EXPERIENCES OF ADOLESCENTS IN A PRIVATE RESIDENTIAL

TREATMENT PROGRAM: AN EXPLORATORY STUDY

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Abstract

A significant number of adolescents experiencing severe psychiatric, psychological, emotional, behavioral, or substance abuse problems are placed in private residential treatment programs annually (Connor et al., 2004). These programs, sometimes referred to as "behavior modification schools," offer the most restrictive form of on-site services for adolescents other than inpatient care. The present qualitative and retrospective study was designed to elicit the elements having the most salient impact on former patients, and thus to help professionals gain an understanding of how this intervention might benefit adolescents manifesting serious emotional and/or behavioral issues. Ten adults who identified as former patients in a private residential treatment center were interviewed about their experiences. Research questions addressed the reasons for referral, the process by which participants entered the center, their experiences within the program, their discharge, and their post-treatment reflections and recommendations. Data were analyzed using a grounded theory methodology to reveal major themes (Corbin & Strauss, 2014). Themes identified included: (a) from struggling child to scapegoat; (b) treatment versus oppression; (c) experiences of maltreatment, trauma, and the conspiracy of silence; and (d) the ability to find solace, sanctuary, and support. The findings of this study suggested important implications for research, residential treatment programs, practitioners, policymakers, and parents. These included the need for: (a) further research into private residential treatment programs; (b) more advanced training of front-line staff in adolescent mental health; (c) increased effectiveness and humane management of misbehavior; (d) an assessment of biases and perceptions of "troubled youth" within treatment; (e) an examination of the dynamics of power and privilege embedded in roles and policies of the institution; (f) a focus on family-centered and youth-driven

approaches; (g) enhanced industry regulation, oversight and transparency; and (g) greater involvement of parents as decision makers concerning placement options and their active participation in treatment.

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This dissertation is dedicated to all of the adults who volunteered to participate in my study, and to anyone who has ever been in or is currently in residential treatment as youth and whose voices may never be heard. You are not alone. Your voice matters. You matter. This dissertation is also dedicated to all of the unsung angels working in adolescent residential treatment centers who offer their genuine compassion, empathy, respect, and guidance to youth during what can be the most difficult and memorable time

of their lives. You and your voice matter to these youth. Never underestimate the

influence you have towards inspiring, healing, and bringing joy and humanity to youth in

these settings.

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Chapter I: Introduction and Overview

Statement of the Problem

A substantial number of adolescents with significant and unmanageable emotional and behavioral problems are referred for compulsory treatment to residential treatment centers each year (Colton & Hellinck, 1993; Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Substance Abuse & Mental Health Services Administration, 2008). Residential treatment centers provide the most restrictive level of care for adolescents other than inpatient care (Burns, Hoagwood, & Mrazek, 1999; Office of Juvenile Justice & Delinquency Prevention, 2010), and aim to decrease problematic behaviors and thus increase adolescent functioning (Bettmann & Jasperson, 2009; Lyons, Woltmann, Martinovich, & Hancock, 2009). Among the options for residential treatment care for adolescents are privately-owned and operated residential treatment centers, often located in less populated and/or rural areas of the United States, that serve youth living throughout the United States and other countries.

Residential treatment programs are comprised of varying components working together to influence behavioral and emotional development. Although there has been a move towards community-based treatments, good residential treatment can be a positive placement for youth, providing them with stable care. As stated by Briggs, Greeson, Layne, Fairbank, Knoverek, and Pynoos (2012):

> [Residential care] remains the most promising approach for youth who have not experienced successful outcomes in other community-based mental health settings or intensive in-home therapy, and/or who require the structure and intensity (e.g., due to heightened risk for self-harm) that these facilities provide. (p. 2)

A limited number of studies have provided data on such facilities, and there is little research regarding the specific service components provided and treatment methods used by these programs, highlighting the need for such information. This qualitative and retrospective study sought to expand the understanding of the unique services that might be provided through this intervention and to ascertain what may be critical in addressing the mental health care needs of adolescents with serious emotional and/or behavioral issues. To achieve this objective, the perceptions of former patients in a private residential treatment program were explored. Semi-structured interviews were audio-recorded, transcribed, and analyzed using the principles of grounded theory (Corbin & Strauss, 2014). Implications and recommendations for research, residential treatment programs, caregivers, and legislation and policy were delineated.

Given the high needs of the adolescents served by residential treatment, it is crucial for these facilities to offer quality mental health services that reflect the use of best practices. There is no regulatory authority that oversees this industry, however, and little state or federal involvement in ensuring that residential treatment centers fulfill their mission to help youth. Through in-depth analysis of the experiences of former adolescent patients who offered their insight on various components of their program, and thus "bring…a human face to the issues" (Warner & Pottick, 2003, p. 1), this study hoped to stimulate positive change in the system.

The Present Study

Areas examined in the current study included participants' experiences: (a) becoming aware that they would be attending a residential treatment center and transportation to the facility (including the use of private transportation agents); (b) living in a highly restrictive environment; (c) governed by a highly structured contingency

management system (e.g., level and token economy) focused on "behavioral

modification"; (h) receiving mental health treatment including psychotherapy;

(f) engaging in relationships with others, e.g., therapist, staff, peers, and family,;

and(g) being discharged from the facility. Additionally, by asking participants what

advice they would give to youth about to enter residential treatment and their younger

selves, this study was intended to facilitate more informed provision of care by therapists

employed in these programs and offer insight to adolescents who have just begun their

placement journey.

      Notice should be taken of the powerful messages expressed by the subjects of this

study by all who seek to enhance the quality of care for adolescents served in private

residential treatment, including researchers, policy makers, developers, and providers.

Chapter II: Review of the Literature

Residential Treatment Centers

When adolescents exhibit significant emotional and behavioral issues, their caregivers often seek to access mental health systems for help. A range of outpatient and inpatient services may be presented as appropriate treatment options. Out-of-home alternatives may include residential programs with mental health services, such as therapeutic boarding schools, emotional growth boarding schools, military boarding schools, teen boot camps, wilderness therapy programs, group homes, or shelters (Reamer & Siegel, 2013). Among the most restrictive out-of-home alternatives is placement in a residential treatment center (National Alliance on Mental Illness, 2008). Such centers are structured similarly to psychiatric facilities, unlike the less restrictive residential programs listed above.

Residential treatment centers are designed for youth, ages 17 and younger, who are struggling with serious problems arising from emotional, behavioral, developmental, academic, substance abuse and/or psychiatric difficulties, but not to the degree that long-term commitment to an inpatient psychiatric hospital or secure correctional facility is warranted. Prior efforts to remediate the youths' issues in the home, community and traditional school, or in lower level, non-secure environments, e.g., alternative schools, partial or intensive outpatient treatment and/or community diversion programs, have often been undertaken but unsuccessful. Thus, for this population, the highly structured, time-limited residential, educational, medical, and clinical services offered in a facility staffed full time may be indicated (Baker, Ashare, & Charvat, 2009; Baker, Fulmore, & Collins, 2008; Bettmann & Jasperson, 2009; Larzelere, Dinges, Schmidt, Spellman, Criste, & Conell, 2001; Lyons et al., 2009).

Resident Characteristics in Residential Treatment Centers

Adolescents placed in residential treatment centers are primarily between the ages of 13 and 17 (Milazzo-Sayre, Henderson, Manderscheid, Bokossa, Evans, & Male, 2000; Warner & Pottick, 2003), and often referred for placement due to significant and complex psychiatric, psychological, emotional, behavioral, or substance abuse problems (Hurley, Trout, Chmelka, Burns, Epstein, Thompson, & Daly, 2009) that are considered to impose a threat to their own or others' safety. Youth in residential treatment centers have high rates of disruptive behavioral disorders (DBDs), such as attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder; affective and anxiety disorders; adjustment disorders; psychotic disorders; and other disorders.

According to a nationwide sample survey of residential treatment centers for "emotionally disturbed children," conducted by the Center for Mental Health Services and the Substance Abuse and Mental Health Services Administration, 39% of the youth held a diagnosis of attention/conduct disorder and 17% had an affective disorder (Milazzo-Sayre et al., 2000). According to a large single-site survey conducted by Connor et al. (2004), approximately 92% of their sample of 397 youth living in residential treatment had at least one psychiatric diagnosis, with conduct disorder, depression, and anxiety the most prevalent. Connor et al.'s (2004) findings indicated markedly high levels (58%) of aggression characterized by rage, hostility, and anger among the subjects, ranging from verbal threats to others, physical assaults, and impulsive property destruction (Connor et al., 2004).

Youth in residential treatment programs also have high rates of trauma exposure (Briggs et al., 2012; Jaycox, Ebener, Damesek, & Becker, 2004). In a study of 212 adolescents entering residential treatment for substance abuse, 71% reported trauma

histories and 29% exhibited symptoms consistent with a post-traumatic stress disorder

diagnosis (Jaycox et al., 2004). In a study of traumatized youth receiving treatment in

residential and non-residential settings, Briggs et al. (2012), comparing National Child

Traumatic Stress Network data, found that 92% of those in residential care had

experienced more than one traumatic event versus 77% receiving non-residential care. In

addition, traumatized youth in residential treatment programs reported a higher mean

number of trauma events (3.6 versus 5.8) and more extensive trauma types (e.g., neglect,

sexual abuse, physical abuse, etc.), and experienced greater impairment (e.g., academic,

behavior, and attachment problems; substance abuse; self-injury, etc.) than traumatized

youth being treated in community settings. Emotional and behavioral disorders in youth

often result in continuing impairments into adulthood that are manifested in reduced

social, emotional, health, and educational/occupational functioning and a lesser quality of

life than youth without such disorders (Davis & Vander Stoep, 1997; Vander Stoep,

Beresford, Weiss, McKnight, Cauce, & Cohen, 2000).

Private vs. Public Residential Treatment

Residential treatment programs for struggling youth comprise both public and

private facilities. Public residential treatment programs are generally community-based,

serving a local population, and not-for-profit entities. Youth in public treatment settings

are often referred in the following ways: (a) by public social service agencies, such as

child protective services; (b) by community mental health centers; or (c) as a result of

involvement with law enforcement, such as the juvenile justice system. Costs for

treatment in public residential treatment programs are generally provided by public

sources (e.g., Medicaid, the local school district, the Department of Family Services)

(Curtis, Alexander, & Longhofer, 2001; Epstein, 2004; Hair, 2005 (as cited in Behrens &

Satterfield, 2006)). In contrast, private residential programs are non-governmental "for-profit" entities, serving a population that is geographically dispersed with youth often living in other states. In addition, parents of youth in private residential treatment centers typically play a comprehensive role in this intervention: they select the facility and customarily fund treatment themselves, either out-of-pocket or through private insurance.

Understanding private residential treatment. In addition to the lack of consensus among researchers as to a precise definition of "residential treatment" (Butler & McPherson, 2007), complications arise when studies concerning residential treatment fail to differentiate between private and public residential programs (Behrens & Satterfield, 2006), categorizing both in literature reviews under the umbrella of "residential treatment" (Government Accountability Office, 2007). The absence of findings particularized to the type of residential treatment program setting has "stymied the development of group care practice" (Lee & Barth, 2011, p. 263).

A related concern for those treating youth at private residential centers is the paucity of research conducted with youth in private facilities as opposed to public residential treatment programs (Curtis et al., 2001 (as cited in Behrens & Satterfield, 2006)). Given the divergence between both sources of referral and funds for treatment, as discussed above, extrapolating findings from research with disparate client populations may be problematic (Behrens & Satterfield, 2006). For example, studies have indicated that youth treated in public residential treatment programs are predominately male, disproportionally from lower-income families, have ethnic minority backgrounds and, as discussed above, are more likely to be referred through public sources (Curtis et al., 2001; Epstein, 2004; Hair, 2005). In contrast, the only large-scale systematic exploration of resident characteristics in private residential treatment for adolescents revealed no

gender disparity (residents were equally likely to be male or female), were from middle and upper socioeconomic backgrounds, predominately white, and typically placed by their parents (Behrens & Satterfield, 2006). A 2006 survey of former clients of residential treatment programs whose treatment had not been funded by public or government systems, demonstrated similar demographic findings: the majority of the 230 respondents were White (87% Caucasian, 6% biracial/bicultural, 3% Latino/Hispanic, 3% Asian or other cultural identities), female (68.6%), and approximately half had family incomes of $100,000 or greater (Behar, Friedman, Pinto, Katz-Leavy, & Jones, 2007).

The argument for differentiation. Just as there are major differences between publicly and privately funded residential treatment centers, private residential treatment programs vary greatly in treatment philosophy, structure, and services. For example, the mental health treatment services offered may include individual therapy, family therapy, psychoeducational counseling, psychiatric evaluation and psychological testing, or any combination thereof. In fact, residential treatment programs vary so greatly in the methods used to meet the multiple needs of their residents (e.g., physical, medical, emotional, behavioral, familial, social, intellectual and academic), that they have been described as using a "tapestry of many therapies" (Fahlberg, 1990). Other specific elements that vary from residential program to program include the number of youth living in the program, length of stay, clinical resources, academics, and medical services. Parental and family participation, recreational programming, vocational training components, and post-discharge supports also differ among programs. Staff may vary widely in their education, training, and qualifications, and may include psychiatrists, psychologists, social workers, licensed therapists, medical staff, and non-licensed direct care staff. Additionally, programs vary in stated purpose; theoretical orientation; milieu

approaches; program structure, rules and policies; methods of behavior modification, rehabilitation and discipline; and level of restrictiveness.

