiation in adolescence, some researchers have argued a contrasting view. It is also espoused that smoking may be a risk factor for depression (Brook, Schuster, & Zhang, 2004; Goodman & Capitman, 2000; Paperwalla et al., 2004; Wu & Anthony, 1999). A 13-year longitudinal study by Brooks et al. (2004) supported findings linking cigarette smoking in adolescence with depression in young adulthood. Adolescent smoking was found to be a predictor of depression onset in young adulthood. Similarly, Goodman and Capitman (2000) assessed the relationship between cigarette smoking and depression among a group of teens in a one-year study with a sample of non-smoker teens (n = 8704) who were not depressed compared to another sample of non-smoker depressed teens (n = 6947). The objective was to assess future risk of cigarette use. High depressive symptomatology increased the odds of heavy smoking. However, this effect was not statistically significant. In a similar prospective study, Wu and Anthony (1999)

corroborated the risk of tobacco use for later onset of depressed mood in youth aged 8 to 14 years, but no association was found between antecedent depressed mood and later smoking initiation.

Several researchers who used a cross sectional design reported that depressive disorders were associated with smoking behaviors in adolescents. For example, Brown et al. (1996) examined the relationship between smoking and major depressive disorder in a community sample of youth (n = 1709) on two separate occasions with follow-up one year apart. An association with smoking in adolescence increased the probability of development of a major depressive disorder (MDD) or drug use disorder. In a national survey of adolescents (n = 4023) in the United States, Acierno et al. (2000) examined specific risk factors [assault, family substance use, depression and post traumatic stress disorder] association with youth smoking behaviors and found a two-fold increase in the likelihood of smoking initiation in depressed adolescents. Gender differences were noted in that depression increased the risk of smoking behavior in females but had no influence among the male adolescents.

The literature has highlighted two views connected to the relationship between smoking and major depressive disorder. One belief being that depression leads to smoking and the other that smoking may be one of the preceding factors associated with the development of depression. However, due to the complexity and dynamics of such an association (Goodman & Capitman, 2000), the evidence supporting these relationships are clouded. Thus, the issue continues to be debated.

Researchers have demonstrated a strong link between cigarette smoking and depression in adolescents (Brown et al., 1996; Escobedo et al., 1998; Vogel et al., 2003)

but other researchers have also reported other psychoactive substance [alcohol, cannabis, and hard drugs] use among youth with major depressive disorder (Anderson, Plant, & Plant, 1998; Brook et al., 2002; Boys et al., 2003). It is also recognized that mood disorders, specifically major depressive disorders in youth, often co-occur with substance abuse disorders. This relationship has been reported in both clinical and non-clinical samples of adolescents (Axelson & Birmaher, 2001; Boyle & Offord, 1991; Bukstein, Glancy, & Kaminer, 1992; Deykin, Buka, & Zeena, 1992; Giaconia et al., 2001; Greenbaum, Prange, Friedman, & Silver, 1991; Kessler et al., 2001; Rao et al., 2000; Son & Kirchner, 2000). These findings support the importance of primary, secondary and tertiary prevention for nurses who have access to an adolescent population whether within a community or school setting.

Brook et al. (2002) in a longitudinal community sample of adults (n = 736) explored the relationship between early drug use during childhood and adolescence, and occurrence of psychiatric disorders in young adulthood. After controlling for a multitude of study variables, it was found that early alcohol, tobacco, and marijuana use predicted major depressive disorder, dependence, and substance use disorder among subjects in their late 20's. In a smaller longitudinal study of female high school students (n = 155), Rao et al. (2000) examined the relationship of major depressive disorder and substance use disorder in the transition from adolescence to young adulthood. Adolescents with depression were more likely to use substances than teens without depression. Having a prior substance abuse disorder predicted the likelihood of developing a major depressive disorder during follow-up.

Similarly, Boys et al. (2003) in a national mental health survey of children and adolescents (n = 2624) in the United Kingdom reported that youth who used alcohol, tobacco and cannabis were five times more likely to have a depressive disorder compared to the non-substance use teens. Costello, Erkanli, Federman, and Angold (1999) examined the impact of childhood psychiatric disorders on substance use in adolescence and reported consistent findings. From a sample of children (n = 1420) they found that disruptive behavior and depressive disorders were associated with greater and earlier onset of substance use among subjects. Alcohol use preceded smoking initiation in these youth.

In several landmark studies, researchers have confirmed the association of psychiatric disorders and comorbidity with substance use in clinically referred adolescents (Bukstein et al., 1992; Deykin et al., 1992; Greenbaum et al., 1991). For example, Greenbaum et al. (1991) reported a high prevalence of substance use disorders comorbid with other psychiatric disorders among an adolescent population (n = 547) with emotional disturbances. Using DSM-III-R diagnostic criteria, Deykin et al. (1992) investigated the prevalence of depression in a group of adolescents (n = 223) receiving treatment for chemical dependence. The subjects who were depressed (24.7%) developed substance dependence at an earlier age compared to the subjects without depression (75.3%). Researchers proposed that substance dependent adolescents had two distinct forms of clinical depression. One form, primary depression associated with features of affective disorder, affected only a few of the study subjects. The other form, depression secondary to chemical dependence with features associated with substance use, affected a number of study adolescents. Females reported earlier onset of depression compared to

males. Bukstein et al. (1992) corroborated these findings among a group (n = 156) of "dually diagnosed' adolescent psychiatric inpatients. A high majority of the subjects had multiple comorbid diagnoses: substance use disorder, affective disorder, and conduct disorder. Secondary major depressive disorder was found to be equally common in male and female adolescents. Similarly, Danielson et al. (2003) have corroborated these findings in exploring the association of depression and alcohol use in a group of adolescent psychiatric inpatients (n = 98). Adolescents who reported using alcohol had higher levels of depression compared to youth that did not use alcohol. In summary, those adolescents who experience mood disorders are at high risk for using substances. The literature is unclear as to why this is the case for some youth. It is believed by some researchers that adolescents use substances as a way of coping with their psychiatric illness. Therefore, timely intervention and prevention is important for this population of youth.

It can not be denied that substance use is a serious risk-taking behavior connected to adolescent depression. However, several researchers have argued that risk-taking sexual behavior associated with depression has received limited attention (Bennett & Bauman, 2000; Brooks, Harris, Thrall, & Woods, 2002; Hallfors et al., 2004; Kosunen, Kaltiala-Heino, Rimpela, & Laippala, 2003; Ramrakha et al., 2000). This fact is notable since the onset of depressive disorders is very common in this population and one of the challenges for adolescence during this stage of development is sexual maturity.

For example, Ramrakha et al. (2000) as part of a multidisciplinary health and development study of a birth cohort (n = 930) examined risky sexual behavior associated with a variety of psychiatric disorders at age 21 years. Study participants with psychiatric

illness were compared with persons with no psychiatric disorders. Individuals with depressive disorders, substance use, and antisocial disorders were more likely to engage in risky sexual behavior. Depression was reported to be the most common psychiatric disorder among the study population. Major depressive disorder was associated with increased rates of risky sex, sexually transmitted diseases, and early sexual experience. The subjects' possibility for risky sexual behavior was tripled if they had a combination of disorders such as depression and antisocial disorder, or depression and substance use disorder. Ramrakha et al. (2000) suggested that young adults engaged in risky sexual behavior to offset the core feelings of depression [hopelessness and worthlessness]. They also proposed that youth became involved in these practices as a part of self- treatment for the disorder. Kosunen et al. (2003) reported similar results about risky sexual behavior and depression from a school-based survey of adolescents aged 14 to 16 years in Finland. For both male and female subjects multiple sexual partners and non-contraception use was associated with a depressive disorder. Shrier et al. (2001) also corroborated these findings in a national longitudinal survey on adolescent health. Adolescents with depressive symptoms were at an increased sexual risk of contraception nonuse and sexually transmitted diseases.

In a similar study, using a longitudinal design, Hallfors et al. (2004) reviewed the association between depression and risky sexual behavior among a group of adolescents in the United States (n = 18,924). Youth who engaged in risky behaviors such as drinking, smoking and sexual activity were at increased odds for depression and suicidality compared to youth that abstained from such behaviors. Gender differences were noted for females who were less likely to engage in high-risk behaviors compared to

males. However, females who participated in such behaviors were more prone to depression and suicidality.

Another consequence linked to depression in adolescents is teenage parenthood (Kessler et al., 1997, Kovacs, Krol, & Voti, 1994; Rao et al., 1995). However due to the dearth of research related to this topic much more work is needed to address the outcome for early parenting and youth with psychiatric disorders. Kessler et al. (1997) reported that early-onset psychiatric disorders in adolescence were associated with unplanned pregnancies and teenage parenthood. Using data collected retrospectively from the National Comorbidity Survey, researchers found that early-onset of anxiety, affective, substance use, and disruptive disorders was significantly associated with teenage parenthood. For respondents, early sexual activity had a stronger association to substance use disorder in comparison to the other psychiatric disorders. There were only a few studies demonstrating the risk of early sexual behavior associated with adolescent psychiatric disorders. However, findings were consistent in showing the need for this issue to have a stronger clinical focus for mental health professionals working with this youth population.

Adolescent mood disorders have been associated with major depressive disorder during young adulthood. Recurrence rates were estimated to be 60% to 70% (Birmaher et al., 1996; Lewinsohn et al., 1999; Weissman et al., 1999). Extensive research supported the argument of the possibility of continuity between childhood, adolescent, and adult depression. Several studies have identified impairments related to career, work, education, and social relationships encountered by young adults from the recurrence of depression that was experienced in either childhood or adolescence (Aronen & Soininen,

2000; Ferdinand & Verhulst, 1995; Garber, Kriss, Koch, & Lindholm, 1988; Lewinsohn et al., 2000; Reinherz et al., 1999; Skarbo, Rosenvinge & Holte, 2004; Wittchen, Nelson, & Lachner, 1998). These risks and impairments have been reported in both clinical and non-clinical populations. Some of these studies have been criticized because of small samples, self-reported data assessments which may lead to recall bias, and lack of a control group (Rao, Hammen, & Daley, 1999; Weissman et al., 1999; Wittchen et al., 1998). However, despite these limitations, the evidence does not negate the importance of studying the relationships between adolescent and adult depression.

Several follow-up studies have identified that depressed adolescents experience recurrence in adulthood and as a result, suffer psychosocial impairments. For example, Giaconia et al. (2001) in a longitudinal community-based study using a control group, found that young adults (n = 365) who had major depression and substance use disorders in adolescence reported work and career dissatisfaction. Youth with substance use disorders were less likely to pursue post-secondary education and had unstable work records. One fourth of the subjects who were depressed as adolescents experienced depression in young adulthood. Notably, both subjects with depression and substance use disorders as adolescents demonstrated increased risk for lifetime suicide attempts and current suicidality as young adults.

In another longitudinal community-based study, Rao et al. (1999) explored the continuity of depression from adolescence to adulthood in a sample of women (n = 155) over five years and reported similar findings. Women who had depression as adolescents were most likely to have a recurrence than those subjects without prior depression. During the five-year follow-up period, 47% of the women had a major depressive

disorder episode. Women reported difficulties in school, work, and intimate relationships. Similarly, in a community sample (n = 739), Lewinsohn et al. (1999) compared subjects with a history of child or adolescent mood disorder, nonaffective disorder and a group with no psychiatric disorder to determine the continuity of adolescent major depressive disorder (MDD) into adulthood. In comparison to the other groups, major depressive disorders in young adulthood were more common in the adolescent MDD group.

In a community sample (n = 274), Lewinsohn et al. (2000) identified factors that predicted the recurrence of major depressive disorder in young adults with previously adolescent onset MDD. Fifty-eight of the subjects (21.2%) had a recurrence of MDD by age 24. Factors identified as leading to a recurrent episode were: more severe episodes of depression during adolescence; emotional reliance; family history of MDD; personality disorder symptoms; and for male subjects, a depressotypic attributional style.

In a controlled follow-up study of 28 subjects who as adolescents had unipolar major depressive disorder, Rao et al. (1995) examined their adjustment into adulthood. In comparison to the control group (n = 35), subjects who were depressed as adolescents demonstrated higher recurrence of depression. As reported in previous studies, subjects with recurrent depression at follow-up had greater impairments in psychosocial functioning than controls with no psychiatric disorder. Thirty-five percent of the depressed subjects became parents compared to (6%) of the controls with no disorder.

In another controlled follow-up study of psychiatrically ill adolescents, Garber et al. (1998) assessed the continuity of problems in a group (n = 20) of adolescents eight years post-hospital discharge at age 22. Using a variety of standardized psychological assessment tools researchers identified that 64% of the depressed youth had a mood

disorder during follow-up. The depressed group also demonstrated greater adjustment problems in social and leisure areas and interpersonal relationships compared to the control group. In a similar, prospective case-control study, Weissman et al. (1999) investigated the continuity of major depressive disorder (MDD) into adulthood with a sample (n = 73) of subjects compared to (n = 37) controls with no psychiatric disorder. Adolescent-onset MDD subjects had a 5-fold increased risk for first suicide attempts and a 2-fold increased risk of MDD but no risk for other psychiatric disorders. The adolescent-onset MDD subjects had also increased rates of impairments in psychosocial and educational functioning.

Several researchers have suggested that adolescent depressive symptoms may be used to predict major depression in adulthood. For example, Aalto-Setala et al. (2002) stated that depressive symptoms in adolescence may impact mental health in young adulthood. Self-reported questionnaires were completed by a high school cohort (n = 709) of adolescents at age 16 years and follow-up at age 21 years. Young adults who were depressed as adolescents were twice as likely to experience a DSM-IV disorder and three times as likely to have a major depressive disorder compared to young adults who reported no adolescent depressive symptoms. In a similar study, Pine, Cohen, Cohen, and Brook (1999) corroborated these findings following assessment of a epidemiological sample of young people (n = 776). They reported a strong predictive association between adolescent depressive symptoms and major depressive episodes in adulthood.

Some investigators have explored the association between child and adolescent depression as predictor factors of psychiatric outcomes in adulthood. In the Maudsley longitudinal follow-up study of child and adolescent depression, Fombonne, Wostear,

Cooper, Harrington, and Rutter (2001a) reported high rates of adult major depressive disorder among a sample of youth (n = 149) with major depressive disorder (MDD) and comorbid conduct disorder (CD-MDD). During the 20-year follow-up, 62.5% of the adult sample had a recurrence of major depressive disorder. Three-quarters of the subjects in both the MDD and CD-MDD group experienced a mood disorder. The CD-MDD group had higher rates of suicidality, criminality, and psychosocial impairment compared to the MDD group (Fombonne et al., 2001b). In a controlled study, Harrington, Fudge, Rutter, Pickles, and Hill (1990) examined the notion of whether individuals who had a childhood or adolescent depression were at an increased risk of psychiatric problems in adulthood. Following an initial assessment, 80 child and adolescent psychiatric patients, who were individually matched with 80 non-psychiatric ill controls, were followed-up 18 years later. Compared to the control group, adults who experienced adolescent or child depression were at greater risk for affective disorder in adult life. Higher rates of suicidality were also identified for this group in comparison to the control group.

Likewise, Reinherz, Paradis, Giaconia, Stashwick, and Fitzmaurice (2003) in a prospective study examined in a community based sample (n = 354) predictive factors related to the continuity of child and adolescent major depression in adulthood. Subjects were assessed at seven major points in time from ages 5 to 26. Over 23% of the sample experienced major depression in the transition to adulthood. Predictive factors associated with adult mood disorder were parental and sibling depression, suicide in the family, and sibling substance use disorder.

Researchers have identified many negative consequences or risks associated with adolescent mood disorders. Mood disorders have been associated with impairment in

psychosocial functioning at school, interfering with the formation of friendships and other peer relationships that are important for youth during this stage of adolescent development. These disorders are also associated with the increase risk of drug use such as alcohol, smoking and other drugs. The magnitude of such impairments has been reported to affect all aspects of the adolescent's social, emotional, occupational, and interpersonal functioning. Thus, it can be argued that these disorders cause severe stress, but the literature is very limited on how adolescents cope and adjust with having a mood disorder.

Coping

Coping as a construct has been well documented in the literature. It has received much attention resulting in multiple definitions and ways of measurement. Most of the research literature has focused on adaptation to stress and how individuals manage to cope with sources of stress. According to Lazarus (1993), the old view of coping from the trait or style focus in the 1960s and early 1970s has been cast aside "in favor of a contrasting approach which treated coping as a process" (p. 235). In these earlier studies coping was conceptualized as certain traits or styles that individuals had in response to particular stressful situations. Coping as a process has been linked to defense mechanisms, responses to stress, and coping behaviors measured by self-report scales (Endler & Parker, 1990; Miceli & Castelfranchi, 2001; Somerfield & McCrae, 2000). A great deal of effort by researchers has been done related to coping for adults and normal adolescents. However, the research literature related to adolescent coping with psychiatric illness was very limited. Thus, due, to this dearth of knowledge, my focus concentrated on coping as it was related to normal adolescents.

Lazarus and Folkman (1984), whose model of coping has a cognitive focus defined coping "as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Similarly, Barry (1994) defined coping as the way an individual's mind responds in relation to his perception of a stressful situation. However, specific ways or strategies persons use to cope with stress are varied because of different subjective experiences of stress. These subjective influences may help some individuals manage stress better than others do. Allen and Hiebert (1991) identified that stress levels in adolescents are higher and their coping resources are more meager than the population at large. These authors espoused that individuals that have meager coping resources are more vulnerable and will be overtaxed by multiple demands they face. This situation will lead to additional stress. Schinke, Schilling, and Snow (1987) argued that adolescents are ill prepared to cope with stress because they lack the experience to accurately appraise stressful situations. Patterson and McCubbin (1987) supported these views and proposed that although coping is important in adolescence, adolescents have not yet had the opportunity to develop a collection of coping strategies. This lack of a coping repertoire will influence how adolescents handle stressful life events.

Although coping as a construct has received much attention in the literature, children and adolescents have been assessed repeatedly using questionnaires developed for adults (Lazarus & Folkman, 1984; Ryan-Wenger, 1992; Ryan-Wenger, 1996). The use of these adult instruments and their applicability to the adolescent population remain untested. There is also a dearth of knowledge about coping behaviors used by healthy adolescents (Chapman & Mullis, 1999; Olah, 1995; Plancherel & Bolognini, 1995;

Printz, Shermis, & Webb, 1999) and lack of knowledge regarding adolescents coping with a mood disorder. Research efforts to study coping for children and adolescents who experience a mood disorder have also been slow to develop. Efforts so far support the scientific or positivist paradigm of inquiry, which had dominated natural science investigation in the Western world (Chapman & Mullis, 1999; Olah, 1995; Plancherel & Bolognini, 1995; Printz et al., 1999; Recklitis & Noam, 1999).

Currently, one of the most common adult theories used to explain coping is Lazarus and Folkman's (1984) cognitive-phenomenological theory of stress and coping. Although this theory is over twenty years old, it is considered to be the dominant paradigm in the field of stress and coping research (Ptacek & Pierce, 2003). According to this theory, two processes mediate the relationship between the stressful events that a person encounters in daily living and emotional outcomes, cognitive appraisal and coping. Cognitive appraisal is the process through which people evaluate the significance and meaning of a specific stressful encounter for their well being-primary appraisal. The individual's assessment and response to the event leads to the process of secondary appraisal-options for coping. Here the individual has a mobilization of coping efforts concerning what might and can be done in relation to one's coping resources. These authors suggested that the amount and intensity of stressors and one's appraisal of the significance of stressors affect a person's ability to adapt successfully. Lazarus and Folkman (1984) also developed an inventory measurement scale of coping called the Ways of Coping checklist (revised). A person completing the 67 item scale is required to respond to a thought or action based upon a rating of 0 to 3. An individual's coping responses are identified within the scale as strategies distinguished as problem-focused

coping and emotion-focused coping. Problem-focused coping is aimed at doing something to manage or alter the problem causing the distress, whereas emotion-focused coping is directed at regulating emotional response associated with the problem. According to Lazarus and Folkman (1984), coping is a complex construct and an individual's process of coping may be situation-specific depending upon one's appraisal of stressors. However, if we endorse Schinke et al's. (1987) notion of adolescents' inability to fully appraise stressful events, then it is questionable if Lazarus and Folkman's (1984) cognitive-phenomenological theory of stress and coping is applicable for use among the adolescent population.

Coping in Adolescence

While researchers have explored the construct of coping and mental illness, the majority of subjects have been adults experiencing mental illness of family members caring for adults or children with mental illness (Badger, 1996; Doornbos, 1997; Nehra, Chakrabarti, Kulhara, & Sharma, 2005; Ritsner et al., 2003; Rose, 1996; Wiedl & Schottner, 1991). The applicability of findings to adolescents with mood disorders has not been validated.

According to Ryan-Wenger (1992), no theories have been specifically designed to explain child and adolescent processes of coping. After synthesizing and critiquing 32 research articles on coping strategies used by children with chronic or acute illness, Ryan-Wenger (1992) indicated that children's repertoire of coping strategies is the same during health and physical illness, although there are often differences in the frequency of effectiveness of their use. Similarly, Compas et al. (2001) argued that research on child and adolescent coping has occurred without an explicit definition of coping. They

contend that a proper definition of child and adolescent coping should reflect the developmental processes.

Several authors have investigated adolescent coping behavior. Using a sample of 276 high school students in Switzerland and the United States, Plancherel and Bolognini (1995) used the A-Cope questionnaire developed by Patterson and McCubbin to compare the behaviors used by students when faced with certain problems or difficult situations. Strategies used by the Swiss adolescents were very similar to those used by the American adolescents. Significant relations between coping strategies and mental health were reported. Girls invested in more social relations and expressed more negative feelings than boys. The girls adopted consumption habits such as shopping or eating; boys used a sense of humor, or practiced a hobby or sport in relation to interpersonal and academic stressors. These investigators stressed the importance of the social environment, particularly the family in the development of youth coping behavior.

