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Adolescents' perspectives on their treatment as inpatients

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of Master of Arts (Clinical Psychology)

Faculty of the Humanities

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: _____ Date: _____

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Abstract:

Adolescent inpatient psychiatric care is an accepted intervention for acute adolescent behavioural and emotional problems, yet little is known about patient experiences of this care. This study explores former patients' views of the therapeutic factors involved in the treatment they received at Kenilworth Clinic's Adolescent inpatient unit in Cape Town, South Africa. Twelve ex-patients were interviewed using a semi-structured interview schedule; the interviews were recorded, transcribed and analysed qualitatively using template analysis. In line with Yalom and Leszcz's (2005) work on the therapeutic factors in group work, some of these therapeutic factors featured as major themes in the interviews, specifically: the imparting of information, universality, group cohesiveness, interpersonal learning and catharsis. Other factors featured minimally or not at all; an attempt is made to understand this as well as the potential value of these factors. In addition to these therapeutic factors, patients generally perceived family sessions as both helpful and difficult. Concerns raised by participants about their treatment experience included underage smoking at the unit, confidentiality in aftercare group and a desire for individual therapy by participants. The recommendations made were for the staff at the unit to maximise the therapeutic space for the factors highlighted as important to the patients, to continue to endeavour to prevent patients without consent from smoking and to use rule-breaking therapeutically as far as possible, and to discuss confidentiality rules and concerns in the aftercare group at every session. Ideas for future research were discussed, these included a questionnaire-based study where both staff and patients rank the therapeutic factors involved in treatment according to perceived value and an outcomes study.

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Chapter 1: Introduction

1. 1 The importance of adolescent mental health care

Evidence suggests that mental disorders are common and increasing in prevalence internationally. The World Health Organization's World Mental Health Survey Initiative surveyed the lifetime prevalence of DSM-IV mental health disorders in 17 countries across the world, finding significant variation from country to country with South Africa having a relatively high prevalence of 30.3% (Kessler et al, 2007). To place this in the context of other countries, the highest prevalence was in the USA (47.4%) and lowest Nigeria (12%) (Kessler et al, 2007). Lopez and colleagues (2006) found that in the year 2000, mental disorders contributed 12% to the global burden of disease and the prediction for the year 2020 was a rise to 15% (as cited in Kleintjes, Lund & Flisher, 2010). The burden of disease, coupled with South Africa's relatively high estimated lifetime prevalence of DSM-IV disorders, make treatment of mental disorders a pressing and relevant issue.

Findings by Kessler and colleagues (2007) indicate that many mental health disorders begin in childhood or adolescence. The vast majority of mental disorders— an estimated 75%- have their onset in youth, with persistent disorders in adulthood tending to have an onset between 12 and 24 years old (Patel, Flisher, Hetrick, & McGorry, 2006). These findings highlight the vital importance of psychiatric care in adolescence.

The healthcare system in South Africa does not adequately meet the need for adolescent mental health care and it is probable that the large majority of adolescents with mental health problems do not receive any professional care at all (Flisher et al, 2012). Only one per cent of beds in public mental hospitals are designated for children and adolescents (Kleintjes et al, 2010); while there are beds in the private system, their number is unknown; and because of costs, they are inaccessible to the majority of the population, who do not have medical aid.

Adolescents with untreated mental health problems likely suffer consequences such as poor scholastic progress, school dropout, poor peer relationships and on-going mental health problems later in life (Flisher et al, 2012). Interventions focussing on early detection and treatment may reduce the persistence or severity of the disorders and prevent the subsequent onset of comorbid disorders (Kessler et al, 2007). Early detection and provision of effective services for the treatment of mental disorders during childhood and adolescence is advised as a central concern on the public health agenda (Kleintjes et al., 2010).

Adolescent psychiatric admission provides an opportunity for intensive treatment, but involves noteworthy implications that include significant disturbance to normal life, exposure to the dysfunctional behaviour of other patients and substantial financial expense (Jaffa & Scott, 1999). Because of these implications, it is important to know whether this sort of care effectively addresses patient needs.

Outcomes studies serve to provide insight into the overall effectiveness of this treatment (Bettmann & Jaspersen, 2009; Epstein, 2004), but do not answer questions concerning patient perspectives, such as perceptions of helpfulness and/or harmfulness of aspects of treatment (Moses, 2011). The importance of drawing on service user feedback has been noted by a number of authors (Buston, 2002; Day, Carey & Surgenore, 2007;; Moses, 2011). Youth perspectives can be used to inform and influence clinical practice: care planning, development and evaluation (Day et al., 2007).

The paucity of literature on adolescent experiences of their inpatient care creates a need for further investigation into these experiences (Haynes, Eivors & Crossley, 2011; Moses, 2011); this thesis will contribute to that limited body of literature.

1.2 Kenilworth Adolescent and Young Adult unit

I was given the opportunity to conduct research at Kenilworth Clinic's Adolescent and Young Adult unit (Kaya), an adolescent psychiatric hospital registered with the Department of Health, after completing my counselling internship at the unit and working as a registered counsellor for one year thereafter. Anecdotal evidence around individual cases suggests the interventions are successful, but Kaya could benefit from formal investigation into the treatment offered at the unit, to assist in informing the programme as well as provide record of the work being done at the unit.

The unit is uniquely placed to provide useful knowledge around adolescent mental health care in the Western Cape and South Africa. Kaya has conducted no formalised research into patient experiences at the unit; which is considered an important source of feedback to inform programme development (Buston, 2002; Haynes et al., 2011; Offord, Turner & Cooper, 2006). The unit could therefore benefit from research that could add to their understanding of adolescent experiences in the unit.

Patients come into treatment at Kaya with a wide range of presenting problems including depressive symptoms, anxiety, self-harm, suicidal ideation/attempts, substance abuse, aggressive behaviour, school refusal, interpersonal problems and irregular eating. Parents normally enquire about treatment at the recommendation of the child's school or a professional such as a psychologist or a psychiatrist.

The nature of each patient's intervention at Kaya is determined by their own needs and limitations (e.g. financial constraints may limit inpatient care and the distance from home to Kaya may exclude the option of outpatient care, which is sometimes included at the end of an admission). Most patients are on a hospital plan of some sort, which normally covers 21 days as an inpatient. Any extension of this is normally at the expense of the patient and their family.

The unit has eighteen beds and occupancy varies throughout the year. There are times during each year when the unit is full and has a waiting list, and other times when the unit has fewer patients. Staff link the fluctuation to the school terms and holidays.

At the time of writing, the counselling team consisted of a senior clinical psychologist, a clinical psychologist, a counselling psychologist, a trainee psychologist, an occupational therapist and a psychiatric nurse. All of these staff members are referred to as “counsellors” in the unit and will be discussed here in the same way. Counsellors run groups and family therapy as well as manage a case load of patients. There is also a nursing team of at least six, who work in shifts and provide support, supervision and containment for patients throughout the day and night. One counsellor is always available by telephone to the nursing staff on duty. There are two administrative staff members (a manager and a unit coordinator) at the unit during the day and there is a security guard on duty throughout the day and night.

The counsellor-run programme takes place between 9:30 and 17:00 and utilises a number of treatment elements, specifically therapeutic milieu, supportive group therapy, Dialectical Behaviour Therapy (DBT), occupational therapy groups called “interpersonal effectiveness” (communication skills, boundaries and self-esteem), addictions focussed groups, psycho-educational groups called “Recovery group” (loss, resentment, destructive thinking patterns), as well as weekly family therapy. Staff disagree on the relative importance of each of the elements. The programme timetable is shown below (Table 1), followed by a brief explanation of each of the groups listed in the programme (as well as other aspects of treatment: parental involvement, weekend leave, aftercare and individual therapy sessions) and then a programme map, which provides a visual explanation of programme inputs and intended outcomes (Diagram 1); the therapeutic modalities are discussed in greater depth in the literature review.

Table 1: Kaya programme timetable

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
07.30	GET READY	07.15-07.45 EXERCISE	07.15-07.45 EXERCISE	07.15-07.45 EXERCISE	GET READY
07.45		GET READY	GET READY	GET READY	
08.00	8.00-8.30 BREAKFAST	8.00-8.30 BREAKFAST	8.00-8.30 BREAKFAST	8.00-8.30 BREAKFAST	8.00-8.30 BREAKFAST
08.15					
08.30	8.30-9.15 SERENITY	8.30-9.15 SERENITY	8.30-9.15 SERENITY	8.30-9.15 SERENITY	8.30-9.30 SERENITY
08.45					
09.00					
09.15	break	Break	Break	break	
09.30	9.30-11.00 COMMUNITY	9.30-11.00 COMMUNITY	9.30-11.00 COMMUNITY	9.30-11.00 COMMUNITY	break
10.00					
10.30					
11.00	break	break	break	break	10.00-12.00 COMMUNITY
11.15	11.15-12.15 GROUP	11.15-12.15 RECOVERY	11.15-12.15 DBT	11.15-12.15 GROUP	
11.30					
11.45					
12.00					12.00-12.45 LUNCH BRAAI
12.15	12.15-13.00 LUNCH	12.15-13.00 LUNCH	12.15-13.00 LUNCH	12.15-13.00 LUNCH	
12.30					
12.45					
13.00	13.00-14.00 IE	13.00-13.30 PLAY	13.00-14.00 RECOVERY	13.00-14.00 DBT	
13.15					
13.30					
13.45					
14.00	break	13.30-15.30 ART	break	break	14.00-15.00 SMALL GROUPS
14.15			14.10-15.10 IE	14.10-15.10 IE	
14.30					
14.45	14.15-15.45 CREATIVE EXPRESSIONS				
15.00					15.00-16.00 ADDICTIONS
15.10			break	break	
15.20		break	15.20-16.20 ROLE PLAY	15.20-16.20 RECOVERY	
15.45	break	15.45-16.45 DBT			free time
16.00	16.00-17.00 RECOVERY	16.00-16.30 HOMEWORK		break	
16.15			break	break	
16.30		16.30-17.30 ADDICTIONS	16.30-17.00 HOMEWORK	16.30-17.00 HOMEWORK	16.30-17.30 ADDICTIONS
16.45			break		
17.00	17.00-17.30 SUPPER	17.00-17.30 SUPPER	17.00-17.30 SUPPER	17.00-17.30 SUPPER	17.00-17.30 SUPPER
17.15					
17.30	17.30-18.00 HOMEWORK	17.30-18.00 SUPPER	17.30-18.00 HOMEWORK	Free time	17.30-18.00 SUPPER
17.45					
18.00	Free time	Free time		18.00-19.00 STEP WORK	Free time
19.00		19.30-21.30 NA	Free time		
20.00	20.00-20.30 REFLECTIONS	20.00-20.30 REFLECTIONS	20.00-20.30 REFLECTIONS	20.00-20.30 REFLECTIONS	

The Kaya programme (Table 1) shows the way in which patient’s time is structured at the unit, including all the various groups attended by patients. The programme elements will now be briefly explained to give an outline of the inputs that patients are exposed to at the unit.

1.2.1 Community group.

Community group, labelled as “Community” in Table 1, is used for the explicit driving of the therapeutic milieu although the milieu is carried out throughout the day.

Therapeutic milieu is the strategic use of the environment to promote therapeutic interactions and promote positive outcomes for patients (Thomas, Shattel & Martin, 2002). The group is run every morning and three or more counsellors are present, as well as a nurse. All patients are present. This is a group where space is provided for patients to process and resolve interpersonal issues and where the culture of Kaya’s values (honesty, responsibility, respect) is overtly instilled. This is also a space where accountability around patient treatment goals is applied. The group is often challenging and confrontational.

1.2.2 Group therapy.

Kaya has group therapy as part of the programme twice a week (listed as “Group” in Table 1). The main purpose of group therapy at Kaya is to provide a space for patients to talk about difficult topics in a containing, non-confrontational space with a smaller number of people (relative to the other groups). The patient community is split in half, and two groups are run simultaneously with one or two counsellors in each group. Different counsellors run group therapy each time. The counsellors responsible for the group on that day select the patients who will be in each group, using criteria appropriate to the day (patient’s interpersonal relationships within the community, gender, life experiences and likely topics for the day are considered). Over the course of this dissertation, this group will be referred to as unstructured group therapy, to clearly differentiate it from other groups.