In one of the few studies on private residential treatment, Curtis et al. (2001) warned that generalizing their findings to all private residential treatment programs would not take into account differences with respect to purpose, service delivery and program structure that might otherwise result in more positive outcomes for individual youth. Lee and Barth (2011) proposed that in order to ameliorate this problem, studies should delineate characteristics or elements that might prove useful in "describing and differentiating programs" (p. 257), as this practice would be likely to enhance understanding of the role and effectiveness of residential treatment, and thus augment the ability to generalize findings across programs.

Lee and Barth (2011), in collaboration with several group care scholars, developed a set of standards to enable between-program differences to be more precisely reported. The resulting data were used to (a) help identify programs along a continuum of the highest to lowest probability of providing benefit to youth, and (b) augment knowledge and understanding of group care effectiveness. The variables identified by Lee and Barth as important factors in studies concerning individual residential treatment programs included:

- population served,
- proximity to home community,
- eligibility criteria,
- setting,
- location,
- population density of living unit or program,

- program model of treatment,

- practice elements,

- educational programming,

- vocational services,

- family involvement,

- mental health services,

- recreational activities,

- staffing,

- systems influences,

- restrictiveness, and

- clearly defined primary and secondary outcome measurements.

In addition to offering a necessary and more comprehensive investigation into private residential programs, further research expanding upon the work of Lee and Barth (2011) may identify other important treatment components of this intervention. As these efforts are undertaken, inaccurate generalizations concerning private residential treatment programs may no longer be as widespread.

Data on Residential Treatment Centers

It is estimated that approximately 42,000 youth receive treatment in public and private residential treatment programs in the United States every year, approximately 20,000-40,000 of whom enter treatment each year (Milazzo-Sayre et al., 2000; Warner & Pottick, 2003). Despite the national emphasis on community-based care for youth and the disproportionate cost of this intervention, the number of youth receiving this treatment

approach appears to be growing exponentially (Connor et al., 2004; Friedman et al., 2006).

Residential treatment is the most expensive mental health service option among the range of mental health care alternatives for youth. Approximately 25% of the federal funds allocated to treating children's mental health issues are utilized for residential treatment services (Butler & McPherson, 2007), despite the relatively small percentage (5% to 8%) of children needing mental health care who are engaged in this modality (Butler & McPherson, 2007; Warner & Pottick, 2003). Indeed, in 2004 Federal funding supported the placement of 200,000 youths in government or private residential facilities (Government Accountability Office, 2008), and much of this form of care is funded by the states. (Note: "residential facilities" and "residential treatment centers" are not interchangeable terms. "Residential facilities" incorporate a much broader group of programs than "residential treatment centers," such as boarding schools and academies, boot camps, wilderness camps, etc.)

The annual residential treatment costs per child vary. Geographical location is one factor that influences costs. For example, the Wyoming Department of Family Services and Departments of Health and Education spent an average of $56,692 for residential services per child for the fiscal year 2003-2004, for a total cost of $40.7 million that year (Management Audit Committee, 2004), while a decade later the average annual cost per child was $91,250 in Illinois (Illinois Department of Human Services, 2014).

In terms of private residential treatment costs, caregivers can pay from $3000 to $5000 per month out-of-pocket for their child's care (Szalavitz, 2006), although various forms of assistance may help defray this cost. For example, caregivers may be able to access public school funding for their child towards the costs of treatment when the

facility offers an academic program accredited as a private non-public special education school. In addition, some private programs may be contracted with state or federal managed healthcare organizations and insurance programs, for example Medicaid, to cover some of the costs (Dixon, Lee, Wade, Byford, & Weatherly, 2004). Despite the high costs, residential treatment is still a widely used service for youth with serious emotional and behavioral problems. It is estimated that approximately 10,000 to 14,000 youth per year are served by hundreds of private residential treatment facilities (Behar et al., 2007).

Much uncertainty abounds, however, with respect to private residential treatment centers. No concrete data exist as to: (a) how many youth are currently enrolled in these facilities, (b) how many programs exist, (c) the costs of this intervention, or (d) how much funding from other sources (e.g., federal or state government, school district, etc.) is available to caregivers. Researchers (Behar et al., 2007; Friedman et al., 2006; Pinto, Friedman, & Epstein, 2005) have argued that this absence of clarity may be due to the lack of regulation, oversight, and transparency unique to the private residential treatment industry.

Industry Regulation, Oversight, and Transparency

  Rationale for increased oversight. Private residential treatment centers were able to function with little government oversight for many years; however, in 2003 media outlets began exposing the harmful and abusive practices frequently occurring in these programs, specifically those associated with the World Wide Association of Specialty Programs and Schools (WWASPS), an umbrella organization of residential programs that provided services to struggling teens (Szalavitz, 2006). Reports of abuse of youth in private residential treatment programs, including deaths, gave rise to responses from both

within government—relevant agencies began scrutinizing private residential treatment facilities (Szalavitz, 2006)—and the mental health field. A group, The Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment (ASTART), was formed to advocate for youth in these programs and their families (Behar et al., 2007).

ASTART, established under the auspices of the University of South Florida and the Bazelon Center for Mental Health Law, was comprised of a "multi-disciplinary group of mental health professionals and advocates that formed in response to rising concerns about reports from youth, families and journalists describing mistreatment in a number of the unregulated programs" (Friedman et al., 2006). They recognized the serious risk to the safety of youth in these facilities and called for: (a) individuals and organizations in the mental health profession, policy makers, and the public to demand licensure, accreditation, and ongoing monitoring of all residential treatment programs by state and independent accrediting organizations; and (b) consistent oversight, enforcement, and regulation by state and federal government agencies (Behar et al., 2007; Friedman et al., 2006; Pinto et al., 2005).

After a history of failure to exercise appropriate oversight, the federal government began to take action to fulfill this responsibility. The U.S. Government Accountability Office (2008) examined allegations of abuse occurring from 1990 through 2007, paying special attention to the deaths of 10 adolescents from 1990 through 2004 during treatment in private residential facilities which were the subject of civil and criminal lawsuits. In addition, the Government Accountability Office uncovered thousands of allegations of abuse that had occurred in residential treatment programs. According to National Child Abuse and Neglect Data System data, 1,619 staff members in residential treatment programs across 33 states were alleged to have been involved in abuse towards a resident

in 2005 alone, and in 2006 one or more youth died in 28 different states. Disclosure requirements did not mandate that the type of facility be identified on reporting documents, so these figures include both public and private residential treatment centers (GAO, 2008).

Accreditation and licensure. Although some private residential treatment programs are accredited and licensed, many are not. Behar et al. (2007) identified 58 programs in 21 states as unlicensed and unregulated in their survey of former residents who attended a residential specialty program. This large number may be attributed in part to differences among states regarding licensing requirements. For example, some states do not requiring private residential programs to hold accreditation or licensure for educational, mental/behavioral health, and/or residential services (Reamer & Siegel, 2013). The states with a significant percentage of unlicensed programs include Utah (15.7%), Montana (13%), New York (10.8%), California (7%), and Georgia (5.7%). In addition, unaccredited and unlicensed programs operate outside the United States in countries such as Jamaica (12.2%), Mexico (7%), and the Dominican Republic, Western Samoa, and Costa Rica (4%) (Behar et al., 2007). The prevalence of unregulated and unlicensed programs is especially troubling given that youth from accredited residential treatment centers have been shown to report significantly more progress (Coll, Sass, Freeman, Thobro, & Hauser, 2013).

Private residential treatment programs. Private residential treatment programs may attain accreditation as a "residential treatment center" or a "residential treatment facility" through nationally-recognized behavioral health agencies, such as the Joint Commission on Accreditation of the Healthcare Organizations (JCAHO), Council on

Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF).

  Programs offering psychiatric services. A program that provides psychiatric services may become licensed as a "psychiatric residential treatment center" or "psychiatric residential facility," depending on the requirements of the licensing agency.

  Programs incorporating schools. Programs that offer an on-site school may seek academic accreditation nationally or within their state (i.e., National School Accreditation Board, National Council for Private School Accreditation, AdvancED, State Board of Education, etc.). Academic accreditation will enable the facility to grant students high school diplomas or award credits for transfer to other secondary schools.

  Limitations of oversight and regulation. Although private residential treatment centers may be undergoing increased scrutiny from the government and, in some cases, receive federal funding (through the Departments of Health and Human Services, Justice and Education), they are not regulated by the federal government (Federal Trade Commission, 2008). Federal policy grants considerable deference to parents: "[Government's role is] not to interfere with the legitimate rights of parents to educate or raise their youth as they see fit, so long as the living conditions and discipline meet generally acceptable norms" (U.S. Department of State Foreign Affairs, 2005). Moreover, even states that take an active role in requiring licensure for residential treatment centers may be inconsistent in regulating and monitoring these programs (Behar et al., 2007). Thus, parents and caregivers are cautioned to take great care when placing youth in private facilities.

  Suggestions for caregivers. Parents and guardians are advised by the nation's consumer protection agency, the Federal Trade Commission (FTC), to confirm with the

relevant state and federal government agencies that the facility is licensed or accredited to provide the services they purport to offer (Federal Trade Commission, 2008). For instance, some programs are licensed only as schools, in which case the residential components of the treatment program would not be subject to oversight. In addition, some private facilities have engaged in "deceptive marketing" practices (U.S. Government Accountability Office, 2008). Therefore, caregivers may need to ask many questions about the program (e.g., therapies, interventions, discipline procedures and supports used to address their child's needs), prior to making the decision as to whether the private residential treatment program is an appropriate placement (Federal Trade Commission, 2008). Furthermore, caregivers are recommended to schedule in-person visits to the residential treatment program, "at both 'peak' and 'off-peak' hours to learn about the physical surroundings, structured activities, the child-care staff, the teaching staff, the administration, and treatment plans" (Cragnotti, 1987, p. 48).

Treatment Components and Outcomes

In an examination of outcome literature on adolescent residential treatment programs, Bettmann and Jasperson (2009) found improvements in youth in the following areas: (a) behavior (Lyons & Schaefer, 2000), (b) adaptive social functioning (Hooper, Murphy, Devaney, & Hultman, 2000), and (c) family functioning (Larzelere et al., 2001), concluding that these programs "are successful interventions for many clients" (Bettmann & Jasperson, 2009, p. 174). The study, as is the case with most studies of residential treatment for youth, did not specify the linkage, if any, between individual treatment components and their outcomes (Knorth, Harder, Zandberg, & Kendrick, 2008). This is unfortunate as the failure to connect content variables with outcomes impedes

identification of the effective elements of residential care (Bettmann & Jasperson, 2009; Lee & McMillen, 2008).

Reamer and Siegel (2008) recommended that programs treating the serious mental health disorders commonly seen in youth in residential treatment be designed in accordance with the best available research published in peer-reviewed professional journals. They identified the approaches that conformed to this standard as: "psychodynamic, insight-oriented therapy, cognitive-behavioral therapy, multisystemic family therapy, coping skills training, parenting skills training, dialectical behavior therapy, eye movement desensitization and reprocessing therapy, biofeedback, group counseling, family counseling, and psychotropic medication." (Reamer & Siegel, 2008, p. 82)

In a comprehensive meta-analysis of 32 randomized controlled outcome studies published between 1965 and 2004, Weisz, Jensen-Doss, and Hawley (2006) compared the effectiveness of psychotherapy interventions for youth based on empirical evidence (also referred to as "evidence-based treatment" or "EBT"), versus those not based on empirical evidence (referred to as "treatment as usual"). Approaches classified as EBTs included: (a) behavioral family systems therapy, (b) motivational interviewing, (c) behavior contracting, (d) multisystemic therapy, (e) parent management training, (f) problem-solving skills training, (g) anger control training, and (h) cognitive behavioral skills training (Weisz et al., 2006). Unstructured, non-behavioral methods, such as non-specific one-on-one talking therapy and discussion groups, were considered to constitute treatment as usual. Findings indicated that EBTs outperformed treatment as usual; however, the differential was modest (Weisz et al., 2006).

Similarly, Reamer and Siegel (2008) concluded after their review of the meta-analysis literature that uncoordinated talk therapy not based on cognitive-behavioral methods was less promising in terms of helping youth struggling with emotional and behavioral difficulties than "structured approaches in which problems, goals, interventions, and outcomes are stated in concrete, observable, measurable terms and that address the teen in the context of the school, neighborhood, peer group, and family [which] show[ed] the best results" (p. 88).

For adolescents with substance abuse problems, research suggests that targeted early-intervention programs that use cognitive behavioral approaches are most effective, especially when motivational interviewing and skills training are incorporated (Botvin, Griffin, Diaz, & Ifill-Williams, 2001; Larimer & Cronce, 2002). According to a meta-analysis conducted by Vaughn and Howard (2004) investigating 15 controlled evaluations of substance abuse treatments for adolescents, cognitive behavioral group treatments and multidimensional family therapy demonstrated the most effectiveness in one-year follow ups or in replication studies. Additional interventions—specifically behavioral therapy, multisystemic therapy, cognitive behavioral therapy combined with functional family therapy, life skills training and psychoeducation—were also found to have clinical significance although, for these interventions, no follow-up studies were conducted.

In addition to the utilization of evidence-based treatments, research has demonstrated the unique importance of staff as a component of program quality. Their qualifications, selection, training, supervision, adherence to treatment principles, and retention are factors that appear related to positive changes in adolescent behavior and functioning (Byrne & Sias, 2010; Schoenwald, Sheidow, & Chapman, 2009). As staff

employed in residential treatment often confront aggressive, challenging and violent

behaviors, state-of-the-art training and treatment adherence in behavioral management

and crisis prevention are critical to keep themselves, the residents, and others safe (Allen

& Tynan, 2000; dosReis, Barnett, Love, & Riddle, 2003).