Similarly, Printz et al. (1999) in a sample of 122 high school students in 9th and 10th grades, used path analysis to investigate factors that buffer the impact of stressful negative experiences on adolescent adjustment. The effects of stressful events experienced by the adolescents were mediated by coping resources, which included a combination of problem-solving abilities and social support. Likewise, among a sample of high school students, Compas, Malcarne and Fondacaro (1988) operationalized concepts of Lazarus and Folkman`s (1984) model and reported that adolescents used both problem focused and emotion focused coping strategies to manage interpersonal and academic stressors. These investigators stressed the importance of the social environment, particularly the family in the development of youth coping behavior.

According to Chapman and Mullis (1999), families have an important influence in shaping adolescent coping strategies, but ways to cope may be subject to change over time. Other authors suggested that adolescents' adaptation to stressors is influenced by positive social support and coping skills (Ell, 1996; Garber, Robinson, & Valentiner, 1997; Printz et al., 1999; van Beest & Baerveldt, 1999). Moreover, Compas et al. (1988) reported that adolescents acquire coping behaviors and styles from four sources: (a) previous personal experience; (b) experience associated with observing the success or failure of others, especially family members; (c) social persuasion; and (d) perceptions of their own influences and vulnerability. Therefore, for those adolescents experiencing a mental illness it could be argued that coping is compromised. In summary, although coping as a construct has received much attention in the literature, theories and questionnaires used for assessment of child and adolescent coping have been developed for adults. It could be argued that their use with children and adolescents is inappropriate. Also, researchers have reported on the factors that may influence coping in normal adolescents, but knowledge regarding coping for adolescents with a mood disorder is virtually non-existent. Would these adolescents use the same strategies for coping as those described in the above studies for normal adolescents?

Literature Summary

The literature revealed that mood disorders in adolescents are more persistent than previously thought and have and have numerous negative associated features, including further episodes of depression, impaired social, academic, and vocational relationships, substance use, and an increased risk of suicide. These factors place the adolescent's health at risk. Coping as a concept has been well documented in the literature. There is a dearth

of knowledge related to how healthy adolescents cope, and knowledge regarding how adolescents cope with a mood disorder is limited. Current literature offers little awareness of how these adolescents cope with a psychiatric illness, as well as their perception of how it impacts on their lives. Presently, no research has been published conceptualizing coping for those children and adolescents experiencing a mood disorder.

CHAPTER III

METHODOLOGY

Method of Inquiry

The proposed method for this study was a qualitative, inductive strategy using grounded theory to explore the phenomenon of adolescent coping with a mood disorder. This method is most appropriate for studying nursing phenomena because it explores the richness and diversity of human experience, considered the essence of nursing (Speziale & Carpenter, 2003). Schreiber and Stern (2001) supported this notion and considered a grounded theory method of inquiry to be well suited to nursing because of its attention with how people manage health concerns.

The phenomenon of adolescents coping with a mood disorder is an unresearched area and as such grounded theory is a useful method in this situation. Several nursing authors have used and written about the grounded theory approach as a rigorous method for investigating previously unresearched areas or for gaining a new perspective in familiar situations (Chenitz & Swanson, 1986; Hutchinson, 1993; Schreiber & Stern, 2001; Stern, 1980). This grounded theory approach was developed in the sixties, and its continuous use by nurse researchers has lead to the development of nursing knowledge (Morse, 2001). Strauss and Corbin (1998) implied that any discipline can use grounded theory, and any theory generated would be useful and reflect a discipline's perspective. Chenitz and Swanson (1986) sanctioned the use of grounded theory in building nursing knowledge to guide nursing action and intervention through theory development. People sharing common circumstances experience shared meanings and behaviors constituting

the essence of grounded theory. For this reason, this method is appropriate for studying adolescents with mood disorder.

The roots of grounded theory can be traced to the symbolic interactionist approach of George Herbert Mead. Blumer (1969) further developed this approach based upon the premise that human beings act toward things on the basis of meaning that these things have for them. These meanings are derived from, or arise out of, social interactions. Hence, meanings are handled and modified through an interpretative process (Blumer, 1969).

Lincoln and Guba (1985) have identified grounded theory as a necessary consequence of the naturalistic paradigm. Chenitz and Swanson (1986) described grounded theory as a method for studying the natural, everyday world. They contend that the method's aim is to generate an explanatory theory that aids in understanding of social and psychological phenomena.

Grounded theory as a qualitative methodology was developed and introduced by the sociologists Glaser and Strauss (1967). Their collaborative work on the processes of patients dying in hospital led to the development of grounded theory as a new approach for scientific investigation. This effort resulted in a joint publication of their text in 1967, *The Discovery of Grounded Theory.* However, since their earlier collaboration on many projects in the sixties, an academic and intellectual disagreement arose between Glaser and Strauss following the 1990 publication of Strauss and Corbin's text *Basics of Qualitative Research* focused on grounded theory. Issues were expressed related to both approaches concerning differences in terminology and levels of coding (Babchuk, 1996; Benoliel, 1996; Heath & Cowley, 2004; Kendall, 1999; Melia, 1996; Miller &

Fredericks, 1999). Grounded theorists continue to debate the philosophical differences and usefulness of the two approaches (Boychuck Duchscher, & Morgan, 2004; Kendall, 1999).

Strauss and Corbin (1998) defined grounded theory as an approach and a method that uses a systematic set of procedures and techniques, with the goal to build an inductively, derived grounded theory. The theory derived from data should represent the "reality" of the phenomena under investigation. I followed the guidelines suggested by Strauss and Corbin (1998) with data collection and analysis occurring simultaneously and generated the theory following data analysis using the various coding procedures, open, axial and selective.

I preferred Strauss and Corbin's more analytic approach rather than Glaser and Strauss's (1967) less structured grounded theory approach (McCann & Clark, 2002). This approach allowed me greater understanding and flexibility in technique for data analysis, concept construction and theory development of the processes of adolescents coping with a mood disorder. This plan will be discussed in greater detail in the data collection and analysis section beginning on page 62 of this report. The purpose of grounded theory in this study was to describe and generate a theory that aids in understanding the processes of coping as experienced by adolescents with a mood disorder.

Preliminary Biases, Suppositions, and Assumptions

My interest in exploring the phenomena stemmed from my professional years of clinical practice in working with individuals and families experiencing mental illness. For my masters` thesis, I completed a phenomenological study that described the experiences of adolescent children living with a parent who had a mood disorder. I found that

adolescent children growing up in families with a parent who has an affective disorder were at high-risk for psychopathology, particularly depression and other health problems (Meadus, 1996). As a psychiatric nurse, I believe that it is instrumental for mental health professionals, working with adolescents experiencing mental health problems, to have a thorough understanding of how adolescents manage the stress of a psychiatric disorder. Adolescent coping is of concern to nurses who facilitate recovery and promote client-centered care. As the investigator, I assumed because of my clinical involvement with these adolescents and families I had personal understanding of their suffering and coping with mood disorders.

Another assumption underlying this research is that the adolescent with a mood disorder is under stress. It has been reported by several researchers that stressful life experiences are associated with the onset of depressive disorders in adolescence (Grant et al., 2003; Grant, Compas, Thurm, McMahon, & Gipson, 2004). I consider the adolescents to be the experts in describing their experience with this illness. I also assume that some adolescents with a psychiatric disorder will cope better than others with the same problem. A limitation is that some of these adolescents may not choose to reveal how they manage to endure the experience of having a mood disorder.

Using the concept of theoretical sensitivity as described by Strauss and Corbin (1998) has strengthened my ability to formulate theory from the data generated from the phenomena under study. To help prevent distortion of data, I used a journal throughout the research study to record and monitor any personal feelings or biases. Additionally, I have used the procedure of peer debriefing and have discussed this process on page 60 of this report. Using this procedure provided an external check to confirm findings.

Ethical Considerations

The necessary steps were taken to ensure that the rights of all participants were recognized and protected throughout the study. This study was conducted adhering to the ethical guidelines of the Canadian Nurses Association (2002) for Registered Nurses involved in research using human subjects and the Tri-Council policy statement for ethical conduct for research involving humans as mandated by the Federal government of Canada. Before initiating the study, approvals were obtained from ethical review boards, including the Barry University Institutional Review Board, and the Human Investigation Committee, Memorial University of Newfoundland, and the Health Care Corporation of St. John's which is responsible for the operation of the health care facilities in the city.

I was careful to avoid coercion when seeking eligible participants for this study. I obtained the help of a Registered Nurse or designee affiliated with each facility or agency to aid procurement of potential participants. The agency designee briefly informed eligible parents/guardian or patients of legal age 19 to 20 years about the study (see Appendix E), and with the parent's consent released to me names of parents/guardian or patients who had expressed interest in learning more about the study. After an authorization (see Appendix F) was signed, I contacted the parents/guardian personally by telephone, informed them of the purpose of the study, and assessed their willingness to allow their adolescent child to participate (see Appendix G). The parent/guardian was asked to give written consent granting approval to contact the adolescent to assess his/her willingness to participate in the study. If the parent/guardian refused, they were told that there were no repercussions; care would not be negatively affected. The parent/guardians were assured that contacting their son/daughter did not obligate him/her to participate. If

the youth were of legal age, (over 19 years) parental consent was not required. Once authorization was obtained (see Appendix F), I contacted the adolescent by telephone and informed and informed him/her about the study (see Appendix H). If he/she agreed to participate in the study, the participant signed a consent form before we began the initial interview (see Appendix I). Each adolescent was given a copy of the consent form.

Participants were told that direct quotes may be used in some cases to report findings, but the language would be changed or any identifying data changed so that quotes could not be attributed to the participant. They were also reassured that no identifying information would be used in reports of the study or in any publications resulting from the study. The participants were informed that they could contact Professor, Dr. Sandra Walsh, who chairs the dissertation committee or me, if they had comments, questions or concerns regarding the study. All transcribed data and consent forms will be kept for seven years in my office in a locked drawer. After seven years, this information will be destroyed.

In explaining the study to the adolescents, I reassured them that their decision to participate would not affect the care that they received from the medical facility/agency and that their participation was voluntary. Moreover, after obtaining parental consent, adolescents were told that they could withdraw from the study at anytime. This information was reflected in the consent forms.

The researcher in a grounded theory study acts as a collaborator with the informants (Lincoln & Guba, 1985). It is important, therefore, to establish rapport, trust and acceptance at the initial interview. I conveyed these attributes by acknowledging that participants may feel uncomfortable talking about their experiences of living with a mood

disorder. I did emphasize to them that it was all right and very normal to feel this way and that there are no right or wrong answers to the questions. During the consent process I informed them that if I asked questions that they did not want to answer during the interview, they had the right to refuse to answer them or stop the interview. I also told participants who I was and of my experience as a Registered Nurse working with individuals and families with psychiatric disorders, and my association with the setting. I encouraged them to speak freely about their thoughts and feelings by using respect and acceptance of them as individuals. I also informed them that any information provided by them would be analyzed using pseudonyms to provide/assure confidentiality. Furthermore, I assured them that their comments would not be shared with other family members, and would not be reported in such a way that they could be identified. However, at the initial interview, all informants were told that if they expressed any suicidal statements, as a Registered Nurse, I had a legal obligation to share such information with their therapist or assigned health professional. A photocopy of the consent form was given to each parent/guardian and informant while I kept the original document.

Because of the highly sensitive nature of this topic, I was cognizant of any signs of anxiety exhibited by the participants as they shared their experiences. Although this did not happen, if it did, I was prepared to take time out, shut off the tape and calm them, and ask if they wanted to continue. If needed, I would have provided support and recommended that the adolescents see their assigned nurse or therapist.

Throughout the research process I ensured and protected the confidentiality of the adolescents and their families. During the sampling procurement process, confidentiality

was maintained, since I did not obtain access to names until the potential participant's parent/guardian or legal age youth (see Appendix F) gave permission. The interviews were tape-recorded and transcribed verbatim. Strauss and Corbin (1998) considered the researcher's role of listening to and transcribing the tapes as cardinal for a full and varied analysis of study concepts. Therefore, I transcribed the first three interviews to get a feel for the content. An experienced typist transcribed the remaining interview tapes. However, I listened to all tapes, read the transcripts and reflected on the content to become immersed in the data. The tapes will be erased after the completion of the dissertation. Data will only be accessible to my dissertation committee and me. The consent forms and transcripts with tapes were stored in separate locked files in my office when not in use and will be destroyed after seven years as stipulated in the Tri-Council policy statement for ethical conduct for research involving humans.

Risks and Benefits

Although participation in this study may not have directly benefited the adolescents, it was expected that talking about their experiences, feelings, and thoughts may have been helpful to them. Having a caring listener and having an opportunity to tell their story may provide an unplanned therapeutic benefit for research participants (Hutchinson, Wilson, & Wilson, 1994; Liehr, Marcus, & Cameron, 2005). This is particularly true with at least some types of qualitative research as the participants serve as co-creators with the researcher. This interactive encounter enables the researcher to objectively give voice to the informants' perceptions, feelings and experiences (Charmaz, 2000). It was expected that the information gathered added to the understanding of how adolescents cope with a mood disorder, and would benefit other youth with the same

problem. Also, although participants may not benefit directly from being involved in the study, their contribution is valuable since it will help contribute to the knowledge regarding the phenomenon for nurses, counselors, and therapists working with adolescents experiencing a mood disorder. As an experienced psychiatric nurse, I am aware that some of the adolescent children in the study may have felt uncomfortable when discussing their experiences of living with a mood disorder. Therefore, by being aware and openly discussing these feelings with the adolescents prior to beginning the interview, I may have helped to decrease some of these feelings.

Sample

The investigator conducting a grounded theory study is primarily concerned with choosing informants and situations that can contribute to the evolving theory. For this reason, choosing informants who had personal experiences on the study topic is paramount (Maijala, Paavilainen, & Astedt-Kurki, 2002). Data collection guided by this technique is called theoretical sampling. It is impossible to determine the number of participants to be involved in the study in advance. In theoretical sampling, sample size is determined by generated data and analyses. Accordingly, the researcher continues to collect data until saturation of categories is achieved (Chenitz & Swanson, 1986; Creswell, 1998; Lincoln & Guba, 1985; Strauss & Corbin, 1998).

During the sampling process, 14 adolescents agreed to participate in the study. The final sample consisted of nine participants. More information on the study sample can be found in the section on recruitment beginning on page 72 of this report. For the purposes of this study the definition of an adolescent was a person aged 15 to 20 years. Inclusion criteria were adolescent age; diagnosis of mood disorder, and ability to read,

write, and understand the English language fluently. Other inclusion criteria were that all participants were receiving treatment in an in-patient or outpatient mental health center or hospital, or being treated by a psychiatrist or family physician.

Study sites consisted of a university-affiliated, psychiatric facility and three other major metropolitan, university-affiliated hospital in-patient and outpatient mental health units. One of these facilities is specifically designed for the treatment of children and adolescents. Other locations included a self-help organization whose purpose is to provide specific services to children/adolescents and families affected with mood disorder and the offices of mental health professionals specializing in the treatment of children and youth with mental illness. According to Chenitz and Swanson (1986) and Strauss and Corbin (1998), the phenomenon of study and where it is found to exist determine sampling procedures. As the research continued, sampling became more focused and purposeful. I terminated sampling and data collection when theoretical saturation was reached. I judged this to be the case when the informants were not adding anything new to the data.

Methodological Rigor

The purpose of rigor in qualitative research is "to accurately represent study participant's experiences" (Speziale & Carpenter, 2003, p. 38). In order to maintain rigor throughout the research process, I was guided by the criteria suggested by Lincoln and Guba (1985) for assessing the trustworthiness or truth value of the inquiry guided by the naturalistic paradigm: credibility, transferability, dependability, and confirmability.

Credibility determines how realistic and accurate is the description of the phenomenon under investigation. Are the interpretations [reconstruction's] of the

respondent's experience credible? Can they recognize these reconstruction's as their own when reading the report? Lincoln and Guba (1985) recommended five activities that may enhance credibility of the research inquiry: prolonged engagement, persistent observation, triangulation, and referential adequacy and member checks [participant validation]. Prolonged engagement and persistent observation encompass the researcher spending time in the field, learning the culture, and checking for misinformation that may be introduced either by the researcher or the respondents. This process allows the investigator time to understand the phenomenon and build trust and rapport with the participants. To support the concepts of prolonged engagement and persistent observation, I spent time with the participants during the interview process and asked questions for clarification when needed. Following the interviews, I used journal notes to record observations of non-verbal behavior or other factors that may have affected the interview process.

One major threat to the credibility of the study is that investigators may become so involved with the respondents that they have trouble separating their own experience from the informant's. To offset that risk, I kept in-depth journal notes focusing on my feelings, impressions and actions during the investigation. This technique enabled me to discuss my own behavior and experiences in relation to the participants. I used the journal to record personal biases, feelings, reflections, and observations that occurred during data collection. Sandelowski (1986) suggested that the credibility of a qualitative study lies within the discovery of human phenomena as they are lived and are perceived by the participants. Thus, the participants having lived the experience under study were considered to be the "experts." For this inquiry, I chose informants based upon their

experience with the phenomenon, coping with a mood disorder, to contribute to an evolving theory.

To be consistent with the tenets of the qualitative paradigm, I used different modes of data collection, such as interviews, patient charts and records. Two participants gave permission to access and review their medical chart (see Appendix I). These adolescents were receiving outpatient healthcare from a psychiatrist at the time of the interviews. Likewise, I used the technique of peer debriefing by consulting two nursing colleagues familiar with this area of psychiatric mental health nursing. This informal collaboration involved exploration of hunches about data from journal notes and confirming data interpretations from ongoing theoretical model development. This provided the opportunity to explore various aspects of the inquiry such as biases, meanings and clarity of interpretations.

A major criterion for establishing credibility is member checks. Lincoln and Guba (1985) considered this technique most pivotal for establishing credibility. In member checks, the investigator solicits respondents' views of data that were originally collected. Notably, several qualitative researchers have argued against using this technique as a criterion for use in the evaluation of qualitative research. These researchers have contended that due to the different roles and perspectives of the participants and the researcher, member checks provide no validation for credibility of study findings (Bradshaw, 2001; Horsburgh, 2003; Morse, 1998; Sandelowski, 1993). I support these views expressed by the researchers and thus I did not use the member check technique as an evaluation criterion.

Creswell (1998) supported the use of eight techniques as helping to establish trustworthiness of study findings in qualitative studies: prolonged engagement, triangulation, peer debriefing, negative case analysis, researcher bias clarification, external audits, rich thick descriptions, and member checks. He recommended that qualitative researchers should engage in at least two of these procedures for verification of study findings. I have used five of these techniques as suggested by Creswell (1998) to demonstrate rigor in this study. These were prolonged engagement, triangulation, peer debriefing, researcher bias clarification, and rich thick descriptions [participant's own words from transcribed data].

With respect of transferability, I met this criterion by engaging in purposeful or theoretical sampling. This means that I chose informants based upon their ability to contribute to the evolving theory, coping with adolescent mood disorder. This sampling process was grounded in the phenomenon under investigation. As suggested by Lincoln and Guba (1985), readers of the study will view the findings as fitting and thus transferable in terms of their own experiences. I planned to also use the participants' own words from transcribed data, enabling readers to judge how well grounded the findings fit. Atkinson, Heath, and Chenail (1991) also proposed that the transferability of the study will ultimately be decided by those who are consumers of the research.

According to Lincoln and Guba (1985), if credibility is maintained in the inquiry, it is not necessary to demonstrate dependability separately. However, they recommended an inquiry audit technique to authenticate dependability and establish confirmability. This procedure involves an individual examining the inquiry process and the product, which included the data, findings, interpretations, and recommendations. I supported this notion

by collaborating with two colleagues who are familiar with the research process and working in the area of adolescent mental health during the inquiry process as discussed (p. 60). Moreover, tape recordings, journal notes and typed transcriptions of the data ensured that each participant's narrative account was analyzed. Actual verbatim quotations from the informant interview are provided in Chapter IV to support the theoretical findings. This process provided readers of this report an opportunity to accurately evaluate how decisions were made throughout the study.

The concept of confirmability, according to Lincoln and Guba (1985), referred to the consistency of the research process or the ability of another investigator to follow the "audit trail" used by the study investigator. These authors argued that confirmability is achieved by establishing auditability, applicability and trustworthiness. This audit trail comprises all the decisions made by the investigator at every step throughout the research process [raw data, field notes, and peer consultation]. Lincoln and Guba (1985) maintained that the methods of data collection, the purpose of the study and the methods of data analysis influence the concept of confirmability. Throughout the research, I followed the concept of auditability by explaining and justifying what was done and why through each stage of the research process in this report. This can be identified by the audit trail.

Data Collection

Data collection in a grounded theory study follows the pattern of field research. Consequently, collection may include a variety of methods such as interviews, observations, review of documents, or a combination of these sources (Strauss & Corbin, 1998; Speziale & Carpenter, 2003). Hutchinson (1993) argued that a variety of

perspectives for data collection are necessary if the researcher aims to generate an accurate theory. She suggested that this technique may prevent undue bias by augmenting the wealth of information available to the researcher.

