FACILITATING GROUP PROCESS: AN EXPLORATORY STUDY OF ADOLESCENT PSYCHOTHERAPY GROUPS IN RESIDENTIAL TREATMENT CENTERS

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Abstract

Residential treatment centers are restrictive and intensive care environments intended to address the needs of adolescents with high-risk emotional and behavioral dysfunction and issues of complex trauma. Individual, milieu, and group therapies are key treatment modalities for adolescents in these settings. While collective treatment outcomes are commonly discussed in previous research, there is a limited body of literature detailing the provision of the specialized services offered—especially group psychotherapy, which targets the critical task of interpersonal development for adolescents through group process. Many features of residential treatment settings differentiate them from settings for which standard models of treatment were originated. Thus there are some significant disparities between theory and practice. A comprehensive understanding of group therapy services for adolescents in residential treatment centers, particularly those with process components, requires a phenomenological examination of the treatment process, as implemented by clinicians with interdisciplinary mental health backgrounds in these settings. This exploratory study investigated the experiences of clinicians facilitating groups with process components for adolescents in residential treatment centers. Ten clinicians who have facilitated such groups within the last five years participated in the study, which used a qualitative research design. Participants were interviewed using a semi-structured questionnaire. Themes emerging from their responses were analyzed using grounded theory techniques. Identified themes included (a) preparation for clinical work in residential treatment centers; (b) impact of variety of contextual factors; (c) clinician influence on facilitation of group process; (d) the need to move to system-level trauma-informed care; (e) impact of direct care staff on group process; (f) attention to and focus on individual needs; (g) balancing structure and

flexibility in group facilitation; (h) variety in group types as treatment component; and (i) the benefit of group process for adolescents in residential treatment centers. Implications for future research direction, training needs, group clinicians facilitating these groups, and residential treatment centers were discussed.

For “Ms. Shemika’s” former YCS girls—may you find strength in knowing that someone cares immeasurably;

And especially for my Mom – this is as much your accomplishment as it is mine.

Ubuntu.

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Philippians 4:13 (KJV) -
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Ubuntu ~ I am because we are.

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Chapter I: Introduction

Background and Statement of the Problem

There is a limited body of research available detailing services offered to adolescents in residential treatment center settings—especially group therapy. Available studies have cited residential treatment centers as highly restrictive, expensive, and frequently used treatment settings (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998; Lyons, Terry, Martinovich, Peterson, & Bouska, 2001; Whittaker, Overstreet, Grasso, Tripodi, & Boylan, 1988) within the system of mental health care for children and adolescents. Studies also emphasize that residential treatment is utilized by a small, but difficult sample of the overall adolescent population (Abraham, Lepisto, & Schultz, 1995; Hair, 2005; Small, Kennedy, & Bender, 1991). The focus of much of the available research has often been on the effectiveness and efficacy of the treatment services provided as a collective (Hair, 2005). There is an underrepresentation of descriptive studies of service provision for adolescents in residential treatment centers. This must be countered in order to provide a clearer, phenomenological understanding of the components of residential treatment..

Residential treatment centers combine out-of-home care placements with a highly structured, therapeutic milieu, within which they provide a range of mental health services to children and adolescents with high-risk emotional and behavioral dysfunction. They tend to be longer-term treatment options, but slightly less restrictive environments than the treatment settings of standard psychiatric inpatient units and programs. Hair (2005) defined residential treatment centers as "out-of-home 24 hour facilities that offer mental health treatment using multi-disciplinary teams that often make therapeutic use of the daily living milieu, but are less restrictive than inpatient psychiatric units" (p. 552). Child and adolescent residents admitted to

these settings often present with a disproportionately high rate of trauma (Abramovitz & Bloom, 2003; Brown, Baker, & Wilcox, 2012; Greenwald et al., 2012; Habib, Labruna, & Newman, 2013; Small et al., 1991) and other chaotic and destabilizing life experiences. Abramovitz and Bloom (2003) described the population as "children who have sustained physical, psychological, social, and moral insults that lead to developmental *injuries*." (p. 131). Ongoing concerns often resulting from their negative life experiences often involve difficulties with impulse control skills (Waltman, Hetrick, & Tasker, 2012) as well as emotion and affect regulation, social learning, and skills in inter- and intrapersonal conflict mediation (Abramovitz & Bloom, 2003).

Adolescents are more likely than pre-adolescents to be in residential care placements; however, adolescent presenting issues more often involve their own behavioral issues while those of preadolescents more often involve high-risk behaviors of their parents (Huefner & Vollmer, 2014). Adolescents served by residential treatment centers are often referred by juvenile justice, mental health service providers, and child welfare agencies (Handwerk et al., 2006; Whittaker et al., 1988)— each of which is a source indicative of behavioral concerns and/or experiences of traumatic life events (Brown et al., 2012)— among other referring sources. Various approaches to treatment have often been tried prior to their admission in residential care (Greenwald et al., 2012). Residential treatment centers are frequently identified as an appropriate level of care for minors following a more restrictive placement such as hospitalization, and/or when a less restrictive environment, such as outpatient or intensive outpatient care, is unsuccessful or ill-equipped to meet and address the needs and presentations of dysregulated children and adolescents (Hair, 2005; Small et al., 1991; Whittaker et al., 1988). Further, it is recommended that the lengths of stay for children and adolescents in residential treatment centers be limited, as to not deplete limited resources (Abramovitz & Bloom, 2003). The length

of each resident's placement should be influenced by ongoing treatment goals focused on placement or reunification with caregivers in a less restrictive and less resource-taxing environment (Small et al., 1991).

Complex trauma—described by Lam, Lyons, Griffin, & Kisiel (2015) as the clinical phenomenon describing multiple experiences of interpersonal abuse in childhood and resulting symptoms of traumatic stress—is widely occurring in and often the impetus for placement in residential treatment centers. As described, pathology is developed when the brain's mechanisms for coping and survival following the introduction of a traumatic experience continue to be applied in non-threatening environments and situations (Lam et al., 2015). The dysregulation and behavioral concerns of adolescents in residential treatment centers are often behavioral manifestations of this phenomenon.

With the high prevalence of trauma experiences that fuel the dysregulation experienced by children and adolescents in residential treatment centers (Lam et. al., 2015), it is important that the system reflects sensitivity to trauma-specific needs. Trauma-informed care suggests that treatment and the treatment setting should be geared towards improving experiences for individuals with trauma histories, rather than to worsen the impact of their trauma histories. As opposed to trauma treatment, which is one component of treatment services provided, trauma-informed care is applied more broadly across a range of client diagnoses, presentations, and modalities of treatment (Greenwald et al., 2012). Trauma-informed care is geared towards systems of care, rather than exclusively focusing on developing trauma-focused treatments or interventions (Berger & Quiros, 2014; Brown et al., 2012).

Three major components—namely, intensive individual therapy, group therapy, and therapeutic milieu—have been cited as the most common modalities of treatment to address the

specific concerns faced by the adolescent populations across residential treatment settings (Abraham et al., 1995; Abramovitz & Bloom, 2003; Lyons et al., 2001). However, discussions of the treatment modalities often describe and focus on the restrictiveness and structure of the settings, without depicting the intensity or the process of the services provided. Further, different theoretical and conceptual approaches influence the provision of individual, group, and milieu treatment components in different settings. These aspects of residential treatment centers have been absent from much of the literature to date.

Many features of residential treatment centers differentiate them from settings for which standard outpatient models of treatment were originated; the services offered in residential treatment centers become more and more specialized, contributing to disparities between (a) theory and/or policies that guide practice, and (b) practice that guides treatment/outcomes (Small et al., 1991). This creates observable challenges in applying evidence-based treatment models to residential treatment center populations (Greenwald et al., 2012). Individual and milieu interventions have been largely represented in literature (Abramovitz & Bloom, 2003), but groups—especially psychotherapy groups, which are clinical in nature and target interpersonal and/or psychological change—have not had much representation.

Various populations of youth benefit from group approaches to treatment, which are also cost-effective (Harris, Brazeau, Clarkson, Brownlee, & Rawana, 2012; Waltman et al., 2012). Different types of groups, including short-term and long-term groups, open and closed groups, as well as structured and unstructured groups, are key treatment components in residential treatment settings (Abraham et al., 1995), with some groups targeting interpersonal processes, while others are purposed to provide skills and techniques for specific topics such as coping and self-regulation. Groups offer the opportunity for members to both learn from their peers and to

develop their own strengths (Harris et al., 2012). With opportunities for in vivo interpersonal learning being a unique component of group treatment (Abramovitz & Bloom, 2003; Aronson, 2004; Bonsaksen, Lerdal, Borge, Sexton, & Hoffart, 2011; Harris et al., 2012; Yalom & Leszcz, 2005) and developing prosocial skills being a common area of need for children and adolescents served by residential treatment centers, it is important to have an understanding of what takes place in psychotherapy groups in these settings in order to identify specific processes that promote necessary developmental tasks for the population.

Group psychotherapy offers members the opportunity to interact with others, with a focus on gaining understanding of self in relation to other and can lead to improvement in interpersonal engagement, increased insight and awareness of self in relationship, and ultimately to psychological change. The classic approach to psychotherapy groups, which emphasizes interpersonal process and more psychodynamically oriented, and based on an open, long-term model for use in outpatient treatment settings, where members are comparatively more stable, cooperative, and motivated to participate (Yalom & Leszcz, 2005). However, Yalom and Leszcz (2005) also described the existence of multiple other group therapies, varying in approach, setting, and populations served. This is consistent with and supported by the guidelines for facilitating group therapy published by the American Group Psychotherapy Association (AGPA). These guidelines posit that flexibility is required in approach to the facilitation of psychotherapy groups in order to most appropriately meet the needs of specific populations and settings (AGPA, 2007). As such, the approach to facilitating psychotherapy groups in more specialized settings requires alterations of traditional approaches, that follow from an assessment of the clinical situation and evaluation of the goals for treatment, based on the setting and the population (Yalom & Leszcz, 2005).

Psychotherapy groups offered in residential treatment centers for children and adolescents cannot be traditionally replicated from the typical psychotherapy group (Yalom and Leszcz,2005). Psychotherapy groups in adolescent residential treatment centers must be adapted specifically for that context (Abramovitz & Bloom, 2003; Bonsaksen et al., 2011; Habib et al., 2013; Hair, 2005; Small et al., 1991). Waltman et al. (2012) discuss using the local clinical scientist model, which is a method of evaluating and adapting evidence-based and/or empirically supported models of therapy to the specific needs of the populations being served (Waltman et al., 2012). This creates a specialized group dynamic, which is not currently depicted in literature. However, systemic and quantifiable research methods have been most achievable in outpatient group settings, due to their having fewer factors that disrupt the ability to establish control or to manipulate variables (Yalom & Leszcz, 2005). Qualitative research, as a method of collecting subjective and detailed information, is thus the best approach for examining phenomena that occur in an uncontrolled way, in such settings as residential treatment centers.

Professional staff members in residential treatment centers represent a range of professional fields and disciplines, with different training trajectories and theoretical orientations. Further, differences exist in both level of experience and licensure requirements between clinical and/or professional staff and non-professional (i.e., direct care) staff in residential treatment center settings (Zirkle, Jensen, Collins-Marotte, Murphy, & Maddux, 2002). Further, psychotherapy groups in particular, like individual psychotherapy sessions, must be facilitated by trained clinicians. Thus there is a need for clinical, professional, and expert support in developing group treatments in residential treatment, as (non-professional) milieu counselors or direct care staff have less training and experience in clinical service provision (Small et al., 1991).

This study focuses on describing the experiences of facilitating psychotherapy groups for professionally licensed and/or supervised clinicians who have experience in the facilitation of group process. This study will seek to provide a foundation for understanding the practical components of facilitating group process in psychotherapy groups for adolescents in residential treatment center settings, which could be applied as a prototype for group treatment in residential treatment settings. This study summarizes common components of current practices of group psychotherapy in residential treatment center settings and explores additional considerations not currently found in represented groups. The results could serve as a foundation that could be built upon by clinicians, across disciplines, who are seeking to develop group psychotherapy components in residential treatment center settings for adolescents in the future.

Purpose and Rationale

Research on the facilitation of group process for adolescents in residential treatment center settings is extremely limited. This reflects the extent of knowledge, or the lack thereof, about practice in these difficult settings as supported by literature. However, the reality of the settings, as has been observed, is often inconsistent with what is reflected in the limited amount of research knowledge available, pointing to a need for continued and more focused studies. Both the population (adolescents) and the setting (residential treatment centers) pose particular challenges to assumptions and standard practices of psychotherapy groups, including limited contact outside of groups, continuity of membership necessary for group cohesion, and commitment of the individuals to the group as a whole (Yalom & Leszcz, 2005). As such, it is important to understand not only that groups are taking place in residential treatment centers, but also how the interventions are implemented. A question to consider is, how are current practices connected with their conceptually distant theoretical underpinnings? Professional clinical service

providers in residential treatment settings, therefore, hold important perspectives about the process, the practicality, and the utility of their clinical interventions.

The purpose of the current study is to describe the phenomenon of adolescent group psychotherapy, and more specifically interpersonal group process, as it occurs in residential treatment center settings. Further, the current study seeks to explore the facilitation and practices of psychotherapy groups for adolescents in residential treatment centers.

Research questions. The current study specifically seeks to provide answers to the following research questions:

1. Considering knowledge of and/or experience with group process, what are the experiences of trained clinicians in facilitating psychotherapy groups with adolescents in residential treatment centers?
2. What are the common components (structural, theoretical, and others) of psychotherapy groups and group process for adolescents in residential treatment centers, as facilitated by group clinicians?
3. How, if at all, are psychotherapy groups for adolescents in residential treatment centers influenced by trauma-informed-care?
4. How do psychotherapy groups fit in with and contribute to the other treatment components for adolescents within residential treatment centers?
5. According to this group of professionals, what additional components of facilitating psychotherapy groups for adolescents in residential treatment centers would bridge theory and practice, and create the most clinical utility for the population and setting?

Chapter II: Review of Literature

The following is a review of relevant literature related to the current topic. It will include studies that describe psychotherapy groups, and some of the aspects unique to facilitating psychotherapy groups for adolescents. Next will be residential treatment settings providing services to adolescents, including the populations served, treatment components, and projected outcomes. Trauma-informed-care will also be discussed in the context of residential treatment centers. Finally, the need for flexibility in methods of and approaches to the facilitation of group process in psychotherapy groups for adolescents will be discussed.

Psychotherapy Groups

The American Group Psychotherapy Association (AGPA) has acknowledged that there is a gap between research and practice of group psychotherapy AGPA has developed specific guidelines for practice, by clinicians across professional disciplines, in facilitating a range of group-based interventions, across settings (2007). These guidelines provide a foundational framework, allowing for a common understanding of the therapeutic factors involved in the facilitation of psychotherapy groups, including, but not limited to, therapeutic relationships, group cohesiveness, development of techniques for socializing, interpersonal learning input and output, vicarious learning, and reality testing. They also affirmed group process as a critical component of the psychotherapy group, and related the concept directly to the process of interpersonal learning that takes place in psychotherapy groups. These guidelines provide a uniting standard for facilitating psychotherapy groups across disciplines.

Puskar et al. (2012) also discussed process, in contrast to content, as a key concept in group facilitation. Further, they indicated that groups are facilitated across multiple disciplines, listing therapists, social workers, psychiatrists, counselors, clergy, peer leaders, teachers, and

nurses as some examples. In their paper discussing process and content, group psychotherapy was identified as a treatment modality offering members opportunities to develop positive relationships with others, through processes of identification with and learning from the insights and experiences offered by other group members. Content, which was noted as involving words spoken by members, topics of discussion covered, and the verbal aspects of conflicts that arise between members during the course of exchange, was distinguished from process—defined by interactions, delivery of communications, intended impact, and actual impact occurring or experienced interpersonally between members of the group. This paper provided an essential description of interrelated concepts in group psychotherapy, that serve as a foundation for clinicians seeking to facilitate interpersonal learning and engagement, which are valuable treatment components for adolescents with histories of interpersonal ruptures.

Bonsaksen et al. (2011) examined differences in group climate development and patterns of engagement between cognitive behavioral and interpersonal group types, in a residential program with individuals with social anxiety. They posited that group psychotherapy is beneficial as a treatment modality, in that groups represent a social system as a microcosm of society, in which members are able to engage in interpersonal learning through engagement, differentiation, individuation, and termination—cited as the general developmental processes for all psychotherapy groups. Group climate was described as resulting from the continuous, evolving, and complex interpersonal processes that occur in psychotherapy groups. The study concluded that the appropriate facilitation of group psychotherapy offers warmth, acceptance, support, and belongingness to members, allowing conflict and avoidances to arise as interactional dimensions. Further, varying levels of engagement were observed throughout interpersonal groups, with conflict decreasing in a linear fashion across time. The study, which

found rupture and repair sequences occurring throughout the interpersonally-based approaches to group, concluded that group development must be viewed based on considerations of the clinical presentations of participants, context, content, and culture. The study and conclusions demonstrate the connection between population and the themes that emerge throughout the group process.

Shay (2011) discussed group development and group process by providing a demonstration of group theory as a social system through observations made in a review of a movie entitled *The Breakfast Club*. The paper illustrated the progression of a group of students in a school detention that paralleled the processes that occur in psychotherapy groups, despite the absence of a facilitator in the movie-group. The paper identified concepts including group roles, developmental phases, and group process, commenting additionally on the mechanisms of change that occur throughout the course of a group. It concluded that individuals inherently play a range of potential roles in group settings. Despite the absence of a facilitator in the group from the movie, this paper demonstrated that grouping troubled adolescents together could ultimately lead to the working through of group issues, due to the interpersonal emphasis in the unfolding of group process.

Adolescent psychotherapy groups. In an early paper, Corder and Whiteside (1990) described methods of facilitating group process in psychotherapy groups for adolescents. One such method included assigning roles to group members in order to provide a structural framework for the group and its adolescent members. The paper posited that opportunities for adolescents to learn to express their feelings appropriately, to give and receive feedback, and to develop group cohesion through the sharing of common experiences were the mechanisms through which group process was perceived as helpful. In addition it indicated that providing

structure for the beginning, middle, and end-phases of a group could serve as an aide in the facilitation of psychotherapy groups for adolescents. This provided a basis for understanding that there are a variety of methods through which group process can be facilitated in psychotherapy groups for adolescents.

More recently, Aronson (2004) discussed group psychotherapy specifically as a practical treatment modality for addressing the issues typically faced by adolescents (2004). Through comparison with a children's book entitled *Where the Wild Things Are,* Aronson elucidated some of the central issues experienced throughout adolescence, as well as group phenomena. Some of the issues identified included fluidity of development and issues related to identity. With identifying groups as promoting interpersonal learning and the development of self-esteem, Aronson's paper discussed the benefits of engagement in group psychotherapy for adolescents, including that mechanisms of group match the developmental tasks of adolescents. This paper detailed the ways in which the processes involved in psychotherapy groups serve and address the needs of adolescents, supporting their use in residential treatment centers for adolescent populations.

Shechtman and Mor (2010) conducted a study with children and adolescents in elementary and secondary schools in Israel who were exposed to traumatic life events following the Lebanon war. After measuring stress related specifically to experiences of trauma, participants were assigned to experimental (group treatment) and control (waitlist) groups for comparison; they also completed self-report measures of additional variables. The study included basic measures of anxiety and trauma symptoms, in addition to measures of social support and group process. Results indicated a significant reduction in symptoms of post-traumatic stress and anxiety following group treatment. As was hypothesized, increases in social support and group

cohesion resulted in a reduction in the experiences of anxiety in a population of adolescents who had experienced some level of trauma in their histories. The study showed clear benefits to group therapy, with outcomes showing marked improvements in comparison to those who were not engaged in group treatment.

Adolescent Residential Treatment Centers

Residential treatment varies in definition, program quality, mechanisms of therapeutic change, and clients served across different settings (Handwerk et al., 2006). These settings can include group homes, residential treatment centers, and juvenile justice placements, among others. Residential treatment centers, in particular, provide a restrictive out-of-home placement paired with reported high levels of intensity of treatment that traverse the different components and modalities of service provision (Hair, 2005; Handwerk et al., 2006). Despite variations in the structural models used in different residential treatment programs, and the range of specific services provided, some commonalities can be observed across residential treatment center settings, and are discussed below.

Needs of the populations served. Small et al. (1991) examined issues related to clinical practice in residential treatment centers, noting particularly that, as a result of the severe emotional and behavioral disturbances displayed by children admitted to these settings, clinical practice becomes disconnected from theory. The paper discusses the concept of abuse reactivity as having a profound effect on the presentation of children and adolescents, leading to increased internalizing and externalizing disturbances. Further, it is posited that children and families receiving services from residential placements are among the most vulnerable and difficult cases; this requires a flexible and dynamic approach in order to engage them and to effectively provide appropriate services. Children in residential treatment centers were described as impulsive and

aggressive; lacking appropriate attachments and guidance; having difficulties in school and social relationships; having limited ability to delay gratification, low frustration tolerance, and poor ability to regulate internal drives; and subject to more experiences of affective flooding, without the cognitive mediation abilities to manage those experiences. With a high percentage of clients who act out severely, and the high prevalence of contagion—or one child's acting out behaviors being contagious to the larger group—, a goal of developing new group therapies that teach adolescent residents social problem solving skills, and interceding between impulse and action with appropriate thought processes, was identified. This paper provided an early understanding of the deficits and treatment needs of adolescents in residential treatment centers, and the applicability of group therapy modalities for the population.

Abramovitz and Bloom (2003) detailed changes in the populations that present in residential treatment centers, noting that these severely disturbed children are disproportionately poor, immigrant, and children of color. The paper discussed also high rates of physical abuse and neglect; exposure to chronic violence; and high, but still underreported statistics reflecting experiences of additional traumas, such as sexual abuse. It outlined the frequent comorbidities of these experiences as including suicidality, depression, substance abuse, cognitive problems, and poor interpersonal relationships and boundaries, which are often reasons for referral that warrant the need for residential treatment. Some of these issues, especially interpersonal relationships, can be targeted and addressed in group psychotherapies.

Handwerk et al. (2006) discussed and studied the implications of gender differences found in male and female clients in residential treatment centers. They found that the differences between genders as described in child psychopathology literature were not often studied in residential settings. Further, they reported that models for residential treatment centers were

originally established to provide services for boys with aggressive and/or delinquent externalizations. The study noted that while boys were most often described as more aggressive and delinquent, with higher reports of psychiatric symptoms and longer lengths of stay in residential placement, girls in residential placements were found to have more difficulties in their family histories, poorer skills in negotiating social and interpersonal interactions, more reports of sexual abuse histories, and more occurrences of self-harming behaviors. After studying the behaviors exhibited by both boys and girls in residential treatment settings, conclusions were found in support of the notion that at least some girls receiving services in residential treatment centers had more emotional and/or behavioral difficulties than boys in similar settings. The study provided information suggesting the prevalence of differences in attitudes towards differences in the severity of disturbance for boys and girls in residential care, but found fluidity in the ratings of disturbance between genders. With this knowledge, it would be important to understand if/how gender plays a role in different treatment components of residential treatment centers—namely, group psychotherapy.

Based on their understanding of complex trauma and its effect on dysregulation in children and adolescents, Lam et al. (2015) hypothesized that development would play a role in experiences of interpersonal trauma and the manifestations of trauma stress. They conducted a study comparing the experiences of children involved with child protective services in six age categories between 0 and 18 years of age. They found that older youth experience higher severity of traumatic stress symptoms due to an increase across the developmental span of youth. Further, they found differences across all age groups compared except between ages 12-15 and 16-18, which they suggest is reflective of the greater influence of puberty and associated changes in cognitive and affective development than chronological age. Despite that this study did not

specifically reflect residential treatment populations, it describes the developmental needs and concerns of trauma-affected children and adolescents involved with child protection services—a population receiving high rates of residential services due to their experiences of and reactions to complex trauma. Further, it speaks to the increased need for services for adolescents in comparison to younger children due to their specific symptom presentations.

Conversely, Huefner and Vollmer (2014) hypothesized that preadolescents would be found to be with greater concerns than adolescents across 1) presenting problems, 2) problem behavior, 3) use of psychotropic medication(s), and 4) utilization of medical and psychological services. They also made comparisons across sexes (male, female) in order to also observe any interactions. They found that whereas adolescents had more issues with delinquency and legal problems, preadolescents demonstrated more problems with aggression, mental health, and developmental concerns. They found significant differences on a number of different dependent variables measured between male and female subjects as well as in the interaction between age category (preadolescent, adolescent) and sex. However, in discussing the limitations of this study, it is posited that the results may be specific to the particular residential treatment center discussed. While the results suggest more severe presentations for preadolescent populations in residential treatment centers, concerns for opposition and lack of appropriate use of skills resulting in delinquency and legal issues for adolescents are consistently reported, supporting the need for high intensity care such as residential treatment.

Treatment components. In addition to commonalities in characteristics present in children and adolescents placed in and served by residential treatment centers, there are components of residential treatment programs that present consistently across program settings. Small et al. (1991) discussed some of the issues and difficulties that present in clinical practice in

residential settings, commenting that "pervasive failure in socialization" (p. 331) is typical of adolescents with needs severe enough to warrant placement in residential treatment centers. This propensity towards interpersonal difficulties lessens the likelihood for adolescents to have abilities such as identifying with, joining, and empathizing with others, especially their peers. It was further noted that the pervasive underlying problem that presents within the population is a severe difficulty in making and maintaining basic human connections. Therefore, group therapies—and especially those with an interpersonal focus—are an ideal treatment modality to address the fundamental needs of the population while in care.

Lyons et al. (1998) reported that children and adolescents in residential treatment centers often received the same services, despite each child's individual need and without regard for their emotional or behavioral dispositions. They highlighted the need for the refinement of treatment approaches to meet the needs of the group as a whole, and as a collection of children and adolescents with individual needs.

Abramovitz and Bloom (2003) also discussed treatment approaches that have been used in residential treatment center settings. The paper initially discussed challenges posed by the population and setting, especially when standard treatment models are applied. Intensive individual treatment and milieu therapy were discussed as most influential in shaping the models of treatment used. The deep-rooted tradition of superimposing traditional theories in residential settings was presented as a downplaying of the structured daily routine and treatment needs specific to and inherent in residential settings, which necessitate specialized foci. In response to the identified need for new or modified interventions, the authors presented an integrated trauma- and systems-informed model that was initially applied to inpatient adult patients who were traumatized as children as a recommended therapeutic approach for residential treatment centers.

They noted the difficulty in replicating and implementing original ideas in empirical studies due to the contextual differences across residential treatment settings, but declared that because of limited coherence existing between theories ascribed within residential systems and their staff, current practice and the application of traditional theories were often misaligned. The described misalignment in practice and theory suggests the need for research that examines the process of facilitating psychotherapy groups in residential treatment centers.

Harris et al. (2012) provide an overview of the experiences of youth participating in a psychotherapy group in a residential treatment center for adolescents with issues of substance abuse. They posited that client strengths are one factor that helps troubled adolescents to increase their engagement in prosocial behaviors while decreasing problematic behaviors. Thus, they implemented a five-week strengths-based therapy approach in application with a traditional CBT group intervention. In open interviews, adolescent member participants provided their perspectives of how the strengths-based approach influenced their experience of group cohesion. Outcomes revealed that the strengths-based discussions implemented in the group sessions resulted in increased group cohesion and positive treatment outcomes. This study demonstrates the positive experiences of adolescents in a strengths-based group therapy in residential treatment for substance use. It highlights the positive effects of the experiences of group members on both group cohesion and on treatment outcomes.

Likewise, Waltman et al. (2012) developed a mindfulness-based group therapy for adolescents in residential treatment centers specifically to address issues of impulse control and other behavioral concerns, based on a variety of previously existing mindfulness therapy models. It outlines the modules of the seven-session Applied Mindfulness Group model and reports on client self-report of mindfulness as well as a measure of programmatic compliance. Results of

the study demonstrated an increase in mindfulness skills and a decrease in issues of behavioral non-compliance for the residents, adding to the body of literature of effective group therapy approaches developed specifically for adolescents in residential treatment centers.

Outcomes of residential treatment. Abraham et al. (1995) were interested in the perceptions of adolescents who had experienced process and specialty group therapy in a residential treatment center, regarding their preferences for the different treatment experiences. They indicated that adolescents faced developmental tasks and conflicts including closeness and trust with peers, and that those adolescents served by residential treatment centers often suffered more severe and chaotic interpersonal relationships, suggesting group as an intrinsically beneficial form of treatment for them. Despite their findings showing that 100% of the participants of their study preferred individual therapy to any of their group therapies, they found that their adolescent participants viewed time-limited and ongoing process group therapy as valuable component of treatment plan. Participants also reported feelings of interpersonal improvement and increased comfort with peers following their group treatment experiences. Further conclusions supported that extended time periods for treatment allowed for both initiation and exploration of involvement with others by adolescents. The outcomes identified support the notion that group therapies are warranted treatment options for residential treatment centers for adolescents.

Lyons et al. (2001) noted that a few studies focus on change- and decision analysis, but none provided a foundation for identifying the trajectory of change that takes place in residential treatment. Therefore, they discussed the potential outcomes and post-treatment trajectories for adolescents, following discharge from residential treatment facilities. In their study of adolescents over a two-year post-treatment period, they found variations in the improvement of

symptoms for discharged residents, across residential treatment programs. However, no measurement was provided of the type(s) of treatments provided at various programs; this was identified as a limitation, despite the fact that each program overtly provided individual, group, and psychiatric services. The study concluded that, despite the modifications and variations made to theory in order to meet the needs of the population, there is an essential uniformity in services offered within residential treatment center settings; as such, greater specification of the treatment services in residential settings could further inform and validate the interpretation of outcomes.

Hair (2005) conducted a review of research literature in order to find elements of residential treatment that improve the chances of positive and improved outcomes for children and adolescents. In this review, it was posited that the efficacy of an intervention could be inferred based on its ability to produce favorable results (such as reduction in internalizing and externalizing behavioral symptoms, and improvement in interpersonal interactions) for residential clients, under conditions that would be ideal for the population and the setting. Conversely, the effectiveness of an intervention was likened to its clinical utility, or the ability for the intervention to produce positive results for typical clients in the setting, when treated by the average clinician, under standard conditions. As such, Hair noted that little can be predicted or controlled when considering the specific intervention(s) utilized in residential treatment center settings. The high levels of risk and clinical need present in the population were also discussed. Conclusions from this review included the notion that clinicians in residential treatment centers need to be flexible and spontaneous in order to keep the children and families engaged, further increasing the level of difficulty inherent in measuring and evaluating different aspects of their treatment. In concluding, Hair identified the need for research to reflect the complex nature of the systems within which the interventions are taking place, the need for qualitative and

inductive approaches to research, and the need for clinicians to provide reflections of the treatment process and the value of the interventions. These conclusions were consistent with the needs of the both the population and the setting, and further exploration of these needs could increase opportunities for future research.

Opposition. In contrast with previous studies, Lyons et al. (1998) disaffirmed the need for residential care. In addition to noting the disproportionately high number of providers seen by children at this level of care, they noted that residential treatment was an expensive and common intervention service designated for minors with serious emotional difficulties, related to child welfare. They highlighted the need for treatment modalities used in public agencies with multiple providers to be succinct and to meet specific goals in order to provide the most utility. In their study, risk groups were described for adolescents in residential treatment, based on their histories of suicidality, dangerousness, eloping, criminal activity, and precocious sexualized behaviors. A needs-assessment was completed, finding that despite the need for high levels of mental health treatment for those children and adolescents in residential treatment programs, high levels of risk were not inherent in the populations served. While the paper reported a strong support for the use of long-term psychodynamic residential treatment for serious emotional disorders in children and adolescents, the researchers concluded that residential treatment centers were not a necessary level of care, due to the lack of risk found in the population. On the other hand, the lack in immediate risk as concern for the adolescents in residential treatment centers, as a whole, is indicative a level of overall functioning that would facilitate safety in group facilitation.

Need for Flexibility

Problems in research—especially those that lead to the need for more flexible treatment models and approaches—have been identified and commented on in literature. Whittaker et al.

(1988) explored successful outcomes in residential care and treatment. They reported common criticisms of research, including, but not limited to, the following: levels of risk in the clinical population are not specified; lack of control or contrast groups for comparison; insufficient specification of treatment procedures, as well as client or program goals; and problems in the measurement of desired outcomes. Their study measured outcomes through the administration of questionnaires to clinical staff, allowing them to share their views on treatment outcomes. One finding was that a key factor in successful completion and returning of the standardized measures used was perceived usefulness of the measure by clinical staff. This highlights the opinions of the clinical staff in research as a central source of information about current practices, but also highlights the difficulty of collecting data through self-report measures. As such, a semi-structured interview method would likely contribute positively to their participation, and ultimately, to the success of future studies.

Small et al. (1991) used vignettes and narrative methods to identify problems related to clinical practice in residential care and treatment facilities. They reported that adolescent clients of residential treatment centers often experience persistent difficulties in social in peer relations in a long-term and ongoing manner. Despite noting the possibilities for progress to be made, they indicated the need for expectations to be adjusted to reflect the relational difficulties experienced by the population served, and their developmental achievements. They reported that incongruities exist in assumptions made regarding the population, setting, and treatment modality, leading to unclear understandings of the impact of these variables on practice, and therefore treatment outcomes. These incongruities included that the long term approaches to therapy, such as that used in higher-level and longer-length residential treatments, were often borrowed from outpatient models, and that there was a need for additional thinking to address the

needs of residential treatment center treatment provision. The paper addressed the need for clinicians working in residential treatment centers to reassess the merits of their clinical approaches, based on their understanding of behavioral, affective, and cognitive functioning of the population, as well as the complexities of the system in which the interventions take place. These conclusions suggest that treatment should include modalities that focus on and target improvement in interpersonal relations and self-awareness in relation to and as a part of a social unit, including psychotherapy groups.

Zirkle et al. (2002) completed a study examining the attitudes and behaviors of direct care staff and professional staff who were working with adolescents in residential treatment centers, regarding dual relationships. The study indicated that child and adolescent clients have less skill in negotiating/navigating therapeutic and social relationships. Further, it was noted that both direct care staff and professional staff in residential treatment centers have varying degrees of education and training; differences that exist between the ethical codes and licensing requirements likely contributed to variance between social workers, psychologists, and psychiatrists in ratings of beliefs and behaviors. The study did not find evidence of sexually inappropriate engagement between adolescent residents and staff, but that differences exist between the ratings of the professional and direct-care staff groups, based on ethical ratings. Beliefs about dual relationships may differ across different levels of training, as well as what is allowed by each field's code of ethics. This study found that different levels and disciplines of staff have different needs for training, policy, and agency-provided supervision. As a result, the study posited that the behaviors of professional and non-professional staff in residential treatment must be guided by a common standard of care, with underlying emphasis on the principles of beneficence, nonmaleficence, autonomy, justice, and fidelity.

Among the contributions and insights offered by Bonsaksen et al. (2011) was the observation that, unlike those in outpatient groups, individuals in residential mental health programs, including residential treatment centers, come across and interact with one another frequently, in a variety of settings throughout their stay. The authors conducted a longitudinal study of climate development in psychotherapy groups for individuals with social anxiety in a residential setting, focusing specifically on a psychodynamic interpersonal group and a cognitive-behavioral group. The results of their study showed benefits to both group types, leading to conclusions drawn that the group climate must be set with relation to the diagnoses, treatment, and level of analysis in each setting. Further, they indicated that more structured sessions and more directive leadership styles may more easily lead to common grounds and increased ability for members to develop a sense of trust, due to associations between structure and an increased sense of predictability in the unfolding of treatment. They added that those styles that focus on learning from processes occurring within the group—i.e., in comparison to content being discussed—may make therapy a more unpredictable experience. Despite it establishing additional factors of unpredictability, the multiplicity in methods of facilitating process in psychotherapy groups could also provide increased structure, and therefore more predictability. The study highlights the need for skill for group facilitators in managing the predictability, and thus the felt sense of the safety, of group process experiences through the use of different techniques and theories of group practice for adolescents in residential treatment centers.