      Residential treatment environment. The treatment environment or milieu is a

very important component of any residential treatment program for adolescents with

emotional and behavioral problems. Programs vary widely in the methods by which they

utilize the environment for treatment purposes (Abramovitz & Bloom, 2003). For

example, some private residential treatment centers create an environment using a

contingency management system model. Adolescents are rewarded or punished in

response to whether their behavior adheres or fails to adhere to the program's rules,

regulations, expectations, or treatment plan. Programs adopting this treatment

environment are sometimes referred to as "behavior modification facilities."

      A widely used behavioral modification method applied to residential treatment

environments is the token economy (Zlomke & Zlomke, 2003). According to Rodriguez,

Montesinos, and Preciado (2005), token economies are "reinforcement systems in which

the occurrence of appropriate behavior (or the absence of problem behavior) produces

secondary reinforcement in the form of tokens (e.g., poker chips) that can periodically be

exchanged for other reinforcers (e.g., food, toys, free time)" (p. 427). Response costs,

another aspect of the token economy, occur when reinforcers are taken away because an

individual engages in behaviors not approved by the program (LeBlanc, Hagopian, &

Maglieri, 2000). Kazdin (2012) explained the token economy as derived from the

principles of operant conditioning—as patients learn that consequences follow behavior,

positive behavior is promoted and inappropriate behavior is reduced.

Other behavior modification methods widely applied in "behavior modification" residential treatment programs for adolescents with emotional and behavioral problems are highly structured level systems in which behavioral adherence to a set of rules, regulations, and expectations are rewarded with advancements in level status. Declines in level status result from behavioral disobedience. Once a level is achieved, the individual has earned the specific rewards and privileges linked to that level status in addition to previously earned privileges linked to lower status levels (Mohr, Martin, Olson, Pumariega, & Branca, 2009). Conversely, rewards or privileges earned with a level may be revoked when the positive behavior is not maintained. Each individual's level reflects his or her current state of engagement in appropriate or inappropriate behaviors according to the rules, regulations, and expectations of the program (Filcheck, McNeil, Greco, & Bernard, 2004).

Entering treatment. A treatment component often overlooked in the research is the method by which the adolescent enters the treatment facility. Although many youth are brought to the facility by their families, and there are instances where a caseworker may accompany them, it is also common that adolescents are unaware that they will be attending a private residential treatment program in which case the introduction, often implemented by force, may have a significant and traumatic impact on the adolescent. Behar et al. (2007) found that almost half (47.6%) of adolescents in private residential treatment programs had been transported by an escort service, hired to remove them from their home and bring them to the residential treatment facility. It is customary for programs to refer caregivers to private transportation services that will escort adolescents from their home to the program (Robbins, 2014).

There are several primary reasons why parents and caregivers choose this option: (a) the facility may be a great distance from the home, often in another state; (b) caregivers may be apprehensive about the child's cooperation, concerned that the child may refuse to attend the residential program, or even flee; or (c) caregivers may be unable to deliver the child due to personal circumstances, such as illness, or competing responsibilities, e.g., work schedules, the need to care for other children in the household, etc.

Most private transportation companies will send a team of physically strong adults, sometimes referred to as "agents," to pick up youths in their homes, at a time that involves the element of surprise, such as late at night or early in the morning. The escorts will inform the youth that they are there to accompany the youth to a residential treatment facility. They make it clear to the youth that the decision is not open to debate, and they will be leaving immediately. If the youth is resistant, escorts may: (a) use force or the threat of force; (c) apply restraints, such as handcuffs; or (c) utilize other physical means, if necessary, to gain the adolescent's compliance for the travel to the facility by vehicle or airplane (Aitkenhead, 2003; Behar et al., 2007; Robbins, 2014). One adult who had been transported to residential treatment as an adolescent recalled: "I did not know where I was going when two strangers came to my room at home at 3 in the morning, handcuffed me and dragged me down the stairs into a car" (Behar et al., 2007, p. 1531). Another youth described the shock of being confronted with the unknown:

> [I woke] to a man and a woman in my room whom I had never seen before telling me that they were "escorts" and we were going to a place called "wilderness." I was not allowed to bring any belongings or tell anyone where I was going. I

didn't know what "escorts" and "wilderness" were, and I was terrified. (Evans &

Jane, 2014, para. 3)

Examples of youth being escorted to a residential facility by the methods

described above are not rare. ASTART, the organization formed to advocate for youth in

these programs and their families, as discussed above, describe how harrowing this

experience can be for adolescents:

[Youth who have been escorted to a residential program] experience years of

nightmares, flashbacks, emotional "numbing," inability to concentrate, angry

outbursts, difficulty sleeping or other symptoms…because of the trauma of being

forcibly taken against their will, by strangers, to a completely unfamiliar place,

and kidnapped with the knowledge and permission of their parents—parents who

are supposed to be the child's trusted protectors (ASTART, 2014).

Thus, it is not surprising that advocates for adolescents argue that transporting children

against their will, even with parental consent, is akin to child abuse, kidnapping, and false

imprisonment (Robbins, 2014). In addition to emotional harm, there is documented proof

that adolescents have been harmed physically as well during the process of transportation

(Robbins, 2014). Despite evidence that the use of escort services may be dangerous and

emotionally traumatic, there is a dearth of research on the impact of this experience on

the adolescent and the youth transportation industry remains unregulated.

Restrictiveness. Most out-of-home treatment programs designed for adolescents,

such as wilderness camps, drug and alcohol rehabilitation facilities, youth correction or

detention centers and emergency shelters, as well as residential treatment centers, impose

exacting restrictions on youth (Rauktis, Huefner, O'Brien, Pecora, Doucette, &

Thompson, 2009). This restrictiveness, an important component of residential treatment

programs, has been defined by Hawkins, Almeida, Fabry, and Reitz (1992) as the "limits

placed on freedom of movement or choice by the physical facility, by rules or

requirements, and by conditions of entry and departure" (p. 54), and by Rauktis et al.

(2009) as "the way in which adults in a youth's life have anticipated that limits need to be

made for the youth's safety, development and therapeutic needs" (p.150).

The level of restrictiveness in residential treatment settings has been a subject of

interest to researchers (Hawkins et al., 1992). Rauktis et al. (2009) developed the

Restrictiveness Evaluation Measure for Youth (REM-Y) which classified the

environments as high, medium, or low. Rauktis, Fusco, Cahalane, Bennett, and Reinhard

(2011) conducted a qualitative study examining how youth had experienced

restrictiveness in out-of-home former placements. There is little research, however,

examining the impact of highly restrictive private residential treatment programs on

adolescents.

High-restriction environments impose strict limitations on youth in terms of

activities, interpersonal relationships, and freedom of movement. Youth may have very

limited access to, or be prohibited from, using the Internet, watching television, listening

to music, playing video games, and/or using personal devices. Activities permitted

outside the facility are also limited to those selected by the program, and participation is

often conditioned on appropriate behavior.

Various mechanisms may be utilized to enforce compliance or manage

misbehavior, such as time-outs, seclusion (a person is voluntarily or involuntarily

confined to a specific area and isolated from others), and physical or chemical restraints

(Rauktis et al., 2009). A physical restraint restricts freedom of movement or normal

access to one's body through a variety of means, e.g., manually, use of devices,

equipment, etc. The definition of a chemical restraint may vary slightly among

jurisdictions, but it is defined by the state of Colorado regulations as a "medication

applied, ingested, or injected for the purpose of altering or controlling behavior"

(Resident Behavior and Facility Practices, 2011, p. 13)

Measures are often taken to prevent or control contact with others. For example,

interactions with family members, such as phone calls, letters or visits, may be limited to

specific times and places, and subject to monitoring and those with friends may be

prohibited or closely supervised. Adolescents may have limited access to many areas

within the premises and no access outside the premises. The most restrictive of these

programs are lock-down facilities, in which youth can only leave their unit or the facility

under limited circumstances with supervision, or upon termination of treatment. In

addition, adolescents have little or no input into treatment decisions. For example, youth

may be given treatment, including medication, without their consent.

Medication. A study performed with child psychiatrists who had either been

employees or consultants for a residential treatment center found that youth in residential

treatment are more difficult to treat than those in less restrictive settings due to their

complex and often significant emotional and behavioral needs (Griffith, Epstein, &

Huefner, 2014). As a result, high numbers of youth in residential care are prescribed

psychotropic medication (Hurley et al., 2009). Research has shown that between 40% and

98% of youth in residential treatment care are prescribed at least one psychotropic

medication (Connor & McLaughlin, 2005; Handwerk, Smith, Thompson, Spellman, &

Daly, 2008; Milazzo-Sayre et al., 2000; Ryan, Reid, Gallagher, & Ellis, 2008).

Griffith et al. (2014) highlighted the challenges faced by mental health

professionals, such as the psychiatrists in their study, in determining accurate diagnoses

and then prescribing effective medications, as youth admitted into these programs often:
(a) present with a multitude of diagnoses, (b) have been prescribed and/or are taking a
variety of medications, and (c) provide limited, if any, medical record histories of prior
prescribed medications. Furthermore, several psychiatrists in the survey reported the
absence of available resources on youth in residential treatment settings that could help
guide pharmacotherapeutic decisions (Griffith et al., 2014).

      The development of self-image and self-esteem during adolescence presents a
separate challenge for prescribers serving this population. Theories of development have
posited that having to take psychotropic medications may be perceived by adolescents as
"failing to validate who they are and who they are becoming" (Chubinsky & Hojman,
2013, p. 361). In addition, the social stigma of taking psychotropic medication may also
influence the adolescent's sense of self (Chubinsky & Hojman, 2013). In a study that
investigated the perceptions of stigma among adolescents taking psychiatric medication,
90% of participants endorsed experiencing stigma, resulting in feelings of shame,
secrecy, and withdrawal from others (Kranke, Floersch, Townsend, & Munson, 2010).
Requiring psychopharmacological intervention may also engender a sense of intrusion,
vulnerability, loss of autonomy, loss of control, and inadequacy in youth, according to
psychodynamic models of psychopharmacotherapy (Rappaport, Chubinksy, & Jellinek,
2000). Not all youth, however, have negative experiences with psychotropic medications.
A survey of adolescents who had been prescribed medication during their stay in
residential treatment found that approximately half of the participants reported benefiting
from medications, and approximately a third reported having positive feelings about this
intervention (Foltz & Huefner, 2014).

The management of psychotropic medication is an important component of residential treatment. Thus, health care professionals in this setting are advised to: (a) understand and take into account the specific meaning the youth has ascribed to being prescribed medications, (b) engage the youth in nonjudgmental dialogue about the meaning, and (c) clarify the reasons for recommending medication. Pursuing this course of action will not only facilitate appropriate medication prescription and compliance, it may also aid in assuaging fears, preserving the youth's sense of self, and increasing treatment alliance (Chubinsky & Hojman, 2013; Rappaport et al., 2000).

Relationships with other residents. The relationships adolescents have with peers in the facility has been identified in the literature as an impactful component in residential treatment. Many researchers have debated over the iatrogenic effects that at-risk youth may have on each other's behavior when placed together (Osgood & O'Neill Briddell, 2006). For example, some studies have shown that grouping struggling youth together can result in "peer contagion" (Lee & Thompson, 2008, p. 31), a process by which exposure to deviant peers may have a negative influence, unintentionally making a youth's problems worse and leading to increases in problem behaviors within the whole group (Bayer, Pintoff, & Pozen, 2003; Dodge, Dishion, & Lansford, 2006).

An analysis of 55 child "friendship groups"—a preventative intervention program to help children improve social cognitive skills and increase prosocial behavior—demonstrated that intervention gains were impeded and aggressive behaviors were increased as a result of peer contagion (Lavallee, Bierman, & Nix, 2005).

Negative behaviors may also be influenced through the process of "deviancy training," in which at-risk youth promote anti-social behaviors of their peers by encouraging them through attention and laughter (Dishion, Spracklen, Andrews, &

Patterson, 1996). Deviancy training has been associated with increases in early

development of conduct problems, including (a) antisocial behaviors, (b) violence,

(c) rule-breaking, and (d) reduced effectiveness of treatment (Dishion, Dodge, &

Lansford, 2006; Dishion et al., 1996; Snyder, McEachern, Schrepferman, Just, Jenkins,

Roberts, & Lofgreee, 2010; Snyder, Schrepferman, Oeser, Patterson, Stollmiller,

Johnson, & Snyder, 2005). Research studies concerning negative peer influence within

residential treatment settings have not uniformly demonstrated the deviancy training

impact, however, and a number of studies have resulted in far different conclusions—that

peers had a minimal influence on youth. For example, in a study of 712 youth admitted

into a large treatment-focused residential program, conduct problem behaviors decreased

significantly over time. These results were consistent for youth who had been diagnosed

with Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD), as well as youth

without such diagnoses. In fact, the improvement occurred at a faster rate for youth

diagnosed with CD. Gender discrepancies were also demonstrated, with females'

improvement outpacing that of males (Huefner, Handwerk, Ringle, & Field, 2009).

Similar findings were shown in a retrospective longitudinal study by Lee and

Thompson (2009) of 744 youth at a residential treatment program: only a small fraction

(7%-9%) of youth had worsened externalizing behaviors over time, and the vast majority

of participants (over 90%) manifested no impact on externalizing behavior trajectories for

exposure to peers in the environment diagnosed with ODD or CD. This study also

indicated that positive peer influences may have been a protective factor (Lee &

Thompson, 2009). Furthermore, Huefner and Ringle's (2012) study of archival data for

1,435 adolescents admitted into a large residential care program found no increases in

conduct or oppositional defiant behaviors in youth who had been exposed to peers

diagnosed with CD. Interestingly, several factors were shown to be related to increases in problem behaviors: time in the program and low levels of direct care staff experience.