Unstructured interviews that were tape-recorded, and a review of some of the participant's health records [two] constituted data collection for this study. The space for all interviews was located in a quiet area of the facility or home, thereby enhancing both the privacy and confidentiality of the investigation. Brenner, Brown, and Canter (1985) suggested that it is imperative that the interview is tape-recorded because it allows the researcher to concentrate on the informant's information without worrying about taking notes. Field and Morse (1985) stated that "a tape-recorded interview does not portray the physical setting, the impressions the observer picks up or the non-verbal communication in an observed observation" (p. 80). Therefore, in order to augment the interview tapes, journal notes were also used to record observations immediately following the interviews. This journal provided a means for me to express personal feelings and reflections, to record observed participant non-verbal behavior and to acknowledge factors that affected the interview process. It also provided an avenue for me to record hunches that arose during data analysis. These notes were transcribed and analyzed along with interview data. The journal will also be kept in my office under lock and key for seven years and then destroyed.

In keeping with the grounded theory method, throughout the interview process I sought descriptions of the phenomenon of concern from the participant's viewpoint. Interview questions were broad and open-ended, designed initially to identify concepts. For example, to begin the interview, I posed the following open-ended statement: "Tell

me what it is like to have a mood disorder [depression]." When necessary, I used reflective or clarifying remarks to stimulate further elaboration and enhance understanding of the informants' responses. According to Hutchinson (1993), interview questions move from the general to the particular, eliciting information crucial to the investigation. Moreover, I asked different participants different questions as the theory evolved (see Appendix J); thus, the interview questions were guided by the emerging theory.

The procedures I used to keep track of the research process were briefly discussed in the methodological rigor section of this report beginning on page 58. I discussed using the criteria espoused by Lincoln and Guba (1985) for assessing the trustworthiness of inquiry guided by the naturalistic paradigm. However, at this time I will elaborate on the criterion of confirmability (Lincoln & Guba, 1985), or the ability of another investigator to follow my decisions or audit trail. Decisions that I have made throughout this study have been recorded in a study journal. As grounded theory research requires interpersonal interaction, this journal allowed me to record my personal feelings and reflections regarding the researcher-informant relationship. Strauss and Corbin (1998) described this concept as theoretical sensitivity where the personal qualities of the researcher are brought to the research situation. As the investigator it was important that I keep aware of these influences and use procedures such as a daily journal for expressing personal feelings, decisions, and reflections throughout the research process. Additionally, I kept in-depth journal notes for recording observations, consulted with nursing peers, revised interview questions, and recorded any decisions, subjective biases and unsubstantiated hunches related to the data, setting and phenomena under study.

Data Analysis

The procedure used for data analysis in this grounded theory study was the method developed by Strauss and Corbin (1998). Data were collected and analyzed simultaneously according to this approach. Each interview was transcribed verbatim and analyzed before the next scheduled interview. The interviews were analyzed concurrently using the constant comparative method. This approach of open, axial, and selective coding allowed a structured process in analysis of data that leads to development of the core category (Strauss & Corbin, 1998). According to Strauss and Corbin (1998), these steps are not to be considered in a strict and rigid way but to be used as a creative and flexible approach in data analysis. Following open, axial, and selective coding categories are integrated leading to refining of the theory. Subsequently, data analysis and data collection was a firmly interwoven process, occurring alternately because the analysis directed the sampling of data. Data analysis began with the initial interview transcript and proceeded through all three levels of coding (Strauss & Corbin, 1998). Then, the core category became the basis for the generation of theory. These authors also recommend that the investigator keep written records throughout the analysis process. These records, consisting of memos, coding, theoretical and operational notes, or diagrams, are identified as essential in enabling the investigator to keep an ongoing record of the research process. These records also supported confirmability within the study. In following this process, I initially listened to the taped interviews and read the transcripts. Then I re-read the transcripts and underlined in red ink any passage related to the phenomenon of study. I wrote the concepts down on the margins as they emerged during reading of the text. I continued this technique throughout the coding process. I reviewed

all data for similar phrases and grouped them on a large writing board. This procedure helped me write memos and diagram my ideas for determining what the data were revealing. This process also helped to identify connections between categories and subcategories.

The process of open coding is identified as the first and most important step in the analysis process. In this technique, data are open and exposed to examination for similarities and differences. Specifically during this first step, data are conceptualized leading to the naming and categorizing of phenomena (Strauss & Corbin, 1998). Using this procedure, I examined the transcripts, journal notes and other documents [health records] for categories and themes that emerged for exploration in the study.
During this process of coding, conceptualization of data takes place, an important step in the building of theory. The goal here is to open up the text and discover concepts. A concept is a labeled phenomenon [object, action/interaction] identified as significant in the data (Strauss & Corbin, 1998). The label may be placed on the object by the researcher "because of the imagery or meaning they evoke, or the name may be taken from the words of the respondents themselves" (Strauss & Corbin, 1998, p. 105). The researcher is able to group similar events, happenings or objects under a common heading or classification termed categories. Categories are important in answering the question, “What is going on here?" (Strauss & Corbin, 1998, p. 114) when reviewing the data.

In the process of open coding, subcategories may come from the analysis of data. Subcategories help to specify a category further by answering questions about the "when, where, why, and how a phenomenon is likely to occur" (Strauss & Corbin, 1998, p. 119). These subcategories and categories are developed in terms of their properties and

dimensions. This process helps the researcher to identify patterns [similarities and differences] discovered in the data. This coding technique lays the foundation and structure for theory building (Strauss & Corbin, 1998). Strauss and Corbin (1998) recommended several ways for researchers to undertake the open coding process. These methods are a line-by-line analysis, analysis of a whole sentence or paragraph, and perusal of the entire document. I used the technique of the line-by-line analysis for my process of open coding. I used red ink and wrote on the margin of each line the identified concept. The process according to Strauss and Corbin (1998) is called conceptualizing, the first step in theory building.

Following open, line by line coding, I used the technique of axial coding or data reconstruction. At this time, I was involved in putting the data back together by identifying connections between the categories and subcategories (Strauss & Corbin, 1998). The focus was to specify a category that refers to a phenomenon, in terms of the conditions that give rise to its context and strategies by which it was handled, and the consequences of those strategies. Questioning of data here involved an inductive and deductive process and making comparisons with the data (McCann & Clarke, 2003). The goal here was to develop and relate the categories further to the subcategories. During this process, Strauss and Corbin (1998) recommended the use of mini-frameworks or conceptual diagrams to aid the researcher in keeping track of categories and subcategories related to the core category.

The last phase of the analysis involved a process called selective coding. This technique required several steps for the researcher in integrating and refining the theory. Initially, a descriptive narrative about the central phenomenon of the data was

conceptualized, leading to the discovery of the core category. This category serves as the basis for the development of theory. Once the core category was identified, it was related to other categories stemming from the analysis by the process of sorting. This category validated those relationships within the study data and those other categories were supported by a secondary literature review. At that time, I reread the literature already reviewed but also performed an additional literature review to support or extend the proposed theory. Once the process of writing the theory was complete, it became a product to submit for publication (Hutchinson, 1993; Strauss & Corbin, 1998).

The data from this grounded theory study are presented in Chapter IV. I will present the findings based upon my diagram [theoretical model], and memos related to data analysis. Segments of actual data and quotes of informants are included. These processes supported the rigor of the study. In Chapter V, I will present my interpretations, implications, and conclusions of study findings.

CHAPTER IV

FINDINGS

The purpose of this grounded theory study was to generate a substantive theory to describe the processes of coping for adolescents with a mood disorder. In this chapter, I will begin by reporting on the recruitment process and give a general overview of the informants who participated in this study. Next, using the principles of grounded theory as espoused by Strauss and Corbin (1998), I will discuss the substantive theory that was developed from the study data. An explanation of the factors influencing the processes of coping with a mood disorder for the adolescents will be discussed. The central categories and subcategories that emerged from the coding procedures will be presented and described as they relate to theory production. Throughout the discussion of the study's findings, excerpts from informants' verbatim transcripts will be provided to support and illustrate the theory generated in the theoretical model.

In Figure 1, the theory of coping is presented in a schematic theoretical model (p. 71) format illustrated and identified by four phases identified by the categories: *Feeling Different*, *Cutting off Connections*, *Facing the Challenge/Reconnecting*, and *Learning from the Experience*. These phases are not linear but the adolescents begin the journey in phase I and may move back and forth through these phases in coping with their mood disorder. These four phases will be explained in greater detail beginning on page 78 of this report. Also, the core category identified in this research, A*n Unplanned Journey: Coping through Connections*, will be discussed. As well, I will provide information demonstrating how the coding techniques open, axial, and selective as described by

Strauss and Corbin (1998) were used in construction of the theory of coping with adolescent mood disorder.

An Unplanned Journey: Coping through Connections

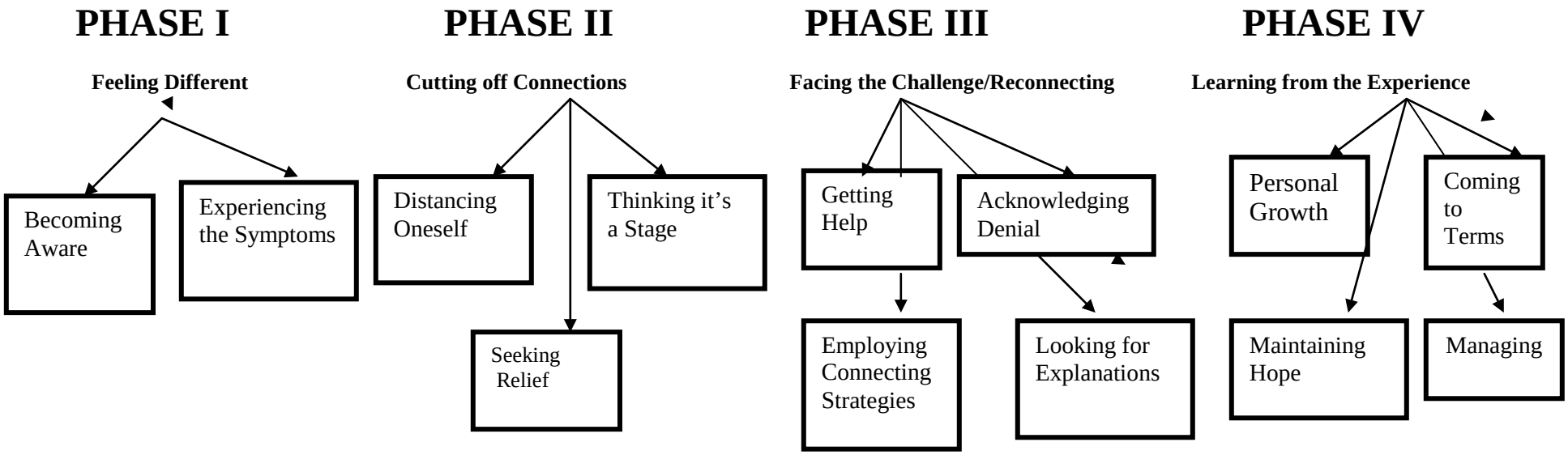

Figure 1: Meadus' Theory of Adolescent Coping with Mood Disorders

Recruitment

In this study, nine adolescents ranging in ages from 15 to 18 years, one male and eight females shared their experience of coping with a mood disorder. During the course of the study, 14 adolescents agreed to participate in this study. Nine completed the study. The reasons that five adolescents did not complete the interviews were a change of mind (1), moved from area (1), lack of parent consent/unavailability (1), and repeatedly not keeping appointments (2). Of the nine adolescents that completed the interviews, eight informants were recruited from a psychiatric facility and one participant was obtained from a university Internet website. This website contained posted personal accounts written by children and adolescents living with a psychiatric illness. Permission to use this information from the person who posted these personal accounts was obtained. At the time of the interviews, one of the informants was attending a university, two were working and the remaining adolescents were attending high school. All informants had been diagnosed with their disorder for about a year or longer. Two of the participants had the illness for a year, the other seven participants had the illness for three to four years. Seven of the participants were reported to have a diagnosis of major depressive disorder and two had a diagnosis of bipolar I disorder. Seven of the informants had been hospitalized for one or more times because of their illness. Some have had previous hospitalizations that involved medication evaluation and readjustment. At the time of the interviews, all adolescents were taking one or more antidepressant medications as prescribed by their psychiatrist. Some of the adolescents were taking other prescribed medications in addition to an antidepressant; these included antipsychotic medications,

antianxiety medications and mood stabilizers. A family history of psychiatric disorder was reported by seven of the participants.

Unstructured interviews with informants were tape-recorded. One took place in the participant's home and the others took place in a private office in a health care agency/facility. All were arranged at a convenient time for both the informant and me. These interviews lasted anywhere from 45 to 75 minutes in length. I remained consistent with the grounded theory approach: as interviews took place, my interview questions were modified (see Appendix J) while I moved back and forth between data collection and analysis. This process allowed me to explore hunches or emerging concepts arising from the ongoing analysis and promote theory development (Schreiber, 2001).

Concept Development

As reported in the methodology section of this report, throughout the process of data analysis, I used the procedural techniques of open, axial, and selective coding proposed by Strauss and Corbin (1998) to develop and formulate the theoretical constructs of coping for adolescents with a mood disorder. These theoretical constructs were the framework for development of an emergent theory named the Meadus' theory of Adolescent Coping with Mood Disorders. The theory of adolescent coping with mood disorders described a four-phase process (see Figure 1, p. 71) that adolescents progressed through as they coped with having a mood disorder. These four phases were (a) feeling different, (b) cutting off connections, (c) facing the challenge/reconnecting, and (d) learning from the experience. To demonstrate the process of analysis using the three levels of coding as mentioned above, I have highlighted aspects of each that facilitated data comparison and theory discovery in this section of the report. Samples of actual

participant data are presented in a table format specific to each level of data analysis that supported my process of coding. Throughout this process of concept formation, asking questions about the data and the writing of memos facilitated the coding process (Strauss & Corbin, 1998).

My first look at the transcriptions included several readings of the text followed by an in-depth line-by-line analysis. These techniques are considered the essence of the beginning of the procedure called open coding. This coding activity is referred to by Strauss and Corbin (1998) as conceptualizing and involved the process of breaking down the data in discrete parts, data coding, and constant comparison of categories that emerged from subsequent interviews. Once the data was broken down I coded and assigned it a conceptual name/label. These names/labels I took from the words of the informants ("in vivo codes"), and I also named some of these data based upon the context. These concepts were written in red ink on the margins of the typed interview transcripts. After deriving dozens of concepts from the data, I grouped them into categories on a large writing board. Table I below provides an example of coding and the categorizing of data using the open coding procedure.

Table I: Participant Data	**Open Coding**
When I got back on my feet and I was out and around,	Being out & about
I didn't know, it got that bad, to the point, I didn't know	Got bad
what to do. I thought it would pass and I kept giving it	Thought it would pass
more and more time, thinking it [feeling] would go away.	In time would leave
I didn't want to let myself think I had something wrong.	Thinking I am okay
I thought it was just a stage that I was going through.	Thinking it's a stage

The next part of the process in data analysis was the use of the procedural technique of axial coding. This procedural process involved a conceptual linking of the data bringing it to a more abstract level. Here the main focus was on the reassembling of the data and the linking of categories [phenomenon] to other categories through the comparison of the conditions, strategies and consequences pertaining to explanations about the phenomenon, adolescent coping. The final level called selective coding, involved a process of integrating and refining the categories constructed during the previous coding procedures. During this level of coding, I focused on the development of the major categories that lead to refinement and development of the Meadus' theory of adolescent coping with a mood disorder (Strauss & Corbin, 1998). Figure's two and three on the next two pages illustrate a partial audit trail for the categories of feeling different, Phase I and cutting off connections, Phase II.

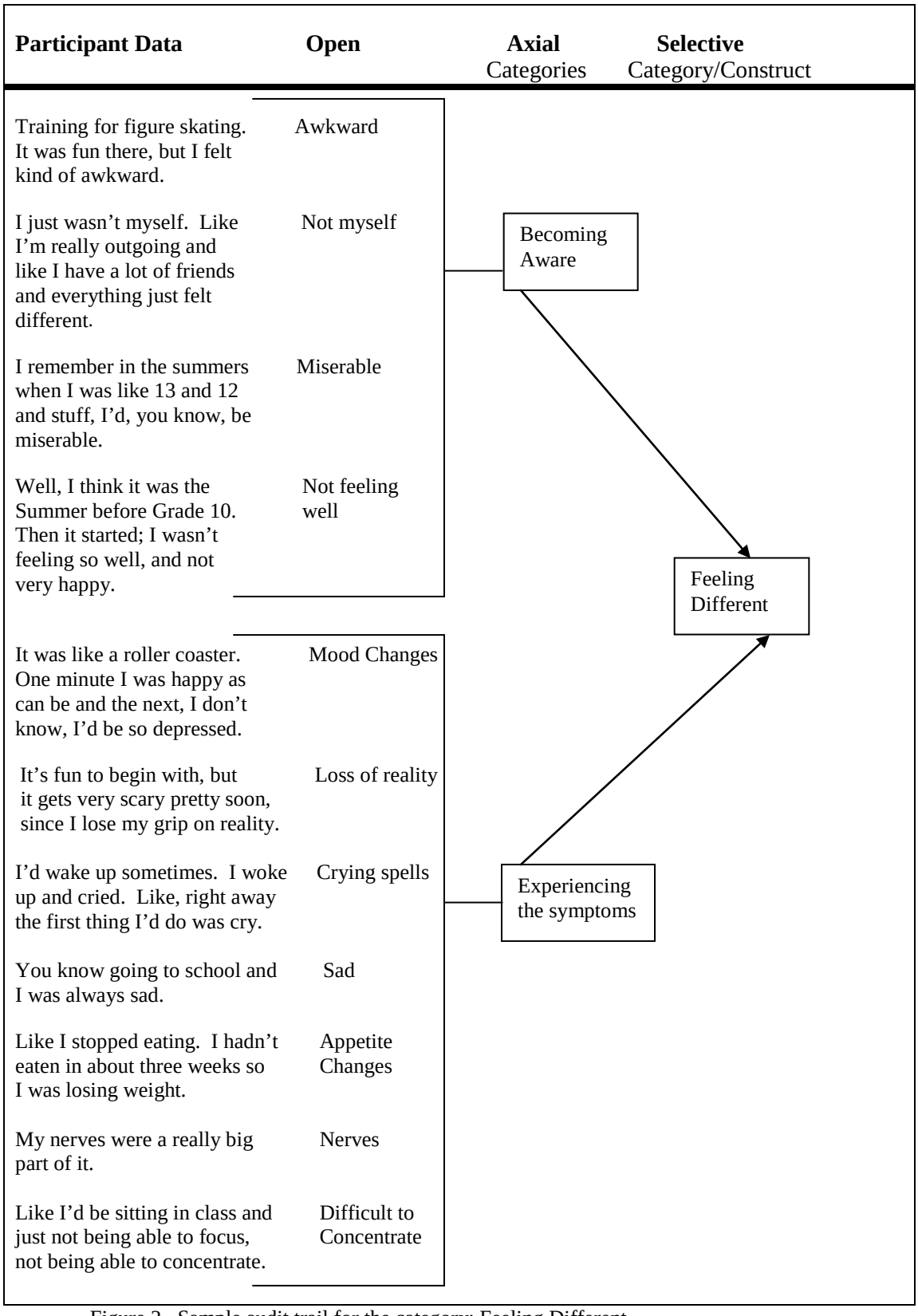

Figure 2. Sample audit trail for the category: Feeling Different.

