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Sharing Their Stories: A Qualitative Investigation of Adolescents'

Inpatient Experiences During Psychiatric Hospitalization

by

Jessica L. Rice

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Curriculum and Instruction
with a concentration in Educational Psychology
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Date of Approval:
December 10, 2020

Keywords: adolescent development, adolescent mental health, involuntary commitment, crisis stabilization, acute psychiatric care

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ACKNOWLEDGEMENTS

This project has been one of collaboration and tremendous support, as such, my deepest appreciation is extended to all of those who educated, encouraged, and empowered me through to its completion.

To Dr. Tony Tan, it has been an absolute privilege to partner with you through this process. The example that you have established as a scholar, educator, and human will forever inspire me, and it is because of you that this project has been made possible. Thank you for your patience, confidence, and unwavering support. I cannot begin to express my appreciation for who you are and all you do.

Dr. Kiefer, your fervor for the field is truly motivating, and I have learned a great deal from you, both in and out of the classroom. Thank you for your dedication to service, commitment to students, and a constant willingness to offer support, each of which have been so helpful throughout this journey. I am so grateful for your expertise and insights.

Dr. Moore, having the opportunity to work with you has shaped who I am as a professional. Thank you for giving so much of yourself to the field of mental health, and for allowing me to collaborate with you. Our community is a better place because of you, and I hope to continue to be a part of the changes you create.

Dr. Wolgemuth, your words and wisdom have served as such an encouragement throughout this journey. Thank you for urging me to engage in research that is truly meaningful to me personally, and for the mentorship that you have so generously provided. I am hopeful that as a future educator, I can encourage others in the same ways that you have moved me.

To each committee member, thank you for the time that you have invested in me throughout the years. You have all played a significant role in this project and shaped who I am today.

To Derek McCarron and the incredible staff at the psychiatric hospital where this research took place, thank you for all you do to support young people in crisis. Your jobs are among the most difficult that there are, yet you give so much of yourselves to those you serve every single day. Thank you for pouring into the lives of those in crisis, and for so graciously opening up your place of work to me, as I completed this research. I am in awe of each of you and hope you know the difference that you are making in the lives of the youth you serve.

To my family and friends, thank you for your patience through this process. Your support is what has carried me through, and I am eternally appreciative of the grace you have afforded me as I work to accomplish this goal. The sacrifices you have each made are the reasons that I have been able to move forward in pursuing this endeavor.

Finally, to the 25 superheroes who allowed me to join them on their journey through inpatient psychiatric hospitalization, thank you. You are each remarkable. Thank you for trusting me with your stories, and for allowing me to share them with others.

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ABSTRACT

Psychiatric hospitalization is an intensive treatment intervention, reserved for youth with severe mental illnesses, considered in imminent danger of harm to themselves and/or others. Although the prevalence of youth that are psychiatrically hospitalized continues to rise, there remains a gap in the available research about adolescents' appraisals of their inpatient treatment, as most studies draw conclusions from surveys, administered after patients are discharged. Not only does this limit insights about treatment changes that could be beneficial in reducing psychiatric hospital recidivism, but it also inhibits youth from sharing their subjective experiences. As such, the current study sought to develop a deeper understanding of the experiences of psychiatrically hospitalized youth by conducting in-depth, semi-structured interviews at the beginning and end of their psychiatric hospitalizations. Four themes (Family Fallout; Criminalized, Stigmatized, and Marginalized; Power of Peer Support; and Cultivating Change) were identified from the data. These themes captured the influence of precipitating factors and the complexities of inpatient treatment for psychiatrically vulnerable youth. By empowering adolescents to share their stories through interviews, the voices of those amidst psychiatric crises can be heard in ways that open up dialogues surrounding mental illness and begin to reduce stigma.

CHAPTER ONE: INTRODUCTION

Psychiatric hospitalization is a type of highly specialized intensive treatment, reserved for the most severe mental health cases (Savina et al., 2014). Although psychiatric inpatient services are only considered clinically appropriate when all other forms of care are unsuccessful, or when youth pose an imminent threat to themselves or others, they represent a highly utilized component of children's mental health services (Moses, 2011; Savina et al., 2014). Since 2000, the number of inpatient psychiatric episodes among children and adolescents has been increasing (James et al., 2010; Savina et al., 2014), and today, psychiatric hospitalization is indicated as the fourth most frequent cause of pediatric hospitalization in the U.S. (James et al., 2010; Meagher et al., 2013; Savina et al., 2014). Though threats of harm to self-and/or others necessitate crisis stabilization (Becker, et al., 2015; Leon et al., 2013; Mathai & Bourne, 2009; Prince, 2013), consensus exists among mental health professionals that inpatient psychiatric hospitalization should serve as a last resort, particularly given the traumatizing effects that hospitalization itself may pose to youth in crisis (Comas et al., 2014; Paksarian et al., 2014). As such, inpatient treatment is designed to focuse on providing intensive, patient-centered, psychiatric services that promote stabilization (Case et al., 2007; Leon et al., 2013).

Specifically, inpatient psychiatric hospitals for youth adhere to acute care guidelines, with length of stay averaging only four days (Case et al., 2007; Leon et al., 2013) and treatment concentrated on the following four features: 1) stabilizing youth with the most severe and complex psychiatric needs, 2) conducting comprehensive psychiatric evaluations by a multidisciplinary team of professionals, 3) providing crisis stabilization through therapeutic

interventions and medication management to ensure that youth are not in imminent danger to themselves or others, and 4) linking youth with outpatient community resources, where they can receive treatment in a less-restrictive setting (Balkin, & Roland, 2007; Blanz & Schmidt, 2000; King et al., 1997). While this current approach to inpatient psychiatric hospitalization addresses a number of ethical and fiscal concerns posed by policymakers, child and family advocates, and managed care companies, it places increased pressure on hospitals to do more with fewer resources and less time (Blanz & Schmidt, 2000; Leon et al., 2013).

Despite efforts to reduce the duration of hospitalization and streamline psychiatric treatment so youth can rapidly reintegrate into their families, schools, and communities, however, re-hospitalization has increased from approximately 25% during the late 1980s and 1990s, to rates between 32% and 37% (Blader, 2004; Fontanella, 2008; James et al., 2010). These findings bring into question the efficacy of inpatient psychiatric treatment, suggesting that the levels of symptom acuity among hospitalized youth create a complex clinical presentation, which may require more comprehensive assessments than those presently provided (Greenham & Bisnaire, 2008; Meagher et al., 2013). From a systemic perspective, high recidivism also contributes to concerns that the ecological supports (e.g., caregiver's ability to provide supervision, placement safety, and organization of outpatient services; Greenham & Bisnaire, 2008) implemented at the time of discharge may not suffice in the maintenance of long-term stabilization (Daniel et al., 2004).

Though information about re-hospitalization among youth has significant planning and prevention implications, research remains scarce, and the majority of studies focus on demographic variables (e.g., sex, age, race, symptoms, placement, mental health needs, community population characteristics, etc.) and their influences on recidivism (Arnold et al.,

2003; Blader, 2004; Heflinger et al., 2002). While findings are generally inconsistent, several demographic risks, particularly those related to disengaged parent–child relations (Blader, 2004), are linked with low service utilization when symptoms first emerge (i.e., 50% of those in need do not enroll in mental health services), ultimately impacting recidivism (Becker et al., 2015; McFarlane et al., 2014). Failure to seek services can result in symptom manifestation throughout childhood, and the subsequent escalation of psychiatric problems during adolescence (Becker et al., 2015; King et al., 1997; Prince, 2013).

The significance of early intervention is further underscored by the fact that youth admitted for inpatient treatment exhibit risk profiles high in both individual and contextual factors (Boxer & Terranova, 2008). If these environmental risks and interpersonal stressors (e.g., parental mental illness, abuse, poor parental and peer attachment, etc.; Prince, 2013) culminate throughout childhood development, they have been found to adversely influence adolescent adjustment and mental health (Blanz & Schmidt, 2000; Case et al., 2007; Chung et al., 2008). As such, when youth present at psychiatric hospitals with problems that have plagued them since early childhood, their symptom severity, coupled with the need for intensive environmental-based interventions, far supersede the services offered during brief crisis stabilization; thus, contributing to the exacerbation of symptoms and rapid re-hospitalization (Chung et al., 2008; Fontanella, 2008; King et al., 1997; Lapointe et al., 2010; Prince, 2013).

Yet another explanation for the rise in re-hospitalization rates among youth is related to lack of treatment engagement, which is hypothesized to predict treatment outcomes and long-term stabilization (Roedelof et al., 2013). Historically, hospitalized youth have been found to under-report their levels of psychological impairment, arguing that their problems do not merit hospitalization, and demonstrating resistance to treatment once admitted (Lapointe et al., 2010;

Szajnberg & Weiner, 1989). This treatment resistance is associated with lack of symptom insight, medication noncompliance, and denial of illness that are often characteristic of individuals with increased likelihood of re-hospitalization (Averill et al., 2001; Hopko et al., 2001). Several speculations exist surrounding treatment engagement. For instance, some (e.g., Jaunay et al., 2006; Sondheimer et al.,1994) have suggested that hospitalization may engender feelings of helplessness; therefore, youth inadvertently sabotage treatment as they strive for autonomy. Treatment non-compliance among psychiatrically hospitalized youth is also thought to be associated with a lack of social support, family dysfunction, and poor parent-child communication (Jaunay et al., 2006), each of which heighten the risk of re-hospitalization.

Statement of the Problem

Though findings derived from outcome studies, which quantitatively survey parents, caregivers, and treatment providers, can offer insights about adolescent psychiatric hospitalization, satisfaction-focused survey results fail to elicit participants' individualized stories as they reflect on their hospitalizations (Moses, 2011). Moreover, the extant research only offers a limited depiction of the microcosm that exists within inpatient psychiatric settings and does not provide a comprehensive picture of the practices employed within psychiatric settings for youth stabilization (Moses, 2011). To date, little comprehensive research has been conducted on the experiences of psychiatrically hospitalized youth (Mohr, 1998; Moses, 2011). In fact, few psychiatric hospitals assess patient perceptions over the course of their inpatient admission, thus failing to allow for modification of treatment plans, and instead employing generic interventions that reduce the likelihood of treatment response (Confer et al., 2015). It is even more uncommon for psychiatric hospitals to provide treatment teams with feedback concerning youth's treatment responses, despite growing evidence that this information can help to improve outcomes (Confer

et al., 2015). As such, patient perceptions about psychiatric hospitalization are too often left unexamined, and psychiatric practices employed to address mental health crises continue unchecked, both of which contradict the patient-centered approach, believed to be critical in crisis stabilization (Confer et al., 2015; Delaney et al., 2015).

Without knowledge about youth's inpatient experiences, their perceptions of the events that precipitated the hospitalization, and their goals for ameliorating the underlying stressors following hospital discharges, the individual implications associated with inpatient hospitalization are ignored. Moreover, the ability to tailor treatment in ways that promote lifelong psychiatric stabilization and prevent re-hospitalization become almost impossible (Heflinger et al., 2002; Mohr, 1998). Accordingly, additional research is needed to encapsulate the individual experiences of young people, and better understand treatment from the perspectives of those that are hospitalized (e.g., Blanz & Schmidt, 2000; Crespi & Ivey, 1987; Mohr, 1998; Moses, 2011; Schwartz, 1989).

Purpose of the Study

Individual and contextual factors not only play a role in the crises that precipitated young people's hospitalizations, but also have significant implications for their long-term stabilization, by either supporting or hindering their mental health throughout development (Boxer & Terranova, 2008). Oftentimes, however, youth are not afforded with adequate opportunities to process the experiences and emotions surrounding their hospitalization, thus causing them to question the purpose of their treatment (Moses, 2011). For youth amidst psychiatric emergencies, a sense of significance and personal agency are imperative, as these characteristics can foster a sense of meaning (McAndrew et al., 2014).

For those with mental illnesses, personal experiences can be made meaningful through the opportunity to tell their stories (McAndrew et al., 2014). The anchoring of previous experiences and precipitating factors to inpatient hospitalization creates clarity as youth contextualize their personal situations (McAndrew et al., 2014). To foster such introspection and gain insights into individual inpatient treatment experiences, youth must be engaged in ways that extend beyond survey questions and satisfaction evaluations, and instead afforded with the opportunity to openly reflect.

The current study was aimed at qualitatively investigating adolescents' interpretations of their inpatient psychiatric hospitalization, based upon the experiences that precipitated their admission and their appraisals of the treatment that they received for crisis stabilization. The purpose of this study was to obtain a more in-depth understanding of psychiatric hospitalization to inform treatment practices in ways that serve to reduce recidivism. Qualitative inquiry into the subjective experiences of youth is thought to aid in the development of treatment approaches geared toward resolving psychiatric crises, rather than merely managing symptoms (Welches & Pica, 2005). Moreover, by affording youth with opportunities to express, explore, and explain their treatment experiences, through in-depth interviews, this study provided youth, whose experiences are too often silenced, a voice with which they can share their stories.

Research Question

The research question that guided the current study was aimed at understanding the subjective experiences of psychiatrically hospitalized youth, as they reflected on the events that precipitated their admissions and engaged in inpatient treatment. Through in-depth, semi-structured interviews, situated within the context of the reviewed literature, the following research question was posed:

What are the experiences of psychiatrically hospitalized youth as they reflect on the influence of precipitating factors and navigate the complexities of inpatient treatment in pursuit of crisis stabilization?

Research Aims

Given this research question, and the focus on developing a deeper understanding of adolescents' inpatient treatment experiences, this study had three objectives: 1) to describe how adolescents perceived the precipitating factors that led to their admissions, 2) to explore adolescents' explanations of inpatient treatment and their evaluations of processes involved in crisis stabilization, and 3) to investigate adolescents' assessments of the potential costs and benefits associated with inpatient psychiatric hospitalization. In addressing these research aims, the current study considered feedback from adolescent participants within the context of inpatient psychiatric hospitalization. Through the insights garnered from the stories shared, treatment experiences for youth in crisis can be enhanced (Hepper et al., 2005).

Significance of the Study

The current study seeks to fill a gap that has long been acknowledged in the extant literature (e.g., Crespi & Ivey, 1987; Holzman & Schlesinger, 1972; Lee, 1979; Osofsky & Fry, 1985; Schwartz, 1989) by providing a broader view of the subjective experiences of youth during inpatient treatment. Through this research, insights can be garnered into the precipitants of adolescents' psychiatric crises, the role of individual and contextual risks, and the complex dynamics that exist within inpatient psychiatric hospitals, each of which influences the treatment needs of adolescents diagnosed with severe mental illnesses. Moreover, conducting interviews from a person-centered perspective, in which youth are encouraged to share and reflect on their experiences openly, establishes increased understanding about the ways youth interpret their

inpatient treatment. From this understanding, discoveries can also be made about the emergence of psychiatric problems within various contexts during adolescent development, and the interpersonal relationships that may be linked with or serve to protect against inpatient psychiatric hospitalization.

This research also has significant implications for practitioners and policy makers, particularly given the changing landscape of children's mental, and the shift toward more community-based programs and wraparound services to promote least-restrictive treatment options (Bruns et al., 2014; Moses, 2011). As a deeper understanding of the precipitating factors that elicit psychiatric hospitalization is developed, for instance, prevention efforts can be introduced to identify youth and their families that may be at-risk, prior to the emergence of a psychiatric crisis. Similarly, gathering data on individual perceptions about inpatient programs and processes can also promote the tailoring of treatment interventions to meet young people where they are and appropriately address treatment needs. Most importantly, seeking the expertise of those that are psychiatrically hospitalization can serve to enhance existing treatment approaches by empowering youth and providing them voices to share their experiences.

Despite efforts to raise awareness about mental illness through various initiatives (e.g., Caring for Every Child's Mental Health Campaign, National Children's Mental Health Awareness Day, Community Conversations About Mental Health National Initiative, etc.), dialogues about mental health crises and psychiatric hospitalization among youth remain absent from public discourse (e.g., in schools, throughout the media, and in various community settings; Substance Abuse and Mental Health Services Administration (SAMHSA), 2013). SAMHSA (2013) suggests that the misperceptions, discrimination, fear of social consequences, and discomfort associated with talking about these issues, tend to keep people silent. As such,

discussions concerning the mental health needs of children and adolescents remain limited, and stigma continues to curb conversations about crisis stabilization for children with severe mental illnesses (Katoka et al., 2002; Pescosolido et al., 2007, p. 613). However, the current study serves as a way of beginning to expand dialogues surrounding adolescent mental illness and inpatient psychiatric hospitalization.

Conceptual Frameworks

Given the research aims described previously, three theoretical starting points (i.e., adolescent development framework, human developmental ecological model, and crisis theory) guided the current study. Taken within the context of psychiatric hospitalization, the concepts that comprise these theories provided a framework for organizing adolescents' treatment experiences. Synthesized together, they also created a broader lens through which adolescent psychiatric hospitalization can be understood, particularly during instances in which emotions and experiences culminate to result in a psychiatric crisis.

Adolescent Development Framework

Adolescence is characterized as a critical developmental period during which young people begin to explore characteristics of the self in an attempt to create who they are and how they fit into the social world in which they live (Steinberg & Morris, 2001). Though the biological changes that accompany this developmental period have long been acknowledged, only recently has research emerged that specifically examines the critical changes in cognitive functions and emotional processes unique to adolescence (Blanco et al., 2015). At the forefront of this research is the adolescent development framework (Hill, 1980), which provides a way of organizing and understanding the dynamic interplay that exists between biological, psychological, and environmental factors during adolescent development (Blanco et al., 2015).

The adolescent development framework serves as a working guide through which to classify the three basic components of adolescence (Hill, 1980). The first component involves fundamental changes (i.e., biological, cognitive, and social), and their significance during adolescence (Hill, 1980). The second component, or the context of adolescence, focuses on the ways in which adolescent development is shaped by the contexts in which youth are embedded (e.g., families, peers, schools, and work settings; Hill, 1980). While the third component encompasses five developmental concerns that become particularly salient during adolescence (i.e., identity, autonomy, intimacy, sexuality, and achievement), and constitutes the psychosocial element of development (Hill, 1980).

As with any period of change, some emotional instability is expected during adolescence, particularly given the complexities that comprise this developmental stage (Meschke et al., 2012; Moses, 2014). Though the majority of youth are capable of coping with stress and adapting to change in ways that propel them toward identity integration (Recklitis & Noam, 1999), approximately one in five adolescents (i.e., a twofold increase as compared to childhood) experience psychological complications (Blanco et al., 2015; Costello et al., 2011). As such, adolescence is considered the peak age of onset for many psychiatric disorders (Blanco et al., 2015; Evans & Frank, 2004; Paus et al., 2008).

Viewed through the adolescent development framework, understanding the various changes and components that comprise adolescence can offer insights into what factors may be responsible for the rising incidence of mental illness during this period. For instance, the influx of mental illnesses during adolescent development may be spurred by changes in neural systems, responsible for reasoning, interpersonal interactions, control of emotions, risk appraisal, and motivation (Paus et al., 2008). However, mental illness may also peak during adolescence due to

gene and environmental interactions that disrupt psychosocial processes and create abnormalities in emotional equilibrium (Costello et al., 2011; Grossoehme & Gerbetz, 2004; Puotiniemi & Kyngäs, 2004; Recklitis & Noam, 1999). While the causes of increased mental health disorders during adolescence may not be fully known, employing the adolescent developmental framework can serve as a way of beginning to understand how biological, psychological, and environmental changes contribute to psychological crises that emerge among youth (Blanco et al., 2015).

Human Development Ecological Model

Bronfenbrenner's (1979) human development ecological model acknowledges that the multiple systems in which adolescents are entrenched, can either contribute to their emotional wellbeing or, conversely, trigger psychological responses (Savina et al., 2014). According to this perspective, psychological problems result from a mismatch that exists between environmental demands and adolescents' skills and resources (Henry et al., 1993; Savina et al., 2014). The ecological model also considers characteristics of adolescents' environments, in addition to how they perceive and navigate elements of their environments (Bronfenbrenner, 1979; Savina et al., 2014).

The human development ecological framework (Bronfenbrenner, 1979) can be used to better understand inpatient psychiatric hospitalization because this treatment approach reflects the combined influence of individual symptoms (e.g., severity, age of onset, coping mechanisms, etc.), contextual factors (e.g., family dynamics and peer relationships), and the overall system of care (inpatient providers, outpatient community resources, etc.; Savina et al., 2014) on adolescent mental health. The framework's emphasis on interaction also suggests the presenting problems that precipitate inpatient hospitalization are the result of problems within and across systems (Lucier-Greer et al., 2014). Therefore, an in-depth examination of factors across social

ecological systems, in addition to the establishment of coordination between them, are essential in providing youth with the appropriate treatment (Lucier-Greer et al., 2014; Savina et al., 2014).

Crisis Theory

Building on the human development ecological model, crisis theory maintains that a crisis event can be viewed as either an opportunity or a threat, depending on individual perceptions (Clarke & Winsor, 2010). According to this model, a crisis is spurred by stressors that compromise emotional equilibrium (Clarke & Winsor, 2010). Considered within the context of inpatient psychiatric hospitalization, adolescents may initially perceive inpatient hospitalization negatively, particularly given potential disequilibrium at home and school (Salamone-Violi et al., 2015). On the other hand, inpatient treatment may present a reprieve from stressors, during which youth have the opportunities to develop new coping skills that assist them reaching equilibrium through crisis stabilization (Moses, 2011; Savina et al., 2014). As such, inpatient psychiatric hospitalization represents the cumulative effect of stressors that result in crisis. Understanding this process and how youth respond to crises offers valuable insights into the ways in which inpatient treatment can aid in the establishment of emotional equilibrium among adolescents (Clarke & Winsor, 2010).

Conclusion

Taken together, these frameworks underscore the fact that severe psychiatric crises often emerge during adolescent development as the result of a culmination of dynamic stressors that exist within multiple contexts of young people's lives. They also describe how seemingly normative stressors can culminate in ways that result in psychiatric hospitalization, revealing the significance of prevention efforts for those youth that may be at risk for psychological disorders. Each of these concepts are discussed further in Chapter Two.

