To The Graduate School:

The members of the Committee approve the thesis of Joshua M. Hamilton as presented on May 8, 2003.

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Quality of life and ease of reintegration into the family and the community are particularly important for the adolescent or young adult with mental illness. Such rehabilitation has long been focused on empowerment, partly by developing insight into one’s illness. Current applications of insight assessment appear to be limited to inpatient assessment rather than fostering its development. Further, no single assessment protocol adequately addresses all accepted dimensions of insight. These tools are written for use by a trained observer rather than as a self-reflection tool. The clinical language of the existing tools precludes their usefulness for self-assessment by adolescent patients who, by virtue of their stage of cognitive development, are a unique group with regard to insight indicators. The purpose of this qualitative study is to explore the experience and language used by adolescents with mental illness related to self-assessment of insight development. Individual interviews with adolescents at a private rural outpatient psychiatric practice were conducted, and the resulting qualitative data were coded and analyzed. Themes specific to the adolescent population with regard to the symptomatic, functional, and resource levels of insight were identified. Based on these themes, the researcher proposes an “Adolescent Insight Development Model” with subthemes related to labeling of problems and symptoms, goal-directed behaviors, functional role performance, role of medications, and relapse prevention. Analysis of this pilot data suggests further inquiry and eventual development of an insight self-assessment tool.
EMPOWERING YOUNG ADULTS:
THE ADOLESCENT INSIGHT DEVELOPMENT MODEL

by
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and The Graduate School of the University of Wyoming
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My love and heartfelt thanks to my partner and my family who, despite my intrinsically “challenging” nature in times of stress, remained supportive and unconditionally accepting of me.
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Chapter I

Introduction

Little is known about insight development and assessment in the adolescent population. Given the potential for improved understanding of young adult clients leading to enhanced assessment and delivery of nursing care, a study was conducted to better understand the lived experience of this patient population.

Statement of the Problem

Quality of life is a critical goal of treatment for chronically mentally ill populations. Quality of life and ease of reintegration into the family and the community are particularly important for the adolescent or young adult suffering from psychiatric illness. Youngsters are more prone toward a fixed orientation to life, which can have a lasting effect on future development (Lau & Lau, 1996). In relation to this goal, deinstitutionalization and community care has largely failed the chronically mentally ill. According to Rosenfield (1992), “The seriously mentally ill often receive only minimal services in the community” (p. 299). Up to 50 percent return to psychiatric hospitals within one year of their last hospital discharge (Anthony, Cohen, & Vitalo, 1978; Lamb, 1981).

In keeping with the national trend toward community-based mental health care, rehabilitation for clients who have been diagnosed with chronic mental illness focuses increasingly on empowerment, a “developing but inconsistently-defined concept” (Segal, Silverman, & Temkin, 1995, p. 215). Research results show that an empowerment
approach is “significantly related to overall quality of life” (Rosenfield, 1992, p. 299). A growing segment of research has focused on the empowerment process, including the development of client insight (another comparatively nebulous construct) throughout reintegration into the community. Clinicians and researchers have undertaken the task of developing a number of definitions and views on the utility of client insight; however, current applications appear to be limited to the inpatient assessment of insight rather than fostering its development. There is little dispute, however, that insight and empowerment may be viewed as personal resources that may aid in coping with effects of stress (Pearlin & Schooler, 1978) and that persons with insight demonstrate improved medication compliance (Baier & Murray, 1999). Existing works on the subject are likewise limited to insight assessment as it relates to the adult client suffering from profound or severe mental illness (i.e. schizophrenia).

Despite the apparent interest and relative abundance of published research with regard to client empowerment and insight, research has yet to demonstrate the actual utility of insight to the young adult client struggling to reintegrate into society. No single assessment protocol could be located that effectively addresses all accepted dimensions of insight. Similarly, the objective nature and clinical language of existing insight assessment tools appear to preclude their usefulness to a client charged with daily functioning through empowerment.

Of particular interest to this writer is the older adolescent or young adult working to transition back into the home or community following an inpatient hospitalization for psychiatric or psychobehavioral illness. Literature which describes indicators of functioning and insight development for this particular population with direct relevance
to empowerment is lacking. An investigation of the related language and unique experience of this patient demographic (related to insight and functioning) is a necessary first step to assessing, understanding, and planning interventions to aid in reintegration of these clients.

**Significance**

Research with regard to this subject is significant to nursing. Understanding of an adolescent client's perceptions about illness and daily functioning (in demographically appropriate language) would enhance the ability of the nurse to teach, facilitate, and eventually to measure patient insight through self-appraisal, thereby providing for better behavioral control, medication compliance, and relapse prevention through empowerment. Better understanding of insight development and maintenance in this age group would also provide a means for designing nursing interventions, including early intervention (both on an inpatient and outpatient basis). Finally, research of this kind presents an opportunity to enhance nursing awareness, perceptual accuracy, and interpretation of assessment findings pertinent to client functioning.

**Purpose of the Study**

The purpose of this study was to explore the experience and language used by psychobehaviorally disturbed adolescents and young adults related to self-assessment of the symptomatic, functional, and resource levels of insight development. A synthesis of the phenomenological and ethnomethodological approaches was used to conduct this investigation.
**Research Question**

In order to fulfill the purpose of the investigation, the researcher sought to better understand the lived experience of a group of adolescent outpatients who had been diagnosed with psychobehavioral illness. Two overriding questions guided this inquiry: How does this patient population understand and describe their unique illnesses? How does this information fit within the context of insight development in the adolescent population?

**Theoretical Assumptions**

This investigation assumed that clients who had received prolonged treatment were more likely to demonstrate insight. It was also assumed that the focused act of self-reflection on functional indicators adds to the likelihood of insight development. Finally, the researcher assumed that interviews would yield accurate information based upon client honesty and forthrightness during the individual interviews.
Chapter II

Literature Review

Overview

Review of available literature centers around key aspects of insight. Experts agree that psychiatric rehabilitation depends upon empowerment. Although it remains a relatively intangible and subjective construct, insight development plays a central role in empowering clients toward rehabilitation through a personal understanding of illness. In fact, only recently are researchers constructing tools to objectively assess client insight. To date, these tools are of limited use in that they only tangentially (and incompletely) seek to assess the identified components of insight. Further, they have been developed in the context of an adult model using clinical language. The adolescent population, owing to its unique developmental attributes, seldom benefits from the use of such tools. Self-report measures, in general, demonstrate greater promise in meaning and, in the case of insight, fostering development of insightful functioning.