Relationships with staff. Quality relationships between youth and residential staff members are crucial to the treatment alliance and serve to promote post-discharge positive outcomes in youth, such as wellbeing, development, and life satisfaction (Byrne & Sias, 2010; Holmqvist, Hill, & Lang, 2007; Marsh, Angell, Andrews, & Curry, 2012; Schiff, Nebe, & Gilman, 2006). Indeed, youth during and after placement in residential care have indicated that relationships with staff were among the most helpful and positive aspects of their residential experience (Anglin, 2004; Schiff et al., 2006). These findings are consistent with the move by some residential facilities towards family-style residential care for youth, similar to the program established by the Girls and Boys Town in Omaha, Nebraska.

An outcome study on the effectiveness of the Girls and Boys Town Family Home Program, a modified teaching family model (TFM), found youth "improved significantly on 6 of 17 standardized outcome scores and were functioning as well as national norms three months after discharge" (Larzelere, Daly, Davis, Chmelka, & Handwerk, 2004, p. 130).

Evidence on the benefits of a family-based approach, however, are mixed. In another outcome study comparing the effectiveness of the model provided by Girls and Boys Town and group care as usual, the youth in group care had more positive outcomes. They were: (a) more likely to be favorably discharged, (b) more likely to return home, and (c) less likely to experience a subsequent formal placement. The researchers hypothesized that discrepancies between sample participants—there was a higher proportion of youth with delinquency-related issues receiving treatment in the group care

as usual programs—may have influenced the results because behaviorally-oriented treatments might be a more appropriate intervention for this population than family-style treatments (Lee & Thompson, 2008).

Another factor influencing the effectiveness of this treatment approach arises from what seems to some youth as the lack of authenticity of "family style" treatment. For example, in Anglin's (2002) grounded-theory examination of staff and youth interviewed from 10 group care residences in British Columbia, youth with intact families living in group homes reported very adverse reactions to the residence's attempts to imitate a family, experiencing a "sense of betrayal when they are faced with the expectation to 'treat strangers as family'" (p. 152). Additionally, the nature of the setting and the functions of the staff are at odds with a family home: the facility is not owned by anyone working or living there, and staff leave at the end of their shift. Although staff living in the residence might allow the facility to resemble a family home more closely, staff reported advantages to their presence in the facility only during their shift: (a) it enabled them not to take the destruction of property personally, (b) it gave them time to recuperate from what they viewed as a demanding job. Another feature of staff rotating in shifts is that with a larger and more diverse staff, youth have more opportunities to connect and build meaningful relationships with adults and perhaps see them as role models.

Bastiaanssen, Delsing, Kroes, Engels, and Veerman (2014) studied the relationship between the interventions implemented by group care workers and their impact on youth problem behavior in residential care. Staff completed an Intervention Checklist that reviewed their own behaviors, and a Child Behavior Checklist that reviewed the behavior of 128 children under their care, at six month intervals during a

year-long period (at the beginning of the treatment, and then after six and twelve month periods). Results indicated that group care workers did not change in their interventions described as "controlling," "warm" and "supportive". The only changes in interventions were that staff granted more autonomy to their youth over time. There were also no changes in youth behavior, externalizing and internalizing, over the time period. A cross-lagged analysis, however, revealed bidirectional influences between the interventions the group care worker used and child behaviors. Specifically, when staff were implementing higher levels of controlling interventions on the youth, increases in externalizing problems of the youth occurred and, correspondingly, when youth exhibited higher levels of externalizing problems, increases in controlling interventions by staff occurred. In addition, higher levels of internalizing problems in youth were associated with lower subsequent levels of autonomy-granting interventions (Bastiaanssen et al., 2014).

Beastiaanssen et al.'s (2014) results are consistent with personal accounts of prior residents of residential mental health treatment centers, who described that the youth experienced fear, frustration, and powerlessness in response to direct care staff's verbal and physical assertions of authority and power to control them (Polvere, 2011). Reports of these youth, many with histories of abuse and neglect, indicated that direct care staff often "were not trained properly and knew little about the traumatic backgrounds and mental health histories of youth-in-placement" (Polvere, 2011, p. 329). They also indicated that power assertion by staff was perceived as threatening, hostile, unjust and even abusive, contributing to negative feelings and resentment towards staff, ultimately leading to youth-staff conflicts (Polvere, 2011). The studies described above highlight the strong impact of group care workers on youth in residential treatment. Further research

assessing the dynamics between residential treatment staff and adolescents in this intervention is indicated.

Relationships with therapists. The therapeutic relationship between clinician and client is important to the treatment process. Effective therapy is strongly facilitated when an affective client-therapist bond includes "rapport, comfort, liking, attractiveness, and credibility" (Cunningham, Duffee, Huange, Steinke, & Naccarato, 2009, p. 64; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). Client participation and collaboration in treatment demonstrates a positive relationship or strong "therapeutic alliance" (Martin et al., 2000). A large meta-analysis of 49 youth clinical treatment outcome studies found that multiple therapeutic relationship variables had moderate-to-large relationships to positive outcomes (Karver, Handelsman, Fields, & Bickman, 2006). These included attributes of the therapist—the therapist's direct influence skills (such as clarity, ability to provide an understandable rationale, provision of feedback, direct guidance, etc.), and the therapist's use of interpersonal skills—as well as attributes of the youth and family, such as "parent willingness to participate in treatment, youth willingness to participate in treatment, youth participation in treatment, and parent participation in treatment" (Karver et al., 2006, p. 59). In a qualitative study analyzing narratives of youth with prior histories in restrictive mental health placements (e.g., residential treatment centers, facilities, inpatient hospitals), many youth expressed disappointment with the services provided in these placements, often suggesting that the residential centers over-relied on medication while offering limited or low-quality counseling services (Polvere, 2011). Thus, despite data indicating that the youth-therapist relationship is important to outcomes, this component of treatment has not been emphasized in many residential treatment programs.

Relationships with family. Research has shown that efforts to incorporate family participation in residential treatment programs for youth have consistently: (a) been linked to positive outcomes, and (b) have been identified as best practice (Affronti & Levison-Johnson, 2009; Leichtman, 2008). According to a study that examined data from 8,933 youth placed in residential treatment programs, successful outcomes were associated with positive levels of family functioning (Sunseri, 2004). Higher parental involvement has also been related to youth in residential treatment facilities achieving discharges to family-like settings and continuing treatment in outpatient care (Robst, Rohrer, Dollard, & Armstrong, 2014). Furthermore, in Sunseri's (2001) report of the results from a survey completed by 222 county placement workers who treated 313 youth admitted into residential treatment, consistent family visitation was the only predictor variable that differentiated residents who met their goals and graduated treatment from those who did not. In a retrospective study of former students of a residential school in Britain, the youth frequently reported that the opportunity for family contact was one of the most positive features of living in the center (Smith, McKay, & Chakrabarti, 2004).

Although the research strongly supports family involvement in the treatment of adolescents (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2014; Waldron & Turner, 2008), and it has been shown to influence positive outcomes for youth in residential treatment (Gorske, Srebalus, & Walls, 2003; Sunseri, 2001; Walter & Petr, 2008), many residential treatment programs have not stressed family involvement in their treatment approach. In a survey of 293 residential treatment facilities for youth, 8% reported limited family involvement, 79% some involvement, and 12% primary involvement. Furthermore, a significant number of facilities restricted contact with family: 27% permitted visitation contingent on the youth's behavior, and 16% did not

allow youth to visit home (Brown, Barrett, Ireys, Allen, Pires, & Blau, 2010). In addition,

some residential treatment facilities impose time-based restrictions, prohibiting any child-

caregiver contact for a period that may last from one to eight weeks (Robst, Armstrong,

Dollard, Rohrer, Sharrock, Batsche, & Reader, 2013). Similar restrictions on family

involvement, such as limiting telephone calls, visits, and therapeutic home passes, have

also been reported (Robinson, Kruzich, Friesen, Jivanjee, & Pullman, 2005). There are

additional barriers to family involvement in care unrelated to treatment center policy,

notably the cost of transportation and distance from the facility (Robinson et al., 2005).

A more recent study of characteristics related to family involvement indicated that

a significant majority (approximately 80%) of youth in residential treatment programs

had regular contact, either in person or by phone, with their family during their treatment

stay. This study also found a number of variables that influenced the level of family

involvement, including: (a) gender of the youth, (b) age of the youth, (c) geographical

distance of the family home from the facility, and (d) the youth's length of stay in the

facility. Results indicated that there was greater family involvement with male youth,

when youth were younger ages, when the family lived in the same county, and when

treatment was a shorter duration (Robst et al., 2013).

Youth engagement. Client engagement is also an important element of the

treatment process and outcomes. This is especially true for adolescents in residential

treatment (Cunningham et al., 2009; Smith, Duffee, Steinke, Huang, & Larkin, 2008). In

a study of 130 adolescents who were treated in residential treatment programs, findings

indicated that engagement was best reflected by: (a) an attitude indicating a readiness to

change, (b) a positive affective relationship with the practitioner, and (c) behavioral

actions taken by the youth towards treatment objectives (Cunningham et al., 2009).

Research has also shown that earlier engagement with treatment providers results in more positive outcomes for youth (Smith et al., 2008). Despite research demonstrating that client engagement is important to outcomes for youth, this component of treatment is not prioritized in all residential treatment programs.

Limitations of the Literature and Implications for the Current Study

By the time that a family decides to choose a private residential treatment center for a child, many less intensive forms of treatment may have been attempted without success. Therefore, youth admitted into private residential treatment centers are a high-need population, often presenting with serious emotional and behavioral problems that have created significant impairments in their social, emotional, and academic functioning. Offering treatments that have been proven to meet their needs is complicated by how little attention private residential treatment has been accorded in the literature (Little, Kohm, & Thompson, 2005). Even in the relatively rare instance that residential treatment researchers draw data from private residential treatment programs, they fail to make distinctions between public and private residential treatment programs. Thus, the degree to which findings solely apply to *private* residential treatment programs is essentially unknown (Behrens & Satterfield, 2006; Curtis et al., 2001; Hair, 2005). In the words of one scholar, youth in private residential treatment programs represent "a neglected population of youth in a neglected part of the U.S. mental health service system" (Rosenblatt, as quoted in Warner & Pottick, 2003, p. 1).

In the absence of adequate research, it has been difficult to determine whether residential treatment programs are employing or properly adhering to evidence-based or supported interventions to meet the high needs of their adolescent patients. An additional

factor that impedes comprehensive knowledge about the effectiveness of private residential treatment centers is related to the lack of regulation, as discussed above.

Research studies with adult consumers of mental health services have demonstrated that they want input in decisions regarding their treatment (Woltmann & Whitley, 2010). It stands to reason that adolescents would want a voice as well. Accordingly, Warner and Pottick (2003) advised caregivers that they "need to consider residential care from the perspective of the children served" (p. 1) before making the commitment to utilize a residential treatment intervention. This is consistent with research indicating that deriving information directly from consumers of mental health services on what outcomes they hope for, whether it be broad or specific, offers an important perspective on what services and interventions are necessary to promote their psychosocial rehabilitation (Klein, Rosenberg, & Rosenberg, 2007).

According to the findings from a research study of self-perception of needs among a sample of 133 former inpatients at a state psychiatric center who had been diagnosed with serious mental illness, treated and then discharged to the community, "[mental health] consumers view their lives holistically and complexly with an equal concern for their social as well as clinical needs" (Klein et al., 2007, p. 66). Thus, including the adolescent consumer's perspective in relevant aspects of residential treatment is advised in order that the services offered are consistent with the adolescent's hoped-for outcome.

The importance of patient feedback during treatment has been shown to lead to fewer treatment sessions and better outcomes (Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). Similarly, in a study of managed behavioral healthcare settings, Brodey, Cuffel, McCulloch, Tani, Maruish, Brodey, and Unützer (2005) found that feedback

given from patients to clinicians had a significant positive impact on patients' mental health outcomes. Those patients who provided their clinicians with feedback at intake showed greater improvement in mean domain scores for total symptoms (0.35 vs 0.25 on a 5-point Likert scale, or 28%) after six weeks than patients who had not provided feedback to clinicians. The positive impact of patient feedback to clinicians can also be demonstrated by a study by Brodey et al. (2005). When asked to respond to the reports submitted by their patients', clinicians were more likely to say that these reports: (a) enabled them to provide better care when the reports revealed that patients were experiencing adverse conditions, i.e., more symptoms of depression and anxiety were reported, and/or (b) when patients assessed their sense of wellness and health as being low.

Implications for Further Study

Important areas for further research examining the experience of youth in residential treatment include: (a) peer relationships; (b) the provision of therapy and the therapeutic relationship; (c) family involvement and how these interactions, or lack thereof, may have impacted the adolescent experience of treatment; (d) youth engagement; and (e) clinical feedback from the perspective of the adolescent patients. Moreover, given the diversity of group care practices within private residential treatment programs, residential treatment research would benefit from studies that elicit patients' responses about specific components of their treatment that they considered beneficial. As stated by Behrens and Satterfield, any "attempts to tie program components to outcomes would have profound clinical implications" (2006, p. 15).