CHAPTER TWO: REVIEW OF LITERATURE

Limited research exists about the subjective experiences of psychiatrically hospitalized youth, while they are actively engaging in inpatient treatment services (Mohr, 1998; Moses, 2011). This not only curtails the scope of current knowledge on patient perceptions of inpatient treatment practices, but also restricts clinical advancements necessary to more effectively support youth amidst psychiatric crises (Mohr, 1998; Moses, 2011). There are however, findings from other psychiatric hospital and children's mental health literature that are each relevant to the current research, and provide a context for qualitatively investigating adolescents' inpatient psychiatric hospital experiences.

Literature Review Aims

This review illuminates key elements of inpatient psychiatric hospitalization and patients' experiences during treatment, providing a framework upon which the current research was structured. Given the dearth of literature that exists, however, findings from several different branches of research are synthesized together to create a more comprehensive understanding of psychiatric hospitalization from the perspectives of patients. Specifically, studies that investigate inpatient psychiatric treatment practices will be reviewed alongside those that have explored how patients interpret and experience their hospitalizations. The inclusion of these studies serves to capture the subjective explanations of hospital experiences and patient treatment perspectives. Taken together and viewed from within an adolescent developmental context, research included in this review will not only establish a broader picture of the complexities and treatment needs of youth during psychiatric crises, but also delineate the deficiencies that exist within current

research, substantiating the contribution of the current study in advancing our understanding of adolescent psychiatric hospitalization (Merriam, 1998).

Methods

This review presents a narrative description of research related to the lived experiences of youth during inpatient psychiatric hospitalization. Given the paucity of data available on this topic, the narrative approach supports the synthesis of information related to adolescent psychiatric hospitalization, creating space for exploration (Mays et al., 2005). Moreover, conducting a narrative review of literature allows for a broader understanding of the significance of the problem and the need for additional research.

Literature Search Strategies

The literature review began with a search of five electronic databases (i.e., ERIC, Google Scholar, Psychiatry Online, PsycInfo, Psychiatry Online, PubMed, and Social Sciences Full Text), for peer-reviewed articles. Searches included terms for youth (e.g., adolescence, adolescent development, teens, teenagers), and mental illness (e.g., psychological disorders, psychopathology, symptomatology, mental health diagnosis), combined with terms related to inpatient psychiatric hospitalization (e.g., acute psychiatric care, crisis residence, crisis stabilization, inpatient psychiatric re-hospitalization) and treatment experiences (e.g., interpretations, perceptions, views). To provide breadth and depth of included literature, searches through the references of retrieved articles were also conducted.

Search results were limited to papers in English, published from 1970 until November 2020. This timeframe was chosen for two reasons. First, adolescent admissions to psychiatric hospitals were not considered common until the 1970s (Blanz & Schmidt, 2000); therefore, only limited research exists on the psychiatric hospitalization of youth, prior to that time. Second,

inpatient treatment modalities have changed drastically in recent years (Chow & Priebe, 2013), and as a result, findings from older studies may not be relevant today. The 1970s cut-off reflects a balance between the inclusion of as much literature as possible to provide a context for the proposed study, and the maintenance of relevant studies that reflect current inpatient treatment practices.

Quality Appraisal

Papers and publications that contained information related to the lived experiences of patients during their inpatient hospital treatments were included in the final selection. If the presented results were not clearly based on the research aims, they were subsequently removed. All included papers met the quality appraisal criteria.

Results

The review that follows begins with an in-depth investigation of inpatient psychiatric hospitalization to establish a framework for the context in which treatment exists, and outline the rationale for the current model of care. Next, studies that explore salient components of inpatient psychiatric treatment experiences of adolescents are each reviewed, offering insights into treatment from the perspectives of patients. The literature review concludes with an investigation of limitations that exist within the available research, as a mean of establishing a starting point upon which to structure the proposed study.

Inpatient Psychiatric Hospitalization

From large asylums that provided long-term care, with limited access to the outside world (Baker, 2000; Chow & Priebe, 2013), to smaller psychiatric units that rely on medication and therapeutic interventions for acute crisis stabilization (Case et al., 2007; Mahoney et al., 2009), inpatient psychiatric hospitals have endured a transformative history throughout the last two

hundred years (Blanz & Schmidt, 2000; Leon et al., 2013; Thibeault et al., 2010). These changes have been accompanied by a shift in emphasis on institutionalization (Chow & Priebe, 2013), toward models of care that emphasize patient-centered decision-making practices (Thibeault et al., 2010). While the deinstitutionalization of psychiatric hospitals has yielded clinical advancements that promote shorter lengths of stay, it has also created, "a daunting and complex job" (Dratcu, 2002, p. 81) for inpatient programs, which some suggest has jeopardized patient treatment experiences and long-term outcomes (Bowers, 2005; Thibeault et al., 2010). To better understand patient perspectives during psychiatric hospitalization, it is first important to outline the history of inpatient psychiatric hospitalization and discuss how the changes that took place have paved the way for the treatment practices patients receive today (Accordino et al., 2001).

History of Hospitalization. During the 19th and early 20th centuries, asylums were the main form of care for patients diagnosed with severe mental illnesses (Chow & Priebe, 2013, p. 169), However, it was not until the 1920s and 1930s that inpatient psychiatric units for children and adolescents were first introduced in the U.S. (Blanz and Schmidt, 2000). Despite the existence of psychiatric hospitals for youth, mental disorders among children and adolescents were thought to be rare, and limited research existed about treatment modalities for young people (Blanz & Schmidt, 2000).

Psychiatric Hospitalization in the 1970s and 1980s. The next 50 years were characterized by the expansion of psychiatric hospitals (Blanz & Schmidt, 2000). As a result, psychiatric hospitals in the 1970s and 1980s experienced both an increase in admissions and a broadening in the spectrum of services provided to youth (Blanz & Schmidt, 2000; Woolston, 1996). Given the comprehensive treatment that was being offered, during the 1970s and 1980s, the duration of inpatient hospitalization averaged from approximately 50 to 70 days (Accordino

et al., 2001; Blanz & Schmidt, 2000; Woolston, 1996).

Psychiatric Hospitalization in the 1990s. In the 1990s, admission criteria became more stringent, and specific indications for hospitalization were introduced **(e.g.,** symptom severity, unsuccessful management of symptoms in outpatient settings, medical complications of severe mental disorders, etc.; Blanz & Schmidt, 2000; Costello et al., 1991; Golubchik et al., 2013). **A**dmissions were restricted to those youth with the most severe treatment needs (Costello et al., 1991; Savina et al., 2014), and the average length of stay for youth admitted to psychiatric hospitals also decreased to 12 days, as opposed to several weeks (Blanz & Schmidt, 2000; Case et al., 2007). By the mid 1990s, treatment costs continued to rise, with inpatient psychiatric services consuming approximately half of the average $3.5 billion spent on mental healthcare each year (Accordino et al., 2001; Bardach et al., 2014; Pottick et al., 2000).

Psychiatric Hospitalization in the Early 2000s. The criteria required for managed care to authorize inpatient psychiatric hospitalization for youth continued during the early 2000s; yet this did not prove effective in decreasing the demand for crisis stabilization (Blader, 2011). In fact, child and adolescent admissions to inpatient psychiatric hospitals rose significantly during the early 2000s (Blader, 2011). While this influx in inpatient psychiatric hospitalizations came as a surprise to policy makers, severe symptom presentations among youth suggested that rising hospitalization rates represented a need among children in the community (Blader, 2011; Blanz & Schmidt, 2000).

Current Model of Psychiatric Hospitalization. Though advancements have been made over the last several decades, the current treatment model for psychiatric hospitalization is largely informed by the services provided during the 1980s, 1990s, and early 2000s (Thibeault et al., 2010). The complex clinical needs of youth who present for inpatient treatment continue

today, and psychiatric hospitalization remains a highly utilized component of mental health treatment (James et al., 2010; Savina et al., 2014). This is true, despite the focus on involvement in community-based outpatient programs (Chow & Priebe, 2013; Fontanella et al., 2020).

Treatment Practices. Though little is known about the specific multidisciplinary interventions that exist on adolescent psychiatric inpatient hospital units, the treatment practices employed are generally grounded in clinical psychiatry and developmental psychology, with a primary focus on addressing severe psychopathology (Balkin, & Roland, 2007; Blanz & Schmidt, 2000; Bobier et al., 2009; Hintikka et al., 2003; King et al., 1997). Recent changes in public policy initiatives have also placed increased emphasis on the recovery model of care, which supports the establishment of a healing framework to address needs that may exist within various domains of patients' lives (e.g., familial, social, and spiritual; Glick et al., 2011; Mahoney et al., 2009). Presently, crisis stabilization and recovery are both accomplished within the therapeutic milieu (Mahoney et al., 2009), which is comprised of psychotherapeutic interventions (e.g., psychodynamic or cognitive behavioral approaches, problem-solving skill trainings, coping groups, independent journaling, etc.), mental health education, and the formation of a working therapeutic alliance with practitioners (Blanz & Schmidt, 2000; Bobier et al., 2009; Hepp et al., 2004).

Criticisms. Despite the improvements in inpatient psychiatric hospitalization that have been made over the last several decades, treatment continues to be driven by financial pressures, which consequently force hospitals to do more with fewer resources and less time (Blanz & Schmidt, 2000; Clarke & Glick, 2020; Leon et al., 2013). As such, psychiatric hospitalization can be a highly intrusive intervention, placing patients in locked facilities and moving them through a hospital assembly line, as a means of achieving crisis stabilization within the safest setting and

shortest timeframe (Balkin & Roland, 2007; Glick et al., 2011). Though this model of care has proven to be efficient, its efficacy continues to be scrutinized, particularly given high rates of hospital readmission among youth (Balkin & Roland, 2007; Blader, 2004; Clarke & Glick, 2020; Fontanella, 2008; James et al., 2010). Shortened length of stays, characteristic of modern inpatient psychiatric treatment, also pose ethical concerns, especially because the reduction in treatment duration is not unique to youth with less severe symptoms (Blanz & Schmidt, 2000; Case et al., 2007; Glick et al., 2011). That is, even those young people who present with complex treatment needs can expect to be discharged rapidly (often within 72 hours; Case et al., 2007; Glick et al., 2011).

This has become a pattern across patient populations, creating a treatment standard that neglects patients' individual clinical needs (Blanz & Schmidt, 2000; Case et al., 2007; Glick et al., 2011). A potential explanation for this is related to reliance on managed care for reimbursement. Since managed care companies focus on specific symptoms, related to threat to self-and/or others, as the primary means for determining discharge readiness, little attention is paid to underlying stressors or the individual and/or contextual factors that may be affecting an adolescent's ability to effectively cope with stressors (Balkin & Roland, 2007; Glick et al., 2011). Thus, a "patch and dismiss" approach to psychiatric hospitalization is perpetuated (Balkin & Roland, 2007, p. 64).

Another significant concern is related to the lack of rapport and trust between patients and staff (Balkin & Roland, 2007; Glick et al., 2011; Gören et al., 2008). Patient-staff connections, especially for youth, are indicated as key components of treatment engagement (Cookson et al., 2012; Moses, 2011; Salamone-Violi et al., 2015). Yet since these are rapidly being replaced with impersonal interventions aimed at rapid symptom stabilization, the

formation of trusting therapeutic alliances are failing to flourish under the current model (Guimón, 2016).

In fact, patients are often involuntarily held until they are considered stable enough for discharge to community-based outpatient treatment, receiving little therapy over the course of their admissions (McManama O'Brian, 2015, p. 699). Failure to therapeutically engage patients, during the time immediately following a crisis not only overlooks the significance of therapeutic alliances, but also neglects a critical time for adolescents, during which they may be most inclined to consider changes in their behaviors (Bobier et al., 2009; Epstein, 2004; McManama O'Brian, 2015). Nonetheless, these limitations are not thought to be the result of inexperience or lack of clinical skills among inpatient psychiatric hospital staff, but rather, the larger system of psychiatric care, which has curbed the types of active and intensive treatments thought to be most useful for adolescent mental health patients (McManama O'Brian, 2015).

The current model of inpatient psychiatric hospitalization is not only informed by the aforementioned changes that have taken place over the last century, but also by managed care efforts to streamline treatment processes (Moses, 2011). While there are benefits associated with the practices employed in psychiatric hospitals today, this current approach may overlook significant patient-centered components focused on communication and care coordination (Greaves et al., 2009). Therefore, exploring patient perspectives on psychiatric hospital experiences is an essential step toward providing efficient and effective patient-centered care (McManama O'Brian, 2015; Moses, 2011).

Adolescent Perspectives on Psychiatric Hospital Experiences

From the hospital environment, to the exchanges shared with clinical staff members and fellow admitted youth, adolescent patients' perceptions about treatment are largely embedded

within the experiences that they have during psychiatric hospitalization (Biering, 2010; Moses, 2011). As such, establishing an understanding of their perspectives could result in a willingness for adolescent patients to continue treatment beyond hospitalization, thus helping to promote long-term mental health stabilization (Hepper et al., 2005; McManama O'Brian, 2015; Moses, 2011; Salamone-Violi et al., 2015). Likewise, investigating patient preferences may also reveal components of psychiatric hospitalization that pose as barriers to help seeking and treatment engagement (Yap et al., 2013).

Though the research related to adolescent patient perspectives on inpatient psychiatric hospital experiences is limited (Biering, 2010), several studies have sought feedback from youth, in the form of surveys and/or interviews (Biering, 2010). While the majority of these studies are driven by efforts to understand contributors to patient satisfaction, rather than subjective treatment experiences, synthesized together, three themes can be extrapolated from the extant research to reveal insights about the significant elements of inpatient psychiatric hospitalization. These include: 1) the inpatient psychiatric hospital milieu, 2) relationships, interactions, and exchanges with fellow patients and staff, and 3) perspectives about the efficacy of treatment (Biering, 2010). Taken together, these perceptions of psychiatric hospitalization can serve as a starting point through which to begin to understand inpatient psychiatric hospitalization among youth (Biering, 2010; Moses, 2011).

Inpatient Environment. Within the healthcare context, the ultimate treatment environment is one in which clinical expertise drives service delivery in ways that promote the establishment of a therapeutic alliance (Mahoney et al., 2009). According to adolescent psychiatric patients, this is achieved within inpatient hospitals when accessibility to services and staff are readily provided, comfort and cleanliness characterize the unit milieu, and the services

offered are tailored to meet youth's unique needs (Biering, 2010; Garland et al., 2003; Lee et al. 2006). For psychiatrically hospitalized youth, the inpatient environment serves as a constant reminder of the restrictions that must exist to ensure patients' safety (e.g., limited access to the outdoors, locked doors, and confinement to areas in which staff are always present; Salamone-Violi et al., 2015). Similarly, the environment itself, though designed to enhance safety, can feel threatening (Biering, 2010; Lee, 1979; Salamone-Violi et al., 2015).

Although attempts have been made to establish a level of comfort within inpatient psychiatric hospital settings, youth describe a sense of detainment from the rest of society while they are hospitalized (Biering, 2010; Balkin, 2007; Kaltiala-Heino, 2010; Salamone-Violi et al., 2015). For some, this can contribute to feelings of frustration; yet for others, the structure of the psychiatric hospital environment is interpreted as safe haven, shielding youth from everyday stressors (e.g., parents, siblings, peers, etc.) that may exacerbate their mental health symptoms (Hepper et al., 2005; Salamone-Violi et al., 2015). Distinctions between the ways in which youth interpret the inpatient environment is largely influenced by patients' perceptions of the treatment modalities employed (Hart et al., 2005). That is, when youth their treatment and service providers favorably, they are more likely to engage and follow recommendations made; however, if they feel unheard, unsupported, and/or unsafe, they are at increased risk for treatment disengagement and subsequent hospitalizations (Hart et al., 2005; Lee et al., 2006; Salamone-Violi et al., 2015).

Interpersonal Influences. Inpatient psychiatric treatment experiences for youth are not shaped by the environment alone, however; instead, they are also influenced by interpersonal relationships that exist within hospital settings (Chesson et al.,1997; Grossoehme & Gerbetz, 2004; Logan et al., 1982; Marriage et al., 2001; Moses, 2011; Salamone-Violi et al., 2015). For

instance, youth who perceived clinical staff members and fellow inpatients as supportive and understanding were less oppositional to the idea of psychiatric hospital admission, and thus viewed inpatient treatment as an opportunity to regain mental health stabilization (Lee et al. 2006; Moses, 2011; Salamone-Violi et al., 2015). Conversely, youth whose interactions with staff and fellow patients were characterized as unaccepting or judgmental, were more likely to endorse negative experiences during inpatient psychiatric hospitalization (Lee et al. 2006; Moses, 2011; Salamone-Violi et al., 2015).

Patient-Staff Relationships. Adolescents' relationships with mental healthcare providers, specifically, is a core component of inpatient psychiatric hospitalization (Biering, 2010). Given the nature and structure of inpatient psychiatric hospitalization, clinical staff members' roles are often more complex than providers in traditional outpatient settings because they take on the responsibility of caregiving, in addition to maintaining the trust and safety of patients in crisis (Biering, 2010; Grossoehme, & Gerbetz, 2004; Marriage et al, 2001; Salamone-Violi et al., 2015). Therefore, an expectation exists that staff will not only demonstrate clinical expertise beyond that of outpatient providers, but also that they will display high levels of involvement in treatment (Salamone-Violi et al., 2015). These treatment expectations are seemingly met when patient-staff connections are perceived as genuine, empathic, interested, and understanding, such that staff are willing to go beyond normative job duties to share treatment information in ways that empower youth, while still ensuring their safety (Biering, 2010; Geanellos, 2002; Grossoehme, & Gerbetz, 2004; Lee et al., 2006; Moses, 2011).

Interestingly, negative perceptions of inpatient psychiatric hospitalization are often characterized by the inverse of positive patient-staff interactions (Lee et al., 2006; Salamone-Violi et al., 2015). Though dissatisfaction in interactions shared with clinical staff members

manifest in a variety of different ways, from perceptions of verbal abuse (Kaplan et al., 2001), to discontinuity of access to the same staff members over the course of treatment (Geanellos 2002; Moses, 2011), communication breakdowns seem to jeopardize rapport (Biering, 2010; Lee et al., 2006; Moses, 2011; Salamone-Violi et al., 2015). Specifically, interactions with clinical staff are identified as unhelpful, or even problematic, when adolescent inpatients are ignored and/or misunderstood by staff members, contributing to invalidation and subsequent loss of connectedness (Lee et al., 2006; Moses, 2011; Salamone-Violi et al., 2015).

Patient-Patient Relationships. The relationships that exist between fellow adolescent patients, like those with staff members, also have the capacity to influence the feedback that adolescents provide about inpatient psychiatric treatment (Moses, 2011; Salamone-Violi et al., 2015). Though the role of peers has been largely excluded from inpatient satisfaction surveys (e.g., Grossoehme, & Gerbetz, 2004; Kaplan et al., 2001; Marriage et al., 2001), in several qualitative studies (e.g., Moses, 2011; Salamone-Violi et al., 2015), participants consistently identified peer support as helpful ingredient in inpatient hospitalization. Specifically, the degree to which patients' own crisis experiences and emotions were normalized by fellow peers contributed to the creation of a sense of community (Moses, 2011; Salamone-Violi et al., 2015). Socializing in ways that were thought to support fellow admitted peers (i.e., engaging in group activities, listening and sharing stories, and offering comfort during times of distress) also promoted positive treatment perceptions (Moses, 2011). While few negative exchanges were noted between patients (e.g., Moses, 2011), fellow patients perceived as having outwardly negative attitudes toward psychiatric treatment and/or other patients, as evidenced by acting out violently or provoking peers during group therapeutic activities, were described as detracting from the treatment experience (Moses, 2011; Salamone-Violi et al., 2015).

Admissions and Discharge Perceptions. Like the inpatient environment, and the interpersonal relationships that exist within it, adolescents' interpretations of the causes and consequences of inpatient psychiatric hospital have significant effects on treatment (Hepper et al, 1996; Chesson et al., 1997). Psychiatric hospital admissions are often characterized by loneliness and feelings of inadequacy, which can deter youth from engaging in treatment (Geanellos 2002). However, when young people perceive the environment and individuals within it as non-judgmental, they tend to be more open to the treatment process, even if they initially opposed admission (Biering, 2010; Geanellos 2002, p. 180; Lee et al. 2006). Likewise, as youth continue to grow more invested and engaged over the course of their hospital admissions, they may develop a sense of empowerment and self-confidence in their abilities to effectively cope with crises (Holliday, & Vandermause, 2015). Consequently, when treatment is accompanied by a renewed a sense of self-efficacy, youth may approach hospital discharge with hope for the future (Kaplan et al., 2001; Marriage et al., 2001).

Taken together, these themes reveal the significance of a sense of connectedness during inpatient psychiatric hospitalization (Holliday, & Vandermause, 2015). Whether connections exist with staff members, fellow patients, the treatment environment, or the services provided, adolescent patients repeatedly endorse desires to connect during their psychiatric hospitalizations (Moses, 2011; Holliday, & Vandermause, 2015; Salamone-Violi et al., 2015). This emphasis on connectedness does not necessarily suggest that adolescent psychiatric patients lack connection outside of the hospital (Holliday, & Vandermause, 2015). Rather, it reveals that the ability to form new connections, through mutual treatment interactions and meaningful relationships with staff and peers, enhances patients' sense of self-efficacy (Holliday, & Vandermause, 2015).

Limitations. Although some insights about adolescent inpatient psychiatric

hospitalization can be garnered from synthesizing findings from the extant literature, an understanding of the subjective experiences of youth, during their treatment, remains superficial (Moses, 2011). This is likely due to several limitations that exist throughout the available research. Specifically, the methodological approaches employed in seeking insights about inpatient psychiatric hospitalization, and the timing of studies in relation to patients' hospitalization, both of which silence elements of adolescents' stories.

