Brigham Young University
BYU ScholarsArchive

All Theses and Dissertations

2007-12-19

Adolescent girls' perception of residential treatment centers: A qualitative study of how treatment works

Tyler Adam Money
Brigham Young University - Provo

Follow this and additional works at: https://scholarsarchive.byu.edu/etd

Part of the Psychology Commons

BYU ScholarsArchive Citation

Money, Tyler Adam, "Adolescent girls' perception of residential treatment centers: A qualitative study of how treatment works" (2007). *All Theses and Dissertations*. 1611.
https://scholarsarchive.byu.edu/etd/1611

This Dissertation is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in All Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.

Adolescent girls' perception of change in residential treatment centers: A qualitative study of how treatment works

by

Tyler Money

A dissertation submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Department of Psychology

Brigham Young University

December, 2007

BRIGHAM YOUNG UNIVERSITY

GRADUATE COMMITTEE APPROVAL

of a dissertation submitted by

Tyler Money

This dissertation has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

Date	Gawain Wells, Chair
Date	Jared Warren
Date	Edwin Gantt
Date	Ross Flom
Date	Dawson Hedges

BRIGHAM YOUNG UNIVERSITY

As chair of the candidate's graduate committee, I have read the dissertation of Tyler Money in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

______________________________ ______________________________

Date Gawain Wells
Chair, Graduate Committee

Accepted for the Department

______________________________ ______________________________

Date Sally Barlow

Accepted for the College

______________________________ ______________________________

Date Elaine Walton

ABSTRACT

Adolescent girls' perception of change in residential treatment centers: A qualitative study of how treatment works

Tyler Money

Department of Psychology

Doctor of Philosophy

RTCs play an increasingly significant role in the continuum of treatment of emotionally disturbed adolescents. However, outcome research in this area has lagged behind the growth of treatment centers. More specifically, there has been very little investigation of the relative efficacy of the many different aspects of residential treatment, which are referred to as mechanisms of change in other research. The present study attempts to develop a phenomenological understanding of RTC patients' experience of all of the interventions that make up residential treatment. Results suggest that patients view social support, non-therapist staff members, family involvement and family therapy, as most prominent in their change process. Patient articulations indicate that they are able to understand a great deal about the importance of multi-modal treatment, and the importance of receiving a broad range of treatment interventions. Limited four year follow-up data is also included.

Mechanisms of change in residential treatment centers: A qualitative study of adolescents' perceptions of how treatment works

Introduction

In the past 25 years, inpatient care of adolescents has been on the rise. Between 1980 and 1985 the number of children and adolescents in long-term inpatient treatment rose substantially. The specific rate of increase in these long-term inpatient facilities, typically referred to as residential treatment centers (RTCs), was 400% (Kiesler, 1993). Along with these considerable increases in the number of adolescents in RTCs, the cost of treatment in many of these RTCs is also considerable, many charging as much or more than $100,000 per year (New Haven, 2003a). However, despite this great initial increase in prevalence, research showing the efficacy and efficiency of such treatments lagged behind (Kiesler, 1993; Nansel, Jackson, Teal, Force & Burdsal, 1998), and continues to do so. Nevertheless, despite sometimes dubious scientific support, RTCs continue to grow in prevalence because of high demand (Kiesler, 1993).

Nansel, Raines, Jackson, Teal, Force, Klingsporn et al. (1998) surveyed a large cross-section of RTCs and found that the majority of facilities reported that they were conducting outcome research (65%). Though encouraging, Nansel et al.(1998) criticizes many of these RTC outcome studies because of a lack of solid methodology. Essentially, many of these studies imply (or blatantly posit) that they have demonstrated quantifiable change without the use of standardized questions, or even quantifiable measures. Moreover, Nansel et al. laments the fact that 85% of the RTCs' studied did not use any type of a comparison group. Essentially, these facilities have tried to demonstrate that their treatment does bring about change, but these facilities are constrained in their methodology. Ethical issues often limit studies having to do with children (Drotar, 2000). For example, it is often considered unethical to randomly deny treatment to children in order to establish a control group. Pragmatic issues involved in largely

privately funded facilities and developing wait-list control groups also constrain research. Because of these constraints, RTCs very often rely on treatment methods that have proven to be effective with adult populations (Foltz, 2004). Regardless of the reasons, RTCs have not shown that their treatment is more effective than intensive outpatient treatment, or even that those in treatment do better than a wait list control group. Many critics have voiced such concerns about the state of empirical evidence for adolescent residential treatment (Epstein, 2004; Foltz, 2004; Nansel et al., 1998). However, given the methodological constraints that RTC research faces, these critics' suggestion and proposed research questions (e.g. are RTCs more effective than other comparison groups) are unlikely to be answered on a broad scale. Moreover, these questions seem to leapfrog more basic questions that are also left unanswered. These more basic questions involve questions as to the basic impact of varying interventions on the lives of adolescent patients and how they experience change in an RTC, which has gone largely unstudied.

Despite dubious scientific methodology, the outlook on RTC treatment outcome overall is far from bleak. Epstein (2004) reviewed dozens of studies that have examined the general outcome of residential treatment. Indeed, Epstein asserts that a vast body of sound scientific research supports the effectiveness of treatment with adolescents in general (Burns, Hoagwood & Mrazek, 1999; Kazdin, 2000). Epstein (2004) proposes that there is sufficient evidence to conclude that adolescent treatment in residential centers is a viable and effective way to treat adolescents with various types of behavioral problems, affective and eating disorders, as well as characterological abnormalities. His conclusions were consistent with previous reviews of the literature in that most studies seem to show that "although most emotionally disturbed young persons improve while in treatment, many do not." (p 424). However, whether or not these same

therapeutic gains could be obtained via less intensive and less expensive means has not yet been shown. For example, Randall & Henggler (1999) describe a multi-systemic outpatient treatment that has been shown by several independent studies to be effective in the treatment of adolescents with severe antisocial behavioral problems. Suggestions for improvements have been made such as conducting comparative research (e.g. comparing different RTCs, RTCs vs. wait-list, RTC versus less intensive treatment etc.), and using more empirically validated assessment instruments (Curry, 1991). While such suggestions sound promising, Epstein points out that these measures may not even be possible. It is simply the case that utilizing such methodologies when ethical constraints of doing research with children are considered may be difficult or impossible. For example, it may be unethical to deny residential treatment when the child is referred for such, so that comparison groups can be formed.

The utility of demonstrating the relative efficacy of RTCs notwithstanding, such an endeavor may be putting the proverbial cart before the horse. In other words, engaging in such a demonstration without knowledge about how those treatments impact adolescents would be building upon a sandy foundation. Little has been studied about the mechanisms of change in residential treatment. In other words, the efficacy of specific treatments used, how this treatment is received, and how adolescents experience change at RTCs (Foltz, 2004; Kazdin, 2003). And given the aforementioned methodological and ethical difficulties that quantitative methods impose upon adolescent populations (and RTCs in particular), alternative methods that avoid such problems may provide a better starting point for filling the gaps in our knowledge about how treatment is working. Despite some doubts about the prudence of the current role of inpatient adolescent treatment, in practice RTCs have become a vital part of the treatment of severely emotionally disturbed adolescents. Therefore, understanding how adolescents are

receiving treatment and what they perceive as being helpful and why, appears to be that much more important.

RTCs typically employ a multimodal treatment approach (Epstein, 2004; New Haven, 2003a). This treatment usually includes a milieu-like setting where a therapeutic community life is established. Adolescents live together as "residents" or "students" in an environment meant to foster interpersonal relating. Specific treatment modalities often include: individual therapy, group therapy, family therapy (either live or via telephone), recreation therapy, community meetings, and obligatory "chores" of some kind. Individual programs vary widely in additional treatments, but most RTCs seem to employ all or nearly all of the modalities mentioned above. However, describing general treatment modalities across different RTCs is problematic because many do not describe the specifics of their treatment in their published outcome studies (Epstein, 2004).

While there does seem to be enough evidence to conclude that RTCs do produce positive change in adolescents (Epstein, 2004), the aspects of RTC treatment that explain that effectiveness remain largely a mystery. With each aspect of treatment in a given RTC, there is an associated cost in time, resources used and financial expense. Therefore, determining which treatment modalities are the most effective would at the very least, help to increase treatment efficiency and reduce costs. Furthermore, understanding the mechanisms that help to bring about change in the patient would also help to tailor treatments so as to maximize benefits. Kazdin & Nock (2003a), who define mechanisms as "those processes or events that lead to and cause therapeutic change" (p. 1117), claim that the study of mechanisms of treatment is largely ignored in adolescent treatment research. They also claim that studying those mechanisms is "probably the best short and long-term investment for improving clinical practice and patient care" (p1117).

Kazdin and Nock (2003a) make several recommendations for studying treatment mediating variables (i.e. various therapeutic interventions) as part of outcome research. They suggest that randomized controlled trials are the best method for studying outcome. They also suggest that including manipulations of proposed mediating variables in randomized trials would address the question of what about treatment is working, instead of simply that treatment is working.

While this appears to be a logical step for adolescent treatment research, it simply may not be feasible at this point in time. As mentioned earlier, conducting outcome research combined with manipulations of treatment mediators would require at least some knowledge of the effects that each mechanism of change has on the individual. This kind of knowledge would serve several goals. First of all, increasing knowledge of the effects that interventions have, and how patients experience change would obviously help to improve treatment immediately. Moreover, because the state of research on RTCs is relatively undeveloped in its conclusions, this type of knowledge will allow for more informed theories to be formed on what interventions seem to be most helpful to the patients, how treatment can be improved, and what aspects of treatment appear to be the best avenues to pursue future research.

The aim of the present study—besides helping to build a more solid scientific foundation—is to aid in the understanding of residents' experiences of progressing through the program, the experiences they believe helped them to make progress, as well as how those experiences helped. The study is a qualitative examination of adolescent residents in treatment and their perceptions of the factors related to therapeutic process. In other words, the aim is to begin to understand the complexities of the experiences of adolescents in residential treatment. Because qualitative methods are somewhat less employed in psychotherapy research, the

justification for this study will include a brief discussion on the value of qualitative versus quantitative research, rationale for choosing qualitative methods, and a brief description of qualitative methods in general.

Qualitative versus Quantitative Methodology

Qualitative research methods have often been described as better equipped to understand the complexities that comprise human behavior (Black, 1994). Since treatment outcome at RTCs involves an amalgam of many interventions, responses to the combination of those interventions can be rather complex. Powell (2001) argued quite succinctly that qualitative methods that focus on individual experiences (instead of group aggregates) may be more appropriate when "assessing interventions in which the impact is poorly understood" (p 929). Given the conspicuous absence of data on the impact of specific interventions in RTCs, this argument definitely applies to the current issue. Qualitative methods are certainly a non-traditional way to study treatment variables. Doing so would typically involve controlled studies where those variables are isolated and manipulated. In this sense, it may be impossible to study mechanisms of change via qualitative research. However, understanding how change occurs in individuals in treatment goes beyond cold, quantifiable changes on an outcome measure. It involves understanding how the individual actually experiences those so-called mechanisms in their real-life experiences. It is the opinion of this researcher that qualitative methods that focus on phenomenological understanding, instead of more traditional quantitative methods, are currently the best method for forming an understanding of how residential treatment works from the perspective of the patient.

Because of this departure from more frequently used scientific approaches, a brief explanation of the basic differences between quantitative and qualitative approaches is

warranted. In addition, I will make further arguments as to why qualitative methods are more appropriate to answer the questions at hand than are quantitative methods.

First of all, quantitative and qualitative methods utilize considerably different ways of investigation or epistemologies. Essentially, quantitative methodology is based on the notion that there exists an objective measurable reality that is observable through the senses, and that can be verified publicly in an unbiased fashion (Giorgi, 1986). This notion of 'positive empiricism' casts doubt on methods of investigation that are open to description and interpretation. Moreover, because this approach assumes that reality gives rise to measurable phenomena, numbers and mathematics (most often statistical analyses) are a hallmark of quantitative methods. This numerical language dominates quantitative thought largely because it is considered to be free from bias.

The qualitative epistemology is one that seeks to capture the dynamic experience that is the human condition (Giorgi, 1986). Essentially, the paradigm in this case is that material objects exist only in the context of consciousness, and since consciousness is never static, then reality is best understood vis-à-vis subjective consciousness. As such, qualitative methods include descriptions and interpretations that are largely free from numbers and make no claims of pure objectivity.

In explicating the perceived differences that separate qualitative and quantitative methods, Silverman (2000) lists several dichotomies as characterizing the two approaches. Qualitative research is flexible and subjective, whereas quantitative research is fixed and objective. Qualitative is politically biased and speculative, and quantitative is value-free and tests hypotheses. Silverman also points out that based on these differences one may argue the superiority of one method over the other. While such a debate is not the aim of the present

endeavor, a closer look at some of these differences that are often seen between the two approaches is necessary. Silverman points out that these dichotomies are deceiving. While qualitative research openly admits to being subjective and biased, quantitative approaches seem to hide the fact that it is virtually impossible to eliminate bias. At its core, quantitative methods are inherently just as influenced by pre-conceived notions and prejudice as qualitative. Silverman explains that quantitative methodologies typically "adopt a purely statistical logic precisely in order to replace common-sense understandings by scientific explanations" (p. 6). In other words, Quantitative methodologies almost always appeal to common-sense everyday understandings of the world in order to create operational definitions so that constructs can be measured. This process is obviously influenced by biased pre-conceived cultural definitions and in this sense is "the cart leading the horse" (p 6). Therefore, despite their claims of objectivity, the foundations of quantitative research are inherently every bit as influenced by individual and societal perception as qualitative methods. By making these biases explicit, qualitative methods are simply more forthright about this fact and allow the researcher to place his/her conclusions within that context. This forthrightness allows the consumer of the research to be more fully informed as to some of the biases that give form and direction to the research questions and method in the first place, as well as some understanding of the reasons for the researcher's interpretations of the data. Also, it allows the researcher to be more directly confronted by the experience of the subjects of the research, as his/her biases are brought into focus and questioned as they are disconfirmed or confirmed by the actual experience of the people being studied.

The present question is simply what methodology is best suited to developing a greater understanding of how adolescents are helped by the interventions of residential treatment, what about those interventions are helpful, and why do those adolescents view some interventions as

helpful and others as not? Since we are interested in such questions, and since treatment at RTCs includes many different interventions that undoubtedly create different experiences from one patient to the next, we are essentially interested in the human experience of being a patient at an RTC. For that reason, qualitative methods, and more specifically, a phenomenological approach, is not only the most appropriate, but the only means for answering these questions.

Phenomenology is "the discipline that devotes itself to the study of how things appear to consciousness." (Giorgi, 1986, p6). The word itself is derived from the Greek, 'phainoemn,' meaning 'appearance.' The origins of phenomenology as a philosophical movement are generally traced back to Husserl (Cohen & Omery, 1994). Husserl posited that phenomenology was not simply a philosophy but was a rigorous scientific method. However, this methodology was not grounded in more traditional scientific tools such as statistics and striving for strict objectivity. Rather, he claimed that to understand human experience that is grounded in consciousness, one must be able to "see" directly. By "see," he did not refer to one's sense of sight. Put simply to "see" is to step away from constructions, idiosyncratic rules and attitudes, and preconceptions in general in order that the essence of experience, as it occurs in a dynamic reality, may shine through (Cohen & Omery, 1994). Essentially, he simply stated that to "know" is to see.

In phenomenological investigation, the investigator seeks to understand the "essence" of experience rather than simply trying to explain or analyze its origins (Kvale, 1997). Specifically, this method aims to reveal the "structures of consciousness" (Cohen & Omery, 1994) that make up an experience and give it meaning. With regards to the present research, the aim is to understand the experience of participating in treatment, and what meaning that treatment has for the students of a RTC. It is in this manner that we can begin to understand how treatment is

working through the descriptions of the participants. Some might argue that perceptions of patients do not actually lead to conclusions about what interventions are driving changes. However, this type of argument assumes that external mechanisms are the causal forces rather than acknowledging the role of individual agency in the change process. The philosophical basis of the present study is that human agency is always the final determining factor in human behavior (Cohen & Omery, 1994). As such, patient perceptions may be the best way for understanding how the change process occurs, and what factors are most influential in helping them to make different choices than they have in the past.