Definitions of Terms

Drawing from the available literature on the subject of empowerment and insight, important concepts are defined as follows: Empowerment is “a process of gaining control over one’s life.” For the chronically mentally ill, developing insight is part of that process (Segal, Silverman, & Temkin, 1995). Insight, then, is defined as “a type of self-understanding encompassing both an intellectual and emotional awareness of the unconscious nature, origin, and mechanisms of one’s attitudes, feelings, and behaviors”
In short, insight is “a patient’s recognition and understanding of his condition” (Baier & Murray, 1999, p. 14). For the purposes of this study, “level of functioning” encompasses cognitive, social, and basic-level physical tasks needed to “live, learn, and work in the [home or] community setting” (Anthony, 1979).

Rehabilitation & Empowerment

According to Anthony (1979), “the overall goal of psychiatric rehabilitation is to assure that the person with psychiatric disability can perform those physical, emotional, social, and intellectual skills needed to live, learn, and work in the community, with the least amount of support necessary from agents of the helping professions” (p. 30). Therefore, quality of life should be a central rehabilitation goal for chronic populations (those clients for whom medicine’s power to cure is limited). Empowerment has been viewed as a personal resource that can moderate in coping with the effects of stress (Pearlin & Schooler, 1978). There is also strong evidence that client perception of loss of empowerment has “destructive consequences for the individual’s psychological well-being in the general population” (Rosenfield, 1992, p. 300). “A low sense of empowerment affects subjective quality of life because it results in feelings of hopelessness and passivity” (Merton, 1946; Rosenfield, 1989; Rotter, 1966; Veblen, 1899).

Rehabilitation & Insight

Rehabilitation literature generally encourages clients to accept their psychiatric diagnoses as a step toward maintaining and possibly improving the quality of their lives (Kravetz, Faust, & David, 2000). In at least one study, psychiatric self-labeling was
found to be negatively related and perceived symptomatic knowledge and control over illness was found to be positively related to quality of life in a number of key functional areas (Kravetz, Faust, & David, 2000, p. 323). This study used a comprehensive measure of the acceptance of the psychiatric label and a self-report measure of the quality of life (Kravetz, Faust, & David, 2000). Another research team reported that "labeling of symptoms strengthened [the client] against the effects of the symptoms" (Baier & Murray, 1999, p. 19).

The work of Baier and Murray (1999) demonstrated that "a major obstacle to an [adult schizophrenic client's] participation in rehabilitation is a refusal to take medications, possibly related to a lack of insight [and] denial of illness..." (p. 14). The study further found that, when a schizophrenic client can "question his or her own perceptions of reality, acknowledge the illness, accept the necessity for medication, and ask for help when necessary, a turning point in treatment has been achieved" (Baier & Murray, 1999, p. 14). Through development of insight, clients are empowered. They are "more likely to recognize the role of their medication in their recovery and continue to take it" (Baier & Murray, 1999, p. 20). The literature on insight also supports the notion that insight includes recognition of symptoms and a verbal understanding that relapse can occur and can be triggered by various factors. Baier and Murray (1999) also report that insight should be considered a "fluctuating and changing process" and that drug compliance and awareness of illness should be regarded as "separate though overlapping constructs which contribute to insight." In their study, "personal cognitive efforts contributed to insight development by those interviewed (Baier & Murray, 1999, p. 19-20). These results appear to imply that the development of insight supports and enhances
empowerment. This study emphasized the importance of client cognitive measures, such as rational self-talk and symptom labeling, to help reduce the disabling effects of schizophrenia.

The Adolescent Population

Notable in the literature is the unique language used by the study population—the particular functions, thoughts, and jargon used by the clients to describe symptoms, triggers, and indicators of decompensation (Baier & Murray, 1999). Even mentally healthy adolescents, by virtue of their unique developmental behaviors, pose special problems for assessment and intervention. In acquiring new intellectual perspectives, adolescents move closer to adulthood. They become open to new vulnerabilities as their thoughts become more comprehensive—but less practical. According to developmental psychologist Dr. Kathleen Berger, “adolescents often are...troubled by their own introspections...” (p. 411). For this age group in particular, recognizing the nature of their mindsets is crucial, “lest they be misled by their bravado to make risky choices that may compromise their futures” (Berger, 1998, p. 411).

One of the unique characteristics of normal adolescent development is a marked advance in metacognition—the ability to think about thinking. Other distinct features with relevance to the development of insight in this age group—both in healthy and mentally ill clients—include entrance into Piaget’s stage of formal operational thought (the theoretical “final” stage of cognitive development), the beginning of hypothetical thought, and maturation of deductive reasoning abilities (Berger, 1998). According to the literature, “advancing to the realm of the possible, the hypothetical, and the abstract has important personal consequences for adolescents, permitting them a new degree of self-
scrutiny” (Berger, 1998, p. 416). Adolescents are more prone to self-reflection about their future possibilities. They begin to think about their thoughts and feelings and to reflect on their experiences. These behaviors progress into adulthood; however, as a new skill, self-awareness “enables adolescents to consider their lives more thoughtfully, but often at the cost of greater self-criticism” (Berger, 1998, p. 418). As cognitive functioning progresses to new levels, adolescents often struggle to express their thoughts verbally and therefore use unique terms and phrases to describe emotions and concepts (Berger, 1998).

Further, adolescence appears to be “the time of greatest upheaval in moral behavior as well as the period of most rapid development in moral reasoning” (Colby et al., 1983; Perry & McIntire, 1995). For the first time ever, teenagers make personal decisions and value choices with far-reaching consequences. This period of development is often characterized by high rates of adolescent risk-taking behaviors (drug use, driving while under the influence, unprotected sex, etc.), juvenile delinquency, and suicide (Berger, 1998).