For instance, the majority of studies that exist about adolescent inpatient psychiatric hospitalization are limited to generalizations about treatment experiences, drawn from consumer satisfaction surveys, rather than subjective experiences (Biering, 2010; Garland et al., 2003; Grossoehme, & Gerbetz, 2004; Kaplan et al., 2001). As such, insights may be lost about the ways in which youth construct meaning of admission experiences (Biering, 2010; Hepper et al., 1996; Moses, 2011; Salamone-Violi et al., 2015). Though frequently used across children's mental health literature, consumer satisfaction surveys are not considered strong indicators of treatment experiences or effectiveness (Garland et al., 2003; Moses, 2011). This is likely due to the fact consumer surveys do not offer opportunities for patients to elaborate on their responses; therefore, it is difficult to garner rich insights about treatment experiences from surveys (Kaplan et al., 2001). Although studies that employ patient satisfaction surveys will sometimes attempt to enhance the depth of information shared by supplementing adolescent patient survey data with information from parents/caregivers (Blader, 2004; Chesson et al., 1997) and clinicians (Blader et al.,1994; Marriage et al., 2001), the inclusion of secondhand interpretations of hospital experiences may skew the ways in which patient perspectives are interpreted (Blanz & Schmidt, 2000; Mohr, 1998; Moses, 2011).

Yet another limitation, consistent throughout the extant literature, is related to the timing

of studies. That is, attempts to engage youth about their treatment experiences typically does not occur until days (e.g., Moses, 2011), weeks (e.g., Chesson et al., 1997), or even months (e.g., Bradley & Clark, 1993) after psychiatric hospital discharge, which can create gaps in youth's recollection of their psychiatric hospitalization. Specifically, patients may not remember certain elements of their psychiatric hospitalizations once they have completed treatment because they are no longer embedded within the environment in which experiences occurred (Chesson et al., 1997; Moses, 2011). Moreover, data collected following patient discharges often lack depth in self-reflection and self-disclosure (Biddle et al., 2013; Moses, 2011). This is thought to be because patients may be concerned that transparency about their current feelings or previous treatment experiences may put them at risk for re-hospitalization (Yap et al., 2013).

Future Directions. Though the practices involved in adolescent inpatient psychiatric treatment will change and evolve over time, just as they have throughout the last century, adolescents' long-term mental health will undoubtedly be affected by the treatment that they received during their youth. Therefore, research that seeks to delve deeper into adolescents' perceptions of their hospitalization is necessary to create heightened awareness of patients' needs, once they are admitted for treatment. This can aid in the delivery of services that are more appropriately tailored to meet patients where they are developmentally, emotionally, and psychologically. While attempts have been made to examine these factors quantitatively, following patients' hospital discharge, the limited insights that have been garnered from such data only provide a glimpse into the experiences of youth during their treatment (Balkin & Roland, 2007; Biering, 2010; Moses, 2011). As such, research that seeks to delve deeper into youth's treatment could help to fill this gap.

Conclusion

In the current review, findings from several different veins of research on adolescent mental health were synthesized together to better understand the events that may shape the experiences of psychiatrically hospitalized youth. While this review establishes a broader picture of the complexities and treatment needs of adolescents diagnosed with severe mental illnesses, presently, there is still a limited understanding about adolescents' individual experiences during inpatient hospitalizations. As such, additional research, during which adolescents' input and insights are shared, so inpatient treatment can be tailored in ways that enhance existing practices in ways that empower youth and their families is essential. By probing beyond the surface, through qualitative investigations, we can begin to determine how psychiatric problems emerge, within various contexts during adolescent development, and begin developing an understanding of inpatient treatment practices that effectively address youth's needs.

CHAPTER THREE: METHODS

This study was aimed at investigating the experiences of 25 psychiatrically hospitalized youth, during their inpatient treatment, as a means of gaining insights into adolescent patient perspectives. Though this study was guided by inquiry (i.e., *What are the experiences of psychiatrically hospitalized youth as they reflect on the influence of precipitating factors and navigate the complexities of inpatient treatment in pursuit of crisis stabilization?*), its purpose was not to gain answers to questions or to test hypotheses, but rather to understand, "the lived experience of other people and the meaning they make of that experience" (Seidman, 2013, p. 9). To achieve this aim, a qualitative interview study design was employed, given that interviewing encourages people to reconstruct their experiences, offering researchers a way discovering what others feel and think about their worlds (Rubin & Rubin, 1995). This approach, unlike methodological designs that have been utilized in previous investigations of inpatient psychiatric hospitalization, serves as a vehicle that provides intimate access to human experience (Brinkmann & Kvale, 2008).

This chapter outlines the qualitative interview study design, providing an overview of the rationale for this approach, in addition to the research paradigm and theoretical orientation in which interviews were embedded. A description of the research setting, participants, and data sources that were used in the study are also included, in addition to an overview of the steps involved in thematically analyzing the data. The chapter concludes with a discussion of trustworthiness, researcher reflexivity, and ethical considerations.

Qualitative Interview Design

The qualitative research interview probes human existence in detail, giving access to subjective experiences by allowing individuals involved in the research to share their stories, which according to Seidman (2013), "are a way of knowing" (p. 7). The opportunity to share one's story is also thought to be accompanied by self-reflection, during which an understanding of the ways in which experiences impact choices and behaviors can be garnered (Seidman, 2013). As such, a basic assumption of qualitative interview research is that the meaning people make of their experiences affect the way that they interpret and internalize their experiences (Seidman, 2013).

This assumption guides the rationale for conducting in-depth qualitative interviews in the current study, and it underscores the significance of engaging youth during their treatment, as a means of not only gaining insights into experiences, but also promoting deeper understanding of the behaviors and emotions that accompany inpatient psychiatric hospitalization. Although the subjective experiences of hospitalized youth can never be completely understood, collecting data about individual experiences, during a pivotal time in treatment, creates a space for the establishment of meaningful interactions between the researcher and participant that can offer deep insights into these experiences. That is, by demonstrating an interest in adolescents' experiences and validating the emotions and behaviors that accompany them, the importance of individual perspectives is affirmed, and young people, who may have previously felt stigmatized or stifled because they were not considered 'stable', have the opportunity to share their stories (Seidman, 2013).

Moreover, the use of qualitative methods in research involving vulnerable populations, specifically individuals experiencing suicidal ideations, has been found to provide meaningful

insights into individuals' experiences, allowing for more in-depth understandings of issues surrounding suicidality (Biddle et al., 2013). Likewise, qualitative research serves as a vessel through which stories of hope and recovery can be accessed and shared (Biddle et al., 2013). Contrary to concerns that may be posed regarding involvement in sensitive research, participation seems more likely to benefit participants than harm them, as evidenced by self-reported mood improvements, in addition to opportunities to derive meaning, purpose, and support through discussions about one's experiences, all of which have been found to stimulate self-reflection, self-disclosure and catharsis (Biddle et al., 2013; Opsal et al., 2016).

Research Paradigm

Given the design and aims of the proposed study, this research was grounded in an interpretivist paradigmatic schema, which acknowledges that the subjectivity of experience creates multiple ways of knowing (Ponterotto, 2005). From an interpretivistic paradigm, reality is construed intrasubjectively and intersubjectively through the meanings and understanding garnered from experiences (Angen, 2000). Epistemologically, interpretivists argue that a single truth does not exist (Angen, 2000; Kvale, 1996). As such, the interpretivist paradigm seeks to gain a deeper understanding of different experiences by exploring the contexts and relationships within which they occur (Angen, 2000). Although this may contribute to some ambiguity in research, interpretivists view subjectivity as an integral part of the way we understand ourselves, others, and the world around us (Angen, 2000).

The interpretivist paradigm aligns with the conceptualization of this study because it does not assume that an objective truth exists, but rather it recognizes the subjectivity embedded in experiences. This has important implications for adolescent participants involved in the study because youth were empowered to share their subjective stories, without feeling pressure from

researchers to uncover an 'objective truth' (Ferguson & Ferguson, 2000). As such, a space was created through which to uncover the structures, policies, and practices that may marginalize youth diagnosed with mental illnesses by shedding light on elements of treatment experiences that have not been previously explored in research (Ferguson & Ferguson, 2000).

Theoretical Orientation

The design of this qualitative study was not only informed by the interpretivist paradigm, but also by theoretical assumptions that shape the ways in which interviews with youth were conceptualized and interpreted (Roulston, 2010). In this study, a romantic conception of the interview was used, during which efforts were made to establish rapport and empathic connections with youth, such that they felt a sense of comfort engaging in intimate conversations about their experiences (Roulston, 2010). Though interviewees' interpretations of experiences remain the focus of romantic interviews, the interviewer has the opportunity to play an active role in the conversation by contributing personal insights that serve to heighten rapport (Roulston, 2010). The researcher-participant connection that is consequently fostered through this romantic conceptualization produces a space that supports in-depth knowledge and understanding of the perceptions, experiences, and opinions of research participants (Roulston, 2010, pp. 61-62).

For psychiatrically hospitalized youth, this romantic approach was critical in achieving the study's aims because it created an interview environment in which youth seemed at ease sharing about their inpatient treatment experiences. Unlike various other interview formats to which youth were exposed over the course of their treatment (e.g., psychosocial assessments and psychiatric evaluations), participants' views and interpretations were not challenged or dismissed; rather, they were validated and explored to generate deeper understanding (Kvale,

1994). This approach encouraged the sacrifice of uniformity of questioning to gain richer insights about inpatient treatment perspectives, thus conveying to youth the significance of their subjective experiences (Roulston, 2010).

Taken together, the interpretivist paradigm and the romantic conception of interviewing underscore the importance of the relationship that exists between the researcher and participants, recognizing that this is not merely established to elicit information. Instead, interviews are a form of communication, during which adolescents shared an intimate journey through their hospital experiences. Since the interviews conducted for this study were classified within the interpretivist paradigm, and grounded in a romantic approach, a constant emphasis was placed on the significance of genuine and meaningful relationships between the researcher and those researched (Ferguson & Ferguson, 2000).

Research Setting and Participant Selection

The research setting and participant selection are both considered key components in qualitative interview research (Roulston, 2010). This is especially true in the current study, given its focus on understanding participants' experiences, within a particular context (i.e., inpatient psychiatric hospitals). As such, careful consideration was not only paid to the ways in which participants were selected, but also the attributes that comprised the study setting.

Setting

This study was conducted on the inpatient child and adolescent unit of a psychiatric hospital. The hospital comprises the acute care component of a larger community mental health agency, located in the metropolitan area of a southern region in the United States. The hospital is a locked, 30-bed facility, providing acute crisis stabilization, psychiatric evaluations, medication management, nursing assessments, case management services, and intensive therapeutic

interventions for youth accepted 24 hours a day. Youth, admitted for treatment at the psychiatric facility are hospitalized for an average of 72 hours, though the duration of treatment may be extended if clinical staff determine that criteria for crisis stabilization have not been met.

Over the course of treatment, patients participate in daily psychiatric evaluations, individual therapy sessions, group therapy sessions, and nursing assessments. In addition, patients may engage in family therapy and various coping skills workshops, depending on their symptoms and the presenting problems that precipitated their hospital admissions. Each of the aforementioned clinical interventions is aimed at stabilizing the crisis and equipping the patient with resources that can assist in the maintenance of stabilization following hospital discharge. Given the brevity of treatment, however, patients are discharged with referrals for follow-up appointments, as a means of providing continued community-based clinical support.

The hospital serves children and adolescents between the ages of five to seventeen, deemed by law enforcement, physicians, and/or mental health professionals to be a threat of danger to themselves and/or others, as evidenced by suicidal/homicidal attempt/ideation, psychosis, and/or extreme aggression. Youth of all demographic backgrounds and socioeconomic statuses are accepted for treatment, and the hospital is the only one in the region to accept patients for treatment regardless of funding, criminal backgrounds, or placement statuses. As such, there is substantial diversity among patient populations served at the hospital. The average patient, however, is a 14-year old, European American, cisgender girl, admitted for suicidal ideation. Primary diagnoses among patients range from depression and anxiety to conduct disorders, and though more than 60% of patients over 13 years old are diagnosed with co-occurring mental and substance-related disorders, mental health disorders are required as the primary diagnosis for patients to be admitted for treatment.

Given the safety features that characterize inpatient psychiatric hospital environments (see *Inpatient Environment* section in Chapter 2), coupled with the 24-hour staff supervision for monitoring the progress of admitted youth, this treatment setting seemed safest for conducting interviews with youth. That is, in the event that participants did experience any distress during the interview process, all necessary resources (e.g., therapists, nurses, physicians, medication, etc.) were available. The appropriateness of the hospital setting was further underscored by the fact that adolescent patients have previously described feeling the safest within the hospital treatment setting because they are surrounded by inpatient staff, experienced in addressing serious or complex clinical presentations (Salamone-Violi et al., 2015).

Selection

Twenty-five participants were selected through criterion-based purposeful sampling. This sampling approach allowed for the selection of participants, based upon specified characteristics, as a means of ensuring that information relevant to the aims of the research study could be gathered (Roulston, 2010). Purposeful sampling aligned with the objectives of this study because it offered the opportunity for in-depth discoveries of individual experiences, rather than selecting participants with the intent of generalizing their stories to a broader population (Roulston, 2010).

Inclusion Criteria. To meet criteria for participation, all youth were hospitalized under a BA 3052a (Law Enforcement-initiated Baker Act) or BA 3052b (Professional-initiated Baker Act), both of which require involuntary examination at a receiving facility. Eligibility for participation also required that youth were English-speaking, between the ages of 13 to 17 years old, and deemed by hospital staff to be sufficiently oriented (i.e. to person, place, time, and situation) and communicative. These criteria were necessary in ensuring that participants were capable of engaging in assent procedures. Participants were required to have at least one

available parent, willing and capable of providing consent in English, and demonstrating the emotional and psychological capacity necessary for the provision of consent for their child's participation in the research study.

Exclusion Criteria. Individuals under an Ex Parte Petition or a Baker Act 3032, which necessitates involuntary inpatient placement, were not included in the study. Adolescent patients demonstrating impaired reality testing, due to acute psychosis, intoxication, or cognitive limitations, were also omitted from the study, due to inability to assent to participation in the research study and potential difficulties participating in interviews. Any patient that I had clinically engaged in therapy during previous hospital admissions was also omitted. Youth between the ages of 5 and 12, and those who were non-English-speaking, in foster care, or considered wards of the state at the time of their hospitalization, were not considered eligible for participation. Any youth whose parent was not available, demonstrated a lack of psychological or emotional stability, and/or was not capable of providing consent in English was also excluded.

The development of these criteria for participant selection was directly related to the purpose and research aims of the study (Roulston 2010; Seidman, 2013). Specifically, adolescent patients between the ages of 13 to 17, demonstrating cognitive orientation to person, place, and situation, were thought to be most capable of reflecting on their treatment experiences by engaging in interviews (Keshavan et al., 2014; Moses, 2010). Likewise, though there is not necessarily a specific number of participants deemed appropriate in qualitative research, this sample size was large enough to capture potential connections and patterns that existed among the experiences of psychiatrically hospitalized youth (Seidman, 2013).

Sample

The current study includes stories that depict the subjective treatment experiences of 25 adolescents during psychiatric hospitalization. Of the 331 youth admitted for psychiatric hospitalization during the study period, 148 met eligibility criteria, and contact was subsequently made with a total of 66 parents of prospective participants. The remaining 82 parents could either not be reached, or they did not return calls regarding study involvement until after the window, during which the initial interview and drawing exercise could be conducted, had already closed. Forty-three of the parents, who were contacted and recruited, provided consent for their children to participate in the study, and 25 adolescents assented to study participation. Based on a 2017, inpatient census of patients in the designated age range, the study sample was representative of the overall adolescent inpatient population at the psychiatric hospital where the research was conducted.

At the time of their interviews, participants' ages ranged from 13 to 17 years old (M= 15.76). Three of the participants were in middle school, while the remaining 22 participants were in high school. Participants' self-identified ethnicities included: European American (40%), African American (24%), Latin American (24%), and Asian American (12%). Approximately 60% of participants identified as cisgender girls, 32% as cisgender boys, 4% as transgender girls, and 4% as transgender boys. Basic demographic information, including each participant's age, gender, and ethnic identity are displayed in Table 1.

Table 1. Demographic Features of Study Participants

Demographics	N	%
Age		
13	1	4%
14	4	16%
15	5	20%
16	5	20%
17	10	40%
Gender		
Cisgender Boy	8	32%
Cisgender Girl	15	60%
Transgender Boy	1	4%
Transgender Girl	1	4%
Ethnic Identity		
African American	6	24%
Asian American	3	12%
European American	10	40%
Latin American	6	24%

Clinical Presentation. For the majority of participants (n = 22), this was their first hospital admission at the study site, while two participants had three previous admissions, and one participant had received treatment at the hospital six times. Similarly, this was the first Baker Act for 16 participants, though some participants (n = 2) had lifetime histories of as many as seven Baker Acts at other psychiatric hospitals. Each of the participants in the current study was hospitalized for suicidal ideation, though suicidality ranged from suicidal ideation, with an attempt to kill oneself, which resulted in the need for hospitalization and/or medical attention (n = 6), and suicidal ideation involving a specific plan to kill oneself but no attempt (n = 15), to suicidal ideation without a specific plan (n = 4). Those who had made suicide attempts, prior to their admissions, did so by either overdosing (n = 4) or strangulation (n = 2). Per hospital policies, self-harm is not considered suicidal ideation; however, it is worth noting that more than half of the study participants (n =13) endorsed engaging in self-injurious behaviors, either involving cutting or burning oneself, at the time of hospitalization.

Each participant had a primary diagnosis of Major Depressive Disorder, as indicated in the DSM-5 (American Psychiatric Association, 2013). In addition to Major Depressive Disorder, 48% of participants were also diagnosed with at least one secondary diagnosis, the most common of which were Disruptive, Impulse Control, and Conduct Disorders, specifically Oppositional Defiant Disorder (ODD; 24%), followed by Attention-Deficit/Hyperactivity Disorder (ADHD; 12%), and Substance Use and Addictive Disorders (12%), which included both cannabis and opioid abuse. One participant was diagnosed with a Feeding and Eating Disorder (i.e., Anorexia Nervosa), and one was diagnosed with a Trauma and Stress Disorder (i.e., PTSD; American Psychiatric Association, 2013), in addition to Major Depressive Disorder. All participants in the current study were hospitalized for three days (i.e., approximately 72-hours).

Table 2 outlines several key components in participants' clinical presentation, including: previous admissions at the hospital where the study took place, the number of times each participant had been placed under a Baker Act (including their current Baker Act), the precipitating reason for the hospital admission, and the clinical diagnosis each participant received upon arriving at the hospital, based upon criteria outlined in the DSM-5.

Table 2. Clinical Characteristics of Study Participants

	N	%
Presenting Crisis		
Suicide Attempt	6	24%
Suicide Ideation with a Plan	15	60%
Suicide Ideation without a Plan	4	16%
Clinical Diagnosis		
Major Depressive Disorder (MDD)	13	52%
MDD/Oppositional Defiant Disorder (ODD)	4	16%
MDD/Attention-Deficit/Hyperactivity Disorder (ADHD)	2	8%
MDD/Cannabis Abuse	1	4%
MDD/Opioid Abuse	1	4%
MDD/Eating Disorder	1	4%
MDD/Post-Traumatic Stress Disorder (PTSD)	1	4%
MDD/ODD/ADHD	1	4%
MDD/ODD/Cannabis Abuse	1	4%
Baker Act		
1	16	64%
2	2	8%
3	2	8%
4	2	8%
5	1	4%
6	0	0%
7	2	8%
Hospital Admission		
1	22	88%
2	0	0%
3	2	8%
4	0	0%
5	0	0%
6	1	4%

Study Procedures

Prior to initiating the study, the following procedures were discussed with the fully-convened University of South Florida Institutional Review Board (IRB), and all relevant permissions and authorizations were obtained to initiate this research on August 18, 2017 (Appendix A).

Recruitment

Recruitment for the study began on November 1, 2017, and it continued daily until 25 participants had been enrolled on December 21, 2017. During the recruitment period, I visited the hospital each day to provide study brochures and speak with patients and their families about study involvement. To avoid disrupting clinical staff workflow and patient processes, I did not make initial contact with prospective participants and their parents until clinical staff members had completed all necessary admission tasks (e.g., psychosocial and nursing assessments, psychiatric evaluations, labs, etc.). Following hospital intake, families were given a study brochure, which included information about eligibility for participation, study aims, procedures, and potential benefits associated with participation (Appendix B). If youth and their parents expressed an interest in learning more, after reviewing the brochure, I subsequently met with them to provide additional details.

Informed Consent

After adolescents and their parents completed all necessary intake procedures, reviewed the recruitment brochure, and expressed an interest in participation, the informed consent process was initiated. During this process, my aim was to provide a thorough explanation of study involvement by describing the study procedures, participation and withdrawal, benefits, risks, privacy, and confidentiality. I also emphasized the voluntary nature of the study and explained that even if parental consent was obtained, the child may still decide not to participate. Prior to signing the informed consent document (Appendix C) and child assent form (Appendix D), all families had the opportunity to ask questions and discuss study participation privately.

Psychometric Testing

Once the informed consent document and child assent form had been signed, but prior to beginning any data collection (i.e., interviews and drawing exercise procedures), I initiated a five-minute, Mini-Mental State Examination (MMSE; Appendix E) with each participant. The MMSE is a widely-used screening test for the assessment of cognition, perception, thoughts, behaviors, insight, and judgment, and considered a suitable instrument for children above the age of four (Ouvrier et al., 1993). The MMSE is constructed such that a range of mental functions (e.g., comprehension, coping, recall, etc.) can be assessed in a short amount of time (i.e., approximately 5 to 10 minutes), thus providing a measure of rapid screening (Ouvrier et al., 1993).

After completing the MMSE, I subsequently scored the responses, all of which were passing. To do so, I followed the guidelines outlined by Ouvrier and colleagues (1993), which indicates that for children 10 years of age and above, a cut-off score of 27 (on a 35-point scale) should be used. While these passing scores were expected, since all participants had already received a formal Mental Status Exam (MSE) from the psychiatrist during their intake, personally conducting this psychometric test with participants provided an additional safeguard, as I observed firsthand, each individual’s readiness for research participation.