1.2.3 Dialectical Behaviour Therapy group.

Dialectical Behaviour Therapy, or “DBT” in Table 1, is run four times a week and the group is an hour long. It combines basic change strategies from cognitive-behavioural therapy with

acceptance-based strategies from Eastern meditative (Zen) practices (Jackson & Linehan, 2010). Many of the patients at Kaya struggle to process and express their feelings in constructive ways and this group aims to give patients alternatives to self-destructive coping mechanisms.

1.2.4 Recovery group.

Recovery group (listed as “recovery” in Table 1) is a psycho-educational group focussed around topics such as loss, resentment and destructive thinking. The topics in recovery group are identified as issues that could potentially keep patients stuck in self-destructive patterns after discharge. The aim is to provide a space where information on these topics can be given to the patients through activities and exercises so that the importance of these topics in the individual patients lives can be understood, discussed and processed as far as possible.

1.2.5 Interpersonal effectiveness group.

Interpersonal effectiveness (listed as “IE” in Table 1) is run by an occupational therapist. The group focuses specifically on relationships with oneself and others and includes topics such as self-esteem, boundaries and communication skills. The aim of this group is to help patients identify their difficulties in relationships and communication and improve their skills in this regard.

1.2.6 Addictions group.

An addictions counsellor from the Kenilworth Clinic Addictions Unit runs three addictions focussed groups weekly (listed as “Addictions” in Table1). Only patients identified by the counsellors as having a substance or behavioural addiction problems, or potentially benefitting from addiction related support after treatment, attend this group. These groups use a Cognitive-Behavioural Therapy approach and aim to get patients to accept the need for abstinence and change.

1.2.7 Other activities and groups.

Outside of the counsellor-run, structured programme there are a number of other groups,

briefly described below. The first of these groups is a patient-run planning group every morning called Serenity. A counsellor is normally present and the group is run by community leaders who are patients in peer-elected leadership roles (they are referred to as the “sheriff” and “deputy sheriff”). In this group, patients fill out a daily diary form (which offers written space to reflect on the previous day and plan for the day ahead- these are all handed to the counsellors by the sheriff after the group), write their daily goal on a designated white board, choose their current feeling on a different board (which displays a selection on feelings from which to choose) and say the serenity prayer as a group. A nightly reflections group is run by the nursing staff members on duty, where patients briefly reflect on their day. Weekly groups include group art therapy (with a consultant art therapist), a group bonding session (varied games, braais, trips to the park and other activities are organised in this time) and a structured, weekend planning and goals group (where weekend leave activities are discussed and planned in detail and each patient’s goal for the following week is discussed and decided). Patients who are identified by the counsellors as potentially benefitting from addictions support after Kaya attend Narcotics Anonymous (NA) meetings two evenings a week (an addiction counselling assistant attends the meetings with the group which is run off-premises and is attended by members of the public). These patients also attend a weekly 12-step oriented step-work group with the addictions counselling assistant.

1.2.8 Individual sessions.

Patients are seen for individual sessions only by a consulting child and adolescent psychiatrist who prescribes and monitors medication when necessary.

1.2.9 Parental involvement.

At Kaya, parental involvement is mandatory and admission is subject to parental agreement to family therapy. Both parents (if alive and living locally) are required to be at the admission assessment and to attend weekly sessions which are roughly an hour and a half long. The admission

assessment is attended by only the patient and their parents. Siblings and other family members are asked to be in later sessions when it considered therapeutically necessary by the counsellors managing the case. When families are not from Cape Town, sessions are scheduled to accommodate parental travelling limitations (for example, parents might be asked to make one trip to Cape Town and two or three sessions may be held within a few days). Where families are split, both parents are required to attend the admission assessment but attendance of further family sessions is negotiated according to the patient's needs.

Historically a parent support group was run on a Friday afternoon and parents were asked to attend although attendance was not mandatory. A parent day was also run on a Saturday, where parents were offered support, psycho-education and parenting skills training. Towards the end of 2011 the parent support structure was re-evaluated and the support group was moved temporarily to a Wednesday. The permanent changed arrangement had not yet been decided or implemented at the time of writing.

1.2.10 Weekend leave.

Weekend leave from the unit is possible for patients after their first week at Kaya. Whether leave is granted or not is decided by the counselling team based on the child's process. This is viewed as an essential part of the programme as it gives the family an opportunity to bond and integrate their process at Kaya into their home environment. Patients are required to be with an adult family member who is aware of Kaya's weekend rules (e.g. no internet, cellphones, alcohol or friends) at all times.

1.2.11 Aftercare.

Aftercare is a two hour therapeutic group run every Wednesday afternoon and is a free service offered to anyone who has completed the Kaya programme. Patients are introduced to this group on the last Wednesday of their admission.

1.2.12 Programme map

Diagram 1, which follows, illustrates the various programme inputs and desired outcomes occurring during treatment at Kaya.

This diagram aims to give a clear visual picture of the various programme elements and how they work together to achieve intended outputs.

1.3 Conclusion

Psychiatric services in adolescence are an important point of intervention in the treatment of mental illness. Kaya is an adolescent treatment unit offering inpatient psychiatric care. The unit's programme has various treatment inputs that were briefly outlined in this chapter. The next chapter discusses the unit's modalities in greater detail with reference to the literature on these modalities and their effectiveness for adolescents. This dissertation will serve as feedback to Kaya staff with implications for treatment and possible future research.

University of Cape Town

Chapter 2: Literature review

2.1 Introduction

The review of literature examines studies relating to various aspects of the research. First of all, it was considered important to establish whether the treatment offered at Kaya was supported in the literature. To do this, outcomes studies from similar units are discussed. The review of outcomes studies shows many similarities in programme design between units (and similar to Kaya's treatment programme), with the literature generally supporting these units as a treatment methodology for adolescents. Literature on the various treatment modalities used at the unit will then be reviewed.

Adolescent experiences at these units are underrepresented in the literature. In a review of the literature on child and adolescent satisfaction with psychiatric care, Biering (2010) found that knowledge about youth perception of quality of psychiatric care is scattered. Available literature will be discussed in detail to follow.

Like most of the units in the literature, Kaya runs a group therapy programme. Yalom's description of therapeutic factors of group work (Yalom, 1970; Yalom & Leszcz, 2005) was used as a framework to analyse the data, this is discussed in detail before the literature review concludes.

2.2 Outcome studies:

Outcome studies can indicate whether adolescents' mental health improves through treatment, and therefore are reviewed here in order to shed light on whether the Kaya programme is likely to be effective

2.2.1 Adolescent inpatient units.

Inpatient treatment in adolescence is generally regarded as an effective treatment for acute behavioural and emotional problems (Bettmann & Jasperson, 2009; Epstein, 2004). However, other

facilities in the literature consider interventions of Kaya's length (3-4 weeks) to be crisis containment or assessment rather than therapeutic intervention (Jaffa & Scott, 1999; Mathai & Bourne, 2009). The outcomes from Kaya's shorter interventions may therefore not be entirely comparable with these units, however, other similarities with these units (for example, intended patient populations, programme structure and treatment modalities) create some comparability and the outcomes studies from these other units can provide a reasonable base to establish whether adolescent inpatient psychiatric care is a supported mode of treatment in the literature.

Three reviews looking at outcomes of adolescent inpatient treatment facilities provide a helpful overview of the literature on the topic. In the earliest of these reviews, Pfeiffer and Strzelecki (1990) looked specifically at outcomes studies of child and adolescent inpatient psychiatric treatment facilities and found that admission was often beneficial, especially when treatment was specialized, aftercare was available and if the child presented with a less pathological clinical picture. Two more recent reviews considered outcome literature on both adolescent inpatient and residential treatment (which tends to involve longer admissions and less restriction than inpatient facilities), justifying the inclusion of literature focussing on both types of facilities because the same populations are treated using the same modalities (Bettmann & Jaspersen, 2009; Epstein, 2004). These two studies shared conclusions; both found that residential and inpatient treatment is an effective intervention for treating many adolescents, but not for all presenting problems.

However, there were some caveats about the existing outcomes literature. Little consensus exists regarding how outcomes should be measured (Epstein, 2004), however, symptom reduction is the most often used measure of success, with social functioning also considered a meaningful indicator of adolescent treatment outcome (Bettmann & Jaspersen, 2009). Theoretical orientation is a neglected area in outcome studies (Bettmann & Jaspersen, 2009; Epstein, 2004). This leaves

questions around the extent to which the efficacy of the treatment versus the theoretical orientation is measured. An identified potential problem with looking at theoretical orientation is a lack of clear theoretical definition at treatment facilities, with many studies failing to acknowledge whether or not the staff implements treatment according to theory (Bettmann & Jaspersen, 2009).

Standard programmes consist of elements similar to those included in the Kaya programme, such as milieu, family, group and individual therapy but specific programme elements are seldom assessed (Zimmerman, 1990). The few studies which have considered programme elements have failed to define the extent to which the elements are delivered to patients (Bettmann & Jaspersen, 2009). Bettmann and Jaspersen (1999) called specifically for future literature to incorporate theoretical perspectives, gauge symptom reduction as well as relational and social functioning.

The two most similar units with published outcome studies are a unit in Texas, USA (Brinkmeyer, Eyberg, Nguyen & Adams, 2004) and one in the South Eastern USA (Leichtman et al., 2001). Both units use a similar combination of programme elements (although both include individual therapy, unlike Kaya) and target roughly the same patient population as Kaya. The Texas unit runs a longer programme with the typical admission ranging from three to four months (Brinkmeyer et al., 2004). In a study into the effectiveness of their programme it was found that patients consistently showed statistically significant improvement during admission and sustained these improvements in the year after discharge (Leichtman et al., 2001). The South Eastern USA unit admits patients for generally shorter time periods than Kaya (a mean of six days) and has substantially poorer outcomes than the Texas unit. Nine months after treatment just under half of the patient's parents reported the patient was the same or worse and just over half reported an improvement (Brinkmeyer, et al., 2004). This study also suggested the existence of a subgroup of patients who undergo repeated hospitalisation with little engagement in their treatment (Brinkmeyer et al., 2004).

An outcomes study at a unit in England, with mean lengths of admission just under three weeks for an assessment admission and fourteen and a half weeks for treatment, found that of those patients who made gains during their admission, one quarter improved further during the follow-up period, half maintained their improvement and one quarter deteriorated (Jaffa & Scott, 1999). Patients who did not make significant improvements during treatment did not tend to make improvement during the follow-up period (Jaffa & Scott, 1999).

The only available study in a South African context is not easily comparable as it took place at an outpatient facility running a 12-week programme; Ahmed (1999) found that 18 months after discharge, although general improvements in mood were reported, adolescents tended to be prone to further long term problems.

Many of the outcomes studies reviewed found that patient outcomes revealed sub-groups of patients who seemed to do better or worse than most. Jaffa and Scott (1999) found that at an adolescent inpatient unit in Cambridge, England, patients who made progress during admission tended to maintain their progress. Chung and Maisto (2009) studied outcomes in adolescent outpatient substance abuse treatment at six facilities in the USA and found that older patients tended to have better outcomes. The same finding was made in an outcomes study at a psychiatric inpatient unit in Japan, with planned discharge also correlating to significant improvement (Setoya et al, 2011). An outcomes study on inpatients with depressive symptoms showed a sub-group of about 13 % (mainly girls) who reported high symptoms levels at follow up (Ivarsson, Larsson & Gillberg, 1997). A study on a children's psychiatric inpatient unit (ages 4 -15) found that the greatest change occurred at the first follow up – five months after admission, and that changes after that were smaller (Sourander & Piha, 1998).

The literature shows that the modalities Kaya uses are used commonly at units targeting similar populations internationally. Two differences were noted: the absence of individual therapy

at Kaya, which is frequently part of treatment programmes in the literature, and the short duration of treatment compared to other units.

There is a notable lack of outcomes studies on the modalities used in an adolescent inpatient context, which may be due to difficulty isolating the effectiveness of each component in a programme. Each modality will now be briefly described and the findings of the most relevant literature mentioned.

2.2.2 Therapeutic Milieu.

Therapeutic milieu, based on the premise that all aspects of the patient's environment should contribute towards patient treatment and recovery (Thomas et al., 2002), is frequently cited as part of treatment at adolescent inpatient units, although literature evaluating the effectiveness of this therapeutic approach in adolescent inpatient settings is lacking.