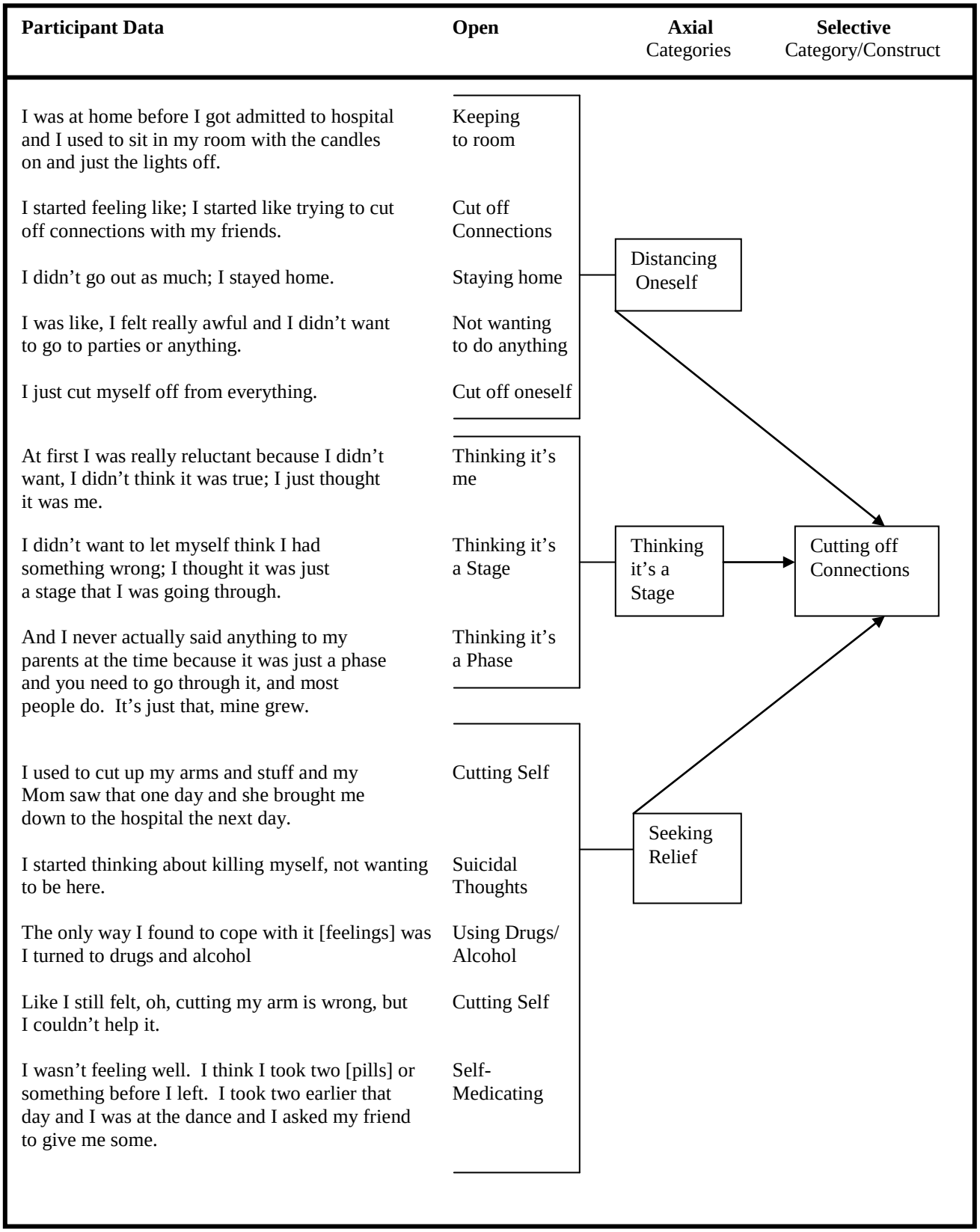

Figure 3. Sample audit trail for category: Cutting off Connections

Feeling Different

Phase I: Feeling Different

All of the information recounted the process that something unusual was going on and were able to articulate this experience of *feeling different* but were unaware as to why or what was happening to them at that time. This process of *feeling different* for respondents was the starting point of the adolescent's unplanned journey of coping with a mood disorder. In this phase of *feeling different* two conditions occurred that contributed to development of the phenomenon discovered through data analysis. These two categories were named *becoming aware* and *experiencing the symptoms*. Most of the participants described the changes as gradually taking place over several months. Consequently, intrusion of symptoms impacted the day to day life of participants. Although the illness varied considerably in course and severity, this onset of illness symptoms was very disturbing for adolescents and caused them to suffer physically, emotionally, and socially. All participants used similar words or phrases throughout the narratives to describe these changes occurring as: "feeling awkward," "feeling black," "feeling miserable," "feeling different," "sadness," "lack of pleasure," and "not myself."

This experience of *feeling different* due to the *onset of experiencing symptoms* described by all participants led to disruption in school, family, and other social relationships. Informants expressed feelings of having a loss of interest, low energy, guilt, difficulty concentrating, being overwhelmed, helpless, wanting to be alone, and having no control.

For example, one participant, who was sixteen years of age and in high school, described becoming aware when she noticed that she found no pleasure from anything.

She found this feeling unusual in comparison to how she felt previously when she was usually with her friends.

> I don't know; I wasn't myself. Like I'm really outgoing and like I have a lot of friends and everything, but I just felt different. Like, when I'd go out with them I usually had fun, but then when I'd go out, I'd just be so blah and nonchalant and just didn't really enjoy myself at anything I did.

Several informants reported in great detail that the onset of change occurred at around the time of entering adolescence. They identified major changes in their mood as the first sign of them *feeling different*. All of them described this mood change as an intense feeling of sadness. At the time the adolescents lacked insight into why they were experiencing these feelings.

> I was sad all the time. I don't know and I couldn't get myself out of it, no matter what. I would go to my friend's house and sleep up there. They would have a lot of friends down, a whole lot of people and I would be around people, but I didn't feel the same as what I did before.

Another participant, who was 17 years of age and finishing her Grade 12, described a sense of sadness and boredom when she became ill.

> Ah, I think that I was probably sick from the time when I hit puberty. I think that's when it came on. I remember in the summer's when I was like 12 and 13 and stuff, you know, I'd be miserable. Like I'd stay in bed all day and I'd be crying and I'd, you know, sort of be really unpleasant. I was hard to live with and stuff. And then school would start again and it would be ah different kind of [pause] sadness. Like ah, like to me it's easy to understand like how I'm feeling. In the

> summertime it would be like boredom, but I wasn’t happy. You know going to school and I was always sad.

One informant detailed becoming aware by first noticing something different in his moods. He reported experiencing more anger that was totally out of character from his previous behavior.

> I was always real quiet; nothing anyone could do ever put me over the edge, but now it doesn't take much; like if someone said the wrong thing to me I'm right down their throat. And, I'll blow stuff way out of proportion now.

An informant who was seventeen years of age recalled feeling like she was riding a "roller coaster" when describing the onset of feeling different at around 12 or 13 years of age.

> It came on when I entered adolescence. It was like a roller coaster. Like you know, one minute I was happy as can be and the next, I don't know. I'd be so depressed and crying all the time. I couldn't stop crying, wouldn't know why I was crying.

Several participants expressed how the onset of symptoms interrupted their ability to attend school or concentrate on their work while at school. Most informants missed significant amounts of time away from school due to the emergence of illness symptoms or hospitalization. On participant experienced much distress and difficulty due to the unpredictability of her illness symptoms.

> School can be very hard to deal with. When I get depressed, I can't concentrate and I fall behind in my schoolwork. Sometimes I just sit in the corridors and cry. I have no energy to do the work, and I am always fighting with my family and

> teachers. When I'm manic I get real airy and it's a struggle to sit down and work, I just want to get up and run around or sing or anything else.

Although one informant believed that all adolescents had these sad feelings, she felt that it wasn't normal for her to be sad for such a long period. She started to worry when this feeling of constant sadness began to impact on her school life.

> I know everybody feels like it [depressed] sometimes but I thought where I was, it wasn't normal. The fact that I couldn't sit through class, I couldn't hold my head up. I couldn't do anything like that, like you know. I used to get really angry with it [depression] after awhile.

Another participant articulated how she felt different because of the onset of illness symptoms. Her fears of her being cornered interfered with her ability to attend school.

> I couldn't go to school. I felt, ah, I felt really nervous when I was in school for some reason. I felt really trapped and caged in, like I had to get outta there. And I just wasn't myself.

One participant, who was 17 years of age and worked for a volunteer agency at the time of the interviews, did not finish high school. I could feel a sense of frustration and pain in her voice as she described the impact the illness had on her not completing school.

> In school, I couldn't stay in class, I was constantly crying, everyone looked at me and I was crying. I was very paranoid. I always thought everybody was out to get me, kind of thing, like nobody liked me, and girls despised me. It never got any better. It only got worse or about the same like, you know? So no one knew about

it [depression] to pick up on it and I don't know my school, schooling suffered really, really bad.

In summary, informants described the process of feeling different as the beginning stage of an unplanned journey in coping with adolescent mood disorder. The process of becoming aware that something was happening to them was related to the onset of illness symptoms on their daily lives. These symptoms reduced their ability to cope and function within the context of their daily experiences and affected activities of daily living, work, school, and interpersonal relationships. The major disruption on the lives of the adolescents due to the onset of illness symptoms was clearly evident from the findings. This onset of symptoms impeded their negotiation within their lifeworld.

Phase II: Cutting off Connections

The second phase of the unplanned journey for the adolescents was named *cutting off connections*. As a result of the conditions [becoming aware and experiencing the symptoms] for the adolescents in Phase I, cutting off connections occurred during Phase II. This phase consisted of three sub-categories: *distancing oneself, thinking it's a stage,* and *seeking relief*. During this phase, adolescents described the turmoil of trying to deal with the intrusion of illness symptoms. At this time, adolescents reported that they wanted to be alone. This detachment from others involved the action of distancing oneself. Distancing oneself may have provided a source of comfort and escape for informants allowing them to "check out" from the stress of trying to make sense of what they were experiencing during this phase. Most of the adolescents who reported feeling sad and lonely preferred to be alone and disconnected themselves from family, friends, and others as evidenced in these narratives.

I was at home before I got admitted to hospital and I used to sit in my room with candles on and just the lights off. Because I was trying to stay clear of my mother who didn't know what was wrong and who was trying to be really overprotective, and sort of "Are you okay? Are you okay?" But that wasn't what I wanted. And so I'd stay in my room and ask her not to come in and this is what I'd do.

(Participant, age 15)

I didn't go out as much I stayed home. I slept a lot, went to bed early, and didn't really want to get up. It was really weird; it was difficult. That's pretty much what I wanted to do. Yeah, because I found when I sleep I don't really think as much. I sort of forget about everything that's happening.

(Participant, age 16)

I started feeling like; I started like trying to cut off connections with my friends. Like I tried, I started [pause] like I, my best friend or I suppose my best friend at the time, I called her like up on the morning of before my birthday and I said, "You're not my best friend anymore." Like just weird things that I would never think to do before.

(Participant, age 18)

One participant articulated a similar experience that for her occurred at around 13 years of age and she reported "everything going down hill." During this time, she noticed a change that began for her in not wanting to be with her friends or even to be around other people.

I don't know, but before that I was outgoing and I had [gesturing with hands] friends, sometimes I couldn't even count them, and then after that I just started to

> draw myself away from them, I guess. It’s just that I couldn’t stand being around people. I don’t know why.

One of the sub-categories of the category *cutting off connections* was *thinking it's a stage*. At this time, participants recalled being unaware that anything was wrong and associated their feelings with an expectation of going through adolescence and thinking it was a stage. For example, several informants recalled feeling different at the onset of adolescence but not knowing that such feelings were related to having an illness. They considered them to be a normal part of adolescence.

> I never knew that it was depression, you know. I've heard tell of depression but I never knew that. I knew what I had gone through off and on for the past three years or whatever. I didn't know it was depression so when I found myself staying home and stuff, Ah, you know I didn't associate it with anything. I just assumed it was a stage, like most people do, it was just teen aches.

Another participant described thinking these feelings would pass,

> I thought it would pass and I kept giving it more and more time, thinking it would go away. I didn't want to let myself think that I had something wrong; I thought it was just a stage that I was going through.

One participant reported a similar experience in also thinking that her feelings were expected because she was going through adolescence. Thus, she did not see the necessity of disclosing how she was feeling to her parents.

> When I didn't know I had the illness. When I was around people, I was always sad and I would envy them because they were happy and I didn't know why I wasn't.

> And I never actually said anything to my parent at that time because I figured it was just a phase and you need to go through it, and most people do.

Another sub-category of the phase, cutting off connections was *seeking relief*. During this part of the journey, adolescents reported using a variety of risk taking behaviors as attempts to seek relief from the physical and emotional turmoil of having a mood disorder. This process of seeking relief demonstrated the adolescents' quest of finding their own solutions to feel better. Seven of the informants described an intrusion of suicidal thoughts during this time while several reported having attempted suicide. One participant recounted her episode with self-mutilation behavior when she was first admitted to hospital. She described her experience as having "no control" over what happened.

> Depression like takes you over basically it like [pause] I don't know what it is. It's like it [depression] changes you into a different person. Like, it totally takes you over. Say it's the depression doing that, would like cut me and make me [pause] I don't know how to say it [softly], would make me depressed or make me upset or make me not act like I was normally. I felt like there was an extra, like I had gone and another person or something had come and taken me over. And [pause] was sort of controlling my body and I had no control over it. Like I still felt oh, like cutting my arm is wrong but I couldn't help it. I knew it was wrong but [pause] it was like an angel and a devil. I didn't know who to listen to basically cause I knew it was wrong, but it still happened.

Another informant reported participating in a variety of episodes of risk taking behavior. It has been reported by several researchers that these types of behaviors serve

to provide a form of immediate relief from the emotional pain of having a psychiatric illness (Derouin & Bravender, 2004; Haines & Williams, 2003). She recalled that "I use to cut up my arms and stuff." This behavior resulted in her being hospitalized. Also she described that at a school dance she wasn't feeling well and resorted to taking an overdose of "pills" in trying to feel better.

> I wasn't feeling well the night before I went anyway, and I was after taking, like I think I took two or, something [pills] before I left [for the dance]. I took two earlier that day and I was at the dance and I was like [pause] I asked my friend to give me some and I took them.

Another adolescent spoke in a low voice as he recounted how he used his own solutions by turning to a variety of drugs in attempts to seek relief from his emotional turmoil.

> Alcohol, there were times I'd go ten days straight, not sober, only sobering up to come home so that my parents wouldn't know. That was fine while I was doing it. It was the alcohol first and then that stopped working so I turned to marijuana and that was good while I was on it. When I came down, I found myself [pause] still my mood was up a little but I still couldn't cope with everything that I was thinking about.

During this difficult time, he also described having thoughts of suicide and stated that he "attempted it twice" but it was only at that moment by chance that the playing of a radio commercial prevented him from following through with his decision to kill himself.

> I had a gun to my head; I was going to do it [suicide]. I can honestly say I was going to do it. I know it for a fact; there was no hesitation. But there was a

> commercial that came on the radio about the family and I started crying and thought about it a bit more than what I would have if I didn't have to hear that. If I didn't hear that, I think definitely wouldn't be here.

Another participant articulated that she was sick throughout her high school years and described Grade 10 as "the worst year of my life." She recalled having thoughts of suicide related to her feelings of sadness that were frightening for her.

> I was just; I remember there was always a sad, you know, when you are feeling sad you get that kind of a feeling in your chest. That was always there. So that's when I began thinking about suicide and stuff like that. I never actually tried, but I remember [pause] one night in particular, I finally kind of decided but you know people say sometimes when they decide, they often feel peaceful. I didn't feel peaceful. I just remember feeling really panicky and anxious. I remember feeling that I had to do something now. You know, I can't wait anymore but ah [pause] at the last moment, I was kinda like, I can't do this and I stopped. Ah and I wouldn't have died anyway [laughing], I was just really sick.

Another informant considered herself to be a "survivor" and stated in a matter-of-fact way that for her suicidal thoughts were constant. She gave the impression that suicide was a pre-determined option for her within the context of her depression identity.

> I've survived this far and I've come very close to just ending it all, like more than once. They're always there [suicidal thoughts] and I believe the choice is mine to act upon them and I mean if I wanted to do it badly enough, it would be alone; there wouldn't be anyone to stop me; there wouldn't be anything to stop me.

In summary, within this phase of the illness journey named *cutting off connections,* participants described a sense of social withdrawal with oneself and others as a means to deal with the emotional turmoil they were experiencing. During this time adolescents reported that they wanted to be alone but were unable to describe exactly why they felt that way. Informants articulated that something was wrong with them but thought "it was a stage" and thus, a part of being an adolescent. In trying to manage the emotional turmoil, respondents resorted to maladaptive ways of seeking relief. During this time, adolescents resorted to the use of risk taking behavioral solutions that included thoughts of suicide, suicide attempts, and drug use. These strategies may have helped to provide adolescents with some initial comfort and relief from the anxiety, tension and emotional pain associated with having a mood disorder.

Phase III: Facing the Challenge/Reconnecting

In *facing the challenge/reconnecting*, the third phase of an unplanned journey, adolescents used five strategies: *getting help, acknowledging denial, looking for explanations,* and *employing connecting strategies*. For participants as described in the data, movement among these categories was ongoing and not a sequential process. On phase flows into the next influenced by the unpredictability and continuance of the illness process. These strategies relate to the actions and interactions used by adolescents to manage the stress that resulted from having a mood disorder.

The most important strategy that emerged with this phase of facing the challenge/reconnecting during the unplanned journey for adolescents was recognition of a problem and disclosure to others. This awareness and talking to others was the beginning point for the participants in getting help. The adolescents most often mentioned the

parent, usually the mother initially as the person to whom they disclosed their feelings. However, for some participants access to help originated because of some crisis that had arisen due to the illness behavior. Seeking professional healthcare was initiated for most informants by the parent as the primary caretaker. However, one adolescent described a different experience in getting help.

While on a skating trip an informant noticed she was feeling different. Upon her return, she described the feelings to a counselor as getting worse. At that time, her counselor initiated a medical evaluation by taking her to the hospital emergency department.

> She [counselor] brought me to the hospital emergency department. I saw an intern or doctor there. He diagnosed me with depression and gave me a prescription for Paxil. I think it was [that medication] and he sent me to see [long pause] a psychiatrist. This was probably in August and I got admitted to hospital on September 3.

Another participant recalled that after her sixteenth birthday, she began to feel different: “I just wasn’t myself.” After about four months, she described these feelings as getting worse. At that time, she disclosed to her mother how she was feeling. Her mother was instrumental in getting her seen by a physician for an overall evaluation.

> I just told her I wasn’t feeling myself lately, and since my mom had it [depression], she realized. Well, she had it when she was sixteen too. And she was like I’m bringing you to the doctor.” I said Mom, I was like, I don’t really want to. I’d feel stupid or something and like I’d look it [depression] up on the Internet.

Another participant whose mother was a nurse realized that her daughter was not well and thought she may be depressed. Her mother suggested that she see her aunt who was a doctor. Although reluctant at first, she did go and see her aunt who prescribed medication. However, she described specific beliefs and negative fears that influenced her decision to not take the medication. The informant believed initially that she was not ill and what she was experiencing was expected as part of her being an adolescent. She also had a concern that taking medication would make her appear "fake" to others.

> At first, I was really reluctant because ah, you know, I didn't want; I didn't think that it was true. I just thought it was me. Then I went and I talked to her [aunt] she gave me some pills to take but I didn't want to take them. I didn't have to tell anybody that at the time because I felt that they [medication] would sort of kinda like taking a drug, like they would make you feel happy but it would be fake. I didn't really want to take them to be [pause], you know, it seemed better to be me even if I was really sad, better than being fake. But anyway, it [illness] just got worse and worse.

Another adolescent described a period of risk taking behavior as the driving force that prompted him to seek medical assistance. He stated that he used a lot of drugs and alcohol to deal with the way he was feeling. Finally, in crisis due to having suicidal thoughts, he realized that he had a problem and sought help from his family doctor.

> I started thinking about killing myself, not wanting to be here thinking I was a burden on my family and friends. The only way I found to cope with it was I turned to drugs and alcohol. I just realized that this is not me. I was always against it [drug use] and I realized there was something more to it than just a stage I was

> going through. But I didn't know whom to go and see. I didn't want to see a psychiatrist because I didn't think; I still didn't think I was at the point where I needed to see one. So, I talked to my family doctor and he put me on Paxil.

One informant described a similar experience in recalling that she had not been herself for months and reported occasions of risk taking behavior. She recounted in detail episodes of self-cutting behavior that eventually her mother became aware of. These behaviors were a concern for her mother who took her to the emergency department of the children's hospital for an evaluation.

> I used to cut up my arms and stuff, and my mom saw that one day and she brought me down [hospital] the next day. And I was there and I think I went two or three times before they [health professionals] diagnosed it as depression, and she [psychiatrist] put me on medication for it. I don't know, I still couldn't deal with it. I ended up back in the hospital again for an actual stay. I never stayed there before. I was there for two weeks, I believe.

Another participant recalled a specific event, the death of her father at the age of 13 years, as the triggering factor that led to a period of hospitalization for several months. During that first hospital admission, she was diagnosed with major depressive disorder. Now at 17 years of age, she described her illness as "it's a war, it's a battle." Currently, she is living away from her family and staying with several roommates. She articulated that having suicidal thoughts was the impetus for her to seek professional help at this time.

> A couple of weeks ago I felt really bad about myself and I was just like, you know? Go off myself. I guess something in me really wanted to live because I

> opened up and I let somebody know, I went and got help, you know. I talked to a friend and then a friend took me to the emergency and I sent myself to the hospital and I took the step.

Steps to get help included evaluation, treatment, and, in some instances, long hospitalizations. The mother was the person most influential for bringing the adolescent for medical assessment. Several of the respondents sought help on their own because of a crisis situation. Regardless of the method of accessing help, most of the informants continued to live through the stress and strain of having other hospitalizations due to flare-ups of the illness. The process of the journey to getting well for all participants also involved several trials of finding the "right medication" in helping to make them feel better.

During Phase III, Facing the Challenge/Reconnecting, adolescents sought and received help. This strategy of getting help was key for the adolescents in obtaining an accurate diagnosis and beginning of a treatment regime. The strategies of getting help by obtaining a diagnosis and treatment were paramount in the development and use of the other strategies [*acknowledging denial*, *looking for explanations,* and *employing connecting strategies*]. The diagnosis of having a psychiatric illness was problematic for several of the adolescents. Initially, all informants were evaluated by a health care provider and are currently being followed by a psychiatrist and other health care professionals on a regular basis. Upon receiving a diagnosis of mood disorder, the adolescent's reactions were initial denial, followed by a sense of comfort in knowing what the problem was, and that it was treatable. One participant who spent several months in hospital described her illness experience as "a roller coaster ride." She

emphatically described how she felt when she was first told she had a major depressive disorder.

> And I went through a stage when I was first diagnosed, [pause] denial basically. Not just thinking that it was a normal adolescent thing and that it was normal; but I got over that and quickly realized that you know, I need to try to overcome this.

Another informant, whose mother had depression in the past, disclosed to her mother about the feelings she was experiencing. Her mother thought she may be depressed and wanted her to see a physician, but she refused initially to seek professional care. The adolescent recalled searching the Internet later after that conversation with her mother. She sought out information on depression to confirm her mother's suspicions.

> And like all the symptoms, I was like maybe I have it. And I just kind of was in denial about it. I didn't think I'd get it. But I was so outgoing and stuff I didn't know why I would have it. I thought there had to be like a reason why I had it. But I realized after it's not. It's like some kind of chemical imbalance. That's what they call it. So I understood it more.

Another young woman, who had been ill for a number of years, described how it is only within the last year that she has begun to stop "denying" that she has an illness.