Data Collection

In-depth, semi-structured, face-to-face interviews with adolescents were the primary method of data collection employed. Interviews were supplemented with participant-produced drawings, as a means of methodological triangulation (Kearney & Hyle, 2004). Given the research paradigm and theoretical orientation upon which this study was constructed, my aim in administering interviews and drawing exercises at the onset and conclusion of hospitalization

was to provide a context that invited youth to share about their treatment experiences transparently, without feeling a sense of pressure from other peers, parents, or practitioners. Recognizing that both of these data collection approaches may elicit deeper emotions than those encountered in other, more traditional, interview formats (e.g., internet, telephone, survey, etc.; Brinkmann, 2014), I approached each interview and drawing exercise as an intimate interaction, during which the laughter, tears, frustration, and fears described in interviews and depicted through drawings were insights uniquely incited from these data collection strategies.

Interviews

Semi-structured, in-depth, face-to-face interviews allow for the generation of rich knowledge, by asking questions that seek to reveal how the social, structural, and procedural components of inpatient psychiatric hospitalization impact youth (Seidman, 2013). Frequently used in qualitative research, semi-structured, in-depth interviews have the capacity to delve into patient experiences and stories, while correspondingly allowing for follow-up and elaboration of ideas shared (Brinkmann, 2014; Seidman, 2013). Semi-structured, in-depth interviews also provide sufficient structure to focus conversations toward topics that align with the study's aims (Brinkmann, 2014).

Although interviewing is considered a standard treatment component in psychiatric hospitalization, as patients meet with psychiatrists, therapists, nurses, and counselors for regular assessments (Thibeault et al., 2010), the intimacy established during the qualitative interview was not taken for granted, and was treated with respect (Brinkmann, 2014). For instance, to ensure that participants felt comfortable, each interview took place in a private office and opportunities for breaks were provided regularly (Owen et al., 2016). Likewise, I offered to conduct a reflexive debriefing, after data collection, as an opportunity for participants to share

feedback about participation in the interviews and drawing exercises (Owen et al., 2016). Participants were also encouraged to view the interviews in which they engaged for research participation differently than those they completed for treatment, in that the aim was not to study symptoms, but rather learn from stories subjectively shared.

Drawings

Drawing has long been accepted in the fields of psychiatry, psychology, and education as a means of glimpsing into unspoken thoughts and feelings by providing a direct route to the emotions associated with difficult experiences (Driessnack, 2005; Goodenough, 1928; Kearney & Hyle, 2004; Koppitz, 1968). Considered a valuable tool in augmenting communication, young people's drawings can offer important clues into their worlds, particularly when they may lack the verbal capabilities to explain them (Driessnack, 2006; Macleod et al., 2013). Insights garnered from drawings have been found to reveal deep facets of individual experiences that would be hard to grasp through language and numbers alone, particularly among young people amidst crises (Huss, 2011).

Considering the current study's aim to shift the focus of children's mental health research from making assumptions about youth, to gaining insights from them, drawing provided a person-centered approach to data collection and presented opportunities for youth to "frame their own experiences" (Kearney & Hyle, 2004, p. 362), by sharing subjective observations and interpretations related to psychiatric hospitalization (Yuen, 2004). This supplementary method of data collection seemed particularly relevant for participants because, like interviewing, it was an activity to which youth had been exposed throughout treatment. That is, clinical staff frequently encouraged youth to engage in art and drawing activities during down time, as a means of practicing self-care, positive coping, and personal reflection. As such, this approach not only

complemented practices that characterized the therapeutic milieu, but also served as an opportunity to cultivate a person-centered account of experiences by employing a less invasive mode of inquiry (Kearney & Hyle, 2004; Vince, 1995).

Interview and Drawing Exercise Structure. Interviews and drawing exercises were conducted with each participant at the onset and conclusion of treatment, in an attempt to capture the range of treatment experiences that adolescents endured during their hospitalizations and to uncover changes that emerged as youth reconcile crises. The first interview was conducted during the initial day of patients' hospitalizations, and at least 24-hours prior to the follow-up interview. The second interview was facilitated on the day of discharge, and at least 24-hours after the initial interview. One-hour time slots were allotted for each interview (i.e., 45 minutes for the interview, and 15 minutes for the drawing exercise), for a total of two hours of data collection with each participant.

Interview and Drawing Exercise Protocol. In semi-structured, in-depth, face-to-face interviews, a prepared protocol, which includes questions and follow-up prompts, can help to guide researchers through the data collection process (Roulston, 2010). The protocol for this study contained two separate components; the first was intended for the initial interview and drawing exercise, while the second outlined the follow-up interview and drawing exercise. To ensure that critical details about the research study were provided, prior to initiating the interviews and drawing exercises, the protocol began with an introductory script, during which information about what was being studied and the rationale for investigating this topic were discussed (Jacob & Furgerson, 2012). The introductory script also reviewed informed consent, and it provided opportunities to alleviate any confidentiality-related concerns (Jacob & Furgerson, 2012). Despite creating a framework for similar starting points, however, the protocol

was designed to allow for variation in the course of inquiry, depending on individual responses and elaboration (Roulston, 2010).

Initial Interview and Drawing Exercise Protocol. The initial interview and drawing exercise protocol began with general prompts, aimed at providing opportunities for participants to share their backgrounds through non-intrusive questioning. As rapport was established, transition questions were used to activate an exploration of deeper patient experiences. The key questions in the initial interview and drawing exercise were focused on stressors and situations that precipitated hospitalization, in addition to an investigation of the emotions associated with initial experiences at the hospital. Once the eight key questions had been discussed, the initial interview concluded with several simpler questions, seeking to shift the conversation toward the drawing exercise. Following a general overview of the drawing exercise, participants were read a drawing exercise prompt, which encouraged them to illustrate their hospital experiences, without the use of words. Specific questions were not outlined in the initial drawing exercise portion of the protocol, as discussions surrounding participant drawings were intended to emerge organically, based upon individual illustrations and their connections to ideas shared during the interview. The initial interview and drawing exercise protocol concluded with clarification of questions or concerns, and a reminder about the subsequent follow-up interview (Appendix F).

Follow-Up Interview and Drawing Exercise Protocol. The follow-up interview and drawing exercise protocol, facilitated on the day of discharge, began similarly to the initial one, in that an overview was again provided to remind participants of the rationale for the research. The follow-up interview protocol also offered an opportunity to discuss any questions that may have emerged since the initial interview (Jacob & Furgerson, 2012). Whereas the initial interview and drawing exercise protocol was directed toward precipitants of hospitalization and

early treatment experiences, however, the eight key inquiries comprising the follow-up protocol were centered on elements of inpatient treatment that were particularly significant. The reflective nature of questions in the follow-up protocol invited participants to share their subjective interpretations of inpatient experiences, and it encouraged them to describe what had changed since first arriving at the hospital. The drawing exercise prompt in the follow-up protocol mirrored that which was read during the initial exercise, but in the follow-up, participants were notified that they could choose to either add to their original pictures or begin new ones. The conclusion of the follow-up interview and drawing exercise protocol outlined clarification of any remaining questions, in addition to the provision of researcher contact information, if future questions were to arise about any component of participation in the study (Appendix G).

Audio Recordings. Interviews and drawing exercises were audio recorded as a means of preserving the words of the participants (Seidman, 2013). Permission was obtained to audio record each interview and drawing exercise during the informed consent and assent processes. However, authorization was again requested prior to beginning each interview and drawing exercise. Participants were also advised that at any point during the interview and drawing exercise, they could request that the recording be stopped or paused.

Data Analysis

Qualitative interviewing is a way of finding out what others feel and think about their worlds, and through qualitative interviews, events and emotions that are unique to each individual can be explored (Seidman, 2013). However, insights such as these may not be initially clear; therefore, the consideration, examination, and reformulation of information, through analysis, serves as a way of transforming large amounts of data in their raw form into key themes and inferences (Roulston, 2010). In qualitative interview studies, much like other qualitative

research designs, the simultaneous collection and analysis of data is emphasized (Brinkmann, 2014). By being attentive to the data being collected during analysis, my aim was to unpack and discover new insights related to the experiences of psychiatrically hospitalized youth.

Transcribing

Transcription provides a means for transforming spoken words into written texts to capture the conversations that took place during the interview process (Seidman, 2013). The transcripts generated from interviews conducted in this study represent the experiences of young people who were psychiatrically hospitalized during the study period, but this representation is somewhat subjective (Bucholtz, 2000; Coates & Thornborrow, 1999; Myers & Lampropoulou, 2016). That is, the transcription process was informed by my own interpretations and perceptions of the interview interaction (Bucholtz, 2000; Coates & Thornborrow, 1999; Myers & Lampropoulou, 2016).

While a range of transcription practices exists within the social sciences, in the current study, a systematic approach was employed (Collins et al., 2019; Roulston, 2012). One such guideline involved the personal transcription of each interview within two days of data collection (Brinkmann, 2014). This approach helped to ensure better recollection of the interview interaction (Brinkmann, 2014). Timely transcription also allowed for the identification of similarities and differences that existed between individual experiences within the psychiatric hospital (Brinkmann, 2014). Despite the fact that each interview was transcribed within two days of the recording, however, transcripts were revised when re-listening revealed a "new hearing" of the words spoken on the tapes (Coates & Thornborrow, 1999, p. 595). Each interview transcript was also formatted identically, with the right half of each page left open for codes (McLellan, et al., 2003; Saldaña, 2013). This included a double-spaced format, with the right half

of each page left open for codes (Saldaña, 2013). Additionally, for the purpose of analysis, each participant's initial and follow-up interviews were combined into a single Word document, creating a complete picture of their experiences throughout hospitalization, from arrival to discharge (Ivers et al., 2018).

Preliminary Analysis

Following the transcription process, each interview was read and re-read a minimum of two times, while simultaneously listening to the corresponding audio recording (Ryan & Bernard, 2003; Crowe et al., 2015). Referred to in the literature as "pre-coding" (Layder, 1998; Saldaña, 2013), during this stage of data analysis, attention was paid to expressions that seemed significant. For instance, words or phrases that recurred throughout transcripts were highlighted, as repetitions can offer cues to potential themes (Ryan & Bernard, 2003; Saldaña, 2013). Additional observational techniques involved underlining emotional moments during the interviews, which were often characterized by pauses, changes in spoken tone, and/or crying (Lakoff & Johnson, 1980; Ryan & Bernard, 2003).

Coding

After preliminary analysis yielded familiarity with interview transcripts, the coding process began. According to Saldaña (2013), a code in qualitative inquiry is, "word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute to a portion of data" (p. 3). Coding in the current study was a cyclical process, during which multiple rounds of detailed line-by-line coding were completed (Auerbach & Silverstein, 2003; DeCuir-Gunby et al., 2011). As new codes emerged, they were added into a codebook, which contained descriptions of the codes and examples of coded text (DeCuir-Gunby et al.,

2011; Roulston, 2010; Saldaña, 2013). Ultimately, the codebook became a reference that helped to guide further analysis (DeCuir-Gunby et al., 2011; Roulston, 2010).

In tandem with coding, a reflexive journal was maintained to record the rationale for various decisions made during this process, in addition to personal ideas and considerations that came up during coding (Roulston, 2010; Saldaña, 2013). This journal was also referenced frequently during later stages of analysis, when codes were translated into themes. Reflectively journaling not only provided a space in which insights garnered throughout the coding process could be documented, but also it also helped to maintain consistency during each stage of analysis (Braun & Clarke, 2006).

First Cycle Coding. First cycle coding served as the initial way of becoming familiar participants' experiences during psychiatric hospitalization. Specifically, it involved exploring stories shared within the raw interview data, identifying elements of the stories that seemed especially significant, and coding those components for later interpretation (DeCuir-Gunby et al., 2011; Fereday & Muir-Cochrane, 2006). To begin first cycle coding, careful consideration was given to which coding methods would help to generate the most meaningful insights. Based on the data contained within the interview transcripts, an amalgam of attribute, descriptive, in vivo, and emotion coding were selected (Saldaña, 2013).

Attribute Coding. A preliminary technique used to enhance the organization of information, attribute coding allowed for the labeling and logging of participant characteristics and demographic data (e.g., gender, age, ethnic identity, mental health diagnosis, etc.; Saldaña, 2013). Attribute coding occurred in tandem with data collection, though codes were updated and revised as new insights and information emerged. Once this initial coding method had been completed, a foundation was established upon which to begin descriptive and in vivo coding.

Descriptive Coding. During descriptive coding, single words were used to summarize sections of interview transcripts (Saldaña, 2013). For instance, when participants reflected on some of the most stressful aspects of psychiatric hospitalization during their initial interviews, many of them described feeling especially overwhelmed upon first arriving, particularly as they became acclimated to an unfamiliar environment with new people (e.g., *"Getting used to being here, in the first like hour or two, in a brand new place with a bunch of people was different because I had never been through something like this before."*). In the current study, the aforementioned passage was coded as 'ADJUSTING', as this code identified the basic topic being discussed. While descriptive coding provided a straightforward method for categorizing, organizing, and labeling data through the use of illustrative or informative words, some codes felt a bit generic and did not completely capture the essence of participants' experiences.

In Vivo Coding. As such, whenever possible and appropriate, in vivo codes were used to supplement to descriptive codes. In vivo coding utilizes the actual language and terms used by participants (Charmaz, 2006; Cope, 2003; Saldaña, 2013). In vivo coding was especially important because it drew attention to the voices of those who are often marginalized (Auerbach & Silverstein, 2003; Saldaña, 2013).

Emotion Coding. The final method in first cycle coding involved emotion coding, which combined in vivo coding together with descriptive codes to capture young people's experiences while hospitalized (Saldaña, 2013). A pathway into participants' subjective experiences, emotion coding required careful consideration of the non-verbal cues that were not necessarily communicated or captured in recordings (Kvale, 2003; Saldaña, 2013). Additionally, emotion coding also calls for a willingness to explore pauses and moments of silence, as these often

marked powerful feelings that emerged for young people during their interviews (Kvale, 2003; Saldaña, 2013).

Second Cycle Coding. Through the application of the aforementioned first cycle coding methods, new discoveries were made about participants and their experiences, as they processed psychiatric hospitalization. Each of these findings outlined the way for second cycle coding, which enhanced the depth and breadth of first cycle codes (Charmaz, 2006; Cope, 2003). In the current study, second cycle coding was aimed at re-categorizing, collapsing, and condensing the number of codes generated during the first cycle into more compact codes that would be conducive for later analysis (Saldaña, 2013). In an effort to complement the first cycle methods that were employed, and to prepare for later thematic analysis, focused coding was selected, as this approach can simplify first cycle codes and support the development of key themes from the data (Saldana, 2013).

Focused Coding. To begin focused coding, data that were similarly coded during the first cycle were grouped together into emergent categories, based upon conceptual likenesses (Charmaz, 2006; Saldana, 2013). During focused coding, some first cycle codes were also challenged, as considerations were made about whether or not they captured significant elements of the stories shared by participants. As categories were constructed and some new codes created, they were compared across interview transcripts (Charmaz, 2006; Saldana, 2013).

The cyclical process that characterized coding in the current study involved constant revisiting and revising during both first and second cycles. Because coding condensed the large amounts of interview data (i.e., hundreds of pages of interview transcripts were whittled down to 86 first-cycle codes, and eventually 24 second-cycle codes), significant insights were beginning to emerge from the coded excerpts that remained. Throughout this process, it became evident

that codes not only symbolized salient ideas discussed during the interviews, but also that they illuminated patterns necessary for later thematic analysis (Charmaz, 2006; DeCuir-Gunby et al., 2011; Fereday & Muir-Cochrane, 2006; Saldana, 2013).

Thematic Analysis

While coding captured and organized essential elements of participants' hospital experiences, thematic analysis restructured the data by clustering them together into categories to reveal connections (Roulston, 2010; Saldana, 2013). A commonly used method of analysis in qualitative research and psychological studies, thematic analysis allows for the identification of themes within data, drawing attention to the ideas that are especially significant (Braun & Clarke, 2006; Harper & Thompson, 2012; Roulston, 2010). The flexibility of this approach not only allowed for the inductive, interpretivist schema outlined in the current study, but it could also be adapted for use with visual data (i.e., participant-produced drawings; Harper & Thompson, 2012).

Bearing in mind that this study sought to shed light on an area of children's mental health research about which little is known, thematic analysis was directed toward providing a rich description of the data. While Braun and Clarke's (2006) six-phase guide to performing thematic analysis was used to outline the analysis conducted in the current study, given that there was already extensive familiarity with the interview transcripts and that codes had already been generated (i.e., Phases One and Two; Braun & Clarke, 2006), thematic analysis in the current study began with the search for themes (i.e., Phase Three; Braun & Clarke, 2006). These considerations not only guided thematic analysis prior to beginning, but they were also reflexively considered throughout the process.

Phase One: Searching for Themes. While specific steps were followed during thematic analysis, much like coding, theming the data was an iterative process, during which interview transcripts were read and reread, and codes were reviewed and revised (Braun & Clarke, 2006; Yeh & Inman, 2007). Although interview transcription and coding contributed to the establishment of themes, as both stages of analysis drew attention to patterns of meaning within the data, thematic analysis formally began by sorting together similarly coded data to create broad themes. To make this process less abstract, note cards with code names and brief definitions were used, providing visual representations of the codes that comprised theme groups (Braun & Clarke, 2006). Throughout this process, several individual codes coalesced to form overarching themes, while a number of others were moved into various subtheme piles, which served as extensions of the main themes, and still some were discarded (Braun & Clarke, 2006; Manning & Kunkel, 2013). This initial phase of analysis yielded six overarching themes and twelve subthemes, but moreover, it drew attention to the connections that existed between coded data, highlighting salient ideas that reverberated throughout participant interviews.

Phase Two: Reviewing and Refining Themes. The second phase of thematic analysis was focused on refining the themes and subthemes that had been established during the first phase (Braun & Clarke, 2006). While the initial phase revealed that there were relationships among the coded data, to ensure a thorough analysis, codes were reviewed collectively (Braun & Clarke, 2006). This task was marked by first carefully evaluating coded extracts to ensure that together they embodied the overarching theme (Braun & Clarke, 2006). During instances in which coded data extracts did not seem to complement corresponding codes or fit within the umbrella of the overarching theme, they were either relocated to another group, revised, or removed completely (Braun & Clarke, 2006). Through this process, six subthemes were

dissolved, four were moved into other theme groups, and two were combined together to create a new theme group, replacing two prospective overarching themes. This resulted in five prospective overarching themes.

Once these themes seemed to appropriately represent the coded data that comprised them, they were subsequently considered within the context of the broader data set (Braun & Clarke, 2006). As each initial and follow-up interview was re-read, consideration was given to whether or not potential themes reflected the stories that participants shared throughout the study. While this process yielded revisions of some themes (i.e., two prospective themes were merged together into one), ultimately, it validated the existing themes and underscored how the themes coalesced to convey key insights from the data (Braun & Clarke, 2006).

Phase Three: Naming and Defining Themes. The third stage of thematic analysis involved determining theme names and developing definitions for those themes (Braun & Clarke, 2006). Prior to beginning this phase, several theme names had risen to the surface. However, as these prospective names were more carefully explored, consideration was given to the language used by participants, and attempts were made to select theme names that were true to the data they represented (Braun & Clarke, 2006). During this phase, the coded data that comprised each theme were again reviewed and compared with the interview transcripts (Braun & Clarke, 2006).

Phase Four: Final Analysis. With the themes and their definitions established, the final phase in this process involved writing a detailed analysis of each theme (Braun & Clarke, 2006). While the participants' stories captured within each of the four themes will be discussed at length in the following chapter, it seems significant to note that the last stage of thematic analysis was characterized by searching for quotes and that not only exemplified the theme itself, but more

importantly, epitomized participants' lived experiences during psychiatric hospitalization (Braun & Clarke, 2006). Extracting elements of the stories shared by youth not only highlighted individual voices, but also yielded an in-depth view of the unique experiences and emotions that could not be gleaned through other approaches. Taken together, they create a narrative that offers a unique view into the lived experiences of young people amidst psychiatric crises.

Drawing Exercise Thematic Analysis

In the current study context, the opportunity to express oneself through art was the focus of the drawing exercise (Bagnoli, 2009; Yuen, 2004). This meant that no psychological evaluation was conducted on the drawings. Instead, like interviews, participant-produced drawings, and their corresponding transcripts, were thematically analyzed (Bagnoli, 2009; Driessnack, 2006). Specifically, participants' own explanations of their art, and the overarching topics that emerged as drawing exercise transcripts were coded and themed using the four phases outlined previously, guided the process (Bagnoli, 2009).

Trustworthiness

Qualitative inquiry rejects the notion that essential truth exists, and instead focuses on individual perceptions and interpretations of experiences (Rubin & Rubin, 2012). Despite this, however, qualitative researchers still adhere to rigorous standards of research practices and conduct thorough, credible, and trustworthy research (Rubin & Rubin, 2012). In the current study, trustworthiness was established and maintained through data triangulation and methodological triangulation.

Data Triangulation. Data triangulation, in the form of two separate interviews with participants (i.e., one on the first day of treatment and one on the last day of treatment) were used as a means of establishing trustworthiness (Roulston, 2010). In qualitative interview studies, data

triangulation achieved through multiple interviews is not only helpful in checking the researcher's understandings of participants' views, but also comparing initial findings with later conversations (Roulston, 2010). Moreover, conducting two separate interviews allowed the opportunity to understand progress and perspective changes over the course of psychiatric hospitalization (Roulston, 2010).

Methodological Triangulation. Methodological triangulation also promoted trustworthiness in the current study, through the inclusion of multiple forms of data (i.e., participant-produced drawings, in addition to interviews; Roulston, 2010). By thematically analyzing data drawn from various sources, adolescents' treatment experiences were more deeply and thoroughly understood. Likewise, by considering the implications associated with information from different sources, key insights from psychiatric hospitalization were derived (Bagnoli, 2009).

Researcher Reflexivity

In making the decision to develop a study that sought to explore the experiences of psychiatrically hospitalized youth, I am deeply aware that my own connection to inpatient psychiatric hospitalization contributed to subjectivities that shape the ways in which I engaged this topic and the participants. Though I have never personally experienced psychiatric hospitalization, I have devoted the last decade to working with youth receiving treatment at an inpatient psychiatric children's unit. Throughout my tenure at the hospital, I have had opportunities to observe adolescents during each phase of their treatment, from the moment that they walk through the facility's doors (crying, screaming, and in some cases strapped to a gurney), to being reunited with their families for the first time, following the conclusion of treatment.