Since forming generalizations about treatment experiences is a subjective process, personal opinion, prior knowledge, and biases that the investigator holds will inevitably affect the exploration of meaning significantly. Nevertheless, as previously stated, qualitative researchers do not try to run from these biases. Instead a technique called "bracketing" is employed (Giorgi, 1986). The point is to suspend one's own preconceptions and explicate them as thoroughly as possible. In doing so, the researcher tries to understand and keep in mind that the study of conscious experience can only be done in the context of one's own conscious experience. And the researcher's conscious experience is of course always had in the context of these preconceptions. Therefore, if the researcher is constantly aware of this fact, it is much more likely that those preconceptions will not wholly drive the interpretations that he/she makes. In short, putting these preconceptions outside of the equation (in brackets) so to speak, allows the qualitative researcher to hopefully arrive at less prejudiced description of the essence of the phenomena. This bracketing "does not involve an absolute absence of presuppositions, but rather a critical analysis of one's own presuppositions" (Kvale, 1997).

The aim of this "bracketing" is to connect with the essence of the phenomenon under investigation without pre-determining what that essence will be like. Aanostoos (1986) explains this process:

> "Thus, this reduction does not result in the disinterest of the researcher but rather in the suspension of all narrowly confining interests preceding attention to the phenomenon, in order to become fully interested in the phenomenon itself. By so deliberately avoiding concentrating attention on any particular pre-determined aspect, the researcher is able to escape the danger of finding only what one expects to see. Instead, one adopts an attitude of open-ended presence to the phenomenon that is unfolding" (p. 85).

Therefore, instead of *extracting* data to support meaning that is expected to be found, by "bracketing" one's biases, the researcher can avoid seeing only what he/she expects to see and can instead *discover* the phenomenological meaning that experiences led to for the individuals of interest. For example, I as a researcher may believe that a punitive act of a therapist at an RTC is done out of love and concern for the patient. However, the recipient of that act may perceive it as hostile. Therefore, regardless of whether the act was hostile or not, the phenomenological meaning of that event was hostile. If understanding is to be had then any interpretation of that event would have to be placed in that context. This process is facilitated by bracketing.

This brief look at qualitative approaches is intended to illustrate the usefulness and validity of such techniques to answer the questions at hand. In summary, the state of quantifiable outcome research in residential treatment is lacking (Nansel, et al., 1998). Given the aforementioned problems that quantitative methods face, and their inability to address questions about how treatment is working from the perspective of the patient, qualitative research that

describes detailed patterns in the experiences of adolescents at RTCs offers the best method toward greater sophistication in this research area.

Additionally, the demand for qualitative research has increased over recent years particularly in child-related areas (Kidd, 2002). It seems that scientist-practitioners are recognizing more and more the need for qualitative data to further explicate the complex experiences inherent in the human condition. Qualitative research is also growing in importance in other disciplines including psychiatry, general medicine, and school psychology (Natassi & Schensul, 2005; Crawford, Weaver, Rutter, Sensky & Tyrer, 2002; Powell & Davies, 2001). Despite this growth in demand and prevalence, little qualitative data can be found relevant to the experiences of youths in RTCs. For that matter, little quantitative data exists on the topic.

Review of extant qualitative research

It appears that little more can be learned about the process of progression in residential treatment unless the current methodology is expanded upon. To this end, some have already begun to delve into qualitative realms. However, this body of literature is in its infancy. A review of this burgeoning field will illustrate the scarcity of what is known about the topic (Abraham, Lepisto & Shultz, 1995; Bernou, 1997; Colton & Pistrang, 2004; Riehman, Bluthenthal & Juvonen, 2003; Shennum, & Carlo, 1995; Tarantino, 2002). A brief summary of the little data that can be found will aid in illustrating the need for further information on this subject.

Riehman et al. (2003) gathered data on 449 inpatient adolescents, and interviewed some of them using qualitative methods in an attempt to begin to understand treatment response differences between boys and girls. Their findings were largely limited to client factors however, and did not focus on the client perceptions of interventions at the RTCs themselves.

Nevertheless, this study did suggest that there exist many differences between boys and girls in how they respond to treatment at RTCs that have yet to be studied. Given that the current study will focus on these issues for adolescent girls, some of these questions will be addressed. Abraham, et al. (1995) began to address a common specific intervention of RTCs, namely group therapy. Specifically, they examined teens' perceptions of group therapy and found that while group therapy is effective, most patients preferred to process their problems in individual therapy.

Colton & Pistrang (2004) conducted interviews with individuals in inpatient treatment wherein they discovered some relatively robust themes in the phenomenological reports of the youths. The authors attempted to gather information about what the adolescents themselves found helpful about treatment and what treatment was like. Some of the themes that emerged indicated that patients felt that being in a collaborative therapeutic community with others with similar problems was very helpful. However, overall, patients perceived that no interventions were helpful unless the patient was "ready" to change. The results of this study were very revealing about the experiences of inpatient adolescents; however, their sample of participants was somewhat limited given that all interviews were conducted at an inpatient eating disorder treatment center.

Currie (2003) conducted a similar qualitative study with adolescents referred for residential substance abuse treatment. Like Colton & Pistrang (2004), Currie found that patients consistently reported such things as a supportive, empathetic, and safe environment were most helpful in promoting change. However, they also consistently reported that the more confrontational and/or punitive aspects worked counter to the support network that they felt was most helpful. This finding may be quite profound in its implications in that a major hallmark of

substance abuse is the use of somewhat "punitive" methods. It may be that such methods (while intuitively making good therapeutic sense) may be overused, and or marginally effective to begin with. Moreover, this may be an example of using outcome data from adult treatment and inappropriately generalizing it to adolescents. Confrontation may work with adults, but not with teenagers. Additionally, like Colton & Pistrang (2004), Currie (2003) provided useful data on the experiences of adolescents in residential treatment. However, Currie's sample was limited to a substance abuse treatment center. As such this information may be quite valuable but likely only to substance abuse RTCs which often are quite different than other RTCs in regards to their treatment approaches.

Bernou (1997) examined adolescents' views of more broad-based residential treatment (i.e. centers treating a range of severe emotional problems) via in-depth interviews, and the adolescents' reported much that was consistent with other literature on the topic. Specifically, ex-residents of RTCs reported that what they valued most were the special relationships with staff members and other residents. Bernou also reported that the residents expressed regrets that the program did not include more life-skills training and aftercare planning. The findings of this study appear to be quite extensive; however, theses findings were only retrospective and were largely limited to aspects of the program that the ex-residents liked, and aspects that they wish were different. Moreover, the sample size included only five treatment successes and five treatment failures. The author did not use a typical expansive method of data collection that is standard in qualitative research. In other words, they set a small pre-determined sample size without beginning analysis of the data and allowing their findings to guide the size.

Shennum & Carlo (1995) conducted interviews with 80 children and adolescents that had spent time in residential treatment. These findings were also quite extensive. For example,

somewhat discordant with other research (Currie, 2003), Shennum & Carlo found that most patients did not object to behavioral interventions that are intended to help them improve on emotional and/or behavioral problems. The authors also reported that children and adolescents claimed that the goals of treatment developed by the staff were rarely in line with the goals that the patients themselves had. Overall, patients reported simply wanting to have contact again with their families. This study also provides much data on the aspects of treatment that patients report as being helpful; however, this data was also collected from a specific population (the abused and neglected) which casts doubt on its generalizability to other residential settings where parents often play an active role in treatment. Nevertheless, these findings and others highlight the need for a further understanding of the child's view of their treatment. Overall, most of the qualitative research on residents of RTCs has focused on the treatment of a specific population. Moreover, very little qualitative research has been done at all. The present research seeks to expand this burgeoning field.

To this author's knowledge there has been but one study that has examined the phenomenological experience of adolescents in a broad-based private residential treatment center. Tarantino (2002) studied, in her words, "what works" in residential treatment centers. She utilized a semi-structured interview format designed to elicit open-ended qualitative statements from the residents. Tarantino's conclusions stated that her research began to show the aspects of RTCs that "work" to bring about change. However, her conclusions were rather overstated in that her research, like some of the previously mentioned research, only seemed to address the question of what the residents of residential treatment liked about the center, and not necessarily what they thought worked the best. Tarantino's interview questions were nearly all phrased as "what did you like" or "what was your favorite…" While Tarantino appears to be

arguing that these "likes" would be indicative of "what works," previous research suggests that this may not always be the case. Children can demonstrate enough insight to be able to report that even things that they do not like (e.g. structured, even punitive interventions) can be helpful (Shennum & Carlo, 1995). Therefore, it may be a slight logical jump to state that patients' statements about what they like about treatment indicate "what works" in treatment. But logical jump or not, Tarantino's study is the only outcome data of RTCs from the patient's point of view that is available for analysis.

While the above summary is not an exhaustive review of all data that has been collected relevant to the experiences of adolescents in residential care (e.g. general effectiveness, parent and therapist reports, relapse rates etc.), this summary does represent a nearly exhaustive summary of the current state of the literature in the phenomenological experience of adolescents in RTCs. Overall it appears that most of the relevant literature thus far focuses largely on what the adolescents in RTCs enjoy about the programs, and what they would like to be different. Very little is known about the resident's beliefs about what helps them to progress in, and eventually graduate from the center.

The present study seeks to address this latter question. In short, the aim of the present study is to understand from a phenomenological point of view how adolescent girls experience therapeutic change in a RTC and by extension, what aspects of treatment are helping residents to progress through a residential treatment center. In order to begin to understand this progression, the reports of residents who are successfully progressing through a therapeutic program are examined. These reports came from three residential treatment centers wherein girls (age 12-18) were interviewed as they were judged by the treatment team to have been progressing in treatment.

At this point, it would be prudent to define what is meant by "progress" within a RTC. Treatment at most centers lasts between 3 and 12 months (Nansel et al., 1998). It has become quite common in adolescent residential care to utilize some type of "level" system (Pazaratz, 2003) to demarcate different periods or phases of this relatively long-term treatment. According to Pazaratz, these systems are typically based on a social learning theory and have several purposes. They are intended to provide structure for the adolescents, many of whom have had a significant lack of such. Structure and standardization of program requirements is also increased by utilizing a standard system of "levels." Overall, "level" systems are intended to provide reinforcement for behavioral change and to encourage therapeutic relationships (Pazaratz, 2003). While the level systems vary between treatment centers, they typically follow a pattern of moving from a high level of external control to less external control and more freedom and responsibility. Essentially, the levels are similar to the stages of moral development (Kohlberg & Puka, 1994) in that the residents are expected to progress to the point that they behave appropriately because of internal reasons rather than because of the fear of external consequences.

In a typical RTC the resident is expected to meet certain standards (e.g. perform certain chores, cooperate with treatment staff etc.) and display changes in behavior (e.g. more appropriate social interaction, appropriate eating, cessation of self-injurious behavior etc.) for a prescribed period of time in order to be advanced a "level" (New Haven, 2003b; Pazaratz, 2003) With level advancements, there is typically an associated upgrade in privileges such as ability to spend time away from the center, or less restriction in the types of activities that are allowed.

The data that was used in the present study was collected from three RTCs that provide treatment to adolescent girls from the ages of 12-18. These centers employ virtually identical

treatments and use identical level systems. The name of these treatment facilities is New Haven, Inc., and the level system is as follows: The residents start out on a "safety" level. By meeting relatively standard requirements, the student advances to "expectation" level, then "exploration," "insight," "integrity," and "interdependence" levels. Each level has its own set of requirements as outlined in the New Haven treatment manual (New Haven, 2003b). These requirements include such things as completing assignments meant to provide insight, setting and demonstrating progress on therapeutic goals, helping others on their assignments, participating in certain activities etc. Like other RTCs, level advancements at New Haven come with privileges such as family passes (visiting family) and ability to participate in activities such as equine therapy.

In order to advance a level, students complete the necessary requirements and fill out an application for advancement. At this point the treatment team, which is comprised of the student's individual and group therapists as well as the other therapists at the facility, reviews the application and discusses the progress of the girl. If all requirements are judged to have been completed and the treatment team feels that the student has made sufficient changes in her behaviors and attitudes, then the level advancement is approved. Each level has its own set of requirements. The requirements of the "exploration" level include such things as completing a collage designed to express who the student sees themselves as, obtaining feedback about themselves from specific persons, and increasing their level of responsibility in the therapeutic community. The "insight" level requirements include demonstrating effective acceptance and processing of peer feedback, developing more appropriate coping skills, and participating in family therapy in a positive "mature" manner. The requirements of the "Integrity" level emphasize greater autonomy and responsibility—in essence, integrity. They include completing

leadership responsibilities, creating and living personalized values, and demonstrating more effective and proactive problem solving strategies.

Given the somewhat subjective nature of level advancements at New Haven, and at RTCs in general, concluding that level advancements actually denote positive therapeutic change is somewhat tenuous. Nevertheless, by their very nature these levels assuredly denote progression through the program of an RTC. The level advancements require that the student demonstrate concrete measurable changes such as more effective communication style, functional problem solving abilities, and increased personal responsibility. Moreover, one cannot generally graduate from the program without advancing through the level system. Since data exists suggesting that RTCs are effective (Epstein, 2003), [even if they are not necessarily the most efficient] in treating severely emotionally disturbed adolescents, then it seems logical to use level advancements as milestones of the change that RTCs have been shown to create.

Additional interviews were also conducted with staff members of these facilities as a point of comparison to the information obtained from the residents. Doing so provided a credibility check (Elliot, Fischer & Rennie, 1999) on the data already obtained. These staff members interact with patients oftentimes more than do their therapists. As such, they often become intimately aware of how the patients are receiving treatment, and what that is like for each patient as an individual. Therefore, staff members represent a resource for expanding upon the themes that begin to emerge from the patient interview data. Additionally, data gathered from staff members allow for an opportunity to determine if the conclusions that are being developed from the patient interview data seem to match the staff members' perceptions (which have been developed through hundreds of hours of interacting with the individuals of interest) of the how treatment is experienced by the patients.

The present study sought to discover themes in participants' experiences and perceptions of how they have changed, as well as responses relative to what they describe as being helpful with overcoming specific problems that they report. In addition, qualitative statements and themes about why the residents believe that those aspects of residential treatment brought about progression were sought. These are the questions that are left largely unanswered by the present literature. In short, the present study sought to answer, in part, the following questions:

- How have they benefited from treatment
- What do residents believe is helping them overcome the specific problems that they have identified? What aspects of treatment appear to be the most helpful with specific types of problems (across residents)?
- How have those aspects of the program helped them?
- How can this information be used to better tailor treatment to individual residents?

Method

Participants

The data that was used in the present study was collected from residents at three residential treatment centers in Utah County, Utah. All were adolescent girls between the ages of 12 and 18. These girls were from nearly all regions of the country, but were all from relatively high SES backgrounds. All residents of these centers and their parents were presented with informed consent to participate in a research project. Those that agreed were interviewed as they advanced a "level." These three particular RTCs were selected because they are all affiliated with New Haven Inc. New Haven Inc. was approached by the researchers because

New Haven Inc. RTCs presented opportunities to gather data from multiple centers while still maintaining other consistencies in treatment program format.

Participants also included staff members from all three New Haven facilities. Of those that agree to be interviewed, random selections were made until maximal redundancy (explicated later) had been reached.

Data Collection

Data was collected using open-ended interviews conducted with residents upon being advanced a level. Interviews were conducted subsequent to level advancements because it is theorized that level advancements denote that the individual is making "progress" in the program (explained above), and would be able to describe their experiences of making progress and what they feel helped them along the way. Only residents who advance to level two or higher were interviewed. The reason for the exclusion of those who advance to level one was that advancement to level one at New Haven facilities does not require much time or effort. In addition it was theorized that the student at this point may not have much insight into their progress. Therefore, interviewing these individuals would provide little relevant data.