> Up until this year, I don't think I accepted it [diagnosis] I don't think; I was just like, "Oh, well, I'm better now, I'm never going to be sick again." I was always like, "Oh, I'm never going to be sick again."

Following the strategy of acknowledging denial, adolescents reported *looking for explanations* as to why they became ill thinking that the information learned might be helpful in keeping them well. Some specific reasons articulated by informants included

difficult family relationships, parental divorce, parental addiction, death of a relative, or friend. For some respondents, an inability to cope with stress was identified as a factor that led to their psychiatric illness. For most of the adolescents this searching for causes of their illness involved a reevaluation of their lives. For example, one participant recounted her difficulty with trying to deal with several family issues that was causing her much stress. She expressed feelings of putting herself last and taking on everyone's problems.

> Ah, [long pause-silence] this, basically the stuff that they [health professionals] think caused my depression was like situational stuff. My parents are divorced and they, they're always fighting and that [pause] sort of stuff. My brother is a drug addict and alcoholic. I, I don't see my father like at all. He's very distant and [pause] my mom has a boyfriend and I don't get along with him and just stuff like that. Just continuations of problems and me getting stuck in the middle trying to deal with everyone else's problems and I didn't really get to deal with my own first.

Three other participants recounted the experience of having similar family difficulties that they believed may have led to their illness. It appeared that the informants were still having difficulty coming to terms with these earlier family experiences.

> Well I think, when I was younger, when I was in grade six, I started to feel when I was a kid I was always doing something. In grade six, I went through a tough time with my parents. They split up, but they're back together. I think ever since then, I've just been on guard and I haven't been able to feel comfortable.

One adolescent disclosed growing up in a “dysfunctional family” because both of her parents had problems with alcohol use. She described having to take on parental roles and tasks at a young age because of instability in parenting. This experience has appeared to have negatively impacted her ability to function in specific areas of her life.

> I think it was, I don’t know, I matured quicker then people my age because I was in a dysfunctional family, like you know. I had to kind of take on a lot of responsibility, you know. With making sure my sisters were okay, keeping the house clean; my mother would be going around bitching like “Get all these dishes.” I took over my mother’s role at a very young age. Well, my aunts and uncles would be going on a drinking spree and I’d be stuck with like you know, seven and eight children, and I mean how wasn’t I suppose to grow up, you know? So I never got to have a normal childhood. So I’ve always felt like the outcast and the freak in the community.

Another participant who moved around a lot as a young child recounted how instability in parenting because of having an ill mother may have caused her to become ill.

> My teachers began to look closely at me, and tried to work out why I was so miserable. Because my mother was very sick and because her medical problems certainly caused a lot of hardship in our family, they [teachers] concluded that my depression was a result of having an ill mother.

Another informant, who was involved in a motor vehicle accident (MVA) three years ago and required surgery on his leg, articulated how the stress of that experience has led to his illness. He emphatically expressed how he hasn’t really felt the same since

the accident. He thought the feelings he was experiencing at the time were a normal expectation because of his accident and would eventually pass.

> When I got back on my feet and I was out and around, I didn't know it got to it, that [Pause] bad to the point that I didn't know what to do. I thought it [depressed feelings] would pass and I kept giving it more and more time, thinking it would go away. I didn't want to let myself think that I had something wrong. I thought it was a stage that I was going through. I thought it was expected because of what happened [accident].

One adolescent, who is now a university student, recalled how she first got sick at age 15 and had to be hospitalized. She described having several admissions since that initial event and attributed her getting sick because of life stress.

> When I would get sick it would usually be around stressful times. But ah, you know my birthday wasn't specifically a stressful time, but I think, I don't know, I guess it just happened. I remember sitting on my kitchen floor and being like sitting there, like I couldn't move. And just feeling like I don't want to move, I don't want to do anything. I don't want to go to school; I don't want to get up because I had like orchestra practice. I had like a whole bunch of things I was supposed to do around that time. I didn't want to move and I wasn't going to move and they [parents] had to force me into the car to get me to the hospital.

Receiving a diagnosis of having a "mental illness" was different for all informants. Some experienced a sense of relief in knowing what the problem was and that it could be treated. For example, one adolescent reported feeling a sense of relief in receiving her diagnosis of depression. She was in grade nine at the time she received her

diagnosis of major depressive disorder after spending three months on the psychiatry unit at the children's hospital.

> I think it's been a relief, like you know? It's been a relief as in, I don't feel so isolated, like I'm not the only one who has that, you know? I'm some kind of outcast to everyone. It's answered a lot of my questions as to why I was so upset, and mad, and confused. I was really confused and I was really scared and lonely, and isolated.

The last strategy used by adolescents during the third phase of the coping process is named and identified from the data as *employing connecting strategies*. This phase encompassed the actions and interactions that participants reported to be useful during their illness journey with regards to coping. The strategies used by participants to achieve reconnection throughout this phase were enhanced by the social support received from health professionals, and from informal social support networks such as family, friends, and others. This emotional support was instrumental in enabling individuals to develop an enhanced sense of self that was important in their efforts to cope with having a mood disorder. As one participant stated, "the treatment and support I do have is making it a lot easier for me to live like a normal teenager." For most adolescents, family was identified as the constant factor in providing emotional support through diagnosis, crisis, hospitalization, and in everyday life. For others this support came from friends and health care providers. Also, during this phase, respondents reported the use of self-care management strategies that they found helpful. This sub-category of *employing connecting strategies* contained five types of strategies: *talking to others, engagement in physical activity, taking prescription medications, distraction techniques,* and *alternative*

therapies. Table 2 (p. 99) outlines the strategies used by adolescents during the third phase of the unplanned journey.

In this table, the first strategy *talking to others* appeared to be the most influential factor influencing adolescent's sense of self through affiliation of emotional support. The connection with family, significant other, and friends were paramount in offering guidance, support, comfort, and instilling hope to respondents in management of their mood disorder. This strategy was beneficial for adolescents as they continued in the helping relationships with healthcare providers and adhered to prescribed therapy. These findings support the benefits of supportive relationships in the promotion of coping and recovery during the illness process.

Table 2

Stage III/Category: Connecting Strategies

Strategies	
Talking to others	Family/Pets/Significant other
	Friends/Teacher
	Guidance counselor
	Healthcare professionals
Engagement in physical activity	Exercise/Walks/Cleaning
Taking prescription medications	Antidepressants, antipsychotics
	Anxiolytics, mood stabilizers
Distraction techniques	Read
	Listen to music/Sing
	Volunteer work
	Sleep
	School work
	Play musical instruments
	Care of pets
	Watch television
Alternative therapies	Yoga
	Pray/Meditation/Relaxation
	Write poetry/Journaling
	Self-talk/Self-help books
	Art/drawing/Painting

The following accounts that were reported by the adolescents highlighted the role of others in provision of social support. Several adolescents referred to their mother as being the main provider of support. One participant whose parents are divorced articulated that her mother has been constantly with her at the beginning and throughout the ups and downs of her illness journey. She was smiling as she recounted the support given by her mother. I sensed she was happy to have had that presence from her mother.

> Yeah, well my mother, you know, is like a saint. Ah, my Dad [sighs] I guess he tries. He's just you know, I kind of depend more on my mother than on him. Yeah, my Mom, my Mom, you know like her and Dad just split up. I was in the hospital so she was working every day because we never had any money. So, but she never [pause] seemed, she was always pleasant and stuff. Yeah my mother would be, if I had to say anybody it would be my mother who got me through it.

Another informant had a similar experience and reported that her family has been very supportive and signaled out her mother as the one who keeps the family informed about the latest up to date information about bipolar disorder.

> Like my sister had depression. Um my Mom is a nurse and she's like completely [pause] like researched everything like you can think of. Like new medication, you know, new homeopathic places, like all kinds of stuff. She's constantly on the Internet, like looking for stuff about bipolar and depression and stuff. So my Mom is like amazing like that's so, it's really good to have someone that's keen on stuff like updating themselves on their daughter's illness, you know what I mean? And my sister is like very understanding. My Dad is too. Um, he doesn't work as hard as my Mom does but I mean you can't expect everyone to be a saint.

Another participant acknowledged that her parents and aunt were the individuals who provided the emotional support during her illness journey.

> Well, I think a big part of that definitely helping [pause] definitely my parents, and my aunt moved back from Texas last year. She was gone for five years and she moved back and she was a real comfort too because she was always there and she's young too; and she's in her twenties. So it was really comforting that I had them. It's just mostly my family; I don't rely on my friends at all.

A couple of the participants identified their boyfriend as a constant support and most beneficial for helping them cope with the stress stemming from their illness. For example, one adolescent stated that when she is depressed it becomes difficult for her to make it to school. She credited her boyfriend with helping her not fall behind in school.

> When I wake up in the morning I'm often very tired because I only sleep for about 2 hours a night. I try to find every excuse not to go to school. My boyfriend calls me every morning to talk me into going to school, so I usually manage to get there with his help.

Similarly, another informant reported her boyfriend to be most supportive and the dependable person in her life during her hospitalization.

> He [boyfriend] was more supportive than my mother, father, brother, or anyone and [long pause], so he was quite supportive and sort of helped me get over the hump of being in denial and getting to action on getting over it [depression]. Like he came to visit me every day and brought me little presents and stuff like that, that made me feel like a good person, that I wasn't feeling at the time.

Several of the participants also articulated the benefits of the presence of their pets. They reported that having the responsibility of providing care for them allowed the adolescents to focus their attention elsewhere rather than on themselves. The adolescents described feeling unconditional acceptance by their pets during the time of wanting to be alone. For example, one young teen stated,

> He's [dog] three months older than me, so he's been there ever since I was born. And I, I found that just laying down with him, like you can say anything to a dog and they won't yell at you, won't respond, but just listen basically. He was deaf, but so, he didn't listen but it made you feel better. At least you're not talking to the wall. Ah, that helped a lot. Just cuddling with my cat or cuddling with my dog.

Another participant, who was involved in the animal rights group at school, described a similar experience with her growing attachment to one of the school rabbits.

> I went in [school] the next day and I just picked him [rabbit] up and he comes home with me, every weekend now. And I don't know [pause] it's like if I'm sad, I'll just go and pick up the bunny and I know he's the school rabbit but I take him home every weekend. He's like my bunny, and I love him so much and [pause] I don't know, its just there's a few of them [rabbits] and I'm in the animal rights in school. And it's helped me so much, it's like if I'm sad, I'll just go and pick up the bunny and it's like, "You love me, don't you bunny?"

Another aspect of talking to others identified from the data was the connection adolescents had with healthcare providers. Several of the participants reported having "someone who listened" to them and who they could "trust" were important characteristics that influenced coping. These feelings are evidenced in these narratives:

> Well, ah, you know talking to the psychiatrist and stuff did help. Dr. Topper [pseudonym] was [pause] helpful. Like, she never, I don't like it when people feel sorry for me. I don't like that and I never tell people because I want them too. Dr. River [pseudonym] has helped a lot, telling me different ways to go about controlling my temper now, thinking things through. You know, just different techniques, like go for a long walk by yourself or just listen to music. I'm working on different ways to cope, whereas before, like I say, I didn't know what to do because I had no knowledge of different things that I could try. I didn't have Dr. River there like to talk to because it's hard to talk to you parents.

One of the participants expressed a different experience with her psychiatrist. She stated that her psychiatrist was not helpful by not talking about things that were of concern to her. She is now seeing a psychologist and finds the relationship of benefit in helping her cope.

> I really think that everyone needs to talk to a psychologist if they have these problems because there's like so much more that goes on with it [bipolar disorder] than just like. Like there's a whole league of problems that go with just having yourself labeled as something. Not just, you know; like I was seeing a psychiatrist for the longest time, and my psychiatrist didn't think I needed to talk to a psychologist because I was talking to her, but that wasn't doing it for me. Like, I wasn't just talking about things that I needed to talk about. And now, I'm seeing a psychologist and that's much better.

All of the participants were taking prescribed medications for their illness. In the narratives below, several of the participants talked about the benefits of the medications in helping them get better and keeping them well.

> Luckily I'm taking an effective medication to control the symptoms now and that's making it easier on everyone. (Participant, age 17)

> But you know, if you, for me, if I take my pills and I do something regular everyday, then I'm just the same as everybody else. (Participant, age 17)

> The medication, like I, like I'm happy with what we have, what I'm on now. I'm not on too much. I'm not on like five drugs that are all like, I'm not on like a big cocktail or anything. Is that what they call it? And then, I don't know I'm glad we found like two things that can work together, to make me feel okay. (Participant, age 18)

All of the participants also talked about other formal and informal strategies that were helpful for them in managing their illness. These strategies or actions as listed in Table 2 on page 99 were important in distracting them from their problems and in the facilitation of coping related to the stress experienced by having a mood disorder. A number of the adolescents commented on how music had been helpful in coping when describing their illness experience.

> I find sometimes if I'm sad, even now, I'll just put like Britney Spears, or something fancy into the CD player, I don't know; I think it's really weird but I dance around my room. My parent's think I'm crazy because like, they'll come down [pause] it could be 2 o'clock in the morning and I'll be dancing around my room.

> Over the years I have found that music is the best therapy I can get, and I have definitely needed therapy.
>
> I just kind of there's a lot of, I don't know, it may sound corny, but there's a lot of music that I'm really into and I just try to immerse myself into. It gives me help.

All participants also described the use of self-care strategies that I have classified under the property alternative therapies as identified in Table 2. Several adolescents utilized journaling and poetry writing as a beneficial approach for coping with the stresses of having a mood disorder. The respondents stated they found these strategies helpful in releasing their emotions without the fear of impacting others. These two narratives reflect the use of poetry by participants.

> I write a lot of poetry. I only started it about a year and a half ago. A couple of weeks before I went to hospital, I started writing them. I have a book and a half written now, so I find that really helps.
>
> Poetry, I do it when I'm depressed, sometimes, but that doesn't help either. Well, it's not that it doesn't help, because I'm not trying to do it to make me better. I'm just doing it to write down what I'm thinking, I guess. But I have written poetry before it's just something I do to make me feel better.

A couple of the adolescents articulated that they found the self-care approach of journaling beneficial in allowing an emotional release of feelings.

> Reading and keeping a journal. Um, I don't know, writing down daily my thoughts and feelings, exactly. I've been keeping a journal of that, like, I don't know; it helps, just a way for me to get it out and release it. And you're not worried about what anyone else will think.

> Writing is a big thing; I'm always writing in my journal. I write poetry, things like that. That helps because if you're just really full of emotion and you want to get it down on paper, it helps. Even if it's negative, it's a way you can do something about it.

Some participants also reported that faith in God and prayer gave them strength to cope during the difficult times.

> Well, I think I always got to have faith that there is something better. That's kind of important, and really it only can get better when you think about it. That's another thing I put a lot of [pause] like I would say it supports me a lot, faith and meditation. I'm not like [pause] I wouldn't consider myself deeply religious, like I don't go to church every week or anything but I have a lot of faith. I have a lot of faith in God and then other forces. So meditation is like a kind of way of grounding yourself.
>
> I think God has some kind of special plans. I believe that religion is helping me. It is, like I haven't been, you know, everyday Sunday goer now, mind you, but that's my depression, like you know? I believe that killing yourself is a sin. I'm Catholic. I don't know, to be condemned to hell for the rest of eternity if you believe in your soul, and that I don't know. I've thought about that, like you know? When I was feeling down and out and thinking about killing myself and that kind of put it off, like you know? I kept thinking about religion like, you know and just having that hope there too because God is there; he does love you.

In summary, Phase III, *Facing the challenge/reconnecting* was important in enabling adolescents to seek help and marshal strategies to cope with the uncertainty of

having a mood disorder. Some adolescents experienced initial denial at receiving a diagnosis but accepted the challenge of having an illness and the wish to get better. This reconnection entailed the emergence of a new sense of control that resulted in the use of self-care strategies by the participants. During this phase, adolescents also searched for reasons of why they got ill in the hope that this knowledge would prevent them from becoming ill again. For all adolescents in this phase, formal and informal strategies were paramount elements that empowered adolescents to make changes and acquire a new sense of connectedness within the context of their lifeworld. The time spent in this phase may be different for all participants but the emergence of a greater sense of understanding and control eventually led into the next phase of the unplanned journey, *learning from the experience.*

Phase IV: Learning from the Experience

Learning from the experience was the final phase in the substantive theory in the unplanned journey of adolescent coping with a mood disorder. This final phase consisted of the following four sub-categories resulting from the strategies adolescents used in the previous Phase III, Facing the Challenge/Reconnecting: *personal growth, coming to terms, maintaining hope*, and *managing*. These four sub-categories were important in enabling the youth to gain a sense of hope for the future and enhancement of a positive attitude. During this phase, there is movement among the categories; thus, they are not finite as the adolescents try to come to terms with their illness and manage their situation in new ways on a day-to-day basis.

Personal Growth

Although the adolescents described their struggle with the ups and downs of their illness, they also reported learning something from their encounter with having a mood disorder. They articulated that this experience has helped to foster a greater sense of understanding and personal growth. For example, a participant stated that her depression has enabled her now to make better choices in life based upon her reflecting on her past.

> So after the depression I had a chance to basically step out and recap my life, just look at it and say, not from another person but like another person would do, oh that wasn't a good choice I went wrong there. And so that's another way you learn is by looking over your life from now, looking over the past after you've done it. You can't change it now, but you can change it for the future. Everything changes; you mature so much during that process cause you have been through so much.

Another adolescent reported that she has learned that she is the same person despite having the illness.

> You know I don't feel that I have been disadvantaged or anything by having the illness. Um, you know because it made me learn a lot of things about myself and that kind of stuff. But I, you know, I can lead a completely normal life if it's dealt with properly. But you know [pause] ah, it's not something to be underestimated because you really can't function if you're really sick with it. But you know, if you, for me if I take my pills and I do something regular everyday then I'm just the same as everybody else.

One informant recounted a similar experience in coming to have a greater awareness and understanding within himself because of his illness. He emphasized that he has now more insight about coping and knows what to do if her required help.

> That's where I'm to now, I understand myself better as a person. I understand that I do have [pause] it's a disease and could lead to death. It's not something that will physically go throughout your body and kill you but it's something that, I know people who have had depression and killed themselves. I think that I don't want to let myself get to that point. Personally I think I still have a long way to go because there are still occasional times where I can't cope with it; I need to go talk with someone. Like, I need to get to see Dr. Lake [pseudonym] or. I realize now that, you know, I can't cope with this [depression] myself whereas, before I didn't look at it that way. I'd thought that eventually I could cope with it, but in reality I couldn't. I couldn't work it out.

One young adolescent described how despite the unpredictability of her illness and disruptions throughout her life, she has learned to find meaning in these experiences. She has been able to use the negative aspects of her illness in a creative way through expression of her music.

> When I'm manic or depressed I find it hard to communicate properly with other people. But often I can draw a lot of inspiration from these times. I have written some of my best songs and plays while depressed. I am lucky because I can express my feelings through performance and through music. And I would encourage anyone else in this situation to do so. In the end you are the only one,

> who knows exactly what is going through your mind, and you can either be afraid of it, or you can use it to your advantage.

Another participant described her depression as “it’s like going to hell and back.” Even though she has had this experience, she felt that she has come to know herself as a person.

> It [depression] made me actually like more, not outgoing, but be whoever I want to be. Yeah, ah [pause] probably dye my hair. Like, I always used to be afraid to dye my hair, like different colors. I did it purple, red, and I made me express myself differently and be more free about myself. I was a “trender.” I used to always be what everyone else would want me to be. I hated that! Doing all that stuff that I do not like, but I’d do it anyway.

Coming to Terms

The sub-category of coming to terms reflected the adolescents' struggle to understand and make sense out of the intrusion of illness. This coming to terms was influenced by the participants' beliefs about stigma and societal beliefs and reactions about someone diagnosed as having a mental health disorder from family, friends and acquaintances. Emotional support, talking to others, thinking positively, and trying to see the illness as just like any other illness were actions utilized by the adolescents to understand and come to terms with owning the illness. The participants articulated no feelings of resentment towards themselves for having a psychiatric disorder. One participant described herself now as having some integration of self and illness which has helped her ability to think positively about further illness demands.

> I hate taking medications, and I hate being constantly monitored, but its part of who I am and part of my journey is to learn to love myself and my illness. I believe that illnesses are like forks in the road; you just have to learn to pick the right one and things will work out for the best.

Over the past few years, another adolescent has confronted the ups and downs of her illness; but, it is only now that she is able to accept that it is an illness and finally realized that it is not her fault that she became ill.

> Ah, and you know, finally kind of accepting that it was an illness and it wasn't me, that helped. Yeah, you know and if I take the pills I'm okay and I don't mind talking about it [illness] I don't feel embarrassed.

Two other participants described how they are now trying to come to terms with having a mood disorder. One adolescent considered herself lucky to be aware of her depression since she feels that it may help to prepare her for whatever lies ahead.

> Yes it's an illness and I've become aware of it, like you know? There are so many other people out there that have this illness and they're unaware of it, right? Really, they don't know why they're feeling the way they do or going through the things they do daily and, I don't know, I consider myself lucky; I'm getting ahead, like you know? Just because I have a lot figured out, you know, and mind you, I have a lifetime ahead of me and stuff I have to figure out, like you know, the point is I am aware of it now. I'd rather be aware of it now than later on down the road like you know, or when it's too late.

Maintaining Hope

Several of the adolescents also talked about the importance of maintaining hope as they struggled to cope throughout the illness trajectory. This feeling of hope enabled them to think more about the future and seeing themselves as better. For instance, one adolescent believed that her feelings of hope stemmed from her self-talk periods. She found these talks helped to give her the motivation to push forward.