Some of the most meaningful moments, however, took place during hospitalization, as youth graciously allowed me to partner with them through portions of their treatment journeys by engaging them in therapy. Given the nature of inpatient psychiatric hospital treatment, and the focus on crisis stabilization, my exchanges with youth were frequently characterized by deep dialogues, during which emotions associated with disclosures of abuse, acknowledgements of addiction, revelations about sexuality, and discussions of death, were processed with the hope of ameliorating symptoms. Despite the difficulties described during therapy, however, adolescents revealed incredible and inspiring insights about identity, empathy, and resilience, and I constantly found myself in awe of their courage when faced with crises.

Unfortunately, though, the brevity of inpatient psychiatric hospitalization, together with the high volume of patients served at the hospital, created an environment that was not necessarily conducive for follow-up discussions with patients about the aforementioned experiences, and patients were often discharged without opportunities to reflect on conversations, interactions, and experiences that characterized the course of their hospitalizations. As a clinician, I struggle with the notion that youth, who are so willing to share such intimate insights about themselves, their emotions, and their experiences during a critical period of their mental health, are often forced to stifle their stories. Whether this is due to the brevity of treatment, the confines of confidentiality, or misconceptions about the capacity of individuals in crisis to communicate their experiences, meaningful insights are overlooked by failing to engage youth while they are still receiving treatment. Yet as a researcher, I acknowledge that this oversight represents a gap in the available data on children's mental health, and one that I aspired to fill through insights garnered from this study.

To fill this gap and engage in meaningful scholarly inquiry, however, I recognized the need to delineate from therapeutic practices, and instead employ an outsider perspective on the field by engaging young people as a researcher, rather than a clinician (Wahlström, 2017). Doing so allowed me to shift my focus away from conversations about coping skills and the integration of therapeutic interventions, to the stories themselves. As a result, I had the opportunity to be fully present with young people, in a way that felt more genuine and intimate than therapeutic encounters I had previously shared with patients at the hospital. As a researcher, listening to the stories of young people and investigating treatment experiences from their perspectives, I was taken by the transparency with which youth shared, and moved by the meaning that they were able to derive from their experiences, demonstrating profound resilience despite such difficult circumstances.

Ethical Considerations

Researchers remain ethically culpable, both for doing justice to the topics investigated, and for asking research questions that have the potential to yield meaningful findings (Seidman, 2013). To maintain high ethical standards of research, I reflected carefully on participants' rights and interests when making choices regarding the research processes, in addition to privacy and confidentiality, and data and safety monitoring. Though I recognize that potential vulnerabilities still remain among the population that participated in this study, it was designed to ensure a focus on person-centeredness, such that participants may be more likely to experience benefits associated with their study involvement (Opsal et al., 2016; Wolgemuth et al., 2015).

Privacy and Confidentiality. Several specific steps were taken to protect the privacy and confidentiality of participants. For instance, interviews, as well as meetings related to the study, took place in a private office. Interview recordings, notes, and transcripts were all de-

identified, and numerical codes were instead used. The master code list and consent/assent forms were each stored separately from the research data (i.e., in different locked filing cabinets). Files containing electronic data (i.e., interview audio recordings and interview transcripts) were encrypted and stored on a password-protected computer. All discarded research records were destroyed in ways that protect participants' privacy (i.e., paper records were shredded and recycled and electronic records/recordings were erased using a software application designed to remove all data from the computer).

Data and Safety Monitoring Plan. Study-related materials and data were reviewed on an ongoing basis. Specifically, I ensured: 1) informed consent was obtained prior to performing any research procedures, 2) all participants met inclusion criteria, 3) the data being collected appropriately addressed the research questions, and 4) the study was conducted according to the IRB-approved research plan. Interview recordings and transcripts, in addition to participant-produced drawings were all discussed with Dr. Tony Tan (i.e., the study's Faculty Advisor and Major Professor) as data were being collected. While there were no study drop-outs or protocol deviations, there was a specific plan in place to report these to the USF IRB, should they arise.

Conclusion

The theoretical assumptions about qualitative interview studies, described throughout this chapter, each shaped the design and data analysis employed (Adams St. Pierre & Roulston, 2006; Roulston, 2010). Though there are many components included in the research conducted, they were each directed toward fostering collaborative relationships with participants, such that rich insights could be garnered about psychiatric hospitalization. Drawing attention to experiences that youth identified and described through in-depth interviews allowed for the investigation of a

phenomena in ways that could serve to enhance the lives and treatment experiences of psychiatrically hospitalized youth.

CHAPTER FOUR: RESULTS

This chapter presents the themes that emerged from adolescents' descriptions of the events that precipitated their hospital admissions and reflections on the treatment they received over the course of three-days to promote crisis stabilization. As young people opened up about their experiences, they provided personal assessments of the costs and benefits associated with disconnecting from their families and friends to instead focus on their mental health. While each of them shared a unique story, many of their experiences were echoed throughout the interviews, revealing four key insights that consistently surfaced.

Through a detailed thematic analysis, outlined in Chapter Three, these insights ultimately became the themes of this study, capturing the essence of participants' subjective experiences during psychiatric hospitalization. These themes, in addition to direct quotes, reflecting the meaning of each theme, are discussed throughout this chapter. Table 2 briefly summarizes the parameters of each of the four themes, indicating their names, in addition to theme definitions, and data exemplars, which capture the essence of each theme, based upon direct quotes shared during the interviews and drawing exercises.

Table 3. Summary of Themes

Theme Name	Definition of Theme	Data Exemplar
Family Fallout: A Primary Precipitant to Psychiatric Hospitalization	Discord within the family unit that contributed to the suicide behaviors that precipitated participants' admissions.	"…the level of stress in our family is honestly why I'm suicidal." (Participant #13)
Criminalized, Stigmatized, and Marginalized: The Processes Involved in Crisis Stabilization	Punitive and prohibiting processes involved in crisis stabilization that set a negative treatment precedent for psychiatrically hospitalized youth.	"I would say that a lot of this feels kind of dehumanizing…" (Participant # 7)
The Power of Peer Support: Perseverance Derived from Partnering with Fellow Patients	Validation and encouragement garnered from connecting with fellow peers and discovering that there were other young people with whom they could identify and relate.	"I just feel like the people here accept me for who I am." (Participant #20)
Cultivating Change: Recognizing Personal Transformation Through Crisis Stabilization	Reflections and descriptions of the personal growth adolescents experienced over the course of psychiatric hospitalization.	"I grew and learned a lot from being here." (Participant #22)

Theme One: Family Fallout: A Primary Precipitant to Psychiatric Hospitalization

One of the most prevalent themes that emerged from interviews was familial conflict. Discord within the family unit, or at least between some of its members, was brought up in 16 out of the 25 initial interviews, particularly when young people responded to interview questions regarding the events leading up to their hospital admissions (i.e., How would you describe the day that you arrived here?). As adolescents reflected on the series of events that precipitated their Baker Acts and subsequent hospital admissions, they opened up about arguments that ensued with their parents and explained how these escalated.

Well, I tried to kill myself after I got in a fight with my mom. The fight we had was just

> like, over the top. We were both calling each other unnecessary things. I mean, it was just blown, and blown, and blown out of proportion. Like, I think we both just had enough, and… It was over text, and it happened like when I was at school. So, I couldn't… The whole day of school was like the worst day of school ever. Then I came home, laid down on my bed, and was just like… wasn't even really feeling anything. Like, I couldn't even get up, and then… Yeah, umm I tried to hang myself, and I was dangling in the air for a good seven seconds, and then it came undone. So… yeah, it was pretty… it was pretty close. I went to the hospital right after that. (Participant #10)

While two participants (i.e., #10 and #14), who identified family conflict as a primary precipitant to psychiatric hospitalization, declined to disclose the details of the disputes they had with their parents, the remaining 14 shared specific insights about the sources of stress that prompted problems with parents. The most frequently cited disputes were those that emerged out of dissatisfaction with the relational dynamics that existed between youth and their parents. Not only were feelings of, "I would say just like disappointment, betrayal, and frustration with my parents; the level of stress in our family is honestly why I'm suicidal." (Participant #13) brought up among 9 of the 16 participants who identified family conflict as a primary precipitant to hospitalization, but those who endorsed greater dissatisfaction in the relationships with their parents also seemed to report increasingly severe suicidal ideations and attempts. For instance, as she revealed the events leading up to an overdose, which ultimately led to a trip to the emergency room and subsequent psychiatric hospitalization, Participant #1 shared:

> My dad and me got into a fight, which isn't that like crazy unusual for us, but like this time, I just couldn't get what he said out of my head… Like, he was basically calling me like a mistake, a failure, an attention whore, and like a bunch of other stuff. *[Pauses]* I

> really just couldn't handle it anymore because it's always the same with him. Like, he wasn't there through things, and he missed out. And now, he says like he's tryin' to fix it or whatever, but like, then why is calling me a mistake? You know? *[Sighs]* Anyways, so, I remembered I had these pills in my pocket that someone had given me – I actually had like completely forgot about them, but then I remembered everything my dad was saying to me, and I just kept replaying it over and over again in my head. And so, I took the pills… like all of them.

Interestingly, the suicidal ideations and attempts that ultimately led to participants' hospital admissions were not described as occurring during arguments with parents; rather, they seemed to happen once tensions subsided, when youth were alone and mulling over the exchanges that they had previously with their parents. Like Participant #1, other adolescents echoed similar experiences, describing how their own suicidal ideations mounted as they reflected and ruminated about disputes with members of their families.

> I mean, I was super pissed at my mom because she said she was going to put into group home because she couldn't handle me anymore. And I'll admit, like, I said some pretty crazy stuff to her, but like, I was pissed. But then, like, the more I thought about it, especially like, when I was just in my room, and like alone listening to music, the more I realized like how completely messed up that was. Like, my mom doesn't want me anymore – my own mother wants to like get rid of me. So, that's when I started cutting. I would have just kept going because I was at that point where I felt like I couldn't handle anymore, and all I was thinking about was how it would just be easier for everyone if I weren't here anymore. But that's when my sister walked in. I felt really bad too, 'cause like, she freaked out when she saw all the blood all over the carpet, and then that's when

she called the cops. (Participant #4)

Whether participants described feeling unwanted by their parents, as Participant #4 shared, or they identified a perceived sense of judgment (e.g., "I started dating a girl, and umm my dad really doesn't like gay people, so he stopped talking to me; it's like he's disgusted by me now, and he won't even look at me." Participant #24), adolescents expressed internalizing the rejection that they felt, which not only appeared to spur feelings of dissatisfaction in their relationships, but also contributed to a negative sense of self-worth. For a number of adolescents, like Participant #8, this manifested as suicidal ideation, which ultimately led to his hospital admission.

> I just feel like no matter what I do, it's never enough for my mom and my stepdad. Like, they're always on me about my grades, homework, sports, my friends, my room, working out, cleaning up, doing this, or that… I don't know, just like… always something. And the thing is, I try really really hard with all that stuff, but it feels like they're never happy… Like, they always find something that's wrong with it. And I think when I was younger, or whatever, I didn't really care, 'cause like when you're little, it's just like whatever. But like now… and I guess like after hearing it for so long, I just feel like it's never going to be enough – like *I'm* not enough. And like, even when one of my coaches, or like someone else does tell me like 'Good job!' or whatever, it's like it can't undo what I've heard for so long. Just like, all that other stuff I always hear about… about how I'm not good. I think it got to me, you know? And I also think I've probably been depressed for a while now because of it, but yesterday was when I… I like broke, I guess, and I told the guidance counselor I wanted to die.

Figure 1. "All Alone" (Participant #4's Initial Drawing)

The pain that young people internalized as a result of family fallout became even more poignant in their drawings, which captured the sadness and loneliness that accompanied familial conflicts. Although participants described tension and arguing with a number of different family members in their interviews, from parents and siblings to grandparents and extended relatives, their drawings often included only one person (i.e., typically themselves), and reflected sadness, isolation, and sorrow. The solitude that existed for young people who felt at odds with members of the families seemed, in some cases, like that of Participant #4, to be filled with self-deprecating thoughts about suicide and self-harm.

> This is supposed to be me, even though my hair doesn't really look like that… But like, it's just supposed to be like me in my room, just like sitting there. 'Cause like, when I'm by myself, I just sit in my room, and just like… I don't know, just like think about everything. It's sucks. I feel like no one even knows I'm in there. Like my mom could care less, and like, after we fight or whatever, she's just like over it, but I'm just there – all alone… And that's what happened today; that's when I started cutting.

Although the direct precipitants to psychiatric hospitalization for participants involved in the current study were related to suicidal ideation and/or attempts, in more than half of the initial interviews conducted, thoughts and actions involving killing oneself, could be traced back to familial conflicts or tensions that arose within the family dynamics. In such cases, it seemed as though the suicidal ideations and attempts that were reported, in addition to the depressive

symptoms subsequently diagnosed, were often adaptions that emerged in response to the tensions that existed at home. While the main focus of psychiatric hospitalization for each participant was to stabilize the crisis that caused the admission, family functioning was a prevalent treatment component for young people, with both inpatient individual and group therapy curricula devoted to topics surrounding family dynamics. Additionally, to further address family conflicts, family therapy sessions were ordered by the attending psychiatrist, as a discharge prerequisite, for 15 of the 25 participants enrolled in the study.

Young people's descriptions of the dysfunction at home shed light on a substantial source of adolescent stress. That is, the impact of family conflict seemed to sever cohesion within the family dynamic, contributing to adolescent self-reported isolation and self-harm. As a result of the conflicts that ensued with caregivers, for instance, young people in the current study endorsed difficulty concentrating in classes, connecting with peers, and maintaining motivation to accomplish personal goals. This was especially true when adolescents described feeling as though conflicts at home had not been resolved.

Theme Two: Criminalized, Stigmatized, and Marginalized: The Processes Involved in Crisis Stabilization

In addition to sharing about the events that precipitated their psychiatric hospital admissions, young people enrolled in the current study also reflected on and described salient processes involved in crisis stabilization, once they had been placed under a Baker Act and admitted at the hospital. Their stories revealed an additional theme, related to the criminalizing, stigmatizing, and marginalizing nature of psychiatric hospitalization and inpatient treatment. This theme was echoed among 18 participants' stories, and it reverberated throughout a number of interview questions asked (i.e., Key Interview Questions 2, 4, 5, & 8, in addition to the

Drawing Exercise Prompt) in the Initial Interview and Drawing Exercise Protocol.

Even before they arrived at the psychiatric hospital, adolescents described exchanges with professionals responsible for initiating their Baker Acts and transport processes that seemed to set a precedent for the treatment that was to follow once they were hospitalized. They characterized many of the practices involved in crisis stabilization as having a castigatory component, which often contributed to a sense of criminalization, by creating the impression that youth had done something wrong in making the decision to seek help.

> I came here handcuffed in a police car, and when I was riding in it… I don't know. It felt like… like I was getting sent to prison or something. I… I feel like the officer was nice and stuff, but I don't know. He wasn't really saying anything to me, and I didn't understand why I had to wear the handcuffs. I felt like I wasn't going to the right place. Like there had been a mistake or something. I just wanted to yell up front to him, 'You know, I'm the really depressed kid, who wanted help, not the one who did something bad, right?'. (Participant #22)

Feelings of being treated as though, "I was some kind of criminal because I was suicidal." (Participant #25), were reiterated by seven participants, each of whom was placed under a Baker Act by a Law Enforcement (LEO) or School Resource Officer (SRO). While all of these participants denied being in any way maltreated or disrespected by the officers, they explained how being placed in handcuffs and transported to the hospital in a police vehicle felt punitive, "Like I was going somewhere for a bunch of bad kids." (Participant #2) rather than therapeutic. Three of the seven also depicted "being detained" (Participant #21) in their drawing exercises, by including illustrations involving, "Me, riding in the back of a police car because that's something I've never done before, and it's not something I ever really thought would

happen to me." (Participant #13). The inclusion of these illustrations, in addition to the corresponding stories that were shared, underscored the impact that criminalization had on young people as they approached psychiatric hospitalization.

> It was just so crazy coming here. *[Pauses]* I was crying, and bleeding, and saying I needed help, and… People were telling me I was going to get it (like help) and everything, but it felt like that all went out the window when the cop car pulled up. Like, it felt like I had been duped or something, and everyone was in on it but me. *[Pauses]* It just felt like… Okay, now that you admitted you were gonna' kill yourself, you're not actually going to get help, you're *actually* getting sent away. *[Pauses]* I just don't get why it had to happen like that. It seems so wrong. (Participant #3)

The sense of delinquency depicted throughout participants' stories was further compounded by feelings of stigmatization, particularly when Baker Acts were initiated in more public contexts (i.e., at school or in a neighborhood). In such instances, adolescents described how their uneasiness was exacerbated by concerns regarding how others may perceive or interpret what they saw, as participants were being placed under a Baker Act and transported to the hospital.

> Even though this wasn't my first Baker Act, this time it was way worse! The last time – or I guess, my first time – my therapist did it in her office, after I told her my cuts were getting deeper, and I didn't feel like my coping skills were working anymore. But like, this time… This time it was at school, and there were a bunch of people around because we were switching classes and everything, and it was just so… I don't know… just like so humiliating. It felt like everyone was watching… *[Pauses]* Well actually, I know they were all watching because they were all just standing there. And our two SROs were

> there, which made it look really bad because the only time they're ever both there is if it's something like awful (like a bomb threat or something). So, I can just imagine the stuff people were saying. *[Pauses and becomes tearful]* And now, I really don't want to go back there. *[Sobbing]* Because now… Now, on top of everything else going on… Now, I'm gonna' to have to deal with all that too. (Participant #6)

Feelings of being stigmatized seemed to lead to perceptions that their mental health symptoms were so severe, they could not be managed within normative community-based settings, and as a result, youth were relegated to a locked psychiatric hospital for treatment. An internalized sense of shame, associated with deviating from cultural and societal norms, led many adolescents to label themselves negatively (e.g., crazy, psycho, dangerous, etc.), consequently limiting their ability to think of themselves as anything more than their diagnoses. The notion of stigmatization was not described as subsiding once young people arrived at the hospital, however. In fact, each of the 16 participants, who identified the current Baker Act as their first, described at least one instance of being "disregarded" (Participant #11), "excluded" (Participant #16), "devalued" (Participant #23), or in some way discounted during the treatment process, which caused them to feel further marginalized.

> From the very beginning of this whole thing, I feel like I've been in the dark. I've had no idea where I was going, or what was going on… Like at one point, when the cop was driving me here, I had no idea even where I was, 'cause it's like kinda' secluded here, and it just felt super closed-off. So like, I didn't know what was going on. Then, when I walked in here, I was like… I was thinking like, oh I'm just gonna' stay here, probably wait for someone to talk to, and that's it. My mom picks me up, and I go. But once they took me through like three sets of locked doors, and I saw all these other kids wearin' the

same green sweatsuits, *and* I got in trouble for getting up to use the bathroom without telling the staff exactly where I was going… Well, I guess that's when I realized it wasn't going to be like that. I mean, I get it now and everything, but I just wish they would have told me that a lot sooner, instead of just acting like… Like I'm just another crazy kid, who's going to go through this, just like all the other ones in there. (Participant #19)

Even for young people who had been previously hospitalized, the feelings shared by Participant #19 resounded throughout interviews, and participants discussed how the criminalization, stigmatization, and marginalization that they experienced contributed to a sense of treatment disengagement, intensifying feelings of isolation. The effects of such treatment among adolescents, who may already be experiencing poverty, discrimination, violence, and trauma, not only shapes adolescents' hospital experiences in negative ways, but may also put them at risk for poor outcomes following hospital discharge.

> I would say that a lot of this feels kind of dehumanizing, which is weird 'cause on the paper that has all the rights of the patients, they're like, you have the right to be treated with respect. But a lot if it doesn't feel that respectful. *[Pauses]* Like, the way you basically get strip searched when you come in here. Or like… like the way you have to give them all your stuff and put on these outfits. It feels like I'm in jail here. And like, you only get a certain number of calls every day, and there's always people watching you. It just doesn't feel like it's all that like… "helpful". And like, I know the people here want to like help us, but… I don't know. I guess just like the whole thing kind of makes you feel like something really *is* wrong with you, so they have to keep you locked in here. I just don't really see how any of this is going to help me, and I just want to get out of here. (Participant #7)

Figure 2. "Bad Kid" (Participant #22's Initial Drawing)

Participants' drawings underscored the significance of the criminalization, marginalization, and stigmatization that they discussed during their interviews, and a number of their illustrations referenced law enforcement vehicles, handcuffs, and/or weapons. As young people drew images representing their initial experiences being placed under a Baker Act, it became apparent that these first encounters largely shaped their interpretations of psychiatric hospitalization. Rather than endorsing a sense of relief that they would be receiving help, participants like #22 were instead overcome by anger and apprehension.

> I just drew this cop car because like, that's just like what's standing out to me about this whole thing, I guess… well like, at least for now 'cause I haven't been here that long yet. But like, I've never been in a cop car before, or like, gotten in trouble like that. So like… I mean, even just sitting here drawing this, like, I can't even believe I was in that. Like, I'm not that kid. I'm depressed, yeah, but like, I just don't get why I had to come here handcuffed in a cop car like I was some sort of bad kid because I'm not. And like, I guess at the time, I was really like freaked out and anxious about it or whatever, but now, like the more I think about it, it just makes me kind of angry that like that's what you have to go through when you want to get help.

The damaging effects of criminalization, stigmatization, and marginalization on

adolescents' mental and emotional wellbeing heightened participants' stress, causing them to feel, "overwhelmed" (Participant #5) and "honestly, really scared about what was happening" (Participant #1). Youth explained how many of the people, processes, and procedures at the psychiatric hospital, rendered them rejected and isolated in their anxiety, fear, depression, self-blame, sadness, and stress. As a result, 18 participants in the current study shared stories in which they were combatting additional stressors related to psychiatric hospitalization itself, each of which posed further challenges, beyond the suicidal ideation that precipitated their Baker Acts.