Trauma-Informed Care

Brown et al. (2012) described Risking Connections, a model used in training staff members who work with children and adolescents in group care settings, to create a culture of

trauma-informed care. In a study purposed to train staffs of these settings in order to provide a foundation for trauma-informed care, results found that milieu staff showed self-reported improvements in their knowledge, beliefs, and behaviors that were indicative of and consistent with trauma-informed care. While knowledge and beliefs were important aspects, behavior change was noted as the most conceptually significant, due to the direct effect on children and adolescents who are in care. This study showed that staff training in models of trauma-informed care could have an impact on the treatment and care experiences of children and adolescents who have experienced trauma in their histories.

Similarly, Greenwald et al. (2012) provided training sequence in the Fairy Tale phase model of trauma-informed treatment to social workers (serving as clinicians for the adolescents in a residential treatment center) as well as a separate set of trainings to direct care staff specifically applicable to their role in the milieu. They found that application of this model of trauma-informed care in addition to established methodologies that were established in the therapeutic programming at the residential treatment center resulted in statistically significant increase in problem (i.e., incident and behavior) reduction, a statistically significant decrease in the length of time required for residential treatment, and an almost doubled percentage of positive/successful discharge to less restrictive settings. This study introduces the importance of providing training and support to both clinical staff and direct care staff in order to integrate trauma-informed care into inter-related aspects of treatment within residential treatment centers for improved client outcomes.

Habib et al. (2013) described a need to shift towards manualized treatment models, stating that oftentimes theory-based models cannot be systematically implemented, and reviewing a number of models, including The Sanctuary Model, that have been implemented

more recently. The article then specifically described the implementation of the Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) model, a 16-session, manual-based, trauma-informed model of group treatment that was implemented in residential treatment settings. The model was described as present-focused, with a curriculum focusing on (1) cultivating awareness, (2) coping effectively, (3) connecting with others, and (4) creating meaning. With pilot results, the article reported improvements in the self-reports of troubled adolescents in a number of internalizing and externalizing symptoms, but an ongoing need for flexibility within maintaining a framework that considers the impact of trauma on the experiences of adolescents in treatment. While this article is not written in support of therapeutic approaches that are not systematically implemented, it shows that using specific techniques that are influenced by evidence-based approaches and trauma-informed care can be useful for adolescents in residential treatment centers and result in improvements in their collective symptomatology.

Berger and Quiros (2014) discussed the importance of supervision in integrating trauma-informed care into practice. The article posited that trauma-informed care at a systems level must involve the training of all staff within the system, and added that providing trauma-informed treatment services, which recognize the interpersonal and sociopolitical effects of traumatic experiences, is better guided through supervision processes. Then it went on to describe the purpose of supervision and trauma-informed practice, concluding with principles of supervision that are useful in guiding trauma-informed treatment, including "safety, trustworthiness, choice, collaboration, and empowerment," as is consistent with the principles that guide direct practice in trauma-informed care. They concluded that supervision should be mandatory in the provision of trauma-informed treatment services, describing the experiences of group co-facilitators who

were engaged in weekly individual and group supervisions. This article suggested that staff in residential treatment centers, where there are high prevalences of trauma experiences in the histories of the children and adolescents served, should be guided by trauma-informed practices and treatment models. While it is apparent that not all residential treatment settings are trauma-informed, it is important to assess the exposure of clinicians, both within the systems within which they work, as well as in current and prior work or supervised training, in trauma-informed care.

Summary

The necessity and utility of residential treatment centers as an appropriate and cost-effective treatment setting for adolescents has increasingly been a focus in relevant research literature. The use of residential treatment settings is not agreed upon by all; however, the different aspects of treatment integrated as components of residential treatment center settings, such as models and techniques used, modifications made to theory, the use of trauma-informed care, and the impact on the experience of providing and/or receiving treatment, have largely been neglected—especially in the representation in literature of the implementation of group psychotherapy. The setting and population lend themselves to the inclusion of psychotherapy groups, based on the inherent group setting of residential programs and the interpersonal deficits of children and adolescents who are referred. However, the literature points to a gap that exists between theory and practice in these settings. The treatment needs of youth in residential treatment centers should be addressed by quality research that is informed by theory and, warrants an in-depth focus on the facilitation of group process.

Prior to quantifying or otherwise interpreting the outcomes and contributions of group treatment in the residential treatment setting, it is important to understand the ways in which

groups are structured and facilitated in these settings. The population and setting make it difficult to implement psychotherapy groups in standard ways, and also to study the application in a controlled and systematic way. Thus, research must focus on exploring the facilitation of group process, as a mechanism of intervention specifically for interpersonal learning, in order to address interpersonal concerns for adolescents in residential treatment center settings.

The current study will focus on the experiences of licensed and supervised professional/clinical staff, with training backgrounds in facilitating group process, who have facilitated psychotherapy groups for adolescents in residential treatment centers. It will use qualitative methods to explore the facilitation of group process in psychotherapy groups for adolescents in residential treatment centers, with a goal of identifying common components that are consistent across residential treatment center settings.

Chapter III: Research Method

The primary purpose of the present study is to identify common components of, and experiences involved in, the facilitation of group process in psychotherapy groups for adolescents in residential treatment center settings. The secondary purpose of this study is to explore additional components that would be important for consideration in developing psychotherapy groups for adolescents in residential treatment center settings. The study is qualitative in nature, intending to describe the phenomenon of group process as a component of psychotherapy groups in residential treatment center settings for adolescents. The focus is on induction and exploration of naturally occurring phenomena, thus developing new theory rather than testing an established one. The following will describe the rationale for research approach, research setting/context, sample and data sources, data collection, data analysis, treatment of data, potential contributions, and limitations.

Research Approach

Standard approaches to group psychotherapy described for use across settings, often borrowed from outpatient models of treatment, are rarely sufficient to address the elevated need of higher-level settings (Small et al., 1991). As a result of the increased risk and vulnerabilities of the families and clients served by residential treatment centers, there is a need for flexibility and spontaneity in order to keep these families and clients engaged (Hair, 2005). This directly and negatively impacts the ability to randomize or to control aspects of the naturally occurring treatment process, such as through systematic and quantifiable research. The resulting incongruities in assumptions between population, setting, and treatment modality have an impact on practice that requires descriptive study. As such, studying the phenomenology of group process by describing the complexities of the provision of treatment services from the

perspectives of group facilitators in residential treatment centers compel qualitative approaches to research (Hair, 2005). The goals of employing a qualitative research design are 1) to explore the rich experiences of clinicians facilitating psychotherapy groups with process components with adolescents in residential treatment centers, in depth; 2) to provide a thorough understanding of a widely occurring practice phenomenon with a specialized population and setting; 3) to generate hypotheses and theory for the development of further study and/or practice implementation.

Grounded theory. Grounded theory is a form of qualitative research outlined in detail by Anselm Strauss and Juliet Corbin in their 2008 book, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. It requires that interview data be coded and categorized using a systematic design (open, axial, and selective coding, respectively) in order to identify themes. Information gathered from the themes identified from the data collected is then compared to existing knowledge and literature. Through the use of this research method, a theory is developed from, and thus "grounded" in, the data collected (Strauss & Corbin, 2008). The current study used grounded theory method of qualitative research in order to describe the phenomenon of group process in residential treatment centers for adolescents from the direct experiences of the participants, thus allowing theory to be developed from the interview data obtained.

Participants

Participants of the current study were 10 clinicians with experience in facilitating group process who have facilitated psychotherapy groups for adolescents in residential treatment center settings within five years of the current study. Licensed clinicians and those in training (i.e., unlicensed clinicians) whose work was supervised by licensed clinicians were included as

participants in the current study. Therefore, the participants of the current study are of diverse or interdisciplinary clinical fields that provide clinical mental health services, of which psychotherapy group facilitation may be a part. Due to the qualitative nature of the study and the in-depth design of the interview, the targeted sample remained small, and a control group was not utilized.

The 10 participants in the study were all cisgender adults with one (10%) identifying as a male/man and nine (90%) identifying as a female/woman. Participants ranged in age from 30 to 62, with the average of ages represented being 38.3 (standard deviation = 10.1). Asked in an open-ended manner to identify their race and/or ethnicity, five (50%) of the participants identified as White/Caucasian, four (40%) of the participants identified as Hispanic/Latinx, and one (10%) of the participants identified as Black/African-American.

A variety of degree fields, licenses, and specialty certificates were represented by the participants of the current study. Four participants (40%) had obtained a Master's Degree in Social Work and had subsequently obtained the credential of Licensed Clinical Social Worker (LCSW). Four participants (40%) had obtained a Doctor of Psychology (Psy.D.) degree and were licensed psychologists. Two participants (20%) were Psy.D. candidates in psychology. Two participants had obtained Masters Degrees in mental health fields, including Forensic Psychology and Art Therapy. One participant (10%) had obtained each of the credentials of Licensed Mental Health Counselor (LMHC), Behavior Analyst, and Registered Art Therapist (ATR). Further, participants identified a variety of theoretical orientations (one or more) as primary for their clinical work. Eight participants (80%) identified a Cognitive Behavioral Therapy (CBT) orientation. Four participants (40%) identified a Psychodynamic orientation. Three participants (30%) identified a Family/Systems orientation. Two participants (20%)

identified an Analytic orientation. Two participants (20%) identified a Behavioral orientation. And one participant (10%) identified a "Psycho-ed" orientation.

Participant experiences represented a wide range of current clinical services, group facilitation experience, and number and type of groups facilitated in residential treatment centers. Two participants (20%) were working in a residential treatment center at the time of their participation. All other participants (eight, 80%) were working clinically in other settings, including private practice, prison, university counseling center, school clinic, community mental health centers, and partial hospitalization; offering services across the developmental lifespan for populations of diverse age, racial/ethnic, socioeconomic, identity, and diagnostic clinical presentations. In their time engaging in clinical work in residential treatment centers for adolescents, participants facilitated a range between one and five distinct groups, between one and four times per week, and for durations between one and 13 years.

All of the participants (100%) identified their primary role in the residential treatment center(s) on which they reported, as members of the Clinical Staff. Six participants (60%) indicated further that they were graduate-trainees (interns, externs, or post-graduate residents) during their work in residential treatment centers.

Procedures

Participants were sought through network sampling techniques. Upon approval from the Rutgers University IRB, the principal investigator conducted a pilot study with one participant who did not meet the criterion of having facilitated psychotherapy groups with adolescents in residential treatment centers within five years of the current study. The purpose of the pilot was to ensure that the questions developed for the semi-structured interview were clear and would result in the targeted pieces of information. Following review of the pilot interview with

appropriate responses, the principal investigator began preliminary efforts to recruit participants, sending the Recruitment Notice (Appendix A) by email using addresses and listservs for professional networks and organizations, including the American Group Psychotherapy Association (AGPA). Initial participants were asked to suggest other qualified group clinicians to participate whom they believed would be willing to participate and who met the inclusion criteria. This included that they had a clinical background involving training and/or experience in group process, and have facilitated at least one psychotherapy group(s) for adolescents with a process component in residential treatment centers at the time of their participation or within up to five years. The principal investigator arranged a mutually agreed upon date and time for each interview, and conducted each interview using a Voice over the Internet Protocol (VoIP)—such as Skype or Google Hangouts—or by phone. The principal investigator was in a private location for each interview, and participants were contacted at an agreed upon time, during which they established a remote connection from any location available to and/or selected by the participants.

Consent form. Each individual who agreed to participate in the current study was sent an Informed Consent Agreement (Appendix B), detailing the purpose and procedures of the study, risks and benefits for participants, the limits of confidentiality, the contact information for all individuals affiliated with the current study and a Consent to Audiotape and/or Videotape form (Appendix C) as an addendum that allowed them to consent for recording procedures. The consent form details the voluntary nature of the current study, and the rights of every participant to decline or withdraw from participation at any time during the data collection process. All clinicians who fit the inclusion criteria and expressed willingness to participate in the study were contacted by the principal investigator. After inclusion criteria were discussed and affirmed,

those selected for inclusion in the current study were electronically sent and subsequently returned a Informed Consent Agreement and Consent to Audiotape and/or Videotape addendum, along with the Demographics Questionnaire (see below) for completion prior to the interview.

Demographics questionnaire. As mentioned above, each individual who was selected for inclusion and agreed to participate in the current study was electronically sent the Demographics Questionnaire (Appendix D) along with the Informed Consent Agreement and the Consent to Audiotape and/or Videotape addendum. The Demographics Questionnaire is a collection of nine questions compiled by the principal investigator, including both multiple-choice and open-ended questions, that were intended to provide a snapshot of the personal and professional characteristics of the participants. Each of the questions was answered by all ten (100%) of the participants.

Interview. At the agreed upon date and time occurring, the principal investigator connected with each participant, between February and December of 2016, using an agreed upon VoIP method or telephone. At the start of each interview, participants were reminded that they have the right to discontinue the interview at any time without penalty to them. Participants were also be informed that the principal investigator may have taken notes as responses were provided during the interview, which was also recorded in order facilitate accurate response reporting, to which they assented.

The semi-structured interviews included both closed- and open-ended questions (Appendix E). The length of each interview was expected to range in time from 45 to 90 minutes each, but varied between 60 and 120 minutes based on the amount of sharing by each participant. No participant was interviewed more than once. Following the interview, each of the participants were given the opportunity to ask questions and to address any related issues that were not

covered in the consent and interview processes. Each participant was then informed that they could contact the principal investigator, or anyone affiliated with the current research, in order to address any questions or concerns that may arise about the current study. Finally, each participant was thanked for his or her participation in the interview and in the current study.

Measures

Interview protocol. The interview protocol served as a foundation for the semi-structured interview. The questions were developed based on the rationale, purpose, and research questions of the current study, with minimal information gathered and input from the review of literature. The interview was sectioned to elicit responses in specific categories, including background information related to training and experiences in facilitating groups, descriptions of the residential treatment center settings, more specific descriptions of experiences running psychotherapy groups in residential treatment centers, and inferences based on professional experiences. The demographic information as well as descriptions of participant training and experiences in facilitating groups were intended to confirm the participants as licensed or supervised clinicians, and to describe the range of levels of training and experience of the participants, as discussed by Zirkle et al. (2002). The Experiences in Adolescent Residential Treatment Centers section provided information for the first and second research questions, which seek to describe the common experiences of group facilitators in these settings, including the populations encountered, program or organizational model(s), theoretical orientation(s) espoused by the system, program structure, and types of groups offered in the settings. Next, the interview focused specifically on the facilitation of psychotherapy groups in residential treatment centers, with descriptions of structural, theoretical, and other components. These included questions about the ways in which trauma-informed care influences the psychotherapy groups in

these settings, as is the focus of the third research question. Finally, the interview focused on inferences made by the participants based on their experiences and observations within residential treatment center settings. These questions address the value of psychotherapy groups in residential treatment center settings, and additional considerations that are important for development of new groups in the future, addressing research questions four and five.

The person of the researcher. Each of the interview questions were developed, interviews conducted, and the data analyzed and interpreted by the principal investigator—processes representing all phases of the current study. As such, and especially in the absence of other objective data sources, the principal investigator was a key instrument throughout the current study. Thus it is important to consider the person of the researcher in order to anticipate any potential influences and/or biases.

The principal investigator for the current study was a Black/African-American, cisgender woman in her late 20s with related interests in trauma, clinical work with child and adolescent populations, and interpersonal process in group psychotherapy. The principal investigator is a member of the American Group Psychotherapy Association. Further, the principal investigator had past non-clinical work experience as a direct care staff member in a residential treatment center for adolescents in the northeast region of the United States of America (USA), which shaped her interest in the current topic.

Throughout each phase of the current study, the principal investigator received guidance and feedback from the dissertation committee and through participation in a qualitative dissertation seminar. The dissertation committee consisted of two women who were both licensed clinical psychologists and members of the faculty/staff of a university in the northeast region of the USA. The qualitative dissertation seminar was a working group of doctoral students

from a variety of backgrounds and theoretical perspectives, and was facilitated by a licensed psychologist and faculty member of a university in the northeast region of the USA. The purpose of the qualitative dissertation seminar was to provide support for doctoral students throughout every phase of completing the dissertation study.

Data Analysis

The current study involved semi-structured interviews. No statistical procedures or other quantification methods were used to analyze or interpret the interview data collected. Due to the qualitative and exploratory nature of the current study, no prior hypotheses were tested as a part of this study. A method of analysis was used based on grounded theory, through which conclusions are generated based on coding of the data collected from the qualitative interviews, as described by Strauss and Corbin (2008).

Once all interviews were conducted and data collected, the audio recordings were transcribed, prior to data coding. Open coding of the data, which examined the interviews in their entirety, then involved extracting relevant issues from the interview transcriptions, leading to the development of conceptual categories as an ongoing process. These categories provided a foundation for understanding the data. Codes and themes were then refined through axial coding, which involved combining codes for issues identified in open coding, in order for connecting theoretical properties to be identified and clarified from those categories identified. Finally, a process of selective coding was conducted, through which themes and core categories were able to be identified based on all responses and coding procedures (Strauss & Corbin, 2008). After systematic coding of all interview transcription data was complete, categories and themes identified were able to be further explored and analyzed in order to identify patterns of particular

themes and issues relevant to the facilitation of psychotherapy groups for adolescents in residential treatment centers.

Treatment of Data

Each participant was assigned a code in order to keep his or her name and any other identifying information confidential. All hard copies of interview materials, including consent forms and interview data, were kept in a locked storage cabinet that could be accessed only by the current principal investigator. Audio recordings, interview notes, and transcriptions were saved on a password-protected computer database; no one other than the principal investigator was able to access to this information. Three years after the completion of the current research, all documents with identifying information will be shredded, and the principal investigator will erase all digital data, including audio recordings, notes, and transcriptions.

Potential Contributions

Psychotherapy groups are a common aspect of treatment in residential treatment centers for children and adolescents. As there is a dearth of literature on the facilitation of psychotherapy groups, there are a number of potential benefits for the current study. Exploring the experiences of clinicians across disciplines that provide group psychotherapy services could serve as a basis for establishing a blueprint for those clinicians who might be interested in group process work with this population and setting. This study could shed light on the disparities between theory and/or policy and practice. This study could also provide a framework that makes group facilitation in residential treatment centers more predictable, and therefore, better able to be evaluated for efficacy and effectiveness in the future. Further, by providing additional insights regarding the views of clinicians of additional considerations that would maximize clinical

utility, clients served by residential treatment centers could potentially receive more effective services in the future.

Chapter IV: Results

The following is a presentation of the results of the current study, with reported responses from the semi-structured interview as described above. The results, as the questions, are divided into four major sections, including the following perspectives for each of the participants: (1) training and experience in group; (2) clinical working experiences in residential treatment center settings; (3) experiences facilitating psychotherapy groups and group process in residential treatment centers for adolescents; and (4) inferences regarding the facilitation of group process and psychotherapy groups with adolescents in residential treatment centers, based on their professional experiences. Finally, a fifth section will highlight (5) other information not mentioned elsewhere. Each section was made up of multiple questions that were relevant to these areas.

Training and Experience in Group

The focus of this portion of the interviews was on experiences that prepared the participants for their work as group facilitators for adolescents in residential treatment centers. Participants were asked questions related to their current and past experiences, which contribute to their perspectives on psychotherapy groups and group process work. These questions included topics such as (a) graduate coursework and institutes; (b) conferences and professional development; (c) supervision and consultation; and (d) other related experiences.

Academic training. Participants were initially asked to describe their academic and course-related experiences related to group psychotherapy. Three of the 10 participants (30% of the sample) described their academic training experiences as lacking focus on specific issues related to the provision of group therapy. Two of those members stated explicitly that they did not complete any coursework on group therapy throughout their academic and/or training

experiences. Two participants discussed the application of individual clinical theory to group work. For example, one participant stated:

> We learned groups at school. We had basic courses that introduced us to all types of therapy individually. And then it goes ahead and makes it a little bit broader so we can apply those individual theoretical concepts to group work.

Two participants also discussed the focus of their coursework being on individual therapy work and on Evidence-Based Treatment.

Eight of the participants (80% of the sample) noted having some graduate coursework through which they were introduced to principles of group work. Seven participants reported having only one course dedicated to group psychotherapy throughout each of their academic programs. One participant, having gone through two separate clinical graduate programs, took a total of two group therapy courses, stating the following:

> So for groups in general [pause] I have a masters in social work, and I had, like, a course in groups that was more like community oriented . . . work with groups. And then through my (doctorate), we had a course on group psychotherapy.

Eight of the participants (80% of the sample) specifically discussed components of their academic learning. Two of those participants specifically described engaging in role play activities to facilitate learning, while three participants reported having the time split during their courses between didactic and experiential presentation styles.

Six of the participants (60% of the sample) reported that interpersonal and/or process work in groups was specifically covered in their coursework. For example, one member described interpersonal group work being applied specifically to their experiences in a group art therapy course:

> It was focused on interpersonal, but it was also a lot of appropriate art directives for groups. And that's kind of the dynamic of a lot of art therapy classes, it's some of the mental health pieces, but then it's also, what are appropriate art therapy directives."

Conversely, one participant specifically stated that there was not a lot of focus on or exposure to interpersonal dynamics in their academic courses.

Three participants (30% of the sample) discussed their learning of group therapy principles to have come from outside of their graduate coursework, such as at the Annual Meeting of the American Group Psychotherapy Association. One participant specifically discussed an experience in an institute specifically discussing the Systems Centered Therapy. Two participants mentioned Irvin Yalom as a helpful contributor to the teachings and learning of psychotherapy group principles. One participant specifically described feeling underprepared for group work with adolescents in residential treatment centers:

> I did take one class there in group psychotherapy. Read Yalom's book. That didn't really prepare me very well [pause]. Well, reading Yalom's book was good preparation, but the class didn't really prepare me very well for what I needed in a treatment center, I mean, nothing really does [pause] for residential treatment, things are quite an experience.

Workshops and conferences. Participants discussed the additional training opportunities in which they have engaged since completion of their most recent certification or licensure. These opportunities included workshops and conferences specific to training in psychotherapy group or process group facilitation. Five participants (50% of the sample) did not engage in additional training opportunities specific to group psychotherapy outside of their coursework during undergraduate study.

Five subjects (50% of the sample) reported attending and engaging in group-specific sessions at national conferences. Two of those participants engaged in training opportunities at the American Psychological Association (APA) Annual Convention while three participant engaged in training opportunities at the American Group Psychotherapy Association (AGPA) Annual Meeting.

Three subjects (30% of the sample) reported engagement in group training at other conferences and workshops, including local affiliates of national organizations. One participant described specific learning experiences covered, reporting that

> . . . they covered it in, for example, [the National conference]. I had one opportunity to go (there) and I had another chance to go to [a state affiliate conference]. And in those conferences I attended sessions in which they covered group processing or when you're working with groups, what to do or something.

Supervision and consultation experiences. Participants were then asked specifically about their experiences with receiving supervision for facilitating psychotherapy groups and a range of both supervision and consultation experiences were discussed. Six subjects (60% of the sample) discussed supervision of group work as a component of their training while on clinical placements. Two of those subjects described their clinical placements while completing graduate study as the first setting in which they had the opportunity to facilitate a psychotherapy group. Four participants specifically described supervision experiences during an internship placement, while three participants discussed practicum or externship experiences and one member discussed receiving supervision during a post-graduate fellowship. One participant described,

> Basically I would have my supervisors come in to observe like a group or two. And then . . . I co-led a men's trauma group with my supervisor. I found that to be most helpful,

> because I could see her style and I could definitely— she would be like a model. And she could also directly observe my interactions and provide feedback to me as to what I could improve on, what I might've been doing okay with. Things like that. So I found that to be really helpful.

Two of the ten participants (20% of the sample) discussed staff trainings at work during consultation meetings that were specific to facilitating psychotherapy groups. One participant described the experience as such:

> I think doing the group therapy trainings that were either here on campus, where we learned about the different stages of group process and what to look for and different interventions to use during those different stages— I think *that* I found to be helpful. And for me personally, instead of getting information from textbooks, it's one thing. But when you're about to sit in practice and kind of see it right in front of you, to me it all kind of starts to make sense. So I think that's helpful for me.

Seven participants (70% of the sample) specifically described their experiences of supervision while in unlicensed practice, engaging in clinical work under a licensed clinician. Two of these participants reported discussions of translating theory into practice. One specifically described,

> It was really helpful, especially in process. Because there's only so much that the books and lectures— a lot of that is just like the academic information, where you can follow, you can even follow a manual if you want to run a group. But a lot of times the hiccups, the challenges come in the actual process part, how the people interact with each other, how they respond. Things that you didn't think would pop up. Those were the times that supervision was really helpful because a lot of times their experience translated really

> well as far as what they could say to, oh, when this happens try this. Or any of their experiences, if they weren't exactly the same, they could at least take you down a road to help you for the next session so that it is still helpful to the client. You still feel comfortable, and more importantly that you're still helping the client and everything is ethical.

One participant noted the need to specifically seek out supervision (i.e., outside of their work environment), describing that supervisors in residential treatment centers do not always have training in psychotherapy group facilitation:

> I had to seek it out. I didn't really get . . . very much in residential treatment. Most of the people I worked with [pause] there was one person I was supervised by . . . she'd not been trained in [psychotherapy group facilitation]. She had a long experience of working with these kids (in residential treatment centers). She lived in [a nearby suburban town]. She was a very good one.

Five participants indicated that their experiences with receiving supervision were most helpful when the supervisors had specific experience in the setting in which they were working (e.g., residential treatment centers). One participant remembered a particular supervisor, stating,

> He had specific experiences, he could give me specific exercises, you know? Do this and do that. So he was much more specific, because he knew the population. Yeah, so with him, I got some really solid ideas and, you know, exercises. That's where I developed my ability to switch modes really quickly. From a lot of the supervision he gave me.

Two participants discussed developing specific group facilitation skills while on clinical placements during their graduate training. One participant described,

> I got a lot of training at my internship. There, I ran a process group for the addictions group. How to talk about my supervision with that? [This supervisor] was an interesting character, and I love him dearly, but he's an interesting character. He pretty much let me do my thing and feel my own way. I'd say that supervision really focused on—because these were really tough kids— and helped me to understand the experiences that I was having and understanding my counter-transference and talk that through in a safe space with him. And then after we talked that through, strategizing how to move forward, in a way— and he also helped me kind of walk into my fears, in a way [pause]. And that was great.

Three of the ten participants (30% of the sample) discussed their experiences specifically with engaging in consultation with staff around issues related to group facilitation, with one member stating explicitly, "it's I guess kind of like group supervision [pause] but it's more for staff, where we process the dynamics of a group. And that was helpful."

Eight of the participants (80% of the sample) discussed a range of topics covered in their supervision and consultation experiences. Two of those participants specifically described theory- or model-based supervision experiences. Five of those participants described specific techniques, strategies, and interventions for group therapy facilitation. One participant specifically described the experience as follows:

> The first guy [pause] even though he was . . . more Gestalt and family systems, and had not worked with that population— he wasn't a great fit, but he still had a good sense of helping me come back to the basics of what I needed and helping me take care of myself. I know, [my supervisor]— it was just [pause] I remember him just telling me one time, you need to tell that group what it's like. To try . . . to be a group leader *with*

> them. You know, when they're jumping up and down and hitting— jumping up to hit somebody or screaming out. You tell them what that's like. You know [pause] so being reminded, of that once in a while. You know, you, you need a supervisor to, just to kind of remind you of the basics once in a while.

Two participants discussed co-facilitator dynamics. One participant gave the following narrative about their experience:

> I was co-leading, and the other person didn't really have the experiences that I've had. So we just sort of like worked it out as a safe space to talk about stuff. My supervision with that was with [the clinic director], and he just helped us sort of understand the dynamics of me and the other co-leader as mom and dad of the group, and so there wasn't a lot of real training involved or supervision— more of just helping us just think things through.

The second participant described an early experience of learning about different styles of co-facilitation in detail:

> I think one of the things that I've learned the most, that's been really helpful for, like, propelling me forward and increasing my competence, and thus my confidence in group in some ways, is knowing that it can look very different. [The co-facilitator] was a very blank slate kind of group leader. And she just went in there and kept like very, kind of like neutral, poker faced expression, and this was like her style in the group room, and it so was not mine. So the first time, especially coming from (working with) juvenile boys, where if I did that, that would've been really really unproductive, so I was just so much more used to being more active and directive and like getting in there and like really moving the discussion. So I had a lot of anxiety when I first started group [in a different setting] because I was really excited; and then as I started it, the experience was not what

> I was like imagining it to be. I felt really anxious in the space. I felt very, like, I don't know what I'm doing, I'm not trained for this. I felt like I needed to mimic my co-facilitator. Especially since she was so much more well-versed in the area of interpersonal process groups than me. So I felt in some ways that I should be like watching what she's doing and then doing that, and that's how I needed to be. And so I struggled for, like, I would say the first, like, month. Like, maybe the first four groups. And then she was out on, like, a family illness, and we were having, like, supervision throughout those weeks and thereafter, and I was getting a lot of support and validation around, like, what I was feeling and just clarity around the different ways that a facilitator can look in that space. Like, . . . what their presence can be like in that space. And that one of the most important things was for me to feel like I could be authentic and be myself.

Further, two participants each talked about covering topics including facilitating process in the group space, client interactions and interpersonal dynamics, and reviewing stages of group development in supervision and consultation experiences, while one participant each explicitly discussed topics of maintaining boundaries in group, defenses, and transference/countertransference issues. For example, one participant described,

> We have had group therapy training, you know, where we've gone through different stages of group, you know— forming, norming, storming, performing— you know different things of that nature. So we have done that, and that wasn't necessarily on a supervisor/supervisee level but more— that was also group supervision as well. So we do that a lot at staff meetings, where we would have a group training specific to group process. But also, on an individual basis, where there's supervisor/supervisee, we could

> also, you know for myself, bring up issues that may be arising in group, whether it be process issues or it can be things like that. It's for additional feedback, additional suggestions for you to utilize in the group.

Three participants (30% of the sample) described issues related to a lack of interest in group process or group dynamics among the staff. They discussed a lack of effort on behalf of the clinicians as well as the openness with which they discussed their non-efforts. One participant stated, “Nobody else really had a lot of interest. Some people [pause] frankly, most of 'em were just trying to get through the hour. They would tell you that, too.”

Four participants (40% of the sample) discussed issues related to the amount of supervision they received. Three of those participants described receiving “very little” supervision specific to group work, and especially that with adolescents in residential treatment centers. Two participants indicated that the amount of supervision was not enough to guide their development as competent and effective group facilitators. And two participants expressed that the focus of much of their experience with being supervised was focused on individual therapy work. One participant described her experience as follows:

> I would say ultimately, I didn't get a lot of supervision that specifically pertained to groups. At the juvenile detention center, we talked more about individual clients more than we did groups. Groups were mandated and so it was kind of like that, you just have to do them, but it's really about the individual.

Other related personal or professional experiences. Participants were asked to share experiences other than coursework, workshops or conferences, or supervision and consultation experiences, that contributed significantly to their development as group facilitators. Nine participants (90% of the sample) discussed having had in vivo learning experiences with group

therapy. Two of those participants were engaged as members in psychotherapy groups prior to becoming clinicians. One of them described,

> When I started my undergrad work, I participated in a group psychodrama, group. You know, as, like, a client. And I think it impacted my, my experience with groups because it kind of opened up my mind to what happens in groups, and how helpful they can be.

Another participant described a training experience as most influential, stating, "I think really my internship was huge. I think that was, like, the strongest, the most powerful (experience). There are other things [pause] you know, I really think it's my internship that really stands out really loudly for me." Similarly, one participant described their development as extending from experiences of facilitating groups without having received much applicable training:

> When I was there, that was my first time that I was really doing groups. I had done some groups in my internships, but they were more psycho-ed based, or like specific activities with young kids in schools. I also did a support group with victims of power based violence when I interned when I was still in my masters program. I didn't get a whole lot of training about group at that time. I was kind of just winging it with the skills that I had learned in school for just general therapy and then applying it to working in a group setting. And my groups class— but since it wasn't like a typical process group, it didn't feel like it translated super well.

Another participant described an experience with groups in a hospital setting as influential for developing the skills in adaptation in group psychotherapy work:

> A lot of times, I had to think of therapy in a one session concept, because I might not see that client the next day. And I might, but it had to a lot of times be, what can we do for this one group? And especially because many of them are struggling with depression.

> And the art therapy group was recommended, but not required. So I had to be very engaging to get them to come to group. So it really made me have to think and be on my toes a lot with that group.

Four of the participants described that having a variety in group experiences contributed to their skills and development as a group clinician. One participant described how individual characteristics paired with exposure to a variety of experiences:

> Just being a person, I think it's always helpful to bring that into groups. Just knowing that you can have empathy for what they're going through at times, and it helps you respond in a more caring, understanding, and more personable way. As far as professionally, there's anything else other than academics and supervision? No, I mean the only thing that has affected me is just the different types of groups I've run and different types of clientele I've had. No groups are the same. And even if it's the same year and you're covering the same material, the people coming in constantly make it different and bring in different dynamics.

Another participant described the ways in which the styles of other group facilitators were influential as well:

> It could be a tough population— a lot of them were juveniles who were in the system for either [pause] they were juvenile offenders or they had some type of significant trauma and/or behavioral issues. So I found that the groups with them were challenging at times. But it was nice because we would combine our groups with other [trainees]. So I felt that that was a really valuable experience because we all had different styles and ideas for the groups. And I felt that it really came together and brought out different aspects of the individuals based upon the different styles of who ran the groups.

One participant described how variations in the amount of experience each co-facilitator has can be influential in development:

> I think there have been times that I've worked with people who have been more experienced than I have been with groups, that've been doing it for years. And I have learned, I guess, two things: I have learned how my freshness into it helps me in some ways and their experience helps in some ways. So sometimes I think people have been doing it too long, because they run it maybe not in a relaxed style or something; but when you're new, you have to keep certain things in mind because you're new. But when you're replacing someone or you're substituting for a while or substituting for a group, you have to figure out your own style, your own way, which will be different from the person who has been running it for a long time. You might think from their experience, and they might tell you think like, don't worry about *this,* or you know, guide you as to how to do things. But at the end of the day you have to figure out your own style in the group setting.

In considering personal and professional experiences that contributed to their development as group facilitators, four participants (40% of the sample) described non-conventional ways of learning about group facilitation through their experiences. One participant described an alternative experiential activity that had therapeutic significance:

> We used to have a strong focus on sort of adventure-based counseling, where we would do a lot of team building activities, not only— with the residents in which we serve [*sic*]. So there's team building, problem solving, conflict resolution. And we'll be involved in that process as well. So you know, not only was it a good activity for the residents, it was also— it helped the staff, whether it was clinical or residential, it really didn't matter— to

> be able to, again, work together, you know because a lot of times in [considering] individual based counseling, you're outside of your comfort zone. So you're outside, you know, you're not sitting in an office, you're not sitting in a conference room in a circle, you *are* outside working on initiatives, working on activities that you have to figure out how to . . . work through in the moment. And if you're not able to work through in the moment— you know which was sometimes okay. Sometimes success was not always the end goal, it was just about the process of how we're going to get to that end result. And if we didn't get to that end result, as long as we worked together as a team, then that was considered a success as well. So I think that the adventure-based counseling piece too, for me, because it took me out of my comfort zone and allowed you to be able to relate and to understand for some of the residents that you're dealing with, some of the things that you're asking them to do that they maybe have never done before. No one has ever taught them how to problem solve or to be able to manage their emotions, so it's a little bit uncomfortable for them. So we were able to kind of share that experience.

Two participants described having prior teaching experience as significant to their development as group facilitators. One stated the following:

> I have a lot of teaching experience. So that definitely influenced me. Because— so as it turns out, in working in K-8, working in [pause] I was kind of in an administrative position, but it turned into one of those catch-alls where I did a lot of substitute teaching and proctoring and assistant teaching and all sorts of things. So running groups of kids and young adolescents and kind of keeping them in check and that kind of was helpful when I was working with adolescents in a group setting. But also, having a lot of experience teaching at the college level was just sort of helpful in terms of more of the

> psycho-educational aspects of it, and kind of just making sure I'm connecting with various— throughout the group, that it's not just a couple people participating and others hanging back, but trying to engage all— a larger group of people with varying degrees of understanding and different ability levels. So I guess, I would say . . . those experiences were important for that.