Inherent in its developmental characteristics, this particular age group presents special concerns. These concerns are amplified when adolescent psychobehavioral illness is considered in this context. The potential exists to discover characteristics of insight development during this maturational period. In so doing, the researcher may also discover methods of intervention to foster insight development with a goal of improving outcomes for this population.
Insight Assessment

As a cornerstone of rehabilitation, insight assessment occurs at the symptomatic, functional, and resource levels (Anthony, Cohen, & Cohen, 1983). Formal assessment of client insight appears to be a relatively recent notion. As such, there appears to be little consistency in inclusion of all levels of assessment. One assessment tool expressly for the purpose of insight assessment is currently under development in England. The Behavioural Status Index (BSI) was developed from previous research carried out in the early 1980’s. It was developed to assess “therapeutic impacts during ‘bridging’ therapy as patient moved from hospital to community-based psychiatric care” (Woods & Reed, 1997, [online]). The insight sub-scale of the BSI consists of items designed to examine a client’s constructs of reality. It is an objective tool designed to be administered over a 30-minute time period by an assessor and is designed for the assessor to “focus his/her thinking about the patient” (Woods & Reed, 1997, [online]).

Indeed, other tools which presumably (although not explicitly) measure attributes of client insight have been in use for varying lengths of time. These include tools designed to assess the skills needed to function effectively. Related assessment scales may be broadly divided into rating two types of skill: cognitive and behavioral. These are further subdivided into social skills, symptom identification, and level of functioning—types of skills that “meaningfully differentiate psychiatrically disabled and normal populations” (Bedell & Lennox, 1994). The majority of the existing assessment tools are objectively administered while others are designed to be self-report measures. Tools that offer some tangential utility in the assessment of insight characteristics include the Global Assessment Scale (GAS) and the Social Functioning Index (Schindler, 1999);
the Behavior and Symptom Identification Scale (BASIS-32) (Diamond Palmetto, 2000, [online]); the Functional Impairment Scale for Children and Adolescents (CBRF-A) (Van Egeren, Frank, & Paul, 1999); the Specific Level of Functioning Scale (SLOF) (Schneider & Struenig, 1983); the Social Adjustment Self-Report Scale (SAS-SR), the Center for Epidemiologic Studies Depression Scale (CES-D), and the Symptom Checklist (SCL-90) (Weissman et al., 1978); the Beck Depression Inventory (BDI) (Mark, Sinclair, & Wellens, 1991); and the Ansell-Casey Life Skills Assessment (ACLSA) (Masse, 1998).

The literature suggests that functional assessment may be the most practical or meaningful way to both assess and to foster insight development because “functional assessment emphasizes the adaptiveness rather than the abnormality of behavior” (Hawkins, 1986). Viewed in this context, level of functioning is reflective of a client’s level of resiliency.

Resiliency refers to “the various personality, family, or environmental factors that compensate for increased life stresses so that expected problems do not develop” (Plotnik, 1993, p. 386). Insight fits the definition of perception as an attribute of resilience defined in the Typology Model of Adjustment and Adaptation (McCubbin & McCubbin, 1989). In this instance “insight” and “perception” may be used interchangeably to refer to the way “the [client] defines the situation, its impact, and [his/her] ability to manage” (Wong, 1997, p. 62). While traditionally viewed as a means to prevent development of mental or physical sequelae, the concept of resilience figures prominently here as a means to cope with psychobehavioral illness because of the resilient person’s “ability to use problem-solving skills” to meet internal and external role expectations and to experience a reasonable quality of life (Varcarolis, 2002, p. 861).
Functional analysis tends to focus on desired rather than undesired behaviors, which are considered important if they “encourage or allow an individual’s successful adaptation to a living, working, or learning environment” (Hawkins, 1986, p. 33). Again, these are the central goals of psychiatric rehabilitation, yet few of the assessment tools for the purpose of insight assessment focus on functional aspects of everyday living.

Further, adolescent and young adult clients commonly present with psychobehavioral symptoms, and functional analysis presents a process for identification of antecedent, sequential, and consequent conditions that surround client behaviors (Kratochwill & McGivern, 1996). A self-assessment approach to functional analysis has implications for the development of client insight.

Self-Reports

Literature suggests, generally, that self-reports are “clearly better for prediction of emotional experience…” (Spain, Eaton, & Funder, 2000, p. 837). According to Weissman et al., self-report scales possess two attractive features: Interviewer bias is removed, and in several cases, results essentially agree with those obtained by the client’s relatives or through interview by a trained assessor (Weissman et al., 1978). According to this research, a number of scales for assessing social adjustment are available, but “the majority are designed to assess adjustment through information gathered by a trained rater who makes a judgment on a scale during an interview with [the client]” (Weissman et al., 1978, p. 317). Other benefits of client self-assessment are implied. For instance, in their 1991 study, Mark, Sinclair, and Wellens concluded that, overall, “subjects reported a more positive mood after completing the Beck Depression Inventory” (p. 457). The utility of self-assessment to assess and foster insight development is likewise implied,
since “the understanding a person has of his or her condition is an individualized view” (Baier & Muray, 1999, p. 14).

Conclusion

Literature on empowerment and insight demonstrates a link and practical importance of each in client rehabilitation; however, there is a paucity of information on assessment and development of insight in young adult client populations. Further, studies have failed to investigate the possibility of fostering and developing insight through a self-assessment-based rubric that can be taught by the nurse. No single existing insight assessment tool incorporates measurement of all accepted dimensions or indicators of insight, even for adult clients with severe mental illness; and the clinical language of those tools precludes direct application to a client sub-population with a distinct language and experience in discussing perceptions and functional indicators.
Chapter III

Methods

Overview

As a means of initial exploration of the research question, a qualitative approach was used to gather information from adolescent clients receiving outpatient treatment at a local mental health practice in a rural setting. Personal interviews were conducted using qualitative data collection methods. The information was then clustered and analyzed in an appropriate manner consistent with an emergent research design. Limitations and ethical issues pertinent to this study were taken into consideration.