> The only thing that I can say that's really helped me is just never giving up, always thinking I can do it, that sort of thing. I'm going to fight this I'm going to get over this, you know. Yeah, I might be depressed now but each little improvement will get me closer to the end basically.

Another informant stated that her initial meeting with the psychiatrist and the starting of medication were the factors that helped to give her hope.

> I felt like there was a hope, like you know; that someone actually cared. And they were actually giving me their time and sitting down with me and listening to my problems. The fact that someone even gave a dam and was actually, you know caring enough to sit down and help me work through my problems and figure out what the problem is and you know, find a solution. Like a path to start working towards getting better. Feeling good about myself, just a little spark of hope made me feel a lot better.

Another participant described a reliance on hope and faith that she found beneficial during the "horrible times" of her illness.

> Well, I think I always got to have faith there is something better. That's kind of important and really it only can get better, when you think about it.

Managing

During this sub-category of the final phase of an unplanned journey, respondents reported some degree of improvement due to a decrease in the severity of the illness symptoms. Also, for some adolescents depression was still an ongoing part of their lives: they reported feeling better, but not completely well. Most respondents defined themselves in a different context now as a result of their experience of being confronted with an illness and trying to cope. Some of the adolescents also questioned whether or not that they would return to the way they were before the illness. For example, one adolescent, who was diagnosed over a year ago and spent several months in the hospital, stated that she still has difficult times even though she is taking prescribed medication.

> I'm out of the hospital for quite some time now I'd still have ups and downs; its not over. But, like I'd can see, ah, significant improvement from the beginning but its still not where I used to be.

Another participant was smiling as she described how she is feeling now in comparison to how she had been feeling over the past few years since becoming ill. She credited her improvement to her current medication.

> I am doing really well and I'm don't know, its funny like you know, the alarm goes off in the morning and it's sort of no problem to get up, you know? Whereas, I use to sort of sit there and then think, is there some way I can get out of going to school. Now, I just get up and go, and it's no problem. Well, ah [pause], like I say, I'm on different medication and obliviously this one works better than any other.

One of the participants, who is 18 years of age and working at a fast food outlet, described how his symptoms still interfered with his work environment and caused him increased stress. Although this was the case, he is learning to manage.

> I still don't know all I need to know about it [depression]. I'm still learning. Now with the medications I'm on, I still havc bad days. I'm still easily agitated and I work in fast food and there's times I can't work. I'll go but if it gets busy, I just got to step back and I have to sit down. I take Ativan when I need it and I've had to take it a few times [at work].

In summary, the final phase, learning from the experience, identified that although the adolescents reported positive and negative aspects of having the illness, they were trying to resume their lives. The sub-categories of personal growth, coming to terms, maintaining hope, and managing were ongoing components of getting well and managing the illness. The previous phase, facing the challenge/reconnecting was instrumental in enabling the informants to employ and develop connecting strategies necessary to facilitate the movement into this phase.

Core Category: An Unplanned Journey

The core category in this study was *An Unplanned Journey: Coping through Connections*. According to Strauss and Corbin (1998), the core category is an abstraction used to describe the essence of what is happening within the research study. Thus, the core category may evolve out of the emergent study categories. During the course of the illness participants described how they traveled an unplanned journey. This experience of traveling a journey articulated by some participants seems to capture the essence of the coping process for the adolescents. This journey involved a struggle to cope with a mood

disorder that affected the adolescents' sense of connection with others. The category, Facing the Challenge/Reconnecting, was an important part of the process of coping for the adolescents. This process of facing the challenge included the aspect of reaching out for help which involved a reconnection to others through a network of support. This phase helped the adolescents to move through the diagnosis of having a mood disorder, learn about their illness, and take action on managing the problem. The other categories, Feeling Different, Cutting off Connections, and Learning from the Experience are part of the process for adolescents coping with their mood disorder. Also the core category, *An Unplanned Journey: Coping through Connections* is used to explain the overall phenomenon, adolescents coping with a mood disorder.

In summary, the purpose of this study was to generate a substantive theory to describe how adolescents cope with a mood disorder. The coping process was presented using a theoretical model and descriptions of verbatim quotations from participants. The schematic model provides a visual illustration of the four-phase process: feeling different, cutting off connections, facing the challenge/reconnecting, and learning from the experience. These phases are not finite but flow into each other, thus allowing the adolescents movement among the phases as they cope with a mood disorder.

Adolescents described several individuals both professional and non-professional who were helpful during this coping process. One of the most useful strategies (see Table 2, page 99) espoused by the adolescents was getting support from family and friends, pets, and healthcare providers. Many other strategies such as talking to others, engagement in physical activity, taking prescription medications, using distraction techniques and alternative therapies were identified by the adolescents as helpful in

aiding movement into Phase IV, which is the final phase of the journey called “learning from the experience.” The sub-categories involved in this phase were personal growth, coming to terms, maintaining hope, and managing. Factors within these sub-categories were essential to prepare the adolescents to move forward and accommodate any improvement or setbacks along the unplanned journey of coping with a mood disorder.

CHAPTER V

REFLECTIONS ON THE FINDINGS

This study was designed to generate a substantive theory about the process of coping used by adolescents to manage a mood disorder. During this phase of writing the dissertation, I undertook a secondary literature review consistent with the tenets of Strauss and Corbin (1998). The review provided the opportunity to compare and contrast study findings with existing literature and theory. Implications for nursing practice, research, policy, and education will be discussed. In the final section of this chapter, I will discuss the limitations of the study followed by a conclusion of the overall study.

Discussion of the Findings

The research literature on coping is voluminous. However, despite the plethora of research studies, several researchers have suggested this knowledge has had limited impact both clinically and theoretically and have acknowledged that gaps in knowledge on coping still exist (Coyne & Gottlieb, 1996; Coyne & Racioppo, 2000; Gottlieb, 2002; Somerfield & McCrae, 2000). One of the most common adult theories reported in the literature related to coping is Lazarus and Folkman's (1984) theory of stress and coping. Applicability of this theory to adolescents has not been tested.

In this study, a four-phase process of coping was conceptualized to form a substantive nursing theory that identified the process adolescents experienced in trying to cope with a mood disorder. The Meadus' theory of adolescent coping with a mood disorder as evidenced by the data is described by four phases: Phase I, Feeling Different; Phase II, Cutting off Connections; Phase III, Facing the Challenge/Reconnecting; and Phase IV, Learning from the Experience. The study findings found that the adolescents

were most vulnerable during Phase I, Feeling Different and Phase II, Cutting off Connections in the unplanned journey of coping with a mood disorder. In reviewing previous research, I found very limited information related to the phases as described above. Thus, this grounded theory presented a more complete picture and new insights into the processes of coping for adolescents experiencing a mood disorder. This four-phase theory provides a voice for youth who are coping with a mood disorder which, up to this point and time, has not been described in previous research literature.

In this study, adolescents reported using a combination of strategies related to problem-focused and emotion-focused behaviors in trying to manage their psychiatric disorder (see Table 2, page 99) during Phase II, Cutting off Connections, Phase III, Facing the Challenge/Reconnecting and the final Phase IV, Learning from the Experience. During Phase II, the adolescents tried to cope with depression on their own. In trying to manage, informants resorted to the process of distancing themselves [avoidance] and thinking it's a stage [not believing that a problem existed]. Also, during this phase, adolescents tried to seek relief from the emotional discomfort through initiation of risk taking behaviors, including drugs, alcohol, self-cutting behavior, and attempts of suicide. Several researchers (Derouin & Bravender, 2004; Haines & Williams, 2003; Portes, Sandhu, & Longwell-Grice, 2002; Rao, 2001) have identified these types of risk-taking behaviors as "worrisome" forms of coping used by adolescents and young adults to deal with stress and sadness. These coping strategies provide initial relief from extreme anxiety, tension, or emotional pain. The sub-categories in Phase II, distancing oneself and seeking relief, confirm findings of previous research confirm findings of previous research (Derouin & Bravender, 2004; Haines & Williams, 2003;

Portes et al., 2002; Rao, 2001). However, one of the sub-categories of Stage II of coping with a mood disorder, "thinking it's a stage," has not been addressed in the research literature. This sub-category provides support for nurses and other health care professionals and emphasizes the importance of assessing adolescents who may have a mood disorder. Adolescents are very vulnerable at this time and may have difficulty describing how they feel. They tend to see these behavioral and mood changes that are occurring as normal mood swings related to adolescence. This is a critical time for interventions, such as giving information and supportive counseling that may help adolescents understand what is happening at this time. Also, teaching these adolescents ways to reduce stress and learn positive coping skills may improve coping strategies. Early assessment, intervention and treatment may lead to more favorable outcomes for these youth. These nursing initiatives may offset the difficulties experienced by adolescents in Phase II, Cutting off Connections.

An important study finding reported by participants during Phase III, Facing the Challenge/Reconnecting, was the use of a combination of problem-focused and emotion-focused strategies described by the four sub-categories: getting help, acknowledging denial, looking for explanations, and employing connecting strategies. Social support during this phase was very influential in promoting development of helpful strategies. Thus, this study supports previous work that indicates the concept of social support as paramount in helping individuals who are experiencing an illness.

Social support as a concept has been well documented in the literature. It has been defined as both a social network and as perceived availability of resources important in the facilitation of coping and well-being (Choenarom, Williams, & Hagerty, 2005; Ell,

1996; Jacobson, 1991; Rogers, Anthony, & Lyass, 2004; Weigel, Devereux, Leigh, & Ballard-Reisch, 1998).

In comparing the literature with the findings in Phase II, Cutting off Connections, and the strategies in Phase III, Facing the Challenge/Reconnecting, some study findings confirmed those reported in previous literature. In Phase II, a sub-category, "Distancing Oneself," described by participants as a coping strategy, confirmed findings from several researchers who have used self-report instruments and reported that a strategy of emotion-focused coping was used by adolescents who were depressed and/or suicidal (Chan 1995; Colomba, Santiago, & Rossello, 1999; Curry, Miller, Waugh, & Anderson, 1992; Ebata & Moos, 1991; Piquet & Wagner, 2003; Puotiniemi & Kyngas, 2004; Puskar, Hoover, & Miewald, 1992; Seiffge-Krenke, 1993; Spirito, Overholser, & Stark, 1989; Weisz, Rudolph, Granger, & Sweeney, 1992; Wilson et al., 1995).

For example, in a quantitative study using an experimental design, Ebata and Moos (1991) examined coping responses in four groups of adolescents (n = 190) between 12 and 18 years of age. The four groups were comprised of control adolescents (n = 38), adolescents with rheumatic disease (n = 45), youth with conduct disorder (n = 58) and adolescents (n = 49) with a mood disorder. The authors used a coping instrument that they developed but not described in their paper, called the Coping Responses Inventory Youth Form (CRI-Y) to assess eight dimensions of coping reflecting the approach (problem-focused) and avoidance (emotion-focused) coping domains. The self-assessment tool had been pilot tested and validated by the researchers prior to use with this population. The findings of Ebata and Moos (1991) revealed that in response to stressors adolescents who had an affective disorder and those who had a conduct disorder

used more passive, avoidance approaches of coping in comparison to the healthy adolescents and youth with rheumatic disease. Adolescents who were depressed also used significantly less approach coping than all other study adolescent groups.

In comparing this study with findings reported in my study, Phase II, Cutting off Connections would support their findings but the strategies involved in Phase III, Facing the Challenge/Reconnecting do not. During this phase adolescent coping strategies were: getting help, acknowledging denial, employing connecting strategies, and looking for explanations of why they became ill. During Phase III, the adolescents were more problem-focused in trying to manage their situation and the strategies initiated were benefited by social support. In this phase, adolescents used a mixture of emotion focused and problem focused strategies. This combination of emotional and problem focused strategies as described in Table 2 (p. 99) by the adolescents in the study were helpful in reducing the discomfort experienced and allowed the adolescents to take action in managing their illness. In this respect, my study extends previous knowledge and provides new insight into the use of a combination of emotional and problem focused coping strategies by adolescents with a mood disorder that had not been reported in past research.

Similarly, these coping findings as described in previous research have also been found in studies with nonclinical [nondiagnosed] samples of adolescents. Herman-Stahl, Stemmler, and Petersen (1995) explored the relationship between coping style and depression in a sample comprised of high school students (n = 603) over a one year period. Using a variety of assessment instruments the authors found that adolescents who used an approach coping style reported few depressive symptoms. Adolescents who

changed from an approach to an avoidance coping style demonstrated an increase in depressive symptoms. Adolescents who changed from an avoidance coping to an approach style showed a decrease in depressive symptoms. Seiffge-Krenke and Klessinger (2000) replicated this study and found a positive association between avoidance coping and depressive symptoms in a nonclinical sample of 194 adolescents over a two-year period. In my study, the sub-categories in Phase II, Cutting off Connections and strategies initiated in Phase III, Facing the Challenge/Reconnecting support those findings reported in these previous studies regarding the use of problem focused (approach) and emotion focused (avoidance) coping among non-clinical adolescents with depressive symptoms.

My study supported findings found by Chan (1995) in Chinese secondary school students (n = 161) between the ages of 15 and 18 years. The Beck Depression Inventory and the Ways of Coping Questionnaire were used to assess adolescent depressive symptoms and coping strategies. The depressed students used such avoidant (emotion focused) coping activities as denial, withdrawal and wishful thinking in comparison to the nondepressed students who used such approach (problem focused) techniques as seeking social support, problem solving, cognitive restructing, and validation of feelings. My study confirmed the above study findings as shown by the sub-categories identified by the data in Phase II, Cutting off Connections, distancing oneself, thinking it's a stage, and seeking relief. These strategies used by the adolescents in Phase II can be considered a form of emotion focused (avoidance) coping that provided adolescents immediate relief from the emotional discomfort they were experiencing. The strategies used by the adolescents in Phase III, Facing the Challenge/Reconnecting, also support findings from

previous literature. During this phase, adolescents changed their coping initiatives to a more balanced combination of problem-focused and emotion-focused coping associated with the seeking of social support.

Findings from my study can be compared to studies of suicidal adolescents. Wilson et al. (1995) used an experimental design to evaluate the use of a problem-solving model to assess problem solving, stress and coping in 20 adolescents who had attempted suicide. Using a variety of assessment instruments, researchers found that suicide attempters and control adolescents generated adaptive strategies to standardized interpersonal problems. However, suicidal youth used fewer adaptive strategies when dealing with their own real life stressors and tended to underutilize problem-focused coping even in situations they rated as controllable. In comparing my study with these findings, there are some similarities and differences. In the Meadus' theory, during Phase II, Cutting off Connections, the sub-categories of having a mood disorder for the adolescents were conceptualized as distancing oneself, thinking it's a stage, and seeking relief. These components of that phase have been addressed in previous literature as emotion focused (avoidance) strategies that indicate poor coping. Although these findings confirm those reported in Wilson et al.'s (1995) study, new insights from my study have provided evidence in Phase III, Facing the Challenge/Reconnecting of the coping process that adolescents with a mood disorder use a variety of strategies such as getting help, acknowledging denial, employing connecting strategies, and looking for explanations. These problem and emotional focused strategies used by adolescents indicated that support is important in development and initiation of action-oriented

strategies. These findings confirm that adolescents with mood disorders who have a support network can learn more useful problem focused strategies that aid coping.

In a similar study, Spirito et al. (1989), used an experimental design to examine the coping strategies used by adolescents (n = 76) who attempt suicide compared to distressed (n = 114) and nondistressed adolescents (n = 72). A self-report rating scale on depression and anxiety was used to differentiate the distressed and nondistressed adolescents. Social withdrawal and wishful thinking (emotional/avoidance approaches) were found to be most frequently used by the adolescents who attempted suicide when compared to the distressed and nondistressed adolescents. In a later study, Spirito, Francis, Overholser, and Frank (1996) corroborated these findings through an examination of the coping strategies used by adolescents who were experiencing suicidality or depression. In comparison to controls, psychiatrically ill adolescents used social withdrawal as a coping strategy and were less likely to use social support. Several other researchers reported similar findings from studies investigating the coping methods of suicidal and nonsuicidal adolescents (Piquet & Wagner, 2003; Puskar et al., 1992).

A major finding that is espoused in the literature and supported by this study is the use of and seeking of social support as demonstrated in the Meadus' theory during Stage III, Facing the Challenge/Reconnecting. Social supports were useful in helping the adolescents with mood disorder build and develop a combination of problem and emotion-focused strategies necessary for coping. These findings were similar to those of Puotiniemi and Kyngas (2004) who, using a case study design, explored the coping of an adolescent girl from age 12 to age 16 in psychiatric inpatient care, as well as the coping experience of her mother over a two year period. While the adolescent girl’s diagnosis

was not reported, it was noted that she had numerous psychiatric admissions for prolonged periods of time. The adolescent stated that she found several hobbies helpful in coping with her illness. These activities were drawing, music, reading, swimming, and watching television. She also described praying as helpful and withdrawal into her "fantasy world." She stated "I spend quite a lot of time in that fantasy world and I really have to, you know, because I have nothing else to do and no people I know, so I have to imagine things" (Puotiniemi & Kyngas, 2004, p. 679). This study is somewhat limited as it provided an example of the strategies used by only one adolescent in trying to manage her psychiatric illness.

My study provides additional understanding of the changes in coping over time that could be applied to the illness reported above. In my study, the Meadus' theoretical model presents a more complete picture of the processes of coping constructed from the voices of the participants over the course of the illness. Additional details are provided to describe the concept of coping over time for adolescents with a mood disorder. Study findings identified the difficulties encountered during the initial stages of the illness and revealed the emotional and problem focused strategies used by the adolescents. The theory provides further insight and explanation of the various stages that adolescents go through in coping with an affective disorder. The theory and schematic model provides evidence for the importance and timing of appropriate nursing interventions to help support and teach coping skills to adolescents with a mood disorder.

While my study focused on depressed adolescents, findings were similar to Hetherington and Stoppard’s (2002) qualitative study on adolescent girls (n = 14) who had not experienced depression. Hetherington and Stoppard (2002), who did not specify

the exact qualitative approach, conducted semi-structured interviews to explore how adolescent girls, age 14-17, understood and described the concept of depression. Researchers identified the concept of "disconnection from others" as the predominant theme of depression articulated by the participants. The girls described talking to others and thinking of or attempting suicide as particular ways for coping with depression. The strategies involved in Phase II, Cutting off Connections and Phase III, Facing the Challenge/Reconnecting, confirms the findings reported in Hetherington and Stoppard's (2002) study. Also, my study provided more detail on the specific strategies used by adolescents experiencing a depressive disorder. The study findings also demonstrated how social support was an important factor in building and supporting appropriate coping skills for adolescents coping with a psychiatric illness.

In comparison to my study, the themes identified in the Wisdom and Green (2004) grounded theory study are similar but also different to some of the components presented in the stages of my coping theory. These researchers explored the experiences of adolescents (n = 22) with unipolar depression. Although Wisdom and Green (2004) did not provide an example of their conceptual model, they presented a theoretical scheme for adolescents understanding of the illness experience. The scheme characterized depression as a "growth of distress to being in a funk, considering whether they are depressed, receiving the diagnosis, and making sense of the depression" (p. 1230). It is also difficult to compare and contrast the two studies because, as previously mentioned, Wisdom and Green (2004) did not provide an example of their schematic model in their published paper. However, in my study, the categories and sub-categories depicted in my schematic model appeared to be similar to some of the themes described

in their study. For instance, the theme, “growth of distress to being in a funk” appeared to be similar to the adolescents' experiences during Phase I, identified by the category, Feeling Different. Several other themes presented by Wisdom and Green (2004) are in keeping with the components of Phase III, Facing the Challenge/Reconnecting and Phase IV, Learning from the Experience. One of the major differences in my study, compared to Wisdom and Green’s (2004), is that the findings reported by the adolescents depicted in the schematic model indicate a change in the processes of coping over the course of the illness.

In comparison to my study, Draucker (2005), in a grounded theory study, explored retrospectively the management strategies used by young adults (n = 52) who were depressed as adolescents. From study findings, participants reported that specific individuals were helpful in assisting them manage their illness. These participants included parents and other family members, school personnel, health professionals, and peers. These findings reported in my study during Phase III, Facing the Challenge/Reconnecting, are in keeping with these findings. Nevertheless, my study, in contrast, is concerned with the process of coping for adolescents as they currently experience a mood disorder. Although the above study reported on individuals that the adults recalled being helpful, my study provides a more in-depth discovery of the coping processes as demonstrated in the schematic model for adolescents with a mood disorder. The difference in Draucker’s (2005) study was a focus on the interaction patterns and management strategies which young adults found helpful. However, my study extends this knowledge by providing specific information about what adolescents are experiencing in trying to cope with a mood disorder. During the specific phases of the

journey for example, Phase I, Feeling Different and Phase II, Cutting off Connections, inform health professionals exactly where interventions are needed for adolescents during the processes of coping with a mood disorder.

My study supported findings by Farmer (2002) who used a phenomenological approach to explore the experience of adolescents (n = 5) with major depressive disorder. In comparison, the study findings, presented as eight themes, relate to some of the stages in my schematic model, but there are also some differences. For instance, three of the themes, emotional homelessness, sense of aloneness and no safety where expected are similar to the experiences of the adolescents in Phase I, Feeling Different, as described in my study. During this stage, adolescents are just becoming aware of illness symptoms, but are unsure of what is happening. In Phase II, Cutting off Connections, the consequences of that experience lead to distancing oneself, thinking it's a stage, and seeking relief. These findings are similar to the themes described by Farmer (2002), a sense of aloneness and no safety where expected, and spectrum of escape from pain. The other themes, perspectives on friendship and gaining a sense of getting well, are similar to my findings evidenced in the sub-categories during Phase III, Facing the Challenge/Reconnecting and Phase IV, Learning from the Experience. During these two phases, the adolescents employed connecting strategies in Phase III which helped with personal growth, a coming to terms and managing the illness in Phase IV of the coping process.