Treatment teams met weekly to make decisions about level advancements. Upon deciding whom to advance, the treatment team at each center would inform the research coordinator of their decisions. The research coordinator at each center would then contact the central research coordinator who would contact interviewers and relay information about names and locations of residents who have advanced. Residents were then interviewed within approximately 1-14 days of receiving their level advancement. Each interview was taped on a standard cassette, and these cassettes were collected and placed in secure locations at each

facility. These tapes were subsequently taken to be transcribed, and the transcriptions were collected by the central research coordinator for later analysis.

Interviewers

Interviewers were all advanced undergraduate students in psychology or marriage, family and human development. All interviewers participated in a minimum of ten hours of training prior to conducting interviews. This training was conducted by a clinical psychologist with extensive experience in adolescent treatment, and by a doctoral candidate in clinical psychology with training in interview methods and research. The training consisted of two hours of debriefing on the purposes and aims of the present research and eight hours of training in interview techniques. This interviewing training consisted of several aspects. One aspect was lectures on the theories of interviewing such as building rapport, conceptualizing interview responses, then restating, and refining those conceptualizations appropriately. Training also included demonstrations of mock interviews by the instructors, and monitored interview role plays. Each trainee received extensive personal feedback from each instructor as interview skills were developed.

Interviews

In order to understand meaning and the context from the participants' point of view (Moon, Dillon & Sprenkle, 1990), the interviews conducted with residents were formalized but open-ended. Similar research has largely focused on the interviewees' general likes and dislikes (Bernou, 1997; Tarantino, 2002). In order to ensure that interviewees would describe their experiences of progressing through the program, and not simply focus on what they liked and did not like, interviews were begun by asking the resident to describe the gains that they have made that earned them their level advancement. This beginning was also designed to ensure that the

meaning of their experiences was understood in the context of the questions that we seek to answer. The questions used to elicit this information were: "What goals or issues did you work on to achieve level __?" or "What has changed since level __?"

After the interviewee had expounded on what they had changed, the interviewer questioned them in detail about each goal or accomplishment that they have listed. These details included such question as:

- How did you accomplish this?
- Who helped you with this?
- Was there any specific event that helped with this?
- What kinds of things did you do to work on this
- What was the most effective thing you did to accomplish this?

The interviewers were directed not to stick exclusively to these specific questions, rather the questions are intended as stems from which appropriate deviations are to be made as circumstances dictate. The goal of these additional questions was to understand the residents experience in advancing a level, how they experienced that change, what aspects of the program they felt helped them to work on their goals, and why those aspects helped.

After the additional questions were asked about each reported goal or accomplishment, a series of more general questions were asked. These questions were:

- Have there been any significant events that you remember that have helped you in your progress?
- Have there been any other specific events you remember that meant a lot?
- Who has been important in your progress during this time? What have they done?

Again with each of these questions appropriate follow-up questions were asked. The overall goal of these last questions was to allow the participant to provide a general sense of their experience in treatment and what and who they felt has helped them to progress overall [see appendix A].

Interviews were also conducted with staff members. These interviews were conducted with a similar focus and a similar format. The goal of these interviews was to use the perspective of the staff as a point of comparison to the residents' point of view. To provide staff with a similar focus on progression through treatment, the interviews were begun by asking them to name three to five common problems that they see the girls struggling with and working on to achieve their goals. Just as with the residents, the staff members were then asked detailed questions about each issue that they name. These questions were designed this time to understand the staff's perception of what aspects of treatment they believe are helpful in facilitating progression, and why those aspects are helpful [see appendix B]. Interviews were preliminarily analyzed as soon as possible. The number of interviews conducted with staff members were determined by maximal redundancy (Flick, 1998). In essence, when no new relevant information is being obtained, maximal redundancy dictates that one more interview be conducted and analyzed, at which point new interviews cease.

Research Expectations and Biases

Inasmuch that I've suggested that qualitative research requires "bracketing" one's biases and pre-conceived notions outside of the "equation" I will know explicate my own research expectations and biases.

The pre-conceptions that I had about how adolescents perceive treatment were influenced by both examining existing literature on adolescent treatment and by my own work in treating

emotionally disturbed youth. Therefore, I considered my opinions and thoughts on the subject as being based on reasonable evidence. However, as explained above, phenomenological exploration requires that these biases be examined, and suspended. In other words, in analyzing the current data I made constant concerted efforts to be open to violations of my beliefs.

One important pre-conception was that I believed that residents at RTCs by and large believe that they are supported by staff, therapists, and other residents, and that this support represents the principle foundation from which change occurs. I anticipated finding that this is true for most residents, and was therefore open to and aware of related experiences and their accompanying meanings that contradict this assumption. Additionally, I expected to find that non-therapist staff members would be seen as being more supportive than therapists since they are often less confrontational. I also believe that adolescents at times lack the insight to see the benefit in that confrontation, therefore the way that they perceive treatment benefits is influenced by that lack of insight.

At the same time, I hold a bias that adolescents are often times surprisingly self-aware and able to see change in themselves and report on how they have experienced that change. I expected that they would describe several aspects of treatment as being helpful, and would be able to articulate well how and why they found these things helpful.

Overall, I expected to find that most youths would view "change" in a positive light and would be complimentary of the program as a whole. This of course must be viewed in the context that a bias of this study is that only girls that are progressing are interviewed, which of course leaves out the "treatment- resistant" patients from our investigation.

In addition to these overall expectancies, it is important to outline my basic philosophical biases as well. Essential to the present research, the concept of "therapeutic change" is viewed

differently by different schools of thought. Some view change as simply symptom reduction while others define it as a change in one's "life-world." My personal construction of therapeutic change includes both these concepts. I expect that individuals will define change within their own constructions and relay particulars of that change in interview. Moreover, I also believe that with this particular population (adolescent girls), that moving away from dysfunctional or anti-social behaviors toward functional pro-social behaviors is by itself an indicator of therapeutic change.

Analysis

The data from the residents was analyzed using the same basic philosophy that guided the interviews themselves. Essentially, the aim was to analyze the data so as to create an understanding of the residents' perceptions of their treatment, and the meaning that treatment has to them. In other words, how did they individually experience change, what about the program do they feel has helped them to progress, how have they changed their behaviors and attitudes, and what impacts have treatment interventions had on their lives thus far? The basic format for analyzing the data was as follows:

- Each interview transcription was read so that an understanding of general manifest content could begin (Kvale, 1996; Flick, 1998).
- Each interview was re-read and analyzed with the intent of discovering more latent content. In other words, looking for deeper meaning through repeated analysis (Kvale, 1996; Flick, 1998)
- A language to describe the thematic elements of the data emerged, and the content of the interviews was color-coded according to those thematic elements (Kvale, 1996)

- The data was iteratively analyzed using the developing language and thematic elements as a frame of reference.
- Data from interviews with the staff were also analyzed for thematic content. These themes served as a point of comparison during the iterative analysis process of the data from the residents. The point of this comparison is to look for convergence and divergence between the staff's point of view and the point of view of the residents.

When the iterative process of analysis matured to a point where solid articulations of themes were emerging, the data and conclusions were analyzed in the same manner by an independent auditor. This auditor was a consultant who holds a Ph.D. in Clinical Psychology, and specializes in child and adolescent populations. He did not participate in formulating the interview, training the interviewers, or interviewing participants. The auditor served as a validity check, and judged whether the conclusions being made seemed to be reasonable and valid interpretations of the data (Flick, 1998). After this analysis, appropriate revisions to the conclusions were made, and the auditing process was repeated until reasonable convergence was reached between the auditor and the author (Kvale, 1996).

Another method that was employed to increase internal validity was to conduct credibility checks with the original residents. Once conclusions and themes were adequately articulated, and were evaluated and revised appropriately, the conclusions were presented to former patients via brief telephone interviews. The point of these follow-up interviews was to test whether the conclusions reached through data analysis match the consolidations of treatment experiences in the former residents' minds (Flick, 1998). These interviews were fairly structured and were designed to elicit brief responses from the respondents. In essence, the respondent was

simply asked whether the conclusion presented to them matched their experiences or not [see appendix C].

Results

As mentioned above, the data was first analyzed for basic manifest content. After an iterative process of trying to organize this content, it was determined that participants' responses could be broken down into categories. Since the most fundamental question of this study is essentially, "what has helped you to change," several different aspects of the treatment program were used as categories. Before preliminary analysis commenced, very basic categories were developed. Namely, these categories were individual therapy, group therapy, social support, family therapy, and recreation therapy. As analysis proceeded it became apparent that these categories were insufficient to describe all of the students' experiences. Therefore, non-therapeutic staff support, work/chores, and miscellaneous program requirements categories were developed. Additionally, students at times discussed aspects of themselves, their history, and their families that were not directly relevant to the present study. Moreover, at times they discussed things that were quite irrelevant to the study, such as small talk with the interviewers, social pleasantries etc. Therefore, two final categories were developed; a category for irrelevant information, and one for self-descriptions not relevant to any particular mechanism of change.

By using these categories, every word of every interview was color-coded so that the content fit into one of them. These categories also served as an organization in writing. In the following paragraphs, I discuss the content derived from the interviews by category. Each category is explained in detail, and then the general findings about the particular mechanisms within that category are discussed by using both general and specific examples from students' responses. Then, the reports from staff interviews (which were also coded using the same

categories) are referenced vis-à-vis the general conclusions from student interviews. Finally, reactions about these conclusions from former student follow-up interviews are presented.

Using the above explained principle of maximal redundancy, the number of interviews necessary for thorough evaluation was determined. Sixteen student interviews were used for the evaluation, because it was determined that no new information was gained after analyzing 14 of them. For some topics no non-redundant information was gained after analyzing fewer interviews. However in most of these cases additional interviews were scanned for potential significance regardless. With some topics such as the "work/chores, responsibility" category, very little information period could be found, so all interviews were scanned thoroughly regardless of the maximal redundancy principle.

Category 1: Individual therapy

I will not elaborate on the specifics of individual therapy as this is a relatively well-understood intervention. While therapists at New Haven RTCs have some specific goals that are specific to their program, their individual therapeutic interventions are tailored to the individual patient. Essentially, we assume that the individual therapy received by these participants is similar enough to typical therapeutic approaches to render detailed explanations unnecessary.

As mentioned earlier, my own biases as a researcher include assumptions about the importance of individual therapy in residential treatment. Therefore, in analyzing the data in this category, I must bracket my conclusions within these assumptions. As part of one iteration of analysis, I made attempts to disconfirm my assumptions using student responses. In doing so, I was able to confirm and at the same time disconfirm my assumptions based on this data set. Essentially, nearly all students appeared to experience individual therapy as a very important aspect of their change process. However, most students seemed to experience individual therapy

as something of a necessary catalyst for change rather than an actual vehicle of change. Nearly all students reported that their individual therapist was a very important part of their changing. However, when actually discussing the process of when, where and how that change occurred, individual therapy was less frequently and/or peripherally mentioned. In other words, when asked about what helped them to change, students often reported remembering specific occasions when change occurred, which were most often outside of a therapy session. Then when asked to elaborate on how they came to that point, they then would often think of their therapist. . For example, when asked what was helpful about the program in general, one student described her therapist as "awesome," and "really cool," and claimed that individual therapy "really helped." Yet in an interview consisting of 340 lines, she only mentioned him in eight. Here again, this suggests that this particular student recognizes the large role her individual therapist played, but when asked about what helped her to progress, individual therapy is not the most significant thing in her mind and she relates more experiences about other aspects of the program. Therefore, the therapist did not seem to be peripheral in the minds of the students with regards to importance. However, the individual therapist was often less prominent in the students' "knee-jerk" recollections of treatment in general. It is in this sense that my assumptions were simultaneously confirmed and disconfirmed. Students did indeed perceive their therapist as being very important. However, most of their memories of actual change occurring did not include their therapist as a central figure even if therapy had been integral in leading to that change.

This apparent discrepancy can be clarified by understanding the phenomenology of students' reports. Students' reports were consistent with basic therapeutic assertions such as the importance of a therapeutic alliance, or as they would call it, their "relationship" with their

therapist. Most students appear to experience this relationship as vital to their progress. After relating the story of finally being able to form a working relationship with her therapist, one girl summed that importance up nicely: "that was the biggest thing that turned my whole stay around." Students also appear to recognize the role of individual therapy in creating insight. They consistently reported that their therapist was responsible for helping them to see inside themselves and understand deeper meanings of their thoughts, feelings and behaviors. As one student put it, "My therapist says so many things that just turns on light bulbs." While many described their experience of individual therapy similarly, most did not experience the gaining of insight as producing change, or rather completely influencing them to change their lives in and of itself. Instead, most students related experiences of using knowledge, insight, or motivation gained from individual therapy to facilitate change via other vehicles such as talking with other students or staff members, changing behavioral patterns during group or recreational therapy, or in talking with family members. One could argue that the students' choices to alter their cognitive and behavioral patterns were directly linked to the individual therapy and the changes in those other settings were simply manifestations of that change. However, this is simply not how students described their experience. Rather, students seem to recognize the importance of the foundational role of the individual therapist, and view changes in their behavior as products of their own choices and the general support from others.

Some further generalizations can be made about the role of individual therapy, and in particular the individual therapist. As in most similar programs, individual therapists serve as basically case managers for their clients. They make up master treatment programs which are followed by all other staff, and they essentially make final decisions regarding most treatment issues. As such, a student's individual therapist plays the largest role in establishing the tailored

structure for that student. Again, students seem to recognize the value that this structure plays in their treatment. Many students seem to see this imposed structure as intrusive and unwelcome at first. However, most appear to recognize the value of an unbiased third party directing their treatment. The following is a fairly long excerpt from an interview. The student relates an experience that occurred when she did not want to participate in treatment at all. Her therapist (and others) imposed restrictive structure on her with results that were eventually perceived as positive:

> "So when I first got here, like I was saying I had quite a negative attitude… So, eventually I just gave up altogether, I just stopped doing my values program, I stopped seeing my therapist, I wouldn't talk to my family, and it was just this big kind of, I felt like it was me against New Haven and eventually I was put on something called, I don't know exactly what is was called, it was shutdown, but it was a therapeutic shutdown, so it wasn't like I had done something wrong to be on it. It was just, they put me on it to make me see something….And my parents were on the phone and my mom started talking and she told me that if I didn't graduate from the New Haven program I wouldn't be able to come home, and that to me was kind of an eye opener, but it didn't do anything for me if just made me madder. So right after we hung up I was told that I couldn't talk to anybody, I was put into my room for twenty-four hours of the day except to eat and when the other girls were gone out, and I was really upset about it……..I had an individual therapy with my therapist, a couple of them actually, and which were also positive where one time she told me about what she's gone through….I had shared some things that I didn't like about her and I shared some things that I had wanted to share for a long

time…And so I realized that I should take that in and I did, and I think that was the biggest thing that turned my whole stay around."

This experience is representative of many related experiences where therapists imposed restrictions and structure on students who greatly resented it. However, in this and other descriptions, those impositions led directly to positive change that the student ended up recognizing and even appreciating.

Another very good illustration of this came with one student's description of her therapist writing her treatment plan. She reported that many people saw her as suffering from Trichotillomania, but she did not. Her therapist told her "maybe this is just something we can rule out." Later she described getting past her defenses and was glad that the therapist had set up the structure to deal with the problem. This illustrates two key points. First, the student does not always possess enough initial insight into their own dysfunction. The therapist thus serves as a vital catalyst for beginning the work of self-improvement. They set up treatment goals independent of what the student thinks at times. In a broader sense parents and other authority figures are usually the ones who initiate treatment in the first place. This external structure is vital for treatment to begin. The second point is that students seem to be able to understand the benefit of this imposed structure later on. Thus resentment turns into gratitude.