Another participant described the influences of teaching experience as well, describing also the importance of maintaining distinctions role as teacher and that as therapist:

> I also taught for many years, so I think teaching also helped me. Because it helped me to have more confidence and control of the group in a way. But at the same time, I didn't want that to overstep my therapy, which is very different than teaching. So I had to find a way to make peace with both professions and stick to the therapy style. But . . . teaching did help me to feel more in control of the room, maybe not be as nervous. Maybe have that feeling that when you walk in the group, you're not intimidated by the group [pause] like you have when you're new at group therapy— especially if the people in the group happen to know each other for any reason, like in residential. Well they did in residential. Because they had contact with each other all the time. It's not people who meet once a week, it's people who have contact all the time, so you're new to them. So they can gang up on you if you don't know how to handle it. So, that teaching experience really helped me in that sense.

Finally, one participant described supplementing their previous training and course experiences with additional reading. They described, “Just trying to, kind of [pause] a lot of reading. Like I read more of Yalom's books. I've just tried to continue feeding myself in those ways to learn more and become more skilled at how I'm intervening with the group.”

Experiences in RTC Settings

This section focused on describing aspects of the residential treatment centers in which the participants engaged in clinical working experiences, including, but not limited to, facilitating psychotherapy groups with process components. Participants were asked questions relating to the overall setting of each residential treatment center. The structure of each of the settings provides a context for the types of groups run, and as such, the experiences of the group clinicians, with adolescents in residential treatment centers. Questions included topics such as (a) treatment components of the residential treatment centers; (b) characteristics of the populations being served by these settings; (c) groups as a form of treatment in these settings; and (d) the presentation of trauma for adolescents in RTCs.

RTC settings. Participants were able to discuss the many components of the settings in which they worked. They described residential treatment centers that served populations of various sizes, with capacities that ranged from 10 residents to 140 residents. These centers, each providing services to adolescents, also differed with regard to the ages of the children who were admitted. All of the programs discussed included adolescents between ages 14 and 18; however, one agency had residents as young as eight years old and another agency provided services to residents up to age 21.

Eight of the participants (80% of the sample) addressed aspects of a behavioral system orientation within the agency in which they worked. Five of those participants specifically described a system that espoused a cognitive behavioral theoretical orientation, while two of the participants stated that their agencies did not espouse a cognitive behavioral orientation. One participant described the behavioral system being integrated with psychodynamic components. Four of the participants described a point system that was employed by their agencies in order to

quantify and to reward appropriate progression for the adolescent residents, and two participants specifically described a level system of advancement through the program. One participant described the following:

> There at [the residential treatment center], they had this model where there were levels or clans, so to speak. . . . (provides names for six different clans). [The first] clan— everybody starts out on [the first] clan. That's learning rules and rhythms. Learning to be accountable to others— that you're behavior has an affect on others. Hygiene. Things like that.

Five of the participants discussed specific models of treatment that were used by the residential treatment centers in order to structure the aspects of treatment provided. One participant described the Restorative Justice Circle Model:

> Restorative Justice Circles [pause] so it kind of follows, I don't know, it's a completely new model for me. So what they do there, is they showed me the models that they follow and . . . everybody is a participant in the group, and everybody has an opportunity. You have like a talking piece, which is an object that the group selects, and the object gets passed down from person to person. And when you get the object you can say, I pass, you know, I don't have anything to add. But you can ask, you can process, you know, a feeling. The object goes to everybody in the room.

Two participants discussed the dissemination of Moral Reconation Therapy (MRT) as an approach used throughout their agencies. One described it as follows:

> MRT had different assignments. Different tasks that they had to complete. It did have to do with their morals. There was some truth to the name, it had to do with like identifying what your morals are and how your behaviors are consistent and inconsistent with

> morals. . . . It was almost reminding me of 12 steps in some ways, because you had to like say and do certain things to pass that step in MRT, and there were a certain number of steps in MRT and you have to like turn in. And it had to be done right. If it wasn't done right, you weren't allowed to make corrections, you had to like redo it and turn it in next week. It was very, like, rigid, and the boys hated it, and I don't know, I guess like the authoritative— the authoritarian side of me liked it. Because I had this like, nope, sorry, I'm going to hold you accountable. So it was a lot on accountability, of like, yeah it might sound silly that it says to only write in pencil and not fill in block number 1 and only fill in blocks two through four. But if you filled in block number one? Sorry, you didn't follow the directions. So it had a lot to do with, like, following specific directions as they're written, whether you think they make sense or matter or not. That was a big message sent by MRT. Similar to the law, right? We don't necessarily have to agree with it or think it makes sense, but we still got to follow it.

One participant described the implementation of a model in a residential treatment center that was developed for application specific to the treatment of eating disorders:

> They functioned under a [pause] I don't know the official name, it was kind of like a sub-orientation within the eating disorder world . . . basically they worked under the assumption that the eating disorder was kind of like a separate identity from the person, and so we did a lot of, like, they named their eating disorder, gave it it's own identity. And a lot of the work focused on separating true self from the eating disorder. And so I don't know what model— it's not, it wasn't given like a name. They talked about it as the separation model within eating disorders [pause]. There was naturally like a psychodynamic element to a lot of the work there. We were drawing parallels to family

> of origin when this eating disorder came up in your life. Where did that come from? What messages did you receive? Who were they from? Are these your real thoughts or are these the thoughts of somebody else that the eating disorder has taken on? And so that was like a lot of how the work looked there.

Three participants described the lack of a model espoused by and implemented throughout the agency or particular setting in which they worked, but reported that the model used in treatment was open to the discretion of each clinician. One stated,

> They were pretty open, now that I think about it. I think there was an overarching, we-don't-care-what-you-do-as-long-as-it's-evidence-based type of thing. But as long as you, of course, weren't harming the child [pause]. If they saw that something was created and worked, they were for that as well. So even though my groups and my individuals and families tended to be more CBT based, I did have a coworker that did have more of a psychodynamic approach. And it all worked, she did just as well. Since we worked with families a lot, a lot of it was also (using) family theories. We would use systems, structural, no real concrete need to follow a certain theory, but if you took a piece from each and it ended up working out, it was great.

Finally, one participant presented concerns for implementing more structured models, recognizing that clients were more receptive to "real talk" than more prescriptive approaches to engaging them in treatment. They stated the following:

> Kudos to people for trying to come up with ways to deal with this particular challenging population. That wasn't my favorite though, I just was like, I'd rather just talk to them like a real person. I think they're more receptive to that than this, like, book of things that half of them cheat on anyway.

Four of the participants (40% of the sample) discussed the overall valence of the residential treatment center programs in which they worked. Two participants described strengths-based approaches, with one describing it as a welcomed change in working with difficult populations:

> I found that extremely helpful, especially with the second residential facility, because it was just a change in experience that they needed. Typically to the point that I'd get them, they are treated very negatively, talked down to by everyone and anyone that they encounter. So [the strengths-based approach] was a great way to build rapport and to build it very quickly.

However, two participants discussed the residential treatment program setting as having punitive qualities.

> I guess you could say that the behavioral rewards and consequences was probably the underlying staff and clinical approach of, you know, you win certain points, with behaviors you're gonna lose points. You get enough points, you get increasing privileges, or maybe you can buy something from the store. You know, programs always changing how they give rewards as well. And always taking away from the kids. You know, just a lot of— although not spoken in that way, just a lot of punitive qualities to it.

And one participant described the disorganized structure as contributing to the negative outlook for the program and its residents. As an example, this participant described the ways in which groups were frequently organized in one setting:

> In terms of org structure too, to say that it was pretty disorganized. Like I got into work in that morning and then I'd know what my schedule was for that day. And I may have been in charge of a group here and there, or several groups throughout the day. And then that

> group would be like, let's say there were 7 people in the program at that time, and they all had to get a certain number of . . . individual sessions in a week. So, like, the groups were super random. They'd just be, like, I'm doing group with everyone who is not in individual therapy at that time. So it was kind of choppy and haphazard, and we just did the best we could with what we were given in terms of the structure.

Five of the participants (50% of the sample) described specific treatment foci or tracks within the residential treatment centers in which they worked. Two participants indicated that their agencies had specific treatment for issues of substance abuse; two participants described specific tracks for eating disorders; four participants noted juvenile justice or forensic tracks or foci; and two participants discussed specific treatments for sex-offending adolescents. One participant provided the following description of foci within a particular setting:

> The . . . current treatment areas that we focus on are emotion management, substance abuse, and sex offending. So when our guys come in, they will be assigned to at least one of those treatment tracks. For some, depending on their background, they may have problem areas in all of those treatment tracks, so we have to address more than one. So a guy may come in and be dual tracked, so he may have substance abuse issues as well as sexual abusive behaviors, so we're dealing with the both. We've also had some subgroups as well. With fire-setting, grief and loss, animal cruelty, trauma survivors— we do, you know, address those issues as well if the resident coming in has that as a problem area that needs to be addressed.

Five participants (50% of the population) described that, besides individual and group therapy as forms of clinical treatment, the residential treatment center also involved other program components. Four participants noted that the residents attended school on campus. Two

participants stated that family therapy was an additional form of treatment that was embedded into the residential treatment center. And two participants noted that the residents also engaged in other clinical activities to occupy their time.

Five of the participants (50% of the sample) discussed issues related to the intensity and/or security of the residential treatment centers in which they worked. Two participants described their settings as classified at moderate risk, with less extreme measures taken to restrict the potential egress of the residents. Conversely, two participants described their settings as being locked down or secure. One described in more detail,

> It's a statewide . . . program. Yeah, and it looks like a camp. Their rooms have dorms. They're divided into girls and boys. They have a play area outside, with a basketball court. But it's a secure facility. If they ran away, we have to chase them. We have everything locked up.

Two participants particularly described their programs as being a "last resort" form of treatment— a diversion from either inpatient level care or sentencing to juvenile detention centers. One participant stated,

> They were generally there for behavioral issues, often including drugs, sex, self-injury, process addictions— like, I had one kid who was there for pornography. So, and kids who could not stay home— they had just maxed out their families, their families could not handle them. And they were at risk to at least themselves, if not others. And families [pause] to send your kid out, that would— you sort of have to be at the end of your rope, they've tried everything.

Eight of the participants (80% of the sample) discussed issues related to the varying presentations and concerns of the adolescent populations served by residential treatment centers.

Two participants particularly addressed the range of presenting issues and diagnoses carried by the residents. One participant described the variety of issues and concerns present in residential treatment centers as follows:

> They all had been assessed to have low IQ, under 70 generally speaking. Most of them have history in the foster care system. . . . And all of them had a co-morbid severe mental illness; generally speaking, major depression, bipolar disorder, severe post traumatic stress disorder, and psychosis.

Another participant discussed the benefits of having adolescents with a variety of presentations together in process groups:

> You create a positive . . . interrelational thing, and you know it's always nice, interesting, it's always nice to have one or two Asperger's kids in the room. Because they're, they really can be very helpful. You know, some of the kids can't read and write. But the Asperger's kids can always read and write. And they're always willing and interested in helping other kids spell. Or help them explain vocabulary words to them. So it's interesting, and they have their own set of problems, that it's nice to find, to get them [pause] to get a child who has a disability to help another child. So Asperger's kids are always— it's always nice to have, like I said, one or two of them in there, so they can help the lower functioning kids in other ways, and then that gives them a little ownership.

Three participants directly addressed the range of IQs that are present among adolescents in residential treatment centers. One of those participants discussed facilitating different groups with considerations of the IQs of the residents, stating, "I run them with like, individuals who have, kind of an average IQ. And I also run those types of groups with individuals with, kind of borderline IQ. The curriculum has been modified for that." Two of the participants directly

discussed the diversity of the populations served in residential treatment centers, especially as it relates to demographic data. One participant described the ethnic/racial makeup of the residential treatment center as follows:

> The population was mixed. Mostly minorities. The minorities were the majority. I would say about [pause] I don't know, 2% Caucasian, and all the rest were either Black/African American— you know Black, Latino, no Asians during my experience, and racially mixed kids. Mixed, biracial kids. Among the Latino population, there were people of Cuban and Mexican descent. Maybe some Puerto Ricans— yeah, there's a couple of Puerto Ricans. And among the black slash African-Americans, there was a mix of Jamaican— kids of Jamaican heritage, and also [pause] were there? Yeah, there were a couple kids that were of Haitian backgrounds as well.

Four participants noted that the majority of the populations served were referred from child protective services, case management services within the behavioral care system, or from the courts.

Six of the participants (60% of the sample) discussed issues related to the existence of distinctions between intended program length and the average length of stay. Regarding average length of stay for clients, four of those participants discussed program stays that were less than nine months in length. Four participants discussed program stays that were between nine and twelve months, and two participants discussed residents with program stays that were longer than 12 months. Three participants noted that the reason for the average program stay being often longer than the intended length of the program was due to extensions as a direct result of misbehavior. One participant described the phenomenon, stating the following:

> So I would say a good nice average would be six months. The 10 to 13 year olds were looking more at the four to six month range. Above 13 year olds were looking at six to nine months, with occasionally it being 10 or 11 months, because they just kept getting in trouble, and their JPO (juvenile probation officer) wouldn't let them leave yet because they hadn't met certain goals that they had outlined to not get in trouble that often.

Two participants noted further that the average length of stay for the residents was often indicative of the severity of the prognosis and/or the background of the residents.

Five of the participants (50% of the sample) described difficulties that were often present at or leading to discharge for the adolescents in residential treatment centers. One participant described programs automatically discharging at age 18, despite progress made: "they have to leave the day before they turn 18." Two participants described discharge most often taking place to a step-down placement. Another issue at the point of discharge, discussed by two participants, was the difficulty finding placements for the adolescents, resulting in an extension of their stay in the residential treatment center setting. One participant stated,

> I feel like they were supposed to be there 6 to 12 months if I remember correctly, but the typical length of stay was much longer than that. And I would probably say it was over 18 months, because they were so hard to place with the multiple conditions layered on top of one another. It was hard to find therapeutic foster families who could handle them. Because none of them could be discharged back to their own families. Many of their parents were also impaired in various ways or incarcerated. Or in residential treatment for substance abuse. So that was a real difficulty getting kids back out of there.

One participant described discharge being initiated due to lack of progress demonstrated on behalf of the residents, noting that for the most part, residents completed the program:

> There were disciplinary problems and the judge would decide then alright, juvy it is. Or we would have to let them go. Like we just couldn't do anything more with them, so [pause] you know, we usually kick out the kid after a year, just because there's no improvement, they've been on [level] B the whole year.

One participant noted that residents have been discharged prematurely due to a discontinuation of financial coverage by their insurance providers:

> They could be there as little as 4 months, and as much as a year. And the reason for that could be, a lot of times it was insurance, because insurance wasn't paying anymore. That would be the time where I think the four month kick out would be. But for the most part, kids stayed between 6 and 9 months.

And finally, three participants discussed residents being discharged due to elopement, absconding, or running away from the program.

Structure and model of groups. Participants were asked to describe in more detail the ways in which the groups in their residential treatment centers were structured as well as any models used in their development and/or implementation. Five of the participants (50% of the sample) described the frequency in which the adolescents in residential treatment centers were engaging in group therapy. Two participants noted that psychotherapy groups were facilitated two days a week, one participant noted that groups were facilitated five days a week, and two participants indicated that groups were facilitated seven days a week.

Six of the participants (60% of the sample) discussed issues related to facilitation of psychotherapy groups for adolescents in residential treatment centers. Four participants described having a single group facilitator as a default within the program. Conversely, one

participant describe having a co-facilitator model specifically for the purposes of training and supervision:

> I had an art therapy intern working under me when I was working with the lower functioning kids, and so I was often co-facilitating with the art therapist. Which was cool [pause]. They would head up the art directives piece of it but then the processing and stuff like that I would still be a part of. Yeah, kind of collaborating talk therapy with art therapy a little bit. Combining those approaches with the boys. So yeah, I would say that that's most of what we did.

One participant noted that co-facilitation was sometimes espoused in order to provide consistency for the group, based on the roles of the clinicians:

> Each group has at least one clinician and a residential staff [pause] that's assigned to the group— actually my group is the only group that has two clinicians, and that's only because of the nature of my role; I'm also the assistant clinical director. So sometimes I get pulled a lot, where I may not be able to always be there, so if I'm not there, there's another clinical staff that's assigned to . . . that group. So there's always a clinical staff, and like I said, a residential staff that's assigned to the group.

Further, three participants directly described interdisciplinary models of co-facilitation, or those across clinical fields of training/study (e.g., art therapist with talk therapist, social worker with mental health counselor); and two participants addressed the experience as group facilitator involving the facilitation of multiple groups in one day (i.e., with different group members and/or different topics addressed).

Six participants (60% of the sample) described issues related to the size of their groups as features of the structure and model. Two participants noted that the size of the groups could be

influenced by licensing standards or contracts for payment. One participant stated, “Now the insurances, it can be 30 people, and they're gonna get money for it. They get the same money for it. The insurance companies don't care, whether it's 30 or . . . (statement discontinued).” Two participants noted that their group sizes were intentionally capped at 10 participants, while three participants noted that their groups tended to be maintained at about eight to twelve members in size, based on the program census, needs, and resources. Only one participant described a group with eight or less members, while three participants discussed large groups of 20 to 30 residents as members.

Four participants (40% of the sample) described issues related to the times that groups were held in the residential treatment centers. One participant noted that groups were held in the mornings. Conversely, another member noted that groups were held in the late afternoon hours, particularly after school but before dinner:

> We tried to do more games, interactive. Especially because the groups were after school, before dinner, which was a terrible time because they knew that as soon as they were done with group they would go to dinner. And they were hungry and they were tired. So that made them even more resistive to group.

Two participants mentioned that groups were designated to be held for periods of 45 minutes. However, two participants explicitly noted that the length of group sessions varied based on the attention span of the members. One participant stated,

> I ran it with a co-leader, and the co-leader was a social worker. And we met weekly for about— well, as long as they could sit basically. Ideally, I was aiming for 40 minutes, 45 minutes. Often we couldn't get them to sit for longer than 20 or 25 minutes, so we would kind of just work within the attention span of what were given.

Another participant described their experience as follows:

> Because again, they are teenage boys, so their energy is like, "AAAAAAAAAH!" You know, so sometimes sitting in a room for 90 minutes for group twice a week, they get a little restless. I would say by the 60 minute hour, that's when I know it's been an hour, because my group starts to get restless. And I'm like, oh okay, now I know that it's four o'clock.

Eight of the participants (80% of the sample) discussed issues related to the variety of groups offered in the residential treatment centers. For example, two participants discussed themed groups for LGBTQ+ populations within the residential treatment centers. Other participants described the particular types of groups being facilitated. Three participants noted that psycho-education was a key component of the group therapy processes. One participant stated the following:

> How we got away with [facilitating groups] seven days a week— because we had to have a therapist on campus every day. But obviously who was there on weekends could not run all the groups for all the boys. So how we got away with it was we did more of the psycho-educational pieces on the weekends. We left them worksheets of [pause] I'm trying to think— social skills, or how to address an envelope, just more of basic life skills.

Three participants discussed the facilitation of "pure process" groups. One participant described the experience, noting,

> I was not doing cognitive-behavioral groups. Doesn't mean I might not bring a piece of that into the groups once in a while. Mostly I was trying to get kids to, to notice how they were reacting to one another, and to process that [pause] and support each other.

Five participants described facilitating “mixed process” groups. For example, one participant described the experience of integrating styles in the following way.

> A lot of handouts, a lot of directives or some sort of activity, like fill out this handout and then pick, you know, the hardest one for you to share or the easiest one for you to share, and then tell one other person or share it with the large group. A lot of like kind of changing the structure of that, but getting them to be more vulnerable, be more willing to disclose. That was kind of my goal at the end. As well as education, so teaching them more about emotions other than like mad and happy, which was the only emotional language that they typically had. Teaching them like, teaching them some level of acceptance around like other feelings, like it's okay to feel sad, that's actually human. It's okay to have other emotions, so, a lot of like really basic insight and awareness around emotions.

Another participant described the integration of specific topics, skills, and here-and-now issues:

> And the process group was kind of based off of topics and you know problem solving and that. It was very dynamic — not dynamic in the psychological sense, but I mean dynamic in the interactive sense. And many times we were just helping the kids process situations that were going on in the unit or going on and bringing up topics that they needed to. Or skills that they needed to learn. So skills training was often used also.

Seven of the participants (70% of the sample) discussed issues related to implementing structure in the facilitation of group therapy. For example, two participants discussed the need to cover specific topics weekly, per the guidelines provided by the agency or program in which they were working. One of these participants stated,

> We were asked to kind of cover certain topics, based on again like those different overseeing agencies that set standards for us based on funding that we had to meet. And so, we were asked to touch on anger management, social skills, emotion management, substance abuse [pause] I think those were the four main ones we had to try to get every week. Like every kid had to try and get every one of those services every week.

Four participants described the groups incorporating discussions of issues that were on the unit or in the residence. For example, one participant noted the following:

> We had sessions where in the middle, everyone had already— everyone in group had already been there for a while, nobody new. But they needed to understand certain rules. And we would automatically, we would realize— the therapists; the therapists would realize, hmmm you guys don't know what you're doing. You don't know why this happened. So we had to talk about it. One time we had to talk about laws, and [pause] it really was a place for them to understand what processes they were going through. And really say, hey, you guys— do you know why you're here? Do you know what this program is supposed to mean for you? And even just having the understanding and going and learning . . . how they could make the most out of this group and program.

Two participants noted that boundaries and respect were embedded in the structure of the groups that they facilitated. One noted,

> They are encouraged— you encourage them to kind of express what they are thinking and what they are feeling. They assume, you know, responsibility for their behavior if they were involved in an incident. But, they are very structured in a sense that it is not like free association. You— you have to respect everybody's turn. And that's weird, it's

> the passing like that, you have like a . . . stuffed animal. And that's the talking piece, and you pass it. Around. So that's just completely different for me.

Two participants noted that they incorporated CBT principles into the structure of their groups. Conversely, three participants explicitly stated that they do not intentionally implement any structure in the facilitation of their groups, but rather allow the groups to be guided on each occasion by their assessment of needs of the residents.

Eight of the participants (80% of the sample) described issues related to the group makeup. One participant explicitly stated that clinicians have no control over the makeup of the group. According to three of the participants, groups are assigned to and divided by living units. Four participants noted that members are grouped by age. Three participants explicitly discussed groups as involuntary or mandatory components of treatment in the residential treatment centers. Only one participant described groups as a voluntary component of the residential treatment center. This participant described the following experience:

> I guess at first they asked me to try anger management because there seemed to be the most need for that. So I was running that on the girls unit. It was an open group to the girls living on the unit, so it was kind of open but in a very small closed system. Because there were only about 10 girls at any given time who could show up for group. Usually the same kids would show up every week.

Three participants discussed having some residents as members of the groups they were facilitating, who were also on their individual caseloads. On the other hand, one participant noted that their group members were randomly assigned with no apparent consistency in the experience. Five participants noted that direct care staff members were included part of the group makeup, specifically for behavioral support. One participant described,

> There were times that it was beyond our control. Because [pause] and we needed to have the techs jump in and kind of control the group more. Especially if it became something that had to be more— you know, had to do with violence. Or if they were becoming aggressive.

One participant described direct care staff being included in the group makeup as group facilitators, noting,

> So most therapists would try to avoid worksheets when we ran it (group), because we knew that on the weekends or if one (clinician) was sick, the direct care staff would have to lead the groups. So we tried to avoid worksheets as much as possible.

Lastly, one participant noted that the entire treatment team, including representatives from all components of the residential treatment program (i.e., both clinical and non-clinical staff) were involved as participants in the groups being facilitated.

Prevalence of trauma in RTC populations. Participants were asked to reflect on the amount of the adolescent populations that they have encountered in residential treatment centers with a history of trauma. All of the participants (10; 100% of the sample) agreed consistently that trauma was very present and highly prevalent in residential treatment centers. Three participants noted that 100% of the population they have encountered in residential treatment centers was trauma-affected, while one participant noted 95-99%, one participant estimated 98%, and two participants indicated 90%. One participant estimated about 75-85% of the population has experienced trauma, and one participant noted about 70%. Finally one participant indicated that they would guess differently based on different settings, with one setting being about 30% of the population and another being about 90% of the population, landing at an average of about 60% of the total population they have encountered being trauma-affected.

In addition, four of the participants indicated specifically that had an impulse to report that 100% of adolescents in the residential treatment centers that they have been exposed to have experienced traumas, but noted that they were unable to. One of those participants said,

> I mean it's hard for me to think of any of them who either weren't— it's hard for me to think of any of them who weren't traumatized when they came in, but certainly when they left they were. So I would say between 95 and 99 (percent). And that [applies to] some of the staff as well.

Another participant stated, "I guess I shouldn't say 100 because nothing's ever complete, but I would say 90% of [one particular] facility had— if not one, typically they had multiple traumas that brought them to this point."

In addition to the prevalence of trauma among the adolescents seen in residential treatment centers, five participants (50% of the sample) additionally discussed specific experiences of trauma that the population has frequently endured. Three participants discussed sex trafficking experiences, three participants discussed physical abuse, and three participants discussed sexual abuse. Further, one participant went further to discuss complex trauma, including multiple experiences of trauma, as a common occurrence for the population:

> Now I'm talking about— I'm talking about complex trauma. I mean, these are not, these are not anything CBT— trauma focused CBT is not [pause] it's useless with this (population). These are kids who've had attachment disorder. They've been, they've been raped [pause] repeatedly. They've been hit, repeatedly. They've gone to adults to complain about it. Maybe years before anybody did anything about it. They've been hungry. You know, the whole thing.

Manifestations of trauma. Asked to discuss the ways in which a previous experiences of trauma might show up or manifest for adolescents in residential treatment centers, participants discussed a range of experiences. Nine of the participants (90% of the sample) discussed specific issues related to acting out behaviors being of concern. Three participants mentioned sexualized behaviors as externalizing manifestations of trauma, while five participants noted observations of heightened reactions (e.g., emotional and aggressive) to perceived threats. Two participants stated that the behavioral reactions of the residents were easily triggered. Six participants indicated that yelling, anger, and aggression were manifestations of trauma. Two participants noted that destruction of property tended to show up as another manifestation of trauma, one participant described another being residents behaving in manners that were outside of their character, and one participant noted another being substance use.

Five participants (50% of the sample) identified internalizing behaviors as manifestations of trauma. Three participants identified cutting and other self-injurious behaviors as trauma reactions. Three participants also identified enuresis as a manifestation of trauma. Other participants described internalized emotional states, one participant each including hopelessness, lack of emotion regulation, inability to self-sooth, low self-esteem, and overall lack of sense of self.

Eight of the participants (80% of the sample) described interpersonal issues as manifestations of trauma for adolescents in residential treatment centers. One participant noted that “drama” was an issue occurring between members that was also an indication of the interpersonal difficulties the residents were having as a direct result of their exposure to traumatic experiences. Four participants described superficial or inappropriate relationships as

another example of interpersonal manifestations of trauma. For example, one member described the following:

> Like because of their histories, they viewed, you know [pause] (there were) some "Stockholmish" kind of behaviors. They viewed [pause] they got along with the person who hurt them when it's obvious that they probably feared them. But their awareness or their [pause]. Especially the girls, it was so sad. Their view on it (their trauma)— or maybe they were just trying to create some balance in their minds and be okay with it some way some how. They really sometimes identified with and sometimes wanted to appease the people who hurt them. So a lot— I saw a lot of that.

Further, three participants described trust and rapport difficulties as manifestations of trauma. Five participants identified the presence of defense mechanisms, and two participants noted that boundary issues (over-boundedness or under-boundedness) were demonstrated by the residents. Two participants noted that the trauma showed up often as a resistance to vulnerability, while one participant each noted that an attitude of crushing others to get when you want, being withdrawn or isolated, and positioning self incessantly as scapegoat were other manifestations of trauma.

Four of the participants (40% of the sample) described issues of traumatic representations of issues present in clinical work as manifestations of trauma as well. Two participants discussed trauma as present in therapeutic directives. One participant provided an example that was demonstrated through the creation of a mask:

> Another girl, she— her mask was very interesting, her mask had horns. She was tough tough tough. And her horns were identified as her greatest strength and her greatest weakness. She was fierce. Or she could be fierce. And her horns have served her really

> well. And a part of therapy was helping her learn how to sort of like recognize the times that she really needed it versus not. And learning how to soften those horns. She was fierce, she was avoidant of a lot, and pushing people out.

On the other hand, three participants described manifestations of trauma through conduct issues such as sociopathy and excessive manipulation. One participant described an example of a young man in residential treatment:

> I don't know exactly what his trauma was, but I'm sure there was trauma in the background because of what he brought. He was— I would argue he was sociopathic, and all that that means. He would show each staff person that person that he figured out they wanted. And it only became clear towards the end of his treatment that it's not sort of consistent. And he was . . . really struggling with a sense of self, and he would try on various diagnoses, and he was a master at becoming that diagnosis. It was really quite something. And I had— even though I'd had him in therapy for half a year I think, we had in all that time, [one] good session. One good, real therapy session. And that session, we did parts work. And he was pained that he couldn't find his core. So we talked about parts. And I said, you know, I said, it just sounds to me like there's this common thread of justice. And that your core self is fighting for justice. And that had like resonated with him. And he just smiled, like he just found something— this cohesive element among all these parts. And then the next week, it was like it never happened. But at least we had that one good session.

Four of the participants (40% of the sample) described classic post-traumatic stress symptoms as manifestations of trauma demonstrated by the residents in residential treatment centers. Two participants discussed their residents having flashbacks, and two participants

indicated that residents had nightmares. Two participants discussed hyper-vigilance among the residents, and finally, one participant indicated that intrusive thoughts were a manifestation of trauma.

Two participants (20% of the sample) described the presenting problems that resulted in their placement in residential care were manifestations of trauma experienced by these adolescents. Both participants discussed poor decision making paired with exposure to situations and experiences beyond their developmental capacity to process. One participant provided an example of witnessing domestic violence as directly related to the presenting concerns for adolescents in residential care. As a more detailed example, one participant described the following:

> Sometimes our kids are put in situations where they are forced to be in a role that they're not— I would say developmentally ready for [pause] they're not emotionally ready for. So in turn, they begin to act out or make poor decisions. Adolescents already as it is [pause] poor judgment, decision making, think they are invincible. And then when you add the trauma on top of that, it just, it enhances the fact that their judgment is even heightened. You know what I mean, I'm using an example . . . a young man, when he goes on home passes, mom has a lot of— a younger mom— has a lot of other kids. And there's times where he's left home and he's responsible for babysitting and watching the other kids. And so he's put in that parentified role. Again, above his capacity. He's only 14/15? But above his capacity emotionally. So his first out, he's looking to escape. And when he does, now he's outside, now he's engaging in inappropriate behaviors. And again, not saying that A always equals B, but sometimes A contributes to our worldview and our perception of the way in which we operate. So I'm one that, as soon as I've got

the green light, I'm going, and now I'm outside doing things that I shouldn't be doing. And I prefer to be doing this because I don't want to be sitting in the house watching my 6 or 7 brothers and sisters.

Facilitating Psychotherapy Groups in RTCs

This portion of the interview data focused on experiences specifically related to facilitating psychotherapy groups with process components with adolescents in residential treatment centers. Further, this section was intended to identify the ways in which different components that structure and guide the development of the psychotherapy groups may also influence the group process. Interview questions focused on topics that include (a) residents assigned to groups, (b) influences on the facilitation of process, and (c) the impact of the resident relationships on groups.

Influences on sex/gender construction. Participants were asked to describe both the gender construction or make up of the groups they have facilitated in residential treatment centers as well as the factors that influenced those dynamics. Eight of the participants (80% of the sample) noted an explicit gender make up for their groups. Three participants described co-ed groups while two participants (25%) discussed groups of all girls and five participants described groups of all boys.

Nine of the participants (90% of the sample) described issues related to the program structure as influential in determining the gender make up of each group. Four participants described working in a single-sex facility as determining the gender make up. Conversely, four participants discussed the presence of multiple units in the residential treatment centers that were separated by gender. One participant described the reason for maintaining the separation of units in the group space, noting, “Basically it was just like the basic structure of the program. They

didn't want them to intermingle, due to they would probably influence each other and—sexually and all that as well." Another participant further described the necessity of maintaining the separation between sexes/genders:

> The groups were always divided. Oh, actually except for the drug and court group. Since there weren't as many kids in that, that was the one group that they did allow the girls and boys to enter. For the most part I think that the division is needed. Because when you combined them in school, you could see that since they don't see each other for most of the day, a lot of their time is spent on each other instead of school and learning, because they're just so eager to see one another. So in the groups I think you get to do a lot more clinical work when they're divided. They don't have to focus on the other gender. I mean, we did had issues where some of the girls were attracted to one another, so you do have that issue. But when you take the boys away or you take the girls away, you don't have the gender piece. So that part is helpful.

One participant noted that higher-level groups were allowed to be co-ed. Similarly, four participants described specialty groups that were co-ed. Despite that this was a systematic factor influencing the make up of the group, one participant noted that the outcome was more arbitrary. When asked about factors influencing the decision to maintain a co-ed group, this member stated,

> I think I alluded to this earlier, but now I'll say it more explicitly: nothing. Convenience. The schedule was made up by a non-clinical administrative person the day of or the end of the day prior. Based on, I have no clue what sort of [pause] it was arbitrary I really felt like, for the most part. Like, logistics of which individual— which therapists would do an individual session, when, and who has had enough individuals this month, and who's left.

> Those people that are left, oh it happens to be girls, it'll be an all girls group. You know what I mean, but sometimes it was all girls and one guy. It was completely completely arbitrary.

Lengths of stay in group. Resident lengths of stay in the program can be parallel with their length of stay in the various treatment components in residential treatment centers in some, but not all cases. Participants were asked to reflect on the amount of time each participant spent on average in each group. Six of the ten participants (60% of the sample) described ongoing groups as a component of their residential programs. All six of those participants noted that members were involved in those groups throughout their stay in the residential treatment center. For example, one participant noted, "So from the day of admission, you're assigned to SO (sex offenders) group until the day that you're discharged. And like I said, on rare occasions, it may change, but the majority of the time it doesn't." Two participants described more specifically that the average time spent in group was a period of six to nine months.

Four participants (40% of the sample) described time-limited and/or cycling groups as a component of their residential programs. Two participants noted that groups rotated in 12 to 16 week cycles. One participant described,

> So the length of stay there is approximately two years, like, you know, between 18 and 24 months. And the groups run like cycles of 12-16 weeks. . . . So depending on how long they're there, they're usually participating on a cycle of group.

One participant indicated that their time-limited groups were facilitated for a period of about six to nine months. And two participants noted that their topic-specific subgroups tended to be time-limited.

Theoretical and other influences. Participants were asked to identify what, if any, theoretical or other influences their groups were modeled after as the groups were developed, by the facilitators or otherwise. Nine of the ten participants (90% of the sample) described a specific theory the was influential to them as their groups were structured and/or facilitated. Two participants discussed Interpersonal Theory. One participant stated,

> I think my main emphasis is interpersonal. You know, I'm all about, they're gonna learn from each other. Gotta learn how to get along. And I need to model it, and I need to help them to model it for each other. I need to help them not overreact. For me it's all about, just like, their families, you know, learning to communicate. You know, one of the things I had a lot of success on was, Agazarians [pause] some Agazarian system-centered psychotherapy [pause] for groups. I do "Anyone Else?" exercise working on communication skills, so, that was a very successful intervention, her "Anyone Else?" exercises. You know, Agazarian. So, you know, that (interpersonal) was a big one.