Research Design

In planning this non-experimental descriptive study, the researcher chose a qualitative approach. Aspects of phenomenology and ethnomethodology were combined to describe the unique experience and language of the young adult population with regard to insight development and functional self-assessment. The final product of this inquiry is a written report based upon the description and analysis of the phenomenon of interest. Phenomenology is an ideal approach to study insight development. Ethnography is the preferred approach to identify behaviors and to elucidate data patterns.

Setting

The field setting for this study was a private outpatient mental health practice in a rural state. The practice provides care to children and adolescents on both short-and long-term outpatient bases and aftercare for those recently discharged from inpatient
hospitalization. Data collection occurred primarily through recruitment of client volunteers whose diagnoses ranged from purely psychiatric/psychobehavioral to chemical dependency and dual diagnosis. The number and types of patients served by this busy private practice were sufficient to support the needs of the researcher and to generate meaningful information that is pertinent to the topic under investigation.

Subjects

The initial purposive sample consisted of client volunteers from the identified population. Client charts were available for the investigator’s review, although chart research was not completed until the initial sample had been selected (in order to avoid bias in the sample). Participants included two male and five female clients between the ages of 12 to 19 years. As trends in the data emerged, sampling “snowballed” based upon suggestions from participants and the degree of saturation or homogeneity of the data as it was collected and classified.

Data Collection

Upon selection of the sample, informed consent was obtained from each participant and/or legal guardian (see Appendix A). Information was gathered by observation and participant observation. As a part of an emergent design, the researcher chose to conduct individual interviews to discuss the phenomenon under study—and to focus, clarify, or gather new information. Permission was obtained for follow-up interview for clarification and validation. Sessions were audio taped to capture the tone and affect of the client interviewee. Each individual interview was then transcribed. Upon completion of the study, all recording media was erased.
The proposed interview and focus questions (refer to Appendix B) for this study stem from the following broad inquiries: (1) What terms does the adolescent use to describe the symptoms of his/her illness? (2) What indicators are relevant to young adults with regard to daily functioning in the context of psychobehavioral illness? (3) What is the experience of a young adult client experiencing a “good day” or a “bad day”? (4) What constitutes a “good day” versus a “bad day”? (5) How do young adult clients feel about their prescribed medication regimens with regard to their treatment? Does medication help? Why or why not? (6) As part of the discharge plan, do adolescent clients know if they are “getting better” and how do these clients know if and when they should seek help to prevent relapse?

Plan for Data Analysis

The investigator utilized self-report and observational information as the source of data for analysis. As part of an emergent design, minor modifications of data collection and analysis were made throughout the course of the investigation. The researcher used open coding and template analysis to isolate thematic combinations that describe the phenomenon. QSR International’s NUD*IST 6.0 software was utilized to assist with the coding and analysis process. A description of the themes is reported in Chapter 4.

Quality of Data

Measures to ensure trustworthiness of the data were implemented. Namely, the researcher was concerned with credibility, dependability, and confirmability of the data obtained in the study. Prolonged engagement was employed in order to improve and document data credibility. The researcher conducted interviews over the course of six weeks in the pursuit of an “in-depth understanding of the culture, language, and views” of
the study group (Polit & Hungler, 1999, p. 427) and to assess for data distortion or misinformation.

Informal peer debriefing was conducted with members of the mental health community-at-large to review, explore, and seek validation of various aspects of the interview data. Likewise, the researcher employed informal member checks with the study participants to validate emerging themes and interpretations. As the researcher has worked in adolescent psychiatry for over eight years, there is a relatively high degree of researcher credibility with regard to this inquiry, as well.

The researcher did not enlist or initiate an inquiry audit to document the dependability and confirmability of the data; however, sufficient materials and documentation exist to conduct an external data audit should the investigator wish to pursue publication of the research. Materials include the raw data (interview transcripts and field notes), data reduction and analysis products (software files used in data coding), process notes (the researcher's journal), and drafts of the final report that could serve as a data reconstruction aid.

Limitations

Since the sample was drawn from a specific rural setting, the conclusions may not be generalizable to all young adult populations in other settings. Since the sample included clients with several types of diagnoses, it may not be possible to generalize results to any single type of psychiatric, psychobehavioral, or chemical dependency diagnosis. Further, many prevalent mental illnesses in the younger adult population are not considered “chronic,” per se; however, relapse is a common occurrence. Finally, since the sample was selected using volunteers (and included only two male subjects),
study results may not be consistent with results obtained in studies using other sampling techniques.

**Ethical Considerations**

The research proposal and informed consent were submitted to the appropriate institutional review boards responsible for the protection of human subjects involved in research. A copy of the consent form is located in Appendix A. Letters of facility support and approval from the Office of Research at the University of Wyoming are located in Appendices C and D. All study participants were asked to sign informed consents prior to participation in focus interviews. Confidentiality of all subjects was maintained by assignment of a random control number to each client rather than identification by name. All recording media were erased upon completion of the study.

Once consent to participate was obtained from the client and/or the legal guardian (as appropriate), participants were informed that they were free to withdraw from the study at any time. Subjects were also notified that they were free to choose not to answer any question and were free to withdraw from the focus group or interview should he or she experience emotional discomfort. Further, subjects were informed that their participation in the study in no way affected the decisions of the facility treatment team, including judgments about preparedness for discharge from treatment.
Chapter IV

Results

The study was conducted over a six-week period, beginning on March 3 and concluding on April 14, 2003. This chapter describes the composition and characteristics of the sample and the relevant themes that emerged as the result of data analysis. A model of insight assessment in young adults emerged as a result.

Sample Characteristics

Table 4.1

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<th>Age</th>
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<td>MDD, BPD</td>
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<td>F</td>
<td>MDD, ODD</td>
<td>Yes</td>
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<td>Low</td>
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<td>37321</td>
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<td>F</td>
<td>BN, BPD, SA (victim)</td>
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<td>None</td>
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<tr>
<td>53725</td>
<td>15</td>
<td>F</td>
<td>MDD, polysubstance abuse, conduct D/O</td>
<td>No</td>
<td>4 months</td>
<td>Moderate</td>
</tr>
<tr>
<td>64532</td>
<td>14</td>
<td>F</td>
<td>MDD, SA (victim), adjustment D/O</td>
<td>Yes</td>
<td>7 months</td>
<td>Moderate</td>
</tr>
<tr>
<td>74537</td>
<td>17</td>
<td>M</td>
<td>MDD</td>
<td>No</td>
<td>6 months</td>
<td>High</td>
</tr>
</tbody>
</table>

Key: MDD (Major depressive disorder); BPD (Bipolar disorder); ODD (Oppositional-defiant disorder); BN (Bulimia nervosa); SA (Sexual abuse); D/O (disorder).