Gunderson (1983) describes therapeutic milieu as needing to be actively implemented and consist of a combination of structure, involvement (active collaboration by patients) and validation (affirmation of patient's individuality). Therapeutic milieu at Kaya is overtly driven in a community group every morning.

Tucker (1983) describes the use of milieu in one unit where, like Kaya, the programme aims to facilitate an integrated message that not only must patients become participants in their own care, but they must become agents of change for other patients. Tucker (1983) describes this as happening because space is given for patients to give and receive support, to give and receive feedback on behaviour and interpersonal interactions, to determine both the pace and specific aspects of other patients treatment plans and to share responsibility for both the care of other patients and the management of the unit.

The literature refers to the use of milieu in inpatient units for treatment in adolescence (Brinkmeyer et al, 2004; Leichtman et al., 2001; Zimmerman, 1990), Schizophrenia (Gunderson, 1983) and acute psychiatric disorders (Almond, Keniston & Boltax, 1969).

In a review of outcomes studies, Ellsworth (1983) looked at the effectiveness of therapeutic milieu and found that very few, if any, of the experimental studies reviewed managed to adequately control relevant patient and programme characteristics enough to determine causality of milieu effectiveness.

In general, however, the literature points to milieu as an accepted modality for this type of treatment facility.

2.2.3 Dialectical Behaviour Therapy.

Dialectical Behaviour Therapy (DBT) is a multimodal Cognitive Behavioural Therapy based therapy (Jackson & Linehan, 2010). Although DBT was developed to treat chronically suicidal patients meeting criteria for borderline personality disorder, it has been adapted to treat other problem behaviours such as substance abuse and eating disorders in patients with borderline personality disorder, suicidality in adolescents, suicidal behaviour in elderly patients with major depressive disorder and antisocial personality disorder in individuals in a forensic settings (Jackson & Linehan, 2010).

Feigenbaum (2007) found, in a review of the literature, that DBT has an emerging evidence base for treatment of borderline personality disorder and that findings suggest effectiveness as a treatment for binge eating disorder, chronic depression in adults, Attention Deficit/Hyperactivity Disorder in adults and suicidal behaviour in adolescents. Quinn (2009) came to a similar conclusion, stating that there is evidence that DBT is effective for reducing mental-health related problems in adolescence, but raised concerns around the quality of the studies included in the review, with confounding variables making it unclear the extent to which DBT has been effective.

Katz and colleagues (2004) found, in their preliminary evaluation on the effectiveness of DBT in an adolescent inpatient setting, that DBT reduced behavioural incidents during admission compared to treatment as usual but was equal to other treatments in reducing parasuicidal behaviour, suicidal ideation and depressive symptoms in the year after an admission.

The literature supports DBT as a modality suitable for the types of patients seen at Kaya.

2.2.4 Cognitive Behavioural Therapy Addictions groups.

Kaya's addiction groups are based on Cognitive Behavioural therapy (CBT) principles. CBT is a structured therapy designed to alleviate symptoms and help patients learn more effective ways to overcome the problems causing their distress (Donaghy, Nicol & Davidson, 2008). As a treatment for addiction, CBT has been found to be effective, equally to motivational enhancement therapy and the twelve step Alcoholics Anonymous programme (Donaghy et al., 2008).

CBT is supported as suitable for use with self-destructive habits (France & Robson, 1997) and has been used effectively to treat substance abuse disorder and co-occurring suicidality in adolescents (Esposito-Smythers, Spirito, Kahler, Hunt & Monti, 2011). CBT is therefore suitable for use in the Kaya's context based on the literature.

2.2.5 Family therapy.

The importance of family intervention for adolescent behaviour problems is supported in the literature. Family interventions are based on the reliable observation that adolescent behavioural and emotional difficulties often occur in the context of family dysfunction. This is supported by studies finding that family environment influences adolescent behaviour problems, such as alcohol use and incidents of delinquency (Nash, McQueen & Bray, 2005; Matherne & Thomas, 2001). Many studies point to the effectiveness of family therapy for symptom alleviation and improved family functioning in interventions for adolescents with the behavioural or emotional problems seen at Kaya (Curry, 2001; Boston & Cottrel, 2002; Ozechowski & Liddle, 2000).

2.2.5 Unstructured group therapy.

Corey (1995) writes that group therapy is well-suited to adolescents because it gives them a space to express conflicting feelings, explore self-doubt and openly question and modify their values in a time during which they are dealing with issues such as dependence/independence struggles, acceptance/rejection conflicts, identity crises and pressure to conform. It also provides an opportunity to learn to communicate with peers, benefit from modelling provided by the group leader and experiment with their reality (Corey, 1995).

In a comparative study between a therapeutic support group and a social skills training group with depressed adolescents it was found that the support group was immediately effective in reducing depression, a change that was maintained over nine months, and that the social skills training group showed less immediate improvement but the same change as the support group at follow-up (Fine, Forth, Gilber and Haley, 1991).

Hoag and Burlingame (1997) found that children and adolescents who receive group therapy are better off than almost three quarters of those in a control group, and concluded that group therapy is effective.

The literature supports the use of group therapy with adolescents.

2.2.6 Psycho-education.

Professionally led psycho-education groups are a space where skills, perspectives and adaptive strategies are learnt (Ettin, 1999). These groups tend to be theme-centred with guidance provided and behaviour change discussed (Ettin, 1999). The group structure can involve processing, exercises, discussion and lectures (Ettin, 1999).

Psycho-education groups in adolescents have been found to be perceived as beneficial by adolescents, with value being placed on interpersonal learning and catharsis (Shechtman, Bar-el & Hadar, 1997).

Psycho-education is supported as a modality and is part of the Kaya programme in the form of two groups, interpersonal effectiveness (where self-esteem, assertiveness and boundaries are the foci of the groups) and recovery group (where loss, resentment and thought patterns are group foci).

Studies focussing on adolescent experiences at inpatient units will be reviewed below.

2.3 Qualitative studies on adolescent patient experiences.

Adolescent experiences of inpatient treatment is an under researched area in the literature; this is supported by various accounts of the literature, where adolescent perspectives on psychiatric hospitalization are described as having been given limited attention in the past (Grossoehme & Gerbetz, 2004; Haynes et al., 2011). Moses (2011) states that there is a need for more in-depth evaluations of youths' experiences as inpatients, utilizing qualitative methods that can provide rich understanding of experiences with brief inpatient treatment.

Only three similar studies could be found. These, like this study, focussed on the perceptions adolescents had of their inpatient treatment.

Offord and colleagues (2006) interviewed ten adolescents who had been admitted with Anorexia Nervosa to a general psychiatric ward (Offord et al., 2006). The other two included participants who had experienced general psychiatric admissions with varied presenting problems (Haynes et al, 2011; Moses, 2011). All of these studies used semi-structured interviews. Haynes and colleagues (2011) had a sample of ten and Moses (2011) had a sample of 80.

Haynes and colleagues (2011) found that the most often noted helpful aspects of treatment mentioned by their participants was support and normalization with peers.

This is similar to the findings made by Moses (2011), who reported that the most critical finding was the role of peers during psychiatric hospitalization, with benefits from peers' support, feedback and normalization.

Haynes and colleagues (2011) noted that participants' close relationships with other inpatients may have held particular importance as a protective factor against negative peer comparisons.

Also of importance in the study by Haynes and colleagues (2011) were, in order of frequency mentioned, support and interpersonal relationships with staff, learning cognitive and behavioural coping skills and group therapy.

In the study by Offord and colleagues (2006), peer relationships came up as a major theme, both inside and outside the hospital. Another major theme in their study, removal from normality versus connecting with the outside world, describes a pervasive sense of having normal adolescent life and development suspended while going through inpatient treatment (Offord et al., 2006); this is similar to a major theme described in a study by Haynes and colleagues (2011) where 'Living in an Alternative Reality' emerged as the core category, centring on the unusual nature of the overall hospitalisation experience from the adolescents' perspective. Other major themes described by Offord and colleagues (2006) were: being treated as another anorexic versus a unique individual in distress (this included patients perceptions of assumptions made by staff and of the programme as inflexible) and control and collaboration (this described a theme of powerlessness and empowerment around treatment and recovery) (Offord et al., 2006).

Other studies had limited methodological similarities to this study but had elements that were similar, for example, as a qualitative addition to a quantitative study, asking patients to write a few lines about helpful and unhelpful experiences (Marriage, Petrie & Worling, 2001). The three elements most often mentioned as beneficial were helpful doctor and nurses, as well as the support of peers (Marriage et al., 2001). Ward rules featured as the most frequently mentioned unhelpful aspect of treatment.

The only South African study looking at adolescent's experiences of a group-based psychiatric treatment programme, based at a 12-week outpatient programme, used surveys including qualitative data in the form of written comments (Ahmed, 1999). Themes highlighted as important were emotional growth, skills acquisition and positive and negative aspects of the programme; included in the final theme were understanding and support of peers (Ahmed, 1999).

Survey data have been used to investigate adolescents' views on broad concepts such as the meaningfulness of different milieu or programme elements, 'Just being with other adolescents' was rated as the most meaningful aspect by a group of 105 young inpatients (Grossoehme & Gerbetz, 2004). Although this study utilised a different approach, this finding is similar to that of Moses (2011) and Haynes and colleagues (2011).

The literature on the framework of therapeutic factors of group therapy that will be used to analyse the data will be discussed in the next section.

2.4 Yalom's therapeutic factors

Yalom's description of therapeutic factors of group work (Yalom 1970; Yalom & Leszcz, 2005) was used as a framework to analyse the data. These factors will be discussed in detail now.

The classic handbook, *The Theory and Practice of Group Psychotherapy*, is in its fifth edition (Yalom & Leszcz, 2005) and contains empirical data and expert clinical observations focussed on the mechanisms of change that are common to group interventions of different kinds, from formal group psychotherapy to peer support groups. Yalom (1970) systematically and empirically investigated factors leading to change in group therapy. On the basis of a review of research, he identified ten curative factors in group therapy: instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behaviour, interpersonal learning, group cohesiveness, and

catharsis. He later added existential factors to the list and moved away from the term curative factors instead referring to therapeutic factors (Yalom & Leszcz, 2005).

This conceptualisation of therapeutic factors has been used in many different contexts to understand the therapeutic factors at play in different group therapies. Many studies have used questionnaires based on these therapeutic factors to investigate group process in different groups with different participants and foci, for example, adolescent issues (Shechtman et al., 2008), issues of long-term psychiatric out-patients (Bloch & Reibstein, 1980), student support groups at a university (Macnair-Semands & Lese, 2000), recovery support for sex addicts (Nerenberg, 2000) and abusive spouses (Schwartz & Waldo, 1999); while other studies have adopted a qualitative approach (Argyraoulis & Zafiropoulou, 2007; Lara et al, 2004;).

The factors, which can be feature in different parts of the change process, and are of differing importance to different individuals at different times (Yalom & Leszcz, 2005), will be explained now with relevant examples from the literature of groups in which the factor has reportedly played a role.

The first factor, imparting information, also referred to as guidance, is a therapeutic factor in group therapy and can be present when mental health and illness information and advice is given in groups (Yalom & Leszcz, 2005). Included here is any direct guidance given to patients by both therapists and patients. Examples of how this is used include transferring information, altering sabotaging thought patterns, structuring groups and explaining the process of illness. Organisations running psycho-educational or support groups targeting specific or general mental health issues, such as Recovery International (an organisation offering peer-run groups for the prevention of mental illness relapse) (Pickett, Phillips & Nobiling, 2012), often make use of this therapeutic factor (Murray, 1996). Imparting of information has been rated by therapists as most helpful in a

study of groups with male inmates (Morgan, Ferrell & Winterowd, 1999) as well as groups for family members of the mentally ill (Citron, Solomon & Draine, 1999).

Universality, the next factor, is the feeling of connectedness attained in group therapy that is often experienced as a relief from feelings of isolation often held when joining a group (Yalom & Leszcz, 2005). The disconfirmation of the uniqueness of patients suffering can be a powerful source of relief (Yalom & Leszcz, 2005). Universality, together with catharsis and group cohesiveness, was rated most highly as important therapeutic factors in a divorced women's group (Øygaard, 1999). In other studies, this factor has been highlighted among the most helpful factors by patients (Lara, 2004) and by therapists (Morgan et al., 1999).