To further disconfirm one of my biases, most students did not seem to experience the emotional support given by their therapists as a great part of change on a day-to-day basis. Again, while a working relationship appears to be important to these students, support from the therapist seems to be less influential than more constant support from non-therapist staff members and other students. While this may simply be a function of the fact that the students spend a limited amount of time with their therapists, and a great deal of time with staff and other

students, other aspects of the nature of therapy may influence this perceived lack of support. The following is a short interchange between interviewer and student after the student described in detail the support that she felt from staff members: "Interviewer: okay. You feel like your therapist isn't a major supporter? Student: yeah. Sometimes I feel like she tries to prove me wrong." While this student went on to clarify that her therapist was very helpful, she seemed to interpret the therapist's confronting and/or challenging her as a lack of support. This one student's experience does not seem to be unique. While some students mentioned their individual therapists in the context of "support," staff and other patients were much more frequently touted as being helpful in that regard.

While students did not confirm my assumptions that their relationships with their therapists would be of utmost importance, they did seem to see their individual therapists as very important in motivating them to change. It was a fairly consistent finding across interviews that students saw their therapists as pushing them towards change, even if they at times experienced this pushing as intrusive and unwanted. Again, it is important to note that even in cases where students were put off by therapists' persistence or intrusiveness, students still acknowledged the therapists role as helpful. This assertion was succinctly illustrated by the following: "I couldn't just do that on my own, she had to prompt me and push me."

The preceding generalizations about individual therapy are all fairly consistent findings across many students. Other findings while not as prevalent, still expand on the understanding of students' experience of individual therapy, and are worth some mention. For example some students did in fact mention their therapists as a significant source of support (it was simply not as frequently mentioned or pervasive as the support described from staff and other students). Students also seemed to view creative attempts to create insight as very helpful. Several students

described such experiences. One student described her therapist giving her a backpack to wear wherein small rocks were placed every time she wallowed in a "victim stance." Similarly, another student described being given a T-shirt that said "I'm a victim," which was to be signed by others every time she acted as such. These are just two examples of somewhat creative interventions that the students seemed to experience as very meaningful and very helpful in being mindful of their therapeutic goals.

Overall, reports from staff members about the role and effectiveness of individual therapy were quite consistent with student reports. They too seemed to see the therapist as the "director" of therapy, but not as the person who actually facilitates that change on a day-to-day basis. Again, this is not to say that staff members saw the role of the therapist as less important. Quite the contrary, they seemed to see that role as central in initiating change and creating insight, or as one staff member put it, "So I guess one of the most important things is why?.....For a lot of things, when it comes to the why, if a therapist is skillful, that is huge." Nevertheless, when talking about how that insight is put into use, when new skills are practiced, and where the students actually show change, they see therapists as less important.

Staff members did have some insights about aspects of individual therapy that were not explicated well by the students. One such important insight was their view of the role individual therapy plays in dealing with sensitive and deep issues. Staff admitted that with issues such as abuse or trauma, many students are reluctant to share those problems with a lot of people. As such, the individual therapist often helps the student through them with little support from other sources. This is a very good example of how my original biases were both confirmed and disconfirmed. Like the students, staff members reported that they saw individual therapists as being a primary source of support for some issues and more of treatment supervisors with others.

Category 2: Group Therapy

Within this category are several different types of groups with one basic format. Every student at New Haven attends a group known as "community." Community is a group session including students, therapists and non-therapist staff members. This session is very similar to group sessions employed by many programs in a milieu-type setting. In addition to community, some girls participate in specialized groups. These include trauma groups designed for girls with a history of abuse. Other students with substance abuse problems participate in substance abuse groups. When reporting on students perceptions of these groups, the type of group will be specified.

As with individual therapy, I must make explicit my preconceptions about the importance of group therapy. I expected group therapy to be a major part of the students' reports. Specifically, I presumed that group, or "community," would be one of the principle ways that girls experienced empathetic bonding, as well as a major source of emotional support. Unlike my biases about Individual therapy, the students' reports nearly completely disconfirmed my assumptions. While the students did not relate negative experiences about group therapy per se, group seemed to be viewed as peripheral and less salient than other aspects of the treatment program. In fact one girl explicitly described community as essentially "busy work," and a "time filler." This opinion did not reflect the attitude of all students. However, by and large, groups did not appear to be a major part of most students' phenomenological recollections.

Nevertheless, the present data does contain some descriptions of group therapy playing important, albeit somewhat limited, roles in the change process. This is not to say that group therapy universally played a limited role for all students. Rather, the present data suggests that group is simply not as prevalent as a major factor as my preconceptions suggested. Group

therapy did in fact play a significant role for some. One girl declared that group therapy was responsible for changing her negative attitude. She related the following:

> "One day I was hanging out with these two girls who got kicked out of here, anyways I was hanging out with them and we'd always be negative together. We'd say how much we hated stuff and we hated it here and we'd have two groups a week about how we're bad and we're doing things wrong and stuff.
>
> Interviewer: other people would tell you this?
>
> Student: yeah. I was just like, Oh my Gosh I am so sick of these groups. I am never going to get my level and I'm not going to go anywhere if I keep this up. So I was just like, I'm not hanging out with them anymore. I'm not going to be mean to them, but they're just not he people that are going to get me anywhere. So I am just going to be positive and try to look at things.
>
> Interviewer: was it the groups that helped you to realize that?
>
> Student: yeah."

While such revelations are theoretically basic functions of group therapy, they were infrequently mentioned in the present data.

One consistent finding (even if it was infrequent), was that students who attended the specific groups (i.e. trauma groups and substance abuse groups) as opposed to the typical "community" group, seemed to find them very helpful. Students described feeling safe in an environment where others could empathize with them and relate to what they went through. When looking at the descriptions of group therapy as a whole, it is fairly clear that students see

these specialty groups as far and away the most significant group therapy experiences. For example, one student described gaining very significant insights in a trauma group,

> "….helped me realize that was their fault, why they did that to me, that wasn't my problem and it wasn't because of me that they hurt me so bad and just realizing that I don't need people to like me if I'm okay with myself."

When groups were mentioned by students as helpful, the aspects of the group that were mentioned seemed to center around the social support derived from the group. In particular, students struggling with self-esteem problems seem to experience the groups as validating what they are told by their therapists, staff, parents etc. One student in particular claimed that announcing her good qualities in group and having the group validate those claims was one of the single most influential experiences in the process of improving her self-esteem when she stated, "probably the best two were to announce my good qualities in a community meeting." In a similar vein, students seemed to experience the group as validating the acceptability of conforming to the demands of the treatment program. In other words, some girls who experienced the treatment program as invasive and "uncool," appeared to be motivated by group members to stop trying to "B.S." their way through the program.

Staff members also consistently saw specialty groups as being very helpful to the students. They related experiences where they witnessed students being greatly benefited by learning from the experiences of others in similar situations, and feeling empathy from and for persons who had dealt with those situations.

Slightly inconsistent with students' perception, were the staff's view of "community." They seemed to think that community was somewhat more important than the students did. Staff saw community as solidifying the unity in the milieu as well as providing a venue for further

insight. One such report asserted, "So when girls confront them about it, I think it hits them harder," suggesting that feedback during community can be even more powerful than feedback from therapists of staff. While such a claim makes intuitive sense, and may in fact be true, few students seemed to perceive group therapy feedback similarly. This is not to say that such claims are false, simply that in the aggregate, group feedback does not seem to be as important in the minds of the students as we may assume.

Category 3: Family Therapy

Because New Haven draws its patients from all over the country, most of the family therapy done is by telephone conference calling. The telephone allows the therapist to employ such tools a muting the sound so that they may talk to the student without the parents listening, and essentially gives the therapist more control over who is speaking to whom. Also included in this category were the family weekend activities that are intermittently planned at New Haven. These include such things as rafting trips and ropes courses. In short, activities are planned that allow and encourage fun along with communication and teamwork.

Unlike my biases about individual and group therapy, my expectations about family therapy were not only met, but often exceeded. Nearly every student interviewed mentioned family therapy as helpful, and many of them described in great detail how it was perhaps the most influential external factor in their change process. Most of the students' descriptions were fairly conventional and made intuitive sense given what one would expect from family therapy. Their reports are nonetheless important because they confirm that family therapy in an RTC context is vital. Moreover, they confirm that students are able to internalize a great deal of this intuitively expected benefit. Not surprisingly, students primarily described family therapy helping them resolve family problems. However, they seemed to experience family therapy as

creating a bridge between their "treatment world" and their "home/real world" (my phrases). In other words, Students seemed to feel good that their parents were part of their change process even if those problems did not directly relate to family issues.

In general there seemed to be a few factors that made family therapy stand out in the students' phenomenological worlds as so helpful. Most students either explicitly or implicitly described family therapy as creating a "safe" environment in which problems could be addressed. The following quote from a student illustrates this point: "…again it helped with having Melissa there because I felt really safe around her. It was a lot about feeling emotionally safe." Another common factor was the family therapist's genuineness in therapy. While one might assume that teenage girls may be offended by direct straightforward feedback, almost all students interviewed seemed to truly appreciate their therapists being open and even harsh and blunt about their family's problems; or as one student put it, "she'd lay it out, she'd tell it like it was." A third common factor was that students seemed to appreciate the family therapist's role as "referee," which is what one student referred to her therapist as. In other words, the therapist's ability and willingness to act as a mediator seemed to contribute to a feeling of security for the students. Moreover, the fact that most of the therapy was conducted over the telephone gave the therapist even more control as mediator because he/she could control whether to communicate about facial expressions, or whether or not to cut off communications completely. Likewise, instead of interpreting this as over-controlling, students seemed to find the therapists "refereeing" and controlling of communication helpful as well. The final common factor inherent to family therapy that was oft mentioned by students was the fact that weekly family therapy provided consistent and repeated practice for improving while in direct contact with parents.

The preceding factors were aspects of family therapy itself that were touted as being helpful. In other words, the "how" family therapy was helpful. Now we will discuss the "with what," family therapy was helpful. Not surprisingly, perhaps the most prevalent way that family therapy was seen as helpful was in opening or improving communication lines between parents and their child. Students described in detail how this improvement in communication led to an improvement in their relationships in general and how they felt closer to their parents. They also often described developing the ability to feel supported by their parents because of these improvements which helped them to feel more motivated to improve, and to feel better about themselves in general. While many students described this process, the following quote provides a typical summary of students' described experiences:

> "The therapists made it safe for me to arrange things. Talk to each other, try not to get into a conflict or power struggles and just more finding ways where we don't have to argue or anything like that. We have a compromise…. so it's easier for us to explain ourselves without the other person judging us or criticizing us."

Students also demonstrated insight about the benefit of developing better communication and conflict resolutions skills. As students described this process, it seemed that they at times were annoyed with the repetitive nature of addressing issues over and over and practicing communicating about them. However, the present data suggests that overall these sometimes arduous tasks remained in students' minds as yielding significant benefits. As one student put it, "And we can disagree and argue about things but in a calm manner and you know, it's okay. Before there was always a winner and a loser, and now it's not like that." Some students were even able to articulate insight about the benefit of their parents learning to set better limits in an effort to steer them in more productive directions. Still others were able to use family therapy as

a platform for setting better boundaries with parents who were too enmeshed in their lives. These kinds of reports are exactly what clinicians would hope for, and as such are not terribly surprising. However, the fact that students' reports seem to match what clinicians would hope for is *very* significant. These reports offer convincing evidence that students perceive the very benefits from family therapy that clinicians intend.

According to the students, family therapy was also helpful in repairing sometimes deep emotional pains within the family. One student claimed that she "hated" her father, but after building a relationship in therapy, was able to come to accept and even love him. While other students' descriptions were not quite as poignant, the general idea that family therapy was an experience that engendered trust and acceptance among family members was very common. Another student reported that she was able to build enough trust with her parents that she felt comfortable admitting past lies and being honest with them. She summed up this experience thusly, "just everything was laid down on the table so that there weren't anymore miscommunications or misconceptions." Similarly, gaining forgiveness from and toward parents was a common theme for several students.

Like the reports from students, staff member perceptions of family therapy were also fairly conventional. Their view of the importance of family therapy was quite consistent with that of the students. One staff stated, "I would say that is the most important thing that you bring the families into it. So it is not just we help the girl and then send her back to an unhealthy environment we are changing the whole family dynamics system." The staff universally saw family therapy as vital to promoting long-term change in the student. Most staff members related this importance to the New Haven focus on "building relationships," which may be due to their common training. The staff's reports indicated that they saw how important creating a safe

environment for solving family problems is to the students. Overall, the staff did not have as much to say about family therapy as the students; however, both groups' understanding of family therapy appeared to be very similar.

Category 4: Social Support

The participants in this study live in close quarters with other patients in a residential setting. As such, they have much contact one with another. Therefore, social support has been defined quite simply as any significant contact with other students. However, within this construct, we have excluded contact with others in the context of group and recreation therapy.

Like family therapy, social support was one of the most commonly mentioned treatment factors. Also like family therapy, most reports about social support were fairly consistent with intuitive expectations. My expectations were that students would report feeling supported and understood by their peers and that this support would help them through the difficult treatment process. These expectations were largely confirmed. Thematically, the most commonly described experiences with peers were related to feeling understood by someone in a similar situation--in essence feeling empathy from and for others in treatment. While not all reports of experiences with peers were glowing with mention of love and support, all students interviewed at least briefly mentioned positive experiences with fellow students. This quote provides a typical assessment of the value of interacting with peers in treatment: "…so it's kind of nice having people here to be there for you too and they know what your struggles are, they know what you're going through so they're there to help you too."

Specifically, many students described benefiting from being around others who were currently dealing with the same issues. However, gathering encouragement was not the only benefit described in these accounts. Having the other students around to remind them of the

issues they were supposed to be dealing with was a surprisingly common theme to this researcher. Several girls reported that they appreciated their peers' efforts to remind them whenever they reverted back to problematic behaviors. Overall, such interactions between students were generally characterized as relationships that were filled with concern and even love. This theme is exemplified by the following: "Student: my peers helped me a lot too, because I realized that they were sincere, and that they were really out for the good for me, they weren't out for them to look good." In essence, having a constant presence of people who know what it is that they were supposed to be working on was experienced not as a nuisance, but rather as an encouraging and helping hand.

As a consequence of feeling genuinely cared for, communication with other students was predominantly seen as validating; and therefore, was self-esteem building. Students described experiencing encouragement from students somewhat differently than encouragement from staff members. This was not always an obvious and explicitly described experience. One student reported, "Wow, people think I am this? That really helped too." Several descriptions indicated that while encouragement and praise from therapists and staff members were helpful, hearing similar positive feedback from peers carried a special weight.

The close nature of these social relationships carried with it some negative consequences that did not go unnoticed by the students. Some students seemed to feel dragged down by others around them who were experiencing their own difficulties. Specifically, some described getting caught up in their peers' problems which distracted them from their own. Others experienced being pulled down into "negativity" when around other students with poor attitudes. As one student put it,

"there's a mix. Some people have more integrity than others, so if I put myself around people who have integrity, then that helps. But I am with mainly people who are negative, then that just makes it harder and worse."

This particular student is simultaneously describing being aided by the examples of others, and being bogged down by still others' examples. Nevertheless, positive experiences and positive examples appeared to be more prominent in the minds of the interviewees overall, as evidenced by such descriptions as the following:

"I think that just being here, there's so many girls that you can relate to. I mean everyone has been through some sort of something here, you know… and everyone here is so, all the girls here are so strong."

Staff members spoke much of the importance of the support of peers. Once again, these reports were often centered on the idea of "building relationships." Again, staff seemed to understand the importance that forming a supportive structure of people can have for the students. However, their reports do not articulate a great understanding of the special role that peers take on in that structure. In general, staff expressed the opinion that peer relationships were important and they provided support, empathy and validation to the students. However, they often lumped such support in with the support that students received from the staff. This suggested an acknowledgment of the importance of social support, but a somewhat limited phenomenological understanding of the experience of being supported by one's peers.