Seven adolescents participated in the study. As shown in Table 4.1, the sample consisted of five females and two males, ages 12 to 19. Subject diagnoses included major depressive disorder, with and without suicidal ideation; bipolar disorder; oppositional-defiant disorder; bulimia nervosa; post-traumatic stress disorder; sexual
abuse (victim); social anxiety disorder; adjustment disorder; polysubstance abuse; and conduct disorder. Levels of insight development included “none,” “low,” “moderate,” and “high.” These ordinal labels were assigned based upon the subjective opinion of the researcher and the subjects’ clinician(s). Three of the subjects had received inpatient treatment of some kind prior to the interview. All subjects had been receiving treatment on an outpatient basis between two and eight months in duration at the time of the interview. Refer to Table 4.1 for a complete summary of sample characteristics.

Emergent Themes

The investigator previously examined pertinent literature on insight and chose to use the levels of insight development described by Anthony, Cohen, and Cohen in 1983 to assist in organizing the data. This organizing process formed the basis for development of a model to describe domains of insight development in the adolescent population. This model includes themes and subthemes defined as follows: The symptomatic (labeling of problems and symptoms, antecedents to treatment); functional (assessment of improvement; functional behaviors); and resource (role of medications, relapse prevention) levels. Figure 4.1 depicts the model of insight development in adolescent outpatients that emerged from this qualitative data analysis.

The development of insight in adolescents is directly related to the three major themes. As shown in the figure, it is evident that the various thematic dimensions are interdependent in that changes in one dimension can affect or be affected by changes in the others. Thematic dimensions are further described as follows:
Symptomatic Level

Labeling of problems and symptoms.

Four of the seven subjects indicated some form of DSM-IV diagnosis when asked about their individual treatment issues. Two subjects described issues that they agreed, when prompted, illustrated a diagnosable psychiatric or behavioral condition. The remaining subject stated simply that the reason for his treatment was “because I don’t like to hang out with people.”

When asked whether their problems could best be described as an illness, the sample population responded in several ways. For example one subject stated, “Yes, because of the way I act sometimes. My mom will just say something real simple, and I blow up on her and start yelling. Little things tend to set me off.” Another stated, “I know from what the doctors have said that I probably have a problem with bulimia and a mood disorder.” Another subject reported that she would not classify her problems as an illness. She called it “problems, because not everybody wants to kill themselves; not everybody has trouble respecting authority.” Two subjects responded that “illness” is not the best descriptor but were unable to explain why not or to suggest what might be a better label. Another stated, “I don’t know, I think it could be an illness. If you watch the Zoloft commercials, they say it could be a chemical imbalance in your brain.” Finally, one subject said, “Actually, I’ve done a lot of studying on this, and I’d say there’s a lot of stigma associated with this. I’d call it an ailment or an illness because it’s an arduous process to cure. They’ve done a lot of studies to compare serotonin levels.”
When asked how their individual symptoms fit with their diagnoses (or issues), even the least insightful subject was able to describe some kind of behavior pattern (or coping mechanism) that had proven to be maladaptive. Symptomatic descriptors ranged from “It just depends on what’s going on in my life” to “Nihilistic thoughts; it’s kind of a stage where you’re stuck between sleeping and awake. You don’t feel like moving, can’t get to sleep. It’s kind of like insomnia without the distractions; and associated with a
sense of unfulfillment and sadness.” Other descriptors that seemed to be specific to this population included “hating everybody,” “constantly crying,” having “really bad mood swings,” “always being in a bad mood,” not being as “‘in’ to things” as they were, getting nervous, sleeping all the time,” “looking sad...head down,” and nightmares.

**Antecedents to treatment.**

The subjects were asked what aspects of their lives changed in the period leading up to their treatment and about the circumstances that made them (or someone else) believe help was needed. Although all of the subjects’ stories were distinct, themes in their answers were remarkably similar in many ways. Changes and problems in the home environment, including divorce or separation of parents, substance abuse by siblings or parents, physical and sexual abuse, and moving to new locations were remarkable antecedents to treatment. Five of the subjects endorsed a period of suicidality (with or without a specific plan) in the period preceding treatment initiation. Other subjects described “hating to be around people,” “favoritism” of a sibling by parents, feeling “hated” by all the girls at school, overdosing on Vicodin, not eating, “throwing up a lot more,” becoming increasingly anxious about leaving the house (“sweaty palms” and making excuses to do other things), “excluding myself from the world and staying in my room,” and thinking moods were “hormonal changes” until “it started interfering with my school work.”

**Functional Level**

**Assessment of improvement.**

All subjects reported that they were aware of some improvement over the course of treatment, although some were not able to explain what had improved other than to say
"I feel much better now" or "I feel happier." Some indicators of improvement included things like "not hating everybody," getting out of bed, and "doing stuff" like "hanging out with friends," listening to music, going to the movies, roller skating, making travel plans for the summer, going to work or school, going to the mall, flying kites, and "partying." Other significant indicators included decrease or absence of suicidality, decrease in purging behaviors, increase in energy (not sleeping all the time), stabilization of appetite, and improvement in interpersonal relationships with parents, teachers, and peers (i.e. making new friends). One subject described these feelings as "being topped off." He also noted that, during recovery, "you do become depressed, but you 'bounce back.'"