Four participants discussed the influence of Psychodynamic Theory on their psychotherapy group facilitation. One participant stated of their experience,

> Psychodynamic always plays a part, especially at the beginning to help out with—usually with the timeline is helpful. To help them see how they got to this point. It's kind of helpful to go back and see what happened when they were babies, what happened when they were younger, any attachment issues. So that's always helpful tools [*sic*]. And always helpful in process too, if you are able to get a good process conversation, a lot of times they pull each other's experiences from when they were younger. And then as a therapist you're also able to educate them on some of those psychodynamic pieces.

One participant specifically discussed the Systems Theory as influential in the development of their group. similarly, one participant described the use of Positive Psychology theory in their work:

> They could see that a lot of our work together is going to be strength based. I'm not the type to really focus too much on what they're doing wrong. I like for them to see that yes they didn't do the best on this situation, they didn't do as badly as before. So I was able to use those techniques and that frame of mind in a way that they ended up being able to develop themselves, and show that even in a negative situation, they could always see the positive or the improvements.

Six participants described the use of Behavioral, or more specifically, Cognitive-Behavioral Theory in their group's development. One participant described,

> Content-wise, I would say I would uphold most often from CBT because I was newer in my profession and that was all I was really trained— I was trained primarily in CBT, so I think that's where the content of the group, that's where my influence— that was what was most influential. The way I was structuring the content of what we were going to address in group that day. And I of course tried to build on it, but it was challenging within the structure.

Two participants discussed the influence of Solution-Focused work in their groups, while one participant described the influence of Object-Relations Theory. Lastly, one participant described using Acceptance and Commitment Therapy in their work in group facilitation:

> Towards the end of treatment, I always ended up using Acceptance and Commitment Therapy [pause] just because there are always things that we spend time over months working on improving, changing, skill building. But there are always things in their lives

> that they're going to have to realize that they can't change, and I don't think they're really able to grasp that in a mature way until closer to the end of treatment. So around that time I start introducing the whole ACT type of treatment so that they get that they may never change their parents. Or they may never change their this or that. And that piece of being able to just accept it and do it in a better and more proactive way is important just for growth so that they don't end up with us again back in the future, or worse.

Five of the participants (50% of the sample) noted other influences through which their groups developed. Two participants described how cultural influences played a role in their groups. One of those participants stated,

> It (the specific model used) came out of a group of academic people from there (a university), but it doesn't adhere to a cognitive or psychodynamic or psychoanalytic model. I know that some of the principles of those circles come from like Native American traditions, like you also have an initial ceremony and an ending ceremony. The group decides what that is. So it could be a few moments of mindfulness before you start or some mindful meditation before you end. Or they could decide to break dance, is going to be how they start the group and how they end the group. The group decides that. But it's like a, some of the basic concepts come from a tradition of Native American ceremonies.

Four participants noted that Yalom was a great influence on the development of their groups despite their not being structured as "pure process" groups. One participant who noted being influenced by Yalom, described having no identifiable theoretical orientation in group:

> It was hard to tell where that was going to go, so we started with a little bit of psycho-education, and then tried to open it up to a more dynamic process group to see if they

> were going to be capable of that, and it was variable success. So I mean, in a way, with the limitations cognitively, it was really hard to stick to an orientation, and kind of just trying to keep a dynamic in tact and keep everyone safe became a primary concern. And sometimes it would just completely go off the rails. So it would be hard for me to really say, when I really looked at what the groups turned into, that there was a real orientation behind that. If you watched the groups, it would be hard to say that.

Another participant discussed the emergence of more embedded interpersonal process work, as outline by Yalom, with skills group work and psycho-education:

> A lot of it was about how to teach basic social skills. How to keep everybody cooperating and getting along, I mean that was really the focus at that facility. And then after being there for many years and getting more acquainted with the presenting concerns of most clients and how they tended to manifest in that setting, and I think just building my skills with rapport building and all of that, I was able to start to do a little bit about what looked like interpersonal process with the boys. But, it was a stretch. I mean mostly, it was psycho-ed where it could've been like a moment of the group where I was getting someone to share something and connect with somebody else, and that was as interpersonal process as it got.

Other elements introduced to facilitate process. Participants also shared what additive elements were introduced in order to help facilitate process in the psychotherapy groups. These may have included activities, games, food, or other elements. One of the ten participants (10%) was not allowed to incorporate food into their groups. Nine of the participants (90%) discussed the use of food and/or candy in facilitating group process with adolescents in residential treatment centers. Three of those participants indicated that food and candy were used as a

reward or positive reinforcer in groups. Three participants discussed using food and candy as a draw or incentive for attending and participating in group. One participant described how food and candy can become a contingency employed by the residents if appropriate boundaries are not established:

> I know it's sad to say but, sometimes if you did not have a snack, they weren't participating. So it had to be a boundary of, I'm not doing this so you will participate, I'm doing this as a reward for participating. So it actually is on the clinician to establish that boundary, and to make sure that they have enough respect from the clients from day one to understand that— its almost like a control issue, and they will automatically test you from that first session and see how far they can go with their power and control.

One participant, described rewarding members for active participation, explicitly stating that residents do not receive a reward if not engaged in the group:

> So I think it held them more accountable to being just more attentive to their behaviors and their decisions during group. And their behaviors went anywhere from like misbehaving as well as just not engaging. So I was moving more toward, I don't care— I don't want you to misbehave, that's a basic requirement of you being here, you're not supposed to be misbehaving. I want you to engage. So a lot of the time they'd be like, "I just sat here, I didn't do anything." I know! I don't want you to just sit here and not do anything. I've gotta be here, I've gotta be working, and so do you. We've all got to do this.

Three participants noted that food and candy are not included in the facilitation of group often. One participant further described,

> Well the kids love food. And some, I would say some groups do food more often than others. My group, we don't do food a lot. And they're always like, why can't we have a party? Why can't we— no. We don't do food. And on special occasions we definitely may do it. But we will do different activities.

Another participant used food and candy as an intermittent reinforcer, describing how the anticipation of it by the residents could negatively affect their behaviors:

> I would introduce candy occasionally. But I tried to stay away from candy because my office was broken into a couple of times because the boys knew that I had candy in my office, so I would try to stay away from that.

Six of the participants (60% of the sample) noted that art directives were often incorporated into the psychotherapy groups in order to guide and facilitate group process. One participant stated,

> We even gave them chances to share their own stories. Almost like, perhaps like make a drawing or a craft that symbolized something about themselves, and then present it to the group. And they each had a turn, so that was good.

Nine of the participants (90% of the sample) described the use of different activities in group in order to help facilitate process. Two participants described using handouts in order to deliver information and to help residents engage in practice of learned concepts. Two participants also described incorporating role-play activities. Six participants described the use of media, such as TV shows and video clips, in order to demonstrate particular concepts and to elicit process conversation. For example, one participant described,

> Sometimes if we stumble across a movie— we watched [pause] in a couple of groups I've had, we've watched the movie “The Woodsman,” with Kevin Bacon. And that's a

> movie about a guy on parole that struggled with sex-offending issues. And while he was out, he ran across a young lady, and, you know, kind of going through some of the stages that we talk about in group. So we brought that into group and kind of watch the movie and kind of point out the different stages that we see the actor going through leading up to being sexually inappropriate. So we've done things like that as well.

Another participant described their used of audio-visual media in group as well:

> I would do recordings of like, for example, for some of my 15 and 16 year old boys, I would do "Intervention." I would do half episodes of "Intervention." Like portions of the episode. Like you know the TV show "Intervention?" It's a really— its been around for a couple— probably like a decade now if not more. But it's just about addiction. So it's about— usually it has one or two people in an episode struggling with an addiction and they believe that they're being in a documentary about addiction. So it's like a reality show. But really the family is setting up this intervention that happens at the end. And the intervention is like a lot of emotion and the family being like you caused me so much pain and if you keep doing this I can't have a relationship with you, and setting these boundaries and these ultimatums to get people in treatment and better. So I would do that sometimes, to like highlight the effects of drugs on the family system.

One participant discussed experiences with incorporating movement, such as exercise and dance, in their groups with positive outcomes. Five participants noted the successful use of different forms of creative arts, such as music and poetry, in their groups. One participant described the impact of a poem on the group members:

> I was thinking about Raisin in the Sun, when I brought that poem in— are you, you familiar with that, A Raisin in the Sun? [pause] I will never forget it, a couple of young

> black boys had never heard anything like it before, they didn't know anything about it. It just, it just made such a difference in their image, and the possibilities, that somebody could actually put into words something that meant what it meant to them— that they could look on the computer screen, this poet had written 50 years before or whatever. So there's always that little piece of education that you can bring in, integrate things and [pause]. But lyrics is [*sic*] a good one, song lyrics.

Two participant discussed the necessity of incorporating activities in order to make the group content more interesting and/or understandable for adolescents in residential treatment centers. One participant described different types of activities that were incorporated in groups:

> I=statements, basic communication, having them write letters to people. You know, things like that, a lot of— write your own eulogy, how would you want to be remembered at the end of your life? How is the way you're living right now working in favor of that desire of how you want to be remembered. Like, stuff like that. So basically doing a lot of, like, identity work and, like, figuring out who you are and who you want to be, but through these, like, creative kind of avenues.

Another participant noted different issues that emerge in group, suggesting or indicating that activities might be helpful:

> Activities, usually I would use to teach a topic that normally would be kind of boring. As far as in process, if I noticed that there was a topic in the past that they either weren't grasping or maybe one of the girls was trying to explain her experience and the rest just did not understand it or maybe relate, a good way for me to try to get them to understand it or bring the message home was incorporating an activity into the process group, so they can understand it. So that they actively go through it, and that way they relate more to

> their peer now because they've been through it or something similar to it. A lot of times it was nice to use activities for big important topics so that it really stayed with them.

Five of the study's participants (50% of the sample) described the inclusion of games in their facilitation of psychotherapy groups. Two participants discussed the use of games to influence skill building, while two participants noted the use of games specific to team building. Two participants described the use of games to encourage the development of skills in prosocial interactions. Three participants used games in order to encourage and to elicit more disclosing between group members. For example, one participant described,

> So I would do things like, I forgot the name, but everybody stands in a circle on like a square and there's one less square than members, and whoever is not on a square has to stand in the middle and say like, almost like a "Never Have I Ever." Or like, move if you have been to a baseball game. Then everybody who's been to a baseball game has to move squares. And somebody who gets to be without a square would have to move to the middle. So like little games like that.

Five of the participants (50% of the sample) described issues related to the inclusion of a variety of additive elements in group psychotherapy with adolescents in residential treatment centers. One participant noted that the residents often have different styles of learning, and thus, activities can often translate to a wider audience:

> The activities were a necessity because you have such a mixture of— sadly the rare ones were smart and intellectual and abstract and could go with you. And then the most of them that had learning disorders and needed more of a hands on type of approach. So the best way to just have everyone be able to participate is to have an activity that could placate on all of their strengths. So the visual part's there, you're talking with the auditory

> part. So those that are just, more of just the street smart, then you have the hands on piece. And then all of them feel like they're excelling and can complete the hands on piece and understand it.

Three participants discussed the ways in which variations in group kept everyone engaged. One participant described,

> It's just a matter of keeping their attention because sometimes the activity isn't fun for some people. Like if it's a music lesson, some of them don't like rap, some of them don't like country. Sometimes, it's a hit or miss. But for the most part, if you're able to just grab their attention with anything, that can maintain it for that amount of time.

Another participant described the ways in which variety was implemented throughout the facilitation of groups as well:

> So I would try to do like a lot of like either art therapy or if it was a nice day outside we'd go have group outside. I'd try to play a lot of skill building, team building games. But just try to be creative with what I did and try to make it different everyday to keep them somewhat engaged.

Five of the participants (50% of the sample) described some ways in which group process was evoked from the incorporation of additional elements in group. One participant noted that the interests and activities incorporated were also integrated with skill-building. Three participants discussed the use of externalized narratives to elicit process from group members. For example, one participant stated,

> We've done things where I may bring a current event article, and based off of the current event article, bring it in, we'll read it, and now we need to apply group concepts to this article. So in the news unfortunately you'll see different people that have committed

> inappropriate sexual behaviors. We'll print that out and we'll kind of bring that. Because a lot of times we want them to see that we're not just working in a bubble. And that it's not just [this agency] or this is specific to [this agency], but unfortunately, these things are happening all over the place. And I'm not just teaching you these concepts for you to use on these 100 acres, where— I'm not expecting that you'll go home and use this exact terminology. Maybe not. But, as long as you're understanding what it means and how it applies to you and having some impact to your behaviors, you can then look at situations and say okay, I didn't have consent, or there's no equality there. And you know, whatever words you want to use.

Another participant, in discussing the difficulty of getting group members to talk about their own narratives with one another, described a discussion following a video clip watched in group. This participant encouraged the participants to reflect on:

> How it impacts people who care about you. And then, is it just drugs, or is it really just, like, bad decisions? And can anybody relate to this, whether you did drugs or not? You know, and so like I would use things like that to get their attention. And it worked pretty well. Like it would get them talking in a way that they couldn't talk about themselves, but they could talk about someone else, like on this TV show.

Three participants discussed the process of reviewing specific content followed by discussion, despite the element involved. One participant described the following:

> A lot of times we found that the "Intervention" show, bringing that in and having them to watch it and talk about it was very helpful. So a lot of times it was watching "Intervention." A lot of Discovery Channel documentaries. If it wasn't that, it was a lot of

> visuals, these kids needed that. So a lot of pamphlets and stuff specifically covering one drug at a time.

Another participant described discussed one way in which the content of the additional elements included in the groups were chosen based on the discussion that needed to ensue:

> Say for instance if I'm noticing the group is having an issue with boundaries, or the group is having issue with— ongoing issue, because they're adolescent boys— with communication, and being able to verbalize their needs or their wants, for being able to have a conversation with their peer without cursing them out, without being disrespectful. That's an ongoing issue. So we will. We will bring in different activities, whether it can be a scenario, and each kid will get a scenario, and we'll kind of process through that and talk about it. Healthy communication versus unhealthy communication, or the ways that the person in the scenario could have handled themselves a little bit differently. We've done things of that nature.

On the other hand, five of the participants (50% of the sample) described ways in which group process as a naturally occurring phenomenon. Four of those participants (80%) noted that the standard occurrences in residential treatment centers make for good, automatic process material. One participant described the another manifestation of this phenomenon, stating, “We didn't pander. I mean these were generally process sort of groups and a lot like [the experiential component of my graduate school] course. If you sat there in silence, then you sat there in silence, and the discomfort would engender something.” Two participants indicated a belief that good therapists can easily evoke process. For example, one participant described,

> I mean I think with a good therapist, if— not to toot my own horn, but if you're a halfway good therapist some process stuff is going to occur because people are still people. Even with a crappy curriculum, there's still going to be some of that.

Lastly, three participants noted that interpersonal issues occurring in vivo on the residential units often generates process material for psychotherapy groups. One participant described how occurrences in the here-and-now can take precedence over anything planned or contrived:

> So I just try to bring different things, but again, depending on the topic of the day, if somebody is working on their disclosure or if a significant incident has occurred, we might not be focused on an activity today. We need to focus on the issue at hand, and what's going on, and the severity of it. And the activity may be another day. But we definitely do bring different things into the group setting.

Techniques used in facilitating groups. Participants were asked to describe any techniques that they used in facilitating psychotherapy groups to engage the adolescent members. Eight of the ten participants (80% of the sample) described specific therapeutic techniques. One participant described the use of basic therapeutic interventions as follows:

> So I try to you know kind of do a lot of listening. I try to do a lot of validation. I try to be in a place of curiosity rather than knowing. So kind of inquiry, like respectful inquiry. Kind of, you know, demonstrating that I'm curious about their experience and that I don't know what, you know, what their life has been like or what their experience has been like, but that I want to learn. Kind of being curious about their experience.

Another participant, similarly describing basic therapeutic interventions paired with use of self techniques, stated,

> Oh, I mean a lot of the classic just therapy skills. So like empathetic listening, and unconditional positive regard, and highlighting their strengths and empowering them and a lot of positive reinforcement. Not just like candy and stuff, but also like, I was a young female, so they appreciated me being like, you did such a great job. So I could just do a lot of that, you know, to kind of just get their buy in. To wanting— they wanted [me] to like them, they wanted [me] to think that they were doing good, so they would do better if they saw that I was giving the attention in that way.

Two participants described the use of mindfulness techniques in order to engage the residents. Another member described an example of using a "parts work" technique with a group member:

> So this is a girl, this is a really great example, and I don't know how to summarize it, so I'll just explain like what happened. So she was a girl who like snuggled naked with her father into late adolescence, or middle adolescence— way later than is socially acceptable. She also was sort of sold— she was like repeatedly sexually assaulted by a family friend, or an uncle or something. And had a girlfriend, a romantic partner, who sold her out for sort of prostitution. So very very very disturbed young lady. She had fantasies that her therapist would rape her, because in her mind that was an expression of being cared for. There was a group that we did parts work, where the therapist— this therapist was real talented, I mean, she was amazing. And she had the girl identify the parts of herself, had her sort of orchestrate their locations, and then she started working with them, and by the end, she had all the parts holding hands, wrapped around each other. There was— everybody was sobbing in the room. And that was her first experience of love without being hurt.

Other techniques were described as well. One participant each discussed the use of psychodrama, "the Monsters on the Bus" technique, and a sticker rewards chart for reinforcement. Two participants discussed using the empty chairs technique. One participant described another technique in detail:

> Again, the "Anyone Else" exercise, the Agazarian communication exercise, where someone says, well, I, I'm trying, you know [pause] I feel like the sky is black. Anyone else? Someone else says, I hear you, you feel like, you say the sky is black, I think you must mean you're feeling dark, you know, maybe you're feeling dark. And they say yes, that's it, you got it. And then that person looks everybody in the eyes real slowly. And then they say where they'd go off in a hole. They can extend that to somewhere else, really slow down communica— slowing things down is a big part. Sometimes learning how to slow things [pause] learning how and when you can slow things down because feelings are about the slow world. You know, feelings and emotions are about— feelings are about turning aside and getting your feet in, it's a slow world.

Five of the participants (50% of the sample) discussed issues related to adolescent groups in residential treatment centers needing more directive facilitation. Two participants provided an example of starting each group with a check-in or another structured or centering directive. Four participants discussed the need of maintaining a level of agility in order to make nimble changes in group focus, as are frequently necessary. One participant described,

> . . . you've gotta really keep it moving. Really keep it moving fast. And so, dance. And everything from drum for five minutes, or do this. I had little feeling cards, so they'd pantomime their feelings, like angry, sad, and stand up, and other kids'd guess what they're doing.

Two participants noted the need to actively keep topics safe, with one participant stating,

> If a client ever did open up, he could be made fun of. So they would do [pause] if they opened up it would be very minimal and it would be very surface level. And I had a hard time even having them open up in individual therapy. And so they're certainly not gonna open up with a bunch of their peers in the same room. And so that's why I said a lot of times the topics that we kept were also— we tried to keep safe topics, like anger management, recognizing the different— we'd do an anger thermometer a lot and talk about, what are your different levels of anger, and let them kind of volunteer. So it was more of safe topics, but even then, getting them to talk was difficult.

Two participants described how modeling was a useful method in directive facilitation of groups. One participant described,

> You try not to react to everything. You make your mistakes. Admit you make mistakes. You model that kind of behavior to the girls. I might get upset, raise my voice, say the wrong thing. Then I model good behavior. Say I'm sorry, I shouldn't've done that. I don't know what got brought up in me. So you're modeling and you're work— you're helping them model.

Another participant described modeling as providing a corrective experience for residents:

> It's just because of the things that they've gone through and the people they've been around. We have to understand that a lot too, but at the same time, I always saw it as an opportunity to teach them what being an adult looks like. That when I asked them to do something, it's never going to be in a yelling manner. It's never going to be in a degrading manner. But I should— this is what respect looks like from me. And this is what you should look for in other adults from now on, on copying. You know, if someone's yelling

> at you, you're right. That's not respect. You shouldn't be cursed at. But I always saw it as an opportunity, but it needs to be set.

Two participants described the need to have a list of questions and/or activities readily available to divert the focus of the group. One participant described,

> I would often have a list of questions in my pocket, and just pull it out if the group was getting too out of control [pause]. And the kids figure it out after a while, what you're doing. I mean, you just tell them, we need to have something. So you get, that way you come back to each kid getting their mind on something else. Each kid gets a seat really quickly, and you just do something very not-confrontational, something very lightweight. I mean you can do your favorite color today, you've done favorite color before. Your favorite color of this day. This month. What color do you think of? And you go around real quick, you know, everybody, everybody really flash by. It gets everybody involved, everybody distracted from before. So you've gotta really do a dance to keep it to the point.

One participant noted that in deciding the activities or games for each group, it is important to keep consideration for balancing difficult sessions with more fun sessions:

> I did activities, I would try to do like— if I did like a deeper group, like the eulogy topic that required them to write and sit and think and actually put forth effort, then the next group, I would try to do something more fun, like [pause] I would do different games of like— like team building games. You know, that still involved disclosing and social skills and things like that.

Two participants indicated that they maintain a directive facilitation approach by introducing novel activities. One participant described,

> So I was just trying to do anything novel that I could do, you know or getting them to think differently. I remember one time I brought in pretzel sticks and marshmallows, and we just built structures out of pretzel sticks and marshmallows, and it was one of the best groups, even though I thought the idea was so stupid. Like someone told me to do it and I was like I don't want to do that at all. Like I wanted to do what we're doing here. I wanted to be doing that. So to me, pretzel sticks and marshmallows was not me moving in the right direction [*sic*]. But it was actually a super lucrative group, people were really proud of themselves, they got really into it. They were kind of like supporting each other. It was a really cool moment.

One participant noted that they have and would continue to try anything: "So I mean, any and everything went, I feel like. Like I've tried just about anything I could try to get them engaged. And most things worked on some level or for some people."

Six of the participants (60% of the sample) noted the use of different empowerment techniques for the purpose of establishing boundaries and structure. One participant discussed the use of a talking piece in group to organize the group content, while three participants discussed the participation of group members in the creation and development of group guidelines. One participant discussed how creating new roles for group members can help to facilitate process:

> There's always a scapegoat in the group. Where the kids always target that particular peer and always, instead of highlighting some of the positive things that that peer is doing, they're always targeting and pointing out, you're doing this, you're not doing this, you're always in trouble, A, B, C, and D. So you want to try to work with the group with creating a different role for the scapegoat in the group. And again, sometimes the

> scapegoat is actually doing some of the things that the group is saying they're doing, so you still have to hold them accountable for that. But then also providing opportunities publicly, where you are giving the positive feedback or information to the resident that's seen as the scapegoat. So one example, we do have these two young men in my group in particular. And one of them used to be— well he still is kind of a scapegoat. And one of them is a newer member. And they tend to go back and forth, they're constantly bickering, they're constantly— you know, one person decides they're going to avoid group, the other person is going to decide they want to avoid group. That just happened earlier this week. On Wednesday, one of them was— the newer member was struggling, and decided he was going to avoid group, not going to do group, and left group. And the other group member did not respond. And just the group before that, he did. He responded and wanted to do the same thing that young man did. So I publicly, before group wrapped up, said to him, you know Bob I just want to acknowledge that I saw that you did something different today. Typically you would have done the same thing that Chris did, but for whatever reason, you chose to make a better decision, to do something different today. So maybe if you continue to seek positive attention, make positive decisions, then maybe Chris will then follow your lead in that way. And then I just left it there. Wasn't looking for anyone else to comment or whatever, but just wanted to publicly acknowledge that in front of the peers so the peers could start seeing this young man in a different way. Because if not, he's always be the easy target.

Two participants discussed the ways in which sharing any known details of the structure of the group can be helpful with the population. One participant noted that,

> As far as ending groups, a lot of times I would have to let them know ahead of time. I noticed that some of my girls— although I didn't see a lot of autistic diagnosis [*sic*], I did see that transitioning was an issue if they weren't ready. So what I started doing was, the last 10 minutes, I would set an alarm and then they would know that in 10 more minutes it's over. So if we had some girls that had anger management problems, or just attitudes that didn't like the activity at all, they would at least know that it was ending soon. And then for those who were enjoying it and liked the group, and they hate that part when they have to go to another activity because they want to stay with you, they also have that time to know that you have 10 minutes to start going through those feelings and know that you're going to leave soon.

Two of the participants (20% of the sample) described ways in which they encourage sharing between members of the groups. One participant described pushing for group process material to unfold in group:

> You know, so there were definitely days where it was just a long shot and it wasn't going to happen, and you have to like accept that. But I worked really hard to really make the groups be insight oriented for them, have them learn something new about themselves or experience some new emotion, whether it's like that awkward vulnerability of sharing [pause]. And they did pretty well. Since it was residential and they were there for a while, they tended to remember things about one another and be able to do some of what we would want them to do in a process group based on history.

Conversely, one participant noted that despite their propensity towards eliciting process material, other clinicians often do not evoke that level of process work:

> I would be pretty insistent on having kids share, I was really determined to make them be willing to be more vulnerable. A lot of other therapists didn't. So [other therapists would be] kind of just like, do the handout, turn it in. You get your credit for group today.

Five of the ten participants (50% of the sample) discussed how behavior management techniques were particularly helpful in facilitating groups for adolescents in residential treatment centers. Two participants noted that specific classroom management skills translated well to the group setting. Three participants noted that through behavior management techniques, they were able to listen for and subsequently respond to triggered content in order to intervene and de-escalate. Further, one participant specifically discussed de-escalation techniques: "I got very good at deescalating kids, doing things like tossing balls, left hand, right hand, you know, doing different activities. You know, things to— psychomotor things and left-right brain stuff to calm them down." Two participants also discussed specific prevention techniques developed from behavioral management skills. One participant described an example of primary prevention:

> So I really had to know my group of girls and know, not in depth their background— I did for my individual clients. But for the groups, I knew a little bit about their backgrounds. I knew their diagnoses. It helped to talk to their teachers and see how they best learned. And then I would mix that all together to do the best activity I could or come up with the best structure possible. Just for example, one girl, she had an issue with space. So I just always had to know, make sure that I had this chair here on this side. She never knew that I did that on purpose, but I would have her over there, and she was always fine there. If she was put by someone else and I wasn't there that session, there usually was a problem because that person didn't know that she just has an issue with space. And she doesn't know how to communicate that. So little things like that that could

> be huge problems, if you know your group enough, you're able to adapt to it and help them out with little things like that.

Another participant described situations needing more secondary and/or tertiary prevention, as follows:

> So we needed to use a lot of different techniques and be very much aware of when it was the right time to send someone out for a break or separate the groups [pause] try as much as we could to separate the groups. We even had times that we had to decide not to have the groups, at that time, because of whatever was going on on the unit. So a little bit of everything.

Trauma-informed care. Participants were asked about the ways in which trauma-informed care is integrated into their groups, if at all. Six of the participants (60% of the sample) described ways in which trauma-informed care is broadly implemented across the residential treatment center system. Four participants discussed education being provided to non-clinical staff in addition to the knowledge of clinical staff. One participant noted,

> Definitely trauma-informed care was something that we talked a lot with the staff about, definitely as far as the things that they said or what they did to the boys. Because the staff would sometimes try to goof around with the boys and come up behind them and scare them and we always tried to educate that you don't do that. And also I saw a lot of, obviously a lot of anger reactions, that would come from them being abused back home.

Another participant described the ways in which trauma-informed care implemented within the system allows for corrective experiences within the group setting:

> When you have the circles, the circle of harm— right, so when something has happened, when somebody does something to somebody else, you will have the perpetrator and the

> victim in the same circle. So I think I have kind of mixed feelings about that, regarding the experience of trauma and what that can represent for the kids. But basically what you try to do is you try to engage the conversation between the two of them about the harm that was done and how can a healthy relationship be restored.

Two participants noted that trauma-informed care implemented across the setting allows for open discussion among staff and residents alike about both the experiences of trauma for the residents and the reactions that may result from those experiences. One participant described the interactions as follows:

> . . . either the kid would tell them their complete background, or the staff would already know about it from like the supervisor. So that conversation was already open, where the therapist is like, you know that this happened to this girl, let's treat it tentatively and remove them because of this. And because the staff already knows now, it's the therapist's job to educate the staff on how— any questions they may have because they're not a therapeutic mind. So they tend to have their own questions. And then tips for them. So trauma-informed actually becomes a little bit bigger in that situation because you're educating the staff on how to understand it and use [pause] not necessarily use techniques, because that was the therapist. But to better understand it so they can better approach the child and understand them better and treat them with a little bit more sensitivity than they would another child who was just acting out for no reason.

Seven of the participants (70% of the sample) described the clinician as trauma-informed. Three of those participants described the perspective that clinicians always keep trauma in mind in their work with the adolescents in residential treatment centers, while two participants noted that clinicians engage and conceptualize with an assumption that the presenting concerns of the

adolescent is related to trauma. Two participants indicated that clinicians maintain boundaries and attend to issues of personal space due to their being trauma-informed. One participant described,

> We had to do a lot of stuff about— help making sure that the participants were like giving each other personal space, because right away we ran into an issue like the first— the very first session I ran with any of the groups, one of the girls touch another girl's leg with her foot, and it turned into a fight, and one of them had to be hospitalized. So that was the level that we were operating at in terms of being able to maintain personal boundaries.

Four participants noted that a major task for trauma-informed clinicians was balancing exposure with tolerance. One participant described an activity demonstrating this idea:

> I have a rhythm stick thing that I developed where I take two pieces of plastic about a foot long and I wrap them in plastic tape and I do this [pause; creates rhythm with hands, repeats twice], where the other kids [pause] where the kids are doing it with me [continues rhythm]. And that rhythm [pause] is calming [stops rhythm]. I often— really traumatized kids are not gonna look you in the face when you do that. That's just too much. But eventually, once they get that rhythm going, and I say let's just, let's see if you can look at me once in a while. They'll look at me, and they'll break the rhythm. And then they'll get through that, they learn to do that, the next thing we actually do all this and look at each other and talk. And then if you start talking about something that's really emotional, they might break the rhythm. And I'm always like, it's okay. It's okay to mess up. It doesn't hurt to mess up once in a while, we can start again. That's— that whole thing summarizes a lot of what I did in groups, when things get out of control, say, it's

> okay. We wouldn't be, you wouldn't be here, we wouldn't all be here if there weren't some things we need to work through, if we didn't expect some mistakes.

Another participant described the difficulty of maintaining that balance:

> We tried not to like raise the intensity level too high, because there was never any telling of if we would be able to bring them back down before ending the groups. So that would be something we always had to be really careful about. Keeping it fairly low with the expectation that it was going to get high anyway.

Four participants discussed the awareness of the clinicians of the hyper-sensitivity of the residents to unknown as related to their experiences with trauma. One participant described how they addressed this with the clients through teaching empathy towards others:

> But every single person in the program that I ever touched definitely had one or two groups where we learned about empathy and practiced it through some role playing or through some like, understanding what it's like to not really know what it's like to walk in someone's shoes, but to try and think about it and consider it and then behave accordingly. Like respond accordingly to these people. So, I did a lot of redirecting of insensitive remarks or assumptions people were making about someone's life based on how they talked about what their life was like.

Six of the participants (60% of the sample) noted that trauma-informed care was specifically integrated in the work done in psychotherapy groups. Five participants described psycho-education about trauma being discussed and processed in the group space. One participant described,

> We would get into psycho-education about what trauma is. Then I would talk about triggers of trauma and certain behaviors are maladaptive that you, you know, to cope with

> the trauma. And then try to give them the skills that— to deal with their trauma in a positive way. And most of the time I felt that it was the first time that they really knew what trauma really was. And it was really the first time that they were able to talk about it.

Four participants indicated that client experiences of trauma were also processed in the group space. Two participants described experiential demonstrations of the effects of trauma occurring in group. One participant noted,

> We weren't making them disclose, but sometimes they would willingly disclose to their group some of their traumatic history and how it affected them. And then there were times when the topics were heavy and the— obviously the clients who had experienced trauma, even though it wasn't directed at them, they were affected by the topic. And sometimes we would have to pull their therapist, call their therapist. They would have to meet separately with their therapist individually, or be allowed to step out of the group and, you know talk individually with their therapist, and make a choice to come back [pause] go back to the group or stay out of it.

Three participants discussed trauma-focused groups occurring as well. One participant said,

> Like I said, one of our subgroups we do have is a trauma survivors group. At first start that was for those guys that had experienced sexual victimization. But then we started— quite a few guys who may not have been sexually victimized, they may have been physically abused, or a lot of neglect and things like that, so we fold that into [pause] in what they were doing. That's like a 6 to 8 week group cycle. And outside of that, it was in the summer time, probably. I want to say, the next two weeks— I'm looking at my board. The next two weeks, we have a series of groups that all of our guys will go through. So

> regardless of your treatment history or your background, at least for one day, all of our guys at some point in time, will have gotten some type of trauma survivors group work done before the summer is over.

Two participants specifically discussed the ways in which being trauma-informed contributed to the considerations of the clinicians of the physical space in which group was held. One participant described the following considerations:

> (For) the girls group, keeping it girls group in itself probably was helpful in terms of many of their trauma experiences. That it was held in a safe area in the unit where they all lived and slept. That there were no men in the area. And no one could intrude in that space during that time. And you weren't allowed to come into that area unless you were in the group. So we did make efforts to maintain that boundary, with some success. The LGBT group, we did not identify to the larger campus who was in the group. We held it in a room where no one could see who was in the room. That we made sure there was a male leader and a female leader.

Influence of client relationships outside of group. Participants described the ways in which client relationships with each other outside of group affected the structure of psychotherapy groups. Two participants (20% of the sample) indicated that client relationships had no impact on structure of groups, with one stating, “It didn't. And the idea there had been, look, this is who you live with, and they'll be in your group, and we'll just have to deal with it in group.” Conversely, seven of the participants (70% of the sample) described the relationships of clients outside of group as having a significant impact. Four participants noted that the phenomenon of clients being with each other all the time was very impactful. One participant this phenomenon:

> You were only in group with your cottage. And your cottage is who you lived with. So they all kind of knew each other anyway because they'd lived in the same building. They went to meals together. They went in two straight lines together to the school every morning, and back, and even if they had different classes to go to. So like they were all together as their own little cottage community. And so the group was half of that cottage.

Another participant added to this perspective, noting,

> It's hard because like I said they're always together. So they have a lot more data on one another than we even have. Because they know what goes on at night in their rooms. They know what like schemes they're involved in, plotting and hiding little pieces of pencil to make a tattoo gun in two years when we have enough of it. They know all of that stuff that we don't necessarily always know about. So we could pick up— but it definitely affected it.

Two participants described the relationships between the group clinicians and the clients as the one relationship that was inherently unique to the group setting. One participant noted how this relationship is different than group process work in other settings:

> So it didn’t have the same sanctity that [the traditional interpersonal process group] has, where its like the only way these people know each other and the only way they spend time together is with me. So I have all the data points. Or I should, right, mostly. Can’t control everything, but mostly I feel like in the groups here we can kind of count on that. That was not the case at all in these groups. So it affected it a lot, basically, in lots of ways.

Three participants noted that because of the significance of client relationships with each other outside of group, psycho-education was easier to facilitate with adolescents in residential treatment centers than group process. One stated,

> So it was very hard. Which is why psycho-education was easiest, right, because that is more individual. I'm giving it to you, you take it and do what you want with it. Whereas interpersonal process requires a certain level of cohesion amongst the group dynamic for it to happen well.

Another participant noted that the significant impact of client relationships outside of group can affect buy-in to process groups:

> And that's why at least in our facility, process group is the dreaded group. Like if process group is cancelled, most psychologists are happy because it is so difficult to run that group when you don't have respect or peace. So it's just an hour of trying to get through it, because the girls don't want to be there, they don't want to talk, they are tired of each other, and there's a hidden attitude of, if you obey and follow the activity or talk about the topic, then you're weak and you're trying to suck up to the therapist, and that's looked down upon.