The next factor, group cohesiveness, is the attraction of members to the group which creates a space of acceptance, support and improves the inclination for meaningful relationships to form (Yalom & Leszcz, 2005). In a cohesive group, members value the group and feel valued in return. Belonging to a group can raise self-esteem and meet dependency needs while also building responsibility and autonomy as each member contributes to the group's welfare (Yalom & Leszcz, 2005). In adolescence, self-esteem and well-being are largely pinned on membership to social group, and exclusion can be devastating (Yalom & Leszcz, 2005). In a study looking at adolescents' experience of psycho-education and art therapy groups, group cohesiveness and hope were rated most important (Shechtman et al. 2008). It was also considered the most valued factor, together with catharsis, by an inpatient group focussed on sex addiction (Nerenberg, 2000).

Interpersonal learning and the development of socialization techniques, the next factor, takes into account the importance of interpersonal relationships, corrective emotional experience and the groups as a social microcosm (Yalom & Leszcz, 2005). Interpersonal learning involves patients getting to know themselves without distortions, understanding how they are perceived by others, and realizing how they can improve interpersonal functioning. This factor offers group members the

opportunity to recognise their areas of difficulty; the development of socializing techniques offers them the opportunity to build on inadequate or maladaptive interpersonal skills with more effective ways of conceptualizing their world and interacting with it (Yalom & Leszcz, 2005). A study on alcoholism found that group approaches can be made more effective if the therapist takes advantage of interpersonal learning (Matano & Yalom, 1991). Interpersonal learning has been rated among the most helpful factors in groups with male inmates (Morgan et al., 1999).

Catharsis, the next factor, is the expression of affect experienced as a relief (Yalom, 1970). This factor connects strongly with the other factors, for example, universality, where acceptance when sharing is important (Yalom & Leszcz, 2005). Catharsis was highlighted as important along with hope, imparting information and universality in an investigation into therapeutic factors in groups with depressed women (Lara, 2004). At least one other study has also noted patients rating this factor among the most helpful (Nerenberg, 2000).

Experiences from the family can influence patient interactions with group members and facilitators; through working out problems within the group, a patient may be working through unfinished business from the past (Yalom & Leszcz, 2005). This is the next factor, the corrective recapitulation of the primary family group, which can be a corrective emotional experience, where behavioural stereotypes can be challenged and new behaviours and exploration of relationships may take place (Yalom & Leszcz, 2005). This therapeutic factor is often highly valued by the therapist, but generally not highly valued by the patient (Yalom & Leszcz, 2005). A successful group experience will recapitulate the early family experience in a growth-inducing manner on an unconscious level; this is not suitable and available for interpretive work in the here-and-now experience of group therapy (Yalom 1970). This factor has been found to be central in psychotherapy groups for sex offenders (Sribneya & Reddon, 2008), and victims of incest (Marotta & Asner, 1999).

Imitative behaviour is where one patient benefits from observing another's therapy. Through imitative behaviour individuals may experiment with new behaviours, even if only to abandon these behaviours afterwards; helping patients to find out what they are not as they improve their understanding of what they are (Yalom & Leszcz, 2005). This factor often does not feature as one of the most prominent helpful factors of treatment, as reported by patients (Argyraoui & Zafiropoulou, 2007; Macnair-Semands & Lese, 2000; Nerenberg, 2000)

Existential issues is the factor that covers issues of responsibility, basic isolation, the unpredictability of life, contingency, the recognition of morality and consequences for the way we live our lives (Yalom & Leszcz, 2005). Existential issues have been rated as particularly important in groups with members facing terminal illness (Antoni et al., 2001; Bower et al., 1998; LeMay & Wilson, 2008), chronic disease and disability (Bullington et al., 2003; Huebner, 2004) and groups of older members (McLeod & Ryan, 1993).

Instillation of hope refers to an expectation of help and is necessary for other curative factors to be effective. Seeing other people improve in a group plays an important role in the instillation of hope (Yalom & Leszcz, 2005). Patients benefit from seeing other patients further along in the group therapy process, where older patients may spontaneously offer encouragement to newer members and therapists can use older patients' improvements therapeutically by calling attention to their improvements (Yalom & Leszcz, 2005). This factor is frequently mentioned as one of the most important therapeutic aspects of group treatment (Lara, 2004; Murray, 1996; Shechtman et al., 2008).

Altruism refers to unselfish acts of support and reassurance between patients. A sense of meaning for patients can be achieved by focussing on something or someone outside of themselves (Yalom & Leszcz, 2005). Both adolescents and psychiatric patients have been conceptualised as self-absorbed populations. Psychiatric patients often have a sense of being a burden to others, and

supporting other patients can boost self-esteem and offer relief from self-absorption (Yalom & Leszcz, 2005); the adolescent life phase has been conceptualised as including egocentricism with particular failure to differentiate between the concerns of themselves and others (Elkind, 1967). As adolescent psychiatric patients, the Kaya community may be a population that may benefit from acts for the aid of other community members. Studies on addiction and recovery have found there are benefits from mutual-help for both the helper and the person being helped; that those who help others help themselves (Ritsher et al., 2002; Zemore, Kaskutas & Ammon, 2004). The benefit to the helper may be attributed to a changing self-evaluation despite no change in objective function or circumstances (Schwartz and Sendor, 1999).

2.6 Conclusion of literature review

An examination of the literature shows that inpatient treatment with varied therapeutic elements is an accepted treatment for adolescent behavioural and emotional problems. The main programme elements (community group, DBT, interpersonal effectiveness, recovery group, addiction group and group therapy) were also shown to be regarded as supported modalities in the literature. The frame of therapeutic factors that was used to analyse the data is also shown as a widely used and accepted frame to examine the therapeutic value of group treatment (Yalom & Leszcz, 2005). It was also shown that the literature on adolescent perceptions of treatment is sparse, a gap which this study aims to contribute towards filling. The methodology section to follow will outline how this was done.

Chapter 3: Methodology

3.1 Introduction:

This chapter outlines the aims and rationale for the research design. The sample, data collection and procedures are explained. Following this is an explanation of how the research question was answered through the use of template analysis; a discussion of ethical considerations and finally a discussion of my own role and experience as the researcher.

3.2 Aims:

This study will contribute to better understanding adolescent perceptions of their inpatient psychiatric treatment at Kaya. Although brief inpatient treatment is regarded in the literature as an effective intervention for adolescent behavioural and emotional problems (Bettmann & Jaspersen, 2009; Epstein, 2004), there is little literature on the experiences of patients, as highlighted in the review of literature. This is the first study into therapeutic factors at Kaya, and possibly of adolescents' experiences at psychiatric units in South Africa. The aim is to explore ex-patients' views of the therapeutic factors involved in the treatment they received while at Kaya.

3.3 Design:

Qualitative research is appropriate when research seeks to develop a holistic picture of an issue of interest; when the goal is to understand phenomena in context, as they are lived (Terr Blanche, Kelly and Durrheim, 2008). This is aligned with the aims of this study, to explore adolescent perspectives on the therapeutic factors involved in the treatment they received, and thus, a qualitative research design has been deemed appropriate. Twelve individual interviews were conducted, allowing for the collection of rich and in-depth data regarding the experiences of adolescents admitted to Kaya. A semi-structured interview, designed specifically for the study, was

used (Appendix 4). Data was analysed using thematic analysis, with a template used to organise the data; this is explained in detail in the *analysis* section.

3.4 Sample and participant screening:

The sample was made up of 12 ex-patients, recruited through the aftercare group and telephonically if they were not in aftercare. This is considered large enough to represent varied experiences. Kelly (2006) states that while six to eight participants may be sufficient in a homogenous sample in a qualitative study, ten or more participants are more suited to uncover issues in more varied samples; as such, twelve was selected as an appropriate number. All participants have been patients at Kaya and therefore were between the ages of fourteen and eighteen years old on admission. An attempt was made to recruit participants who, on initial admission, presented with a diversity of problems, reflective of the variety of difficulties typically treated in the unit. As far as possible, participants who represented different age, race and gender groups and who were discharged no less than two months prior to the interview were recruited; the rationale for recruiting participants some time after discharge was to allow for potential reflective time after their admission. There was one exception to the two month criterion: Participant L, who was completing her second admission at the time of the interview. She was recruited through aftercare, which is attended by current patients in their last week of treatment. An exception was made because of her previous admission, which had taken place seven months prior to her interview. It was thought she could offer a valuable perspective having had both time to reflect on her admission and the need for a second admission. A summary of participant information is shown below in Table 2.

Table 2: Biographical details of the participants interviewed.

Name used	Gender	Race	Presenting problem on admission according to the participant	Month and year of admission	Admission duration	Age on admission	Age at interview	Method of recruitment
Participant A	F	White	Self-harm, substance abuse, eating disorder	11/09	48 days	17	20	Aftercare
Participant B	F	White	Self-harm, family conflict, eating disorder, too much power in the family	01/11	28 days	16	18	Phone call
Participant C	F	White	Family conflict, substance abuse	03/11	28 days	17	18	Phone call
Participant D	M	Coloured	Depression, family conflict	06/11	25 days	17	18	Phone call
Participant E	M	Coloured	Substance abuse	01/10	21 days	16	18	Aftercare
Participant F	F	Coloured	Suicide attempt, suicidal thinking	10/11	21 days	17	18	Phone call
Participant G	M	White	Low confidence, anxiety, peer relational problems (no friends and bullied by peers)	01/11	21 days	15	16	Phone call
Participant H	F	White	Self-harm	04/12	20 days	14	14	Aftercare
Participant I	F	White	Self-harm	11/07	28 days	17	21	Aftercare
Participant J	F	Coloured	Self-harm	06/10	28 days	16	18	Phone call
Participant K	F	White	Suicide attempts, self-harm, substance abuse	02/10 02/11	21 days 14 days	16 17	18	Aftercare
Participant L	F	White	Conflict with parents, running away, eating disorder	10/11 07/12	24 days 21 days	15 16	16	Aftercare

3.5 Recruitment, consent and interview procedure

The participants were recruited through two avenues: through Kaya's aftercare group and through phone calls to the parents of ex-patients. I briefly explained the nature of the research and asked for volunteers at four consecutive aftercare groups, after which volunteers could come and speak to me, where I again explained the voluntary nature of potential participation, responded to their questions and asked them their age and date of discharge. In cases where the participant was willing to participate but had been discharged within two months of that conversation, I declined to have them participate and thanked them for volunteering. In cases where the volunteer had been discharged more than two months prior to the phone call and was under the age of 18, permission to contact a parent was sought from the child. The volunteer's parent was then contacted, the research explained, and verbal consent sought. The need for written consent prior to the interview was explained. All these parents provided consent for their child to participate. Other participants were recruited telephonically. In these cases, I contacted ex-patients who lived locally and had been discharged at the time I worked at Kaya, between six and 18 months prior to the phone calls were made. The parents were contacted first and after I had explained the research and the parent verbally consented, the child was then contacted directly telephonically. If the child agreed to participate, the parent was contacted telephonically again, and practical details around interview time and the need to obtain written consent were discussed.

Parents who brought their child to the clinic personally signed written consent, having the form explained to them in detail before doing so. Parents who were not able to bring their child personally were emailed the form, and it was explained to them over the phone. In those cases the child was required to bring the printed, signed form with them to the interview. Some of the participants were eighteen years old or older and could give consent themselves. Interviews were set up at a time convenient for the participants and their parents. All interviews were conducted at Kaya, although all participants were offered for the interview to take place in their homes for their convenience, but all opted to do the interview at Kaya. Before the interview commenced, I reminded the patient of my

name, the purpose of the research and I talked the participant through key issues outlined in the consent form. I asked them to sign a consent form (for those who were under eighteen years old) or an assent form (in cases where the participant was under 18 and parental consent had already been obtained). The interview then commenced.

At the end of the interview, the participants were given the space to ask questions. The participants were invited to attend aftercare, reminded of Narcotics Anonymous meetings (if substance abuse was identified as an issue during treatment) and to contact Kaya or their psychiatrist if they were struggling. The participants were thanked for their participation in the study.