Other than the aforementioned slight limitations in the staff's reports, their descriptions of social experiences in treatment were very similar to the students' Like the students the staff viewed the experience of having many girls of similar age around as providing real-life practice with developing burgeoning skills. They also discussed the value of following others' examples

that were changing their lives for the better. Finally, the staff acknowledged (as did the students) that at times this influence works against the girls if they associate with individuals who are not doing well in treatment.

Category 5: Recreation Therapy

Recreation therapy includes a fairly wide variety of activities. Equine therapy, ropes courses, and sporting activities, are some of the common activities used. Also included in this category were activities done during visits with parents. My preconceptions of recreation therapy were that it would be viewed as peripheral by the students, and consequently, not particularly significant. These biases did not seem to be confirmed much at all. While recreation was not one of the most frequently mentioned treatment intervention, it also did not seem to be peripheral at all in the minds of the students. In fact, in the section of the interview where students were asked to talk about experiences in general that were helpful (as opposed to talking about specific problems that they worked on), recreation therapy activities were the most commonly mentioned experiences. One student went as far as to say, "…actually, I really think Amber helped me the most."

The most common theme in the experiences related by students was that they seemed to feel that recreation therapy more closely resembled "real life" than did other activities/treatments. They described enjoying actually "doing" something instead of "just talking." In clinical terms, we might refer to this phenomenon as 'in vivo' practicing with therapeutic issues. This in vivo work seems to be very meaningful to many students because they see recreation therapy as bringing out genuine feelings and behaviors in themselves as well as others. One student described it thusly, "I think the rec therapy is really good. Because it kind of shows your, what you do in rec therapy shows how you play in real life. It really helps just

seeing how you do things." Students seem to have insight into how being able to process genuine emotions and deal with genuine behaviors is of great benefit in propelling change. This was a fairly consistent finding whenever recreation therapy was mentioned. The following is a representative summation of this insight expressed by students:

> "Amber, the rec therapist always helped me and she would always ask me my feelings. Amber's helped me a lot because with a lot of activities she asked me how I was feeling and then she would ask me why I was feeling that way and so I would have to open up."

Feeling loved and supported during recreation therapy activities was not an explicitly expressed theme. However, a similar and perhaps related theme emerged when students described recreation therapy as promoting unity among the students. Many of the activities that were significant to the students were group activities designed to require teamwork. And as was designed, students seemed to experience a greater sense of trust in each other as a result. As part of this increase in trust and teamwork, several girls described building leadership and assertive skills. This skill building also seemed to be a goal of the recreation therapists which was not lost on the students. One girl reported,

> "We do tasks where we all have to work together. If you aren't caring if your needs are met, then you're going to out yourself out there to get hurt and you're not going to say anything because it makes you uncomfortable, you know? And people who say what they're comfortable with and what they're not comfortable with are the ones who are getting their needs met"

As with other students who spoke of genuineness in recreation therapy, this same student went on to describe how girls could not hide their lack of assertiveness.

Very few negative experiences with recreation therapy were reported. This is somewhat unique to recreation therapy as all other forms of treatment seem to have at least some negative thematic elements to these students. The only reported negative experience appeared to be somewhat of a side note to the reporter. She claimed that she did not like being coerced to participate in activities involving horses, as she did not like them. However, even this student seemed to have experienced recreation therapy positively overall.

Staff members did not have a great deal to say about recreation therapy. Those staff that did mention recreation therapy as being important mostly seemed to see it as a way for students to learn and practice pro-social skills and activities. There was also some mention of recreation therapy creating insight, and building self-esteem through completion of difficult tasks. However, these descriptions were few and somewhat limited. Overall, staff's perception of the role of recreation therapy was not inconsistent with the experiences related by the students. However, there was very little evidence that the staff understood how recreation therapy helped the students, or rather, what it meant to them. Instead, they only articulated somewhat superficial (albeit correct) observations of with what issues recreation therapy was helpful. This by no means is an indictment of the staff. Instead, it illustrates that there are aspects of the treatment program that are meaningful to students in ways that are not fully understood by the staff.

Category 6: Non-Therapist Staff

Time spent with therapeutic staff is somewhat limited for the students. While there is almost always some form of supervision, this supervision is largely handled by paraprofessionals and staff with limited training. While these staff members do not necessarily possess degrees or certificates, they are often undergraduates in clinical fields. Moreover, all staff members receive

regular training in effective ways to handle students and offer support. This support often comes in the form of resolving conflicts and what they call "processing" which consists of essentially of listening to students' problems and offering limited suggestions.

My expectations of what students would report about their experiences with staff members were largely confirmed. I presumed that students would mention staff members quite a lot, and that they would be viewed as a great source of emotional support. However, students' overall experiences with staff seem to go beyond just a source of emotional support. Rather, a more accurate generalization of their phenomenological experiences would be to characterize non-therapist staff as almost ubiquitous guides. In other words, students seemed to see staff as the ever-present influences that nudged them in the right direction. While not all of this 'nudging' was experienced as positive emotional support, the nudging was almost always described in some form.

One of the most common ways that students saw the staff as directing them was that most students seemed to see the staff as always making themselves available to talk. This staff trait seemed to be particularly helpful with students for whom sharing their thoughts and feelings was difficult. Nearly all students seemed to draw a sense of security from the staff always being around to "process" any issue that came up. However, this is not to say that the staff was seen as being the primary source of support. Rather, the staff seemed to create a greater breadth of support. Considering the following two student quotes together illustrates this point:

> "The staff helped because if you're able to talk to someone about it, usually it kind of feels good to be able to get it off your chest when something is bugging you. They would help you with that."

"Becky [referring to a staff member]. She's so easy to open up to. I mostly talk to her about Bulimia and my experiences, so. There are certain people that I talk to about certain things. With Amber, it was trust and pain. With the girls it was my mom. With Becky it was Bulimia. So I opened up to a lot of different people about different things. All of them individually helped me with something."

Many students described experiences wherein they felt appreciated and loved by staff. This praise and validation seemed to make it easier for many girls to accept encouragement and the gentle prodding that was referred to above. While many appreciated the praise and positive feedback, many students demonstrated insight into the value of being confronted and reminded about dysfunctional behaviors. At least from the students' perspective, this prodding was seen as being an extension of what their therapists had already directed. Therefore, the staff served as the enforcers of treatment plans. The following exchange between interviewer and student succinctly describes this process:

"Student: my therapist doesn't really confront me. He just tells me what I need to do and what I need to stop. Not really what I've been doing, it's what I need to learn. That helps me.

Interviewer: so it sounds like you therapist kind of lets you know what you are to work for, and the staff and peers kind of point it out when you do it.

Student: ya"

This description illustrates how the staff member becomes an extension of the therapist. The therapist helps the student to gain insight and figure out how they want to live. However, the therapist does not do much direct observation of that student's life. Therefore, the staff member plays a vital role in actually witnessing everyday life and providing daily feedback to the student.

In this way, the students seem to see the staff members as carrying out the treatment goals of the therapist.

In this same vein, the staff was often seen as exemplars of healthy boundaries. Students who had troubles with this issue almost all described how staff helped to consistently stick to boundaries such as holding to consistent expectations and not allowing themselves to be taken advantage of through rule breaking or through favors. One student reported,

> "at first they didn't, they were just like, you know, I'm not going to do that. I was kind of like, whoa, because I would tell my mom what to do and she would do it. But then I came here and they were like no, and it was like a slap in the face, like wait, what did you say? …eventually I realized."

This example exemplifies how students were able to interpret firm boundaries as helpful instead of punitive. As such, the staff members that maintained this firmness seemed very significant to those who had not had such authority figures in their lives before.

It should be noted that not everyone described their experiences with staff as significantly helping them to change and progress. Nevertheless, most did, and there were zero examples of students describing their overall experiences with staff as negative. Rather, they were either not mentioned or simply described in a peripheral manner such as: "Interviewer: okay, sure. How about any people who have really helped you out? Student: my therapist obviously, she has really helped me the most. And some of the girls here. Not staff so much."

Perhaps it is not surprising that non-therapeutic staff members discussed their own role more than any other treatment factor. Their reports did not generally sound overly self-aggrandizing. However, they generally saw the role of the "staff" as very important. Here again, most of their perceptions about the importance of staff involvement centered on the idea of

"building relationships." As such they seemed to think that the primary benefit of having staff around almost constantly is to provide emotional support, validation and praise. This of course is very consistent with what the students experience and find significant.

Likewise, staff members seem to understand how being available to serve as a mediator of conflicts as well as policemen of appropriate behaviors is very important to the students. Perhaps most importantly, staff members demonstrated a thorough and detailed understanding of how the students see them as carrying out treatment plans. One staff member stated, "I mean the therapist will work on it in therapy and like groups but we are with them on a day to day basis trying to carry it through." This is a very good articulation of what seems to be a very important concept for the students. Both students and staff see and appreciate the need for the staff members to function as a day-to-day extension of the therapist. Reminding students of their treatment objectives, and aiding them in meeting those objectives was a frequent theme of both the students' experiences as well as the staff's reports. Staff members claimed to serve one more function that was not recognized as by students. In addition to carrying out students' treatment plans, the staff reported that returning to therapists with feedback about how the girls are doing, and what they think additional treatment goals could be. While this function was not explicitly articulated by the students as important, it does seem to coincide with students feeling more understood by staff about certain issues.

Category 7: Work/chores and assigned Responsibilities

As part of the requirements of the program, students are expected to complete a few basic chores. These typically consist of basic household cleaning jobs such as vacuuming or cleaning a bathroom. These chores are designed to give each student some personal responsibility for the maintenance of their living establishment. These chores are not extensive and are not used as a

punitive measure. However, because many of the students have problems with personal responsibility, these chores are at times no small matter.

My assumptions about this particular treatment intervention were that students would see responsibilities as irritating but helpful. I presumed that students would mention chores as a character building exercise (although not in those words). Upon examining the data, my presumptions were somewhat accurate; however, these aspects of the program were quite infrequently mentioned.

A few students did in fact describe these responsibilities as character building. There were two positive character traits that were described. The first was leadership ability. While this concept was mentioned quite infrequently, it is worth noting that a few students reported that being given responsibilities and jobs to do provided them with some opportunities to practice being in leadership role and learning assertiveness. The second way in which chores and responsibilities were experienced as helpful was in fact teaching responsibility and integrity. This concept was more frequently mentioned. Although it is important to note that learning responsibility was usually not mentioned as a direct result of being assigned tasks per se. Rather learning responsibility was usually mentioned vis-à-vis task assignments in combination with therapist support or support from other students or staff. In other words, being given tasks and assignments seems to have been of little value to these students without other people and treatment interventions in place as well.

There were very few mentions from the staff of this particular aspect of the treatment program. In fact, there were so few that generalizations about staff's perception can not really be made. What little that was mentioned was however quite consistent with student reports. Specifically, there was some evidence that staff members understood how responsibilities can

sometimes be internalized to bolster self-respect which was consistent with students' descriptions of the importance of such things.

Category 8: Miscellaneous Program Requirements

As explained earlier, students at New Haven (and most RTCs) work to advance through a system of levels. While advancement is somewhat tailored to the individual, each level has a set of specific requirements. Additionally, parents are encouraged to participate in treatment through visits, therapy (already mentioned) and family/group activities. There are several non-specific interventions that are simply part of the program at RTCs that do not easily fit into any specific category. Therefore, a miscellaneous category was developed for such things.

It is difficult to make general statements about this category since "miscellaneous" inherently does not lend itself to generalization. That being stated, the following statement is justifiably awkward. Students seemed to think that just "being" in treatment was helpful. In other words, many of their descriptions were not about any particular treatment intervention. Rather, many seemed to be greatly benefited by simply the experience of being in a place where the focus of life was self-improvement. One student simply stated, "So I opened up to a lot of different people about different things. All of them individually helped me with something." It is very clear that from the students' perspective this treatment environment would not have been helpful without the different treatment interventions that have already been discussed. But the present data suggests that all of these interventions would not have yielded as profound of experiences without being in a "different place." Another student stated that "just being in a different place" helped them to progress. For the purposes of succinct discussion, this "different place" will be defined as the encapsulation of the general aspects of the treatment program and the fact that the students are placed in radically different environment. This radically different

environment, independent of the other interventions that were used, seems to be helpful for students by itself. It allows them to escape their old lives and start new ones in a new place. This idea seems to be implicitly central to the experiences of the students in residential treatment. They do not often explicitly claim it, but it is quite clear that they believe that few of their life-changing experiences would have been possible without being in this new environment that is focused on treatment.

One of the most general aspects of the treatment program is the aforementioned level system. The benefits of this system were not lost on these students. While many described the requirements to advance as arduous, every such person also saw them as beneficial. These levels are associated with rules and privileges, and the pursuit of these privileges was seen as very motivating. The following student explicitly admitted, "the only reason that I decided to do anything, was honestly because I didn't want to get my level dropped." The students almost universally saw self-improvement as hard work. As such, most needed some motivation to endure that hard work above and beyond the intrinsic value of the self-improvement. Seeking progression through the level system as well as the structure and discipline inherent to that system were frequently mentioned as providing this motivation. For example, being placed on "team" (increased supervision without any time alone) or "safety level" (removal of most all privileges) were quite unpleasant to some and effectively increased motivation to comply with treatment requirements.

Another general aspect of the program at New Haven that was significant in the minds of the students was the focus on relationships. In the staff interviews, this concept was by far the most frequently mentioned aspect of the program, and seemed to be viewed by the staff as the foundation of treatment. The clinical term for this construct may be therapeutic relationship;

however, in this case, it goes beyond the relationship between therapist and patient. At New Haven there is an attempt made to focus on all relationships, familial, friends, between students, and between students and staff, etc. The effect that this appears to have on the students is apparent in the present data. Almost universally, students' descriptions bespeak (implicitly) that they see themselves as being engulfed in a multi-faceted cushion of support. One student reported, "with relationships, you can feel so loved and you feel so great giving love and knowing this other person feels it." The data consistently suggested that the students saw benefit not only in being supported by a variety of other people, but also in being a part of the support system of others.

Various other miscellaneous interventions are mentioned by the students. The one most worthy of mention is the New Haven focus on "values." These "values" include such things as integrity, self-worth, and spirituality. Through various assignments, students are encouraged to develop and stick to their own value system. They earn "value beads" which are designed to facilitate this process. Several students' reports indicated that they experienced these assignments as significant and helpful. All such reports were not as glowing as the following, but this quote does illustrate the point well.

> "We have beads for everything. No, I'm serious. I've done so many beads. But level three is the last beads that we do. Which I'm sad about because I really enjoy them; I chose an extra one because I think they're so helpful."

Descriptions that fit into this miscellaneous category made up the biggest part of the staff interviews. Most of the staff's descriptions of the program fell into two general categories. The first one was that the program focuses on "building relationships" which includes learning pro-social skills and more adaptive behaviors. These relationships include all of the factors that have

previously been discussed, but in general the gestalt of this focus is more than the sum of these aforementioned parts. In other words, the staff seemed to think that having a *team* focus on relationships was more effective than participating in several *separate* treatment interventions. This conceptualization is an implicit thematic element of the students' reported experiences as well. They simply did not articulate it as well as the staff.

The second was basically that putting girls in a totally different environment where an atmosphere of safety and positive values can be fostered is of great foundational importance. One staff member stated,

> "The first thing that helps for any of this stuff to be effective or for any of the girls to heal is a safe environment–if a residential treatment center does not provide that, it can be emotional safety and physical safety, if they do not feel that, then basically what they are doing may look good, but no healing is going on."

This was a very consistent finding throughout staff interviews as well as students. All seemed to feel a great need for a safe environment in order to feel able to change their lives. Another general aspect of the environment that was a significant part of the students' experience was the high level of structure in that environment. Again, this concept was not well articulated by the students, but came through on an implicit level. The staff seemed to understand how important this was to the students and discussed it in more detail. For example, one staff reported,

> "I think, giving them structure and holding boundaries with them and having them learn how to hold boundaries in their life is important. It is that structured environment a lot of our girls don't have any kind of structure and just kind have always done what they wanted. There is safety in boundaries and structure in there life. That is one thing that we provide."