Chapter III: Methods

Qualitative Research

This qualitative and retrospective study of adults who, as adolescents, had received treatment in the same private residential treatment facility utilized in-depth, semi-structured interviews to: (a) explore how the former residents perceived their time in private residential care, (b) identify the components of treatment that were influential in their experience and development from arrival through discharge, (c) examine how this experience impacted their lives as adults, and (d) obtain the advice they had for treatment providers and for youth who were entering private residential treatment facilities. The semi-structured interviews were audio-recorded, transcribed, and analyzed using the principles of grounded theory to identify common themes among the participants' experiences.

Participants

Study participants consisted of 10 adults (6 females, 4 males), aged 18 or older, who had previously been treated in the same private residential treatment facility for a minimum stay of six months during adolescence, i.e., between 13 and 17 years of age. In order to protect the confidentiality of the participants, their ages and the years they attended the program are not identified in this study.

Selected Residential Treatment Program

This study focused on the experiences of these participants at a private residential treatment program located in a rural community in the Mountain West of the United States. In order to protect the confidentiality of the participants, the residential treatment program was not identified by name or location in this study. A brief description of the

selected program, guided by Lee and Barth's (2011) index of reporting standards, was used below to avoid generalizations to other private residential treatment programs.

The program specializes in treating adolescent boys and girls, ages twelve through seventeen, who are manifesting emotional and behavioral disturbances and have been unresponsive to outpatient psychotherapy, inpatient psychiatric treatment, or substance abuse programs. The duration of treatment is considered long-term with length of stays that may exceed 6 months. The adolescents are separated by gender, with boys and girls having their own campus and facility, but otherwise operating with the same treatment program. The combined facilities have a capacity of over 200. Approximately 30 residents are in each unit, and residents live in dormitory-style conditions with four adolescents sharing a bedroom.

The program is fully accredited both as a psychiatric residential treatment facility (having received accreditation from the Joint Commission on Accreditation of the Healthcare Organizations, or JCAHO) and as a non-public school (providing a year-round on-site academic program). It is formerly associated with the World Wide Association of Specialty Programs (WWASPS) and it is not a current (as of November 2015) member of the National Association of Therapeutic Schools and Programs (NATSAP). The program receives nationwide referrals from caseworkers employed at health- and mental health-related social service agencies (including agencies serving the developmentally disabled) and entities associated with law enforcement, e.g., juvenile justice.

The program's goals are to: (a) improve academic skills and (b) reduce inappropriate behaviors to the extent that adolescents can return to their homes or be placed in less restrictive environments. The program's treatment milieu consists of

contingency management level and token economy systems. Practice elements or

activities within the program include: (a) family involvement through weekly telephone

meetings; (b) educational and vocational skill training; (c) recreational programming;

(d) mental health services that include individual, group, and family counseling; and

(e) medication management with full-time psychiatrists and nursing staff. Adolescents'

activities are directed and monitored by direct care staff who work in shifts.

The program meets the criteria on the REM-Y Restrictiveness Evaluation

Measure to qualify as a site that provides a "highly restrictive" level of care (Rauktis et

al., 2009). For example, facilities are locked, residents cannot leave the building without

permission and supervision; they can only attend the alternative school located within

their facility; and opportunities to pursue leisure activities, such as watching television,

listening to music and reading, are extremely limited in terms of time and content

choices.

Procedures

Recruitment procedures. Upon approval from the Institutional Review Board,

the researcher recruited individuals who had lived in the particular residential facility

during their adolescence through networking. The recruitment began with a small number

of participants who were known to the researcher and individuals who had voluntarily

identified themselves on non-restricted internet forums (e.g., Facebook public groups) as

having lived in this facility during their adolescence. Participants were sent an

advertisement (see Appendix A) and asked to consider forwarding it to other former

residents who might be interested in participating in the investigation. The advertisement

contained the researcher's telephone number and e-mail address.

Individuals who contacted this researcher and expressed interest in participating in the study were provided with further information about the purpose and procedures of the study. Participants were informed that this study offered no compensation for participation both in the advertisement (see Appendix A) and by the researcher. The researcher assessed each potential participant's eligibility to participate in the study. Once eligibility was confirmed, the researcher scheduled either an in-person interview (for those who lived within 70 miles of the researcher) or an interview via phone or Skype.

Consent procedures. Prior to participation, each subject submitted a completed informed consent form (see Appendix B-1) that provided contact information for all individuals affiliated with the study, and explained: (a) the purpose and procedures for participation, (b) the risk and benefits of the study, (c) confidentiality and limits to confidentiality, and (d) the voluntary nature of participation and the right to terminate participation at any time during the interview process without penalty. An addendum to this form requested the participant's consent to audio record the interview (see Appendix B-2). Each participant granted consent to the recording. All participants were given a copy of the dated and signed informed consent form for their records. The researcher placed all signed consent forms in a locked file cabinet in her home accessible only to the researcher. The consent forms were kept separately from participant interview responses.

At the beginning of in-person interviews, the informed consent form was reviewed with the participant (see Appendix B-1). For interviews taking place via Skype or phone, participants were emailed, mailed, or faxed the informed consent form (see Appendix B-1) prior to the interview. Participants were asked to initial all pages, sign the informed consent form, and then return it to the researcher, whether in person or through

electronic or other means. After the researcher received the signed copy of the form, it was reviewed with each participant during the interview.

Interview procedures. The current study utilized a semi-structured interview protocol developed by the researcher (see Appendix C) to gather data. All interviews were audio-recorded and subsequently transcribed. No identifying information was attached to audiotapes or transcriptions. Each interview lasted approximately one and one half hours. No participants were interviewed more than once.

Of the study's 10 participants, only one was located within 70 miles of the researcher. The in-person meeting with the investigator was scheduled, and a convenient, private and comfortable setting was chosen. Prior to the interviews with the nine remaining participants who would be interviewed by Skype or phone, the researcher alerted the participants of the importance of finding an interview setting that was comfortable and allowed for privacy and confidentiality. Seven interviews were conducted via phone and two interviews were conducted via Skype.

Participants were reminded at the start of the interview that they could terminate the interview at any point without any penalty, and would be thanked for their participation. No participants chose to discontinue, although one participant requested a brief break before continuing with the interview. Participants were also informed that the researcher would be taking notes, in addition to the interview being audio recorded, to ensure accuracy.

The majority of the interview focused on participants' adolescent experiences during their placement at the residential treatment program. While the interviews were guided by the protocol (see Appendix C), questions were primarily open-ended to facilitate free-flowing responses. Participants were provided with prompts and questions

to clarify and expand answers when indicated. The interview remained semi-structured. This allowed for a dynamic process in which the researcher could explore themes that arose during each individual interview and across participants. For example, during the initial set of interviews, the school held inside the residential treatment center was cited by participants as significant an to their experiences. Questions were then adjusted in subsequent interviews to include participants' experiences associated with the school.

At the close of the interview, participants were given the opportunity to address any further related issues not covered during the interview and informed that they could ask questions. All were thanked for their participation and told that they could call the researcher if they had any concerns or questions about the study, or thought of anything they wanted to add.

Semi-structured interview protocol. Once participants consented, they were asked to provide their age, gender and racial identification, and a brief explanation of their residential treatment history. Participants were then prompted with the following statement: "You have had a unique experience to have lived in a private residential treatment program as a teen. *Tell me your story* beginning with how you arrived to (name of treatment program)." Following this open-ended prompt, participants were presented with a series of open-ended questions, close-ended questions, and prompts designed to gain an understanding of their perceptions of how specific residential treatment components impacted their wellbeing and development (see Appendix C). Questions were structured to correspond to the three phases of treatment: (a) admission; (b) treatment (specifically the treatment milieu, treatment involvement, therapy, school, and relationships); and (c) discharge. Covered topics included: professionals who were influential during their placement, the availability and use of supports within the

program, and their family members' involvement. Lastly, participants' reflections on their experiences, and their advice for residential treatment centers, parents, and adolescents who might attend RTCs in the future, were elicited.

Treatment of Data

Signed consent forms were kept in a locked file cabinet in the researcher's home. All participants were assigned a code in order to protect their identity. Interviews were audio recorded for later review and transcription. No identifying information was attached to interview data, audio recordings, interview notes, or transcriptions beyond the participant code, and all data were managed and stored in accordance with IRB rules and regulations. Any information that might identify prior or current residents or staff at the residential treatment facility was not included in the transcript, and the facility was referred to throughout the transcripts as "RTC" to further protect confidentiality. Both digital audio recordings and the transcriptions were stored on the researcher's password-protected and firewall-protected computer and encrypted, using the AES-256 encryption standard, on an additional password-protected file. It was determined that all study data will be kept for three years after completion of the research, after which time all documents, audio files, and other computer files will be destroyed by the researcher.

Data Analysis

Data were analyzed using grounded theory methodology developed by Corbin and Strauss (2014). The primary goal of data analysis was to identify common themes among the participants' responses. Guided by the grounded theory method, the researcher read the complete transcripts, then coded the interviews, identifying: (a) similarities and differences in responses, and (b) micro- and macro-level themes. Grounded theory analysis consists of three sequential phases. The first phase is *open coding*, where data—

language used by participants contained in the transcripts—were extracted, labeled, and separated into more general categories. This process of data construction is accomplished by: (a) first breaking the data down into manageable pieces, (b) interpreting the properties of those data pieces, (c) grouping data with similar properties together, and (d) assigning the ideas in the data to a category (Corbin & Strauss, 2014).

The next phase was *axial coding*. Axial coding is the process of developing connections between a main category and its subcategories, as well linking the various levels of concepts to build themes (Corbin & Strauss, 2014). This process also checks the relationships, based on incoming data, and then either accepts, modifies, or discards concepts or themes (Corbin & Strauss, 2014). *Selective coding* is the process of linking individual categories to a core category and abstracting the analytically central content (Corbin & Strauss, 2014).

Based on participants' perspectives relating to the factors that affected their wellbeing and contributed to the impact of their treatment on their lives during placement, hypotheses could then be developed using the grounded theory approach. As grounded theory analysis is an exploratory approach seeking to remain open to the themes that arise from the data, no prior hypotheses were tested in the study.

Chapter IV: Results I

This study utilized grounded theory methodology, as discussed above, to obtain

rich, in-depth descriptions of the experiences of individuals who had been placed in a

residential treatment center (RTC) during adolescence. To aid in understanding the

participants' complex experiences, the results have been divided into two chapters:

Results I describes the reasons for placement and how the participants arrived at the

RTC—for many, the transition from home to facility was quite traumatic, and has had a

long-term impact. This chapter also describes their early experiences at the RTC. Results

II describes the participants' experiences in the program, the treatment process and their

post-discharge reflections and recommendations.

Rationale for Placement and Transport to the RTC

Reasons for placement in the RTC. Nine participants (90%) reported a specific

reason or reasons they understood to be the basis for their placement in the RTC. Seven

participants (70%) noted behavioral problems (e.g., not going to school, running away

from home, drug use, fighting, arguing with parents, "sexually acting out," and having a

"bad attitude") as reasons for their placement. Participant 8 prefaced reporting his reason

for the placement—his pattern of running away from home—with a suggestion of his

pre-intervention incorrigibility:

> I was certainly a rascal when I was a kid. I'd run away from home, [went] to a
>
> little runaway house with runaways for a month, and then [went] to rehab for
>
> about two months before they made a decision to send me up there to RTC.

Participant 6 reported multiple issues that prompted the intervention: "I was using drugs,

and I was going crazy, and I was prostituting, and all this stuff. It was just really bad

before I left….That's why I got sent away."

Five participants (50%) cited mental health problems, such as eating disorders, depression and suicidal ideation, as grounds for their placement. Four participants (40%) ascribed their pre-intervention mental health and behavioral problems to having experienced trauma. One of the participants experienced an extremely violent incident: her family was held at gunpoint and her father was shot and seriously injured during a home invasion. The remaining three participants' trauma exposures were sexual in nature (child sexual abuse, sexual abuse, and sexual assault), and/or were primarily the product of deviant parental behaviors (severe physical abuse and chronic substance abuse). Participant 4, described how her decision to escape her home life as a young teen precipitated even further trauma and despair:

> My mom was a drug user. She abused pills and…drank a lot….After I was 14, I left home. I ended up being raped….I hated myself. I didn't want to live. I didn't want to be near my parents. I didn't want that kind of life anymore. And so my behaviors were more…self-destructing and not suicidal. I wasn't trying to kill myself, but I didn't care if I died. I completely shut down and I [agreed to enter] long-term treatment the first time [rather than returning home]. And the second time I went [to RTC], it was again because of my mother. I stopped going to school….It wasn't drugs or alcohol. It was just the destruction of my family and…I mentally couldn't handle it. My mom was convinced that I was bipolar and she tried to keep having these doctors put me on medications and it was almost killing me. My blood levels were crazy. I was hospitalized because they were overmedicating me. And it was just insane. I was like, I just can't do this anymore.

Participant 7 described his behavioral issues as reactions to the extreme physical abuse his father was inflicting on him:

> My Dad was…an ex-cop, and he used to beat the hell out of me. He always took out all his anger out on me.…I got hit with chairs, and he'd handcuff me to the bed, and beat me with a belt. My mom, she was always caring and loving. But she supported her husband, even though he beat me like that, until it would get so bad that she thought he was going to hurt me real bad, like kill me, or severely injure me, so she would try to stop him.…Probably a lot of the behavior that I had was because my dad beat on me all the time, so I acted out.