In comparing my study with qualitative findings for adults with psychiatric illness, there are some similarities, but also differences for adolescents. Generally, the coping style that dominated these studies was emotional focused coping, particularly

rumination and diminished social support seeking (Greenhouse, Meyer, & Johnson, 2000; Holahan, Moos, Holahan, Cronkite, & Randall, 2004; Knowles, Tai, Christensen, & Bentall, 2005; Matheson & Anisman, 2003; Wang & Patten, 2002). In Phase II, Cutting off Connections, the consequences of the conditions as experienced in Phase I, Feeling Different were: distancing oneself, thinking it's a stage and seeking relief are considered aspects of emotion-focused coping. In contrast, my findings do not support the findings of the above researchers of diminished social support seeking for adults who are experiencing a psychiatric disorder. In my study, as described in Phase III, Facing the Challenge/Reconnecting, social support was found to be instrumental in helping adolescents develop and support the enhancement of a combination of problem-focused and emotional focused coping strategies necessary for adaptive coping.

My study confirmed the findings reported by several researchers who have used qualitative methods for studying coping among adults with a psychiatric illness. Peden (1994) used the Interpersonal Theory of Nursing by Peplau to guide her study of women (n = 7) recovering from depression. Findings were that women used three categories of strategies in coping and recovery. These strategies were identified as cognitive, active-behavioral strategies, and information seeking. The strategies used by the women were very similar to the strategies described by the adolescents in my study. For example, adolescents demonstrated all three types of strategies when they reported the following activities helped them cope: positive self-talk, exercise, writing in a journal, meditation, relaxation techniques, and information seeking were helpful in managing their illness. These strategies were not evident throughout the coping processes for adolescent until Phase III of their unplanned journey. During this phase, adolescents described the

employment of formal, informal, cognitive, and behavioral strategies which helped in facing the challenge of having a psychiatric illness. During this phase, social support was found to be instrumental in enabling the adolescents to develop strategies which were important for the management of their illness.

In comparison to my study, the themes reported by Skarsater, Dencker, Bergbom, Haggstrom, and Fridlund (2003) and Skaraster, Dencker, Haggstrom, and Fridlund (2003), who used a phenomenological approach to examine women's (n = 13) and men's (n = 12) perspective of coping with a major depressive disorder, were very similar to the strategies reported in my study by adolescents with a mood disorder. Thus, my study would support these findings during specific phases of the coping process for the adolescents. For example, during Phase III, Facing the Challenge/Reconnecting, the strategies identified as important for coping were: getting help, acknowledging denial, employing connecting strategies, and looking for explanations.

My study provides insight into coping as experienced by adolescents with a mood disorder. My schematic model confirms some of the findings by Beck (1993) who used grounded theory to explore the processes for women (n = 12) coping with post-partum depression. A substantive theory of postpartum depression called Teetering on the Edge was developed from participant observation and interview data. The theory was described by four stages that included encountering terror, dying of self, struggling to survive, and regaining control.

The four stages as described by Beck (1993) for women experiencing post-partum depression are similar to the aspects of specific phases during the coping process for adolescents with mood disorder. For example, the themes, encountering terror, struggling

to survive, and regaining control in the above study are similar to several aspects of the coping process for adolescents as illustrated in the four-phase process: Phase I, Feeling Different, Phase II, Cutting off Connections, Phase III, Facing the Challenge/Reconnecting and Phase IV, Learning from the Experience. These phases provide a detailed description of the difficulty encountered by adolescents and how they managed to cope through connections to others during the unplanned journey of the illness. In comparison to the above studies with adults, my study provided a four-phase process of coping and highlighted where specific nursing interventions can be designed to target the troubled stages for adolescents experiencing a mood disorder.

As confirmed in my study, social support was found to be paramount in enhancing the coping ability of the adolescents. Carver, Scheier, and Weintraub (1989) identified social support as a component of problem focused coping. These authors suggested that individuals seek social support for instrumental or emotional reasons. This process entailed getting or seeking support, assistance or information. Social support has been studied extensively in adults and adolescents and has been described as a multidimensional concept. The concept of social support is believed to be comprised of three components: network support, actual and perceived support (Aro, Hanninen, & Paronen, 1989; Bloom, 1990; Cheng, 1998; Ell, 1996; Frey & Rothlisberger, 1996; Hagerty & Williams, 1999; Jacobson, 1991; Kinsely & Northouse, 1994; Kuehner & Buerger, 2005; Mahon, Yarcheski, & Yarcheski, 1994; Tremethick, 1997; Uchino, Cacioppo, & Kiecolt-Glaser, 1996; Weigel, Devereux, Leigh, & Ballard-Reisch, 1998; Yarcheski, Mahon, & Yarcheski, 2001).

An important feature of coping demonstrated by the adolescents in my study was the use and seeking of social support from family, significant others, pets, friends, and professionals. The adolescents took the first positive step in the coping process by reaching out to others. During Phase II, Cutting off Connections, more maladaptive coping strategies were used. However, the initiative undertaken by adolescents during Phase III, Facing the Challenge/Reconnecting, within the theoretical framework enhanced their understanding of what was happening to them in the illness journey. A positive association between social support and recovery, coping, and quality of life has been described in the health care literature. Cohen and Wills (1985) developed the stress buffering theory related to the processes of social support. They suggested that social support protects or reduces the impact of stress on individual health. Other authors have reported that actual and perceived social support helped to promote recovery, coping and alleviate depression (Barrera & Garrison-Jones, 1992; Cheng, 1998; Jacobson, 1991; Kaltiala-Heino, Rimpela, Rantanen, & Laippala, 2001; Krantz & Moos, 1988; Nasser & Overholser, 2005; Rubin et al., 1992).

The findings in my study identified the concept of coping as a process consisting of four phases beginning with Phase I, Feeling Different and ending with Phase IV, Learning from the Experience. The concept of coping related to adolescents with a mood disorder as discussed in the literature is limited in scope. After conducting a search of the literature using the words cutting off connections/disconnection, I found several studies that used these terms. A small number of researchers have used the terms connection/disconnection in studies related to women and abuse (Belknap, 2002; Leenerts, 1999; Weingourt, 1996). For example, Leenerts (1999) used grounded theory

and an exploratory descriptive design to explore the social factors that low-income white women (n = 12) with HIV/AIDS, who experienced physical and emotional abuse, participate in self-care activities. Findings reported a core category called disconnection from self-care. This disconnection from self was related to a traumatized self-image and a confused self/other images that impact facilitation of self-care practices. Interventions in the model entailed a building of connections to self-care. For women in the study, the building of self-care connections required the identification of self-care role models, education for self-care skills and mobilization of self-care resources.

In another qualitative study, Belknap (2002) used an interpretive approach to report on the experience of women (n = 18) who had been abused by their partner. From study findings, four constructs of separation and connection in relation to women's narratives were reported: voices of separation, voice of self separate from self but connected with others, voice of self finding self, and voice of self-knowledge and connection with self and others. Although these findings are related to women who had experienced abuse, they are similar to the findings in my study for adolescents coping with a mood disorder. The concept of coping as identified by Phase II, Cutting off Connections and Phase III, Facing the Challenge/Reconnecting, in the unplanned journey for adolescents suggested that the aspect of coping through reconnection is important in adaptation. During Phase II, adolescents described a cutting off connections from self and others which may serve as a maladaptive coping response in order to deal with the feeling experiences in Phase I, Feeling Different related to the conditions of becoming aware and experiencing the symptoms. Adolescents in this stage eventually evolve into the Phase II process, where adolescents described cutting off from their social and interpersonal

connections. During this phase, several adolescents reported the use of risking taking behaviors such as the use of drugs and alcohol, cutting of self and attempts of suicide in their efforts to cope. During the next stage, reconnection to self and others occurred when adolescents sought help. During this time, the adolescents reached out to others which enabled them to loosen the burden of trying to cope with a psychiatric disorder alone. This process of reconnection for adolescents helped to provide social support, while adolescents used additional management strategies to aid in the coping process.

Following the initial literature review, several other studies were found that included the concept of connection/disconnection. The concept of connection/disconnection was described by several nurse researchers that studied the experience of personal illness, and also the experience of being a patient within a hospital environment (Forchuk, Jewell, Tweedell, & Steinnagel, 2003; Secrest & Thomas, 1999; Shattell, Hogan, & Thomas, 2005; Thomas, Shattell, & Martin, 2002; Wuest, Ericson, Stern, & Irwin, Jr., 2001).

My study adds new information to these concepts: cutting off connections and reconnecting for those adolescents who are experiencing a mood disorder. In a phenomenological study, Secrest and Thomas (1999) described the experience for patients (n = 14) living life two years post stroke. The authors characterized the experience as a life of loss integrated with the three themes of independence/dependence, in control/out of control and connection/disconnection with others. These themes solidified the importance of connection with others as necessary for coping and recovery. According to the researchers, this connection with others also enhanced the continuity of self which coexists with discontinuity in the effort to understand oneself.

Several other researchers reported on the concept of connection/disconnection in studies that explored the world of the hospitalized patient (Shattell et al., 2005; Thomas et al., 2002). Using a phenomenological approach, Thomas et al. (2002) explored the experience of being a patient (n = 8) on a psychiatric unit. The participants described the hospital as a place of refuge. From study findings, three interrelated themes emerged that characterized the patients' experience. The themes were: me/not like me, possibilities/no possibilities, and connection/disconnection. The final theme, connection/disconnection referred to the patient's experience of feeling connected or not to the hospital milieu. The feelings of connection or disconnection expressed by the patients were influenced by themselves, others patients, health care professionals and other hospital personnel who worked in the place of refuge. The theme of connection and disconnection, articulated in the Thomas et al. (2002) study of being a patient, is completely different from how the concepts cutting off connections and reconnecting are described in my study for adolescents with a mood disorder. The theoretical framework identified in my study provides a different interpretation of these concepts. Therefore, my study adds new knowledge to the understanding of how these concepts can be defined in reference to coping.

In a similar phenomenological study, Shattell et al. (2005) explored the experience of being a patient (n = 20) in the hospital on the medical/surgical unit. Three themes that characterized the patient’s experience were disconnection/connection, fear/less fear and confinement/freedom. The first theme, disconnection/connection, was influenced by the patient’s perception of a connection to the nurse and other health care providers. The connection to nurses consisted of both verbal and non-verbal interactions

that aided recovery, coping and comfort. These research findings support and validate the theoretical concepts of coping as characterized in the Meadus' theory of Adolescent Coping with Mood Disorders.

Implications of the Study

This study has implications for nursing practice and nursing research, and also for nursing policy and nursing education.

Implications for Nursing Practice

Today, mood disorders are one of the most common disorders affecting adolescents and young adults. It has been reported that adolescents who have experienced mood disorders have impaired academic, social, and cognitive functioning. These disorders seriously impact the adolescent's current quality of life and also elevate the risk for mental health problems in later adulthood (Skarbo et al., 2004). It is paramount then that nurses and other health care professionals have knowledge and understanding of how adolescents cope with such disorders. One of the important implications for nurses is the education of adolescents and young adults around the enhancement and development of healthy coping skills. Such initiatives will help adolescents' problem solving, demonstrating alternative ways to deal with stressful situations and prevent or modify maladaptive behaviors (Hess & Richards, 1999).

Adolescents spend a majority of their time in school; thus, nurses who work within the school system have access to this population. Nurses need to focus efforts on primary, secondary, and tertiary prevention within the school system to prevent, detect and treat mental health problems. For example, nurses can provide educational sessions to all students on the importance of maintaining mental health; provide information on

the risk and protective factors for psychiatric disorders and coping with stress. School nurses can also assess students at risk and provide referral services to meet their needs. These services may include a referral to a psychiatrist or an advanced practice psychiatric mental health nurse practitioner for assessment, treatment, and ongoing counseling. The nurse in collaboration with the school counselor can help students with a mood disorder, if they are able and wish to stay in school, by providing needed support. Also, if the school nurse is aware of a student with a mood disorder, the school nurse can be a helpful source of support in helping the student adjust with the demands placed upon him/her because of the illness. The nurse can be an important resource in teaching adolescents specific coping skills to help them gain appropriate ways to deal with problems and stress. In addition, the nurse can also be an excellent resource to provide information to parents about the illness. Such initiatives may help parents understand the problems of their adolescents and be better able to support coping and recovery efforts. In this study, several adolescents reported on the use and importance of support from others in their coping and recovery efforts.

Several adolescents in this study reported that their teachers understood little about what was happening to them. Some of the participants also described feeling stigmatized by their teacher because of their illness. The school nurse is in a prime position to provide informational sessions on mental health disorders to teachers. These actions will help to enhance the teacher's knowledge base on adolescent mental health issues and coping. The teachers may then be more sensitive to students who are having mental health problems and provide guidance for them to seek support and treatment.

These initiatives may help to decrease feelings of stigmatization experienced by the adolescents at school.

In addition to the above suggestions for addressing the needs of the ill adolescent at school, this study also has implications for the adolescents who are admitted to an inpatient unit for treatment of a mood disorder or seen in an outpatient mental health clinic or emergency department. Nurses are presented with the opportunity to assess adolescents with a mood disorder and their difficulty with coping. This study has contributed to the knowledge base of nursing science by providing a theory about adolescent coping with a mood disorder. The theory should provide an increased focus on the coping needs of such adolescents. The Meadus' theory of Adolescent Coping with Mood Disorders can serve as a guide for initiation of particular interventions during the stages of the coping experience. For example, during Phase II/Cutting off Connections nurses could intervene to help adolescents express feelings, provide supportive counseling, and assist with problem solving initiatives. Following the assessment and intervention process, nurses can assess for improvement outcomes and continue with future health planning. Also, nurses can help adolescents develop positive coping strategies through the use of psychoeducational group interventions. Nurses can provide information through group interactions about mood disorders, medications, and positive ways to learn how to cope.

In addition, study findings validate that support from families was helpful in enhancing the adolescent’s ability to seek help and cope with the consequences of the illness. This information heightens the need for nurses and other health care providers to refocus on the family in the plan of care when assisting or providing health care for

adolescents with a possible mood disorder. The family must be involved and considered part of the health care team from the onset and must be an active participant in decisions affecting treatment of an ill son or daughter. When the adolescent is admitted for treatment, nurses should inquire about the concerns the parents may have about their adolescent. Such initiatives will help to promote recovery and coping for the ill adolescent. Also, nurses are present and available as a valuable resource for the parents who are trying to cope themselves with the illness of their son or daughter. Thus, it would be an important part of the nursing assessment to inquire how the parents are coping with having an ill son or daughter.

Implications for Nursing Research

This study provided evidence of the development of a substantive theory for adolescents who are coping with a mood disorder. This theory contributed to the area on evidence-based mental health care for ill adolescents. The next step would be to test the theory in the practice setting. This would require development of a quantitative tool based upon concepts within the model or, since there are tools available, a collaborative effort with these researchers to modify existing tools would be beneficial. These concepts could be evaluated with the same population of adolescents from an outcome research perspective based upon the coping phases and strategies presented in the grounded theory. This initiative may lead to the development of best practice clinical guidelines for health professionals to use when working with this population of adolescents. These guidelines may lead to policy endorsement of best practice guidelines by provincial and national nursing organizations such as the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) and the Canadian Nursing Association (CNA).

A longitudinal study of adolescents with a mood disorder may provide further information about the ability of coping for adolescents over time. It may also provide an opportunity to assess how specific factors within the adolescent's life impede or facilitate coping. A study of how parents cope when caring for a child or an adolescent with a mood disorder may add to the knowledge on how health professionals, including nurses, can provide competent family focused care. Also, a study on how adolescents cope with other psychiatric disorders, such as schizophrenia, may illuminate a different aspect of the coping processes in comparison to adolescents with a mood disorder.

Differences between the ideas that adolescent females are more prone to depressive disorders in comparison to males have been reported in the literature. In this study, there were one male and eight female adolescents. An area for future study would be to study the perceptions of positive and negative coping experiences for male and female adolescents who have a mood disorder.

Implications for Nursing Education and Policy

Due to the increase of mental health problems for adolescents and other vulnerable groups worldwide, it is imperative that future nurses have the knowledge about mental health promotion and prevention when working with these individuals. Nurses working in a variety of settings, and not always a mental health setting, such as schools, acute care environments and community may be required to provide care for these individuals. The nursing curriculum (including the AD and BSN level) should provide course content related to information on nursing theory, mental health promotion, and prevention of mental illness. It is particularly important that nurses who are educated at an advanced practice level require greater skills related to knowledge of mental

disorders, treatment, and counseling in order to meet the societal needs for mental healthcare now and in the future.

This study may also have some implications for policy development related to promotion of community mental health strategies for adolescents. Advanced practice nurses who work at the community level have the expertise in developing policy around prevention of mental health disorders. Also, nurses need to work with school personnel to develop an effective policy around mental health prevention and intervention within the school system. Better links between the school system and the hospital based mental health service system are needed so adolescents requiring service are able to access the system in a timely manner. This initiative would help in early detection, treatment and tertiary prevention.

Limitations

One of the limitations of this research study is the sensitive nature of the research topic, adolescents coping with a mood disorder. As previously reported in this report, a total of 14 adolescents agreed to participate in the study; however, the final sample size was nine, with eight females and one male. This final sample size and gender may be a limitation. The way in which males and females are socialized to express their feelings is different. Thus, the experience of how male and female adolescents express their feelings in coping with a mood disorder may be different. Also, the feelings of stigmatization may have impacted some potential participants to change their participation decision. Adolescents who agreed to participate but later changed their decision may cope differently than those adolescents who did participate. Also, those adolescents who have a mood disorder, but have not sought assistance from the mental health system, may have

different methods of coping in comparison to those adolescents who seek assistance. Also, a review of only two of the adolescents' medical charts may be a limitation as no information was obtained for contribution to the study findings. In addition, one has to consider the ethical issues related to gaining access to medical charts, which is influenced by federal legislation.

Conclusion

The purpose of this study was to explore the phenomenon of adolescent coping with a mood disorder and to develop a substantive theory of coping for these adolescents. The grounded theory approach as espoused by Strauss and Corbin (1998) was used. Data were gathered through tape-recorded interviews with nine adolescents, one male and eight females. Consistent with Strauss and Corbin's (1998) coding process, interviews were transcribed verbatim, coded, and analyzed. The Meadus' theory of Adolescent Coping with Mood Disorders was presented. The phases describing the phenomena of coping were Feeling Different, Cutting off Connections, Facing the Challenge/Reconnecting, and Learning from the Experience. Following a discussion of the findings of the study, a discussion of the findings in relation to validation and support of the theory was presented. Implications of the research for nursing practice, nursing research, nursing education, and nursing policy were discussed. This was followed by a discussion of the limitations of the study and final study conclusion.

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APPENDICES

Appendix A

Barry University IRB Approval Letter

Barry University

Institutional Review Board
Office of the Provost and Vice President
for Academic Affairs

11300 NORTHEAST SECOND AVENUE
MIAMI SHORES, FLORIDA 33161-6695
Direct (305) 899-3020
FAX (305) 899-3026

Research with Human Subjects
Protocol Review

To: Robert Meadus Jr., RN

From: Constance Mier Ph.D., Chair

Date: July 20, 2000

Protocol Number: 00-07-040

Protocol Title: Adolescents coping with mood disorder: A grounded theory study

The Board has approved the protocol and consent form for the above study.

Constance Mier
Dept of Sport & Exercise Sciences
Barry University
11300 NE 2nd Ave
Miami Shores, FL 33161
If you have any questions, please contact the Chair at 305-899-3573.

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Note: The investigator will be solely responsible and strictly accountable for any deviation from or failure to follow the research protocol as approved and will hold Barry University harmless from all claims against it arising from said deviation or failure.

Appendix B

Memorial University HIC Approval Letters

Memorial
University of Newfoundland

Office of Research and Graduate Studies (Medicine)
Faculty of Medicine
The Health Sciences Centre

September 22, 2000

TO: **Mr. R. Meadus**

FROM: Dr. F. Moody-Corbett, Assistant Dean
Research & Graduate Studies (Medicine)

SUBJECT: Application to the Human Investigation Committee - #00.120

The Human Investigation Committee of the Faculty of Medicine has reviewed your proposal for the study entitled **"Adolescents Coping with Mood Disorder: A Grounded Theory Study"**.

Full approval has been granted for one year, from point of view of ethics as defined in the terms of reference of this Faculty Committee.

For a hospital-based study, it is **your responsibility to seek necessary approval from the Health Care Corporation of St. John's**.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

F. Moody-Corbett, PhD
Assistant Dean

cc: Dr. K.M.W. Keough, Vice-President (Research)
Dr. R. Williams, Vice-President, Medical Services, HCC

St. John's, NF, Canada A1B 3V6 • Tel: (709) 737-6762 • Fax: (709) 737-5053 • email: rgs@morgan.ucs.mun.ca

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

August 27, 2001

Reference #00.120

Mr. R. Meadus
26 Canada Drive
St. John's, NF A1E 4H2

Dear Mr. Meadus:

Thank you for taking the time to complete the annual update form for the research study entitled "**Adolescents Coping with Mood Disorder: A Grounded Theory Study**".

The Chairs' of the Human Investigation Committee reviewed your annual update form and granted approval of this study until **September 2002**, at which time you will be contacted for another update. This decision was formally reported to the full Human Investigation Committee at a meeting held on August 23, 2001.