Theme Three: The Power of Peer Support: Perseverance Derived from Partnering with Fellow Patients

Despite a number of problematic processes involved psychiatric hospitalization, an additional theme that surfaced from within the stories shared was related to an element of psychiatric hospitalization that transformed treatment for participants enrolled in the current study. The power of peer support and the validation that encompassed, "bein' around other kids who actually get what I'm going through" (Participant #18), was what 19 adolescents identified as the most helpful part of psychiatric hospitalization (i.e., Key Interview Question 6, in the Initial and Follow-Up Interview and Drawing Exercise Protocols). Moreover, as participants weighed the costs and benefits associated with psychiatric hospitalization and assessed whether or not they would elect to receive inpatient treatment again, if they could go back to the day that they were admitted, 17 confirmed that the validation they received from discovering that they were not alone, and that there were other young people with whom they could identify, outweighed their negative experiences. In some instances, this even provided relief from the stigmatization and marginalization youth described.

Some of the initial ideas that arose regarding peer support were related to a sense of surprise associated with the number of peers present at the hospital, who were also experiencing crises. During their interviews, youth explained how walking into an environment in which they were surrounded by other young people felt disarming and contributed to an initial feeling of comfort, even though they did not know each other.

> "Honestly, my first thought when I walked in here was just like, 'Jeez! I can't believe how many kids are here!'. Like, I knew they weren't all there 'cause of the exact same thing as me, but just like seeing all of 'em was like… not what I expected, I guess. And like, I guess I've kinda' always felt like I was the only one with like… like no dad and like a real screwed up family and stuff. But just like… when I walked in and saw all those other kids, I was like, maybe… maybe not. Like, maybe I'm not the only one who's got stuff. (Participant #9)

Peer support was described as feeling almost immediately apparent. Participant #17, for instance, recalled her first experience at the hospital, after being admitted as, "walking into this room with a bunch of other kids, and literally two minutes later, this girl came up to me and asked me what my name was". Whether it was by introducing oneself, initiating a casual conversation, or inviting someone to sit with them, the friendliness that participants described seemed especially beneficial for newcomers. Furthermore, the mutual trust established within just a few short hours of knowing each other seemed to transform treatment.

> Like, whenever I first went in there it was quiet and like these two kids came up and were like, 'Oh are you okay? Are you feeling alright?', and I was like… That made me feel really good 'cause I wasn't talkin' to anyone, and they came up and talked to me. (Participant #12)

This social inclusion that existed at the hospital was contrasted with the environments at the middle and high schools, where participants were enrolled, and they shared how feelings of comfort, closeness, and comradery were established much more quickly at the hospital than they typically were at school. Similarly, the divisions that commonly exist between students in different grade levels appeared to be absent throughout the unit milieu, as adolescents socialized and interacted with peers of all ages.

> Every time someone is new at school – I mean, it's unfortunate, but I do it too – but, you kinda' ignore them. Whenever I was new here, like two years ago, I was ignored for a couple weeks. And I mean, it's kinda' sad. I don't do it as much 'cause I know what it's like, and I'll talk to them. But for the most part, it's like there's a separation, and you don't wanna' talk to the new kid. But I don't feel like that at all here. I don't know these kids at all. I've known them for three hours, but I already know a lot about them. Like the kids at my school are exactly my age, like seventeen/sixteen, but some of these kids are like twelve and thirteen and still, talking to them, it feels like someone my age. (Participant #21)

As young people reflected on the closeness that characterized the social atmosphere at the hospital, some described feeling as though the context itself was conducive to peer support, explaining, "Even though we're not here for that long, we're together like 24/7, so you get to know everyone real quick." (Participant #15). Others, however, seemed to attribute the formation of close connections to conversations that were cultivated during the frequent group therapy and coping activities, sharing, "I've been super open here with the other kids; I mean like, I talked about something in group today that my best friends in the whole world don't even know about." (Participant #20).

Regardless of the driving force behind the closeness experienced, young people explained that the connections they had established with other peers were especially meaningful because they related to each other in ways that same-age peers at school or within their neighborhoods and communities may not understand.

> I just feel like the people here get it, and like, I feel way closer to girls here than girls I've been in school with for like years. Because like, it just feels like the people here get it. Like, they know what it feels like to be like super alone. And like, a lot of them have cut before too, so it's just like… And look, I know we're not supposed to talk about it or whatever, but I mean like, you can see it, if you know what to look for. And like, sometimes, it just comes up, and like… I know a lot of people think it's weird or gross or whatever, but most of the people here like understand it. (Participant #5)

The establishment of these connections, together with the culture of peer support that was consistently noted throughout the study period, seemed to drive young people to seize opportunities to champion and encourage one another, particularly when they noticed that a fellow peer was experiencing emotional turmoil.

> I guess *[Name]* and her mom don't get along, or whatever. So like, I tried to like brighten her up when she gets off her phone call and stuff because she always seems upset. So, I'm just like jokin' with her or tryin' to make her laugh… Well, 'cause yesterday, she had a meeting – like a family therapy session with her mom – and she came out crying, and I was like, 'What's wrong?'. Like I'm tryin' to help her like feel comfortable because I know what it's like to not get along with your mom. I just want to like be there for her, you know? And like, for her to know she has a friend. (Participant #24)

For the 19 adolescents who identified their fellow peers as a source of support, more than half of them (n = 10) referenced the significance of acceptance in their interviews. Whether they were identifying instances in which they felt acknowledged or understood by peers (e.g., "I just feel like the people here accept me for who I am." Participant #20), or expressing the importance of demonstrating acceptance toward others (e.g., There's not really any bullying here because we all just kinda' like accept each other." Participant #11.) The non-judgmental nature of the exchanges between peers not only seemed to be a primary way of demonstrating support, but also appeared to be a priority that youth preserved throughout their time at the hospital.

> There's this girl, I think her name is *[Name]*, who said something in group, and the girl beside me kinda' like laughed at her. I just looked at her, and was like, 'Nah, don't be like that here.'. I feel like *[Name]* probably gets made fun of a lot, and this just ain't the place for that. I mean… who knows? Maybe that's like why she's here or whatever. I get that she's maybe like different or whatever, but like, I don't know… I just feel like we're all in here for a reason, and we're all goin' through somethin'. (Participant #25)

Figure 3. "A Friend Who Understands" (Participant #15's Follow-Up Drawing)

Participant-produced drawings captured the essence of peer support and represented the connection and comradery that young people discussed in their interviews. For instance, images depicting peer support were characterized by positive interactions, close proximity of the individuals in the drawing to one another, or engagement in an activity together. Regardless of the way in which peer support was illustrated or interpreted, however, drawings that highlighted relationships that existed between peers at the hospital championed the power of partnership and the encouragement that youth derived from having the opportunity to connect to other young people with whom they could relate.

> I just drew me and like *[Name]* because like she came here the same day I did, and like, we've become pretty good friends already. 'Cause like, they put us in the same room or whatever, so we've liked talked a little more, and like, it turns out like she's goin' through a lot of the same stuff as me. 'Cause like her dad's not really around either, and she said she gets bullied a lot at school too, so like, she gets it. That's why I put her in my picture 'cause like, it's been good for me to like have a friend here… like one who actually understands, because like, it helps you realize you're not always alone, even though it feels like that sometimes (Participant #15).

The ways in which adolescents demonstrated support for one another by making efforts to cultivate a climate of openness and acceptance, served as a salient feature of psychiatric hospitalization for the majority of youth enrolled in the current study. Recognizing that they were not alone, and having opportunities to connect to other young people with whom they could relate, did not necessarily change the components of hospitalization that participants identified as challenging or costly. However, the influence of peers on the treatment process did seem to profoundly shape the stories shared.

Theme Four: Cultivating Change: Recognizing Personal Transformation through Crisis Stabilization

A unique component of the current study's design was that it allowed participants to share the stories that shaped their entire inpatient experience, from their arrival at the hospital to their discharge from the facility. In conducting interviews with youth at two separate timepoints (i.e., on the days of admission and discharge), young people had opportunities to reflect on their total treatment process, and as they did so, they described significant changes that took place throughout psychiatric hospitalization. All 25 participants enrolled in the current study identified at least one change that occurred as a result of their admission at the hospital, though the majority (n = 15) pinpointed multiple changes. Whether these changes ensued within the first few hours of arriving at the hospital, or they were just beginning to emerge as young people were packing up their belongings to leave, psychiatric hospitalization was a transformative process, during which participants explained, "I grew and learned a lot from being here." (Participant #22).

In response to the prompt, "What has changed since you first arrived here?" (i.e., Question #7, in the Initial Interview Protocol) only 8 adolescents endorsed feeling as though change had occurred during the first few hours that they had been at the hospital. For the one-third who did respond, however, change was most commonly experienced as the result of being removed from the stressor(s) that precipitated their admissions. Participant #14, for instance, shared about the behavioral and affective changes he noticed, once admitted at the hospital and away from the environment at home.

> I know it sounds kind of bad, but I do feel different now that I'm here and not at home. Like, I just feel like I'm calmer and not as angry, and like, I'm still obviously depressed,

> but I just feel like being here just kind of changed like… like my outlook, I guess. I don't really know what else to call it. Like, I'm not as anxious, and I feel like I'm going to get to talk to someone here – like a therapist, or doctor, or someone who will help.

Initial changes, like those identified by Participant #14, were also discussed as participants described how being removed from environments in which the stressors were embedded fostered change, and in some instances, like those shared by Participant #17, promoted a sense of safety.

> It's weird, but like, I actually feel safe here, and that's not really the case when I'm at home. *[Pauses]* Like at home, I'm alone a lot – 'cause like my mom works all the time, and my sister stays with her dad most of the time… So like, it's just me and the cat most of the time, which is fine. But lately, like… that's when my thoughts have been getting like really bad. And like, once the voices in my head start, I feel like I can't turn them off, and a lot of times, that's when I'll just start cutting. But like here, I feel like that's not really going to be an option because there's all these people around, and they already told us about how they take all our stuff away so we can't hurt ourselves. (Participant #17)

Although the changes that youth described during their initial interviews did represent improvements in the way that they felt, the shifts they noted seemed somewhat subtle and superficial. As they progressed through treatment, however, adolescents noted much more considerable changes. When asked the same question in their follow-up interview (i.e., "What has changed since you first arrived here?"), all 25 participants enrolled in the current study endorsed a change. Moreover, the changes that youth described during their follow-up interviews seemed substantial and significant, in that these appeared to be more intrinsic, reflecting deeper introspection that had taken place over the course of treatment.

> I've definitely been tryin' to change like my behaviors, especially like um trying to be open 'cause like it's actually really hard for me to talk about what happened. But the more I thought about it while I was here, like… like the more I realized not bein' open really isn't workin' either. So like, while I was here, I just like decided, okay, I'm gonna' answer their questions (like the staff), and I'm gonna' share in group, and, I'm gonna' talk to the other kids, even though like, I don't open up very well, and it'll be really hard for me to like talk to someone. *[Pauses]* But it's been helpful like knowing that I'm not the only one with like, you know, issues… so. *[Pauses]* And now, I know I gotta' keep being open, like especially if I start havin' thoughts about killing myself again. I'm not gonna' just keep it bottled in. (Participant #18)

A number of adolescents (n = 10), like Participant #18, described changes related to the validation they derived from being more open about their feelings or transparent about their experiences. Whether participants attributed this change to a therapeutic interaction with clinical staff (e.g., "The therapist I saw here was really nice, and she just helped me to like realize I actually could talk about what I was feeling, even though I didn't really want to when I got here." Participant #23), or exchanges shared with other young people at the hospital (e.g., "I had like zero plans to talk to anyone when I first got here, but then, all the other kids were really nice, so after like the first day, I changed my mind and started opening up more." Participant #11), the decision to share, even intimate aspects of their mental health, seemed cathartic for study participants and appeared to evoke change as they reflected on goals following their discharges from the hospital.

> Even though I didn't like it here, like at all, this whole thing did make me realize that I really do need to change the way I treat myself. Like, I'm pretty hard on myself,

physically and emotionally, and I guess I didn't realize how bad it had gotten, until I started opening up about it here…. *[Pauses]* Like, actually saying it out loud and talking about it in group a little; it just like hit me. *[Pauses]* I think once I get back home, I just need to start trying to find like better ways of coping with my feelings because like, I really can't keep doing what I've been doing. (Participant #7)

The decision to demonstrate increased transparency and openness over the course of hospitalization seemed to be due largely in part to the interactions that adolescents shared with clinical staff. This became apparent as participants shared about interactions, during which staff would reveal their own lived experiences, or offer non-judgmental feedback, even when youth would discuss self-harm, sexuality, or substance use. As a result of these conversations, adolescents identified increased ease associated with sharing. Moreover, the transparency that youth described embracing as they progressed through treatment was frequently met with a realization that healthier coping skills were warranted, particularly during the final day of hospitalization.

> Being here showed me that I need to find a better outlet. I need to talk about what I'm going through instead of bottling it up, like I've been doing for months. I don't know. I've been ignoring my mom's requests for me to like go to therapy and stuff, and I feel like it's time. It's time to talk to people and get the help I need. Like whatever… whatever the people here think is necessary for me to make my life not as bad… not as *sad*, I guess. It's not bad. I have a good home life and everything. It's just… my emotions get kinda' crazy sometimes. (Participant #2)

For some (n = 11) changes in the way participants coped with their emotions and

experiences also meant modifying their habits and routines to more closely align with the boundaries to which they had been introduced during psychiatric hospitalization. For instance, rules on the children's unit of the hospital required that no cell phones were permitted, a minimum of two hours each day be devoted to activities deemed as "high quality relaxation" (e.g., outdoor play, art, journaling, meditation, etc.), and youth participate in at least one therapeutic activity (e.g., individual, group, and/or family therapy) per day. Initially, many of these were met with substantial pushback (e.g., "I'm so freakin' pissed they took my phone! It makes no sense, and I don't have any of my contacts' numbers memorized, so how the heck am I supposed to get a hold of anyone during phone time?!" Participant #4). However, over the course of treatment, participants reflected on the ways in which engaging in "high quality relaxation" and therapeutic activities allowed them to self-reflect on their emotions and experiences, without minimizing or masking them.

Likewise, they noted that "playing" with other peers, either outside during free times or indoors with board games and cards, were activities in which they had not regularly engaged, prior to arriving at the hospital. Although at times some of these activities were described as feeling "juvenile", during their interviews, adolescents identified a series of physical, emotional, and social benefits that accompanied play activities. Specifically, they described how in some ways, the face-to-face activities with other peers felt more engaging than the electronic exchanges on various social media platforms to which they had grown accustomed.

> At first, I was just like oh, I wanna' get outta' here, I miss my friends, and like I kept reaching down to look at my phone, but I would be like, oh wait, I don't have it…it sucked. But then like, since no one's got their phones, we all just like talked, and it felt good to get away from it, 'cause I'm kinda' on it 24/7. It just kinda' made me realize I

don't need that 24/7. Like, I don't have to be on my phone all the time. And like, yeah, I missed my friends, but also like, eh… *[Laughs]*, I'll see 'em when I get back. I've kinda' just been thinking about myself in here, and I realized I need to do that more, instead of always like worrying about my friends, or social media, or whatever. (Participant #10)

The reluctance associated with embracing many of the aforementioned rules were echoed by other participants, yet much like Participant #10, as treatment progressed, there was acknowledgement, and in some cases appreciation, of the significance of making changes to promote self-care and healthy boundaries. For example, in relation to participation in daily therapeutic activities, Participant #16 advised, "At first, I thought like talking to someone every day sounded annoying, especially because I have a therapist outside of here, but the more I did it, I realized it was nice to talk about what I was feeling." Likewise, Participant #17 shared, "When I'm bored at home, I usually just sleep, but here, they make you do activities. I didn't really like it at first, but then I started to feel it was better than being depressed at home." Although the time spent away from social media, school, friends, and family was brief (i.e., three days), it was described as a, "break from normal life and like the stress all around me" (Participant #6), which brought about opportunities to reflect on feelings and engage in novel activities to promote self-care and coping skills.

Figure 4. "Personal Growth" (Participant #7's Follow-Up Drawing)

Personal change was portrayed through a variety of different illustrations, with some drawings depicting initial sadness to later happiness, and others representing the transition from feelings of loneliness to a sense of connection at the time of discharge. Yet for participants like #7, the transformation that took place during psychiatric hospitalization was marked by personal growth. Albeit small for some, many adolescents were able to reflect upon the ways in which their inpatient experiences stretched them, revealing insights about who they are and how they can move forward.

> So, this is supposed to be like a ruler, and it's kind of abstract but like, it's supposed to be showing like how I grew a little from when I came here. Like, when I first got here, I was really sad, and I didn't want to like talk to anyone or say anything about myself because I'm just pretty private like that. But like, after being here a couple days, you start to open up, and see like how there are things that like really aren't working. And like look, I'm not saying that like three days here, and I'm a new person or whatever. But I just mean like, you have a lot of time to like think and reflect, so it makes you just like… I don't know, like realize some things about yourself.

Despite the challenges and costs associated with hospitalization, particularly those experienced and described at the onset of treatment, participants did describe feeling as though some degree of personal growth and positive change could be derived from their experiences, many of which have lasting implications for their mental health. From a reduction in the level of stress that they experienced, and improvements in the way that they reported coping with triggers, to an increased openness associated with sharing their emotions, participants in the current study were able to identify how taking time away from the stressors that precipitated

their admissions allowed them to connect and engage with fellow peers and clinical staff in ways that felt meaningful.

Conclusion

The four themes that emerged as 25 participants shared insights related to their subjective experiences during psychiatric hospitalization together tell a story about the salient features involved in crisis stabilization. As young people opened up about the familial conflicts that precipitated many of their suicidal thoughts and ideations, transparently shared the punitive and prohibiting processes that that characterized a number of treatment practices, championed the value of support from fellow peers, and reflected on the changes that were cultivated as the result of each of these experiences, they provided a unique glimpse into psychiatric hospitalization. Taken together, the stories that these themes collectively share can be used as tools to shape future treatment experiences for young people amidst crisis.

CHAPTER FIVE: RESULTS

The current study was aimed at qualitatively investigating adolescents' interpretations of inpatient psychiatric hospitalization, based upon the experiences that precipitated their admissions and their appraisals of the treatment received for crisis stabilization. Through in-depth semi-structured interviews, conducted with youth at two distinct timepoints during their treatment (i.e., on the days of their admission and discharge), this study sought to obtain a deeper understanding of psychiatric hospitalization, from the perspective of those experiencing it. As a result of the insights garnered through the subjective stories shared, meaningful discoveries can be made about suicidality during adolescence, the stigmatizing effects of the processes involved in acute crisis stabilization, and the interpersonal relationships and intrinsic values that may serve to protect against inpatient psychiatric hospitalization. Moreover, by amplifying young people's voices and sharing their stories, we can begin to inform treatment practices in ways that serve to reduce recidivism and promote person-centered care, uniquely tailored to meet adolescents' development needs.

In this chapter, the intimate ideas that participants shared about inpatient treatment are explored through a discussion of the four themes that emerged from the thematic analysis conducted on initial and follow-up interviews and drawing exercises. The implications associated with these themes are also investigated from policy and practice perspectives, and ideas are presented about the ways in which the stories shared can begin to fill a gap in the extant literature on children's mental health. The chapter concludes with an analysis of the study's limitations and consideration of directions for future research in this area.

Theme One: Family Fallout: A Primary Precipitant to Psychiatric Hospitalization

As discussed in Chapter Four, each of the four themes that emerged from the research conducted together tell a story, and for many adolescents, their stories began prior to arriving at the hospital. As they provided their personal perspectives, more than half of the participants in the current study (i.e., n = 16) described circumstances in which their coping capabilities were jeopardized by conflicts with members of their families, which ultimately led to the suicide behaviors that precipitated their hospital admissions. This theme is not only one that was significant for participants in the current research, but it is also an idea that has been widely explored throughout child and adolescent mental health literature, with findings suggesting that family conflict is responsible for increasing symptoms of depression, in addition to suicide behaviors among adolescents (Academy of Pediatrics Committee on Adolescents, 2000; Sigfusdottir et al., 2013; Smith et al., 2019; van Renen & Wild, 2008).

Family Conflict

Although there is limited data about the significance of family conflicts among psychiatrically hospitalized youth specifically, one study by Asarnow (1992), revealed that suicide attempts among adolescents are frequently precipitated by family problems. In her research, which included 55 child psychiatric inpatients, between the ages of 6 to 13 years old, Asarnow (1992) discovered that youth who had made suicide attempts described their families as less cohesive and expressive with high levels of conflict. Likewise, suicide attempts were strongly associated with young people's perceptions of their family environments as stressful and lacking in support (Asarnow, 1992). While the family conflicts discussed during participant interviews in the current study took on many different forms, with root causes ranging from

academic achievement to perceived problematic behaviors, they contributed to a sense of dissatisfaction in the parent-child relationship.

Dissatisfaction in the Parent-Child Relationship. Oftentimes, participants in the current study, who endorsed dissatisfaction in the relationships with their caregivers, described feeling as though their discontentment could not be communicated, for fear that doing so may culminate in additional conflicts. As a result, adolescents seemed to internalize self-deprecating cognitions, which ultimately led to ruminations about suicide. The significance of adolescent dissatisfaction with the relationships at home has been echoed throughout the extant literature, with data suggesting that dissatisfying parent-child relationships, characterized by distrust, feelings of judgment, and lack of support aggravate the risk of suicide by increasing depressive symptoms (Au et al., 2009; Gencoz & Or, 2006; Miller et al., 2012). Similar insights were also observed by van Renen and Wild (2008), who noted that high school students between the ages of 14 to 16 endorsed higher levels of hopelessness and suicidal ideation when there was increased familial conflict, citing ongoing and dissatisfaction in their relationships with parents.

Lack of Conflict Resolution. For adolescents in the current study, stories surrounding family conflict demonstrated an inability of family members to effectively negotiate disagreements and contributed to ongoing adolescent stress. The impact of conflict resolution, particularly within the family system, has been highlighted across adolescent research, with data indicating that when appropriate conflict-resolution and coping skills are not modeled to youth at home, there is a tendency for increased stress and hopelessness, in addition to poorer problem-solving skills (Miller et al., 2012; Smith et al., 2019; van Renen & Wild, 2008). Similarly, adolescents, who reported experiencing high levels of stress, identified conflicts with parents as their major triggers, consequently creating significant increases in depressive symptoms and

suicidal ideation (Kim, 2020; Smith et al., 2019). These findings suggest that interpersonal familial problems might cause more severe psychological distress than other stressors common throughout adolescent development (e.g., individual academic achievement, autonomy, peer acceptance, etc.; Kim, 2020; Smith et al., 2019).