Eight participants (80%) expressed the view that their behavior did not justify placement in the RTC for a variety of reasons. Three participants (30%) indicated their placement was inappropriate because they were unfairly targeted as "the problem" without any accountability on the part of their parents. Three participants (30%) stated that their placement at the RTC was inappropriate because it was not the venue in which their admitted mental health issues could be addressed properly. For example, Participant 9 noted, "I got sent [to a hospital] because of depression and suicidal thoughts, stuff like that.…But then they sent me out of state to…a place where they don't even focus on why I'm here." Five participants (50%) reported believing that their placement was inappropriate because their behavioral problems were negligible and did not warrant long-term placement at the RTC. As Participant 2 stated:

> I don't know why I was there. I didn't do drugs, I didn't have sex, I didn't run in a gang. I went to school....I'm in some locked f---ing institution because I argued with my adopted mom 'cause she was like narcissistic.…I'm not going to f---ing go to some place with…strange people for no reason.

Participant 7, while acknowledging that his placement at the RTC was initiated as an alternative to juvenile detention, deemed his three-year placement more as a result of authorities' deceitful manipulations than misbehavior on his part:

> I don't even know if I really would've ended up in as bad…trouble as they told me I was going to be in. I may have just got out and gone on probation, but back then they were telling me that if I didn't go to this school…I was going to end up in…Youth Authority and all this garbage….It was probably more of the threat to scare me....I doubt I would have ended up there.

Three participants (30%) expressed the view that their long-term placement had more to do with underhanded practices of mental health providers than the adolescents' needs and best interests. One participant reported that the psychiatric inpatient hospital that referred her to the RTC received "kickbacks" for the placement, and two participants referenced the financial incentives for the RTC to extend treatment. One participant explained that her long-term treatment continued because her parents' were "paying out of pocket" for the services, and another suggested that "good insurance coverage" resulted in unnecessarily protracted stays:

> If the person gets better, [the RTC is] not going to certify [you] as healthy and send [you] home, they're going to do what they can do to keep you there longer, so they can take more money from the insurance.

Consent of youth. Only one participant (10%) considered her RTC placement as voluntary due to the choice she was given between living at home with her parents or returning to the RTC where she had been treated twice previously. The remaining nine participants (90%) asserted that their placement at the RTC was involuntary and facilitated with the consent of their parents.

Location of origin. All participants (100%) reported that they were living outside the area prior to placement. Participant 5 reported: "They shipped me off to a different state." Nine participants (90%) had been transported across U.S. state lines and one participant (10%) was transported from another country. Seven participants (70%) reported that they had been transferred to the RTC from another mental health facility, e.g., "psych ward," "rehab," "treatment center" and "hospital," where they were receiving inpatient or residential psychiatric treatment to the RTC. Three participants (30%) indicated that they were transported from home.

Transportation approaches. One participant (10%) reported being driven to the RTC by his parents alone, but the vast majority of respondents, eight out of 10 (80%), had been escorted to the RTC by hired youth transport agents (YTAs) who were unknown to them prior to this experience, Five participants (50%) noted that the YTAs had picked them up from the mental health facility where they were receiving treatment at the time, and three participants (30%) reported that one or more YTAs had picked them up at home. One participant (10%) did not identify who was involved in the transportation process.

Parental participation in the transportation process was cited by three subjects (30%), who had been escorted by YTAs. Participant 5 commented: "[YTAs] took me to the airport and put me on a plane and my parents were there." Participant 9's parents accompanied him and the YTAs for the entire trip: "We went straight from the hospital to a plane to [the RTC. My parents] flew with me on the plane there." After disembarking, his parents continued to the RTC, but "I was in a separate vehicle" with the YTAs. The parents of six participants (60%) were not present during transportation to the RTC.

Forewarning. Five participants (50%) reported having no prior notice of their placement so that they were not prepared for YTAs to pick them up and transport them there. Participant 10 related his had a harrowing experience:

> I was kidnapped…while I was sleeping at my house….I woke up to two males standing over my bed saying good morning or wake up, we're going to [RTC]. I knew what [RTC] was. I'd been to [a] three-week survival thing up in [the same state] that was for troubled kids, and one of the kids was telling a story about this place called [RTC] that was the worst of the worst, you don't want to get sent there, kind of a campfire story…so I'd heard of it….I got out of bed. I had a pair of jeans on the floor, so I put a pair of jeans on and a t-shirt. They took me out to our car and they put me in the backseat.

This participant's analogy to being kidnapped is not isolated among the respondents in this study. Two other participants (20%) used this language. Participant 8 stated: "Parents would hire the school to come down and kidnap [people that wouldn't come willingly] out of their bed in the middle of the night, and flown to [the state] to be put in a jail, basically."

Participant 8 further reported his surprise that his parents hired YTAs to take him, as well as his brother, to the RTC for long-term treatment, although he believed he had successfully completed detoxification treatment at a rehabilitation facility for substance abuse and he assumed he would now be returning home:

> I was in rehab…and after I got there, my brother ended up getting there….At the completion of our rehab, [our parents] felt like we still needed some attention. [Transportation agents] just handcuffed us, and took us to the airport, and flew us up to the [RTC]. And they had some counselors come and pick us up from the

airport…and [take] us to the facility….We weren't told anything going out there.

We didn't know what to expect.

Five participants (50%) reported that their parents had given them prior notice of

the long-term treatment placement. Participant 9 stated, "They told me the night before."

Participant 1 had been informed while receiving treatment at an inpatient facility. She

was able to go home for one night and "the next morning they had two people come pick

me up at the house." Because of her prior knowledge, her experience with the YTAs was

not as negative as that of other participants: "It wasn't violent. I didn't resist. It wasn't a

surprise like while you are sleeping kind of thing." Participant 3's reaction to her

mother's advance warning about entering treatment was likely to have reinforced her

mother's belief that this was an appropriate intervention: "They told me that I was going

to go somewhere….I threw a book at my mom….I'm like, 'I'm not going anywhere. F---

you'.…Not long after that…I got sent to [RTC]."

For two participants (20%), entering long-term residential treatment was known

about in advance because youth were presented with two options: the residential

treatment placement or a less desirable alternative. For one youth, the placement was

preferable to returning home to live with parents and for the other it was preferable to

serving time in a youth detention center. Participant 7 recalled: "I'd gotten in trouble and

my parents talked to the judge, and they said that that they would accept [RTC] as an

alternative. Dorm instead of jail."

Restraints during transport. Five participants (50%) recollected restraints of

various types being utilized at some point by the YTAs during the transportation process.

Three participants (30%) described YTAs using methods, such as being "held,"

"subdued," or "grabbed" by the YTAs' hands, to prevent them from running away.

Participant 2, unaware that she was going to the RTC, described the circumstances that

led to the YTAs retraining her:

> [There were] two people at the end of my driveway, and I…thought they
>
> were…crossing the street to go into a neighbor's house. So I…stopped…to let
>
> them cross, and then they grabbed me….I f---ing should have ran the other way.

Two participants (20%) noted being physically restrained with handcuffs, one of whom,

Participant 10, was "handcuffed…to the chair" of the private plane used for transport.

Two participants (20%) described having been chemically restrained. Participant

3's recollection of being drugged without her awareness or consent illustrates this

process, the underlying rationale, and concerns about whether such invasive efforts are

justified:

> They doped me up on [a] type of drug [that] was like a tranquilizer, because they
>
> had to sit me in a wheelchair and I remember going in and out….I woke up, and
>
> then I was at [RTC]. Now that I look back on it, I don't really think that that was
>
> right that I was put on [a] drug…just to transport me, but I think they
>
> thought…that I would run, so that's why they did it, but I think that it was wrong.

Experiences Arriving at the RTC

Feelings of youth after arriving at the RTC. When the participants were asked

about their first experiences upon arrival at the RTC, eight participants (80%) expressed a

range of negative feelings. Fear, cited by six participants (60%), was most common. The

next most frequent feelings were confusion (30%), anger (30%), shock (20%), disbelief

(20%), and sadness (20%). Other negative feelings included powerlessness and betrayal.

Participants often spoke of feeling different negative emotions simultaneously or in rapid

succession. For example, Participant 6 "cried for…two days straight," and was "really

scared because of what I heard about the place, how I heard about how it was crazy."

Participant 7 expressed the negative feelings arising out of the transition from being in a

place where people cared about him to one where no one cared: "It's depressing to be

stripped away from your family and friends and the only people [you've] ever known,

and put some place where people really could care less about your well-being."

Participant 9 expressed fear, but did not internalize it as depression and sadness,

as other participants had:

> To be honest, [I felt] pissed. I didn't think I needed it. I was mad I was being sent
>
> out of state, all that stuff….On the one hand, I was scared, and on the other hand,
>
> I was extremely defiant."

This participant, as will be discussed below, had been rewarded for defiance in previous

placements, so his reaction of fear was appropriate to what he perceived as the situation.

Participant 8 suggested that his reaction was more intense than it would have been if he

were older and had experienced more in life: "We were young so it was kind of

frightening. Kind of really the first time I'd ever been shipped away to a place that I

didn't choose to go, so it was kind of traumatic."

Participant 3 expressed confusion, followed by shock and anger: "I didn't know

what to think. My mind was blown totally, like, why am I even here in this place? I was

just in complete shock and…and I was angry." Participant 1 expressed that a sense of

betrayal was also present in her initial reaction: "I probably felt really scared. I think I

was also a little bit in shock. I couldn't believe this would actually happen. It seemed

surreal, it seemed like this isn't my life. I felt betrayed." Participant 5 analogized her

disbelief and lack of control to a song:

> You are powerless against everything….It was like a dungeon, like really
>
> scary…like Pink Floyd['s] "Another Brick In The Wall", and the kids going
>
> through the meat grinder and all….It was just crazy. I couldn't believe that was
>
> my situation.

Three participants (30%) recollected how the realization that they could not leave the facility became pivotal in their feelings about the placement. Participant 4 stated, "Your whole world changes the minute you step behind those locked doors." Two participants (20%) recalled that being informed of their parents' departure was an ominous sign of what awaited them at the RTC. Participant 8 recounted:

> When we got there…they walked us into the secure area and said, "We're going
>
> to let y'all meet everybody, then you'll say goodbye to your parents"….Then they
>
> took us back to the secure area and…thirty minutes later, we were like, "Can you
>
> tell [staff member], we'd like to see our parents again?" and [were told], "Oh no,
>
> you are not going to see your parents again. They are on a plane by now. They're
>
> gone. You're stuck." And then [we knew we] were essentially locked up in a jail.

Three participants (30%) described initially feeling confident that they would be discharged from the RTC quickly. Participants had different strategies for accomplishing this goal. Two participants (20%) expressed the thought that compliant behavior would enable them to achieve an early discharge. Participant 6 stated, "At first, they said I was…one of the more normal ones…, one of the higher working people there. So I thought, okay, I could just totally coast through this, and be good, and be fine." Participant 10 expressed a similar plan:

> I…really focused on what do I need to do to play this game, to make them give
>
> me the green light, and get me out of there. They talked about a year-long

> program, and people get out before a year, the really good ones. And I thought,
>
> I'm going to be out of here before a year.

Participant 9 was convinced that trying the opposite tactic, defiance, would accelerate his

discharge:

> I was in two other [treatment facilities], and those didn't last long. Basically, they
>
> decided "we can't help him, and it's just a waste of time." I was pretty confident
>
> I'd be out of there in like six months, tops. Little did I know.

> **The welcome at the RTC.** When participants were asked about how they were

first treated by the staff upon arriving at the RTC, all participants (100%) offered

responses. Although eight participants (80%) experienced attitudes that were either

positive or neither positive nor negative, two participants (20%) believed RTC personnel

were not at all welcoming. Those participants identified the unwelcoming attitudes as

suspicious, judgmental, hostile, and uncompassionate. Participant 1 expressed that staff's

initial conveyance of negativity toward her made her apprehensive about how they would

treat her in the future:

> As soon as they met me, [their tone and attitude] were very hostile towards me.
>
> They greeted me with…not suspicion, but almost…preformed ideas or judgments
>
> about…what I was going to be like, and that I was…"bad" or…a "bad kid." This
>
> is a "manipulative kid"….It felt like instantly…they were going to try to break me
>
> down.

The other participant who perceived the staff as unwelcoming, Participant 4, had been to

the RTC twice before which had allowed staff several opportunities to be unwelcoming

and form, in her opinion, mistaken judgments about her:

I can't really say that the staff [the first] time was compassionate or

understanding. Especially the first few weeks you were there, it just felt

like…stripping down…..There was…no compassion….This is terrifying. It was

[a] "This is what we do, screw you," kind of thing. The second time was more

judgmental because people remembered me. I hadn't been gone long. So people

are like, "Oh, you're back again! What'd you do this time?" And I don't think a

lot of people understood that it wasn't me that had the problem, it was my family

that had it.

Four participants (40%) described experiencing staff attitudes upon arrival that

could not be characterized as either welcoming or not welcoming. For instance,

Participant 10 couldn't point to any unpleasant interactions other than a search for

contraband:

They weren't really welcoming. [They didn't] make you feel good, but I wasn't

harassed that I recall. The strip search was really awkward, you're naked and the

whole bit. There was nothing negative about the way I was treated on that first

day.

Two participants (20%) remembered their welcome as consisting of staffs' rote

recital of the rules at the RTC. According to Participant 7: "Basically, [staff] just told you

what you were allowed to do and what you weren't allowed to do." Two participants

(20%) stated that their welcome was contingent upon which staff member interacted with

them at the time. Participant 8 stated, "When I first got to intake, [staff member], who

was one of the intake counselors, was actually pretty cool, but then there was [staff

member, who] was kind of a piece of s----." Two participants (20%) noted having a

positive initial experience with staff. Participant 6 stated: "They were all super nice,

super comforting. Wanting me to know that I'm welcome and everything's okay, and I

need to calm down and just realize where I am. and just learn to be okay with it."