Four of the participants (40% of the sample) described ways in which client relationships with each other outside of group can have a positive impact on the group structure. Two participants noted that client relationships increase mutual accountability among them both inside and outside of group. One participant described the ways in which clients were encouraged to account for one another based on their relationships outside of group:

> So they do form some bonds— I'm not going to say all of them are really friendships. Some of them are actually genuinely friendships, some of them are acquaintances, some

> are more (of), we're just in the same place at the same time so let's just get along. So you will see some of that manifest itself in the group if you have a cohort or two or three guys who do a lot of things together. So they're in clinical group together, they're in cottage together, they're on the basketball team together. They tend to kind of, I guess work together or operate together, you know, if you're doing this then I'm doing that. What I try to do is I had two guys who were pretty— I think genuinely they were friends and they were on the basketball team, they both liked to dance. They both had common interests. So they were in a lot of different things together— I think they were in the band together. So a lot of different things that they had in common. And, like I said, I genuinely think they were developing a friendship. So I was challenging them, if one person was struggling or one person was off task, you know I was able— it's interesting because you pride yourself on, this is my boy and this is [pause] we do this or this is my friend and I want to make sure that they're doing what they're supposed to be doing. Well then you also need to be holding them accountable. So to sit by and to idly watch them self-destruct, that's not true friendship. That's not true genuine healthy and appropriate connection, you should be the first person to pull their coat tail and to say, no what you're doing is inappropriate. What you're doing is wrong. So I try to do it that.

Two participants discussed the group space as presenting structured opportunities to teach the residents how to disagree or problem solve, such as when they did not inherently have positive relationships with one another outside of group. One participant described the following:

> Because the topics discussed, you're teaching them how to discuss these things in a healthy mature manner. So even if they don't like what each other's saying, or get upset with how each other— disagree, in the process, you're supposed to as a (clinician), teach

> them how to properly disagree. Teach them how to be angry, and they can be angry, but they have to show it better. And they have to be able to learn how to be angry in a way that society approves of. Not throwing things. But just being angry. So in that bubble, I think it's completely up to a [clinician] that can really own the room— but not in a power struggle control way, but in a, the clients feel safe way. And once they have that atmosphere of safety with you, then they're able to get to that point where a lot of deep conversations happen. And again, whether or not they're agreeing with each other or they feel upset with each other, they feel more relieved when they leave.

Six of the participants (60% of the sample) described different ways in which the relationships between clients outside of group can have a negative impact on the structure of the groups. Two participants noted that their developing toxic relationships could result in changes in group membership. One participant described,

> I think it had more of an impact on the dynamic than anything that we did have control over. Because it's like yeah, they live together. So it's like being in a group with your siblings. You're with each other 24 hours a day. So yeah a lot of impacts. There were times that I would request a team change because of a dynamic with a student, or with a client. But typically it wasn't solely based on group, because it would've been happening all the time. If it was solely about group, I would've been— I don't even know. I would have probably never would have won even, I would've constantly been moving people around and been dissatisfied with the makeup. Because again you're working with mandated clients, so on some level they're all resistant in their own way. But there were times that because of a dynamic that was more— that was really interfering with therapy, like these two people are like arch enemies and they both used to participate fine in group

> and now I have one sitting in the corner cursing about the other one the whole time I'm trying to do group with the other one, but I can't put him in a room by himself, because it's a facility, they all need to be within view of a staff member. And I can't count on a staff member to do it because they're all talking about how they got drunk this weekend in the corner. So there were times when I just was like, no. This can't happen. Like this person needs to be on B team. He can't be here. It's getting completely in the way. I can't run group.

Five participants discussed the ways in which the roles and relationships that clients developed outside of group caused trouble. One participant described how good relationships could have a negative outcome:

> The other side of it was— because I just discussed conflict; but sometimes the clients were so close and they were such good friends, and they were friends, like they said, on the outs. So if they were friends outside, meaning in the community, when they came here, and they both would come in to the same unit, they would come in around the same time, and they would be causing trouble because they were so close.

One participant discussed the affect of different client roles developed outside of group on the ways in which clients showed up in group:

> It definitely affected it because there would always be the one alpha male in the team. So our cottages had two teams, and they shared a hallway. And you could definitely tell there was the alpha male, there was the cool guy, there was the goof ball [pause]. And typically the boys would try, they would do whatever the alpha male, like the leader would do. So if the leader was goofing off, they would not— you lost them all. And they would try to form like their own little gangs, their own little cliques too, which we had to

> try to be aware of. [Air quotes motion with fingers] *Try* to be aware of. So yeah, you always had to try to watch, even outside of group, what are the dynamics, and what's going on, and who's kind of the one in charge now.

Another participants described the following:

> So it really just depends on who was the leader of the pack at that time, and there usually was like one or two. Or sometimes they would kind of split and there would be a leader of this pack and a leader of that pack within the same group. I hate to make it sound like gang like, but I feel like it kind of is in some ways, not literally. Sometimes it really was literally about gangs, that's another thing. Another element. Another layer entirely. But yeah, it always impacted it.

Two participants described the ways in which conflicts occurring between members outside of group could become the focus of the group process. One participant described anger escalating to aggression in the group space:

> Because they were living together, if they had a bad week, the group had a bad week. If the unit had a bad week or two of the members had a fight, sometimes they would just not come to group or they would come to group sniping about each other. Or they would come to group and use that as a setting to get into a fight— and that stuff became process. So sometimes, something that started out as psycho-education would become more process oriented because they were bringing in a conflict from outside of group that had to be dealt with because it was right in front of us. But I would say that was major. It definitely reflected in who was participating from week to week.

Similarly, another participant described dealing with aggression and conflict in group:

> Sometimes it caused a problem because if they were— depending on what it was right, because if they had gotten in an argument or something before the group— Because they were even in school together, there was school on the unit, they were in classes. If there had been a problem during the lesson on that day or an interpersonal conflict, sometimes they would of course bring their conflict into the group. Sometimes we would deal with it as, okay let's talk about it as a group, let's discuss how it's affecting everyone on the unit. You know, using that style. However, sometimes it was more like aggression, and that had to be dealt with in a different way. And there times in which the two people who were kind of conflicting with each other had to be removed from the group, but the rest of the group had to process what was going on.

Six of the participants (60% of the sample) described group work as unpredictable, specifically as a result of client relationships with each other outside of group. Three of those participants noted that the ever-changing attitudes that clients have towards one another contributed to the inability to predict what the atmosphere and/or cohesion would be like among members from group session to group session. One participant stated,

> So it depended [pause] they had some good weeks and they had some bad weeks. And when they were having a bad week, it derailed an entire session. And when they were having a good week, it seemed to go really well, and they learned to communicate really well. And it just contributed to a lot of inconsistency, and it made some other kids worry about coming to the group if they didn't want to be close to another particular member.

Four participants further described the variability in the group atmosphere, noting that tension was often observable among members. One participant described their observations as follows:

> And so a lot of it would just come into the group and you could just see it. And the dynamics of the group would change. And sometimes we would have to have an entire group just on that, you know on just even noticing what was going on and happening on the unit.

Another participant described situations that would arise with the tensions continued to rise to the point of the groups becoming out of control:

> And there were times in which the entire unit was really out of control. And then it would be different. At times our supervisors would have to come in and talk to each group and find out what was going on, because it was way out of hand. And sometimes that happened if there was an elopement, like if somebody ran away, or attempted or there were a few attempts [pause] you know, when there was an extreme situation, the whole unit would get really riled up.

Three participants described that group member relationships could become the topic or focus of group, and especially when combative or conflictual, could take priority in the group space. One participant described,

> Like I'd have this great group planned and some scuffle with some of the boys or some issue with the direct care staff right then when I was going to do group, so I had no one else there with them and a problem would come up [pause] I mean it was just endless, the number of things that came up that impacted the ability to peacefully do group.

Two participants noted that group facilitators were unable to rely on the cohesion developed to remain consistent. One participant stated,

> I will say there were times where we, just had this one team that maybe with the exception with one or two who weren't completely ostracized, but were kind of neutral

> sources of the group. Like didn't really mess with it. There was a cohesive bunch that had been together many months and they had a lot in common and they'd grown close. And I could get a lot of work done, but it was all like very variable, I couldn't count on it.

Three of the ten participants (30% of the sample) noted that because of client relationships outside of group, the structure of the work done in group was often targeting generalization, describing issues related to the interpersonal work done in group being carried out of group. Each of these participants noted that group work can positively affect ongoing interactions. One participant stated,

> I think that [group work] improves their relationships outside when they leave, but if they have any issues or they have any cliques that they've developed at school or in the cafeteria, or just in their rooms together, they can bring that into process and improve that or maybe discuss it, maybe if I have a group with a bunch of different girls from a bunch of different cliques, at least in process group they can be at peace with one another. And it'd be nice for them to keep that peace, and come out of the group and not have to be in cliques. But at least if they go back to their cliques, they will respect the girls at least in their group.

One participant also briefly mentioned that issues or conflicts between members that result from their relationships outside of group are sometimes resolved by session end, due to the interpersonal process work done in the group space.

Impact of changes in group membership. Participants described the ways in which changes in group membership impacted the groups. Seven of the ten participants (70% of the sample) noted some ways in which group changes created different dynamics in the groups. Five

participants noted that as the members of the groups change, the groups are inherently changing as well. One participant described,

> Of course the kids who came in and were quiet and just minded their business, unless they were getting bullied, of course it usually was not a problem. And I'm not going to say there wasn't bullying because [pause]. You know, because fortunately the staff and the therapists and everybody was always monitoring. So yeah, they (the groups) would change less if they (the new members) were quiet. But they would still change somewhat.

One participants indicated that changes in group membership could potentially improve group functioning:

> I can just recall several group members where they (the dominant member) did something or they said jump and all the guys would jump. So obviously, when that person left, the dynamics changed greatly. Or you would have the guy that would rap in the corner and not care whether or not you said to stop [pause]. Drum, beat box, whatever. And not care at all that it was group. So that made it very destructive. And then when he left, the group dynamics would change to where they would be at least more attentive, or pretend to be more attentive. But yeah, you would occasionally have the guy that just did not care about therapy and did not care to participate no matter what the consequences, so . . . (statement discontinued).

Two participants noted that changes in group membership were helpful for clients to learn to adjust and to coexist. One participant described using incidents of change in group membership to reinforce such concepts:

> They're all in that group for a reason. So I try to continue to allow them to understand, you're all in the group for a reason. Nobody's better than anyone else. Some of you may

> have charges, some of you may be on [the state sex offender's registry], some of you may have never seen a judge a day in your life. Maybe you've never been on probation, some of them may have been contact offenses, some of you may have not been. However, you're all here for a reason, because some of your behaviors were inappropriate. So you need to work together as a group on empowering each other and figuring out how to work through this, as opposed to being judgmental and looking down on each other— and I'm very clear with them. At the end of the day I really don't care if you like each other. [Laughs] You don't have to.

One participant described that the difficulties that clients face in adjusting to changes result from their lack of exposure to different people and/or settings prior to their admission in residential treatment centers:

> We take guys from all over [the state], all different neighborhoods, all different walks of life, all different backgrounds. So for some, they've never been exposed to people unlike them. So you know being able to not only work on my treatment issues, but adjust and figure out how to live in this world, at [the residential treatment center] for instance, live in this world with people that are not like me. So they're learning and developing in that aspect too.

Nine of the participants (90% of the sample) discussed issues related to adolescents in residential treatment centers struggling with change. Four of those participants noted that regression is often observed in groups when there are changes in group membership. One participant described regression presenting as a discontinuation or halting in the group progress with the introduction of new members.

> They almost had to prove themselves all over again, whenever a new person came in. So typically when we would get a new girl, they are angry and scared, but they wouldn't share that of course. A lot of it was just shut down and a lot of attitude. So when they're in their first group, they have to show that they're the bigger person and create a scene. Typically the other girls will kind of stay silent and see what this girl's about. So they could be interruptive, a lot of times.

Two participants described issues of resistance of veteran members to changes in group membership due to their perception that their treatment progress would be interrupted. One participant descried,

> The team would grow and mature and really learn how to process, and learn how to work really really well. And then some students would graduate, and then we'd get new people who didn't really know how to do group, and that'd introduce this element of lack of safety and frustration. Because those girls who had gone through it, they had gone through that process, and they really did not want to feel like returning to an earlier phase in their treatment, but they kind of had to.

Another participant described the ways in which member resistance to changes in group membership would manifest in group:

> Some would occupy the group, some would be sleeping, some would dominate, some would make side comments about somebody else, and sometimes they would even use projection, where one of the group members is really talking about themselves and how they were angry at themselves, would use another person as the object.

Three participants noted that changes in group membership made group process more difficult to facilitate. One participant described,

> I never got to go through any typical, like forming, norming, storming. Like I never got to follow that, sequentially because of the nature of all their lengths of stay being different. On any given month, there was probably one person, at least, leaving. Which meant there would be one person coming. And sometimes there were several. Sometimes there were three people being released this month, and three new people would be coming in.

Five participants noted that the established group dynamic and group cohesion was interrupted by any changes in group membership, and two participants noted that this phenomenon was not much different from more classic interpersonal process groups. Two participants discussed that changes in group membership could result in the instability and/or dissolution of specific groups in residential treatment centers. One participant stated, "Well in the LGBT group it was very clearly— it demised because of changes in the group membership. And then the girls groups, it varied in its ability to function depending on which girls showed up." Another participant, having a similar experience, stated,

> When a couple of the main kids stopped attending, the other kids didn't want to do it anymore. So that was that. But you know that LGBT rose out of a need, not because it was a part of the program or of our program of our residents. That rose out of a need that we saw. So when we saw that people were not attending anymore, it just kind of dissipated. We didn't force it. We just convened with them one time and we said you know we don't need to continue this. Like this was made for you guys by you guys, you wanted it. But if you don't want it anymore that's okay too. So that was that.

Addressing member absences. Participants described the ways in which absences from group by group members were addressed. Five participants (50% of the sample) indicated that there were few absences from group by group members. Four participants noted that the clients

had little room to refuse to attend group. Also, four participants described that group therapy is a required component of the treatment for adolescents in residential treatment centers. One described the importance of the participation of the residents in group as a means of assessing their functioning:

> Dealing with your sexually inappropriate behaviors is uncomfortable. And it's something that some of them try to avoid. So I'm not in the business of, they don't come to group then you're on punishment or anything. No, the group process, the group work happens in the group. So I can't make certain decisions about your safety, about your risk level. If you're not in group for me to assess these things, then I can't make these decisions, so we're at a stand still.

Three participants described the consequence of residents not attending group being the loss of privileges and other program-level consequences. One participant noted,

> So in the group, there's certain things you have to do, so a lot of them look forward to getting their safety plan so they can access trips with the cottage or access home passes if that's an option for them. But, again, I can't make certain decisions for you or against you if you're not giving me anything to work with. So I come to work every day, I'm not going anywhere, you're not going anywhere, we have nothing but time. So whenever you feel that you are able to get it together for us to work through this, then we will be— but it's not going anywhere. And because treatment is first, if you're neglecting your treatment obligations, everything else is secondary. So all the other things you may want to do, you may not have access to or the ability to because you're not taking care of your first priority. And again, some guys struggle with that because they don't want to be here in the first place, they think they don't need to be here [pause] or you know, my mom sent

> me here, or the judge sent me here, or I'll just do my time in [the local juvenile detention center]. You know, you hear all of those things. So it's somewhat of an adjustment to accept the fact that this is my reality.

Another participant described the ways in which the lack of group attendance for the residents could negatively impact their privileges gained through a point system or token economy:

> The structure of the program kind of caused them to have to do group. If they didn't they would get zeroes on their point card. Like I would just zero their point card out. Like for participation and cooperation they would get a zero. For respect they would also get a zero, because always I'd be like come on let's do group, so they would be disrespectful by not abiding. So I would like— you know, it would affect their point system which then affects other larger scale perks. Getting to go to the point store and get snacks, or whatever. Getting to go on field trips, getting to participate in other activities, special events, parties for a holiday. All sorts of things.

One participant discussed the ways in which the program consequences for not attending group could negatively influence the ability for clients to advance through the level system and/or delay discharge:

> So, it's not like if they missed one they'd be like you're not making progress, because they might've been like in a place where they were never doing group. So them missing one could be like a huge step in the right direction for them that month. So the behavior system as well as the, just the progression, the level system to progress out of the program. To be able to leave by a certain date, you knew that you had to make it through the levels by that date. And if you missed leveling up at one staffing, you might be there a

> whole additional month because you won't be on level four in time for your discharge date. So it could have greater ramifications in some cases than in others.

Eight of the participants (80% of the sample) described group absences as often having identifiable reasons or justifications. Two participants noted that client refusal to attend group occurred only on occasion. Conversely, participants particularly described two excusable categories for client absences from group. Five participants described scheduling conflicts as a common reason for clients to be absent from group. One participant noted,

> A lot of the absences were created by the residence itself, so that was unfortunate. They would have nurse's appointments or doctor's appointments, or they'd be taken on a trip off campus and the whole unit would be gone. There were days that I would show up to the unit to run group and the entire unit would be empty. They'd gone on a field trip. So not great. Not a great situation.

As described by another participant,

> Usually, there was a clear reason why. Like if they had a parent visit. The kids that usually would attend regularly, if there was a reason why they weren't going to be there, that was definitely a systemic reason, not a personal reason. Not like they chose not to come that week sort of thing, it was almost always that it was scheduled at the same time as their parent visit or it was scheduled at the same time as their [child services] worker coming, or something like that.

Five participants also noted that illness, crisis, or hospitalization could be a reason for absence from group.

Seven of the ten participants (70% of the sample) described issues related to the present group members acknowledging member absences in group. Two participants stated that clients

would ask about missing members if they didn't already know their whereabouts. One participant described the interactions among the group when a member entered the group late, without their prior awareness:

> When they come in the room, one of the first things their peers are going to ask them, where you been? And why are you late? And if it's something that transpired at school, well I had detention. Well why'd you have detention? Oh because I got into a fight. Well why you get into a fight? So, you know, they'll have those— they have to be held accountable to their peers.

Two participants discussed the groups processing the absences of members in the group space. One participant described,

> So basically what happens is with that model of the circle, you kind of talk about it. Somebody brings it up, you know, where is So-and-So, and you know [pause]. And they talk about how they feel, how unfair it is, because they're not there, and you know they don't want to be there either, so why do they have to be there if the other person is not there. So basically they talk about how they feel. How unfair it is that they have to be there.

One participant noted that when a missing member was unaccounted for from the perspective of the group facilitator, the clients sometimes hint at issues having taken place on the unit:

> There might be some glances around, you know, it might be because somebody's dating someone, and somebody broke up with someone, they don't want to be in the same group. You know, the girls always doing [air quotes motion with fingers] dating— and I put that dating word in quotes. It means, it means somehow they, they're in some kind of relationship. The girls were often in a relationship. They may not touch each other, they

> may not, whatever, but it was just kind of a way [pause] complicated things. So there was a lot of that kind of thing going on, a lot of drama.

Three participants discussed ruptures occurring in the group process due to or as a result of member absences. One participant described a rupture occurring when a group member left group abruptly: “Sometimes, somebody would just leave halfway through group because they had trouble staying there, and that would create a real like rupture. A sense of lack of safety [pause]. Yeah, it was quite abrupt and rupturing I would say.” Another member described a difficulty in maintaining group boundaries, and as a result, consistent group attendance, due to different ruptures:

> I would say . . . the first girls group lasted about three or four months. The second girls group did not last as long, it lasted for about two then it petered out, because they didn't want to go anymore and people were— some of the people were starting to be discharged, and the ones who weren't discharged were being sent to the hospital, and there was just [pause] it just became a hopeless endeavor, so we said this is over. The LGBT group, I would say it also kind of lasted about two months maybe. And we weren't particularly able to have that one every week because there were so few residents involved. So if they all weren't planning to be there, we didn't have a group. So if one of them had a doctor’s appointment and one of them didn't want to go, there was no group that week. So it lasted for about two weeks and that really disbanded because the residents were no longer there. Two out of the four were no longer residents, and the other two [pause] you know, it just didn’t make sense anymore.

Eight of the participants (80% of the sample) indicated that there was, at least sometimes, no need to address member absences from group in the group space. Three participants noted

that as a general rule within the residential treatment centers in which they worked, groups did not talk about missing members, despite the reason. One participant described,

> So as far as the runaways, we weren't allowed to discuss it in process group. If someone was restrained they (the other residents) somewhat knew, whether they were there to hear it or the gossip ran through and they were able to hear it from their peers. But again, it's not something that we covered in process group.

Four participants noted that missing members were not discussed in group because the residents already knew the rationale for their absence. One participant noted that the reactions of the present group members to absences varied:

> . . . it wasn't like a classic interpersonal process group where it's like how do you feel that this person is not making group a priority and hasn't been here, and all these dialogues and narratives that we're talking about. It wasn't that because that's not what it was. So sometimes it created more opposition, like a ripple effect. Like, if he doesn't have to do group, I'm not doing group, fuck group. You know . . . other times it would be like they would be really good in group because they were trying to do the whole like, look how great we are while you're being a jerk. So it varied.

Four participants described that there were no within-group consequences for member absences, and as such, absences were not an issue to be dealt with in group. And one participant noted that member absences were not discussed due to issues of client privacy:

> The main thing that supervisors would explain was like, there's no reason to (discuss absences), don't give attention to it, continue as normal; we don't want them to think they're going to be a topic of discussion when they leave or if something happened to

them and their restrained, just out of the privacy of the client, don't talk about it. So a lot of times it was not addressed.

Members leaving group. Participants described issues related specifically to established or veteran members leaving group, such as at discharge. Five participants (50% of the sample) discussed issues related to the last group for the departing members, during which other members were able to say goodbye. Two participants described there being an opportunity for members to provide feedback to the departing member in the goodbye group. One participant described the process as follows:

> Well when they're getting ready to leave or to transition out, we talk to the guys about what do you think you've learned? Do you think you're ready? Are you nervous, are you anxious? Which is actually okay. I want them actually to say, yes I am nervous, yes I am anxious. Because for a lot of our guys, they've been here 14 to 16 months. And if they're going back— especially if they're going back into the same home environments in which they left where they displayed these behaviors in the first place, you know it does create some anxiety and some nervousness, which is fine. Which is completely normal. So they— we try to get them to talk about that. And also have the guys also go around, those that are willing, and give them feedback about you know, Johnny I'm proud of you. Make sure you stay out of trouble, don't make the same decisions. And if there's something that a particular resident was struggling with, they may say, learn to keep your mouth shut when somebody is talking to you. Try to listen as opposed to trying to have the last word. So we try to have them give that particular person feedback on their way out of the door as well.

Another participant described the departing member receiving feedback from group members as well as from others involved throughout their time in the residential treatment center, through the use of a specific technique:

> Something that some kids would opt for at the end of treatment is a Johari's Window—which I don't know if you know what Johari's Windows are. It's sort of like 360 feedback, where you put all of these questions out, and this like list of all these questions, and you hand those questions to various individuals in your social contexts, so that you get feedback from your teacher, your therapist, your intern. Your peer. From all these elements of your social world. To see how they see you. So and I think that that is a valuable element of group therapy, is learning the effect that you have on others.

One participant described the ways in which a veteran member's discharge was particularly hard on the clients remaining in the residential treatment center:

> We would also have a group when someone was leaving, I think that really affected people, especially if they had to stay in the program. Or maybe if they were supposed to leave and they did something behaviorally, and now they couldn't leave the program, because they felt it would be beneficial to stay in the program longer. So all the things like that definitely played out in the group and affected the participants.

Finally, one participant described the ways in which the departing member may have had a significant impact on the remainder of the group, and thus represents a significant loss:

> So it might've been like a member that was there for six, seven, eight months that really valued like being real and keeping it 100 and would like have this whole theme going of this is how you be cool in this group. This is how you are considered cool in this space, because this is the coolest one here and he's been here a long time and he's cool with all

> the staff and he's cool with all the therapists. Like whatever. So when that person was discharged from the program, it would create a shift, naturally.

Adding new residents to groups. Participants also described the process of adding new residents to the psychotherapy groups, including at what point beyond admission they were added and any processes that occurred during their transition into the group process. All ten of the participants (100% of the sample) described the new residents receiving some level of clearance after admission and/or intake. Eight participants noted that new residents were added to groups right away. One participant the inclusion of new residents in group,

> Right away. Depending on what time they were in— like their intake was completed once they got in, which wasn't a biopsychosocial, it was actually an intake where they were signing forms to be intaked [*sic*] into the program. And like their head was shaved and they got a shower and they got their uniform [pause]. Yeah, like little tiny boys with shaved heads. Because they can have paraphernalia in their hair. So their heads were shaved. Which was also kind of like dehumanizing I think, but [pause]. Yeah. So once all of that was done, if it was in time for group— like if they were going to be on B team and B team hadn't started group yet, they'd be in group that very day. Minutes after getting their intake done.

Five participants described that new residents were added to already existing groups. Four participants discussed an introduction process occurring in the first group for new residents, during which veteran members often welcomed new members and/or modeled group processes. One participant described,

> Sometimes we called it a welcome group, because sometimes it took up half, a good half of the session. Because everybody had a turn to welcome them, we used to also

incorporate it into our group session, whereas— re-address the rules or re-address the unit rules. So oftentimes when someone new came in it was a good opportunity to refresh everyone's memory of what happens. And by each client reminding the new person, they were also remembering themselves or talking about past experience, like don't try to run away, or don't try— make sure you eat all your food on Wednesdays, because that's all you're gonna get. I don't know, they'd bring up silly things and they'd also bring up serious things. But the best part of it was it was sort of a review of and a way to welcome the new person. And we also gave the opportunity for the new person to introduce themselves and tell the group where they were from if they wanted to share. A lot of times if the group had already shared why they were there— which sometimes they wanted to share, like I'm here because of this, or I'm here because or probation, or I'm here because of whatever reason, then the new person would already understand that that is how open we were in the group. So it automatically led to them opening up and understanding that it was an open group and we would be discussing all these things, and it was fine. So they would also say why they were there or disclose some personal information. Usually the person felt welcomed. It was a time where some people kind of gave the— it was sad sometimes because some of the kids gave them the once over. But then you'd also find out who knew who from the outside because, they'd say— [laughs] I'm like remembering faces as we're talking [pause] one of them would say, welcome to the group, this is what we do, and I know you from the outside. So now everybody knew that the two kids knew each other, you know. Then they'd have a giggle, and then they'd move on.

Three participants noted new members being added to groups after a wait period. One participant stated,

> This is again program policy— they were not immediately— I think they have to [pause] I think it's two weeks. I think they have to stay isolated from everyone for two weeks. So they're not allowed to enter into any groups for the first two weeks that they come in. I can't remember— oh because they're a flight risk. So they have to prove that they can be trusted. And it also gives them an opportunity to calm down and get acquainted to seeing that, look like it's not that bad in here, nobody is getting beat up, nobody is like yelling every hour, no one's throwing bats. And just get used to the feeling inside of the building, of just going through the motions. When to shower, when to eat, they're not even allowed to go to school, they have to, their teacher comes onto the unit. So they really spend those two weeks on the unit. And they don't go to groups. So they have individual therapy and family therapy if their family is involved. After the two weeks, then they join group. And by then, they still can be the type that interrupts, but usually they're not because they had that time to calm down.

Another participant described that new members would most often be added to groups immediately, but that there were also occasions when they were unable to attend on their first day:

> Usually it would be. Unless they were acting out or needed a day or two to kind of get acclimated. We had groups twice a week, so if they didn't participate on Tuesday, they would participate on Thursday, if not then the next following week.

One participant described other exceptions that resulted in new residents not being added to group immediately:

> We've had some clients who were in a detox mode. So they'd come in and they had to— they were really out of sorts, so they were, I don't know. We had one kid who tried to pretend he was delusional. So he came to the first group, but he didn't come to the second group because he was acting out. Not necessarily aggressive, but we found out later that it was a front. It wasn't a real situation, but they did need to keep him under watch, so they had to remove him from the group. So we had that situation, when we had kids who were detoxing so they needed to just come in and sleep for a few days, they were not able to participate. Or if they were under— obviously if they were drug intoxicated, they were not allowed in group, so they wouldn't participate.

Six of the participants (60% of the sample) described issues related to the reactions of new members observed in group. Three participants noted that the new residents often went through a period of emotional adjustment to both the residential treatment center setting and to the psychotherapy groups. One participant described,

> . . . the process of having this person new in group [pause] and invariably, they would feel uncomfortable, and there'd be tears at some point in it. Also they were pretty newly on campus, and there's a lot of trauma with leaving home and stuff. So that would come out in group also, and they would feel, I'm sure, very alone.

Three participants described new residents as often demonstrating attitude towards group members and/or group facilitators, and two participants noted that new residents would be seeking escape from their new realities. One participant noted, “The newer people who came in were not— didn't seem to be as interested (in group). They were more interested in figuring out when they were going to be able to leave the residence.” Two participants described the veteran

members as playing a role in introducing and modeling the group norms in order to aid the new member in their adjustment. One participant stated,

> Even if the girls came in with an attitude, there was also one of my girls that it was also known as an attitude. But they were either able to, what they would call it, check her. Because they were like, no don't worry, this is our therapist, she's okay. Like they had this level of safety and respect, so then the new person quickly— they were very useful now that I think about it. The clients were very useful to the new people coming in. Just because we could jump into doing clinical work a lot faster because they had the approval by their own peers, like no, this one is okay, or this is a safe place, we promise, for you to talk. So someone coming in was much easier.

Five of the participants discussed the ways in which the status or reputation of the new resident could affect the group dynamics. One participant described the ways in which a lack of substantial status could result in a scapegoating phenomenon:

> If they were like a mild-mannered, you know, and the group was sort of like scapegoating that person, that would happen and that would create a diversion of attention. Like no, this is what we're doing in group. This is not about whatever you guys are trying to make happen right here with this new person. Attention up here. And sometimes it would just be a distraction.

On the other hand, a participant described that if a new resident was entering the group with more influence, a different reaction could be observed in veteran members:

> Other times the new person that joined was someone who was like the shit in their home town and other people from the same town knew the guy and knew that he was a big

> person in some gang. And so now everybody is like not saying anything in group and just letting him kind of monopolize the space with how cool he is.

Another participant described,

> A few times we had situations where the new person was going for the lead role, let's just say, and they wanted to [pause] be a leader and would try to sway some of the residents to act differently. And then that would kind of take— some kids who had been there longer, sometimes it would take them a step back, because they would have to get talks, like hey, what's going on? You've already been here six months, you know how this place is; what are you doing following the new kid, who doesn't really know the rules yet and is going to get in trouble for certain behaviors that you already know are not permitted? So you know it required a lot more talking to in that sense, it would send some kids on a backward for a little bit until everything in their micro environment would settle.

Inferences Based on Professional Experiences

This portion of the interview data is specifically related to the judgments and opinions of the participants about psychotherapy groups and group process with adolescents in residential treatment centers, especially with consideration of their experiences in the setting. More specifically, this section provides information that is intended to be helpful in conceptualizing group process as a component of treatment in residential treatment centers. Questions focused on topics such as (a) the role and value of psychotherapy groups, particularly with process components, in residential treatment centers; (b) barriers and difficulties for facilitating groups for adolescents in residential treatment centers; and (c) considerations that would address ongoing concerns.

Role of psychotherapy groups in RTCs. Participants shared their opinions about the role of psychotherapy groups for adolescents in residential treatment centers. Nine of the ten participants (90% of the sample) described psychotherapy groups as having an interpersonal focus or role. Six participants describe psychotherapy groups as a setting within residential treatment centers in which clinicians could facilitate appropriate interpersonal interactions. One participant described,

> And you know, you've got the just the basic things. You've got, you've got 10 girls talking about [pause] the exposure in controlled situations, talking about say, let's say sex. So, we had several girls who had sex with older men, one's there, guy's being prosecuted, you know [pause]. She's 16, he's 28, you know, got a lot of girls thinking, "ooooh!"— It was really fascinating, to hear them work that out. One day, they were all saying, I'm never going to date a man again who's not, who's more than two years older than me. They did that on their own, together. I mean I just kind of sat there, kind of managing the boundaries. You know, and showing them where the boundaries and such were, but they did that on their own. That's very valuable for kids to not just be guided to a— you know, not just talk about size, you know, blah blah blah, but actually come back and you know tolerate that and then kind of encouraging them to come back to what's really important.

Seven participants described psychotherapy groups as intended for the development of specific prosocial, interpersonal, and coping skills. Five participants indicated that psychotherapy groups were intended to be an opportunity for the residents to relate to one another and a space to normalize their experiences. One participant stated,

> In my opinion, I think like social skills a lot of times, like socialization and having them have an opportunity to— the same role it plays everywhere I guess, but on a more simplified level [pause]. Right, so like get normalized and validated and realize that you're not alone in this and decrease shame, and openness, and vulnerability. And connecting with others that have similar experiences to you and you thought yours was totally unique and unable to shake kind of a thing.

Another participant described these phenomena occurring especially within an LGBTQ+ group, creating increased safety within the common identity of the members:

> Occasionally there were moments where it seemed really helpful. I think the LGBT group was helpful momentarily because at the very least, those kids were able to see that they weren't the only kids walking around campus who felt the way they felt or identified the way they identified. And it had the potential to be more helpful. And I think that even if the campus had been a little bit bigger, or if the staff had been a little more accepting of non-heterosexual, non-cisgender identities, then we could've had more success with that group. But it was a struggle.

One participant specifically discussed the opportunity present in group for members to receive feedback from their peers about other people's perception of them:

> Oh, I think it's incredibly valuable, in just interpersonal work, learning how you're perceived through others' eyes. Helping you learn how to work through your interpersonal stuff— that's not a very good word. Interpersonal troubles that you may or may not even realize that you have until you're in a group that highlights them and shows them to you.

Two participants discussed the role of group psychotherapy with adolescents in residential treatment being to increase accountability among the residents. One participant noted that,

> With the residential setting, with you know, with the group, too, you know, like I said, they're living with these young men. So again, now you're outside of group, and you're doing things you're not supposed to be doing, or you're doing things that you said in group that you would not do [pause] and now, so either some of the guys are strong enough to outside of group pull your coat tail, like you know what are you doing. But other guys may wait until they get back into the group session and say, I saw this, you did this, you said that. So it's not as easy to, I wouldn't say hide per se, because if you're just doing individual therapy and it's just you and the therapist and then you leave, and you come back, who knows what you really, what you really doing. So I think with the adolescent population— and not to say that individual therapy is not important, because it is [pause] but with the adolescent population I would say group is very influential.

Three participants specified that the role of psychotherapy groups in residential treatment centers is to provide a space for residents to process occurrences on the unit. According to one participant,

> I personally think it was the most relevant and fit in the most because they lived there, the clients, and there's so much happening all the time. So even just discussing issues on the unit, issues with maybe the techs— the mental health techs (direct care staff), were all really critical. And it gave them an avenue for them to discuss these critical issues that were arising on a daily basis while they were there in the program.

Two participants noted that the role of group psychotherapy in residential treatment centers is specifically to provide residents with a space to work through interpersonal dynamics. One

participant noted that this can occur with peers as well as with clinicians and other staff, stating, "So you have those parental figures, and all those transferences and counter-transferences that go on. So you hope to provide opportunities to provide that corrective emotional experience."

Finally, two of the participants (20% of the sample) noted that the role of psychotherapy groups is for rehabilitation through psycho-education.

Value of groups in RTCs. Participants were asked to share what their perceptions were of the value of psychotherapy groups and group process in residential treatment centers, including a quantification of that value on a scale of one (least valuable) to five (most valuable). Five participants ascribed psychotherapy groups and group process with a value of 5; one participant ascribed a range of 4.5 to 5; two participants ascribed a value of 4; one participant ascribed a value of 3; and one participant ascribed a range of 1 to 2.

As they discussed their perception of the value of psychotherapy groups, six of the participants (60% of the sample) discussed psychotherapy groups as being of significantly high value within residential treatment centers. Five of those participants described group process as essential, vital, and or crucial for adolescents in residential treatment. One participant stated, "I think that once you learn about your [pause] how you are interpersonally, that translates to a change in how you are in the broader world [pause]. Yeah, it's really important." One participant held a strong belief that clients in residential treatment would benefit from more (frequency) group process work:

> . . . this is my opinion, I don't think everybody shares it [pause]. Not where I worked. But, I think they are essential. I think they're the best, I think they should be happening everyday. I think they should be happening on Sundays, when kids are doing nothing. I think they should pay therapists to come in there on Sundays and run the

> groups, and [pause] I think they should be happening more often, at least five days a week. You know, and they can lighten it up some, but it needs to be happening more.