The Impact of Family Functioning on Adolescent Development, Suicide Behaviors, and Psychiatric Hospitalization. Although parents may underestimate the significance of their influence during adolescent development (Hill et al., 2007), previous literature has shown that family dynamics, and in particular the degree of satisfaction within the parent-child relationship, contribute significantly to young people's emotional development (Connor & Rueter, 2006; Kim, 2020; Smith et al., 2019). Viewed through the adolescent development framework, these findings are consistent with Hill's (1980) developmental perspective, which suggests that progression through adolescence is shaped by the contexts in which youth are embedded, one of the most significant of which is the family. As such, when the biological, physical, and emotional changes that adolescents normatively encounter during this stage of development (e.g., navigating environmental demands at school, increasing internal emotional regulation and self-awareness in relationships with peers, and simultaneously becoming more autonomous and less reliant on caregivers; Smith et al., 2019) are compounded with psychological and environmental stressors within the family system, youth become especially vulnerable to psychological crises and suicide behaviors (Blanco et al., 2015; Connor & Rueter, 2006; van Renen & Wild, 2008).

Theme Two: Criminalized, Stigmatized, and Marginalized: The Processes Involved in Crisis Stabilization

In addition to discovering adolescents' perceptions of the events that precipitated their hospitalizations, another research aim in the current study was directed toward exploring youth's evaluations of the processes involved in crisis stabilization. Inviting youth to share their lived experiences and valuing their voices as key stakeholders not only generated new data about adolescent psychiatric hospitalization, but also allowed for the triangulation of existing research. Through the stories that adolescents shared, particularly as they reflected on their initial experiences at the hospital, participants brought to light unique perspectives about psychiatric hospitalization, revealing how efforts directed toward crisis stabilization can feel criminalizing, stigmatizing, and marginalizing.

Criminalization

For 18 participants enrolled in the current study, there was a sense in which some component of hospitalization caused them to feel criminalized, as though they had done something wrong by seeking help. This typically began during the initial interactions with the law enforcement officer responsible for initiating the Baker Act, and based on the stories shared, it appeared to continue throughout transport to the hospital. While the processes involved in involuntary hospitalization for youth demonstrating suicidal behaviors differ from jurisdiction to jurisdiction, law enforcement officers are traditionally the first responders to incidents involving suicide behaviors (Canada et al., 2011; Comartin et al., 2019).

As the most common entry point for psychiatric care, law enforcement officers are responsible for making critical decisions about crisis stabilization (Canada et al., 2011; Dhossche & Ghani, 1998; Neilson et al., 2020). Even when officers demonstrate calm and empathetic

exchanges toward adolescents (e.g., offering appropriate personal space, utilizing a calm voice, and providing youth with options, etc.), however, their very presence has been found to make adolescents feel defensive and uncomfortable, exacerbating existing mental health-related symptoms (Kubiak et al., 2019). For instance, youth transferred to psychiatric hospitals by law enforcement, as compared with other referral sources (e.g., schools, family members, pediatricians, outpatient mental health professionals, etc.), tend to endorse higher levels of stress, due to the criminalizing nature of their police escort to the hospitals (Evans & Boothyroyd, 2002). Likewise, as compared with individuals whose referral sources were family members or other clinical professionals, those who were accompanied to psychiatric hospitals by law enforcement demonstrated higher levels of aggression upon arriving, and they had higher rates of recidivism following hospital discharge (McNiel et al., 1991; Sales, 1991). The criminalizing nature of these initial encounters caused young people in the current study to question their decision to seek help, and consequently contributed to a sense of distrust in the people and procedures associated with psychiatric hospitalization.

Stigmatization

In addition to feeling criminalized by the processes involved in psychiatric hospitalization, during their interviews, participants also spoke about feeling stigmatized. The notion of stigma has been widely discussed throughout children's mental health literature, with a substantial body of research pointing to stigma as one of the most debilitating aspects of being diagnosed with a psychiatric condition (Miller et al., 2006; Moses, 2011b; Moses, 2015; Thoitis, 2011). In the current study, the theme of stigmatization surfaced most frequently among youth who were placed under a Baker Act by law enforcement officials and by those who were transported to the hospital from more public contexts (i.e., at school, or in a neighborhood). For

these 15 participants, there was a sense in which situations that should have been sequestered were instead broadcast publicly and treated as spectacles for onlookers, thus resulting in stigmatization.

Despite how significant such stigmatizing experiences can be for adolescents in particular, considering their preoccupation with social image, peer acceptance, and identity consolidation, only one study has touched on adolescent stigmatization, as it relates to psychiatric hospitalization (i.e., Moses, 2010). In her qualitative analysis of interviews conducted with 56 adolescents, more than half of whom had been previously hospitalized (i.e., n = 31) discovered that a substantial amount of study participants (n = 35) described feeling significant stigmatization from peers (Moses, 2010). Like young people in the current study, the stigma depicted by participants in Moses' (2010) research involved prejudicial attitudes and discriminating behavior from other youth, who had some level of knowledge about participants' psychiatric involvement and mental health needs (Link & Phelan, 2001; Moses, 2010).

Marginalization

It is not surprising that youth who felt criminalized and stigmatized, as a result of their mental health and suicide behaviors, also endorsed a sense of marginalization. As an age cohort, adolescents are already vulnerable to marginalization, given the economic, political, and procedural barriers that prohibit their participation in decision-making processes (Offerdahl et al., 2014). Moreover, like many adolescents, participants in the current study also faced additional layers of marginalization due to their membership in excluded demographic groups (e.g., ethnic minorities, individuals with disabilities, individuals who identify as LGBTQI, those who are economically impoverished, etc.; Narendorf et al., 2018; Offerdahl et al., 2014).

This sense of marginalization was further compounded by prescriptive, rather than person-centered practices, which made 18 participants in the current study feel as though treatment was being imposed on them in ways that failed to consider their individual needs and preferences. Unfortunately, the extant research concedes that the prevailing ideology in inpatient psychiatric services has been predicated on inflexible practices, which may contribute to stigmatization and marginalization (Moses, 2010). While these practices are deemed to be those most efficacious in promoting safety, they seem to ignore the multiple forms of exclusion with which psychiatrically hospitalized youth must contend (Moses, 2010; Sapiro & Ward, 2019).

The Impact of Criminalization, Stigmatization, and Marginalization on Psychiatric Hospitalization. Viewed through the crisis theory lens, which contends that crises can either be experienced as opportunities or emotional hazards, depending on the ways in which they are interpreted (Reynolds & Turner, 2008), the impact of negative experiences during psychiatric hospitalization has significant implications for young people's mental health (Frueh et al., 2005). That is, if adolescents perceive crisis stabilization as criminalizing, stigmatizing, and marginalizing, it is likely that they will lack a sense of resolution at the end of their treatment (Turner & Avison, 1992). As such, they may begin to engage in self-doubt, which has the potential to undermine future coping efforts and perpetuate psychological symptoms and suicide behaviors (Tedrick & Wachter-Morris, 2011).

Theme Three: The Power of Peer Support: Perseverance Derived from Partnering with Fellow Patients

In seeking to understand adolescents' subjective treatment experiences, the current study also investigated participants' perceptions of the costs and benefits associated with psychiatric hospitalization. As youth shared stories about elements of crisis stabilization that they found both

helpful and harmful, one of the most frequently occurring themes was associated with the power of peer support. According to 19 adolescents in the current study, the most beneficial part of psychiatric hospitalization was the validation that they received from connecting and engaging with fellow peers who could relate to their experiences.

Social Connectedness

A widely researched and broadly conceptualized topic across adolescent literature, social connectedness has been found to aid in positive identity formation, and it underscores the importance of belonging to a group, in which one feels cared for and empowered (Czyz et al., 2012; DiFulvio, 2011; Gunn et al., 2018; Long et al., 2020). For adolescents with histories of mental and behavioral health disorders, like those in the current study, however, there are a number of factors that can create difficulties defining a coherent and stable sense of identity (Preyde et al., 2017). This not only shapes young people's transition through adolescence, but also complicates their ability to form connections with peers (Negru-Subtirica & Pop, 2017). Specifically, research has found that young people who reported having fewer numbers of friends, reduced frequency of social contact with same-age peers, and increased levels of social isolation, endorsed higher frequencies of suicidal thoughts and behaviors (DiFulvio, 2011; Groholt et al., 2000; Uchino et al., 1996).

Peer Support in Psychiatric Hospitals

Conversely, when youth, like those in the current study had the opportunity to identify with other individuals, who they believed were "like" them, a sense of validation emerged. Whether the perceived likeness stemmed from similar symptom presentations, or specific experiences within the psychiatric hospital system, adolescent participants described significant benefits associated with the support they derived from engaging with fellow inpatient peers.

Although research with psychiatrically hospitalized adolescents is limited, the few studies that have engaged youth directly remarked on the connections with other peers as an important factor in helping youth reach their inpatient treatment goals (e.g., Biddle et al., 2007; Moses, 2011; Piersma, 1986).

For example, in a study with 80 adolescents, hospitalized for the first time in a psychiatric program and interviewed within one week of discharge, Moses (2011), found that 59% of youth identified their interactions with peers as the most helpful component of hospitalization. Similarly, Piersma's (1986) study, which included both adults and adolescents admitted to a private psychiatric hospital, also found that patients consistently ranked peer contact as one of the top two most important elements of treatment. In a study by Grossoehme and Gerbetz (2004), examining how adolescents experience acute hospitalization in a crisis stabilization unit, peer contact was again distinguished as the most meaningful treatment experience among 105 adolescents surveyed at the time of their discharge from the unit. Taken together, the aforementioned research findings, viewed alongside stories shared in the current study, point to the power of peer support during especially vulnerable times (de Wilde et al., 1992; Kerr et al., 2006; Miller et al., 2015; Moses, 2011).

Theme Four: Cultivating Change: Recognizing Personal Transformation through Crisis Stabilization

Despite the brief nature of psychiatric hospitalization (i.e., three days), as participants in the current study reflected on their treatment, each of them described feeling as though changes had occurred. Whether these changes ensued as a result of the structure and safety that the milieu created, or they were more intrinsic in nature, characterized by improved coping strategies and an increased openness associated with sharing one's feelings, all 25 participants enrolled in the

current study endorsed some degree of growth and transformation. The fact that adolescents were able to derive a sense of purpose from their psychiatric hospital experience, after so many of them described feeling criminalized, stigmatized, and marginalized, draws attention to several salient elements of psychiatric hospitalization and the ways in which they prompted change.

Reduced Stress

For adolescents in the current study, psychiatric hospitalization was accompanied by a reduction in stress and an alleviation of some of the most problematic symptoms that prompted their admission. Even within the first few hours of arriving at the hospital, adolescents described how urges to engage in self-injurious behaviors, in addition to feelings of anger and anxiety, seemed to subside. The opportunities to disengage from high-conflict family systems, separate from school-related stressors, and even disconnect from social media, provided an emotional reprieve for youth, even though many admitted that initially they were reluctant about such changes.

Although the literature on adolescent treatment experiences is very limited, in the few studies that have engaged youth after inpatient treatment, participants presented similar ideas as they reflected on their own experiences during psychiatric hospitalization. For instance, 34% of the 80 adolescent participants in Moses' (2011) study touched upon the ways in which the physical environment at the hospital promoted a sense of calmness which was contrasted with the suicide behaviors, aggression, and substance use that the study's participants endorsed prior to their treatment. Similarly, like young people in the current study, almost one-third of those in Moses' (2011) research reported feeling less stress after having the opportunity to experience a "time out" (p. 128) from everyday pressures. In a review of literature, conducted on child and adolescent perceptions of psychiatric care, Biering (2010) also discovered that the hospital

environment itself was responsible for producing positive changes among patients, particularly when young people perceived the milieu as safe.

Improved Coping Capacities

For young people in the current study, inpatient hospitalization not only presented a reprieve from everyday stressors, but also offered an environment where access to maladaptive coping mechanisms, which many adolescents admitted employing when they experienced stress, were minimized. As such, adolescents were afforded opportunities to explore alternative coping strategies, and as they did so, they described feeling increasingly motivated to continue these, even after their hospital discharge. For adolescents who may be at risk of suicide behaviors or experiencing severe mental health-related symptoms, highlighting adaptive coping strategies that involve physical activity and interpersonal interactions seem to have unique developmental benefits that can provide support and offer healthy emotional outlets (Nijhof et al., 2018).

Much like adolescents in the current study, previous research has shown that young people who engage in self-injurious behaviors tend to use less adaptive coping styles in their management of negative emotions (Guerreiro et al., 2013). Interestingly, however, in a study of 34 adolescents between the ages of 13-17 who were recently psychiatrically hospitalized due suicide behaviors, Czyz and colleagues (2019) found that at 28 days following hospital discharge, adolescents reported engaging in some form of coping behavior on the majority of days (i.e., 86%). Consequently, youth who utilized more coping strategies in general, relative to those who tended to use less, had a significantly lower likelihood of self-injurious behaviors (Czyz et al., 2019).

Increased Openness

For youth in the current study, participation in the aforementioned coping activities provided opportunities to engage with staff and other inpatient peers, both of which led to increased openness. During their interviews, some youth reported reluctance associated with sharing about their emotions and experiences, particularly with adult clinical staff and fellow peers they that they had never met. Yet as they opened up more over the course of treatment, 10 participants in the current study described deriving a sense of validation from sharing.

While the limited literature on adolescent psychiatric hospitalization has not explicitly addressed the significance of increased openness, one study conducted by Biering and Jensen (2011), with 14 adolescents at a psychiatric ward in Iceland, did reveal that participants identified opportunities for self-expression as key treatment components. In their reflections about elements of hospitalization that they found helpful, participants shared satisfaction associated with the encouragement they received to openly share their feelings with both peers and hospital staff. Moreover, as they described developing more trusted relationships with peers and staff throughout the course of their stays, there was a greater comfort associated with confiding in others, making the entire process feel safer (Biering & Jensen, 2011).

In addition to the notion of self-expression, several studies have consistently shown that positive interactions with staff can transform treatment by encouraging young people's engagement (Marriage et al, 2001; Moses, 2011; Reavey et al., 2017). For instance, Reavey and colleagues (2017) discovered that when they reflected on their hospital experiences, at 6-months post-discharge, adolescent participants identified positive interactions with staff, during which staff members would engage in non-scheduled or informal activities (e.g., playing games or holding 'ordinary' conversations), as opportunities to build trusting bonds. As a result of such

interfaces, adolescents felt cared for, heard, and accepted (Reavet et al., 2017). Likewise, Moses' (2011) research on the experiences of recently hospitalized youth also revealed that interpersonal interactions with staff and the opportunity to learn specific coping strategies from them were key helpful ingredients which enabled adolescents to feel more comfortable and open to treatment.

Although inpatient psychiatric hospitalization is fraught with difficulties, findings like these prove that transformative change can occur in the ways in which adolescents share about and cope with their stress, particularly when they perceive the environment and staff as safe and supportive (Moses, 2011). The fact that youth can experience meaningful changes in such a brief amount of time indicates that there are positive treatment components associated with psychiatric hospitalization. Yet, it also points to practice reforms needed to ensure that growth is maximized.

Clinical Implications and Considerations

The positive changes that participants identified during psychiatric hospitalization marks a starting point from which to begin building clinical interventions that are tailored to meet adolescents' unique developmental needs. However, the subjective experiences shared also raised awareness of treatment gaps that exist. Through heightened clinical attentiveness, community collaboration, and system reforms, mental health service delivery for adolescents can be improved (Brent et al., 2020; Michelson & Bhugra, 2012).

Early Intervention and Advocacy

By the time most adolescents present to health services, they are already experiencing severe psychological distress (Ospina-Pinillos et al., 2018). As such, there is a need for integrated multidisciplinary services for youth, focused on early intervention and advocacy (Platell et al., 2020). One such way of addressing this treatment gap is through the expansion of mobile crisis response teams. Uniquely equipped to provide highly accessible services for youth,

mobile crisis response teams are comprised of clinical professionals and law enforcement officers, who collaborate to offer on-site crisis management to young people and their families (Lamb et al., 2002; Neilson et al., 2020; Vanderploeg et al., 2016). In addition to community wide partnerships, advocating for legislation to expand mental health funding is a way of promoting educational services and training programs aimed at enhancing the clinical competence of mental health providers and law enforcement professionals, who frequently engage with adolescents in crisis (Comtois & Linehan, 2005; Gonzalez et al., 2020).

Hospital Interventions

In the event that youth's mental health needs warrant crisis stabilization, insights garnered from adolescents' hospital experiences can be used to guide and inspire quality improvement in psychiatric care (Biering & Jensen, 2011). For instance, since staff's acceptance and empathy are viewed favorably by adolescents, training efforts should be directed toward fostering these qualities in clinical professionals (Biering, 2010; Marriage et al., 2001; Moses, 2010). Likewise, given that peer support was identified as a transformative treatment component, embedding more opportunities for youth to connect may help to promote treatment engagement (Moses, 2010). Expanding the availability of peer support programming may also promote hope for recovery and a sense of social inclusion, as youth engage with young people who have shared experiences (Greden et al., 2010; Simmons et al., 2020; Solomon, 2004).

Rehospitalization Prevention

For youth who are psychiatrically hospitalized, the threat of suicide behavior after discharge is extraordinarily high, putting adolescents at risk for rehospitalization (Brent et al., 2013; Kennard et al., 2018). As such, targeted interventions, like those offered through suicide-focused Intensive Outpatient Programs (IOPs) can begin to address this critical gap and promote

continuity in clinical care (Kennard et al., 2018). IOPs provide concentrated therapeutic services, in addition to medication management at higher frequencies than traditional outpatient programs (Brent et al., 2020; Fontanella et al., 2020), and from a cost-based perspective, the average rate of a typical 5-week course in IOP, equates to the cost of 4 psychiatric inpatient days (Cook et al., 2014). By continuing to use adolescents' feedback to develop of a continuum of crisis-oriented services, bolstered by developmentally appropriate evidence-based practices, the prevalence of psychiatric hospitalization may be reduced. In the event that crises do emerge, however, ensuring that the processes and procedures involved in psychiatric hospitalization are person-centered can help adolescents to engage in treatment that feels meaningful (Kazdin & Rabbitt, 2013; Kennard et al., 2018; Vanderploeg et al., 2016).

Future Research Directions

While findings from the current study began to bridge a gap in the extant child and mental health literature, by uncovering several salient experiences of psychiatric hospitalization, they also revealed the need for additional research. For instance, future studies aimed at examining the relationships between symptom severity, family factors, and perceived peer support, should be explored within other cultural and global contexts to aid in the identification of risk and protective factors among adolescents. Likewise, studies that investigate the implementation and efficacy of developmentally appropriate treatment interventions, designed and tailored to meet adolescents' unique needs, could reveal important insights about ways of engaging and retaining young people in treatment to avoid re-hospitalization. Finally, research that considers ways of modifying the current policies, procedures, and practices involved in psychiatric hospitalization, toward more community collaboration and child-centered care, may

promote a type of crisis stabilization whereby individual needs, feelings, and preferences shape the types of treatment provided.

To some extent, the aforementioned recommendations for research have been considered, yet the data remains limited. This is likely due to the fact that the majority of available information associated with adolescent psychiatric hospitalization has been gathered through generic survey questionnaires, or from the assumptions provided by adult clinicians and caregivers about adolescents' experiences. While each of these have established a foundation for our current knowledgebase, continuing to rely on these secondary sources will encumber progress in psychiatric hospitalization. Instead, to truly move the field of adolescent mental health forward, future research must involve youth. As findings from the current study suggest, adolescents can offer rich insights about the practices involved in psychiatric hospitalization that could only be gathered from individuals who are direct service recipients.

Limitations

While this study contributes new insights to our current understanding of the experiences of psychiatrically hospitalized adolescents, its results should be considered within the context of limitations, specifically related to the sample. In the current study, the sample was elicited from one psychiatric hospital, located in a metropolitan area of a southern U.S. state. The young people who are served at this particular hospital primarily come from the surrounding area, and since this region may differ socioeconomically from other areas, it is not known if the adolescents who participated were representative of American youth in general. Furthermore, while the sample was representative of the overall adolescent inpatient population at the psychiatric hospital where the research was conducted, based on a 2017 inpatient census of patients, the stories captured represent a small and specific sample. As such, future research, in

which inclusion criteria is broadened to include young people in foster care or group home placement, in addition to those whose caregivers are not their biological parents, may offer valuable insights, especially considering the significant role of the family system in adolescents' suicide behaviors. Since the generalizability of findings from the current study is limited by the sample utilized, future studies should also include larger samples, comprised of young people hospitalized at several different facilities, to understand how experiences might vary based on individual and contextual characteristics.

Conclusion

For adolescents diagnosed with mental illnesses, demonstrating suicide behaviors, and endorsing a sense of marginalization and stigmatization from family members, peers, and community members, a chance to be heard and to share their stories in needed. Yet as considerations are made regarding how to best support adolescents, throughout communities and within treatment facilities, it is important to consider what we as providers, researchers, and most importantly, advocates can do to encourage and empower young people. Recognizing the value that young people placed on connections with others and reflecting on their descriptions about meaningful interpersonal relationships fostering growth and change, we are reminded of the importance of investing in young people. While there is much that remains to be understood about the ways in which psychiatrically hospitalized youth experience the events that precipitated their admissions, in addition to processes involved in crisis stabilization, as the current study demonstrated, there is a great deal that can be learned from the subjective stories that young people share about their lived experiences.