Intake and orientation. When asked about their experience upon first arriving at

the RTC, eight participants (80%) discussed intake and orientation procedures. Five

participants (50%) described being forced to undergo a strip search, and five participants

(50%) stated that they were instructed to change into facility-issued clothing to replace

the clothes they arrived with that had been confiscated. Participant 10 described this

process: "[After] they took me to [the RTC], they took me to intake. They did a full strip

search, and gave me a pair of gray sweatpants and sweatshirt. I don't think they gave me

shoes." Participant 2 recalled how she chose to be compliant with the strip search when

she realized that otherwise she would be coerced by staff:

> I was taken upstairs to a back bedroom where five people stood, and I was told I
>
> have to take [off] all of my clothes. When I refused, people started to put on
>
> gloves, so I gave in because I did not want to be restrained. They took all of my
>
> clothes, left me with some underwear, flip-flops, and some sweats.

Participant 5 alluded to a similar situation in which staff actions hinted at impending

coercion: "They wanted me to change out my clothes into pink sweats and they sent in

this body builder chick and this other chick…yeah, it was pretty bad, I mean, it was not

cool."

Participant 1 stated that having a photograph taken was part of the initial intake

process, followed by "the part…where you are stripped down and [put through searches

involving staff's] fingers in your hair, giving you your sweats. and all that." Participant 5

referred to unique staff suspicions about her hair: "[Staff] wanted to shave my head

because I had lightened my hair from its natural color."

Four participants (40%) mentioned the requirement to learn the rules of the RTC immediately. Three of them (30%) noted that they were given handouts of the RTC rules to read on their own and were tested on them subsequently. Participant 1 described the process which she had concluded was "part of orientation": "[The staff member] sat me down at a chair…and gave me this binder, and told me I needed to read them and learn them, study them."

Four participants (40%) described being isolated in a secure area upon arrival. Participant 5 referred to a location at the facility known as "the Box": "They started off with me in [a] cement box with [a] drain in the middle….That's where you go when you're in trouble, and when you first get there." Five participants (50%) recalled being restricted to living in a unit, and gave other examples of having a lack of freedom to orient youth toward following the rules of the RTC. As Participant 8 reported:

> [When] you start the program out there's a secure area where you go [for] the first two weeks. You're stuck. You're not doing anything. You can't even play games. After the two weeks,…you started phasing up, and it's like three to four months, if you didn't get in any trouble, you can go from the secure area up toward a good unit…where you have a little bit more freedom.

Participant 10 recounted his treatment within the unit as alienating and inconsistent with the purported mission of the facility to help youth:

> Intake for two weeks at a minimum and never going outside. If you think about that, as an adult, and you told somebody you're going to close the blinds, you're going to blacken everything out, and you have to live within your home for two weeks, and never go outside and feel fresh air, smell fresh air, you have to live with a lot of other people….It's so inhumane. That's totally insane….You

definitely knew that a lot of stuff wasn't right, wasn't helpful, was

counterproductive to what they thought they were trying to do.

Two participants (20%) mentioned that interacting with parents was another

freedom that was severely restricted initially. Participant 7 explained the RTC policy:

"We can write letters and stuff, but I think it was quite a period of time, maybe a couple

of months, before I was able to talk to my parents for the first time."

Chapter V: Results II

This section of the results provides the participants' experiences during their time in the RTC, including: (a) the strict rules and codes of conduct, (b) the hierarchical system of levels within the program, and (c) the forms of punishment. While some participants experienced a gradual process of adjustment to the RTC, others described a pervasive culture of physical, sexual, and verbal abuse. Aspects of the youths' treatment, such as (a) their participation in treatment decisions, (b) individual and group therapy, (c) the involvement of their families, (d) medical treatment, (e) psychotropic medication, (f) recreational activities and recreational therapy, and (g) school experiences, are explored. Participants additionally describe their interpersonal relationships with therapists, staff members, and peers, etc. The discharge process, a very emotional one for some of the participants, follows. The final part of this chapter describes the reflections and recommendations of the participants for: (a) the RTCs, (b) parents considering this placement for their children, and (c) youth currently being treated or about to be treated with this intervention.

Experiences While Going Through the RTC

Imprisonment. When recounting their experiences of living in the RTC, all participants (100%) made references—whether implicit or explicit—to imprisonment. Six participants (60%) compared living in the RTC to a "jail" (40%) and/or "prison" (30%). Participant 5 compared the RTC to a "dungeon," as discussed above, and Participant 3 compared the RTC to a "concentration camp." While also using language suggestive of imprisonment, Participant 1 offered an even stronger condemnation: "It didn't feel like these will be the people taking care of you. It felt like these will be the people guarding you. It felt…very war-like." Participant 8, who had extensive prior

experience living in extremely restrictive and punitive environments, found RTC to be in

a class of its own:

> That [treatment is] for prisoners. That is what you do in Guantanamo Bay. [RTC]
>
> was like a jail more than anything….It's worse than jail. I've been to jail. I've
>
> been through solitary. I've been through rehab. I've been to boot camps and
>
> everything else. [RTC] is the cherry on the cake.

> Participants experienced the RTC as imprisonment for a variety of reasons,

among them: being locked inside without the ability to leave at will (70%), the lack of

freedom (50%), being treated like an inmate/prisoner (20%), being sent away (20%),

living in an environment with constant punishment (10%), and being subjected to

excessive force (10%) and strip searches (10%). Participant 7 expressed the sense of

desolation arising from a lack of freedom:

> Once you're in there and you've lost your freedom, then you feel more…like
>
> [you're] in a jail, at a juvenile facility….Most people don't know what that ache is
>
> like, losing your freedom….When you have it actually taken away it's not like
>
> being put in your home as a punishment, or anything like that. It's kind of like
>
> being shipped away from home, and [then being] locked up.

Participant 4 elaborated on the jail analogy, but from the perspective of a person innocent

of the crime that has resulted in imprisonment:

> I felt like it was jail….I felt trapped….Every door in that building was literally
>
> locked….It was terrifying. We had no freedom whatsoever….It was [run] almost,
>
> in the beginning, like you were an inmate, like you just committed the worst of
>
> the worst….I think in the mindset I was in then, [I thought], why am I being
>
> punished? I didn't do these things to be punished.

Although four participants (40%) experienced negative feelings about being locked inside without the ability to leave, two of them (20%) also expressed a sense of acquiescence.

Six participants (60%) mentioned the lack of privacy in the RTC, three of whom (30%) described continued surveillance or, in the words of Participant 2, the "day in and the day out of constantly being watched." Participant 6 made the most of the few opportunities she had to be alone with her thoughts and find refuge:

> I never had time to myself unless I was in [the] isolation room [and] that is a miserable place to have time to yourself. You don't even have time to yourself in there. There is a camera in there and they're watching you….There is a camera everywhere except your room and classrooms. [When I went] to the bathroom, I would announce, "Okay I'm pooping….No no one come in," and no one comes in when you poop. I would just sit in there, and I would just think and relax in the bathroom, but the most you could be in there was 10 minutes.

Interesting, she was the only participant who mentioned cameras, although the majority referenced the lack of privacy. Participant 10, on the other hand, was unable to find privacy, even in the bathroom, during the early Investment phase of living in the RTC:

> There were no stalls for the toilets. For a guy, when you have to sit down to use the restroom, you literally were sitting right next to the next guy. There's no wall, there's no door. We'd have a towel and you'd just kind of put the towel over your lap, that was your privacy.

Participant 4 reported that staff would not respect one of the few allowances the facility made for patient privacy:

> Those journals that we had to write in…had…confidentiality, and the staff weren't supposed to read them. Well, I had staff reading mine. And they were

caught by my therapist….It wasn't their right to know everything about us. It was

only their right to know enough to help us.

Three participants (30%) reported that communication with their families was

another area in which they experienced a lack of privacy. One denied ever having a

private conversation with family members, and Participant 1 described a privacy

violation committed by her therapist, "He is delivering and reading our letters….It just

felt…like another stripping of privacy, autonomy, dignity." Participant 2 offered a vivid

depiction of staffs' subterfuge in using hygiene policies to violate her privacy in actions

she characterized as making her feel "worthless" and "useless":

I woke up one morning and a staff member commented that my hair was greasy

and told me that I needed to wash it….That night when I came back from school I

was informed that I was on "shower watch," which means that you must get in the

shower and get shampoo in your hair and soap all over your body and then yell

"shower check!" so a staff member can come and look at you naked and make

sure you are clean. So they did that to me for a while….I think it's total

garbage….There [were] so many different staff members seeing me

naked….After a while, they [acknowledged] that there was no need for me to be

[inspected for cleanliness], but it was too late. So many staff members had already

seen me.

Strict system of rules and codes of conduct. The establishment and imposition

of a strict system of rules and codes of conduct at the RTC was a major part of

participants' daily experience. All participants (100%) mentioned rules in their interview,

and five participants (50%) cited the volume of rules. As Participant 3 explained, "It was

just rules upon rules for everything." Rules reported varied from the general, such as

Participant 1's statement: "We had to…ask for permission for things," and Participant 2's remark that youth had to "do…what they say when they say it," to specific prohibitions, some of which were inarguably appropriate (no causing harm to self or others), conducive to a culture of respect (no touching others, no cursing); others that might have some underlying rationale but otherwise seemed gratuitous (no colored hair, no sleeping on top of sheets); others that seemed devised for preventive reasons but were subjective and unenforceable (no talking or looking at patients of the opposite sex without permission); and limits to personal activities where some level of privacy was allowed (15-minute showers, and 10-minute bathroom breaks).

Participant 3 recalled rules she described as "very strict": "[You] couldn't wear certain stuff because those were gang colors….You couldn't have certain stuff because you could transfer drugs onto it, like [a] pad of paper because people would [use it to] transfer coke." Participant 1 mentioned the need to "ask permission to leave your room at night," but found the rules surrounding interactions with her female peers most noteworthy: "You couldn't sit on the same bed as another girl. You had to go into the bathroom to change….You couldn't talk about your past with other girls."

Three participants (30%) compared the strict system of rules and conduct to that of the military. For example, three participants (30%) remarked about the requirement to form a line while walking within the facility. As Participant 1 described, "we had to go places…single file or double file." Three participants (30%) reported having to do chores. As Participant 5 described, "They had us do all the…cleaning of the place and stuff like that." Two participants (20%) mentioned rules about how to make a bed and sort clothes. According to Participant 5: "You had to…roll your socks in a certain way…and put them

in a certain corner of your drawer, and everything had to be folded in a certain way, and

structured a certain way."

Hierarchical system. Nine participants (90%) mentioned the system of

hierarchical "levels" or "statuses" that governed life in the RTC, ranging from the lowest

level, Investment, mentioned by three participants (30%), through Pre-Orientation (10%),

Orientation (40%), Pre-Unit (10%), Unit (30%), Achievement (10%), Advanced (20%),

and Hotel, the highest level, mentioned by five participants (50%). Hotel was literally a

hotel. It referred to the Holiday Inn, close to the RTC, where residents at the highest level

would work, as discussed more thoroughly below.

The process of progressing up the hierarchy, and consequently being rewarded

with more "privileges," was mentioned by seven (70%) participants. Privileges allowed

included more access to activities (80%), which included more freedom of movement

(leaving the unit, going outside, going-off campus, and participation in recreation); more

contact with peers (talking to others, participation in the "Talk Time" activity, as

discussed below); more personal freedom (wearing makeup and/or perfume, listening to

music), and better treatment by staff, examples of which were an increased allotment of

praise (10%), trust (10%), and empathetic interactions with staff (10%). Participant 1

shared, "As I progressed through the ….hierarchy of privileges earned, I started to be

treated better by the staff in general." Participant 7 explained the transformation of staff

interactions as youth earned upper echelon status:

> The ones that do progress, they get…praised. [Those with] advanced status…were
>
> treated like honor students….They had privileges. They could go anywhere they
>
> wanted to….They…played video games…whenever they wanted. I would see the

counselors chatting with them, patting them on the back, shaking their hand, just talking to them.

Three participants (30%) reported that Hotel status was accompanied by a work requirement. Participants had different attitudes towards their employment experiences, which included housekeeping (20%), construction (20%), maintenance and gardening (10%), kitchen (10%), and laundry (10%). Participant 10, who enjoyed the freedom Hotel status conveyed, as discussed below, also expressed a negative attitude towards the work component because they were paid poorly and did not have the opportunity to enjoy the benefits of their labor: "We [performed] construction, digging ditches for [a] water slide park, and we were getting paid 25 cents an hour for digging ditches for the new water slide park that we would never get to go to."

Two participants (20%) expressed appreciation for their employment. Participant 7 found the opportunity to learn new skills a very positive experience:

When they first bought the Hotel, we went in there to scrape the floors, fold up the carpets. We started learning some construction trade, mainly the labor portion of it, and I liked doing that….It was awesome to do that part of it, to be involved with something on the ground floor that I've never done before.

Participant 8 who also worked in the Hotel, was aggrieved about the exploitation of youth; however, as with the participant quoted directly above, he perceived benefits to this experience as well:

We'd get to go out to the movies, and spend the money [we] made working as child labor slaves at the Hotel, and that kind of taught us [a] work ethic….I worked in laundry at one point. I learned how to fold clothes pretty good I guess. That is the only good thing I [have] to say about the place.