Two participants specifically described group process work in psychotherapy groups with adolescent in residential treatment centers as "powerful work."

On the other hand, six of the participants (60% of the sample) noted the devaluation of psychotherapy groups, and especially group process, for adolescents in residential treatment centers. Two participants noted that there was an idea within the residential treatment center system as a whole that group was a "silly" and unhelpful endeavor. One participant described that some situations that arose in group threatening the safety of the residents resulted in their tendency to agree:

> I think a lot of people there felt that group was a kind of silly endeavor. And there were times when it felt like a really silly endeavor, when you have two girls getting into a fist fight literally two minutes after you sit down for group, and at the end of it, someone winds up getting carted off to the hospital, you're like that was not therapeutic or useful. And maybe that would've happened anyway— and in all likelihood, it would've happened anyway, these are girls who live in a very small space together. If they got in a fight at 5:30, they were going to get into a fight by 7:00 anyway. But it sometimes was more frustrating than helpful.

Another participant, who also agreed with the idea that group process work was not as useful stated, "I would say it's very difficult to have an effective group processing with mandated clients who are very guarded in general, and especially with each other. So I didn't view them as highly effective." Three participants noted that some staff (both clinical and non-clinical) within

the residential treatment center system cared less about group psychotherapy and group process than others. One participant stated,

> I think they valued it as a place to have the kids for another hour, where the staff gets a break. The staff— gives the staff a chance to take breaks because the therapists are gonna count as one of the staff people watching the kids, and [pause] they get paid for it, so it's an income source. To be quite cynical about it, I don't think they really consider much else other than what's being required and what they can get paid for.

Three participants indicated that individual therapy was the preference and/or priority with regard to treatment components in their residential treatment centers. One participant described,

> They're supposed to be the big bad attitude girls, don't mess with me, but if you're forcing them to talking about some sensitive issues, it's like fine I'll talk about it because she's making me. And it was nice to for them to be able to talk about some of that sort of stuff and be able to let their guard down. So in that aspect, group was always very helpful. But if it's being compared to individual, I think a lot more work got done individually because they were able to just trust you and talk about themselves more than they would in front of all these other people.

Two participants noted that one common factor that is contributing to the devaluation of groups is the lack of supports in place for the group clinicians, including those who were trainees. For example, one participant described their experience as follows:

> I would say it was a huge struggle and it didn't seem like a priority. It was something we were expected to do as trainees, but then a lot of the necessary supports weren't really there [pause]. I suspect that there are better ways of doing this, but I think there were a lot of systemic issues in the place that I was working that made it very difficult to run a

> successful group and to really get a lot of meaning out of it. And some of it had to do with the pathology, and some of it had to do with the structure and the system and the support and non support for the groups. There were a lot of people saying yeah do groups, you know, applauding the idea, saying it's great that you recognize the need in the community; but then not providing the support that you need.

Another participant described the lack of sufficient support put in place for the clients in order for them to maintain interpersonal and intrapersonal gains made in the course of the psychotherapy groups:

> So having that group to do that was very complimentary, a very effective way of helping those clients understand what that process is. As well as how to survive it or how to make the best of it and how to transfer it to their home environment. Which was I think the hardest part of the program. Because they'd be successful in the program, but then they'd go back to the same home environment. And that's the downfall. I don't know if that's your experience professionally too, but that's what I saw. It was the saddest part of the program was when they had to leave. Knowing that there was not gonna be a system good enough to support all the changes that they had made in the group. And then when you heard that the people who had shined and became positive leaders and positive influences on peers in the unit, went out and relapsed and did everything all over again and ended up in jail. You know all that? That's the sad part. Because now you know that they can be successful— they know that they can be successful in certain environments.

Relationship of groups in RTC program structure. After discussing the value of groups, participants discussed the relationships of psychotherapy groups to other aspects of treatment, including the ways in which psychotherapy groups fit into the program structure of

residential treatment centers, if at all. Seven of the ten participants (70% of the sample) described ways in which psychotherapy groups are interrelated to and/or interconnected with other treatment components of residential treatment centers. Four participants noted that group psychotherapy fits well with individual therapy. Three participants noted that all components of their treatment (such as family therapy, milieu, and school) in residential treatment centers are all connected. One participant provided an example of a group members actions in one setting affecting them across different areas within the residential treatment center:

> That also connects back to when they get back to the cottage, you know because they had detention, when they're back in their living unit, there's certain things they may not be able to do or access for that— think about at home, when you come home from school, and you got a bad report from the teacher, your mom might say, you can't do A, B, or C tonight because you didn't take care of your responsibility in school. So we try to do the same thing here, whether it's from school or the cottage level or the group level, we try to have them see how everything is connected and we're not all operating on separate islands.

Three participants noted that the interconnected nature of the components of residential treatment is facilitated through communication among clinicians. One participant noted,

> Hopefully, there is good communication between the clinicians running the groups and the clinicians working with the kids individually. You can use the material to deepen, if something needs to be working in a more deep way in an individual session, so hopefully that can happen. And vice versa. Sometimes you see the gains that the kids are doing in individual therapy in group and they kind of become positive peer models for the other kids. So they go together, I think they go together very nicely.

Further on the topic of communication between clinicians, one participant discussed the benefit of treatment team meetings:

> I find it really helpful because we would have weekly meetings with the entire treatment team. And sometimes we would learn a lot of information in groups that the patients might reveal that they might not in individual therapy, or maybe they displayed a certain behavior toward a peer that we learned about. So it's nice to see them in different aspects of their treatment. To see as a total how they handle different situations and different environments. And different people.

Conversely, one participant described communication among clinicians as varied due to the lack of an electronic system for sharing client notes:

> It wasn't terribly well integrated, and the individual therapist for the patient wouldn't necessarily know about what was going on in group. We didn't have an electronic medical record system where they could read what was going on in group. So it would really be on a case by case basis. Some of the social workers would speak to me about it, and others wouldn't.

Four of the participants (40% of the sample) indicated a perception that residential treatment centers could not exist without group psychotherapy. Two participants noted that without the core clinical treatment components, including group psychotherapy, residential treatment centers would be "just housing" their clients or providing an equivalent of juvenile detention centers. One participant noted that group psychotherapy is a most appropriate form of treatment for adolescent development, and two participants noted that adolescents respond more to their peers. One participant stated,

> Group therapy I think is very powerful, especially for adolescents. Because you know you can pull someone into your office, and we follow more of a milieu therapy approach as opposed to like a hospital setting, and I'll go back to that [pause] but adolescents respond more to their peers. So if their peers are the ones who have had similar circumstances, that are in similar situations [pause] the ones that they're having style a little bit. Not saying all the time, but they're probably more inclined to be more receptive to them as opposed to just coming to my office every Tuesday at 5 o'clock, and we're going to talk about this, and then you go back on your way.

Lastly, three participants indicated that group psychotherapy facilitates program success, with one participant stating,

> It's essential to the residential treatment. I wouldn't change it for anything because I think it was really crucial to their development and the growth of the individuals. Each individual that was part of the groups. And it was crucial to their success in the program.

Two of the participants (20% of the sample) described psychotherapy groups as an ineffective component within the structure of residential treatment centers due to groups being "worn out" due to overuse. One participant indicated that mandated clients are too guarded for group process work to occur in psychotherapy groups in residential treatment centers, describing the difficulty of getting them to open up:

> I'm thinking of specific clients right now where I got a lot accomplished with them in individual [pause]. And even some of the boys, like one thing I accomplished was that they even started talking to me, that was huge. But then we'd go into group and they would clam up again. So I think as far as the role of treatment, they definitely— it was kind of a nice psycho-education piece about trying to do [pause] like budgeting, and

> maybe it was helpful, maybe not. But I definitely think individual therapy was much more productive and beneficial for the clients than group therapy.

One participant noted that groups occurred too frequently, and both participants noted that group became "like a checklist item" that therapists and residents alike were often not enthusiastic about or motivated to engage in. One participant described psychotherapy groups as "ineffective" as a result:

> I think it ended up being more of a headache for the boys, a checklist, an I gotta do this because I have to do therapy in order to leave. And for the direct care staff it was [pause] you know, they didn't enjoy doing it. Half the times on the weekends, like if I watched the camera, they would do Saturday and Sunday's worksheets at the same time on Sunday right before— you know, so they could just slide it under my door. So, yeah, I think the role [pause] had good intentions, but it was uneffective [*sic*] when we actually had to implement it.

Barriers to engaging adolescents in group process. Participants were able to identify barriers to engaging adolescents (both in general and in residential treatment centers) in group process based on their observations and professional experiences. All ten participants (100% of the sample) described issues related to the population served by residential treatment centers as barriers to adolescent engagement in group process. Three participants noted that the wide range of developmental presentations among adolescents in residential treatment serve as a barrier to their engagement. One participant stated,

> Just kind of like naturally, they're all— let's say I'm working with a bunch of 13 year olds. I'm still looking at different things. Versus if I was looking at a bunch of 25 year olds, you still could be looking at different things, but less gaps. A little less I guess

> distinction between where somebody could be. Right, I think as you get a little bit older into latter stages of development, there's a little bit more like [pause]. There's probably a little less discrepancy in where people are at developmentally in a group of 23 year olds than a group of 13 year olds. Because there's so much more influence on them, like their family of origin, their neighborhood, their community, their school. Like what is going on in their world and how does that shape their development.

One participant described the ways in which the differences in the developmental presentations of the clients can affect the group clinician's interventions:

> I have some of the guys educationally all on different levels. They're all, except for one I think, educationally classified. So they all learn differently. They all process different, and they all retain different. So this one particular young man, when we're talking about something, I may stop the conversation and, if we're having a conversation with him, I may say, repeat back to me what you just heard. What do you think I'm saying? Well I don't have to do that with four of the other guys, but with one or two of them I might have to say, okay what did you hear me just say? And not only do I want them to repeat it back to me, but okay what do you think I meant by what it is I just said? So you have to be flexible in that regard, because if you just stick to, well I'm only going to say this and then everybody's going to get what I'm saying, you're going to miss it. And that one particular young man where you know may have a processing issue or his perception or worldview, you know is also— you're saying one thing and he's thinking you're saying something completely different, he's going to leave the room thinking one thing and completely have missed the mark.

Another participant noted simply, “Sometimes it's the maturity level— they can't stay tuned for a long period of time. So you have to constantly engage them and meet them where they're at.” Eight participants noted that the adolescents in residential treatment centers are at an impressionable and ego defended age. One participant described,

> I think with adolescents, going back to, I don't need this. This is not a problem. I'm invincible, I don't know why I'm here [pause]. And you know, adolescents, they're very impressionable. You know, so they're easily influenced, so helping them to work through that. So you're working through a lot of different things at the same time that you're working on their primary treatment focus.

Another participant responded similarly, stating,

> And also tons of ego stuff. Which, a lot of that I think is also tied to these same issues, but I don't want to be seen with *those* kids, so I'm not going to group. You know, group is for *these* kinds of kids, and I'm not that kind of kid. Or them saying, I'm not going to be here for very long so I'm not going to group because I'm moving back home. And a lot of that sort of stuff.

Two participants noted that the underdeveloped sense of identity of adolescents is a barrier to their engagement in group process. One participant stated,

> I also think that adolescents are still— they're just at a place in development that's really hard. They're still trying so hard to be a certain way and they haven't figured out what that way even is yet. Like their identities are so so not formed. So I think that that's a really really big challenge. And you see it all the time, especially in a residential setting where membership changes. You see people like totally change, like their role in the group. Like totally. And that's not as common, I would say, in my experience in the

> college counseling center, you're not seeing that. Yes, you see people naturally evolve and grow as they're finishing their treatment, yes, the way that they present in that space might look very different than on day one. But I'm talking about just totally unstable identities for adolescence, which isn't pathological. It's just where they're at developmentally.

One participant described, “because of that like unstable identity at that age and having more people in the room might maybe give more credence to like the need to be guarded and defended in that space against so many different ideas, opinions, beliefs.”

Two participants noted that the adolescents in residential treatment centers being mandated to treatment is a barrier to their engagement in group process. One participant described,

> I think probably being mandated was a big barrier for what I worked with personally [pause]. Like I wasn't working with people that were like, I really want this, I'm ready to change. You know, and so I think that's a big barrier that I experienced with the adolescents I worked with.

Two participants discussed as a barrier an antisocial means of connecting with others in the history of some adolescents in residential treatment centers, one stating,

> They connected and had fun in ways that were antisocial in nature. Like, we're going to beat people up and we're going to go steal from people, and we're going to plot and scheme about how to get these drugs from this guy. That was kind of the mindset and that was how they connected with other people.

Two participants noted that for many adolescents in residential treatment centers, the development of accountability and skills in the context of group process can be viewed as countercultural. One participant described this phenomenon as follows:

> I guess it had some pros. In the sense of, you know, it was cool to see kids calling each other out. Like no, you're not being honest. Because one of the things was like pledge not to break any rules or make any offensive comments to anyone. So then the kids would be like, no, in So-and-So's class earlier, you told someone that they were this and that. So they were calling each other out more and holding each other more accountable, which is really countercultural for them. Because then you're a snitch and then you're this, you know what I mean? So it did bring up some good data to work with for me I think as a clinician.

Two participants noted that the state of many of the adolescents being without caring families was a barrier to their engagement. One participant described,

> I think it was two months into the program I noticed that if a lot of the kids did not have families that were hands on and cared, none would really celebrate any of the holidays, and it was just really a down sad time in the building. Or some would go home and celebrate, and then they'd come back with all these stories, and then the ones that had those families had nothing to say and never celebrated the holiday whatsoever.

Six of the participants (60% of the sample) described issues related to the addition of trauma to adolescent development as a barrier to their engagement in group process. Two participants noted that adolescents in residential treatment centers, most of whom have experienced trauma, are easily triggered. One participant stated,

> I also, in my particular setting, because of their cognitive limitations, a lot of their primary therapists kind of gave up on trying to use psychodynamic strategies with them, or to even get them to do things like trauma narratives and get them to process their trauma experiences. So that was also a huge barrier because we had a bunch of kids with unprocessed trauma walking around, triggering each other left and right, not having the language to express what they were experiencing.

Two participants noted that boundary issues resulted from trauma and adolescent development, creating additional barriers. One noted that even when intending to provide clients with psycho-education, they were managing group process work due to the inability of clients to maintain appropriate boundaries:

> I guess generally I'd just be doing like a psycho-educational type of group, but process kind of came into it. It was a portion of it, but it came in a lot. Partially because the kids don't all have very good boundaries. So in talking about something psycho-educationally, they were often not able to keep it distanced in any way and it became very personalized very quickly.

Two participants described the level of pathology of the clients with trauma histories as negatively impacting their engagement in group process. Five participants noted that adolescents often employ maladaptive coping strategies in dealing with their experiences of trauma that also negatively impact their engagement in group process. One participant noted,

> Because they're so close to each other and they learn each other's triggers very— some of them were very very good at figuring out how to hurt other people as an adaptation that they developed. Sometimes they would use it when they were triggered. And sometimes they set someone else off and then they get into a fight and one of them ends up in the

> hospital, and then you come to group the next week and no one's there because all of them are in the hospital, because they needed a higher level of care or they became violent or they tried to hurt themselves and they couldn't handle what had happened in the previous week.

Another participant described heightened responses to attention deprivation that can interfere with group process:

> I also think the population I worked with, they're very attention deprived. So with so many people, it increases the likelihood of acting out behaviors to get attention in that space, because I'm one and there's 10 of them. And they're all coming from places where that is how they get their needs met, that's how they get attention, is by being, like, the problem child. And then by default, I have to address the problem child. I can't just totally— I can try, I can of course be creative about like, okay well you just need to sit here and if you don't want to listen and then I'm going to ignore you. But then they start cursing at the top of their lungs in the corner. So now I can't do group.

Six of the participants (60% of the sample) discussed specific issues related to the content of groups that serve as a barrier to engaging adolescent residents in group process. One participant discussed the need for topics for adolescent psychotherapy groups in residential treatment centers, noting,

> What we started seeing is that if you do not bring in a topic, and one that is immediately engaging, what the girls would go ahead and do is take it as an opportunity to fight, yell at each other, bring up drama that may have happened in school or the cafeteria. And it's never constructive. And it's very difficult, especially on the girls' side, to get them to stop

> and calm down and actually process. So as far as process group, it always starts with a topic.

Four participants noted that in implementing specific topics, there comes a tendency for clinicians and/or clients to aim for meeting those specific program criteria rather than focusing on process work. One participant stated, “Like half of them just copy off of each others answers. Now they're trying to like get the criteria met and not— the content is getting lost, because who cares.” Another participant stated the following:

> I think some of the difficulties were that we had to have topics everyday rather than letting the therapists dictate or having the natural flow be of— let's talk about this for a couple of sessions. Like with our process groups here, there's just a natural flow of whatever's coming up. But for the [pause] for the [juvenile justice] facility, we had to talk about anger management every week. So no matter what's going on in the world with a client, and it's something we could talk about, we have to address anger management this week and get that checked off. So I think having that structure was beneficial but at times restraining, because it limited— maybe they would've been a little bit more open if we had been able to choose our own topics.

Two participants noted the need for flexibility and variety for adolescent engagement in group, thus pointing out that the lack thereof with a prescribed structure serves as a barrier. Two participants noted that the common issue of manipulation by clients serves as a barrier, especially with regard to group content. One participant stated,

> Half of them were helping each other cheat, or like doing their homework for them in their MRT book or like changing the cover of their MRT book for somebody else's MRT book so it looked like they did the work but it was somebody else's. And I would have to

> see it to look at it and be like, I know this isn't yours. So I mean, they got to test out all of their various manipulative tactics. And some therapists were probably less attentive or cared less than I did. So I just found overall globally within the system, it was a pretty ineffective method.

Another participant described the difficulties in assessing client needs due to their ability to manipulate even within the therapeutic relationship:

> There's a lot of smooth talking. And really smart kids, so they learn the therapy language, and I think that they become very astute at using it, and it's hard teasing out are they being genuine or are they just using that language really well. And if you can't figure that out, if you can't tease that out, then you don't know if you should challenge them, should you drill harder, you know what I mean?

Nine of the participants (90% of the sample) discussed issues specifically related to process that interfere with the ability to engage adolescents. Four participants noted that adolescents not wanting to open up, is a barrier. One participant described,

> I think within residential treatment centers, they just did not want to open up and be vulnerable with each other. And they were stuck with each other all day every day. And they were brutal. They would make fun of each other a lot.

Two participants discussed the task of group process for adolescents in residential treatment centers, noting that oftentimes, they were not ready to process their issues and experiences. Two participants indicated that adolescents, especially in residential treatment, have a need for structure in the group setting, which they described as barriers to group process. On the other hand, one participant described that oftentimes, there was a need to abandon a preset plan in order to focus on process work:

> Sometimes you just have to be like very present and go in and do it. I had their [pause] other therapists? Because of course we would have little pow-wows— other therapists would come and, they'd be all to tears because they had not run a group like this before. And those of us who had more experience would have to just [pause]. We'd say how are you doing this? Oh, I'm following the program, I'm following what we had to— Yes, but what was going on? Well these two kids were fighting. Well you need to focus on the situation for a minute and get away from your plan because this takes precedence. Sometimes you just have to be just in the moment, in the here and now of the group. You can't just try to blindly go and close your eyes and go with the program. That's not gonna work.

Two participants noted that the process occurring in group was also affected by client-staff relationships. One described,

> Also any changes in staff. Like any changes affect the residents, within the houses, because sometimes you will have like a significant key staff person who is there and the kids kind of like a lot, and they resign or that changes, and so now you have to kind of process the loss, and it's very difficult for the kids to kind of establish that trust again. Because their history of abandonment and rejection, you start over, all over again. And it's difficult.

Two participants described adolescent engagement in group process as being affected also by negative outcomes of appointments or visits, and noted the lack of control that the group facilitators had in managing those concerns was a barrier in group. One participant described that,

> There were times that we believed that maybe it wasn't in the client's best interest to have visitation until the client was in a better place. That was out of our control. The client had a right to visitation. And that was an uphill battle because it wasn't in the best interest of a client, especially when they were in the process of group and were healing and, and that.

Four of the participants (40% of the sample) described issues related to the need for including activities in group as a barrier to adolescent engagement. Each of those participants noted more specifically that the absence of activities will serve as a barrier to adolescent engagement, and one participant more specifically noted that activities help the adolescents to understand the content being delivered, such as when they are unable to understand their own legal outcomes:

> It was just, go around the room, state why— state basically your crime. What did you do, how did court go, do you know what you have to do to not end up at the juvenile facility, do you know what you have to do in the program so when you go back the judge is proud of you? That type of thing. And really just dumbing it down. A lot of times, they had no idea what the charge meant, what they had agreed to in court, what they had to do here, how long they had to be here. They had no clue. So a lot of the court group was aiding through that process, answering their questions, having them support each other. So sometimes it did end up feeling like a process group. But for the most part it was educational, just defining certain terms that are legal jargon.

Notably, two participants (20% of the sample) described how cultural barriers can affect adolescent members. In addition to one participant describing the incongruence between skills desired and the cultural norms of the adolescents in residential treatment centers, another

participant noted that the level of education achieved by clinicians can serve as a perceived barrier to the adolescent residents due to issues related to privilege:

> I would say one barrier is cultural. And I don't mean racial necessarily, I mean cultural in that they see us as— they see therapists as [pause] they might not know what we've been through in life and we may not have been through what they've been through. So matching that or finding a way to go around that and say okay maybe I haven't been through exactly what you've been through. But trying to explain to them that is also very intense. Trying to get them to still listen even though we haven't necessarily been through what they've been through. And I also mean culturally in the sense of privilege, because usually people who've been through school and grad school and that have a certain amount of privilege that they don't— the clients feel that they may not understand— be understood. Sometimes they approach us in a very fearful way, like you went to school you did this this and that, I bet you had a supportive family; you have no idea what I've been through. And they would stand there, and you're looking at them like, yeah you're right, I haven't been through what you've been through. And then having to find a way to talk to them or empathize with them to a point that they can feel comfortable opening up.

Pragmatic & structural difficulties for groups in RTCs. Participants were asked to described some pragmatic, structural, and other system- or setting-related difficulties that might arise in attempts to establish psychotherapy groups for adolescents in residential treatment centers, notwithstanding training in group facilitation. Five of the ten participants (50% of the sample) noted that policies imposed on system can interfere with group development. Three participants noted that court or legal issues have an effect on groups. One participant described,

> In any residential treatment center, you can't mix— you know, you have to— there are legal issues when you start getting more than three years apart. You can't put two boys that are four years apart necessarily in the same room. Same thing for girls. Once there's a certain amount of age difference, then you have to be careful, you have to [pause] it depends on what the diagnoses are, whatever, whatever have you— I guess you could put certain— if you have a child that's sexually acted out at all, then you can't put them with a younger child, with just any kind of history. So there are all kinds of things like that you need to watch out— so, even though the dormitories are generally separated by age, there was another level where you had to switch a kid to a different dormitory because there was [pause] things were too hot between them and somebody else. So you've always gotta be [pause] it's difficult. Operations is a difficult job of moving everybody around sometimes to keep everybody safe. And to stay within the legal restrictions of [multiple] states.

Another participant described how specific guidelines and restrictions put in place by judges must be considered in residential placements:

> For those guys in the sex offenders group, like I said, you know some of them also are on probation, so there's court orders involved, there's legal involvement, there's contact restrictions. So there's a lot of different things that we have to take into consideration before incorporating them into other areas. Even also too, we may have guys that come in, and their probation conditions are so strict, it may say that they can't go out into the community until reviewed by the judge.

Further, one participant described the influence that legal issues can have on the discharge of clients from the residential treatment centers:

> The court system actually, I should say, does also determine when they leave. If a judge has seen that they've done enough work and they've made enough improvement, they will go ahead and agree to lower them to another facility for like a group, but isn't as intense as our facility.

Four participants described the influence of contract requirements on residential treatment centers and psychotherapy groups therein. One participant noted, "Also too, you know on the state level, you know they have certain requirements depending on licensing standards or different contract standards; you have to have this many groups this many times, this many—you know." One participant also described how competing interests can cause conflicts that interfere with group, stating,

> Like I said, in residential you have so many competing interests— and we don't really have this issue with groups, but just in general, so many other competing interests, whether it's you got your groups and you've got to get your family sessions done, and your family can only come during the time the kid is in group, then the kid is not in group because he's got to get his family session. Or if they're at a doctor's appointment or a specialist, and that's the only time a specialist can see them. So they're at the specialist and not in group. So it's a lot of moving parts that come into play with this on a larger scale.

Four of the participants noted that the policies within the system of the residential treatment centers can also affect the development of psychotherapy groups. One participant noted specifically that any changes, including those proposed in response to an identifiable need, have to go through an extensive approval process. Three of the participants described that with the many components of treatment and care in residential treatment centers, there is often no

time to add any new groups, even if they are needed and/or would be beneficial to the clients. One participant described the following:

> Well I found that it was really difficult to fit it into their schedules. That was like a huge— that was like a basic issue that was consistently a problem. So, you know, if the program doesn't prioritize that and make a time, then you wind up trying to kind of squeeze into a pre-existing schedule, and that I think communicates to the participants or potential participants that it's not really important if you're trying to get squeezed, like in between the time when they get home from school.

Seven of the ten participants (70% of the sample) described issues related to trauma-informed care with regard to difficulties that could arise in group development. All seven of those participants noted that training in trauma and crisis management is needed specifically for direct care staff. One participant described,

> We were all trained in TCI— what was it [pause] Therapeutic Crisis Intervention. So that was helpful, and I definitely recommend that people have some sort of training in that if they don't have training in therapy or, sometimes the groups are co-facilitated by people who aren't mental health professions, that's an absolute necessity— being able to kind of diffuse those high intensity crisis situation.

Another participant noted,

> A lot of staff that have nothing to do with therapeutic group, goes to groups, not trained. You know, so sometimes when you're the clinician, you end up worried, because then their own trauma comes out or their own issues come out. Then you're like, Oh No! So then you act as a container, and that's kind of difficult, and if you were able to give them

> a different space or training so they know what their role might be there, would be more helpful.

Finally, four participants further specified the need to implement trauma-informed care across the agency, rather than for it to be only the ethical responsibility of the clinicians.

Eight of the participants (80% of the sample) described issues related to training in facilitation of group psychotherapy as contributing to difficulties in establishing new psychotherapy groups. One participant noted that there are many models available for groups in residential treatment centers, but the lack of training and investment in the models makes it difficult to implement them. Four participants noted specifically that training and/or supervision in group facilitation is needed for clinicians facilitating group. One participant stated,

> . . . they couldn't care less about spending money out here getting supervision. They don't understand why we want to get supervision, it's just a group. It's just a simple process group [pause] you know. They don't see the nuances at all, so . . . (statement discontinued).

Conversely, two participants described that training in group facilitation without exposure to the population and setting does not translate well into psychotherapy groups in residential treatment centers. One participant noted,

> I think until you've worked with adolescents in residential treatment, you're not going to be good at establishing the structure for a group of that nature. So I think that would be the biggest difficulty. Especially if you've come from a place like here (an outpatient clinic with service-seeking clients). Think of someone whose training was all here, and then they go into a residential treatment program with adolescents. They might be way more skilled than I would ever consider myself to have been before I worked here, in

> terms of like the principles of group psychotherapy and how to intervene with a group and all of that. But I don't think that the same kind of thing necessarily translates, and I think a lot of times in adolescent programs, just by nature of like why is there an adolescent program, typically there's some degree of urgency on some level, like foster care, getting in trouble with the law, having behavioral issues in class.

Another participant also described the limits of training in the principles and/or facilitation of group psychotherapy as it applies to work with adolescents in residential treatment centers:

> I think the way I see it is no matter how much you get trained in facilitating group, it's until you actually do it and you're put in that situation, that you're gonna learn from the hard knocks. So I think that in that sense it was very much like teaching because every group is gonna be different. A lot of it depends on, you know [pause] even if you're given a manual, it's not going to go like the manual in residential treatment, it just isn't. So you just have to go through the process. I think that there are things that cannot be taught in manuals or in books that it's experience that has to lead you. So having been taught to run a group for a group of willing people who choose to— who like groups, who chose to participate, who were willing subjects to, hey let's make a group, is very different from being in the residential— kids who don't even want to be there, who would rather be in the street. It's very, it's challenging on a different level.

Two participants noted that having an experienced co-facilitator could provide one form of appropriate support for those early in their experience with group facilitation. Another participant noted explicitly that despite its widespread use as a form of treatment and the pervasive lack of training and experience, "not everyone can (or should) do group psychotherapy." Three participants noted that the lack of understanding of purpose of group

process and the cycles of group often contribute to programmatic difficulties in developing new psychotherapy groups. One participant noted the ways in which lack of understanding by administrators can interfere with groups:

> In terms of understanding the cycles of a group— you know, there's a cycle of a closed group, and the cycle that I had was a— you know, (in) residential treatment, my group could be disbanded next week and you know, reorganized if the staffing says, you know so, the resi— you know, often the resi— the operations people couldn't care less about who's in your group, you know? Here's 10, you've gotta take this 10. You know, that's not the 10 I had last week. We were really making progress.

Seven of the participants (70% of the sample) described issues specific to groups being developed in residential treatment centers that present difficulties in their development. One participant described the physical space associated limitations of the location as creating difficulty with regard to groups. Another participant described how the loss of individual identity for the residents, upon admission, can pose difficulties for groups:

> They were actually all in like uniform and they couldn't even dress like— you know, they lost a lot of their individual identity as part of being in the program. But they would all talk about it even more so because of losing it. And so they would make a lot of assumptions about what people's life was like. And they would try to make themselves sound like they had lots of money when really they were dirt poor. Like assumptions would be made based on things they would say, and so there was lots of insensitivity globally.

Another participant described,

> So yeah, in some ways I think the stripping them of their external representations of their ego was wise. Right, like you don't get to be the cool guy that's wearing the nice name brand clothes while somebody else is looking like they just came from poverty. It puts everybody on the same page, which in some ways I think is like really good and really useful. And then in other ways I felt like they created other problems. Like that still needs to go somewhere, that still needs to come out in some other way. So it just created other kinds of acting out and behavior issues I feel like.

Three participants discussed the ways in which the residential treatment center context necessarily meant that access to materials, spaces, etc. would need to be limited and/or restricted for the residents as appropriate to situations that can arise. For example, one participant stated,

> They can't necessarily have chairs. But when I could, I had the kids sitting in chairs. In a circle of chairs, not on sofas or anything, most of them— of the groups met on sofas, and they were scattered or in a square. But I liked for mine to be in simple chairs. Chairs that were about a foot or [pause] a foot apart. In a circle. That's a much different experience from people being scattered about.

One participant noted that due to the restrictions on specific materials, any art directives were limited in group:

> And obviously with art therapy, we had to be very careful about what supplies we could have. Like we couldn't have clay or anything that would harm them. We had to use markers, but if we had markers we had to count them. Nothing that could be sharpened, so no coloring pencils. And we had to count all, like if they gave them the number two pencils, we always had to count them. So that would limit my art therapy groups too, as far as what I could do.

In addition, one participant described that, because stealing could be an issue, some activities that might be otherwise helpful were limited, stating, “I wish we could've done a bit more drumming, but it was hard to manage where the drums end back up, putting the drums back or they're disappearing,”

Three participants noted that inconsistent model implementation across residential treatment centers could affect the group clinician’s ability to implement psychotherapy groups as well. One participant described how inconsistency among staff led to discontinuation:

> We were supposed to keep doing it, but slowly but surely people just stopped, and then it was harder for me to be the only one doing it. I was more type A, like I'm following the rules given to me by my administrators. But other people were like, they don't care, they're not even looking, I'm not going to do this stupid material. I'm like okay then I can't do it because I can't tell them they have to have it done and then nobody else is doing it. So it just made it really hard to keep going. It was hard to keep the flame alive on that.

Two participants noted that the absence of group being enforced within the residential treatment center could contribute to obvious issues, even when developing new groups. Two participants further noted that the lack of or limit to resources or materials within residential treatment centers can have an impact on group development, potentially limiting the activities or tasks to be included in the psychotherapy groups. One participant stated,

> You're in a tiny little room, you're on top of each other, maybe you don't have adequate equipment, sometimes the movie wouldn't work or your computer doesn't work. So things like that— or the printer doesn't work. So things like that might . . . go in with a plan and then something arises.

Another participant described how a lack of funding for group activities resulted in further limitations on the development of groups:

> Funding I think is often a topic that doesn't come up. But a lot of times it's coming from the therapist's pocket. So I think that that I guess also could've gone into the barrier question that you mentioned. Some of my colleagues or give out candy and snacks at all or as much because it was coming out of their own wallet. So that is a problem that you don't think would be, but that's kind of also what hinders having as many activities or having as high quality activities when you have to pay for it.

One participant specifically described that within the structure of residential treatment centers, the heterogeneous mixing of client experiences can have an affect on new groups that are developed in residential treatment centers, noting that the differences can come up as an issue needing focus and attention in the group therapy space:

> I think the major problem was when you dealt with [pause] I don't want to say lighter, but I guess for a lack of a better way of explaining, if you had one girl coming in who only came in because she had a drug charge and it's a diversion instead of going to juvy. And then you had one girl who had been sexually assaulted, sexually trafficked, and came in against her will off the street because she was found and if we were to just let her leave she would go back into that same world again. If you have those two in the same group, even though they're similar in age, one is worlds more advanced and mature than the other one. And they've seen a lot of horrible things and been through a lot of horrible things as opposed to this one who just got caught with— at the wrong time. So those are the kinds of issues that they don't teach about in the books and were problems when it came to some of that down time in the cafeteria or when they're outside talking, so no

> one's down there. Because we don't want the extremely experienced person giving ideas and sharing their life with the more simple type of charge person. But it would happen all the time and unfortunately those are just things that we would try to address in process group when topics like that came up, but as far as ages, that really wasn't an issue as far as like the experience of the ages that were more of an issue.

Two participants (28.6% of the sample) noted that same-sex attraction can often be an issue in residential treatment centers that also affect psychotherapy groups. One participant described how this became an issue in one of their groups:

> I remember one time we had a gay male— I think we had two different gay males that I can think of— [pause] he was a big challenge for us. Because that was just not really acceptable to these people (the other clients) in their lives. Like where they come from, that's not cool. That's not something we're okay with. That's not something that's allowed. And now you're sleeping in the same house as me. You know what I mean, so there was like so much going on around that at the time. And we had to work really hard to both support this young man and his own sexual identity and try to let him be safe being who he is, while also not making himself like a total target. Because he would amp them up. You know the, so what if I like dick. You know just odd— like come on, you don't need to say that right now. It's okay if you do, it's also okay if everybody else in here likes other parts and we still wouldn't want them talking about it.

Three of the participants (30% of the sample) discussed the ways in which staff attitudes and belief across the residential treatment center were other manifestations of difficulties existing within the residential treatment center setting, that could impact group development. One

participant noted the under-valuing or devaluing of group process work specifically due to the pervasive lack of training and/or exposure:

> I don't think groups get used enough. I think that in residential treatment centers I've known about, most of the people don't have any training in groups [pause]. And they've never been in a group themselves. They don't even have, in terms of what I would think of as say, a process group, they don't really know much about that. They don't have any sense of that. They more, thinking about psycho-education [pause] they always come in with the topic and [pause] most will come in with a plan, and they might be doing a game, and they might be doing— some of them were good, some of them were good things to be doing. But they're [pause] there's not a sense of, most of— from what I was doing, there's not a sense of [pause] of really aiming for process work. It's really hard. It's very hard to do. You know, I've had other therapists come to my groups, and they would just be amazed— well, you're actually doing [pause] real groups, you know, real stuff here. You know, there was a lot of obstacles [*sic*]. You've just gotta, again, like that skiing through ice, and looking for a little snow to turn.