3.7 Procedure:

The data collection took place over a period of six weeks. Interviews lasted between 45 minutes and 90 minutes and took place at Kaya. Semi-structured interviews were conducted to allow participants to talk about their experiences in some depth (Kelly, 2006) The interview schedule was designed to elicit data representing participant experiences broadly, and to allow participants to emphasize the aspects of their treatment that felt pertinent to them. Three broad areas were covered: experience of treatment, how treatment impacted the participant's life and suggestions about changes to improve the Kaya programme. These areas were chosen to elicit rich data concerning patient experiences and opinions on the strengths and weaknesses of the programme. Prompts were prepared to scaffold the interview if needed (see Appendix 4 for the interview schedule), and flexibility was allowed to explore issues that arose in the interview. I clarified points made in the participants' accounts when deemed necessary. The interviews were then transcribed and analysed. Transcriptions protected participant confidentiality by making participants anonymous through removing all identifying data from the transcripts. Transcriptions were destroyed after they were analysed.

An initial research proposal was presented to the Ethics Committee of the Department of Psychology of the University of Cape Town before data collection commenced. Ethical approval was

received. One pilot interview was conducted in order to test the relevance and quality of the interview schedule. The initial interview schedule was not adjusted as it was deemed suitable. Written informed consent was obtained from all participants and parents when participants were under eighteen years old.

3.8 Analysis:

A researcher must construct a design for the process of interpretation just as they design a research project (Crabtree & Miller, 1999). It is important that the theoretical framework and methods of analysis match what the researcher wants to know, and that a researcher recognises and acknowledges them as decisions (Braun & Clarke, 2006). Thematic analysis was chosen to meet the research aims of this study; this is a method for identifying, analysing, organising, describing and reporting patterns within data (Braun & Clarke, 2006). An application of thematic analysis is to provide a detailed and nuanced account of one particular theme, or group of themes, within the data; this may relate to a specific area of interest within the data as is the case with the data obtained for this study (Braun and Clarke, 2006). This type of thematic analysis has been called “theoretical thematic analysis” and tends to be driven by the researcher’s analytic interest, and is thus more explicitly analyst-driven, tending to provide less a rich description of the data overall and more a detailed analysis of an aspect of the data (Braun and Clarke, 2006). When a limited facet of data is being explored, a structured analysis process using a template organising style and a coding manual may be used (Crabtree & Miller, 1999). The researcher defines a template or codes based on prior research and literature review (Crabtree & Miller, 1999); in the case of this research project, an existing template of therapeutic factors in group psychotherapy was used, as developed by Yalom and Leszcz (2005). The researcher may begin with an immersion phase (Crabtree & Miller, 1999), which was done in this analysis process. Following this, the research process involved focussing on particular aspects of the text, bringing together related data (Crabtree & Miller, 1999). The complete analysis process of this study involved: immersing myself in the data, creating a coding scheme, coding the text, sorting the

text so that similar segments were together, reading the segments and making connections that are substantiated (Crabtree & Miller, 1999). Analysis involved a constant moving back and forward between the entire data set, the coded extracts of data for analysing, and the analysis of the data that we being produced (Braun & Clarke, 2006).

3.9 Ethical considerations

The study protected the autonomy and dignity of all participants, which was done through asking for voluntary participation and informed consent, and protecting participant's confidentiality (Wassenaar, 2006). The nature and the purpose of this study were thoroughly explained to participants and their parents (when the participant was under 18) thus allowing each participant to decide if they wanted to take part. The participants were informed that they may at any time during the course of the research interviews decide that they no longer wanted to participate in the research project. Written consent was also specifically obtained for recording the interviews. Parents/ guardians were asked to give consent for their under aged child's participation and the participants were asked to give consent for their own participation. The measures taken to protect participants' anonymity were explained. The interviews were subsequently transcribed verbatim. The participants were informed of the measures taken to ensure confidentiality of the transcripts. The study endeavoured to achieve non-maleficence through transparency and a supportive approach in interviews. Beneficence was achieved by offering a referral service. A protocol was designed for the event that a participant disclosed suicidality (Appendix 3). All participants were re-invited to aftercare, which is freely available to all those who have completed the Kaya programme.

3.10 Reflexivity

It is important for the researcher to explicitly recognize and examine their role in the research process, including their assumptions and possible influence on the research process (Terr Blanche,

Kelly & Painter, 2008). Reflexivity is an important part of transparency in qualitative research (Yardley, 2008).

Sensitivity to context should be shown in the way the researcher engages with participants (Yardley, 2008). As a previous employee of Kaya, I was familiar with the programme and some of the participants; I worked directly with some of the participants and have known others from the aftercare group. My experience at Kaya evoked my interest in this research topic. The potential impact of my dual role on the trustworthiness of the research, and the nature of this impact, was considered throughout the research process. My position may have served to provoke more honest responses as participants may have regarded me as understanding them and thus been more open with me than they may have been otherwise. However, it may also have created a desire to please and give socially acceptable responses (Yardley, 2008). With this in mind, an effort was made to maximise the trustworthiness of the study by remaining cognisant of the potential impact of the dual roles throughout the interviews and analysis. Special sensitivity was shown during the interviews to promote honest responses. Potential bias was explicitly discussed with the participants and honesty as far as possible was requested. This is congruent with the philosophy instilled at Kaya, where honesty, even if it is not palatable, is encouraged. Leading questions were avoided and interest was shown in what the participants had to say, allowing the participant to talk freely about their experiences, rather than being restrained by researcher preoccupations (Yardley, 2008). The supervisor on this study played an important role in minimising this bias by critically examining analyses.

Chapter 4: Analysis and Discussion

4.1 Introduction:

This section aims to present a qualitative analysis investigating the significant therapeutic mechanisms operating in group therapy using the categories described by Yalom and Leszcz (2005). The application of Yalom and Leszcz's (2005) factors was considered a useful framework to understand the therapeutic factors involved in patient treatment at Kaya.

Some of these factors featured as major themes in our interviews, specifically: the imparting of information, universality, group cohesiveness, interpersonal learning and catharsis. Other factors featured minimally or not at all: the corrective recapitulation of the primary family group, altruism, imitative behaviour, the installation of hope; an attempt is made to understand this as well as the potential value of these factors, by drawing on relevant literature.

Because Kaya's interventions are supplemented with family therapy, the discussion of therapeutic factors of group intervention is supplemented by discussion on patient accounts of the therapeutic value of family sessions, drawing on relevant literature. The discussion concludes by noting additional concerns raised - where concerns from the interviews will be discussed - with the intention of providing helpful feedback to the Kaya team.

4.2 Overall therapeutic value and change.

All participants discussed some kind of positive change linked to their admissions to Kaya, motivating for this investigation into the therapeutic factors at play at Kaya. Moses (2011) reported a similar finding, where all participants in her study reported helpful aspects of treatment. The accounts of positive impact varied in degree; on the one end of the spectrum, Participant C reported minor changes but did not report change in her family relationships, which she considered the main reason for her admission. However, she did say she viewed her admission as worthwhile and said that she became

more mature at Kaya, and that she lessened her substance abuse and drinking as a result of her admission.

I think it matured me, if that makes any sense. (Participant C)

On the other end of the spectrum, some participants described big changes after their admission.

Participant A described feeling that she had changed during her admission.

But what's weird with that...obviously, it's been a while...but I can't really remember the person I was before Kaya. I changed a lot, like seriously, with my whole outlook on life. (Participant A)

Participant E laughed when asked how long it was since her admission; when this was probed, she responded with disbelief at how much she had changed.

Because when I think about it now, then it's like I can't believe the person I was, under a year ago to now... I didn't expect to grow so much. (Participant E)

All participants reported finding the programme helpful in some way. Participant A thought the effectiveness of treatment was a result of the programme and the peer group at the unit in combination.

I don't think there was really one main (helpful) thing. I think it was a combination of the content and the community. (Participant A)

This is reflected generally over the interviews, through different comments made about both the programme and the importance of peer groups, which will be discussed in greater depth in the course of the discussion.

In summary, all participants reported their admissions as beneficial to differing degrees, with some reporting small positive changes and others experiencing profound shifts in perspective.

4.3 Therapeutic factors

4.3.1 Imparting of information.

Imparting of information, which can be present when mental health and illness information and advice is given in groups, includes direct guidance given to patients by both therapists and patients (Yalom & Leszcz, 2005). Kaya offers groups that would fit into this category - where both psycho-education and coping skills are taught, such as DBT, recovery, interpersonal effectiveness and addictions groups. This factor has been found to generally not be a highly valued therapeutic factor of group work for participants over time (Yalom & Leszcz, 2005).

A South African study noted skills as an important part of what adolescents valued about the 12-week outpatient programme, highlighting feeling better equipped to cope with their difficulties (Ahmed, 1999).

Two other adolescent inpatient studies considered how similar groups were experienced by adolescent inpatients. In one study, these groups were found to be considered less helpful than other therapies (Grossoehme & Gerbetz, 2004), which is in agreement with Yalom & Leszcz (2005). Moses (2011) describes a different finding, where the psycho-educational groups were considered one of the most helpful elements of treatment by just over half the 80 participants. The participants in our study are in agreement with Moses (2011), with just over half the participants experiencing these groups as one of the most helpful elements of treatment. Some of the participants commented on the psycho-education and skills programme overall. Participant J said she thought everyone could benefit from the skills she learnt.

I think everyone should know the skills that we learn here. I think it's helpful. It's not even if you have like a problem or anything, it's just that I think it's helpful. (Participant J)

Participant C suggested more be added.

I think maybe more lessons offered, like actual skills lessons would have been more beneficial... I think things where you can actually take some knowledge from (unclear). (Participant C)

Other participants spoke about the specific groups with psycho-educational components and were generally positive about the specific groups, experiencing these sessions as beneficial and offering something applicable to their lives, with DBT being mentioned most often. Although DBT is widely regarded as an effective treatment for a wide range of psychiatric problems in adolescence (James, Winmill, Anderson & Alfoadari, 2011; Katz et al, 2004; Quinn, 2009), at this time no qualitative studies on patient experiences of the treatment can be found. However, low dropout rates in outcomes studies with this age group suggest DBT is accepted by patients (Hjalmarsson et al, 2008).

Participants who discussed the individual groups viewed them as helpful. Participant J described DBT as helpful and significant to her.

I found DBT incredibly helpful. I think that's you know right at the top of the list for me, you know just the skills or things like you know I still use today and that kind of you know really have helped you know on a very sort of instrumental level. (Participant I)

Four participants spontaneously named specific tasks from these groups that had been helpful. Participant J described finding mindfulness and distress tolerance exercises helpful when she left Kaya. Using the senses to distract one's self from strong negative emotions is included in the DBT distress tolerance programme, as is mindfulness. Both are mentioned by Participant J.

Just being mindful, and taking my mind off things, like doing something like making tea. (Participant J)

Some participants described not using the information or applying the skills from these groups, however, no participants were negative about these specific groups. For example, Participant L said

that she did not use the content of these groups on her first admission, although she said she saw the groups as relevant.

So I thought the sessions were good, but I didn't want to work them, so I thought they were a waste of time. (Participant L)

A recurring concern, discussed by two of the participants, was a substance abuse focus in groups, when the participant concerned was not admitted with a substance abuse history. Participant I spoke about feeling frustrated because of this.

I think sometimes I was frustrated because things were a little bit too substances oriented in terms of you know the addiction things and stuff like that. (Participant I)

A similar thought was expressed by Participant B,

But I just know that a lot of issues I actually was (unclear) about, it was that we thought that Kaya was more equipped to deal with, like drug-related, or alcohol or drug addictions. And a lot of us were actually here for that - a lot of us were - but most of us were just depressed, or there were like other issues. (Participant B)

In summary, most participants were positive about the psycho-educational and skills groups and reported benefitting from them, with some recalling specific groups that they found helpful. DBT was mentioned most often as helpful, with a third of participants recalling specific helpful content. This highlights that the imparting of information is a valued therapeutic factor for the participants in this study, with specific value attached to applicable skills. The concerns raised about groups being too focused on substance abuse is an issue worth consideration for the unit.

4. 3.2 Peer relationships: Universality, Group cohesiveness and Interpersonal learning.

Three therapeutic factors are discussed under the theme of peer relationships: universality, group

cohesiveness and interpersonal learning (Yalom & Leszcz, 2005). These factors are discussed together because of their relatedness, and the lack of separation of these therapeutic factors in discussion in similar studies.