As part of a self-assessment of improvement, subjects were asked whether they could tell whether today would be a "good day" or a "bad day" and, if so, how soon after rising in the morning this became apparent. Responses varied considerably. Summarily, most subjects interviewed had some degree of awareness of the overall "tone" of the day ahead within a short time of awakening. One interviewee stated that, "it's like there's this knot in my stomach if I'm going to have a bad day. I pretty much know when I open my eyes in the morning." Another stated that, "if my hair doesn't look good, I'm real grouchy because my hair makes me mad. Also, it's a bad day if my mom didn't do laundry, and I don't have any cool clothes to wear." One of the older subjects stated, "Back then, I felt like when I woke up, I had been praying that I wouldn't wake up in the morning. Now I just can't wait for the day to start. I'm just ready to go for it. I'm more independent now than I was before. I can tell whether it's going to be a good day or a bad day. If I'm in a bad mood when I wake up, I just know it's going to be a hard day for
me, but if I’m in a good mood, I just know it’s going to turn out okay.” A 17-year-old male subject reported that “you have to take days one at a time. There’s only so much you can do without the support of others. You try for your best. And in the end, you determine how things go for you (unless it’s a chemical process). It could still be a good day despite what happens.” Only two of the subjects denied some sense of what to expect from the day ahead upon awakening in the morning.

Functional behaviors.

As part of the emphasis on insight as it relates to functioning, the researcher asked subjects about goal-directed behaviors. Five interviewees do not set daily goals as part of a routine. One subject stated, “I’m feeling good right now, so I don’t have to have goals.” One subject reported that it’s important to “start small; set goals I know I can accomplish. I don’t make a goal for the day that I know will be almost impossible.” Other subjects set longer-term goals for themselves independently or in collaboration with their therapists. A representative statement in this regard was made by a 17-year-old male interviewee: “My daily goal is to try to wake up and get to school. Sometimes I set goals, but you never know what situations are going to come up. Long-term goals are great.”

Notable as part of the goal-setting process and of the subsequent interview focus on role expectations and behaviors is the adolescent’s reliance on others’ appraisal of their role performance as well as his or her appraisal of situations based upon the actions of others. One female interviewee reported that the tone of her day is established when she first sees her mom and little brother. “If they’re fighting, it’s not going to be a good day [for me].” Other subjects reported on their role performance as children, siblings,
students, friends, employees, etc. in similar terms. They were asked how they know they are satisfactorily performing in those roles. Answers included things like “When my parents don’t yell at me for telling them something,” “When my mom tells me she’s proud of me,” “When my sister will talk to me,” “When my friends are still there when I don’t have a car,” “When my mom says ‘I love you,’” being invited to participate in activities with friends, and physical or monetary rewards (i.e. pay raises at work, good grades, special privileges at home or school, gifts, more responsibilities at work).

Other subjects reported on role performance from a more internally aware perspective. For example, a 19-year-old female reported that she is “not pushing people away as much” and not being as obsessive about why others might be upset with her. Another female subject explained why she felt she was not a good daughter or sister because “I’m putting my mother through all of this, and I ran away last weekend. And my little brother has started doing all the same stuff I’m doing, except for the suicide attempt.” Other subjects agreed that effective role performance has to do with staying in school, holding down a job, “doing what I’m told, not using drugs or alcohol, trying to help my family,” and “trying to help my dad with his alcohol problem.” Finally, a male subject indicated “I don’t care. I never saw my parents as perfect like other kids did. There were circumstances where that cloak of invulnerability that teenagers have was removed, and I saw that my parents were not always going to be there to protect me. Ever since then, I saw that they were flawed, and so was I; but we could work off each other. You cannot measure whether you’re a good kid. Family is something you don’t choose. You’re just thrown into it, and there are a lot of things you keep from each other.”
Resource Level

Role of medications.

Regardless of each subject’s overall appraisal of whether or not his or her problems could be classified as an illness, all subjects interviewed were taking medications. Only two subjects did not feel that their medications were helpful in some way. A 15-year-old male indicated that he had been on Zoloft for a few months and had been switched to Prozac that day. Although the only change he felt when on Zoloft was an increased appetite, he did note that his parents felt his behaviors had improved since on medication. A 15-year-old female subject had also been on Zoloft but admitted that it was “messing with my head; giving me bad cravings for crank.” She reported that she took her entire prescription of Zoloft at once some time ago, began “puking up blood” and was treated in the local emergency department.

Of those subjects who endorsed some sort of improvement from medications, most could more easily discuss what may (or did) happen should they discontinue medications than how, directly, the medication was exerting beneficial effects. Answers to these questions included “Because if I don’t take them [medications], it’s bad. I am so crabby. Someone even looks at me, and I yell at them. I feel like throwing things at them and knocking them out.” A 12-year-old female subject stated, “I can control myself better; I can control my anger; I feel less emotional (like before I was on meds, I would cry over everything).” The bulimic interviewee stated that her Remeron helps her sleep but that it has also helped her gain weight, “so it makes it harder for my bulimia.” The most interesting response was elicited from an older adolescent male. He stated, “I have been on Prozac. It didn’t really work out that great; no effect at all—or maybe a slight
effect. It made me more mercuric. Zoloft seems to have the more balancing effect. I'm still mercuric, but I was that way before I was depressed. Prozac took the edge off the depression, but it didn’t make things better.” Other beneficial effects of medications included improvement in energy levels.

When asked about how long medication therapy should continue and what may happen if medications were discontinued today, some subjects had very clear ideas. Answers ranged from “hopefully not very long” to “six or seven months” to “maybe for the rest of my life, depending on how I do.” In terms of hypothetical implications for medication discontinuation at the time of the interview, answers again varied. One subject stated, “My house would explode. When I don’t take ‘em [medications], me and my mom fight so bad.” A 19-year-old female said, “If I were to quit now, it would not be good. When I stopped last time, my emotions were extreme. I would end up back in the hospital.” A 14-year-old female was not sure about when she could stop her medications; however, she was clear on what might happen if she did stop that day. She said, “If I stopped, I’d probably get depressed again, because I’m still trying to work on things with my dad and his drinking and smoking pot. My medication helps with stress at school, helps me make better choices, and stay positive about things.” A male patient stated, “I’m a lot better off if I stopped taking it today than when I started out, but I’d still like to go with the statistical analysis and continue on it for the full time.” Interestingly, a 15-year-old female subject first stated that she may need medications for the rest of her life; then she reported that if she were to stop her Zoloft that day, “probably nothing would happen.” Finally, a male subject stated that he would probably “get more active; start doing a lot more stuff than I do” if he discontinued his medication that day.
Relapse prevention.