One participant noted how assumptions of client limitations among staff can affect groups that are developed as well, stating,

> I guess the thought was that they wouldn't be able to do process based groups because of their cognitive limitations, which was somewhat true for some of the kids, some of them were able to involve themselves more in that way and others weren't.

According to one participant, misguided leadership within residential treatment centers can contribute to difficulties in group development:

> I just felt like the work was really qual— it was good work and needed work, like it was a necessary kind of facility for this town. But it was super mismanaged and very clearly for profit. People— I feel like the people higher up who dictated how everything went were really in it for the money. So I didn't feel like the work was of high ethical quality.

Further, one participant noted that negative relationships within the residential treatment center setting can affect the ability to engage effectively in clinical work, noting that "it's just one of the things you have to deal with in residential treatment, somebody gets jealous of somebody else or something like that."

Considerations to ensure safety and benefit of groups. Participants discussed additional considerations that would influence the safety and benefit of psychotherapy groups for adolescents in residential treatment centers, especially given the context of these experiences and the likelihood of traumatic pasts. All ten of ten participants (100% of the sample) discussed issues relating to responding to needs of the adolescent residents. Three participants noted that it is important to get to know the clients in order to both make them feel safer and to increase the likelihood of their benefitting from treatment. Six participants noted further that clinicians must know the limits and thresholds of the clients with whom they are working, including in psychotherapy groups. One participant stated,

> I think it's important to keep an eye on each individual in the group. Seeing like when they're over threshold, or when they're moving to being over threshold. And creating that balance of keeping everybody safe, but not too safe. Challenging them enough to go deep enough to result in change, and not getting anybody over threshold. Yeah. That's a hard balance.

Four participants noted that maintaining a consistent presence, both by being physically present and by maintaining consistent boundaries, is an important consideration for group clinicians to keep in mind. One participant noted,

> I think one of the most important things has been being consistent. Showing up for every single group. Unless something really urgent happened, like a big crisis or something [pause]. Being honest with the adolescents has also been really important. You know, even if they want something, but I know it's a no. So setting limits can be very clear to them right away.

Two participants described showing care and support for the residents as potentially transformative for the adolescents in residential treatment centers. One participant described,

> The one thing I would hear most often from kids, if one kid was getting upset with me, the other kids might come out and say, think what you want of [this staff person], but he really cares about us. Give him time, you'll see, he really cares. And so you have to, you have to care. And you have to allow the kids to see that you care. You've gotta be willing to let them see that you care. And you've got to find a way to show them you care.

Another participant noted the ways in which encouragement and verbal praise provided significant and effective positive reinforcement:

> It is kind of a novel experience to be rewarded for being good so to speak. And so some of them really eat that up. And they've never been given that kind of attention. So in some ways, it can give me a little more leverage, or just like, you know, it was more bang for my buck. Like a simple positive reinforcement that might not do anything with a college student that's in treatment could have been like the most incredible moment of like that year of that kid's life.

Two participants discussed the need to adjust interventions for the ability level of the adolescents presenting in residential treatment. One participant provided an example, stating,

> "You've got 10 kids and, say one of them can't hardly do anything, and I'd give him some grease pins and paper, and he'd go off in a corner and do his thing, and he'd come back to show it, and everybody'd clap and cheer him on. And if you get the kids, but, you know, to do that, you'd say, is it okay if we let Michael do this, even though everybody else is doing this? So you'd get the other kids kind of involved in it. So they'd feel like they're taking ownership of helping Michael getting through his therapy even though he's really different."

One participant described helping the residents build tolerance for their differences through adaptations:

> Even for the kids with a low IQ, they still learn how to sit in the group, and the other kids learn to tolerate their differences. You teach kids, you know, like I gave the example of the kid that would go and sit in the corner and draw and come back— I mean I show those kids what it is to, to— how to [pause] let a child who's in a different place in life, be part of the group. And have to do exactly the same thing as everybody else. They didn't have to be burdened by that, and he didn't have to be burdened by it. He could still be— feel like a member.

Three participants noted that clinicians should consider involving the adolescent clients in decision making processes. One participant described an example, noting that members of a particular group were required to serve as leaders of the group:

> Typically one of the group members will run the group discussion. Myself or the other facilitator, we don't run the group discussion. Definitely we're there to help guide and to

> ask questions and to intervene and to prompt discussion. But we want them to lead the group because this is their treatment. And it's better to find that, I can tell them a lot of different things, or I can guide them or I can suggest to them, or I can hold them accountable— which is fine, it's part of our job; however, when it comes from peers who are going through the same issue or struggle, they tend to be a little more receptive.

One participant discussed how providing a loose structure, rather than a tight or rigid one, is beneficial in order for the adolescents in residential treatment to develop, stating of their experience,

> So it was interesting, it wasn't as firmly structured as I would have thought. They might've also benefited perhaps from like a pre-set structure. But you can't in residential, sometimes you have to just go with the flow of whatever's going on.

Two participants described how taking an inviting approach in attempts at engaging adolescents in residential treatment can be beneficial. One provided an example of an intervention used in a group setting:

> Somebody might, like I said, somebody might be laying on the floor. You know, halfway through group, I'd say, would you like to take a chair, do you feel like taking a chair. Would you like to join us in a chair? They may try to ignore you. They may get up and walk down, sit down in a chair. And you realize they just wanted to be asked.

One participant recognized the importance of addressing confidentiality concerns of the adolescents in order to facilitate their engagement in group. And two participants identified the need to provide skills to the residents for stabilization before engaging in group process. One participant described,

> We also had clients that had high levels of anxiety, so they needed to be given tools ahead of time before group so they wouldn't be fidgeting or interrupting or calling out or screaming or yelling, or walking out. We had to make sure that those clients had supports and coping skills so that during group they could sit and participate. Whether it's skills on how to fidget without interrupting group or giving appropriate breaks at a certain time.

Five of the participants (50% of the sample) described considerations related to the familiarity of the clinician to the context of the residential treatment center that ultimately affect the experience of group therapy for adolescents in residential treatment. Three participants thought it necessary that clinicians spend time on the unit in order to be made aware of the context, setting, and issues faced by residents. One participant noted more specifically the need to be mindful of specific restrictions for the residents individually and collectively. One participant described,

> And then also too, so just take the treatment track that I work with, inappropriate sexual behaviors. Depending on what their specific treatment history is, where some of them may have had offenses with younger kids, or ones of them that are more vulnerable than them, or they look to seek out other people to engage in sexual behaviors. So you have to look at that too, to determine, okay well Johnny wants to do this particular group. Okay who else is in that group? Is him [*sic*] paired with these peers, is this an appropriate group, or do we need to find another group for him to engage in also? Because we do want them to engage in like I said prosocial skills at different recreational activities, so they can learn how to take some of the things that they have learned from their therapy group and apply it to their day to day behavior. So we want them to do that. However, I

> would never make a decision for them to do things like that at the expense of other people.

Four participants described how increased communication and collaboration among staff would be beneficial. One participant stated,

> And that's why we would often bring the techs in because the techs were with them throughout the day, where perhaps we saw them for a few hours during group, maybe some of them during individual therapy, but the techs would inform you of like what was going on throughout the day. Sometimes it would be good to have those updates before group started so that you would know the conflicts or situations, any situation that arose, ahead of time. So you'd know how to better or cope for what was coming in to your session when you had group.

Three of the participants (30% of the sample) discussed the need for behavioral support within the group setting for the benefit of both the facilitators and the group members. Two participants explicitly stated that each psychotherapy group needs to have two clinicians as co-facilitators. One participant described the following:

> The prime example that I would say is that I was provided with a social worker to co-lead my groups with me, and she wasn't there 60% of the time. And it's really imperative that you have two people running the group, because especially in these situations, you need to be able to have someone who can remove two kids who are starting to get into a conflict with each other so that it doesn't derail the rest of the group. Especially kids who've been traumatized and they witness domestic violence or experienced domestic violence, or whatever; that now they're being exposed to it in their living space because two kids in the group are getting into a fight and I'm the only one there. My options are

> very limited in terms of, I could try to get some of the unit staff to come and help so I can try to keep the group going, or I can shut the group down so I can deal with the conflict just between two group members.

Two participants noted the need to involve direct care staff in group as appropriate. One stated,

> So many times we would have groups and we would ask the techs to be present in the group. Because if a client or group member was specifically more conflictive, or impulsive, or might need to be escorted in the middle of the group, it would have to be escorted; we needed some support in there.

Seven of the participants (70% of the sample) described considerations that would be beneficial, but unrealistic for implementing in groups for adolescents in residential treatment centers. Four participants noted that a smaller group size would increase the feeling of safety and allow for more effective group therapy work. One participant described,

> With the growing agency, so logistically you can run into, is the group size getting too big? And if I only have a certain number of people on staff, I can't run 20 groups a week and plus be responsible for my cottage, and plus do my case management, and plus do that. So you don't want to put everybody all together and make the group sizes enormous. But we run into that issue. It'd be great to have a group of six or seven. But it's not realistic. Because we don't have enough staff to do that or enough time to run that many groups in a week.

Another participant questioned the common practice of expanding the group size in residential treatment, noting that group research has consistently reflected a more limited group size:

> Show me the evidence that the large groups are the same as what Yalom and other resear— their research seems to think six to eight is the right size. Is that changed? I don't

> think so. Are we teaching ourselves that whatever's convenient is the way to go? And it leeches out into residential treatment and other places. I haven't seen evidence of [pause] having 14 people in a group is okay; much less [for] kids. So size of the group— sticking to the basics of what research has shown.

Five participants discussed their desire to have more exclusionary selection and preparation criteria for determining who is added to the ongoing groups. From the perspective of one participant,

> And then there's like the common things, right, like it would be ideal if it wasn't, like in the setting I was in, to be thoughtful about group composition. Right, and like screen people. And identify members that are going to be likely to grow cohesive as a group.

Addressing identified issues. After identifying various issues and barriers that could interfere with group development and adolescent engagement in group process, participants provided accounts of what would it would take to address those issues in developing new psychotherapy groups in residential treatment centers. Seven of the participants (70% of the sample) described approaches that would result in better assessment of the difficulties and needs of new residents. One participant noted that assessments of new residents should wait until they are acquainted with the residential treatment center in order to provide a more authentic reflection of their functioning. Three participants suggested that clinicians developing new psychotherapy groups develop a more specific treatment plan for each adolescent entering the residential treatment center. One participant stated,

> I would create programs specifically based on each child's treatment plan. So there's no need for one child to go to a substance abuse group and take away that one hour of their day. I would replace that one hour with something that pertains to their background

> specifically. Not that substance abuse is not important in life and for teenagers, because I think the assumption is they are going to encounter these types of problems and issues in life. But in all honesty, we also see the data that a lot of the time, we're introducing the topic to girls that probably wouldn't have thought about it or could care less about it or kind of like ignorant to it. Now there's an interest. Now we see sometimes they come back to us into the program and now have a drug problem. And they learned some of that from their peers in the program. And it starts from just the topic of it. So of course important topic to talk about, but I think I would specialize treatment, of course in an ideal world, so it wouldn't be just every child going through the same program.

Three participants noted that more serious concerns for each resident should be addressed in individual therapy. One suggested,

> To like recognize maybe what those traumas were in like individual therapy. Figure out where they are with it so that when you're in group you can more like temper it if you need or like switch avenues if you need. Switch the direction of it. I think that having individual therapy helps you have like a heartbeat on that sort of thing and there may be some topics that some individuals of the group are not yet ready for until they do some strong individual work around their trauma. So I think that would be one consideration that'd be really important.

Four participants suggested that group clinicians be mindful of time and/or length of group. One warned,

> If you're interrupting their group when they're playing basketball, that's a problem. I just didn’t realize how like huge that was, but yeah, they need their outside time. And if

> they're playing basketball, that is not the time to grab them for group. Other than that, they're fine.

Two participants discussed limiting the frequency of occurrence of group for more benefit. One participant stated,

> I would not have run group seven days a week. I think that was not very effective. I would have run group two or three days a week, maybe giving them [pause] if they wanted us to focus on psycho-education, maybe creating a curriculum for the clients to do on their own throughout, maybe that they could check in with their individual therapist about [pause] you know all the anger management pieces, the psycho-education pieces, all the topics, the substance abuse, that we had to touch on. And allowing it to be more of a process group to allow more fluidity of conversation and topics. I think that would've been more effective.

Three participants discussed the need for de-escalation skills for clinicians and staff, noting that both the population and the context are indicative of higher-than-average levels of conflict.

Five of the participants (50% of the sample) provided suggestions specifically related to issues of group selection. Four participants noted that groups for residents at similar levels of development or insight would likely be more beneficial and more successful than randomized heterogeneous groups. One participant stated, "Maybe need to change them around and have people of the same skill— interpersonal skill level in groups, and right before they leave, have them in groups where people are more developed." Two participants suggested that groups be developed for residents with similar histories or experiences. One participant noted,

> In all honesty, they should be plucked out and put into a smaller just trauma-informed program. But, I don't ever see that being possible because of money and logistics. I just

> [pause] because they just do not belong together. And they're not getting the treatment that they deserve for the experiences that they've been through.

Additional Information to Capture the Experience

This final section includes information that was not gathered elsewhere in the interview data. The final question was a more open-ended one, focusing specifically on any areas that were not covered elsewhere in the semi-structured interview. Participants were able to reflect on any additional information they thought might be important to consider in order to capture the experience of facilitating psychotherapy groups for adolescents in residential treatment centers. Eight of the participants (80% of the sample) described additional information related to the distinctions present among residential treatment centers in comparison to other settings. Five participants noted that nothing they learned prior to their experiences in residential treatment centers applies directly to their work with the adolescents in the setting. One participant stated,

> I think it would've been helpful for me, maybe as a clinician, to maybe have more supervision with mandated groups, and how to facilitate communication [pause]. I probably could have and would have run groups differently had I had supervision or training specifically on, how do you facilitate communication with a— maybe with a client who doesn't want to be there? As opposed to just having it be just a check off, I completed my group for the day.

Three participants noted that the clinical work in residential treatment center settings is taxing for clinicians and that much energy is required. One participant described their experience as follows:

> It's a very dynamic process. It's a very interactional dynamic process, you need to have a lot of energy. I would say that the worst groups I've ever seen run are the ones where the

> therapist takes . . . like a traditional teacher role and we're just— I'm gonna talk to you about whatever, and we're gonna process, and that's it. It's not linear. It's very dynamic. It's very interactional. And I feel that the times when I've gotten the most out of it is when you have the energy to keep up and keep them going. You know, kids, teens, every 20 minutes they needed a different activity or a different question or a different thing; when we started doing— we realized that as we were going along. When we realized that, we started changing the activity, changing it up every 20 minutes or so.

Another participant stated,

> Most people who have worked in residential treatment centers who are therapists are absolutely exhausted [pause]. It's, you're being traumatized yourself. It took me eight months to get over, being there, after I left one. I developed somatic symptoms while there, I just [pause] and, I found that a lot of people that I worked with, a lot of them had drug and alcohol problems; maybe they had them before they came there, but they certainly had them. One of them had OCD, got worse and worse. And you're, you're just exhausted.

Three participants pointed out that the adolescents in residential treatment centers are raw and unfiltered in their interactions with their peers as well as with staff. One participant stated,

> I think to be able to be open to the adolescents. I think I have learned— I feel like I have learned a lot from my experience with them. Because they will definitely you know put you on the spot. And you know, they tell it how it is. How they feel.

Another participant warned, "Oh, be prepared for some racial slurs to get thrown. Because, I definitely saw a lot of that. And I experienced that myself personally. Yeah, when they're digging to hurt each other, they'll pull out anything." Five participants noted that group

clinicians in residential treatment centers have many responsibilities that also come with much paperwork and documentation. One participant described,

> In residential facilities, there's a tremendous amount of paperwork and things that you have to turn in in a very short amount of time. So you actually have to work very quickly. So that means jumping into the rapport, building that super quick.

And finally, one participant noted that clinicians can often retreat to withdrawing as a form of self care, in response to their unyielding responsibilities.

Seven of the participants (70% of the sample) discussed having a realization that they needed to adjust their expectations as clinicians in the residential treatment center setting. One participant described the difficult transition into the setting for both adolescent residents and staff alike:

> It's difficult when if you came from a more traditional hospital outpatient setting, and then coming into this, for some it's a difficult transition. Not only just the residents, but for the staff as well. The residents and their family are used to this particular model, and we don't operate in that way, they kind of struggle with that adjustment. But then also too for clinical staff, where I said, it's not just an office job. So if you're looking for, to just be here and to just be an office job, and I just run my groups two to three times a week in this building, then you might not see the value in the way in which we do it. Because like I said, we're out of our office, we're in the cottage, we're in the cafeteria. We don't have a separate cafeteria from the residents, we're actually in the cafeteria. And when the kids are transitioning from point A to point B, we're outside, we're present. We're able to help to kind of trouble shoot or problem-solve things that are going on right there in the moment. So if that's not what you're into, or you just want to be— and again, nothing

> wrong with it. But if that's just your preference, is to be in the office, you know and just to have a session at three, have a session at four, have a session at five, then I would say this particular setting where we do a lot of work in the milieu, then you won't see the value, and you would kind of struggle.

Two participants noted that success looks different with adolescents in residential treatment centers. One participant stated,

> You know, maybe, if you have three classes— three groups in a week, you can have one group where you end up spending 20 minutes where they really talk about their feelings, or get it, what it is to talk about their feelings. That's a huge success. That's a huge success. So you've gotta adjust your expectations a little bit.

Another participant reflected,

> I learned to appreciate some of those things as being like, this is productive. This is a good outcome, even though it's not like everybody sitting here having a really deep dialogue about deep psychological matters. I just couldn't expect that. So I think a lot of it was expectation management with myself. Like, this is, this is a good group right here.

Two participants addressed the issue of patience as a challenge for clinicians in facilitating group process. One participant described,

> So I think here (current outpatient work environment) I've got real experience with interpersonal process groups, and one of the challenges is just patience. Knowing how to just wait. And at [the residential treatment center], with the boys, I had to be more directive, so I didn't often have to wait, because I would've been waiting forever, like it never would have happened if I had to wait and sit back and let the process happen. I mean they might've been there six to 12 months, and that wouldn't've been enough time

> if I was just waiting. Because they weren't as invested, they were involuntary to treatment. So I think now kind of learning how to sit with seeing something playing out and not really wanting to touch it yet, letting the group figure it out and kind of stumble through it, so like those kinds of things I think have been challenging but rewarding.

Two participants described their observations of progress for individuals in group as demonstrated in their presentation in group over time. One participant provided the following example:

> A child was leaving, and somebody wanted a summary of her progress in my group. And I wrote down, well, the first day, she stood up, and said, you're staring at me, if you don't st— she looked at another girl and stood up, balled up her fists, and said you've been staring at me, I don't know what the fuck's wrong with you, I'm gonna knock your head off if you don't stop staring at me. The other girl ran out of the room. Went AWOL. State had to— staff had to chase her down. Now the first girl that made that threat, right, the last week before she left, she would be sitting there just as cool as a cucumber. Sweet, and somebody might say something rude to her, and she'd just [pause] shrug her shoulders and say, I don't know what that has to do with me. So [pause] that's progress.

Three participants described that interpersonal process work is essential for adolescent treatment in residential treatment centers. One noted,

> Sometimes those people have no training and no sense of what we're trying to get the kids to do, process work. It's totally out of place now, it's a big fight or something. And so, I think the place of good process work, it's essential, myself, I think it's not being done enough. You have people like [names a child and adolescent psychologist who is also a certified group psychotherapist], he's led a lot of it and done a lot of it. But, some places

> are doing it, but a lot of places are not. I think it's sad, because I think the interpersonal stuff is essential, I don't know how you can expect [pause] kids to develop unless you, you know, give them some exposure to that.

Another participant stated,

> Those of us who were able to manage it better, I think we were able to focus on that interpersonal relationship a little bit more. And even though it was a group, you could still have a one on one kind of rapport with each individual client and make the group flow better. Because of that rapport. Instead of just trying to run it without it. Yalom was right, you know.

Three participants noted that behavior management is a group clinician's biggest job with adolescents in residential treatment centers. One participant described de-escalating clients by listening and reflecting their feelings back to them:

> They could be interruptive, a lot of times. And I think the quickest way to challenge that is to just show them another way. So if they're used to a lot of staff giving them reprimands and yelling, the opportunities that I always felt was that as a [clinician], I always felt that I had to show them a different way of just them knowing that I'm not the one giving them the reprimands. I understand where you're coming from— I'm actually listening to you. So I adjust the actual topic and content of what they're saying instead of the cursing and yelling part.

Two participants noted that group clinicians in residential treatment centers do not learn about the complexity of their populations and settings in textbooks. One participant described,

> An example of it would be someone who has just been— who just came off of being trafficked and is going through an FBI case, so agents are coming to see her every week,

> and the prosecution to get her ready to testify against the two, what they call boyfriends, who run a huge ring of girls in three different places all in [the state] . . . so it's like a major issue. And she's been used for years. And this is just one issue for the girl. She also has drug problems, she also has— let's see what else [pause] kicked out of school, parents who've abused her, taken away when she was three. So most of the girls have multiple traumas and multiple problems. Where most of the case studies at school, it's just one that you're focused on. And that's the hardest part of being a [clinician] at this facility. You're not used to getting clients with this much trauma. Like where do you start?

Three participants described that the role of the group clinician leads to encountering issues that you are unable to plan for. One detailed,

> There's so many little things that happen and little unexpected things and twists and turns. Just, in my experience, there was just so much stuff that you couldn't plan for. And that I think is the most [pause] it's probably the best thing that someone needs to know if they're going to attempt to do it. At least with the level of pathology that I worked with. Your best made plans are like total garbage, and more of the work really has to be you thinking on your toes as things are happening and just being prepared to respond to things that are happening that you didn't predict. Because that's I think more of a reality than it— at the end of each session when you look back at it, you don't say like, that went exactly the way I thought it was going to go, it's more like, okay everyone got out of that without getting injured. And I think maybe some people benefited from it, and now let's everybody regroup. And now it's time for everyone to eat? Great.

Four of the participants (40% of the sample) described issues related to concerns arising in working with direct care staff. Two of those participants discussed clients having specific

concerns about confidentiality, especially in the group therapy space, due to the presence, and oftentimes the lack of discretion, of direct care staff. Two participants noted that direct care staff members often have similar backgrounds as clients in residential treatment centers. One participant noted the following:

> But then there's these direct care staff that's spending so much more time with the kids, that most of them have like a GED or equivalent, if that. You know what I mean, so [pause]. And [they] are growing up in environments that quite frankly aren't so different from some of these boys. So in some ways they were really relatable, which was really cool. But then in other ways they kind of fed a lot of the negativity that we were trying to work against in the program.

One participant noted concerns due to use of threats (i.e., of program consequences, withholding perks, etc.) against the clients by direct care staff members in attempts to address behavioral concerns among residents. Three participants expressed issues related to the presence of direct care staff members interfering with the facilitation of group process. One participant noted,

> Sometimes they also— the dynamics with the staff, because the staff were also culturally of the same mindset a lot of times. So sometimes I couldn't get them to be as vulnerable as they could be, because they would be that way in individual with me, in group, because staff was there. And they had to be cool for the staff. Otherwise the staff would fuck them up later or not give them the snacks that they give them that they're not supposed to be giving them, or [pause] like something. It was always something.

Another participant described a situation in which direct care staff members conspired with a resident to have that resident not attend group:

> So occasionally, like I had a client who would go work in the kitchens. And I had to really put my foot down with him and the kitchen staff, that he could not continue to miss group— which caused a big uproar because he cussed me out in front of the whole group because I wouldn't allow him to go work in the kitchen. And then the kitchen staff was very angry with me because they wanted him to go up there and help and I wouldn't let him leave early.

Lastly, one participant described the view that direct care staff often maintained of the adolescents in residential treatment centers being "difficult," resulting in their disapproval of the efforts of clinicians to de-escalate client behaviors:

> I could walk in any treatment center I have never been in, and if I start interviewing for a job they're going to ask about the problems, it's always going to be the same thing: well, some staff feels like we're rewarding them when we [pause] de-escalate them. You know, we should be punishing more— even the nurses'll say, these kids just need good spankings. You'll get that everywhere. And you're al— constantly— the therapists don't see it that way, so you constantly battle that.

Chapter V: Discussion

Although there is no measure of statistical significance to quantify the information collected, it was apparent through the outcomes of the current study that the issue of the experiences of clinicians in facilitating group process and group psychotherapy with adolescents in residential treatment centers was very important to the participants. Throughout the topics and the narratives presented in the data analysis, specific themes emerged. The following discussion explores the themes of the experiences and perspectives shared by the participants; considers limitations to the current study; and summarizes resulting implications.

Themes

Participants were asked a range of questions that provided a structure for sharing their experiences with facilitating group process for adolescents in residential treatment centers. They provided responses to questions that touched on the following categories: (1) training and experience in group; (2) clinical working experiences in residential treatment center settings; (3) experiences facilitating psychotherapy groups and group process in residential treatment centers for adolescents; (4) inferences regarding the facilitation of group process and psychotherapy groups with adolescents in residential treatment centers, based on their professional experiences; and (5) other information to help capture the experience.

Through the qualitative data collected, consisting of the independent narratives of the participants, themes emerged that included (a) preparation for clinical work in RTCs; (b) the impact of variety of contextual factors; (c) clinician influence on facilitation of group process; (d) the need to move to system-level trauma-informed care; (e) impact of direct care staff on group process; (f) attention to and focus on individual needs; (g) variety in group types as treatment component; (h) balancing structure and flexibility in group facilitation; and (i) the

benefit of group process for adolescents in RTCs. The following is a presentation of the emerging themes discussed.

Preparation for clinical work in RTCs. The participants of the current study discussed the ways in which working with adolescents in a residential treatment center setting is a unique experience. They described structural aspects of the setting as well as the developmental needs of the population served— consistent with the results of the study by Lam et al. (2015)—, with the presence of clinicians in the residential milieu being one component that is qualitatively different than in other settings.

Further, participants noted that group therapies in residential treatment centers do not meet the basic assumptions present in more typical psychotherapy groups, such as described by Yalom & Leszcz (2005). The assumption of group psychotherapy challenged most by psychotherapy groups in residential treatment settings is that of contact between members being exclusive to group sessions, which was previously discussed by Bonsaksen et al. (2011). The dynamic of group members in residential treatment centers— influenced by residents being with each other in multiple contexts, over an extended length of time, and often at the exclusion of the group facilitator(s)— mediates other processes and dynamics that typically occur in group, such as the impact of member absences and frequent changes in group membership (Yalom & Leszcz, 2005). As such, the phases of group development that are observed within psychotherapy groups in residential treatment centers do not progress in the ways that are described in textbooks and classic teachings, but reflect that it is a specialized clinical setting— which was also concluded in the discussion of research by Shay (2011).

As a result of the unique perspective of residential treatment centers, the work done in these settings would not be experientially comparable to that described by other training and

learning experiences. Participants noted that it is not until one has worked with adolescents in residential treatment centers that one could feel prepared to do such work with such populations, despite previous coursework, training, and other experiences. Participants also described the ways in which they could be limited in clinical scope of practice by the presentation and issues particular to this population (e.g., limited access to materials, spaces, objects in the setting). They described the need for support from others who have direct knowledge and experience as well in order to bridge the gap between theory and clinical practice as applied to their work, as described by AGPA (2007) as well as Small et al. (1991).

Group facilitators in residential treatment centers need not only to know how to facilitate groups with adolescents in a general sense, but also how to engage resistant, oppositional, and/or involuntary group members; techniques for de-escalation of oftentimes traumatized and easily triggered residents; and strategies for managing acute presentations of intrapersonal and interpersonal crises and behavioral issues. These skills are critical for responding to the issues that often present with adolescents in residential treatment centers.

As related to these observations of the differences present in the population and setting, the participants emphasized the importance of specific preparation for their experiences with facilitating group process with adolescents in residential treatment centers. Each of them noted that their initial clinical learning and exposure processes made lasting impressions on them in their navigating the process of facilitating group. Many of the participants described their supervision and training experiences as significantly impactful in their overall development as group facilitator, with those who attended additional conferences and workshops specific to group work beneficial as well.

Participants also emphasized personal experiences that stood out to them due to the ability of those experiences to both provide perspective for the facilitators and to contribute translatable skills and knowledge to their group work. Whether they described their own personal experiences as group members or professional experiences that provided them with additional context for their work with the adolescent residents, participants emphasized that in addition to coursework, institutes, supervision, and consultation experiences, they developed an appreciation for their personal and professional experiences that they were able to apply to their group psychotherapy work and would eventually shape their development and identities as group facilitators as well.

Participants consistently noted, however, that more training, supervision, and support are needed for clinicians facilitating psychotherapy groups— especially those with process components— in residential treatment centers. Most noted having completed one course during their graduate study; however, due to the incongruences between what is taught in textbooks and what is experienced in practice, as described above, participants discussed how beneficial and applicable training and supervision specific to group therapy work in residential treatment centers is, or could be, for developing and maintaining skills in facilitating process between members in psychotherapy groups with adolescents in residential treatment.

The impact of variety of contextual factors. As consistent with contributions made by Handwerk et al. (2006), participants described the residential treatment center settings in which they worked, noting a broad range of contextual factors that make up the structure and provide boundaries for the clinical treatment components of residential treatment. Their experiences varied immensely with regard to size, structure, model, length of stay, theoretical orientation, treatment foci, and other aspects specific to the residential treatment setting.

On the other hand, participants noted consistently and recurrently that the contexts of their settings greatly influenced their experiences, as is consistent with the findings of the study by Bonsaksen et al. (2011). For example, those in settings with smaller capacities or less residents did not face as many challenges with regard to group size or composition as did those with much larger capacities. Participants described the ways in which the policies and contextual factors impacted group makeup, which in turn impacted the group experience and foci, supporting the outcome a previous study by Waltman et al. (2012) that demonstrated a relationship between positive experience and group treatment outcome.

In most cases, participants noted that the adolescent residents were separated by sex and/or gender. Some facilities were single-sex, while residents in mixed-gender or co-ed were often assigned to units designated for one sex/gender or the other, from a binary perspective. Those few groups that did allow for mixed-gender makeup tended to be for those more advanced or mature residents, such as in the level system of progression, or focused on specific shared experiences or issues. Participants shared their views of the influences of gender makeup, of both the facilities and of the groups, suggesting that keeping residents separated by sex or gender removes the added issue of influences of the opposite sex— especially relevant during the adolescent stage of development. This perspective of the participants paired with their described experiences in clinical practice are further supported by research conducted by Handwerk et al. (2006) and by Huefner and Vollmer (2014), which consistently concluded that there are often gender differences in the presentations of adolescents in residential treatment centers.

Whether or not groups were mandated and supported within the residential treatment centers was also discussed by participants. They described the impact of voluntary group participation versus involuntary group participation. The sustainability of the groups was

impacted by whether or not residents had to attend as a component of their treatment and progression out of the programs. Those groups without mandates were more susceptible to dissipating, while those that were required saw more consistent and stable group processes as a whole.

Participants noted that the mandatory nature of the majority of the groups was influential in how the group members responded to absences. No consequences were dispersed or addressed directly in the group space, and the individual needs of each resident were an important consideration in response to their absences. Thus, residents missing group could be interpreted as a lack of commitment to the group, but was could also represent any number of conflicting scheduling needs that could arise throughout their stay in the program. As such, the context of the residential treatment center, even as it relates to addressing group membership and attendance, could impact the ways in which group facilitators respond and manage reactions to observations of who is present for each group session.

The theoretical orientation and/or model applied throughout the system were also impactful on the experiences of facilitating groups, as described by the participants. They discussed the ways in which consistency across the agency or program was required in those settings that were more stringent, such as in response to the level of risk for the resident population. Participants noted the ways in which having a specific model and/or theoretical orientation put in place throughout the agencies or programs would be the frame for each resident's course of treatment, both inside and outside of group. The model used, as determined by the treatment philosophies of the programs, might contribute to which treatment components were required as well as how frequently. The theoretical orientation might be reflected in systems of reward (e.g., point systems or token economies) and the ways in which skills were

reinforced for the adolescents. Because there was such variability in experiences based on context, it is important to consider the ways in which each of those contexts influenced the differing experience of facilitating process in the course of group psychotherapy.

Finally, the context of the setting was influential in determining factors such as the length of stay for each of the members; changes in group membership; and who, when, and how new members were added to or changed between groups. Those settings that required members to stay in a particular group throughout their stay in the program would then have less disruptions than those that see more frequent changes. Each of these factors, as determined by the context the policies superimposed thereon, helps to color the experience of, and can create ongoing disruptions to, facilitating groups with process components.

Clinician influence on facilitation of group process. In most cases for the participants of the current study, the model and orientation espoused by the system was not so prescriptive as to dictate the flow of groups. Some of the participants were in systems that used specific models that were applied across multiple treatment contexts, informing the structure of individual therapy, group therapy, milieu treatment, work with families, and school components. However, clinicians described the ways in which they used those as well as other models and theories as a structure to guide their group facilitation, but that that they also introduced other components to the group psychotherapy based on their clinical judgment, as is consistent with early work contributed by Small et al. (1991).

Especially due to participants discussing group experiences with process components, they did not describe manualized or strictly skill-based psycho-educational groups at length, which is inconsistent with research by Habib et al. (2013) that promotes manualized and systematically implemented therapies. Most participants noted that there was a large degree of

freedom for group facilitators in determining the direction of the psychotherapy groups. As such, and with the participants being from various clinical degree fields in mental health as well as practicing within various contextual frameworks, their experiences and inferences about those experiences varied based on the many factors that influenced their individualized experiences.

Participants described how their prior experiences and their clinical judgment helped to guide them in forming relationships with their groups as a whole and encouraging processes between members. This was achieved by engaging the residents in discussions and other elements of participation that helped to demonstrate concepts, among other techniques that were introduced. Bringing in external components (e.g., activities, games, and food) as well as providing some level of structure that could be anticipated by the group members (see Balancing Structure and Flexibility in Group Facilitation theme below) were widely thought to be appropriate and helpful means of engaging the adolescents in the group process. However, the selection and/or creation of each of those elements used to facilitate the therapy groups were left to the clinician's discretion.

In a general sense, most of the participants noted that they facilitated their psychotherapy groups by using a specific topic or theme. Some programs required, through the model implemented or the contract or licensing standards in place, that specific topics be covered weekly, while other clinicians introduced topics in the absence of such a directive. Participants varied in their beliefs about the necessity of prescribing topics to each group therapy session, as evidenced by statements that ranged from suggesting that it was not at all necessary to suggesting that the adolescent residents would not engage in group process without them (topics).

Analogously, the previous trainings and experiences that each clinician engaged in prior to their work facilitating psychotherapy groups with process components played a role in determining how they chose to facilitate the psychotherapy groups for the adolescent residents as well as those group outcomes. Collectively, the participants came from a range of training and educational backgrounds. However, those participants with demonstrated interest in group psychotherapy beyond graduate coursework (e.g., those who participated in a national and local group psychotherapy conferences and workshops as well as those who sought further exposure through additional supervision, reading, etc.) demonstrated more confidence in their ability to engage adolescents in group process than did those who did not demonstrate interest similarly.

With the participants representing such a range of experiences, both in preparation and in execution of facilitating psychotherapy groups with process components for adolescents in residential treatment centers, it is clear that the influence of the clinician in the facilitation of such groups was significant. That clinicians may come from different perspectives than that which is imposed by the system is suggestive of and consistent with results of a previous study by Abramovitz and Bloom (2003).

The need to move to system-level trauma-informed care. As participants explored the influence of trauma-informed care on the psychotherapy groups in residential treatment centers for adolescents, they also provided their perspectives on how trauma-informed care plays a role more broadly in their settings as well— which is similar to the conclusion of Zirkle et al. (2002), noting the need for a common standard of care to be implemented in interdisciplinary and multi-level clinical settings. The narratives provided a clear depiction of trauma being an important consideration in conceptualizing both the initial assessment of treatment needs as well as the ongoing assessment of the experiences of adolescents in residential treatment settings. However,

settings described by participants varied in the ways in which trauma-informed care was implemented— whether initiated/integrated by the clinicians or by the system as a whole.