Universality, the feeling of connectedness attained in group therapy, is often experienced as a relief from feelings of isolation experienced at the point of joining a group and before (Yalom & Leszcz, 2005). Group cohesiveness is the attraction of members to the group which creates a space of acceptance and support, and improves the inclination for meaningful relationships to form (Yalom & Leszcz, 2005). Interpersonal learning and the development of socialization techniques is the process of developing social skills through feedback, which takes into account the importance of interpersonal relationships, corrective emotional experience and the groups as a social microcosm (Yalom & Leszcz, 2005). These factors are intimately connected in the interviews and literature, and thus connected here as the theme of peer relationships.

Studies at similar units describe similar findings to this study; that peer relationships are a significant part of the adolescent inpatient experience, but discuss the importance of peer relationships without discussion of the therapeutic value of these relationships. Offord and colleagues (2006) found that a sense of acceptance and community was regarded as a helpful therapeutic experience by their participants; this would fit into the therapeutic factor of group cohesiveness. Haynes and colleagues (2011) say that over time participants felt a sense of connection that assisted with loneliness, understanding and putting their problems into perspective; which highlights elements of the therapeutic factors of universality and group cohesiveness (Yalom & Leszcz, 2005). Moses (2011) states that peer relationships were considered the most important helpful factor during admission by the majority of the participants in her study. These relationships are discussed by Moses (2011) as providing normalization of experience, support, advice and companionship, describing elements of universality, group cohesiveness and interpersonal learning. Peer relationships have also been cited as important in another study (Grossoehme & Gerbetz, 2004). Similar studies with adult participants have not found this factor

as key to patients' experiences (de la Rey, 2006; Biancosino et al, 2004; Thibeault et al., 2010). This may be due to the central role of the peer-group in the adolescent experience (Corey & Corey, 1992).

A sense of universality came up in more than half the interviews as a helpful experience during their admission at Kaya. These participants discussed being able to relate to their peers and feelings of connectedness. Participant A described relief from feelings of isolation experienced as part of the group

We all had similar issues, even if the reason we came in was different. They had weed issues and friends at school, so I realised that I wasn't that different to everyone else my age, and that was comforting. (Participant A)

Participant J expressed surprise that she was not alone in her struggles.

It was the first time I spoke about my feelings and that other people related to it, because I thought I'm the only one feeling like this. And there are so many other children that are actually dealing with things worse than yours, or maybe dealing with the same things. (Participant J)

Group cohesiveness was discussed indirectly, where a sense of acceptance and valuing meaningful relationships were discussed; which are possible in a cohesive group (Yalom & Leszcz; 2005). These were discussed in almost half the interviews, where belonging to the group and building relationships within the group were considered essential to their treatment. Two participants described building meaningful peer relationships during and after their admissions for the first time. Participant E described experiencing authentic connections with peers that she had not experienced before her admission.

I didn't have many friends. I just feel the friends I made here, it's like they know everything about me and they didn't judge me for that. (Participant E)

Participant F thought the bonds formed was the most important therapeutic factor during his admission.

I think it comes down to the relationships that you make. (Participant F)

Participant B describes her peer experiences at Kaya as retaining importance for her.

My favourite part of Kaya still now, it's the people that I met and made friends with and bonded with. (Participant B)

The third therapeutic factor included in the theme of peer relationships is interpersonal learning, which is discussed as the advice and opinions of peers in Moses (2011) and contributes to the major theme of peer relationships in her study. Other studies reviewed do not discuss this explicitly, but it is likely that this factor is broadly incorporated under the role of peer relationships which is found to be important in all the available published analyses of adolescent experiences at inpatient units (Grossoehme & Gerbetz, 2004; Haynes et al 2011; Offord et al, 2006; Moses, 2011).

Interpersonal learning is discussed explicitly by some of participants in our study. Participant A described experiencing conflict at Kaya as inclusive, in contrast to the conflict between the adults in her life that she felt excluded her.

It was a very different kind of confrontation to the confrontation I was used to at home...

It was different because it was more about me when there was confrontation. In the community it was more about me. I felt more part of it. (Participant A)

Participant J experienced interpersonal difficulties during her second admission, and described learning from those difficult relationships.

And I think my community being that difficult, I think it helped me even more. I think maybe I needed that community to help me to be more assertive. So I thought maybe I shouldn't look at that as a bad thing - maybe it was helpful because I wouldn't have confronted anyone if they were all

good. So it helped me. So I think I'm more confronting when I'm outside, now that I know that.

(Participant J)

Other participants were less explicit but rather implied that this factor held importance.

Participant G discussed his peers at Kaya as the most helpful element of treatment. He was unable to explain what was helpful but described improved confidence and competence with relating to peers after admission, a significant problem for him prior to his admission. It is likely that interpersonal learning played a role in this change, although he did not articulate the process as such.

Maybe it was like meeting new people and they are not judging you at all, that was great. Maybe it was that, I am not sure. But it was not like straight after Kaya, I was confident and more trusting and everything, it was like it took a while but now I am fine. (Participant G)

Participant J did not describe as great a change as Participant G, but also described increased interpersonal confidence.

I wasn't so good at speaking to people and communicating with them (all people). And I find that I'm more able to speak to people and (unclear) with them. (Participant J)

Half the participants spoke about learning new ways of communicating at Kaya and it is likely that this therapeutic factor accounts in some part for this learning. Participant B described Kaya as providing the foundation for communication change, saying this change had been an ongoing process in individual therapy after leaving Kaya.

I think Kaya sort of just gave me the basics...the sort of groundwork on me communicating differently and thinking about things differently. (Participant B)

A quarter of the participants spoke specifically about becoming more assertive at Kaya.

Assertiveness is specifically taught in the interpersonal effectiveness skills group, and coached in the milieu, using psycho-education to stimulate interpersonal learning.

Participant G said assertiveness training had helped him move away from his passive communication style.

Being taught how to be assertive and that helped to – that helped like at first too, like I said before like I would not do anything if someone made me angry. (Participant G)

Peer relationships were also a source of conflict and challenge for some of the participants. Some participants reported frustrations or difficult relationships with their peers at the unit, without reporting therapeutic value in these challenges.

Participant D described frustration when sessions were not taken seriously by his peers.

My mindset started to change because you don't want to take me seriously, why should I. Or why should I respect you guys for not taking it seriously. (Participant D)

Participant H described finding it difficult to connect with her peers.

I just found like with some of the people I just did not get on with and then I found it quite hard to like mix with the people that were here for substances. (Participant H)

In summary, peer relationships were a major theme across the interviews, featuring to some degree in all interviews. Universality was discussed by over half the participants, interpersonal learning by half and group cohesiveness by almost half the participants. This is in line with the literature on adolescent inpatient care, where these relationships are generally discussed as an important treatment element. The strong presence of these therapeutic factors in the interviews suggests that in this sample, peer relationships were among the most important aspects of treatment.

4.3.3 Catharsis.

Catharsis, the expression of affect that is part of the therapeutic process (Yalom & Leszcz, 2005), was discussed by almost half the participants as important during their admission. Unstructured group therapy is primarily the space in which this talking occurred. Another space mentioned with reference to Catharsis was the reading of their life story. For example Participant E described cathartic value in sharing her life story:

I remember when I first opened up, when I first wrote my life story, I remember how hard it was for me, and the feeling after that - that relief - getting it all out. (Participant E)

Just prior to the writing of this, the unstructured group therapy sessions were discontinued at Kaya because staff thought that the group had less therapeutic value than other programme elements. This opinion is in line with Yalom and Leszcz's (2005) expressed opinion prior to conducting their own research with adult group therapy participants; they were surprised at how highly the cathartic elements of group therapy were rated, ranking second only to interpersonal input. Similarly, in this study, almost all participants said they liked the unstructured supportive groups and found these groups helpful. Participant H discussed talking about her feelings, and trusting others to witness this as important for her at the unit.

I was like just kind of to trust people and then to actually open up honestly about how I really felt and things that had happened in the past (Participant H).

Kaminer (2006) found, in a review of the literature on therapeutic processes facilitating recovery from trauma, that both catharsis and empathic witnessing featured among those consistently proposed. The unstructured groups at Kaya and the reading of one's life story in a group provided a space for these therapeutic processes to take place. Moses (2011) describes cathartic elements of treatment as the opportunity to "release emotions" and make sense of one's own story while being witnessed by others.

Over a quarter of the adolescents in her study experienced this as a critical ingredient of treatment (Moses, 2011).

In contrast to the results of the study, other studies looking at inpatient experiences highlight different elements as helpful, for example recreation and relaxation (Thibeault et al, 2010), with cathartic aspects of treatment not mentioned (Haynes et al, 2011; Offord et al, 2006).

In summary, catharsis was mentioned by almost half the participants as helpful, and may serve an important function along with having accounts witnessed empathically. Despite not being highly valued by Kaya staff and Yalom & Leszcz (2005), this factor has been found to be important to the participants interviewed.

4.3.4 Instillation of hope.

Instillation of hope refers to an expectation of help and is necessary for other curative factors to be effective. Seeing other people improve in a group plays an important role in the instillation of hope (Yalom, 1970). Yalom and Leszcz (2005) say that older group members often offer testimonials when new group members join. It was my experience that this was often the case at Kaya, frequently taking place spontaneously. When prompted to offer opinions, community members would also offer encouraging accounts of their experiences to newer members. Two participants discussed this directly. One participant described feeling encouraged by a previous Kaya patient who returned for the day when she was a patient. She describes feeling inspired and wanting to inspire as a result.

I remember, probably the first month after I got out of Kaya, there was like an old person (maybe 20 to 21), who came (unclear). He was like one of Kaya's success stories. And that quite inspired me and I thought to myself, I want to come back here at 22 and say, I haven't cut¹ in years.

(Participant A)

¹ The term *cut* is used by Participant A to refer to self-harm, or breaking one's skin with a sharp object to induce physical pain, which may be experienced as a relief from emotional pain (Crouch & Wright, 2004)

Participant L described feeling encouraged by seeing community members' progress.

Because so many people are doing it, I can do it. (Participant L)

In summary, two participants discussed feeling hopeful because of seeing peers make progress. However, in the course of the interviews, my sense was that Kaya had offered most, if not all, of the participants a sense of hope, often connected with being understood by their peers and gaining awareness of alternative ways of being, although this was not explicitly discussed in the interviews.

4.3.5 Existential issues.

Existential issues, the term used to describe issues of responsibility, basic isolation, contingency, life's unpredictable nature and consequences for one's life conduct (Yalom & Leszcz, 2005), were mentioned by three participants, a quarter of the sample. This factor has not been mentioned in previous similar studies (Grossoehme & Gerbetz, 2004; Haynes et al, 2011; Moses, 2011; Offord et al, 2006).

The thoughts expressed in connection with this factor can be interpreted as significant to the participant concerned, due to the expressed lasting impact these realisations had in all three examples.

Participant A discussed a realisation of the impact of her actions on others

"I had to sort of take responsibility and realise that it's not just myself that I'm hurting when I hurt myself - it's my family and my loved ones. And I kind of knew it at the back of my mind, but I never really acknowledged it"

Responsibility was also a feature for Participant B; however, she discussed a realisation that she was choosing the life she was living, with an implication of an awareness of consequences.

"That is the one thing it did teach me, to sort of just be able to objectively look at where I'm heading and take responsibility for it".

Participant L spoke about coming to understand consequences for her actions during her first admission, and making different choices as a result of this realisation.

“Also what I learnt here was that with every action you have a reaction, and therefore you have a consequence. And that idea went into my mind, when I'm lying I'm going to get caught lying, and I'm going to get a consequence. So I think that stopped me from lying”

This factor may have featured differently if different questions had been asked by the interviewer, and it should not be concluded that this factor was not important for participants who did not mention it.

In summary, three participants discussed existential factors as important, two speaking specifically about responsibility, and one about consequences. These ideas appeared significant to the participants concerned.

4.3.6 The corrective recapitulation of the primary family group and imitative behaviour.

Neither the corrective recapitulation of the primary family group nor imitative behaviour as therapeutic factors came up in interviews. This should not be interpreted to mean that these factors are not at play; they may have contributed therapeutically outside of the awareness of the participants. They could also be within the awareness of the participants but simply not have been mentioned because specific questions concerning these factors were not asked.