The level system is part of this structure, and the staff members appeared to have a high level of agreement with the students in regard to their views about its importance and efficacy. Overall, the students interviewed seemed to buy into the general aspects of the program. The present data suggests that with these general issues, the staff and the students are on very similar wavelengths with regard to their views about what is helpful.

Follow-Up Results

Seven former students were interviewed. These women were between the ages of 17 and 22, with an average age of just under 20. All of them had been treated about 4 years previously. These women consisted of those that had been interviewed initially, and used in this study, as well as those who were in treatment at the same time, but not interviewed. It should also be noted that out of 26 former students that we attempted to contact, only seven were successfully interviewed. Nevertheless, maximal redundancy was achieved for nearly all subject areas. The interviews themselves were structured, and were designed using the same conclusions presented in the results section of this document [see Appendix B]. The former students were read conclusions about all the different aspects of treatment and asked if this matched their current opinion or not. Essentially, these questions were designed to elicit "yes" or "no" answers thus confirming or disconfirming the conclusions reached. The vast majority of responses were simple "yeses," however some respondents chose to elaborate briefly.

Originally, conducting follow-up interviews was designed as a validity check, a way to ascertain whether former students agreed with the conclusions drawn from the original data. Conducting these interviews did indeed accomplish this task. However, in attempting to validate the results of the original data, additional data was obtained that was not intended. Since the intent of the present study was essentially to determine what students believed helped them to

change while in treatment, new data (as opposed to simply confirmatory data) gathered four years post-treatment goes beyond these original intentions. However, this information is related to the basic question of what patients believe helps them to make positive change. Therefore, this new information is worthy of note. First, the degree to which former students agreed with the conclusions from the original data will be discussed. Then, the aforementioned new information will be presented.

The vast majority of responses were in the affirmative. Even with those who seemed to hold fairly negative opinions about either a particular part of treatment or treatment in general, tended to agree with the statements about *how* interventions were helpful or positive. For example, one interviewee held a very negative overall view of her treatment, and had very few positive things to say about it. She was asked if being placed in a radically different environment helped her to escape her old life and change. Her response was very telling of the apparent power that just being in an RTC setting seems to have. She responded, "That's the one thing that I'm grateful for." Another girl who characterized treatment overall as "traumatic" nevertheless, repeatedly admitted that different interventions were helpful and provided benefit. Just participating in a comprehensive treatment program that addressed multiple issues and did so in an isolative environment seemed to be one of the most powerful aspects of treatment for these individuals.

There were really no conclusions that were presented to former students that they consistently disagreed with. In fact, there were very few conclusions that they disagreed with at all. Most (four of the seven interviewed) who held an overall negative opinion of their treatment did not seem to hold that opinion because they thought that treatment was ineffective. Rather,

they seemed to dislike treatment because they saw that treatment as coercive and/or excessive (discussed below).

Those who continued to have a positive outlook of their treatment experience overwhelmingly agreed with the conclusions from the original data. As stated above, the majority of these responses were simply "yes," or "definitely," or some other short affirmative response. In other words, they agreed with the conclusions that were presented to them. One of the most poignantly positive responses came from a former student who was describing her relationship with her mother. She related briefly that this relationship before treatment was very poor. She agreed heartily with the conclusion that family therapy was very helpful in building relationships and teaching communication skills. Then she stated that "I still have a good relationship with my mom. That never would have happened without New Haven." Improved relationships with parents seemed to be one of the most long-lasting and significant perceived benefits of treatment. Interviewees mentioned this benefit resulting from treatment in general and not just family therapy. While they did not explicitly discuss this theme a great deal, it appeared that the overall difficulty of being separated from their family combined with the difficulties of treatment bred an increased closeness that persisted for years following treatment. While this assertion is more dramatic than statements made explicitly by the former students, almost all of the students did state that their relationships with parents continued to be better than they were before treatment, and that they attributed that improvement in part, or entirely, to their treatment.

While not all presented conclusions elicited such strong statements from respondents, it was very clear that the conclusions reached from the original interview data matched the current perceptions of former students very well. As such, the follow-up interviews suggest that the

conclusions of this study are reasonably valid with respect to how patients view their treatment in the long run.

The aforementioned additional information derived from follow-up interviews does not invalidate conclusions, so much as it simply adds to them. It should be noted that this new information comes from a small sample size, and should therefore be interpreted accordingly. Former students used the interviews to voice criticisms and complaints, and offer feedback. This feedback began to fall into several themes, and these themes will now be briefly discussed.

The most prominent theme had to do with the values and goals promoted by the treatment team. Several students reported that they did not like that they seemed to have little control over what they worked on, or how they should act. These criticisms ranged from accusations that the staff was simply not open to feedback, to one girl who repeatedly accused the program of "brainwashing" her. Another former student described feeling very confused throughout treatment. She related that she felt out of place and that she wasn't sure what people wanted her to change. She stated that she "didn't ever really understand what I was supposed to do," and that she felt "programmed" by the treatment team. This same girl agreed with most conclusions about the helpfulness of interventions, but overall thought that treatment team was not responsive to her individual needs and that she was kept much too long. Being kept in treatment too long was a fairly common opinion. Another girl, whose overall opinion of treatment was much more positive, shared the same view that while treatment was very helpful to her, six months would have been sufficient as opposed to nine.

This perceived rigidity affected the promotion of "values" as well. A few former students thought that the values were fairly rigid and even somewhat religiously based. These individuals reported that particularly non-therapist staff members spoke of religion too much.

Although, only one person reported being offended by this, the others simply being "put off" by it.

Another related theme that emerged centered on the perception that residential treatment was inappropriate. Four out of the seven former students held the perception that they did not really need the level of treatment that they received. Again, these feelings ranged from thinking things were "blown out of proportion" to thinking that they were "brainwashed" into thinking that they should change things about themselves. One student reported that "I didn't feel like I belonged…..other people were much worse than me." The young woman who reported feeling "brainwashed" was definitely an anomaly with regards to other interviewees. However, there were several others that reported that they did not seem to "fit in" with others in treatment. This may in part be due to personality conflicts with other students. However, it appeared that these criticisms had more to do with the perception that long-term (9-14 months) residential treatment, was not necessary for them.

Discussion

In searching for a vehicle for conveying the significant information of this study, many are available. In order to do so in as succinct and cogent manner as possible, the following paragraphs will be written similarly to a report to RTC administrators. As such, they will contain information about the perceived significance of the structural elements of the New Haven Program. Additionally, psychological themes that have been observed across the responses of the students will be discussed. This discussion will apply most directly to the program at New Haven RTCs. However, since many RTCs employ very similar treatment approaches, a fair amount of generalizability is expected.

Perhaps some of the most interesting findings of this study pertain to individual therapy. None of the students interviewed described their overall experiences with therapists as negative. Additionally, nearly all experienced these relationships as positive and helpful. However, these positive relationships were usually not perceived as being one of the central components prompting change in the moment that such change occurs. While nearly all students reported that their therapist was very important in helping them to change, the therapist was often somewhat peripheral in their phenomenological recollections. In other words, the students described the therapist as very important overall, but often did not talk about them when they described their change process. This apparent contradiction may be easily explained by a simple proposition. The simple maxim, "fish are often the last to see the water" may be applicable. The influence of the individual therapist is always present. The students themselves acknowledge that the therapist is the primary "director" of what they work on and when. They also describe gaining insight and motivation from their therapists. These sorts of elements are ever-present, but not always consciously visible (the ubiquitous water surrounding the fish). Therefore, it seems very reasonable that students do not easily recollect and describe their influence. However, it is important to note that with very little prompting from interviewers, students had a remarkable amount of insight into the importance of individual therapy despite its subtleties.

Feeling supported emotionally seemed to be a very important part of treatment for students, which will be discussed further later on. However, for the most part, students did not experience their therapist as being the central figure of this emotional support. No students described wholly negative experiences with their therapist (although some described periods of strained relationships), but the overall tone of their descriptions did not suggest that their therapists were the persons that they always looked on for support. Rather this role was

primarily filled by a variety of other persons. This does not mean that the therapist was not seen as supportive. In fact, the students' descriptions suggest that almost all saw their therapists as caring and sincere. Essentially, the students seemed to think that having a caring therapist was important and necessary for their progression. However, this relationship (while necessary) was not the ever-present supportive structure that buoyed them up through treatment.

These conclusions suggest that some subtle and easily applied changes may be in order. It would be helpful for the therapist to understand that from the students' perspective, having a good relationship with them is important. However, it may not be necessary that this relationship be the sole source of emotional support outside of the therapy session. In fact, it may be helpful for the therapist to shy away from being the primary source of support, and instead encourage the student to "lean on" other persons such as staff members, other students, and perhaps most importantly, their family members. Such subtle changes may be helpful for the therapist as well. Making such adjustments could take some pressure off of them if they can accept that they need not always "be there" for their clients, because others may be able to fill that role even better than they can. This is consistent with the fact that in normative adolescent development, teenagers are often looking to people other than direct authority figures for social support as they prepare themselves to individuate. None of these conclusions downplay the importance of the therapist. Rather, the goal here would be to better define the individual roles of all members of the treatment team to maximize the benefits of treatment.

Students also had some very interesting experiences with group therapy. As mentioned above "group therapy" in this context refers to the daily "community" meeting, as well as the more specialized groups which were assigned as needed for students with specific problems. Overall, it seems that "community" at the time was not seen as particularly useful or significant.

Nevertheless, students may have seen this activity as less helpful because they did not quite understand its purpose. When the students described their experiences with "community," they seemed to be comparing its usefulness directly with the utility of recreation therapy or individual and family therapy. Therefore, since they gained less insight, learned few skills, and practiced little, they did not see the benefit. However, perhaps the purpose of this daily meeting was different. Such a meeting can be conducted to facilitate better communication between the students. It can be conducted to afford the students a time for airing grievances, and resolving day-to-day conflicts. It need not be intended for working out individual issues. The students may not understand this, and therefore, did not see "community" as very beneficial. However, this apparent lack of insight may not be entirely their own doing. Perhaps making the goals of "community" more explicit would allow the girls to develop a more positive outlook of it. This is evidenced by the report of one student during a four year follow-up interview. She claimed that she did not really see the benefit of community at the time but now, "looks back on it and sees it as more helpful than I did." She went on to described how she continues to use those lessons to help her today when she makes efforts to talk about her problems to her group of friends.

The lack of perceived benefit of "community" need not be passed off exclusively on the idea that students lack insight. Again, it should be noted that the present data suggests that the students do indeed possess an unexpectedly high degree of insight into the structures of treatment. The fact that group therapy was not experienced as very important for many suggests that the manner in which group therapy is utilized could be altered. The effect of specialized groups seems to be overwhelmingly filled with positive experiences, both in initial interviews, as well as long-term follow-up. Some of the reasons for the benefits of these groups were made

explicit by the students, and were explained earlier. However, perhaps the success of these specialized groups went beyond the students' claims of being smaller and composed of people with very similar problems. It seems that these specialized groups followed a more traditional group therapy format. They processed more personal issues, received feedback, and supported one another in the "here and now." It seems likely that this more focused approach likely led directly to the more positive and effective experiences that the students described. Therefore, it may be beneficial to examine how these specialty groups are assigned and perhaps expanded to include more students. If this were done, perhaps the general perceptions of group therapy would improve, thereby increasing its efficacy.

In one sense, the students' descriptions of family therapy were fairly predictable, however, in another sense, they were pleasantly surprising, and very informative. Predictable was the fact that most of the students reported working on family problems in family therapy, and that these problems began to be resolved as they did. They also described building relationships with parents, developing communication skills, and becoming more comfortable with being open with one another. Additionally, they described family therapy creating a safe environment that could allow these changes to occur. None of this is surprising given what we would assume about the purposes and benefits of family therapy. However, the deeper substance of these descriptions and the nature of the way that students perceived family therapy were remarkable.

The students' descriptions went well beyond superficial statements about working on family problems. Their experiences evidence the great importance that close family contact is vital to successful residential treatment. There is emerging evidence that suggests that family involvement is a strong predictor of general success in residential treatment (Nickerson, Brooks,

Colby, Rickert & Salamone, 2006), and the present data strongly supports that conclusion. Not only did the students describe family therapy as allowing them to repair broken relationships, and improve communication, but they actually seemed to derive a great deal of support from their parents through the therapy. Regular family therapy appeared to keep the students and parents "on the same page," and therefore afforded the parents opportunities to support and reinforce progress. Moreover, these students (by and large) genuinely appreciated this contact and support.

Even more interesting, was the fact that several students were able to articulate personal insight about the value of their parents learning to set better limits. Obviously, firm boundaries and clear structure are a part of any treatment program. But getting an adolescent to see the value of their parents developing limitations and boundaries strikes this researcher as a powerful revelation. Even more powerful would be to create such insight while still repairing relationships and building closeness and unity within the family, which was also usually part of the students' described experiences. Moreover, improved communication skills were also a big part of their descriptions. The depth of the impact of these improvements is evidenced by the fact that most of the students interviewed four years after treatment reported that improved family relationships had endured and were one of the biggest benefits of treatment. Even those who, four years post-treatment, had fairly negative views of the program admitted that their family relationships had improved.

One of the most interesting finding of this study involves the use of telephone family therapy. All of the aforementioned gains in family support, boundaries, and communication occurred in large part as a consequence of therapy conducted almost exclusively over the telephone. Some clinicians might assume that meaningful emotional connections and empathetic

understanding would be difficult to achieve on the telephone. However, the current evidence suggests that this is simply not the case at all. In fact, all current evidence suggests that family therapy over the telephone may actually be more effective, or at least easier from the adolescent's point of view. Students seemed to feel safer because the telephone created an artificial indirectness that made genuine disclosure easier, or at least less threatening. The therapist is given more control over who is speaking to whom, and if they wish they can literally cut someone off by pushing the mute button (which several students admitted occurred fairly frequently).

The present data strongly indicates that regular family therapy over the telephone may be more helpful than sporadic live family therapy, or certainly better than no family therapy at all. At New Haven, nearly all of family therapy is conducted over the telephone. This therapy is conducted by the individual therapist with the patient in the room and the parent(s) on speaker-phone. This therapy is very regular (at least once a week), and in addition, parents are required to keep in regular contact with the treatment team, and fulfill treatment goals of their own. Overall, this data suggests that additional research on the comparative efficacy of telephone family therapy be conducted, and offers very strong evidence of the importance of regular strong parental involvement in residential treatment. The applications and of this type of family involvement are many, especially in residential settings. Telephone family therapy can solve a myriad of logistical and travel issues. It can increase the likelihood that more family members would be able to coordinate schedules to attend therapy, and it can greatly reduce costs to patients and their families. Perhaps most importantly, because of the aforementioned advantages, telephone family therapy may actually be more effective independent of other

considerations. Regardless, the importance of RTCs utilizing all available methods for increasing family involvement seem to be becoming more and more clear.

Descriptions of peer relationships were not surprising, but nevertheless, very helpful in understanding students' phenomenological worlds. As discussed earlier, RTCs (and clinicians in general) tend to make assumptions about the value of certain aspects of treatment. This is true with respect to being in treatment with peers. Clinicians often assume that students would appreciate and benefit from peer support, without actually verifying the claim through study. The present data does indeed verify this claim and provides us with a greater understanding of just how peer support tends to benefit students.