Sincerely,

Catherine Popadiuk, MD, F.R.C.S. (C)
Co-Chair
Human Investigation Committee

Sharon K. Buehler, PhD
Co-Chair
Human Investigation Committee

CP;SKB/jjm

C Dr. C. Loomis, Acting Vice-President (Research)

Memorial
University of Newfoundland

Office of Research and Graduate Studies (Medicine)
Faculty of Medicine
The Health Sciences Centre

August 9, 2002

Reference #00.120

Mr. R. Meadus
26 Canada Drive
St. John's, NF A1E 4H2

Dear Mr. Meadus:

Thank you for taking the time to complete the annual update form for the research study entitled "**Adolescents Coping with Mood Disorder: A Grounded Theory Study**".

The Chairs of the Human Investigation Committee have reviewed your annual update form and have granted approval of this study until **September 2003**, at which time you will be contacted for another update. This decision was formally reported to the full Human Investigation Committee at a meeting held on **August 22, 2002.**

Sincerely,

Catherine Popadiuk, MD, F.R.C.S. (C)
Co-Chair
Human Investigation Committee

Sharon K. Buehler, PhD
Co-Chair
Human Investigation Committee

CP;SKB/mc

C Dr. C. Loomis, Vice-President Research, MUN

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

September 22, 2003

Reference #00.120

Mr. R. Meadus
26 Canada Drive
St. John's, NF A1E 4H2

Dear Mr. Meadus:

Thank you for taking the time to complete the annual update form for the research study entitled "**Adolescents Coping with Mood Disorder: A Grounded Theory Study**".

The Chairs of the Human Investigation Committee have reviewed your annual update form and have granted approval of this study until **September 2004**, at which time you will be contacted for another update. This will be reported to the full Human Investigation Committee, for their information, at a meeting scheduled for **October 2, 2003**.

Sincerely,

Sharon K. Buehler, PhD
Co-Chair
Human Investigation Committee

Richard S. Neuman, PhD
Co-Chair
Human Investigation Committee

SKB;RSN\jjm

C Dr. C. Loomis, Vice-President (Research), MUN

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

October 4, 2004

Reference #00.120

Mr. R. Meadus
3 Stenlake Crescent
St. John's, NL A1A 5T4

Dear Mr. Meadus:

Thank you for taking the time to complete the annual update form for the research study entitled **"Adolescents Coping with Mood Disorder: A Grounded Theory Study".**

The Chairs' of the Human Investigation Committee reviewed your annual update form and granted approval of this study until **September 2005**, at which time you will be contacted for another update. This decision will be formally reported to the full Human Investigation Committee at a meeting scheduled for **October 14, 2004**.

Sincerely,

Richard Neuman, PhD
Co-Chair
Human Investigation Committee

John Harnett, MD,BCh, FRCPI, FRCPC, FACP
Co-Chair
Human Investigation Committee

RN;JH\jd

C Dr. C. Loomis, Vice-President (Research), MUN

Memorial
University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

September 7, 2005

Reference #00.120

Mr. R. Meadus
3 Stenlake Crescent
St. John's, NL A1A 5T4

Dear Mr. Meadus:

Thank you for taking the time to complete the annual update form for the research study entitled **"Adolescents Coping with Mood Disorder: A Grounded Theory Study".**

The Chairs of the Human Investigation Committee reviewed your annual update form and granted approval of this study until **September 1, 2006**, at which time you will be contacted for another update. This decision will be formally reported to the full Human Investigation Committee at a meeting scheduled for **September 15, 2005**.

Sincerely,

Richard Neuman, PhD
Co-Chair
Human Investigation Committee

John Harnett, MD, FRCPC
Co-Chair
Human Investigation Committee

RN;JH\jd

C Dr. C. Loomis, Vice-President (Research), MUN

Appendix C

Health Care Corporation of St. John’s Approval Letters

HealthCare
Corporation of St. John's

October 20, 2000

Mr. R. Meadus
Memorial University
School of Nursing
Health Sciences Centre

Dear Mr. Meadus:

Your research proposal ***HIC 00.120 - Adolescents coping with mood disorders: A grounded theory study*** was reviewed by the Research Proposals Approval Committee (RPAC) of the Health Care Corporation of St. John's at its meeting on October 12, 2000, and we are pleased to inform you that the proposal has been approved.

This approval is based on the understanding that it has the necessary funding and that it is being conducted in the Psychiatry units at all sites. Additionally, the Committee requires a progress report to be submitted annually.

If you have any questions or comments, please contact Lynn Purchase, Manager of the Patient Research Centre, at 737-7283.

Sincerely,

Pamela Elliott

Pamela Elliott
Vice President
Patient Care Services

mh
c Ms. Lynn Purchase
Manager
Patient Research Centre

HealthCare
Corporation of St. John's

November 1, 2000

Mr. Robert Meadus, R.N., M.Sc.
Assistant Professor
School of Nursing, Memorial University of Newfoundland
Health Sciences Centre
St. John's, NF A1B 3V6

Dear Bob,

This will acknowledge your correspondence of September 21, 2000, informing me and seeking my support for the qualitative study titled, ***Adolescents Coping with Mood Disorder: A Grounded Theory Study***.

The Mental Health Program recognizes the need to promote and support research in mental illness. Qualitative research is desperately needed in the study of mental illness, particularly within the adolescent population. As I am sure you realize, adolescent mental health services are under resourced locally; and adolescents with mental illness, in particular, are a population who could greatly benefit from increased research and understanding.

Please let me know if I can be of any assistance as you begin your sample selection. As well, I would be most interested in hearing about your preliminary results.

Thank you for your anticipated contribution towards increasing our understanding of how these young people cope with mood disorders.

Sincerely,

Cathy Matthews
for Colleen Simms
Program Director, Mental Health

cpm

cc Dr. Tom Cantwell, Clinical Chief
Dr. Ted Callanan, Chair of Psychiatry
Division Managers, Mental Health Program

Appendix D

Approval to Use Internet Interview

Meadus, Robert

From: Joan Fleitas [fleitas@fair1.fairfield.edu]
Sent: May 12, 2001 3:07 AM
To: Meadus, Robert
Subject: Your research, my website

Robert, you are most welcome to use any of the material on my website. Each of the stories was approved by each of the children/teens prior to my publishing them on my site. I edited their work, but they had the final say. None of the stories are composites. Best wishes with your project. Great topic! Joan
--
Joan Fleitas, Ed.D., R.N.
Associate Professor of Nursing
Fairfield University
Fairfield, CT 06430
Phone: 203-254-4000 #2707
fax: 203-254-4126
e-mail:fleitas@fair1.fairfield.edu
http://www.faculty.fairfield.edu/fleitas/

Appendix E

Introduction of the Study to the Adolescent/Parent by

The Registered Nurse/Designate

Robert Meadus is a Registered Nurse employed with Memorial University School of Nursing, but is a student currently enrolled in graduate studies in the School of Nursing at Barry University, Miami Shores, Florida. He is conducting a study about how adolescent children cope with a mood disorder.

Would you agree to my giving your name to Mr. Meadus so that he can meet with you to discuss the study in further detail? He will only contact you if you agree for me to give him your name. For adolescents of legal age, agreeing to see Mr. Meadus does not obligate you to participate. Adolescents below the age of legal consent will be contacted if a parent/guardian has agreed. Agreeing to see Mr. Meadus does not obligate your child to participate. Should you desire further information anonymously Mr. Meadus can be reached at work (709) 777-6716 between the hours of 0830 AM and 0500 PM daily or at home (709) 738-5361. His dissertation chair, Dr. Sandra Walsh, Professor, Barry University may be reached at 1-800-756-6000, extension 3810 or via e-mail at swalsh@mail.barry.edu for further information or any questions you may have.

Thank you for your time and consideration of this matter.

Appendix F

Authorization for Release of Patient's Name

I hereby give permission to _____

(Registered Nurse or Designee) at _____

(institution or agency) to release my name to Robert Meadus. Mr. Meadus can contact me in person or by telephone to discuss the study in further detail, and see whether I would agree to participate in the study.

_____ _____

Date Signature of Adolescent

_____ _____

Date Signature of Witness

I hereby give permission to _____

(Registered Nurse or Designee) at _____

(institution or agency) to release my name to Robert Meadus. Mr. Meadus can contact me in person or by telephone to discuss the study in further detail, and see whether I would agree to his contacting my son/daughter.

_____ _____

Date Signature of Parent/Guardian

_____ _____

Date Signature of Witness

Appendix G

Explanation of Study & Consent Form for the Parent/Guardian

My name is Robert Meadus; I am a Registered Nurse employed as Assistant Professor with Memorial University of Newfoundland, School of Nursing and a graduate student with the School of Nursing, Barry University, Miami Shores, Florida. I am conducting a study to learn about how adolescents who have a mood disorder cope with this disorder. I hereby request your permission to contact your son/daughter to explain the study, and if he/she is interested, to request his/her participation. Your son's/daughter's participation in this study will involve two interviews. The first interview will take approximately one-hour. To begin the initial interview, I will pose the following open-ended statement: "Tell me what it is like to have_____?" The interview will be audiotaped. Also, during the interviews I will be recording notes. If your son/daughter agrees, I will meet him/her at a prearranged time that is mutually convenient for both of us. The second interview provides an opportunity to validate the transcripts from the first interview with the adolescent. This may take approximately a half-hour or less. The interviews will take place in a private office at (name of facility/agency). Your child's participation involves reflecting upon his/her thoughts/feelings about coping with his/her illness. A review of your son's/daughter's health record during hospitalization or outpatient stay will take place during the study by the investigator, if you so agree. This project is being

conducted under the supervision of Dr. Sandra Walsh, Professor, School of Nursing, Barry University.

Although you son/daughter may not benefit directly from being involved in this study, his/her contribution is appreciated and valued. The information gained by his/her involvement will help nurses, doctors, therapists, educators, and other health workers better understand and care for adolescents with a mood disorder.

Your son's/daughter's involvement in this study has minimal risk. As an experienced psychiatric nurse, I will be aware that you son/daughter may be anxious talking about his/her experiences of living with a mood disorder. I will convey these attributes by acknowledging that he/she may feel uncomfortable talking about his/her feelings.

I will emphasize that it is all right and very normal to feel this way. I will be cognizant of any signs of anxiety exhibited by your son/daughter during the interview process. If this happens, I will stop the interview, shut off the tape recorder, calm your son/daughter and ask if he/she wishes to continue. I will provide support and referral to an available counselor, if he/she so desires.

The decision to be involved in this study is entirely up to you and your son/daughter. If you do not wish me to contact your son/daughter, I will not do so. If you give me permission to contact your son/daughter, this does not obligate him/her to participate. Your child's health care will not be affected whether he/she

chooses to participate or not. If your son/daughter agrees to participate, your son/daughter is free to stop the interview, or to refuse to answer any questions or talk about any issues that make him/her feel uncomfortable. Also, your son/daughter has the right to withdraw from the study at any time without repercussions.

All data collected within the study will be kept confidential. Once the interview tapes are transcribed and the study is completed the tapes will be erased and destroyed. Data will be kept in a locked drawer in the investigator's office, and made available only to my dissertation chair, Dr. Sandra Walsh, committee members and myself. Following study completion, data and consent forms will be kept for seven years. No names or identifying information will be used during the data collection and transcription process. Your son's/daughter's name will not appear in any report of the study. Although direct quotes may be used in some cases, any information that might identify your son/daughter will be removed. Your son/daughter will be assured that his/her comments will not be shared with other family members or their therapist. However, if your son/daughter express any suicidal statements, he/she will be told that as a Registered Psychiatrist Nurse, I have a legal obligation to share such information with their therapist or assigned health care professional.

The approximate number of potential participants being sought for this study is 24.

I am available to clarify any questions or concerns that you may have related to this study now or later and can be reached by telephone or e-mail as indicated below. Should you have any additional questions or concerns, please feel free to contact Dr. Sandra Walsh by telephone or e-mail or the Office of Research (HIC), Faculty of Medicine, Memorial University of Newfoundland as indicated below.

Thank you for your time and interest in learning more about this study.

I hereby consent to having my child, _____ participate in this study if they so desire.

I hereby consent to having my child's medical records accessed by the investigator. Yes____ No____

I have received a copy of this form for my records.

Liability statement

Your signature indicates your consent and that you have understood the information regarding the research study. In no way does this waive your legal rights nor release the investigator or involved agencies from their legal and professional responsibilities.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Researcher Date

Participant Initials_____ Page 4

Robert Meadus

Telephone: (H) (709) 738-5361

(W) (709) 777-6716

E-mail: meadusr@mun.ca

Dr. Sandra Walsh

Telephone: 1-800-756-6000, extension 3810

E-mail: swalsh@mail.barry.edu

Office of Research (HIC)

Faculty of Medicine

Memorial University of Newfoundland

Telephone: (709) 777-6974

Appendix H

Explanation of Study for the Adolescent

Hello_____. My name is Robert Meadus. I am a Registered Nurse and employed as Assistant Professor with Memorial University School of Nursing, but a graduate student in the School of Nursing at Barry University, Miami Shores, Florida. If applicable, your parent/guardian has given me permission to contact you. I am asking for your participation in this study being conducted to learn about how youth/adolescents cope with a psychiatric illness. This project is being conducted under the supervision of Dr. Sandra Walsh, Barry University School of Nursing.

The purpose of this study is to gain an understanding of how youth/adolescents cope with having a mood disorder.

Although you may not benefit directly from being involved in this study, your contribution is valuable since it may help other nurses, teachers, and other health professionals to learn better ways to help young people cope with mood disorders.

Taking part in this study will involve two interviews. During the interview process I will be taking notes. This first interview will take approximately one-hour, which will be audiotaped. The second interview will take approximately a half-hour or less. I will meet you at a time that we agree to at (Institution/Agency). Your participation involves telling me about your thoughts/ feelings, and sharing your experiences of living with a mood disorder. A review of your current health record during hospitalization or outpatient stay will take place during the study by the investigator if you so agree.

The information you provide will remain confidential. Although direct quotes may be used in some reports of the study, any identifying information that might identify

you will be removed. To protect you and your family's identity, the tapes, once transcribed into written form will be erased after the study's completion. Your name will not appear in any report of the study.

Your involvement in this study has minimal risk. You may feel anxious talking about your experiences of living with a mood disorder. It is all right and very normal to feel this way. I will be cognizant of any signs of anxiety you may exhibit during the interview process. If this happens, I will stop the interview, shut off the tape recorder, calm you and ask you if you wish to continue with the interview. I will provide support and referral to an available counselor, if you so desire.

The decision to be involved in this study is entirely up to you. There will be no consequences whatsoever if you decide not to participate, and the care you are receiving at (name of facility/agency) will not be affected. If you so decide to participate, any information you provide will not be shared with any of your family members or therapist. However, if you express any suicidal statements, you will be informed that as a Registered Psychiatric Nurse, I have a legal obligation to share this information with your therapist or assigned health professional. You are free to stop the interview, or to refuse to answer any questions that may make you feel uncomfortable.

Information will be made available only to Dr. Sandra Walsh, Professor, Barry University School of Nursing, Miami Shores, Florida, dissertation committee members and myself. When not in use, data will be kept in my office in a locked drawer. Information and consent forms will be kept for seven years after the study's completion in a locked drawer in the investigator's office.

If you have any questions about the study I will answer them, now or in the future. I am available to clarify any concerns that you may have related to this study, and can be reached at telephone numbers and e-mail address as indicated below. Should you have additional questions or comments, Dr. Sandra Walsh, research supervisor may be contacted at the telephone number and e-mail address as indicated below.

Thank you for your time and for considering participating in this research study.

Robert Meadus

Telephone: (H) (709) 738-5361

(W) (709) 777-6716

E-mail: meadusr@mun.ca

Dr. Sandra Walsh

Telephone: 1-800-756-6000, extension 3810

E-mail: swalsh@mail.barry.edu

Appendix I

Adolescent Consent Form

Title: Adolescents Coping with Mood Disorder: A Grounded Theory Study

Investigator: Robert Meadus

I have been requested to participate in a study of coping behaviors of adolescents living with a mood disorder. I understand that this study is under the supervision of Dr.Sandra Walsh, Professor in the School of Nursing, Barry University, Miami Shores, Florida. I understand that the information might help nurses, other health professionals and teachers care for adolescents experiencing a psychiatric disorder.

If I am under 19 years of age, I understand that my parent/guardian has agreed to my participation, but the final decision is mine. Furthermore, I understand that my participation will involve two interviews. The first interview will be approximately one-hour long, and the second interview will be approximately a half-hour. Both interviews will take place with Mr. Robert Meadus. He has asked my permission to tape record the interview so that he can better remember what I tell him. Each interview will take place at a private office at the (name of agency/institution), at a time that is mutually convenient for Mr. Meadus and myself. My participation involves reflecting on my thoughts/feelings, and sharing my experiences of having a mood disorder.

I understand that what I say in the interview will be kept confidential. The

tapes will be erased after the study's completion. Data will be available only to Mr. Meadus, Dr. Sandra Walsh and dissertation committee members. When not in use, data will be kept in a locked drawer in the investigator's office. Data and consent forms will be kept for seven years. Although direct quotes may be used in the report of the study, and I may recognize my own words, information, which might identify me to others, will be removed. My name will not appear in any report of the study.

I understand that the decision to be involved in this study is entirely mine.

I understand that if I do not wish to participate, my care will not be affected in any way.

I understand that I can stop the interview at any time or not answer any questions that make me feel uncomfortable.

I have received a copy of this form for my records.

Approximately 24 participants will be taking part in this study. If I have any questions after interviews are completed, I can call Dr. Sandra Walsh or Mr. Meadus at the numbers or e-mail addresses as indicated below.

I agree to participate in this study. Yes____ No_____

I agree to have the interview audiotaped. Yes____ No____

I hereby consent to having my medical records accessed by the investigator.

Yes_____ No_____

Participant Initials_____ Page 2

Liability Statement

Your signature indicates your consent and that you have understood the information regarding the research study. In no way does this waive your legal rights nor release the investigator or involved agencies from their legal and professional responsibilities.

_____ _____

Signature of Youth/Adolescent Date

_____ _____

Signature of Parent/Guardian Date

(If youth/adolescent is below legal age of 19)

_____ _____

Signature of Researcher Date

Robert Meadus

(H) (709) 738-5361

(W) (709) 777-6716

E-mail: meadusr@mun.ca

Dr. Sandra Walsh

Telephone 1-800-756-6000, extension 3810

E-mail: swalsh@mail.barry.edu

Office of Research (HIC)

Faculty of Medicine, Memorial University of Newfoundland

Telephone: (709) 777-6974

Appendix J

Interview Guide

Examples of questions to guide the interview (after the first two interviews).

1. Reflect back and describe how you first became aware that something was going on?
2. What led you to seek help?
3. How did you feel when you found out it was depression?
4. What were your major concerns or worries once you found out?
5. What helped you cope with the illness? What was not helpful?
6. Some participants have described finding music and support from family and friends helpful? How about you?
7. What would you describe as the most difficult thing about having this illness?
8. In reflecting back on your experience, do you think anything in particular might have triggered becoming ill?
9. Are there other comments you would like to share with health professionals related to your illness experience?

Appendix K

VITA

Robert John Jacob Meadus, Jr.
3 Stenlake Crescent
St. John's, NL
A1A 5T4

Office (709) 777-6716
Home (709) 738-5361
Fax (709) 777-7037

Experience

Assistant Professor	2000-Present
Memorial University	
School of Nursing	
St. John's NL A1B 3V6	
Nurse Educator	1998-2000
Centre for Nursing Studies	
100 Forest Road, Southcott Hall	
St. John's, NL A1E 1E5	
Nursing Instructor II	
Human Resources Development &	1995-1998
Planning/Education	
Health Care Corporation of St. John's	
General Hospital site	
St. John's, NL A1B 3V6	
Nursing Instructor II, General Programs	1989-1995
Staff Development Department	

The General Hospital Health Sciences Centre

St. John's, NL A1B 3V6

Education

Doctor of Philosophy (Nursing) May 2006

Barry University

Miami Shores, Florida

33161-6695

Master of Science (Nursing) November 1996

University of Toronto, Faculty of Nursing

Toronto, Ontario M5S 1A1

Bachelor of Nursing May 1989

Memorial University of Newfoundland

School of Nursing

St. John's, NL A1B 3V6

Bachelor of Vocational Education May 1995

Memorial University of Newfoundland

St. John's, NL A1B 3V6

Diploma Mental Health/Psychiatric Nursing May 1986

Memorial University of Newfoundland

St. John's NL A1B 3V6

Diploma Nursing September 1978

General Hospital School of Nursing

St. John's, NL A1A 1E5

Research Grants

Association of Registered Nurses of Newfoundland & Labrador (ARNNL) Education & Research Trust 2000-2001

Project title: *Adolescents Coping with Mood Disorder: A Grounded Theory Study*

Amount: $1300.00

The Janeway Research Advisory Committee Health Care Corporation of St. John's 2001

Research Grant for Project titled:

Adolescents Coping with Mood Disorder: A Grounded Theory Study

Amount: $8846.99

Publications

Meadus, R. J., & Johnson, B. (2000). The experience of being an adolescent child of a parent who has a mood disorder. *Journal of Psychiatric and Mental Health Nursing, 7*(5), 383-390.

Meadus, R. J. (2000). Men in nursing: Barriers to recruitment. *Nursing Forum, 35*(3), 5-12.

Meadus, R. J. (1995). Testicular self-examination (TSE). *The Canadian Nurse, 91*(8), 41-44.