According to Yalom and Leszcz (2005), a successful group experience will recapitulate the early family experience in a growth-inducing manner on an unconscious level; this is not suitable and available for interpretive work in the here-and-now experience of group therapy (Yalom & Leszcz, 2005). Experiences from the family can influence patient interactions with group members and facilitators; through working out problems within the group, a patient may be working through unfinished business from the past (Yalom & Leszcz, 2005). This can be a corrective emotional experience, where behavioural stereotypes can be challenged and new behaviours and exploration of

relationships may take place (Yalom & Leszcz, 2005). According to Yalom and Leszcz (2005), this therapeutic factor is often highly valued by the therapist, but generally not highly valued by the patient. The way this factor is described, as taking place largely unconsciously, may offer an explanation to the lack of mention of this therapeutic factor in the interviews.

Imitative behaviour is where one patient benefits from observing another's therapy, through which individuals may experiment with new behaviours, even if only to abandon these behaviours afterwards; helping patients to find out what they are not as they improve their understanding of what they are (Yalom & Leszcz, 2005). This may be particularly important in the developmental stage of adolescence, where the task, according to Erikson is to develop a sense of identity, of who one is and what one believes in (Erikson, 1985).

This therapeutic factor was not discussed in the interviews, but one should not conclude that it was not at play. Through my experience at Kaya, I believe that this factor played a role (differing in significance for each individual) and that there was benefit from having patients observe each other's therapy; that self-understanding may have been enhanced through witnessing others process.

4.3.6 Altruism.

Both adolescents and psychiatric patients have been conceptualised as self-absorbed populations. Altruism refers to unselfish acts of support and reassurance between patients, often experienced as a relief from self-absorption and boosting self-esteem when the patient has experienced a sense of being a burden to others (Yalom & Leszcz, 2005). Elkind (1967) describes the adolescent life phase as including egocentricism with particular failure to differentiate between the concerns of themselves and others. As adolescent psychiatric patients, the Kaya community may be a population that may benefit from acts for the aid of other community members.

Studies on addiction and recovery have found there are benefits from mutual help for both the helper and the person being helped; that those who help others help themselves (Zemore et al., 2004; Ritsher et al., 2002). The benefit to the helper may be attributed to a changing self-evaluation despite

no change in objective function or circumstances (Schwartz & Sendor, 1999).

Although altruism was not a theme in the interviews, because peer relationships were a major theme it is likely that support between peers played a significant role in these relationships despite not being explicitly discussed.

4.4. Family therapy

Yalom's (1970) framework of therapeutic factors in group therapy does not capture perceptions of the experience of family therapy, which is a supplement to Kaya's group therapy inpatient programme. Family therapy is considered an effective intervention for adolescent behaviour and emotional problems, and frequently supplements inpatient interventions, although the efficacy of this application of family therapy is not well researched (Chamberlain & Risicky, 1995; Moses, 2011, Bettmann & Jaspersen, 2009). The literature on adolescent experiences of family therapy is sparse. In one study, family therapy during adolescent inpatient treatment was rated among the helpful elements of treatment by adolescents (Moses, 2011).

From a family systems perspective, a maladaptive family structure is characterized by interactions repeatedly eliciting the same unsatisfactory responses from other family members, which is an important contributor to the development and maintenance of behaviour problems (Szapocznik & Williams, 2000). Healthy families are able to speak to one another directly and individuals are able to assert themselves (Becvar & Becvar, 2006). Almost half the participants described an experience of talking openly with their parents for the first time in their family sessions and found this helpful. One can view the participant's reports of open communication in family sessions as a movement towards healthy family communication. Participant B described talking to her family in family sessions as opening up issues.

I don't know if we actually sorted out any of the issues, but it kind of opened it up and that's what sort of helped in the end, just that opening up kind of thing. (Participant B)

For Participant E, speaking to her parents was new, and described by her as a change for the better.

Basically the main problem was that I didn't speak to my parents. And in the family sessions it was hard, but the more I spoke it was opening up, so it got better. (Participant E)

Participant L said her family did not speak about feelings before her admission, and the sessions were an opportunity to start speaking about previously difficult subjects.

They (the family sessions) are pretty hard and they are pretty hectic because you talk about things that you don't really talk about in the family... So if you want to go to deep stuff, for me, it's hard - and for my parents. So the first family session, for the first time I could tell them how I really felt. (Participant L)

The majority of participants in this study experienced family sessions as both helpful and difficult.

Participant B described the sessions as helpful and important.

It was very difficult, but I (unclear), one of the best things that Kaya does do. (Participant B)

A quarter of the participants did not view the family sessions as beneficial. Participant C said nothing new was talked about in her family sessions, and thus, they had little impact.

So I think it was really like a whole traumatic experience once a week, but it wasn't like there was anything new they haven't heard. (Participant C)

Participant H was resistant to speaking to her mom. Resistance to family therapy is considered a major barrier to the effectiveness of this treatment modality and may account for Participant H's negative experience (Chamberlain & Rosicky, 1995).

I was just like I am not going to be honest to my mom, it is not going to happen that all of a sudden I will cry and going to start opening up and telling here everything, it is just not the way it is. I just

did not like family sessions... So it is on that aspect Kaya really did not help that much but it would have taken like two and a half miracles to change that. (Participant H)

Participant G also spoke about resisting talking openly in his family sessions, however for different reasons; he viewed his mom as fragile.

Participant G: And I just felt not good. So it is more because – I think it is more because my mom has depression and she does not cope that well, and that is ... (indistinct).

AB: Okay. So you did not want to ... (intervention).

Participant G: I did not want to stress her out.

Participant G described his mom as depressed but did not elaborate in terms of diagnosis or treatment and therefore it could not be determined if and how this was addressed during his admission. Regardless, his concerns about his mom's fragility appear to have limited his willingness to engage in family therapy. Adolescents have been found to experience a variety of challenges related to their parent's mental illness, including unpredictability, instability, fear and loneliness (Trondsen, 2012). It would be desirable for these challenges to be addressed in therapy. Family care should include focussing on communication around problems and concerns between families and health professionals (Rose, Mallinson & Walton-Moss, 2004).

Three participants highlighted the significance of sibling relationships when discussing family sessions, although siblings are not routinely part of these sessions. Participant A had her brother present in a family session and discussed the helpful significance of this.

It was difficult. It also meant I had to sort of take responsibility and realise that it's not just myself that I'm hurting when I hurt myself - it's my family and my loved ones. And I kind of knew it at the back of my mind, but I never really acknowledged it until my brother actually spoke about how it had affected him. That was big. (Participant A)

Two participants expressed regret about not having their siblings in a session, saying they thought it would have been valuable to have done so. Siblings can be a source of strength and resilience in adolescence and more frequent inclusion in treatment should be considered, even when they are not the identified problem (Caspi, 2011).

Participant E discussed regret about not having her brother at a family session, where she thought an apology for her behaviour may have been taken seriously.

I think I would have told him that I'm sorry for the way I treated him. I can't blame him for things that's not his fault. I think I would have (unclear). Because if I were to tell him that just at home, he wouldn't take me seriously. (Participant E)

Participant D discussed the difficulty of going back to family life with siblings who had not been a part of his process at Kaya.

Because in the family sessions it's only your parents that are there, and now you go back into the same environment where only your parents understand and not your siblings. So now you are doing certain things that they find weird and confusing, and you try to explain that, but they are not understanding or grasping what you're actually doing. You get frustrated, and you just withdraw yourself because you don't want to get angry and upset. (Participant D)

In summary, family therapy was generally considered helpful and difficult by participants, who described experiencing new ways of communicating with their families in these sessions. The role of siblings in family sessions was highlighted by a quarter of participants who felt sibling participation in family session was helpful, or potentially helpful; this should be considered by the unit for future interventions.

4.5. Other noteworthy issues raised

Although participants describe their admissions as helpful in varying ways and to varying degrees, concerns were also raised and these should be noted and considered by Kaya staff for future research or alteration.

Underage smoking was raised as a concern by three participants including Participant H.

Under aged smokers were smoking here all the time. (Participant H)

During my work at the unit, enforcing rules about smoking was an ongoing challenge. Patients under eighteen years old were permitted to smoke with parental consent, but not all regular smokers would be given consent by their parents and would, at times, be given cigarettes by smokers who did have parental consent, providing an on-going challenge for staff and community members. As far as possible, attempts are made by counsellors to use rule-breaking, and the interpersonal processes around rule-breaking, therapeutically. Although the concern of under-aged smoking is known by Kaya staff, it is noted here as highlighted in the interviews.

Confidentiality in aftercare group was raised as a concern by a quarter of participants.

Confidentiality in groups is especially important when members have contact with other members or other member's associates outside of the group (Corey & Corey, 1992); this is true for many of the patients who attend aftercare as many of them live and go to school in the local area. Participant L explains her concerns about confidentiality in aftercare:

What I also struggle with...I don't know aftercare, because I don't know if there's a (unclear) issue because if there's a lot of people that go, hey, I saw you at Kaya, and I'm like, well, I don't want the whole world to know I was at a rehab place. So maybe confidentiality, It should be said that's important in aftercare. (Participant L)

If members gossip about other members of the group, the process may come to a halt (Corey &

Corey, 1992) as illustrated by Participant L. It is recommended that confidentiality is frequently emphasized and specific concerns are addressed as quickly as possible (Corey & Corey, 1992).

Another concern raised was the breaks between sessions, which were highlighted as too long by four participants who said long breaks were disruptive to their process.

There is a lot of time that we don't know what to do. So instead of having one cigarette I will have three or four. I will talk to a lot of people and get so away from...detached from my relations...because for me, it takes me quite a while to get vulnerable again, and then to come into a session and be like, hey, I'm here, I'm here to open up. (Participant L)

Kaya staff should be aware that at times breaks are perceived as unhelpful rather than helpful. Staff could consider ways to address this, such as shortening breaks or providing increased structure during the time outside of groups.

Three participants discussed wanting individual therapy during their admission. The three participants had different reasons for this; Participant H discussed wanting to talk about others in the community without risk of offending them and Participant J said she would have liked to speak more about her suicidal thoughts, which she felt uncomfortable discussing in the group context. Participant F said that during treatment at Kaya he did not disclose his past experience of being sexually abused as he had not felt comfortable to discuss this in the group setting. He said he would have been more likely to make this disclosure if individual therapy had taken place at Kaya. He viewed holding the secret as a major contributing factor towards his relapse.

You've only been with those people for two weeks or three weeks or whatever, and to open up with something like that, you are taking a huge risk. So I mean, with a one-on-one with a counsellor, then you know you have that privacy or whatever, so then I think it would have been a lot easier. (Participant F)

In summary, participants raised concerns that should be noted by Kaya staff. Where possible these issues should be addressed or additional research should be conducted. This is discussed further in the recommendations section. These concerns included underage smoking at the unit, confidentiality in aftercare group and a desire for individual therapy by participants.

The final chapter, conclusion, will outline a summary of findings, recommendation and limitations of the study as well as offer a conclusion to this dissertation.

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Chapter 5: Conclusion

5.1 Introduction

This chapter recapitulates the main findings that are previously illustrated in the analysis and discussion. It also presents some of the limitations of the study and possible recommendations for future research.

5.2 Conclusion

This study makes a contribution to the understanding of adolescent perceptions of their inpatient psychiatric treatment in the literature. The aim was to explore ex-patients' views of the therapeutic factors involved in the treatment they received while at Kaya; the therapeutic factors of group psychotherapy described by Yalom and Leszcz (2005) were used as a framework for analysis.

The literature review contextualised the analysis and discussion by examining outcomes studies from similar units, literature on the various treatment elements, qualitative studies on adolescent experiences at inpatients units as well as the therapeutic factors of group work, as described by Yalom and Leszcz (2005).

All participants reported their admissions to Kaya as benefitting them in some way, with some participants reporting small changes and others experiencing profound shifts in perspective. The therapeutic factors that were discussed as significant themes included peer relationships and catharsis.

Peer relationships were a major theme across the interviews, featuring to some extent in all interviews. Under the heading of peer relationship, the therapeutic factors of universality, group cohesiveness and interpersonal learning were discussed. Universality was discussed by most of the participants, interpersonal learning by half and group cohesiveness by almost half the participants. This finding is in line with the literature on adolescent inpatient care, where these relationships are generally discussed as an important treatment element. The strong presence of these therapeutic factors in the interviews suggests that in this sample, peer relationships were among the most important aspects of

treatment.