While students did not explicitly use the words "safe environment," having a large group of peers seems to greatly contribute to creating such a setting for them. Without a lot of contact with same-age fellow patients, students would likely have difficulty accepting their circumstances. Again, students did not actually use such words, however, their descriptive experiences are filled with stories of difficult adjustment. They are taken from their homes, often with little or no warning. In most cases they are taken across the country to a place with which they are totally unfamiliar, and know no one. Some described literally being torn from their bed in the middle of the night. Then amidst these uncertain and even frightening circumstances, they have restrictions and rules placed upon them. On top of all of this, many of these students are not accustomed to high levels of structure (often one of the reasons they are placed in treatment in the first place), and have a tendency to rebel against it. The students' reports repeatedly describe such experiences. They also repeatedly describe how seeing others, and talking to others in similar situations helped them to overcome their reticence to actually engage in treatment. More specifically, seeing others accept their circumstances, and in so doing

change their lives for the better helps students to let go of their initial rebellious feelings. In simple terms, having a lot of peers around them "doing" the program, seems to make treatment acceptable or even "cool." Students are asked to do a lot of things such as achieving levels, earning "value beads," and sharing their deepest feelings, which are traditionally simply not cool. Having peers around to be examples, offer encouragement, and simply validate the legitimacy of treatment seems to have an important role in the experience of <u>choosing</u> to engage in treatment.

Additionally, students' descriptions of peer feedback and correction seem to be quite significant. Receiving criticism from peers is often unpleasant for teenagers. While it is clear that students had a significant amount of conflicts amongst themselves, it is also clear that receiving advice and correction from peers was often appreciated. Perhaps feedback from peers carried as special weight for some girls. Having these peers around to constantly remind them of what they were supposed to work on carries the added benefit of additional reinforcement that a problem worthy of attention exists.

These findings offer some of the best evidence for the importance and potential benefit of residential treatment. This level of social support is virtually impossible to establish in outpatient treatment. Helping girls with this level of emotional disturbance requires fairly drastic changes in life-structure. It also requires the patient to "buy into" treatment and make an effort. These necessities would be very difficult to achieve without the aforementioned social support inherent to residential treatment, which makes RTCs a valuable and perhaps vital resource for treating teens with higher levels of emotional disturbance.

Students' perceptions of recreation therapy went beyond what was expected, and offer some unique and perhaps surprising insights. Additionally, the juxtaposition of these insights with the perceptions of staff members provides useful information as well. Students' described

recreation therapy as more "real" than other interventions. They seemed to think that these activities brought out everyone's "real" issues. This is probably because recreational activities are closer to real-life activities than anything else that the students do. The key word in the preceding sentence may be "do." Recreation therapists "do" things, while therapists generally just talk. A recreation therapist is often a "can-do" kind of person who is healthy, loves the out-of-doors, and appeals to the more action-oriented side of girls. This "action" seems to add some life to the students' experience. They are forced to interact in situations similar to those that they may find themselves in during their regular lives. Therefore, it seems very likely that in such circumstances it would be harder to hide one's true self. Ergo, recreational therapy becomes somewhat of a controlled "test" of the student's progress. Are they actually applying their new skills? Are they demonstrating actual changes in their everyday behavior?

This assessment is in contrast to the interviewed staff members' perceptions. They seemed to largely look at recreation therapy as skill building, and intended to promote unity and teamwork. While these perceptions are not contrary to students' reported experiences, they seem to demonstrate a lack of students' phenomenological understanding. Staff members were not wrong in their perceptions, they simply failed to grasp that these activities carried a deeper meaning for the students, and were perhaps more meaningful than the staff originally thought.

In this study, only non-therapeutic staff was interviewed. Therefore, we can not conclude that all treatment team members view recreation therapy the same way. However, the fact that this study has revealed that this particular intervention seems to have meaning for students that goes beyond the intentions and/or expectations of a portion of the treatment team suggests that the deeper meaning of treatment may often be misunderstood or simply missed. It may therefore behoove RTCs to keep an open mind about the impact of their interventions and periodically

gather information about how those interventions are perceived by patients. It may be impossible to predict the impact of treatment on all patients, and there will always be some variability. However, it seems clear that better understanding the patients' experiences can only increase the benefit of treatment.

As mentioned earlier, individual therapists were viewed as being very important in the change process; however, they were not generally seen as being the most important source of emotional support. If students did in fact perceive any one group of persons as being the most important source of emotional support, it would be the non-therapist staff members. There are many possible explanations for the students' experiencing the staff members as being the most supportive. The most obvious one is that the students spend a great deal of time with these people, much more so than with any other group. In fact some of the students explicitly stated that this was the reason. Another possibility is that most of these staff members are in their early twenties. As such they are not much older than the students themselves. This alone would likely help them to relate to the students more easily than the older therapists and administrators. It may be easier to take advice from someone who seems like they may have actually experienced adolescence recently. Moreover, they are also more likely to be culturally simpatico, listen to similar music, enjoy the same movies, etc. Because of these similarities, the students seemed to see the staff members as "cool," and they look to some of them as role models. All of these factors combined with the fact that they spend a great deal of time with the students make the staff members a powerful influence.

This power seems to be particularly useful in that it is used to keep the students working on valuable therapeutic goals. The students seem to see the staff members as extensions of their other therapists. In this way, the students have a constant therapeutic arm steering them to

constantly work on therapeutic goals. This is an aspect of treatment that is unique to residential treatment. It is simply not possible in other settings to have a paraprofessional around to continually reinforce and encourage productive therapeutic work. As such, this fact is perhaps one of the most significant advantages that residential treatment has over alternative treatment settings.

The value of this power is not lost on the students. Their descriptions of interactions with staff once again demonstrate the remarkable insight that they have about their own change process. Most students described the staff members as providing constant support. But perhaps more surprisingly, many were able to simultaneously understand the benefit of having responsible persons constantly around them to monitor their activities and provide feedback and correction. The students even expressed that they appreciated that most of the staff members continuously held firm boundaries and would not allow the students to cross them. It should be remembered that many of these students are diagnosed with Oppositional Defiant Disorder or even Conduct Disorder. Yet, the overwhelming majority was able to accept the authority of the staff members while simultaneously developing close supportive relationships. This not only suggests commendable insight, but further evidences the profound impact that non-therapist staff members can have in these adolescent lives.

Staff members at New Haven and most other RTCs are non-professionals. While they are often college students in clinically related fields, they are usually young, and do not necessarily have a great deal of experience working with troubled youth. It is therefore reassuring to know that students in the present study found the vast majority of staff members to be positive influences, and very helpful. Nevertheless, in such descriptions most students mentioned (usually as an aside) some negative experiences with staff. This would usually be

some sort of statement to the effect that not all staff members were fair, reasonable, mature, and helpful. It is probably impossible to always weed out such persons. Moreover, personality clashes and other factors may account for at least some of these negative reports. However, given how important they seem to be to the students, the attempt to hire the best possible non-therapist staff members may be one of the most impactful ways to improve treatment. Moreover, making sure that RTCs are conducting reasonable amounts of training for these individuals is likely to be equally impactful. Investing in more extensive training for these individuals could yield even greater benefits. Expanding such training programs provides a vast array of possibilities, and could possibly be one of the most promising areas for improving treatment. However, the prudence of such investments would require additional research.

There was surprisingly little mention in the present data relating to "working" interventions or chore assignments. As such the perceived benefits of such interventions are somewhat limited. The reason for the sparse mentioning of these interventions is probably that New Haven does not use such interventions as a main focus of their program. Since many residential programs do use labor, chores, and work in general to teach life lessons, examining the efficacy of such interventions is a worthy endeavor. However, because of the particulars of the New Haven program, the lack of evidence for the benefit of such interventions in the present data should not be generalized to other programs that do utilize such techniques.

Similarly, little mention was made of psychopharmacological interventions. However, the nature of pharmacological intervention makes the treatment somewhat incognito. Particularly given that most of the data in this study was gathered from patients themselves, it is unlikely that such individuals would have much insight about the often subtle benefits of medication. Separating out the benefit of psychoactive medication is difficult even with adults,

therefore it is not surprising that adolescents rarely mentioned it. Nevertheless, there was little evidence that medications were perceived as harmful by the students. Additionally, nearly all follow-up student interviewees agreed with the proposition that medication gave them at least a "jump start" toward improvement. Therefore, it seems reasonable to conclude that psychiatric interventions in residential treatment are perceived in general as providing benefit. However, the fact that several follow-up interviewees reported that they felt that they had little to no say in their medications is worthy of consideration. It may be that the distance physically between parents and the students made close consultation between psychiatrist and parents (the persons who would normally make final decisions regarding medication) difficult. Regardless, this feedback from students suggests that RTCs could investigate ways to improve this communication so that such concerns could be reduced.

One theme that seems to generally permeate the experiences of all students is the physical reality of being placed in a residential facility. This escape from life seems to engender many emotions for students. They become scared and often angry at being flown hundreds or even thousands of miles away to a place where all is unfamiliar and freedoms are limited. While they almost universally resent this displacement initially, most grow to appreciate it. It is this displacement that is most unique to residential facilities, especially ones that cater to wide geographical areas. There seems to be something about this radical change in environmental setting that is very powerful, a power that is independent from the specific interventions of the treatment program. The students had a difficult time articulating this phenomenon. However, most seemed to circle the topic through discussions of finally realizing that there was something that they should change about their life if they wanted to be happy. These discussions almost invariably implied that there was just something powerful about being in a place that only

existed to prompt people to change. In other words, it seems that living in an environment whose design centers around self-improvement makes it very difficult not to think about self-improvement. This of course offers very good evidence for the utility of residential treatment over alternate settings.

This displacement relates to a psychological theme that continually emerged, namely, motivation. Again, few students directly and explicitly described how they became motivated, but the construct of motivation was an implicit part of many of their experiences. Participating in a structured treatment program seemed to be a big part of motivation for these girls. There were many parts of this structure that were motivating, but the most general factor was that treatment constituted a program that the student must "graduate from" in order to go home. As such there are certain assignments, projects, and specific tasks that must be completed in order to return to "normal" life. As such, these requirements motivate students to work. In essence, the entirety of the program itself becomes the biggest motivating factor. While this motivation almost invariably becomes a positive, there seems to be an element of "going through the motions" for nearly all students. Even with students who seemed to sincerely want to change, at least some of what they did was motivated by appeasing the treatment team so that they could advance in the program. As such, the level system became a major factor in this motivation. With increased levels come increased privileges. It is of course by design that level advancement is motivating. Therefore, it is reassuring to discover that even though some of the initial motivation to work on treatment comes from the desire to earn privileges and get out of treatment, the vast majority of students end up internalizing their therapeutic work and external motivation becomes internal motivation. Students seem to be able to understand and recognize that cooperating with the treatment team actually improves their lives and makes them happier.

Because of this transition from external to internal motivation, perhaps it is not a bad sign for students to be "going through the motions" at first, or even far into treatment. In essence, it may be more acceptable to students to show this type of motivation than some clinicians assume.

On a related note, while all students interviewed reported that residential treatment was benefiting them, several seemed to think that their placement in such as setting was somewhat unnecessary. This perception seems to also be linked to the perception of some that they were kept in treatment for too long. Much of this discontent can likely be attributed to a lack of insight into the severity of their own problems on the part of the student. However, it could be fairly easy for the clinician to fall into the trap of keeping a patient in treatment until all maladaptive patterns have been addressed. However, the principle of keeping the patient in the least restrictive setting that is appropriate should always be followed. Of course, such considerations must be balanced with the danger of the patient quickly relapsing if sent to a less restrictive treatment setting prematurely. The present data does not begin to solve this delicate problem. However, it does suggest that perhaps RTCs could improve their evaluative processes by which they make these decisions.

Probably the most important psychological theme that pervades students' experiences is the general focus on building relationships. As evidenced by staff interviews, the New Haven treatment team strives to focus on helping students to build relationships and to see the benefit thereof. This focus translates into the students feeling surrounded by all different types of individuals that they perceive as trying to help them. The following quote from a student typifies this phenomenon. This student was being asked if staff members (referring to non-therapist staff members) encouraged her, she responded,

> "There are certain people that I talk to about certain things. With Amber, it was trust and pain. With the girls it was my mom. With Becky it was Bulimia. So I opened up to a lot of different people about different things. All of them individually helped me with something."

The girls are encouraged to build all of these relationships, which allows them to build this multi-faceted support network while in treatment. Not all students reported feeling close to all of these groups as this particular girl did. However, all students described improved relationships with those around them thereby building a stronger support network.

More importantly, these support networks were by far the most common elements of the students' described experiences. When describing how self-improvement occurred, the students were most impacted by the support and encouragement from others. They sometimes mentioned specific insights and information that they were given, and it seems like this type of training was helpful. However, it was clear that what was really significant in their minds were the relationships that provided support, praise, encouragement, and validation. It was clear that the nature of these relationships is what allowed the students to internalize the feedback and information that they received from others. This finding suggests that the content of a residential program may be less important than the process by which that content is presented. Therefore, it would seem to be more important for RTC administrators to focus on improving the quality of personal interactions rather than adding to information dissemination.

Finally, a psychosocial theme that is somewhat unique to the New Haven program was quite prominent in the recollections of the students, and deserves some discussion. This program is strongly geared toward developing "values." Both initial interviews as well as follow-up interviews suggest that this focus did in fact encourage the students to develop their own values

and discover what kind of persons they wanted to be. However, whether these values assignments were appreciated is somewhat dubious. Certainly, there were individuals who seemed to be genuinely benefited by this pursuit. It seemed as though many students were able to develop more pro-social attitudes and behaviors in general. This of course makes the focus on "values" a very helpful psychosocial intervention.

However, it was somewhat unsettling that several of the follow-up interviewees described feeling somewhat coerced into adopting specific values that they felt were inappropriate. That they described some of these values as religious in nature is particularly concerning. Additionally, reports that students' perceived that the adoption of these values was used as criteria for assessing progress is concerning as well. Therapy itself inherently tends to push certain values such as the importance of openness, sharing, love, etc. These fairly well-accepted societal values are not likely to be perceived as inappropriate to teach to impressionable adolescents. However, these values can easily start to lead to values about service, sex, health standards etc. As these values are approached, differences in accepted societal norms are approached as well. For example, it would be fairly easy for an adolescent to interpret her therapist encouraging abstinence from sex as a religious value. As such, the discussion of "values" becomes a delicate ethical issue. Therefore, such discussions should be handled by trained clinical professionals who are trained to balance the needs of the patient with ethical standards. It seems likely that lesser trained paraprofessionals such as the non-therapeutic staff members would be more susceptible to crossing these lines of ethical propriety. This assumption was evidenced somewhat by the reports of students to that effect; however, complaints in this area were not focused exclusively on the non-therapeutic staff. It is important to note that in all initial interviews and follow-up interviews, only one student reported a wholly negative opinion

of these "values assignments." In fact, most appreciated the fact that these interventions caused them to look at their own values. Most of those who stated that they felt that the treatment team espoused rigid and/or inappropriate values seemed to simply be mildly 'put off' by it. Nevertheless, these reports highlight an important ethical problem. While solving such a problem goes beyond the scope of this study, some suggestions can be made about addressing it. The most obvious is that RTC administrators could make concerted efforts to ensure that delicate issues such as these are primarily handled by trained professionals and avoided by others. Additionally, more specific disclosure of any such values could be made at intake to ensure more comprehensive informed consent. If parents choose to have their children experience specific value orientations, that is their right as guardians of their children's future.

Inevitably in any comprehensive treatment program, there will be those who are unsuccessful in treatment. There will be those who leave treatment prematurely, and others who simply try to get out of treatment by going through the motions. It is unlikely that any administrative or treatment team changes can solve all of these problems. Moreover, patients at RTCs are theoretically among the most treatment-resistant populations, and are therefore more likely to view treatment in a negative light. However, this does not mean that it is wise to ignore negative feedback from these patients. Even if their negative perceptions are largely influenced by more extreme psychopathology, understanding these perceptions and attempting to make adjustments to correct them can only improve treatment for others. Therefore, the fact that four out of seven students that were interviewed four years after treatment reported that they do not look positively on their stay in treatment is worthy of attention.

The first conclusion that can be reached from this finding is simple. There seems to be a great need for more long-term follow-up research. There is an absolute dearth of this type of

information for adolescent residential treatment. We simply do not have any comprehensive information about the long-term effects. The present data does offer at least some information on this topic and does suggest some explanations.