Participants collectively identified themselves and other clinicians as trauma-informed, based on their clinical awareness of and ability to address issues related to trauma in the histories of their clients, as well as the impact of involuntary placement in residential treatment. As a result of their clinical awareness in their roles as group facilitators, participants described that those factors, such as past and present traumatic experiences, were monitored in the context of each group psychotherapy session. Further, some clinicians restricted or limited the conversations facilitated in group based on their consideration of the effects of trauma on the population.

Some of the participants demonstrated familiarity with the system-level approach to trauma-informed care, such as described by Brown et al. (2012) and Berger and Quiros (2014). Participants described discussions being conducted during clinical staff meetings to maintain their competence in providing services to address the needs of adolescents exposed to traumatic experiences. They discussed these experiences as helpful to their facilitation of group psychotherapy, in that they were able to consult with other clinical staff members about the ways in which trauma was manifesting in group as well as interventions and strategies for addressing acute issues, further supporting findings by Berger and Quiros (2014), which suggested supervision and consultation as a means by which trauma-informed care can be implemented and the knowledge reinforced.

Further, participants discussed the system-level implementation of trauma-informed care by way of trainings and dialogues initiated with not only clinical staff, but also direct care staff, with whom the adolescent residents spend the most of their time. Details were provided of

conversations that clinical staff members had with direct care staff, discussing the varying levels of sensitivity that clients had to stimuli due to their histories. Participants noted that direct care staff, who were not trained clinically, were at times present in the psychotherapy groups and thus directly exposed to the clinical treatment of the residents, warranting the ongoing need for conversations about addressing and responding to trauma, which further supports results from the study by Greenwald et al. (2012).

Whether they were engaged in systems that implemented trauma-informed care or they considered themselves to be trauma-informed from an individual perspective, participants highlighted the need for trauma-informed care to be integrated throughout the various components of the residential treatment centers that they represented. Those who experienced trauma-informed care at the system-level noted the need for continued and ongoing training for clinical and non-clinical staff, while those working in systems that were not trauma-informed noted the need to distribute knowledge of dealing with and responding to the traumatic experiences of clients, especially to non-clinical staff.

Impact of direct care staff on group process. The participants discussed the many ways in which the direct care staff (also referred to as non-clinical staff, residential/milieu counselors, and mental health techs) were influential to the experiences of the adolescent residents as well as to the work done in the psychotherapy groups. Of all the members of the staff contributing to the treatment within residential treatment centers, direct care staff, who often have little-to-no clinical training in mental health, are the largest group and spend the most time with the residents. Based on the mere-exposure effect alone, adolescents in residential treatment centers, who were described as impressionable and ego-defended, are likely to be heavily influenced by

the opinions and the presentation of the direct care staff, even across multiple facets of their treatment.

As a whole, participants described that direct care staff needed to be present in or near the spaces in which the psychotherapy groups were held in order to provide additional behavioral support, with some noting explicitly that direct care staff were responsible for escorting difficult clients and initiating restraints when necessary. Participants noted that the presence of direct care staff poses potential threats to the experience of confidentiality and sense of safety for the adolescent residents within the clinical group space. This was inferred to be a result of the position of direct care staff within the residential treatment centers not requiring a clinical background or training—which was also consistent with the study by Zirkle et al. (2002).

Participants discussed the variable quality of relationships that the adolescents in residential treatment centers have with the direct care staff, ranging in valence from positive to negative. Those direct care staff members who built positive relationships with the residents were more likely to serve as a support in the therapy group sessions, while those who did not have positive relationships could serve to further escalate triggered clients.

Further, participants discussed the ways in which unhelpful behaviors and attitudes demonstrated by the direct care staff could affect the groups. They described occurrences of the engagement of direct care staff in conversations about their personal lives interfered with treatment for the residents. They also noted as an example that negative attitudes towards group therapy on behalf of the direct care staff could serve as a barrier to the engagement of the adolescent population being served, especially if those attitudes were expressed in the presence of or communicated directly to those adolescents. In other cases, apathy on behalf of the direct

care staff members, expressed or demonstrated towards group treatment was discussed as being detrimental to the facilitation of group process and group psychotherapy as a whole.

Participants noted an awareness of the value placed on group by direct care staff persons. They discussed the decreased likelihood of the direct care staff being able to respond to changing situations as necessary or as appropriate, occurring when direct care staff members consider the group therapy time for the residents to be time for them to be off-guard and on a break. Participants described this as impeding on the group facilitator(s) agility, often resulting in constant redirection, shifting the group focus, or abrupt termination of group sessions to focus on member(s) in conflict, at the expense of the group. With some direct care staff described by participants as ineffective and/or inappropriate, such as discussing their social or personal activities, their impact on the psychotherapy groups can be a contributing factor to ongoing difficulties experiences in facilitating group.

The participants, noting the frequency with which the direct care staff share histories and backgrounds, are from similar neighborhoods, and are close in age to the residents being served was also significant. Residents can be better able to relate, and are likely to be more easily triggered by direct care staff members who share a common background with them. Thus both controllable and uncontrollable variables influence the relationship between direct care staff, the residents, and the engagement and facilitation of group process components of psychotherapy groups for adolescents in residential treatment centers.

Attention to and focus on individual needs. Participants discussed there often being more emphasis placed on the work done specifically with focus on the individual therapy components rather than emphasis on group. In some settings, supervision, consultation, and treatment team meetings did not designate time to discuss group process, but attended only to the

issues discussed and concerns faced in individual or family treatment. This, and other experiences described by the participants, demonstrates the incongruence between the emphasis placed on the group as an important and mandatory component of treatment and the negative attitudes or lack of support expressed frequently among staff. It further demonstrates a common failure to understand the value and potential impact of group treatment by staff and by programs or agencies as a whole.

Participants noted commonly that groups were a requirement of the residential treatment programs in which they worked, and there was often an expectation or a mandate that clients attend each session due to group therapy being a component of their overall treatment. Participants noted most often that residents did not refuse to attend group, most commonly due to participation in group sessions being associated with their growth and progress. When they did miss group sessions for unexcused reasons, the consequences were handled outside of group, such as by demerits or the loss of points within a point system; loss of privileges; or the residents being stagnated or halted in their progress towards successful discharge.

The clinician's attention to individual needs played out in group sessions as well. Participants discussed implementing structure and restricting the focus of discussion in the psychotherapy groups in order to keep "safe" topics and to remain in control of the conversation, often as related to the traumatic individual histories of the group members. They described this as an effort to reduce the reactivity of the group members to or to create a sense of safety that would allow otherwise vulnerability and/or interpersonal risk-averse clients to engage. These considerations by participants of the current study are consistent with results from Lyons et al. (1998) who similarly noted the need for treatment specificity based on individual client needs.

Clinicians described the need to consider and to focus directly on the individuals in their groups as well. They discussed efforts to manipulate even factors such as the physical space of group in order to address the individual needs that clients may present with. For example, participants described considerations such as how much space between chairs, how many extra chairs to place in the room, or whether to have chairs at all. They described allowing some members to exit the group or to isolate from the group based on their threshold of engagement, developmental needs, or clinical concerns. Participants emphasized the need to know the histories and the backgrounds of group members in order to make adjustments in-group that would allow for each of the members to benefit.

Balancing structure and flexibility in group facilitation. Participants discussed components of facilitating process focused psychotherapy groups that allowed for them to engage the adolescent members in the work. They noted consistently that unlike groups in many other settings, there is some level of structure necessary in order to maintain focus and control in the group space with the population being served.

The adolescents in residential treatment centers were described in ways that communicated a high level of difficulty in their presentations and ongoing concerns as was consistent with descriptions provided by Abraham et al. (1995), Hair (2005), and Kennedy and Bender (1991). Participants described that the residents vary in developmental presentation, learning styles, process of identity formation, and willingness to engage in their own treatment, among other factors, as was also noted by Aronson (2004). Further, adolescents in residential treatment often present with issues of higher risk, including exposure to inappropriate ways of engaging with others and experiences of trauma, that contribute to the reasons for their admission at the residential level of care or treatment, as described by the participants, and is

consistent with previous studies of adolescent populations in residential treatment centers by Abramovitz and Bloom (2003). These factors also support findings from Shechtman and Mor (2010), which suggest that psychotherapy groups are beneficial for adolescent populations with previous experiences of trauma.

In response to the needs of the population, participants most often developed a holding environment for the therapy groups by introducing structure that created an increased sense of safety and containment in the group.. Some participants described the use of opening and closing or centering-exercises in order to bring group members into the here-and-now of the therapy group and to allow members to demonstrate their readiness to engage. Others discussed a talking piece or other means of maintaining order and mutual respect for sharing and listening to one another. Participants also described providing indicators of when shifts and transitions would be anticipated. Each of the structural pieces that helped to guide the participants in their group facilitation was implemented for the containment of the adolescent group members and the process occurring or elicited between them, supporting previous research conducted by Corder and Whiteside (1990).

Participants also discussed the ways in which their preparation for group sessions guided the structure that was in place. Some participants specifically described having a plan prior to entering each group session, while others developed a plan of action or drew from their general knowledge of interventions in response to whatever was occurring in the here-and-now of the group space and/or the residential treatment center as a whole. Participants noted one or both approaches being necessary for their specific clinical situations, noting that the absence of such methods resulted in a lack of predictability and control, as was described by Hair (2005), and an overall negative experience for other clinicians.

Despite discussing specific ways that they provided structure for their groups, participants also discussed the need for flexibility and agility in being prepared to react to issues and concerns as they arose. With some of the manifestations of their often traumatic histories being demonstrated through externalizing behaviors, interpersonal conflict, and high reactivity, which supports previous research by Small et al. (1991); paired with the impact of their relationships with each other, with staff, and with others outside of the group being brought into group; the mood presentations and dispositions of adolescent making up residential treatment populations often shift quickly. Thus, clinicians must be prepared for those shifts as well.

Participants described a number of situations during which escalation in distress or conflict resulted in both intrapersonal and interpersonal behavioral concerns. De-escalation techniques must then be employed in order for the clinicians to maintain control, thus clinicians must maintain the flexibility to engage such techniques promptly. On the other hand, participants described situations during which it is important to abandon pre-determined plans or activities in order to address here-and-now concerns that did not pose a threat— most often to process occurrence on the unit or issues being faced by the residents. Without maintaining the flexibility to address the needs of the residents as they occur in the moment, clinicians could miss out on opportunities for providing corrective experiences, facilitating interpersonal growth and development, or working through more significant concerns, at the expense of the residents.

Variety in group types as a treatment component. For inclusion in the current study, participants affirmed that they have facilitated psychotherapy groups with process components as at least one component of their work with adolescents in residential treatment centers. Participants described the structure and model of each of their groups, as well as theoretical influences that contributed to their development and the ways in which process was facilitated

between and among members. This revealed a common theme of variety in types or forms of group treatment— which is not consistent with results reported by Lyons et al. (2001) concluding that services across residential treatment centers are consistent or uniform.

From their narratives, it is clear that groups in residential treatment centers are comprised of different components and experiences, based on the setting and the context. Distinctions were not made initially by participants to delineate psychotherapy groups in contrast to other types of groups— such as support groups, self-help groups, skills groups, or training groups described by Yalom and Leszcz (2005). However, participants demonstrated the influence of context by discussing their experiences of providing services in response to the clinical needs of the population resulting in the provision of different types of groups.

Participants tended to describe whether or not they were facilitating "pure process" groups in comparison to groups that were mixed— most often skills groups/psycho-educational groups mixed with group process. It was noted consistently that pure process groups are most often conceptualized as those described in textbooks, denoting classic or typical groups that are facilitated in outpatient settings with voluntary, treatment-seeking clients. Even the descriptions of pure process groups, however, involved the implementation of additional structure or boundaries due to the needs of adolescents in residential treatment.

Mixed skills and process groups tended to be described as developing in response to the attempts of clinicians to meet the needs of both the system or setting in which they were facilitating groups and the residents to whom they were providing services. The policies of the setting, which could also be influenced by external factors such as licensing and contract agreements, commonly dictated what types of groups were offered and/or the topics covered

regularly. Participants noted, however, that the needs of the residents in the here-and-now as groups were being facilitated were important to address.

Participants also described varying levels of involvement of direct care staff in group facilitation. The role of direct care staff was defined mostly as in-group support in their direct involvement with the psychotherapy groups facilitated. In some cases, participants discussed direct care staff serving as facilitators of groups in the absence of clinicians. Participants did not demarcate those groups facilitated by direct care staff from the psychotherapy groups that clinicians facilitated. However, those groups facilitated by direct care staff— e.g., to meet contract requirements for daily group services provided— are distinct in their scope, such that they were described to involve distribution, completion, and/or review of skills worksheets for the adolescent residents.

The benefit of group process for adolescents in RTCs. Participants communicated their appreciation for and understanding of the value of group therapy and group process work for adolescents in residential treatment centers. They described the role of psychotherapy groups, especially for adolescents in residential treatment, being to encourage and to facilitate growth and development in interpersonal interactions, as is supported by findings from Bonsaksen et al. (2011). Further, clinicians emphasized that processing relationships, conflicts, and situations occurring in the here-and-now of group and/or the overall experiences of the adolescents in the residential treatment center setting was a unique and essential component of the treatment provided. This is consistent with results of the study conducted by Abraham et al. (1995), which identified group process as a beneficial and effective tool for interpersonal growth.

The descriptions of process experiences in the psychotherapy groups varied based on a number of factors, including the ways in which the groups were conceptualized (see Variety in

Group Types as a Treatment Component theme above) and other factors including, but not limited to, the exposure of clinicians to coursework and/or training experiences specific to group process. As described, process components of groups sometimes involved particular methods of invoking interpersonal exchange between resident group members, while at other times, it involved in depth discussions of specific topics to promote individual understandings. Though not described as such in vivo, these distinctions are consistent with the issues of content versus process as described by the study by Puskar et al. (2012).

Based on their experiences, participants described that psychotherapy groups in residential treatment centers are not always implemented in such ways that allow them to be as impactful or as beneficial as they should be. They discussed the impact of factors such as lack of preparation, training, and support for group facilitators; lack of selection and preparation of new members; the influence of theoretical orientation or models that inhibit the flexibility that would allow for more process work to be facilitated; and the inexperience in and/or devaluing of group by both clinical and non-clinical staff persons that influence the active engagement of the residents in group psychotherapy treatment. For the participants of the current study, group psychotherapy was seen as a valuable and advantageous treatment component, and one that tends to fit well within the structure of residential treatment centers and the other components of treatment therein; however, many factors were noted to have influenced, and oftentimes limited, their utility.

Limitations of the Current Study

The following will present a number of limitations that were identified in the current study.

Sample bias. The current study, as an exploratory study, included a sample size of 10 participants. With such a small sample size, the ability to generalize the findings of the current study more broadly to the experiences of all clinicians facilitating psychotherapy groups for adolescents in residential treatment centers is limited. It is not likely that the demographic qualities of participants— including, but not limited to, age, race, training and professional experience with group facilitation, and geographic location— are representative of the comprehensive experiences of clinicians who have training and/or experience with facilitation of groups for adolescents in residential treatment centers across settings.

The networking sampling method further contributes to the limitation of the sample. Firstly, despite that the principal investigator contacted large audiences of clinicians through listservs and agency directories, very few fitting clinicians (i.e., who met inclusion criteria) responded and were included in the present study. Thus, the participants in the present study are likely to reflect a participation bias, with those who agreed to participate making up a non-representative sample due to a homogeneity in an unidentified trait.

Further, with the sample derived originally from affiliates of professional organizations and the limited responses of those affiliates as a whole, it is important to consider the potential effects of selection bias on any observations, results, and conclusions. However, this study seeks to add to the available literature in a qualitative and in-depth manner, as a foundation for further research on the facilitation of psychotherapy groups for adolescents in residential treatment center settings.

Research method bias. The qualitative nature of the current study compels consideration of particular research method-based limitations. The use of interview data rather than numerical or quantifiable data, precludes any statistical analysis. Thus the data presented is more subjective

and less likely to result in consistent interpretation among reviewers. Further, the study used neither a randomized sample nor a control group. This poses further limits to the generalizability of the data due to potential bias.

In qualitative research, specifically that which uses Grounded Theory as a research method, it is important that the themes and theories developed come directly from exploration of the phenomenon of interest. As such, there is a risk that review of the literature could have colored data analysis. Strategies that enable researchers to stay close to the data are critical to avoid bias from the literature review. One such strategy, prior to collecting data, involves developing neutral questions that would allow a reflection of the experience of the interviewees, rather than the knowledge available to the principal investigator through research.

Two other strategies for minimizing the potential for bias as influenced by the research method include (1) using in vivo codes and memoing (in addition to in vitro codes) throughout the process of constant comparative analysis in order to authentically reflect the experiences of the participants; and (2) suspending further review of the literature until the themes are identified and the theory is developed. These strategies were implemented throughout the data collection and analysis, but due to the review of literature having occurred prior to data collection as a requirement of the dissertation process, information bias must be considered.

Researcher bias. Finally, the involvement of the principal investigator in the research at each stage of its development, from conceptualization through interpretation, is a limitation for the current study. As mentioned above, the principal investigator had specific interests in trauma, clinical work with adolescents, residential treatment, and interpersonal process occurring in psychotherapy groups. Further, the principal investigator had previous work experience in a residential treatment center setting, driving interest in the current study. The principal

investigator was influenced throughout the development and execution of the current study by the members of the dissertation committee as well as the facilitator and members of a qualitative dissertation seminar.

All interviews were conducted, transcribed, and analyzed by the principal investigator. This, paired with considerations of the person of the researcher as mentioned above, including having history with and interest in work with adolescents in a residential treatment center setting in various capacities, provides a high likelihood of some degree of bias being present through the analysis of the data.

The literature review conducted prior to the collection of data did not directly inform the development of the interview questions; however, as the literature review and the development of interview questions were both completed by the principal investigator, their being mutually exclusive is not inherently assured.

Despite the steps taken to minimize the influence of potential researcher bias, such influence must be considered as a limitation, especially due to the lack of inter-rater reliability or concordance that would be present with the addition of another researcher to analyze the same data set. Data gathered through the semi-structured interview focused on and emphasized the views and experiences of the participants in the context of the residential treatment centers in which they engaged in clinical work. The high involvement of the principal investigator in determining what information was sought after, collected, analyzed, and interpreted must be considered as limitations in conceptualizing the implications of the findings discussed.

Implications

The current study was conducted in order to provide a phenomenological understanding of what the experiences are of clinicians facilitating psychotherapy groups with process

components for adolescents in residential treatment centers. Such a focus was intended to provide a blueprint for clinicians looking to develop and/or engage in process work in these settings in the future, as previous research has not been done to describe the experience. Based on the themes and the limitations contributed above, the following implications could provide direction for future research, theory, and practice.

Implications for research. The current study laid the groundwork for observing and evaluating group process work that is being conducted in psychotherapy groups for adolescents in residential treatment centers. Very little previously published research specifically focuses on the impact of group psychotherapy treatment within residential treatment centers, much less emphasizing the facilitation of group process. Thus, the current study provides an initial understanding of the processes involved in the facilitation of psychotherapy groups for adolescents in residential treatment centers.

Due to the variability in experiences of clinicians from different degree fields in mental health and with different levels of training and experience in group therapy, there was much variance in the data collected that could be confounded by these differences. Future research could hold specific levels of education and/or degree fields as constant in order to focus more on the contributions of some specific level of experience. Thus, inconsistencies in the phenomenological data collected would be more attributable to differences in settings as opposed to individual differences in the knowledge of clinicians as well.

Additional qualitative research in the future could also specifically explore the phenomenon of group process in psychotherapy groups with adolescents in residential treatment centers, from the perspective of the clients. This would provide an additional context for describing socio-relational and experiential components of group process, which emphasizes

intrapersonal change through interpersonal means. Paired with the current study, exploring these issues from the perspective of the clients would provide a more complete view of the phenomenon in question.

Quantitative research could also be done in the future, providing broader and more generalizable data points that reflect the continued need for additional focus and attention in research. For example, a study could be done surveying residential treatment centers to compare treatment components including a quantifiable comparison that demonstrates how prevalent different types of groups are in these settings. This would provide a sense of how much process work is being facilitated in psychotherapy groups in residential treatment centers. Such a study could specifically address some of the concerns present in the current study, such as the difficulty in obtaining participants, which could then potentially be shown to be a reflection of a scarcity of the specific type of work being studied, rather than a true participation bias.

The current study could contribute substantially to previous studies of clinical work and treatment in residential treatment centers. Due to the needs of the population being unique to the setting, it is important that a greater understanding be developed of how those needs are met. As such, this study provides a foundation for such knowledge— one from which many additional studies and understandings could grow.

Implications for training. Participants in the current study consistently described the need for additional training and/or supervised experience for facilitating groups in residential treatment centers. This speaks directly to the need for additional learning experiences and support for clinicians engaging in a specialty setting. Residential treatment centers provide a unique context that mediates the implementation of its treatment components. As such, ongoing work in group psychotherapy for adolescents in residential treatment centers should be bolstered

with training opportunities specific to that work, for facilitators. Without such opportunities, clinicians are often underprepared for the challenges imposed by the population and the setting.

As is demonstrated by the individual experiences of the participants in the current study as well as the themes discussed collectively, it is not uncommon for clinicians in residential treatment centers to have only one course in group therapy during their graduate-level study, if at all. With group psychotherapy being different from other modalities of treatment, and with these differences moderated by the varying contextual factors of residential treatment settings, it is imperative that group facilitators in these settings receive additional support for their role. Training in group dynamics, phases of group development, behavior management, de-escalation, and crisis management would be beneficial for group facilitators and would positively influence their ability to facilitate process in the context of psychotherapy groups.

Further implications for training include that for direct care staff. It was apparent that the influence of the direct care staff on the ability of the participants of the current study to engage clinically with the adolescent residents, and thus on the experience in psychotherapy groups, was significant. Direct care staff were often present in or near the space designated for psychotherapy groups due to the need for them to handle behavioral issues. The insensitivity of direct care staff to the needs and the concerns of the population can negatively affect the ability of adolescents to experience corrective and trustworthy relationships during their treatment. When they are unable to do so, they can develop additional maladaptive interpersonal strategies, such as described by Small et al. (1991), rather than prosocial ones. With experiences of trauma being pervasive among the population of adolescents in residential, the need for trauma-informed training for direct care staff, who most often do not receive advanced clinical education or training in their

role, is essential for the well-being of the residents and for the functioning of the residents in group therapy.

Implications for group clinicians. The setting and context of the residential treatment center will determine the purpose and influence the structure of the groups provided. Group clinicians trained in the theory and practice of group psychotherapy should expect that the groups in residential treatment centers will not be comparable to those described in general group therapy textbooks and course materials. Group processes occurring may be similar, but the context is different, which in turn limits the ability to apply the assumptions made in facilitating classic process groups. As such, clinicians must know about the needs of the setting in which they are working in order to determine what the structure of the groups will be and to interpret the group dynamics.

It is important to have some level of exposure to group psychotherapy prior to facilitating groups for adolescents in residential treatment centers. As the participants described in their experiences, even those with previous coursework and experience felt underprepared when entering into this new and specialized space of residential treatment settings. Thus, clinicians engaging in group therapy facilitation in residential treatment centers would benefit from previous and ongoing exposure to competencies in psychotherapy group facilitation.

As group clinicians have flexibility in determining the direction of the ways in which they facilitate groups, they would do best to have an understanding of group dynamics and to know the limitations of that understanding when applied to the specific setting. Varying levels of development must be considered, and as a result, structure was consistently recognized as a necessary component for engaging adolescents in group process work. Having elements such as

activities or games to help demonstrate points is a common alternative to talking alone, even in facilitating process or interpersonal engagement.

Facilitators of psychotherapy groups in residential treatment centers should seek out supervision and consultation of their early and ongoing work. Further, group facilitators would benefit from having additional supports in place for psychotherapy groups, including emphasis on and a consistent understanding of the importance of group therapy across the setting (i.e., with clinical and non-clinical staff as well as residents), behavioral supports for acute issues arising in group, and a contingency plan for addressing unforeseen issues that could interfere with the process work of group psychotherapy. Clinicians should keep in mind that the needs of the setting and the population, as well as the needs of the clinicians in conceptualizing and facilitating groups in residential treatment centers, should be considered as approaches to engaging in the work are established.

Implications for RTC settings. Due to the diversity in presentations and structure of residential treatment programs, it would be difficult to describe a specific model or theoretical orientation to demonstrate or influence group dynamics across residential settings. However, the importance of applying trauma-informed care to clinical practice was tremendously relevant, and appeared to influence the system as a whole, based on the experiences of the participants of the current study. It would be beneficial for trauma-informed care to be integrated in all aspects of treatment within residential treatment, including milieu treatment and non-clinical components of the settings.

Group psychotherapy is deemed valuable by the majority of those facilitating groups in residential treatment centers. Groups have an inherent interpersonal component, and are thus linked to key social and developmental tasks of the adolescent. Group therapy is also more

impactful considering the space that it provides for often traumatized and isolated adolescents to relate to one another with often shared incidents of trauma in their pasts. of the adolescent populations in residential treatment. While groups can serve many purposes and take many different shapes, it is clear that the work of group therapy is to facilitate and/or to allow for interpersonal interactions between residents in an appropriate and prosocial manner. This, an area that is often lacking for the residential treatment center populations, is a key restorative feature of the residential treatment center.

Groups should be occurring regularly, but cannot be modeled after the typically forming or developing group. Groups made up of consenting adults who are seeking services such as in an outpatient setting are inherently different, and thus the interpretations made are different. For example, unlike outpatient groups, it is not uncommon for member absences in residential groups to be known to other members at the same time as, or before, they are shared with the therapist. This and other differences make psychotherapy groups in residential treatment centers a specialized clinical situation. Yalom and Leszcz (2005) outlined steps for modifying traditional group therapy for specialized clinical situations, and with that knowledge considered, groups in residential treatment centers could thrive in a similar manner to traditional therapy groups.

Conclusion

Residential care, is often long term, highly structured, and is a restrictive environment. It provides for critical mental and behavioral health needs of what tend to be high-risk, trauma-affected adolescent populations. Residential treatment is often made up of multiple components that can include individual, group, family, and milieu therapy. Previous studies have described the components of treatment, have reported on the outcomes of residential treatment as a whole, and have discussed the populations being served, but the literature is lacking in the area of noting

what occurs during treatments that are not specific to the individual clients, such as group therapy.

Through the current study, clinicians across multiple mental health multiple disciplines were given the opportunity to discuss and to provide details of their experiences with facilitating group process work in psychotherapy groups for adolescents in residential treatment centers. Their narratives captured diverse experiences for clinicians in these settings, as influenced by population and setting-specific factors. Thus, a phenomenological understanding of the facilitation of psychotherapy groups with process components for adolescents in residential treatment centers was established. Through the narratives of the participants, a general theory of how group process is facilitated with the population, in the setting, was developed. Contributing factors that influenced that process were described, as were strategies for responding to the processes occurring, and potential outcomes. This includes the ways in which clinicians can prepare for and support their work in facilitating psychotherapy groups, the impact of the setting or context on the group work being provided, ways to influence outcomes, and reflections on the benefits of the work. Psychotherapy groups were considered an important component of treatment for most of the participants and were often mandated components of treatment, and thus of high value to those residential treatment settings. With the implications provided, future direction of both research and practice can be influenced in order to increase the knowledge base regarding group psychotherapy work and thus its utility and benefit for the adolescent populations being served in residential treatment centers.

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Appendix A

Recruitment Notice

Email Message

Dear _____,

I am a fourth (/fifth)- year doctoral candidate in the Clinical Psy.D. Program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. I am conducting a dissertation study exploring clinicians' experiences with the facilitation of group process in psychotherapy groups for adolescents in residential treatment centers. If you are willing to participate, have any questions, or would like to suggest a clinician for the current study, please contact me by phone at (908) 505-5320, or by email at shemika.brooks@rutgers.edu. Also, please consider forwarding this email to other clinicians as appropriate.

Thank you for your time and consideration.

Sincerely,

Shemika Brooks, M.A., Psy.M

Psy.D. Candidate in Clinical Psychology

Graduate School of Applied and Professional Psychology

Rutgers, the State University of New Jersey

Appendix B

Informed Consent Agreement

Study Title: Facilitating Group Process: An Exploratory Study of Adolescent Psychotherapy Groups in Residential Treatment Centers

Invitation to Participate: You are invited to participate in a research study that is being conducted by Shemika Brooks, M.A., Psy.M., an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision.

Purpose: The purpose of the study is to explore adolescent psychotherapy groups in residential treatment center settings, as facilitated by clinicians with training and/or experience in facilitating group process. Literature in the public domain regarding group process in residential treatment center settings is very limited. Further, some structural elements within residential treatment centers pose challenges to the facilitation of psychotherapy mechanisms, modifications, and considerations for adolescents in these settings. This study aims to explore and to describe common aspects of psychotherapy groups in residential treatment centers, and to identify additional components to address any ongoing challenges.

Participants: This study will use a network sample of approximately 10-20 experienced licensed and/or supervised clinicians who have facilitated psychotherapy groups for adolescents in residential treatment center settings.

Procedure: If you participate in the study, you will be interviewed individually during a designated time. It is expected that the interview will take 60-90 minutes to complete. However, the length may vary depending on the depth of the answers provided. All interviews will take place using a Voice over the Internet Protocol (VoIP) such as Skype or Google Hangouts, or by phone, as mutually agreed upon by you and Shemika Brooks. As such, it is important to choose a place to talk that is comfortable and private. In these cases the interviewer will be alone in a location that offers privacy.

Risk/Benefit: There are no known risks associated with your consent and participation in this research study. Participation in this study may not benefit you directly; however you will play a role in helping other researchers, social workers, psychologists, and others understand the experiences of facilitating psychotherapy groups for adolescents in residential treatment centers.

Compensation: There will be no compensation for your participation in this research study.

Cost: There will be no cost to you for participating in this research study.

Confidentiality: This research is confidential. The research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, ethnicity, education history, and clinical practice setting(s). Also, you will be asked to talk about clinical experiences as part of this interview. You will not be asked to disclose any confidential information about clients. Please refrain from providing identifying information. Any information that you provide that may be used to identify the client

will be removed from the transcript. Names of people and places will be replaced with pseudonyms.

Please note that we will keep information confidential by limiting individuals' access to the research data and keeping it in a secure location in the researcher's residence. Hard copies of interview data and audio recordings will be stored in a locked filing cabinet and no one other than the researcher will have access to this information. Audio recordings and transcriptions will be stored on a password-protected computer. In addition, you will be given an identification code and a pseudonym, and only the researcher will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law.

If a report of this study is published, or the results presented at a professional conference, your information will be disguised to not include any identifiable information. All study data will be kept for at least three years after completion of the research; all documents with identifying information will be shredded and all audio recordings and any other computer files will be erased by the researcher at that time.

Withdrawal: Participation in this study is voluntary. You may choose not to participate, and you may withdraw from the study at any time during the study procedures without any penalty to you. In addition, you may refuse to answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact Shemika Brooks by phone at (908) 505-5320 or by email at shemika.brooks@rutgers.edu. You may also contact the faculty chairperson, Dr. Susan Furrer at susan.furrer@rutgers.edu.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848-932-0150
Email: humansubjects@orsp.rutgers.edu

I have read and understood the content of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix C

Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: Facilitating Group Process: An Exploratory Study of Adolescent Psychotherapy Groups in Residential Treatment Centers, conducted by Shemika Brooks, M.A., Psy.M. The researcher is asking your permission to audiotape/videotape the interview as part of the research study.

The recordings will be transcribed to maintain the authenticity of your responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all subjects.

The recordings will include the responses that you provide throughout the interview. Please avoid mentioning names of individuals or any identifying information of clients. Any names of people or places that are disclosed will be replaced with pseudonyms. If the interviews are video-recorded, recordings will include full facial features. Your name will not be attached to any form of recording. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password-protected database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password-protected computer, and any hard copies of transcriptions will be stored in locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any reason other than that stated in the consent form, without your written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix D

Demographic Questionnaire

1. Age: _____
2. Sex/Gender: Female Male Other: _____
3. Race/Ethnicity:
4. Credentials (Highest Degree Completed, Field/Discipline, License):
5. Years Running Group in Supervised and Licensed Practice:
6. Primary Theoretical Orientation used in psychotherapy practice:

   CBT Psychoanalytic Psychodynamic Behavioral

   Family/Systems N/A Other _____
7. Describe the current population(s) that you see in your clinical practice, including typical demographics, SES, presenting problems:
8. Number and types of groups run in residential treatment centers currently? To date?
9. Primary Role in Residential Treatment Center(s; RTCs):

   Direct Care Staff Clinical Staff Contracted/Consultant

   Other _____

Appendix E

Semi-Structured Interview

A. Training and Experience in Group

1. What is the extent of your academic training (e.g., coursework, institutes) in facilitation of groups? Group psychotherapy & group process? Interpersonal process groups?
2. In what, if any, additional training opportunities (e.g., workshops, conferences) have you engaged to continue your training in psychotherapy and/or process group facilitation since completion of your most recent certification/licensure?
3. Briefly discuss your experiences with receiving supervision for experiences of running psychotherapy groups; if you had supervision, in what ways did it benefit your development as a group therapist?
4. Any other experiences, personal or professional, that have significantly influenced you as a group leader?

B. Experiences in Adolescent RTC Settings

5. Describe the residential treatment program setting(s) in which you work (e.g., capacity, organizational structure, population served, service delivery model, theoretical orientation espoused by system).
6. Describe the structure and model of groups in the residential treatment center in which you are or were affiliated.
7. Roughly what percentage of the populations you have encountered in adolescent RTCs has had a history of trauma?
8. Describe some of the manifestations of trauma in your practice in adolescent RTCs?

C. Facilitating Psychotherapy Groups in RTCs

9. What was the gender construction of the groups you have facilitated? (Single-sex vs co-ed). What factors influenced the makeup of the group as related to sex/gender?

10. Considering the groups that you have run is adolescent RTCs, what have been the typical lengths of stay for the members participating in the group, during the course of their group membership?
11. What, if any theoretical or other influences was your group(s) modeled after in its development?
12. What, if any other elements (e.g., activities, games, food) were introduced into psychotherapy groups to help facilitate process?
13. Describe any techniques used in facilitating psychotherapy groups in residential treatment centers to engage the adolescent members.
14. How is trauma-informed care integrated into the psychotherapy groups in residential treatment settings?
15. How do client relationships with each other outside of group affect the structure of psychotherapy group(s)?
16. In what ways is the group(s) impacted by changes in group membership?
17. How are absences addressed in psychotherapy group(s)?
18. When and how are new residents included in psychotherapy group(s)?

D. Inferences Based on Professional Experiences

19. In your opinion, what is the role of psychotherapy groups in residential treatment program settings?
20. How would you describe the value of psychotherapy groups & group process in RTCs? On a scale of 1 to 5?
21. How would you describe the relationship of psychotherapy groups to the other aspects of treatment in RTCs? How does this type of group fit in the RTC program structure?
22. Based on your observations and professional experiences, what barriers exist to engaging adolescents in group process, both in general and in RTCs?
23. Based on your experiences, what are some of the difficulties (pragmatic, structural, etc.) that could arise for trained group therapists in establishing psychotherapy groups for adolescents in residential treatment program settings?

24. Given the contexts of adolescent residential treatment centers, and the likelihood of the population having trauma histories, are there additional considerations that need to be put into place to ensure the safety and benefit of psychotherapy groups for adolescents in RTCs?
25. Given the issues identified, what considerations would be important to be taken into account in developing new psychotherapy groups in residential treatment centers in order to address them?

E. Other

26. Is there any additional information that is important to consider in order to effectively capture the experience of facilitating psychotherapy groups for adolescents in residential treatment centers?