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APPENDICES

Appendix A: IRB Study Approval Form

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX(813)974-7091

9/27/2017

Jessica Rice
Educational and Psychological Studies
4202 E. Fowler Ave.
Tampa, FL 33620

RE: **Full Board Approval for Initial Review**
IRB#: Pro00031271
Title: SHARING THEIR STORIES: A QUALITATIVE INVESTIGATION OF ADOLESCENTS' INPATIENT EXPERIENCES DURING PSYCHIATRIC HOSPITALIZATION

Study Approval Period: 8/18/2017 to 8/18/2018

Dear Mrs. Rice:

On 8/18/2017, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
Pro00031271- Protocol Document V 1.0 (08.31.17).docx

Consent/Assent Document(s)*:
Pro #00031271- Parental Consent Form V1 (8.31.17).docx.pdf
Pro#00031271- Child Assent to Participate (8.31.17).docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

Research Involving Children as Subjects: 45 CFR §46.405
This research involving children as participants was approved under 45 CFR 46.405: Research involving more than minimal risk to children but presenting the prospect of direct benefit to the individual subjects.

Requirements for permission by parents or guardians: 45 CFR 46.408
Permission of one parent is sufficient.

Assent is required of all children.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted

to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board

Appendix B: Recruitment Brochure

RESEARCH STUDY

Sharing Their Stories:

A Qualitative Investigation of Adolescents' Inpatient Experiences During Psychiatric Hospitalization

USF Study ID: Pro#00031271

Children **between the ages of 13 to 17**, admitted to the CCSU for treatment, are invited to participate in a research study.

The study seeks to understand children's treatment experiences through interviews and artwork, collected at the beginning and end of treatment.

Potential Benefits of Study Participation:

- Insight and self-understanding
- Knowledge about ways of improving future psychiatric hospital treatment

Note: No compensation will be provided.

Participation Includes:

- Two 5-minute Mini-Mental State Examination to assess cognitive functioning
- Two 45-minute interviews (at admission and discharge)
- Two 15-minute drawing exercise, after each interview
- Answering interview questions about hospitalization
- Total participant time commitment of 2 hours

For additional information about the study, please request to speak with investigator conducting research, Jessica Rice.
Email: jkemph@mail.usf.edu Phone: (813)272-2882

Appendix C: Informed Consent Document

Parental Permission for Children to Participate in Research Involving Greater Than Minimal Risk and Authorization to Collect, Use and Share His/Her Health Information

Information for parents to consider before allowing your child to take part in this research study

Pro # 00031271

The following information is being presented to help you and your child decide whether or not he/she wishes to be a part of a research study. Please read this information carefully. If you have any questions or if you do not understand the information, we encourage you to ask the researcher.

We are asking you to allow your child to take part in a research study called:

Sharing Their Stories: A Qualitative Investigation of Adolescents' Inpatient Experiences During Psychiatric Hospitalization

The person who is in charge of this research study is Jessica Rice. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. Jessica is being guided in this research by Dr. Tony Tan.

The research will be conducted at Gracepoint Wellness' Children's Crisis Stabilization Unit.

Purpose of study:

This study seeks to understand how youth, who are admitted to inpatient psychiatric hospitals, experience their treatment. By interviewing participants about the circumstances leading up to their hospital admissions, and their interpretations of the treatment that they are receiving while hospitalized, this research explores psychiatric hospitalization from the perspectives of those experiencing it.

Why is your child being asked to take part?

We are asking your child to take part in this research study because he/she is between the ages of 13-17 and currently receiving treatment at a psychiatric hospital.

Study Procedures:

If your child takes part in this study, s/he will be asked to:

- Complete a 5-minute Mini-Mental State Examination (MMSE), before each interview, to ensure that s/he is stable for participation in research. (*Note: If a participant does not meet the minimum score on the MMSE, s/he will not proceed with the remaining study procedures.*)
- Participate in two separate 45-minute interviews (i.e., one at the beginning of treatment, and one on the day of discharge).
- Answer interview questions related to the events leading up to his/her hospitalization, the treatment that s/he receives throughout hospitalization, and his/her thoughts about discharge.
- Engage in a 15-minute drawing exercise at the end of each interview, and answer several questions related to the drawing.
- Commit approximately two hours of time, during his/her hospital admission, to participation in the study, which will take place in a private office on the Children's Crisis Stabilization Unit.
- Before we start each interview, I will ask for permission to audio record the conversation, as a way of helping me to remember what we discuss. The audio recording component is completely optional. Each interview will last approximately 45 minutes.
- Provide permission for each interview to be audio recorded. *(Note: Only the research team will have access to the tapes, and information contained on the audio recordings will not be identifiable. Tapes will be maintained five years after the Final Report is submitted to the IRB, after which time, they will be permanently deleted from the recording device.)*

Total Number of Participants

About 25 individuals will take part in this study.

Alternatives / Voluntary Participation / Withdrawal

If you decide not to let your child take part in this study, that is okay. Instead of being in this research study your child can choose not to participate. You should only let your child take part in this study if you want to. You or child should not feel that there is any pressure to take part in the study to please the study investigator or the research staff.

If you decide not to let your child take part:

- Your child will not be in trouble or lose any rights s/he would normally have here.
- Your child will still get the same inpatient treatment services s/he would normally have.
- The length of your child's treatment here will not be affected.

You can decide after signing this informed consent form that you no longer want your child to take part in this study. We will keep you informed of any new developments which might affect your willingness to allow your child to continue to participate in the study. However, you can decide you want your child to stop taking part in the study for any reason at any time. If you decide you want your child to stop taking part in the study, tell the study staff as soon as you can.

Benefits

Involvement in studies, like this one, have been linked with positive participant experiences (e.g., feeling better, gaining insight and self-understanding). Findings from this research may also contribute to knowledge about ways of improving future inpatient psychiatric hospital treatment and services provided to youth.

Risks or Discomfort

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Participation in this study has the potential to cause psychological discomfort to participants. For instance, participants may feel uncomfortable if are asked questions about a sensitive topic, a disturbing memory, or a personal traumatic event. They may also experience mental fatigue, embarrassment, guilt, or frustration during the interview process. There is a risk of breach of confidentiality, during which hospital personnel will be notified, if participants disclose information that puts them at risk to themselves or others around them (e.g. self-harm, abuse, neglect, etc.), due to mandatory reporting.

Although these risks and discomforts are usually temporary, participants may withdraw from the study at any time. If any question(s) asked during the interview or drawing exercise cause feelings of discomfort, participants may stop at any time. Hospital staff will be available to participants if discomforts persist, or if they would like to discuss emotions associated with participation in the study.

Compensation

Your child will receive no payment or other compensation for taking part in this study.

Costs

It will not cost you anything to let your child take part in the study.

Privacy and Confidentiality

We will keep your child's study records private and confidential. Certain people may need to see your child's study records. Anyone who looks at your child's records must keep them confidential. These individuals include:

- The research team, including the Principal Investigator (i.e., Jessica Rice), the secondary study coordinator (i.e., Dr. Tony Tan), the independent monitor (i.e., Dr. Kathleen Moore), and all other research staff.
- Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.
- Any agency of the federal, state, or local government that regulates this research.
- The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.

While we will keep information confidential to the extent provided by law, we cannot guarantee it will not be disclosed pursuant to court subpoena.

We may publish what we learn from this study. If we do, we will not include your child's name. We will not publish anything that would let people know who your child is.

You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, contact Jessica Rice at (813) 272-2882 or contact by email at jkemph@mail.usf.edu.

If you have questions about your child's rights, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

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Authorization to Use and Disclose Protected Health Information (HIPAA Language)

The federal privacy regulations of the Health Insurance Portability & Accountability Act (HIPAA) protect your child's identifiable health information. By signing this form, you are permitting the University of South Florida to use your child's health information for research purposes. You are also allowing us to share your child's health information with individuals or organizations other than USF who are also involved in the research and listed below.

The following groups of people may also be able to see your child's health information and may use that information to conduct this research:

- The medical staff that takes care of your child and those who are part of this research study;
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance and the USF Health Office of Clinical Research.
- Data Safety Monitoring Boards or others who monitor the data and safety of the study;
- There may be other people and/or organizations who may be given access to your personal health information, including Gracepoint Wellness staff.

Anyone listed above may use consultants in this research study, and may share your child's information with them. If you have questions about who they are, you should ask the study team. Individuals who receive your child's health information for this research study may not be required by the HIPAA Privacy Rule to protect it and may share your child's information with others without your permission. They can only do so if permitted by law. If your information is shared, it may no longer be protected by the HIPAA Privacy Rule.

By signing this form, you are giving your permission to use and/or share your child's health information as described in this document. As part of this research, USF may collect, use, and share the following information

- Your child's research record
- All of your child's past, current or future medical and other health records held by USF, Gracepoint Wellness, other health care providers or any other site affiliated with this study as they relate to this research project. This includes, but is not limited to records related to HIV/AIDs, mental health, substance abuse, and/or genetic information.

You can refuse to sign this form. If you do not sign this form your child will not be able to take part in this research study. However, your child's care outside of this study and benefits will not change. Your authorization to use your child's health information will not expire unless you revoke (withdraw) it in writing. You can revoke this form at any time by sending a letter clearly stating that you wish to withdraw your authorization to use your child's health information in the research. If you revoke your permission:

- Your child will no longer be a participant in this research study;
- We will stop collecting new information about your child;
- We will use the information collected prior to the revocation of your authorization. This information may already have been used or shared with others, or we may need it to complete and protect the validity of the research; and
- Staff may need to follow-up with your child if there is a medical reason to do so.

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To revoke this form, please write to:

Jessica Rice
For IRB Study #00031271
College of Education
Department of Educational and Psychological Studies
4202 East Fowler Avenue
Tampa, FL 33620

While we are conducting the research study, we cannot let you see or copy the research information we have about your child. After the research is completed, you have a right to see the information about your child, as allowed by USF policies. You will receive a signed copy of this form.

Consent for My Child to Participate in Research Involving Greater Than Minimal Risk & Authorization to Collect, Use & Share His/Her Health Information for Research

I freely give my consent to let my child take part in this study. I understand that by signing this form I am agreeing to let my child take part in research. I have received a copy of this form to take with me.

_______________________________________ ______________
Signature of Parent of the Child Taking Part in Study Date

____
Printed Name of Parent of the Child Taking Part in Study

Permission to Audio Record

I provide permission for the person conducting this study to audio record the conversation with my child.

______________Yes ______________No ______________
Initial of Parent of the Child Taking Part in Study Date

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect from their child's participation. I confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in their primary language. This research subject has provided legally effective informed consent.

_______________________________________ ______________
Signature of Person Obtaining Informed Consent Date

____
Printed Name of Person Obtaining Informed Consent

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Appendix D: Child Assent Form

Assent of Children to Participate in Research

Pro #00031271

Title of study: ***Sharing Their Stories: A Qualitative Investigation of Adolescents' Inpatient Experiences During Psychiatric Hospitalization***

Why am I being asked to take part in this research?

You are being asked to take part in a research study about the experiences of youth in inpatient psychiatric hospitals. You are being asked to take part in this research study because you are between the ages of 13 and 17, and receiving treatment at a psychiatric hospital. If you take part in this study, you will be one of about twenty-five people at this site.

Who is doing this study?

The person in charge of this study is Jessica Rice. She is being guided in this research by Dr. Tan. However, other research staff may be involved and can act on behalf of the person in charge.

What is the purpose of this study?

By doing this study, we hope to learn how youth, at inpatient psychiatric hospitals, experience their treatment, the evets leading up to their hospital admissions, and their feelings about the treatment they are receiving.

Where is the study going to take place and how long will it last?

The study will be take place at the Children's Crisis Stabilization Unit at Gracepoint Wellness. You will be asked to participate in 2 visits which will take about 1 hour each. The total amount of time you will be asked to volunteer for this study is 2 hours over the course of your hospital admission.

What will you be asked to do?

- Complete a 5-minute Mini-Mental State Examination (MMSE), before each interview.
- After successful completion of the MMSE, you will be asked to participate in two separate interviews, the first interview will take place at the beginning of your treatment, and the second one will be on the day of discharge.
- During each interview, you will be asked you questions about the events leading up to your hospitalization, the treatment that you receive during your hospitalization, and your thoughts about discharge. There are no right or wrong answers to these questions, and your answers will not affect your hospitalization.
- Before the start of each interview, you will be asked permission to audio record the conversation, as a way of helping to remember what was discuss. The audio recording is completely optional. Each interview will last approximately 45 minutes.

- At the end of the interviews, you will also be asked you to draw a picture that describes your treatment. Once you have finished, you will be asked questions about your picture. You will not be evaluated on artistic ability. The drawing exercise will take about 15 minutes.
- Both of the interviews will take place in one of the offices here.
- At the beginning and end of each interview, you can ask questions or discuss any concerns.
- By volunteering to participate in this study, you are helping us understand the experiences of psychiatrically hospitalized youth.

What things might happen if you participate?

Although we have made every effort to try and make sure this doesn't happen, you may find that some questions we ask upset you. If so, we will tell your parent and the hospital staff, who may be able to help you with these feelings. We will also notify your parent and the hospital staff if you share any information that puts you at risk to yourself or others around you (e.g. self-harm, abuse, neglect, etc.), due to mandatory reporting procedures.

Is there benefit to me for participating?

People who have been involved in studies like this one have described positive experiences (e.g., feeling better, feeling more open, and feeling that their opinions are being heard). Findings from this research may also help us to improve future inpatient psychiatric hospital services for youth.

What other choices do I have if I do not participate?

You do not have to participate in this research study.

Do I have to take part in this study?

You should talk with your parent(s) and other people you trust about taking part in this research study. If you do not want to take part in the study, that is your decision. You should take part in this study because you want to volunteer.

Will I receive any compensation for taking part in this study?

You will not receive any compensation for taking part in this study.

Who will see the information about me?

Your information will be added to the information from other people taking part in the study so no one will know who you are.

Can I change my mind and quit?

If you decide to take part in the study you still have the right to change your mind later. No one will think badly of you if you decide to stop participating. Also, the people who are running this study may need for you to stop. If this happens, they will tell you when to stop and why.

What if I have questions?

You can ask questions about this study at any time. You can talk with your parent(s) or other adults you trust about this study. You can talk with Jessica Rice, the person who is asking you to volunteer by calling (813) 272-2882. If you think of other questions later, you can ask them. If you have questions about your rights as a research participant you can also call the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

Assent to Participate

I understand what the person conducting this study is asking me to do. I have thought about this and agree to take part in this study. I have been given a copy of this form.

____ _______________
Signature of person agreeing to take part in the study Date

____ _______________
Printed name of person agreeing to take part in the study Date

____ _______________
Signature of person providing information (assent) to subject Date

____ _______________
Printed name of person providing information (assent) to subject Date

Permission to Audio Record

I provide permission for the person conducting this study to audio record our conversation.

_____________Yes _______________ No _______________
Initial of person participating in the study. Date

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Appendix E: Mini-Mental State Examination

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APPENDIX

Mini-Mental State Examination

Orientation		**Score**	**Points**
1. What is the	year? season? date? day? month?	______ ______ ______ ______ ______	1 1 1 1 1
2. Where are we?	Country State or territory Town or city Hospital or suburb Floor or address	______ ______ ______ ______ ______	1 1 1 1 1

Registration

3. Name three objects, taking one second to say each. Then ask the patient all three after you have said them. (Tree, clock, boat). Give one point for each correct answer. Repeat the answers until the patient learns all three.		3

Attention and Calculation

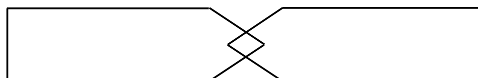
4. Serial sevens. Give one point for each correct answer. Stop after five answers		5
5. Spell WORLD backwards		5

Recall

6. Ask for the names of three objects learned in Q.3. Give one point for each correct answer		3

Language

7. Point to a pencil and a watch. Have the patient name them as you point.		2
8. Have the patient repeat "No ifs, ands or buts"		1
9. Have the patient follow a three-stage command. "Take a piece of paper in your right hand. Fold the paper in half. Put the paper on the floor"		3
10. Have the patient read and obey the following: "CLOSE YOUR EYES". (Write it in large letters).		1
11. Have the patient write a sentence of his or her choice. (The sentence should contain a subject and an object, and should make sense. Ignore spelling errors when scoring).		1
12. Have the patient copy the design printed below. (Give one point if all sides and angles are preserved and if the intersecting sides form diamond shape).		1
Total		**35**



Appendix F: Initial Interview and Drawing Exercise Protocol

Pro #00031271 INITIAL INTERVIEW AND DRAWING EXERCISE PROTOCOL

INITIAL INTERVIEW & DRAWING EXERCISE PROTOCOL
Introduction Overview
• Expression of appreciation for participation • General purpose of the study • Aims of the interview and expected duration • Why the participant's cooperation is important • What will happen with the collected information and potential benefits • Questions
Introductory Script
Thank you for your willingness to participate in this study! As we discussed earlier, this study seeks to explore how youth, who are admitted to inpatient psychiatric hospitals, experience their treatment. By sharing about the circumstances leading up to your hospital admission, and your interpretations of the treatment that you are receiving while here, this research is directed towards developing an understanding of hospitalization from patients' perspectives. *Our meeting today will last approximately one hour (i.e., approximately 45-minutes for the interview and 15-minutes for the drawing exercise). During the interview portion, I will be asking you a little bit about yourself, the events leading up to your hospitalization, what your experiences have been like here so far, and what you feel has been helpful or unhelpful (e.g., therapy, talking to other peers, coping skills, etc.). After the interview, we will begin the drawing exercise, during which you will be asked to illustrate a picture that represents your hospital experiences so far. Once you have completed the drawing, I will ask you to describe your drawing and what it represents.* [Review Assent Form] *Earlier today, I went over the consent/assent forms with you and your caregiver(s). The completed form indicates that I have your permission (or not) to audio record our conversation. Are you still ok with me recording (or not) our conversation today? ___Yes ___No* If yes: *Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off of the record.* If no: *Thank you for letting me know. I will only take notes of our conversation.* *Before we begin, do you have any questions?* [Discuss questions] *If any questions arise at any point in this study, please feel free to ask them at any time. I would be more than happy to answer your questions.*
Opening Questions Overview

• Begin to establish rapport through relatively neutral questions
• Elicit general and non-intrusive information about patients' backgrounds
• Ask approximately 3-5 opening questions
• Sample Opening Question:
  ○ Based on the information indicated in your chart, you arrived on ________. Is this the first time you've been here?
  If yes: Go to next question. If no: When were you last here?

Transition Questions Overview
• Link the introductory questions to key questions • Ask approximately 1-2 transition questions • Sample Transition Question: ○ Your chart indicates that you were sent to a medical hospital before coming here, is that correct?

If yes: What was that like? If no: Where were you before you came here?

Key Questions Overview

- Related to the research questions and purpose of the study
- Ask approximately 8 key questions

Key Interview Questions

1. How would you describe the day that you arrived here?
2. What was it like coming here?
3. Why do you think you were brought here?
4. How would you describe some of the initial thoughts or feelings that you had when you first walked in?
5. What has been the most stressful part about being here?
6. What has been the most helpful part of being here?
7. What types of things have changed since you first arrived here?
8. How would you describe this place to someone who has never been before and does not know what a psychiatric hospital is?

Closing Interview Questions Overview

- Simple to answer
- Provide opportunity for closure
- Ask approximately 1-2 closing questions
- Sample Closing Question:
    - *Before we finish up the interview, is there something about the events leading up to your admission or your treatment experiences that you think are important that we have not yet discussed?*

Drawing Exercise Overview

- General purpose of the drawing exercise
- Aims of the exercise and expected duration
- Questions related to the exercise
- Provision of materials (e.g., paper and crayons)
- Drawing Exercise Prompt:
    - *Please draw a picture that describes what this psychiatric hospital experience has been like for you. If possible, try not to use words. You are not going to be evaluated on your artistic ability. 'Stick people,' for example, are fine.*

Drawing Exercise Questions Overview

- Interpretation of drawing
- Feelings in response to drawing as part of the research process
- Explanation of how the drawing represents hospital experience
- Sample Drawing Question
    - *How does this drawing compare to the description that you provided of your hospital experience during the interview?*

Closing Overview

- Refer to the introductory script
- Patient is reminded of subsequent follow-up interview and drawing exercise

Appendix G: Follow-Up Interview and Drawing Exercise Protocol

Pro#00031271 FOLLOW-UP INTERVIEW AND DRAWING EXERCISE PROTOCOL

FOLLOW-UP INTERVIEW & DRAWING EXERCISE PROTOCOL
Introduction Overview
• Expression of appreciation for participation • Review of general purpose of the study • Review of aims of the interview and expected duration • Review of why the participant's cooperation is important • Review of what will happen with the collected information and potential benefits • Questions
Introductory Script
Thank you for your willingness to participate in the second interview of this study! As we discussed last time, this study seeks to understand how youth, who are admitted to inpatient psychiatric hospitals, experience their treatment. By sharing about the circumstances leading up to your hospital admission, and your interpretations of the treatment that you are receiving while here, this research is directed toward developing an understanding of hospitalization from patients' perspectives. *Like last time, our meeting today will last approximately one hour, during which I will ask you about the course of your treatment, any parts of your hospitalization that were particularly significant, and how you interpret the overall experience that you have had here. After the interview, we will begin another drawing exercise, during which you can choose to add to the drawing that you illustrated last time, or create a new one to represent your hospital experiences. Once you have completed the drawing, I will again ask you questions about your drawing and what it represents.* [Review Assent Form] *As we discussed during our first meeting, the completed form indicates that I have your permission (or not) to audio record our conversation. Are you still ok with me recording (or not) our conversation today?* ___*Yes* ___*No* If yes: *Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off of the record.* If no: *Thank you for letting me know. I will only take notes of our conversation.* *Before we begin the interview, do you have any questions?* [Discuss questions] *If any questions arise at any point in this study, please feel free to ask them at any time. I would be more than happy to answer your questions.*
Opening Questions Overview

• Begin to reestablish rapport through relatively neutral questions
• Elicit general and non-intrusive information about patients' progress, since the last interview
• Ask approximately 1-3 opening questions
• Sample Opening Question:
    ○ Based on the information in your chart, it looks like you are scheduled for discharge today. Is that correct?
    If yes: Go to next question. If no: Do you know how long you will be staying?

Transition Questions Overview
• Link the introductory questions to key questions • Ask approximately 1-2 transition questions • Sample Transition Question: ○ How are you feeling about leaving?
Key Questions Overview