As reported earlier, students seem to think that they did not belong in residential treatment, and/or that they were kept in treatment too long. This perception is likely due to several factors. First, patients with significant psychopathology often have limited insight. Moreover, these patients are adolescents who are known to sometimes have limited introspective insight anyway. Furthermore, many of these patients come from dysfunctional environments that go beyond their personal psychopathology. Therefore, it is likely and prudent that such individuals are kept in treatment despite lacking insight into their problems. Additionally, these patients are also likely to be kept in treatment not because they themselves have not progressed, but because their home environments have not stabilized sufficiently to support them. As such, it is not surprising that such a person would be frustrated by the perception that they were "well enough" to return home and were not allowed to do so. Moreover, adolescents often do not appreciate restrictions that are placed upon them for their own good. However, RTCs often admit patients from wide geographical areas. It is therefore common to have conducted limited assessment of potential patients until after admission is complete. This leaves the potential for desperate and/or confused parents to send their children into residential treatment when less restrictive and less intensive treatments may be more appropriate. In such circumstances there may be a dangerous propensity for RTC treatment teams to assume a greater severity of dysfunction than is actually present. This would not render residential treatment necessarily ineffective, but it would be inefficient and perhaps overkill. Nevertheless, even in these situations where residential treatment is not necessarily the optimal form of treatment, students

seem to experience positive growth by such a placement. Therefore, it would seem that the present data suggests that residential treatment appears to lead to positive change regardless of whether or not the patient likes the overall experience. The question then becomes more of problem with efficiency, money, and resources, and time rather than one of black and white effectiveness.

This is a difficult problem to avoid. It is good for RTCs to be enthusiastic and optimistic about being able to treat a wide variety of patients. More importantly, it is very difficult to determine when parents are simply being over-zealous or they have not appropriately pursued less-restrictive alternatives. Nevertheless, continually re-evaluating minimum admission criteria, and developing referral systems may help to avoid later resentments on the part of the patients.

In summary, the findings of this study suggest that RTCs fill a unique, perhaps vital role. In some situations they treat patients that have been unsuccessful elsewhere, and in most cases treat adolescents who are out of control in their home environment and are, therefore, difficult to treat in other settings. RTCs employ a variety of therapeutic mechanisms that allow them to beneficially "reach" a broad variety of persons and problems. This study suggests that, while not all students find all of these interventions to be helpful, all of these interventions are helpful to some. This study admittedly focused on adolescents who may be said to have "bought into" the program. By design, the patients interviewed were those identified as having made progress in the program. These findings offer a glimpse into the experiences of patients in residential treatment, which opens the door to more focused research on how these patients make positive change. In one sense, it provides an opportunity for the consumers to speak to the providers about what is and is not working for them. Further and more controlled research on the relative efficacy of all of the discussed aspects of treatment would be useful to aid administrators in

making treatment more efficient and quicker. The present study is hopefully one more step toward reaching these goals.

References

Aanastoos, C. M. (1986). Phenomenology and the psychology of thinking. In Ashworth, P.D., Giorgi, A. & Koning, A.J.J. (Eds.) *Qualitative Research in Psychology.* Pittsburgh, PA: Duquesne University Press.

Abraham, P. P., Lepisto, B. L, Shultz, L. (1995). Adolescents' perceptions of process and specialty group therapy. *Psychotherapy: Theory, Research, Practice, Training 32,* 70-76.

Bernou, E. A. (1997). *Residential treatment for severely emotionally disturbed* adolescents*: An outcome study.* Unpublished Doctoral Dissertation, California Professional School of Psychology, Alameda.

Black, N. (1994). Why we need qualitative research. *Journal of Epidemiology and Community Health, 48,* 425-426.

Burns, B. J., Hoagwood, K., Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2,* 199-254.

Cohen, M. Z. & Omery, A. (1994). Schools of phenomenology: Implications for research. In J.M. Morse (Ed.) *Critical issues in qualitative research.* (pp 136-156).Thousand Oaks, CA: Sage.

Colton, A. & Pistrang, N. (2004). Adolescents′ Experiences of Inpatient Treatment for Anorexia Nervosa. *European Eating Disorders Review, 12*, 307-316.

Crawford, M. J., Weaver, T., Rutter, D., Sensky, T. S. & Tyrer, P. (2002). Evaluating new treatments in psychiatry: The potential value of combining qualitative and quantitative research methods. *International Review of Psychiatry, 7,* 6-11.

Currie, E. (2003). "It's our lives they're dealing with here": Some adolescent views of residential treatment. *Journal of Drug Issues*, 33(4), 833-864.

Curry, J. F. (1991). Outcome research on residential treatment: Implications and suggested directions. *American journal of orthopsychiatry, 61*, 348-357.

Drotar, D., Overholser, J. C. & Levi, R. (2000). Ethical issues in conducting research with pediatric and clinical child populations in applied settings. In Drotar, D. (Ed) *Handbook of research in pediatric and clinical child psychology: Practical strategies and methods*. Dordrecht, Netherlands: Kluwer Academic Publishers.

Epstein, R., (2004). Inpatient and residential treatment effects for children and adolescents: A review and critique. *Child & Adolescent Psychiatric Clinics of North America, 13*, 411-428.

Flick, U. (1998). *An introduction to qualitative research.* London: Sage Publications.

Foltz, R. (2004). The efficacy of Residential Treatment: An overview of the evidence. *Residential Treatment for Children and Youth, 22,* 1-19.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14,* 1492-1454.

Giorgi, A. (1986). Theoretical justifications for the use of descriptions in psychological research. In Ashworth, P.D., Giorgi, A. & Koning, A.J.J. (Eds.) *Qualitative Research in Psychology.* Pittsburgh, PA: Duquesne University Press.

Kazdin, A. E. (1984) Acceptability of aversive procedures and medication as treatment alternatives for deviant child behavior. *Journal of Abnormal Psychology, 12,* 289-301.

Kazdin, A. E. (2000) Developing a research agenda for Child and Adolescent Psychotherapy. *Archives of General Psychiatry 57,* 829-835.

Kazdin, A. E. & Nock, K. N. (2003a). Delineating mechanisms of change in adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry, 44,* 1116-1129.

Kazdin, A. E. (2003b). Research Design in Clinical Psychology. Boston: Allyn and Bacon.

Kidd, S. A. (2002). The role of Qualitative research in psychological journals. *Psychological Methods, 7,* 136-138.

Kiesler, C. A. (1993) Mental health policy and the psychiatric inpatient care of children. *Applied & Preventative Psychology 2*, 91-99.

Kohlberg, L., Puka, B. (1994). *Kohlberg's original study of moral development.* New York: Garland.

Kvale, S. (1997) *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage Publications.

Moon, S. M., Dillon, D. R., Sprenkle, D. H. (1990) Family therapy and qualitative research. *Journal of Marital and Family Therapy, 16,* 357-373.

Naitove, P. D. L. (2002). A comprehensive review of adolescent residential treatment outcome studies. Unplublished dissertation, Antioch New England Graduate School, Keene, New Hampshire.

Nansel, T. R., Raines, S., Jackson, D. L., Teal, C. R., Force, R. C., Klingsporn, M. J., Burdsal, C. A., (1998). A Survey of residential treatment centers' outcome research practices. *Residential Treatment for Children and Youth, 15,* 45-59.

Natassi, B. K. & Schensul, S. L. (2005) Contributions of qualitative research to intervention research. *Journal of School Psychology, 43,* 177-195.

New Haven Inc. (2003a). *Parent manual*. Lehi, Utah: New Haven Inc.

New Haven Inc. (2003b). *Values program*. Lehi, Utah: New Haven Inc.

Pazaratz, D. (2003). The Application of a Reinforcement/Level System in the Residential Treatment of Adolescents. *Residential Treatment for Children and Youth, 21,* 17-32.

Powell, A. & Davies, H. T. O. (2001) Qualitative research may be more appropriate. *British Journal of Medicine, 322,* 929.

Randall, J. & Henggleler. (1999). Multisystemic Therapy: Changing the social ecologies of youths presenting serious clinical problems and their families. In: *Handbook of psychotherapies with children and families.* New York: Kluwer Academic/Plenum Publishers.

Riehman, K. S., Bluthenthal, R., Juvonen, J., (2003). Adolescent social relationships and the treatment process: Findings from quantitative and qualitative analyses *Journal of Drug Issues*, *33(4)*, 865-896.

Shennum, W. A. & Carlo, P. (1995) A look at residential treatment from the child's point of view. *Residential Treatment for Children and Youth, 12* 31-44.

Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook.* London: Sage.

Tarantino, J. (2002) The Child's perspective on what works in residential treatment: A solution-focused program study. Unpublished Doctoral Dissertation, California Professional School of Psychology, Alameda.

Appendix A

Student Interview Form

Semi-Structured Interview

Student's name: ________________________________ Date ____________________
Level ______________ Interviewer ________________________________

I. *Let them know this interview is regarding their recent level advancement.*
Example: "So you recently achieved level ___?"

II. *Find out what they did to achieve the level.*

A. How did you accomplish that? (What did you do to achieve level ___?) If they are hesitant to answer, use encouraging questions. "What did you work on?" "What have you accomplished since you achieved level ___?" "What has changed since level ___?" "What goals have you been working on since achieving your last level?" In response to this question you should get 3 to 5 main areas of focus. List them:

1.

2.

3.

4.

5.

At some point you need to ask the following (it may be now, or may be after you work on B): "You mentioned these 3/4/5 things you worked on to achieve level ___: (list them). Was there anything else you worked on that was important?"

B. Areas of focus - Details. Write each one down and ask follow up questions about it to get details.

1. ____

Potential questions: "How did you accomplish this?" "What kinds of things did you do to work on this?" "What did working on this entail for you?" "Did it go smoothly, or were there rough spots?" "What was the most effective thing you did to accomplish this?" "How were you with this goal when you achieved (last level, or entered the program)?" "What specifically have you done since then to make progress on this goal?"

"Where do you think you are now with this issue?" "Is it something you're going to continue working on?"

2. ____

Potential questions: "How did you accomplish this?" "What kinds of things did you do to work on this?" "What did working on this entail for you?" "Did it go smoothly, or were there rough spots?" "What was the most effective thing you did to accomplish this?" "How were you with this goal when you achieved (last level, or entered the program)?" "What specifically have you done since then to make progress on this goal?" "Where do you think you are now with this issue?" "Is it something you're going to continue working on?"

3. ____

Potential questions: "How did you accomplish this?" "What kinds of things did you do to work on this?" "What did working on this entail for you?" "Did it go smoothly, or were there rough spots?" "What was the most effective thing you did to accomplish this?" "How were you with this goal when you achieved (last level, or entered the program)?" "What specifically have you done since then to make progress on this goal?"

"Where do you think you are now with this issue?" "Is it something you're going to continue working on?"

4. ____

Potential questions: "How did you accomplish this?" "What kinds of things did you do to work on this?" "What did working on this entail for you?" "Did it go smoothly, or were there rough spots?" "What was the most effective thing you did to accomplish this?" "How were you with this goal when you achieved (last level, or entered the program)?" "What specifically have you done since then to make progress on this goal?" "Where do you think you are now with this issue?" "Is it something you're going to continue working on?"

5. ____

Potential questions: "How did you accomplish this?" "What kinds of

III. *To find out about specific events/people who have made a difference.*

III. Since entering the program/achieving your last level, have there been any significant events that you remember that have helped you in your progress? (If they ask like what, answer "maybe a significant therapy session or assignment, a parent visit or home pass, or even something as simple as a talk with staff that really affected you".) Ask follow up questions to get details.

IV. Have there been any other specific events you remember that meant a lot? (Keep asking this until they say no.

V. Who has been important in your progress during this time? What have they done? Get details. Ask follow-up questions.

IV. *Goals for the future*

What do you think you'll be working on to achieve your next level?

Appendix B

Staff Interview Form

Structured Interview

Staff name:____ Date:____________
Interviewer:______________________________

Things to remember

- Build rapport
- Test the tape/recorder
- Remember to "put on the brake" if needed
- Follow inverted "general-specific" pyramid
- Remember "students" not patients!
- Try to avoid the word "treament"
- Conciseness is the key!

Intro

I am a student at BYU, and currently we are conducting research for our Psychology Department. We are interested in what helps students to make positive changes in a residential setting like this. Since you are around the students daily, and talk to them often, the information you can share is very important. We need your input. (At this point, add whatever else may be needed.)

Find out 5 areas of focus – look for 3 to 5

Question- *What are some of of the most common issues students work to change?*
Make sure you are clear on just what the issue is- conceptualize, if needed.

1.

2.

3.

4.

5.

Areas of Focus- Look for details. Write down each one, and ask follow-up questions

1. ____

Potential questions: "What kinds of things do students do to work on this?" "What was the most effective thing to help work on this?" How, What, et.c.

2. ____

Potential questions: "What kinds of things do students do to work on this?"
"What was the most effective thing to help work on this?" How, What, et.c.

3. ____

Potential questions: "What kinds of things do students do to work on this?"
"What was the most effective thing to help work on this?" How, What, et.c.

4. ____

Potential questions: "What kinds of things do students do to work on this?" "What was the most effective thing to help work on this?" How, What, et.c.

5. ____

Potential questions: "What kinds of things do students do to work on this?" "What was the most effective thing to help work on this?" How, What, et.c.

Other details and wrap-up

Potential questions- "Have there been any other specific things that have meant a lot?" "Is there anything else can think of that was important, or helped?" "Any other main issues?"

Appendix C

Follow-up Interview Form

Structured follow-up interview for former students

Current Age: Today's date:
Date of treatment:

- Greeting and explanation for brief interview
  -Conducting some follow-up research about treatment at New Haven RTC
  -what former students believe was helpful about the program.
  -Brief survey that will take approximately ten minutes
  - You may remember participating in an interview while you were in treatment about what you thought was helpful. Many interviews have been analyzed and we have come up with some generalizations about what most students seem to think is helpful about residential treatment. The purpose of this survey is to determine whether or not our generalizations match your current view of the treatment that you received. So, with most of these questions, you can simply respond: "Yes or no" In other words, does the statement about treatment match your perceptions. You may elaborate if you would like.
  -I will go through several different treatment interventions and ask a few quick questions about each. Any questions?

- Individual therapy
  -necessary for guidance, but not necessarily the primary source of emotional support

  -creating insight

  -important in directing student on what problems to work on and when

  -important for motivation

  -general thoughts?

- Group Therapy
  -Were you involved in any specialty groups such as "trauma group" or substance abuse? If yes, these groups seemed to be viewed as very helpful

  -Community often viewed as not particularly helpful, but not necessarily negative

  -Created a "safe" environment to share with others and learn from their experiences. (over and above conversations outside of "community?")

  -general thoughts

- Family Therapy
  -Family tx very important for family problems as well as facilitating support with other issues

  -Helpful in developing communication/conflict resolution skills, as well as building closer relationships?

  -general thoughts

- Social/Peer Support
  -Constant source of support was very important in creating "safe" environment.

  -Getting advice from individuals who had been through similar situations was helpful

  -Praise, recognition, encouragement from peers carried a special weight above and beyond such help from staff.

-Positive examples were motivating, but negative examples were also detrimental.

-General Thoughts?

- Recreation Therapy
  -was more realistic and brought out more real-life problems. Somewhat like a reality test.

  -Built unity and closeness among students.

  General thoughts?

- Non-therapist Staff members
  -Having someone constantly around to monitor their activities and provide feedback

  -Big source of emotional support because they were around a lot

  -Set good example and motivated students to change

  -General thoughts?

- Work/Chores and assigned responsibilities
  -helped to teach integrity and responsibility

  -Helped to develop leadership and assertiveness

-General thoughts?

- Medication
  -Was helpful, but it only provided a "jump start" to progress, but was not enough on it's own

  -General thoughts

- Miscellaneous
  -Just being in a radically different environment, helped to escape "old life."

  -Level system provided motivation to make change

  -Focus on "relationships" helped to create "safe" environment where change could happen

  -Doing "values" assignments helped to develop my own sense of what I wanted out of life.

  -General thoughts?

- General thoughts about how helpful residential treatment was overall.