Catharsis was mentioned by almost half the participants as helpful, and may serve an important function therapeutically in conjunction with having personal accounts witnessed empathically. A quarter of participants discussed existential factors as important, with two speaking about responsibility, and one about consequences; ideas which appeared significant to the participants concerned.

Other factors did not appear as themes in the interviews and the possible reasons for this were discussed. Altruism was not a theme in the interviews. However peer relationships was a major theme and thus it is likely that support between peers played a significant role in these relationships despite this not being explicitly discussed.

The corrective recapitulating of the primary family group was not discussed in the interviews; however, Yalom and Leszcz (2005) describe this factor as taking place largely unconsciously, which offers an explanation for the lack of mention of this therapeutic factor in the interviews. A factor discussed in a limited way in the interviews was imitative behaviour, but one should not conclude that it was not important.

Participants generally regarded family therapy as helpful and difficult, and described experiencing new ways of communicating with their families in these sessions. The role of siblings in family sessions was highlighted by a quarter of participants who felt sibling participation in family session was helpful, or would potentially have been helpful.

Participants raised concerns that should be noted by Kaya staff to be researched further or addressed. These concerns included underage smoking at the unit, confidentiality in aftercare group and a desire for individual therapy by participants. These matters are discussed further under recommendations.

5.3 Limitations of the study.

By interrogating the degree to which subjectivity may have been compromised, an understanding of the limitations of the study may be gained. Qualitative methodologies allow for a detailed understanding of data in context, it is important to acknowledge and bear in mind the criticisms made against qualitative research, namely that the interpretation of the data is by nature subjective (Durrheim, 2008). The nature of the research means it is not statistically meaningful and cannot be generalised. Nevertheless, this is a preliminary investigation offering rich, detailed accounts of a real-world situation which has generated results that could be used to inform treatment decisions, and explore this and related topics in greater detail.

On reflection, a further limitation became apparent; different questions could have been asked during the course of the interview which might have further clarified points that were raised by participants. This may have helped in enriching the data and may have provided answers to some of the questions which were subsequently raised.

Because the interviews were only conducted with participants who live in the area surrounding the clinic, the data did not describe the experiences of patients in treatment form elsewhere in the province and country (which make up a small portion of the patient population).

Despite limitations, this study makes a contribution. It provides feedback to an existing programme on patient perceptions of what is important therapeutically. The findings could be used as a basis for further investigation and add to a conversation between staff about patient experiences. Alterations to aspects of treatment could be made as a result of this research. This could ultimately benefit future patients at Kaya and other units like it.

5.4 Recommendations

This section considers ways that this research could be used helpfully at Kaya and ways that future research could add to the knowledge generated through this thesis.

Firstly, the findings of this dissertation should be viewed as a first insight into the therapeutic factors at play at Kaya, and further empirical research would add to the ability of these findings to be used to enhance the therapeutic value of patient admissions.

Although the results are not generalisable because of the qualitative nature of the research, they can be used to add to staff understandings of patient experience, and inform intervention as deemed appropriate by staff. Results highlighted peer relationships and catharsis as perceived as holding significant therapeutic value for patients. Staff should provide space for these factors to be maximised therapeutically.

At the time of interviews, unstructured group therapy had been discontinued; staff should re-evaluate this decision as patients suggested that this group provided the primary space where catharsis took place. Alternatively, further research should be conducted with Kaya patients to determine whether the perceived value of the group is consistently high in a broader sample.

Participants raised concerns about underage smoking at the unit, generally referring to it as common place and concerning. Although this is a known challenge at the unit, staff should continue to endeavour to prevent those without consent from smoking and to use rule-breaking therapeutically as far as possible.

A noteworthy concern raised by participants was uncertainty and lack of trust around confidentiality in aftercare group. This may serve as a significant barrier to patients making use of this group. This is a concern with clear treatment implications and something that can be addressed relatively easily at no additional expense to the unit. Leaders of the aftercare group could be advised to discuss confidentiality rules and concerns in the group at every session, perhaps introducing a confidentiality contract among new members.

The desire for individual therapy was expressed in interviews. Most noteworthy of these reports was the report of one participant who described his lack of disclosure around his sexual abuse while in treatment and the negative consequences he perceived this having for his recovery after admission.

Although others reported the same desire for individual therapy, it is my opinion that this particular account provides enough concern to warrant opening a team discussion around including individual therapy in the programme. Further research to inform this decision may include further investigation into patient perceptions of this need, in the form of interviews or questionnaires.

It may be useful to supplement this study with a questionnaire-based study where a larger sample of patients and therapists rank therapeutic factors according to perceived value. This would generate a more generalisable result, allowing staff to build on the therapeutic factors most valued by patients.

Investigations into the perceptions of staff of the therapeutic factors at play would be a useful study as this would uncover a different perspective.

An outcomes study may also be useful to the unit, as this could provide an indication of which patients the unit is treating successfully (Brinkmeyer et al., 2004, Jaffa & Scott, 1999).

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University of Cape Town

Appendix 1: Parent consent form

Consent to participate in a research study

Dear Parent,

Formal Title: Adolescents' perspectives on their treatment as inpatients

Study Purpose

Your child is being invited to participate in a study being conducted by researchers from the University of Cape Town. The purpose of the study is to give Kenilworth Clinic Adolescent and Young Adult Unit (Kaya) feedback on their experiences at Kaya. This will ultimately help present and future patients.

Study Procedures

If you consent for your child to participate in this study, they will be interviewed for approximately 1 hour at a time convenient time for you and your child.

Possible Risks

You or your child may feel uncomfortable remembering things you experienced before or during your treatment at Kaya.

Possible Benefits

Most people find it helpful to reflect back on treatment. By agreeing to participate you are helping us understand adolescents.

Confidentiality

All participant names will be confidential. Only I will have access your names. Any reports or publications about the study will not identify you or any other participant in any way. The interview will be recorded. Assistance may be used to type up the transcription, in this case, your name will not be accessible to the transcriber and that person will have committed to keeping all information confidential.

The only time I would break confidentiality is if your child is suicidal, likely to hurt someone else or being hurt. In this case I would discuss my need to disclose this with your child and work with you to ensure their safety.

Alternatives

You may choose not to participate in this study, and this decision will not affect your or your child's relationship with Kaya or any staff member in any way.

Voluntary Participation

Participation in this study is completely voluntary. Your child is free to refuse to answer any question. If you decide to consent to your child's participation, you and your child are free to change your mind and discontinue participation at any time without an effect on your medical care or future care.

Questions

Any questions related to this study may be addressed to:

Amy Benjamin (Registered Counsellor) at Kaya 0216719109

Dr. Catherine Ward (Clinical Psychologist) 021 6503422

Department of Psychology, UCT 021 6503417

I have read the above and understand the purpose of the study and its possible risks and benefits. All my questions about the study have been answered. I understand that I can withdraw from the study at any time and do not have to answer all the questions. I voluntarily consent to participate in this study as it has been described.

Name of participant

Date

Signature of researcher – verbal consent gained

University of Cape Town

Appendix 2: Participant assent (Under 18s)/ consent (over 18s) form

Assent (Under 18s)/ Consent (over 18s) to participate in a research study

Dear Participant,

Formal Title: Adolescents' perspectives on their treatment as inpatients

Study Purpose

You are being invited to participate in a study being conducted by researchers from the University of Cape Town. The purpose of the study is to give Kenilworth Clinic Adolescent and Young Adult Unit (Kaya) feedback on your experiences at Kaya. This will ultimately help present and future patients.

Study Procedures

If you consent to participate in this study, you will be interviewed for approximately 1 hour at a time convenient time for you.

Possible Risks

You may feel uncomfortable remembering things you experienced before or during your treatment at Kaya.

Possible Benefits

Most people find it helpful to reflect back on treatment. By agreeing to participate you are helping us understand adolescents.

Confidentiality

All participant names will be confidential. Only I will have access your names. Any reports or publications about the study will not identify you or any other study participant in any way. The interview will be recorded. Assistance may be used to type up the transcription, in this case, your name will not be accessible to the transcriber and that person will have committed to keeping all information confidential.

The only time I would break confidentiality is if you are suicidal, likely to hurt someone else or being hurt. In this case I would discuss my need to disclose this with you and work to ensure your safety.

Alternatives

You may choose not to participate in this study, and this decision will not affect your relationship with Kaya or any staff member in any way.

Voluntary Participation

Participation in this study is completely voluntary. You are free to refuse to answer any question. If you decide to participate, you are free to change your mind and discontinue participation at any time without an effect on your medical care or future care.

Questions

Any questions related to this study may be addressed to:

Amy Benjamin (Registered Counsellor) at Kaya 0216719109

Dr. Catherine Ward (Clinical Psychologist) 021 6503422

Department of Psychology, UCT 021 6503417

I have read the above and understand the purpose of the study and its possible risks and benefits. All my questions about the study have been answered. I understand that I can withdraw from the study at any time and do not have to answer all the questions. I voluntarily consent to participate in this study as it has been described.

Name of participant

Date

Signature of researcher – verbal consent gained

University of Cape Town

Appendix 3: Protocol for managing suicidality if expressed by a participant in an interview

Protocol for managing suicidality if expressed by a participant in an interview

If a client raises suicidal ideation or intent, I will assess the degree of suicide risk:

- 1) I will assess level of intent by asking whether the patient has a specific plan for how they will commit suicide and whether they have made any steps towards putting this plan into action.
- 2) I will find out if there are any deterrents currently preventing the client from acting on their suicidal feelings.
- 3) I will be mindful of higher risk associated with the presence of previous suicide attempts, an unstable psychiatric history, or a history of extreme responses to stresses or losses.
- 4) I will be mindful of support the client may or may not have, remembering that poor support increases risk.

If I assess that the level of risk is high and immediate, I will offer support and ask for a commitment from them to take no immediate action and discuss the possibility of informing their parents, so that they can be kept safe.

I will immediately notify the parents of the patient, assuring them that I will work with them to ensure their child's safety.

I will advise immediate hospitalisation at an appropriate hospital and schedule readmission to Kaya as soon as possible. I will advise the parent that they should also immediately contact the child's psychiatrist, and that because I was the person interviewing the child, I will do the same. Each child is

seen by a psychiatrist during their treatment at Kaya and those details are in the patient files and will be accessible to me.

I will immediately notify my supervisor and consult around the best course of action.

If the parent declines to follow my advice, I will advise that they ensure their child is kept safe and reiterate that an intervention is necessary. I will give them appropriate telephone numbers and follow-up the next day. I will contact the child and invite them to come spend a day or two at Kaya at no cost (if they are local). I will let them know that I will check in with them the next day.

If I assess that suicidal ideas are present but that the immediate suicide risk is not high, I will discuss with the patient ways that they can optimize their support at home, and speak to the parts of the patient that want to stay alive. I will also invite the patient to return to Kaya either for aftercare, for few days as a visitor or as an inpatient.

I will document the entire process.

Appendix 4: Interview Schedule

I am interested in hearing your views and opinions about your experiences of treatment at Kaya.

There are a number of areas that I would like to cover in this interview:

- 1) Experience of treatment
- 2) How treatment impacted your life
- 3) Suggestions you may have about changes that you think might improve the Kaya programme

Personal Particulars

1. What is your name, age and when were you at Kaya.

1) Experience of treatment

What was helpful, hard, challenging and unhelpful in treatment?

Probes:

1. What was it like arriving at Kaya and what were the first few days like?
2. What was surprising about Kaya and the programme?
3. What was helpful/unhelpful about the specific programme elements (community group, relationships in the community, skills groups: DBT, Interpersonal effectiveness, recovery, addictions, family sessions)?
4. What was the most helpful part of treatment?
5. What was the hardest part of treatment?

6. What was it like leaving Kaya?
7. What would you tell someone about to come to Kaya for treatment?

2) How treatment impacted your life

How did treatment impact your life?

Probes:

1. How, if at all, did treatment impact your family life and relationships?
2. How, if at all, did treatment impact your school/ college life and your peer relationships?
3. What was it like being removed from your regular life while you were at Kaya?
4. What, if anything, did you do differently after you left Kaya?
5. How are you now?

3) Suggestions you may have about changes that you think might improve the Kaya programme

Probes:

1. What do you think could be done differently in the programme? Any group changes, additions, changes to programme structure, more or less of anything?
2. What do you think would make arriving and leaving Kaya easier?

Is there anything else you'd like to add?