Subjects were asked to consider the potential for relapse, particularly how they know they are “doing okay,” how they might know things are getting worse (or to the point where help is needed), and what they might do or who they might contact in that instance. Answers to these questions included “I’m doing okay if I don’t get mad at myself,” “I know I’m doing okay because I’d be doing things that I wouldn’t normally be doing if I was depressed,” and “not feeling suicidal.” It seemed easier for these adolescents to discuss indicators of decompensation, such as “I feel alone when I’m getting depressed,” “no real feeling; just ‘junk’ inside,” “mania comes on suddenly,” “I can tell I’m going to get depressed because I start eating—or just start sleeping a lot,” “I can tell my anxiety is getting worse if I want to go home,” and “I wouldn’t be talking very much, I’d be sad, not feeling like doing anything.” The older adolescent male subject stated, “I would probably have to go for the ‘rule of three.’ If I go through a really bad time, bummed out, then I can see that. But if that happens, and I’m still depressed, I look for the categorical symptoms of depression, and if there’s nothing situational that would adversely affect my mindset and my mood, then that would be one of those ‘red flags.”’

Subjects identified several ways they might cope with potential relapse, including creating a distraction such as exercising, “sticking it out” before calling for a ride home, listening to music, and seeking social support (“Most of the people I hang out with know I have this problem. They have to kind of remind me once in awhile. They tell me to ‘chill.’”). Many interviewees identified people they could contact for support, such as parents, friends, cousins and other family members, and school counselors or social workers.
workers. Interestingly, only two subjects mentioned the option of calling their treating psychiatrist or therapist should the need arise.
Chapter V

Discussion

The major contribution of this study is the development of a model that integrates an age-appropriate description of the experience and language of adolescent outpatients into the development of the symptomatic, functional, and resource levels of insight. Despite the similarities of many of the descriptions generated by this fieldwork to those reported in the literature, the Adolescent Insight Development Model offers a richly detailed (and specific) understanding of insight indicators in the young adult population. Such a model may allow clinicians to better understand the lived experience of adolescent outpatients who have been diagnosed with psychobehavioral illness and to design nursing interventions better suited and more effective in fostering insight development. To further that end, additional research may be useful to determine whether this model may be used as the basis of an insight assessment tool which could be adapted for use in self-assessment by the patient.

Much of the information gleaned from this study validates pre-existing concepts and theories (which have been incorporated into the insight development model). The idea that an adolescent can become depressed or psychologically impaired and can “bounce back” and lead an adjusted life illustrates resilience (as described by Wong, 1997, and Varcarolis, 2002). A young adult’s self-awareness of “the cloak of invulnerability that many teenagers have” not only validates developmental theories, but
it is a step toward understanding and measuring insight as it relates to a young client’s realization of the invincibility fable (as discussed by Berger, 1998). Congruent with the literature on the subject, the intellectual and emotional self-awareness demonstrated by the interviewees represents “recognition and understanding” (Baier & Murray, 1999). These are accepted steps toward gaining control over one’s life; and such knowledge and control are major components in the empowerment process (Segal, Silverman, & Temkin, 1995).

Practical application of the Adolescent Insight Development Model is based on the usefulness of the information gained about the adolescent population. This is particularly true with regard to how young adults label their problems (“issues” versus “problems” versus “ailments” versus “illnesses”), the way they identify and rate symptoms in their own terms (using their own jargon), and how this population places emphasis on the appraisal of those around them (sometimes at the expense of self-awareness). It should be noted how the adolescent then tends to shun this important source of feedback during the period of decompensation or relapse.

With regard to potential clinical application of this information, the insight development model stresses the unique language teens use to describe (and how they think about) their level of improvement and overall functioning. It is important to note how few of the subjects set a daily goal as a direction for the day’s activities. Compared to the relatively large percentage of interviewees who felt they knew whether the day would be “good” or “bad,” the model may prove to be advantageous in stressing the importance of (and assessing the level of) goal-directed living (as an indicator of the functional level of insight). Likewise, an important part of insight development within
this population might include a focus on one’s ability to fulfill role expectations, particularly with regard to school, family functioning, social life, and one’s choice of occupation for monetary gain. The Adolescent Insight Development Model addresses this.

Finally, this proposed model emphasizes renewed attention to the high rates of risk-taking behaviors in the young adult population, particularly as those types of behaviors relate to psychopathology. The high rate of suicidal ideation (often with a practicable plan) in the pre-treatment period for this study population is alarming. Suicidal ideation also figures prominently in the adolescent’s appraisal of functioning and relapse. This is more troubling when considering the suggestion that many of these subjects may not first choose to contact their treating psychiatrists or therapists in the event of relapse or decompensation. Insight assessment should, therefore, include teaching and questioning about the young adult’s personal indicators of relapse, available coping skills, and the existence of a “supportive contact.” The insight development model addresses these issues.

Nursing Implications

Study of the Adolescent Insight Development Model will further the understanding of a young adult’s perceptions about illness and daily functioning (in age-appropriate jargon). This enhances the nurse’s ability to assess, teach, facilitate, and (perhaps someday) to measure patient insight through self-appraisal. Enhanced knowledge will allow nurses to more accurately interpret assessment findings with regard to insight in the adolescent population. By using the model, nurses may realize the importance of integrating significant others’ appraisals, supporting goal-setting,
encouraging daily symptom analysis, assessing for level of risk, and reminding clients to keep in touch with the treatment team.

Improved assessment leads to improved nursing intervention, thereby improving behavioral control, medication compliance, and relapse prevention through client empowerment. Nurses need to seek to understand insight development in this population in order to provide early intervention at all levels of care. Becoming aware of the unique needs and habits of adolescents with regard to insightful functioning is the first step toward such understanding. The insight development model conceptualizes and streamlines this process.

Recommendations for Future Research

Further studies with regard to insight development and measurement in the young adult population are recommended. The model generated by this study might be expanded and compared to similar data generated by a larger population. Perhaps focus groups might be conducted to examine the effect of peer interaction on the information. It may also be advantageous to conduct the same inquiry with a group of inpatient clients or with clients from an urban location. Since gender may also play a role, subject separation by sex may also generate useable information in this regard. Lastly, a pilot project that incorporates self-assessment points particular to this population (such as those presented in the insight model) in a daily self-assessment rubric may be conducted to examine if such an intervention has an effect on the client’s level of insight or its rate of development.
Conclusion

This study has contributed to the available knowledge base on development and assessment of insight in the adolescent population. Understanding the perspective and language of the clients forms a basis for establishing therapeutic relationships, fostering insight development, and improving assessment of self-awareness. The Adolescent Insight Development Model could be used to generate a self-assessment tool used to support a young adult client’s “personal cognitive efforts” (Baier and Murray, 1999) which contribute to insight development and client empowerment.
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Appendix A: Consent Form

PARTICIPANT CONSENT FORM

Empowerment and Insight in Adolescents Living with Psychiatric Illness

You are invited to take part in a research study to explore the way adolescents like yourself understand your illness; how you know whether today will be a “good day” or a “bad day” and how clients in your age group talk about feelings and coping with your particular problems. Information from this study will be used to understand and evaluate the way members of the treatment team measure insight in adolescents.

The person in charge of this study is Josh Hamilton, BS, RN-C, a graduate student in nursing at the University of Wyoming. The information gathered from this study will be used in the student’s thesis project. You will be asked to participate in an individual interview (approximately 15 minutes in length) where we informally talk about the issues mentioned above. Our conversation may be audio taped, and your answers will be objectively (non-judgmentally) recorded. Only Josh Hamilton (and/or a transcriptionist) will have access to the taped information. The staff of the facility will not be able to listen to the tapes. Your medical record will be reviewed (if you give permission for this), and you may be contacted for clarification or for further information at the end of the information-gathering period.

Your participation in this research poses only a minimal risk to you. Risks include sacrifice of time that may normally have been spent in other activities (possibly some free time) and the discussion of some of your treatment issues, some of which may be “uncomfortable” topics. A follow-up meeting with your therapist or psychiatrist will be arranged if you would like. You may choose to stop participating in the study at any time—for any reason—without fear of punishment or negative consequences.

Your identity will be protected. An identification number will be assigned to you, and your name will not be used. Your answers to questions remain confidential, and your treatment course will not be affected. Recording media will be erased at the conclusion of the study. Study results may be used as the basis for further studies; however, only group data will be reported. Your name will not be used in published study results.

If you have further questions about the study, please contact Josh Hamilton, RN-C, at [contact information removed].

Your signature below means that you have read the above information, have received answers to your questions, and have agreed to participate in this study. You will receive a copy of this form for your records.

MAY WE HAVE YOUR PERMISSION TO REVIEW YOUR MEDICAL RECORD?

No _______ Yes _______

Volunteers under the age of 18 require approval of their parent(s) or legal guardian. Please tell us your:

Date of birth: _____________________________ Age: _____________________

Participant Signature ____________________________ Parent/Guardian Signature ____________________________

Date ________________ Date ________________
Appendix B: Sample Interview Questions

1. Why are you receiving treatment? What are your current treatment issues?
2. Do you think you have an illness? How do you know?
3. Tell me about your diagnosis. What does it mean to you?
4. Can you explain how your behaviors (or symptoms) fit with your diagnosis?
5. What aspects of your life changed in the period leading up to your treatment?
6. Describe the circumstances that made you (or someone else) believe that you were in need of this kind of help?
7. Can you tell if you’re getting better? How do you know?
8. How do your thoughts or behaviors change on a daily basis? Can you tell whether today will be a “good day” or a “bad day”? How?
9. How do you know if you will accomplish your daily goals?
10. Tell me about different roles you play in life (i.e. son/daughter, brother/sister, student, friend, employee, patient). How do you know if you’re a good kid, sibling, student, friend, employee? Has your treatment changed the way you fit these roles? How?
11. Are you taking medications as part of your treatment? Do they seem to help? How?
12. How long do you think you’ll have to continue taking your medication(s)? Why? What do you think might happen if you were to stop taking your medication(s) today?
13. Have you ever received inpatient treatment? When? Have things changed since then? What has changed about your life since your discharge?
14. Have you begun work on a discharge plan or a relapse plan? How will you know if you’re doing OK? How will you know if things are getting to the point where you might need to ask for help? Who will you call or where will you go if that should happen?
Dear Sirs:

I am writing to relay my support of Josh Hamilton's thesis proposal for his graduate studies. I have agreed to allow Josh to pursue his group work through my outpatient practice. I have some concerns regarding the possible attendance in this group, as adolescents are notorious for skipping groups. I have suggested that Josh contact CWCC to find out if he could set up his group through their school counseling program. The attendance in the school setting would likely be more consistent than in an outpatient clinic. However, if Josh is unable to garner their cooperation, then I will be happy to work with Josh in my office.

Sincerely yours,

Patricia L. Payne, M.D.
Child & Adolescent Psychiatrist

Cc: Josh Hamilton
Dear Mr. Hamilton:

The Institutional Review Board for projects involving human subjects reviewed the proposal referenced above at their meeting December 12, 2002. The Board approved the project as one that would not involve more than minimal risk to participants, subject to the revision of the consent form to include a specific request to access patient medical records and written in age-appropriate language for the targeted population.

We have reviewed the requested revisions, and the consent form is approved for your use in obtaining informed consent from or on behalf of the subjects.

Please be aware that IRB approval for the project is for a one-year period. If human subject participation in the research project extends beyond January 1, 2004, please provide the Board with a report on the status of the project and request an annual review to extend the approval. In addition, any significant change in the protocol as approved should be submitted to the board for review and approval.

You may proceed with the project and we wish you luck in the endeavor. Please feel free to call me if you have any questions.

Roger Wilnert
Associate Vice President for Research
Chairman, Institutional Review Board

Cc: N. Wilkerson