Two subjects (20%) expressed positive attitudes about advancing levels. Participant 10 made the most of his status of "Hotel," as it gave him a level of freedom previously unimaginable at the RTC:

You could move out of the main [facility] area to the Hotel [that functioned as a hotel] but [had] no doors on [the rooms]. There was one bathroom per floor for four kids, as opposed to one bathroom for 40 kids….You worked at the hotel during the day as housekeepers, then they'd bus you back to the school at night….There were special jobs, too. One of the guys had a job…, maintenance, gardener, did a little bit of everything on the grounds. He was leaving, and they offered me that spot. That's huge, you had so much freedom doing this job. You had to start at something like 5:30 in the morning, you just tell the adult counselor, "Hey, I'm going to work"….For that entire time, you literally are on your own.

Other participants expressed ambivalence about advancing levels. Three participants (30%) found that the benefits achieved were not particularly meaningful. Participant 7, discussed below, who spoke of how he thought others who had achieved Advanced status were treated admiringly by staff, expressed disappointment in the lack of recognition his efforts received:

I was going to leave in a few months…I had been there already 3 years….It didn't matter….I was a good guy all this time, and it didn't get me any miraculous prize, not really….I lived a little better than some, but I didn't have any [great] treatment per se.

Conversely, three participants (30%) expressed the drawbacks of achieving higher levels. As moving up in categories became increasingly more difficult, it was harder to

justify the effort. In addition, one participant, Participant 3, found that advancing in the

hierarchy prompted peers to attempt to sabotage her, and resulted in higher staff

expectations:

> I moved up all the way to Achievement status and [it] was hard to [maintain that
>
> level] because a lot of people didn't want to see you at Achievement status.
>
> People weren't genuinely happy for you. Some people were, but some people
>
> weren't, and they'd purposely try to agitate you, so you could lose your spot at
>
> Achievement. I ended up losing it because it was…too overwhelming….It's not
>
> worth it to have to go through people messing with you so you could lose your
>
> status….I felt pressured, and I didn't want to deal with that anymore….Staff too,
>
> because they were like, "Well, you have to live up [to] the [label] of Achievement
>
> status."

Punishment. All ten participants (100%) described experiences of their being

punished during their time in the RTC, generally for violating the strict system of rules

and conduct, or engaging in behaviors found objectionable by staff. Nine participants

(90%) delineated the reason(s) for which they received punishment, including:

- not responding to punishment appropriately, e.g., refusing to comply with

  punishment (30%) and not taking a punishment seriously (10%);

- not asking permission before engaging in an act that required permission, e.g.,

  going into the bathroom without permission (10%), talking to another youth

  without permission (10%), and leaving the line formation without permission

  (10%);

- violating rules regarding interpersonal relationships, e.g., hugging another

  youth (10%), "sexually acting out" (10%), and "playing with a female"

  (10%);

- violations of hygiene or personal appearance, e.g., not washing hair (10%),

  not wearing makeup (10%), sharing makeup (10%);

- failure to accept responsibility for one's own misbehavior or for failing to

  report the misbehavior of others, e.g., not admitting to wrongdoing (10%),

  refusing to "tell on" another youth for wrongdoing (10%);

- objectionable conduct with staff that ranged from (a) subjective perceptions,

  e.g., having an "attitude" (10%), (b) unacceptable interactions, e.g., arguing

  with staff (10%), spilling water on staff (10%), to (c) criminal behavior, e.g.,

  physically attacking a teacher (10%);

- petty offenses, e.g., saying "Jesus Christ" (10%); and

- engaging in dangerous, self-destructive and/or illegal behavior, e.g., suspicion

  of running away (20%), self-harm (10%), dealing and using "drugs" (10%).

In addition, participants recalled being punished for more ambiguous offenses such as "not acting right," not conforming (Participant 7 stated, "It was just conform or get in trouble for not conforming"), and engaging in behaviors that "cause problems" for staff. Participant 9 explained how important it was for residents to not be oppositional with staff:

> If you don't cause trouble, and you get along with staff and all that, you're
>
> perfectly fine. If you do cause problems for staff, it's not going to end well for
>
> you. I've seen some pretty bad things happen there with people that have been in
>
> trouble with staff.

Behaviors identified by participants as troubling staff included the amorphous not "getting along" with staff (20%), speaking up against maltreatment (20%), "talking back" to staff (10%), informing parents of negative incidents or conditions at the RTC (10%), interfering with staff efforts to drug or restrain other youth (10%), and being friends with peers who frequently were in trouble (10%). There were, conversely, instances where staff took appropriate action. Three participants (30%) described witnessing youth receive punishments for behaving violently towards other youth and staff.

   Methods of punishment. All participants (100%) had been subject to discipline for behavior that violated staff expectations or the strict system of rules and conduct, although the punishments they received, as described below, varied.

   Chair sitting. Five participants (50%) described experiencing this form of punishment which Participant 1 described:

> If you broke a rule, you would get an infraction and a chair, where you would have to sit down, face a wall for [an indeterminate time] until a staff member came over. Then…you had to recognize what you had done…,say how you were wrong, and get some scolding.

Two participants (20%) reported that they received this punishment frequently. One of the two participants, Participant 2, indicated that imposing this punishment on herself gave her the opportunity to gain agency: "I spent a lot of time on chairs….whether it was self-directed or by staff. I just couldn't deal with their total control and their craziness, so I just chose to take a chair and not listen to them."

   Writing assignment. Two participants (20%) reported being subjected to a punishment consisting of a verbal confession of wrongdoing followed by writing ways in

which they would demonstrate approved behavior in the future. Participant 3 described this frequent experience as a component of the chair sitting punishment:

> To get off the chair, you'd have to say what you did wrong, what you're going to do better next time, how you're going to do it next time so it doesn't happen again. And then the staff has to okay it, like that you learned your lesson, and then you had to write the "I CARE" statement which is, "Interested in working with staff, Contribute to the unit, Ask the staff [for] help, Responsible for self-supervision, and Establishes positive staff and peer relations."

She added that she had no problem reciting these statements verbatim as she "had to write them so often."

Losing a level. Five participants (50%) reported experiencing losing one or more "levels," i.e., being assigned a lower level status and experiencing a loss of the privileges associated with that level or status, as a form of punishment. For example, Participant 8, who had achieved Hotel Level, was punished by having all the levels he had previously earned revoked and returning to the lowest level:

> [I was in the] Hotel, but then I got in some trouble for playing with a female, and ended up going back to the Investment area and then had to phase up to the Unit again, and [come] back to the Hotel.

Infraction points. Seven participants (70%) reported receiving infraction points (IPs), also referred to as "investment periods" and for short as "ips" (rhymes with "chips"), "IRs," or "infractions," for engaging in a punishable offense. Each IP represented a specific amount of time that youth were required to "sit" or "stand" in one spot. Four participants (40%) described the accumulation of IPs as resulting in a "Class"

designation from 1 to 3, with Class 3 rating the most severe punishment. Participant 8 described the conversion in his narrative:

> [The] punishment of…IPs, where…we had to stand and stare at the wall. You know you have a Class 1, Class 2, to Class 3, and if you f---ed up…,a Class 3 was 100 IPs….You had to stand there with your nose against the wall for twenty-five minutes and then you squat down for five, and that served one IP.

Investment Unit. All participants (100%) received the punishment of spending time on the Investment Unit (alternatively referred to as "lock down area," "investment," "development," or the "troubled unit," "bad unit," or "stabilization unit"). Three different events were associated with this unit: (a) it was common for youth to start there as part their intake process upon arrival (20% of participants experienced this); (b) it served as a "time out" venue for youth temporarily removed from the regularly assigned unit for part of the day (90% of participants experienced this); and (c) youth who were removed from their regularly assigned unit for an extended period of time were sent to live on the Investment Unit as punishment, also referred to as "losing your bed" (80% of participants experienced this). For example, Participant 2 received this punishment when she engaged in conduct that was not only prohibited but dangerous: "[Another resident and I] were doing this little drug dealing ring, and we got busted because I took so many drugs that I went unconscious. So we both lost our beds, and then we went up to Investment."

Time on the Investment Unit, as reported by participants, lasted anywhere from a few days to months. For example, the participant quoted directly above lived on Investment for 7 months after arrival. Time on the Investment Unit, aside from sleeping and eating, was spent sitting at a desk and doing homework (30% of participants reported this), or engaged in other forms of punishment, e.g., standing and staring at a wall (50%

of participants reported this) or sitting facing the wall (20% of participants reported this) for an extended period of time, in proportion to the number of IPs they received. Participant 7 described his experience on the Investment Unit: "You're in an empty room with nothing but kids standing there, just staring at the wall.…The counselor would be sitting watching you to make sure you weren't goofing off or looking away, or chatting with the other students."

Dial 9. Five participants (50%) discussed a punishment called "Dial 9" that involved staff radioing "Dial 9", which signaled multiple staff members to convene together to restrain a youth through physical and/or chemical methods and transport the individual to an isolation room. Four participants (40%) reported experiences of being physically restrained. Participant 8 described how events culminated in his being in isolation, restrained in a device known as "the Box":

> If you acted violent or physical they could put you on a board and strap you down, and you weren't going anywhere. Most of the time they'd just get on their radio and say, "Dial 9 to the gym," "Dial 9 to the Investment area," "Dial 9 to the cafeteria," wherever you were at. Usually within a few seconds, available staff would start pouring in to overpower you.…If you're in a fight and you're being violent, they'd tackle you down and carry you out of there to Investment, board you up, and put you in the Box.

> Five participants (50%) expressed negative attitudes toward the restraint practices. Participant 1 experienced a range of reactions to this form of punishment:

> It was a pretty traumatic experience being hauled off by [your] arms and legs. I was flat on my back, I was being carried off the ground.…I felt like I was being treated like an animal. I felt…an animalistic anger. It felt really dehumanizing.…I

felt both very angry at myself for not having taken [the original punishment of]

the chair, and very shocked it had escalated to that point when I was just trying to

be heard.

Three participants (30%) described staff use of chemical restraints, referred to by

the name of the medication, e.g., "Haldol" and "Thorazine," or generally, e.g., "shot,"

"injections," "PRN shots" and "booty juice," to subdue residents. All three participants

(30%) asserted that these psychotropic medications were forcibly injected without the

consent of the youth. Two of those participants (20%) experienced being chemically

restrained themselves. Participant 3 described the process:

> They will…throw you to the ground, and hold you down, and restrain you like
>
> they do not care. You will get bruises and all of that, and they will [give you] the
>
> shot in your butt, and that's it, you will fall asleep. I was…crying and begging
>
> them not to give me a shot in my butt, but they did it anyway.

Participant 2 reported that the use of chemical restraints became the preferred option of

staff who lacked the patience to engage in less extreme practices:

> I got Dial 9 all the time. Then they decided that they didn't want to deal with me
>
> because I was too emotional, so they made my PRN Haldol shots….All the staff
>
> basically were like, "Do you want to give her Haldol?"….There were so many
>
> times when I would be in the Observation Room, and a bunch of staff would be
>
> holding me down, including male staff, and they would…physically be ripping
>
> my pants off me because they had to get the needle in my butt.

> *Solitary confinement.* Six participants (60%). identified solitary confinement, or

isolating youth in a locked room, as another form of punishment. Participants described

that the amount of time spent in solitary, referred to as "isolation," "the box,"

"observation" and "timeout room," would vary, from several hours to a number of days, before staff let the youth out. Five participants (50%) spoke of solitary confinement in an extremely negative manner. Participant 1 felt "really demoralized" in the room she described as "the inner most ring of hell of this place." Two participants (20%) felt distress related to the temperature of the room. Participant 2 stated:

> Those observation rooms…are really freezing cold. There were times…my lips would turn blue, and…medical would come in, and they'd be like, "she's faking it." I'm like, "How would you fake your lips turning blue?"…I'm a hundred pounds. These rooms aren't insulated, there is…a skylight, it's the middle of winter…,and the only air that's coming in is the freaking cold air….You go crazy. I remember I always tried to pretend that…my grandfather and mom were actually sitting in there with me.

> *Denial of food.* Another form of punishment described by three participants (30%) was the withholding of food. Participant 3 stated: "If you weren't acting right how they thought you should have been acting, they didn't have to give you a tray." Participant 2 described a particularly sadistic practice of staff when the adolescent has been denied food as a punishment, the food is available, and it appeals to the staff:

> Depending on the food that they serve, staff [may] like to eat it….One day I was in Observation, and they came up with my food, and [staff] were eating up the food in front of me and were [saying things] like, "We're so lucky that we get to live at home and our parents love us because we get to eat food."

The third participant who cited denial of food as a punishment, Participant 10, recalled how one day, during a four-day stint "in the Observation Box…,they fed me an orange and a Sprite for the entire day."

Communication ban. Two participants (20%) mentioned a ban on communicating with others for an extended period as a punishment that invoked negative feelings in them. Participant 2 shared the extensive nature of this punishment:

> For a long time they had me on this standing order where they wouldn't allow me to talk to anyone at all, including staff….A lot of my friends left, and I wasn't even allowed to say goodbye to them. I'm pretty sure that when they wrote letters, since I was on communication block with them while I was there, they were kept [from me].

Hula-hoop program. A final punishment, evoking negative feelings in the one participant, Participant 6, who reported it, was being put on a "hula-hoop program" which she characterized as "really rough": "They give you a hula-hoop and you have to hold it…everywhere you go….Hold it to class…when you're doing exercise….It's so you don't touch people, because your hands are constantly on the hula-hoop."

Attitude towards punishment. Analysis of participant responses revealed that a significant majority of participants, seven out of 10 (70%), expressed strong negative attitudes towards the punishments; however, three participants (30%) expressed both negative and positive attitudes, depending on the punishment and how it was delivered. For example, two participants (20%) found that sitting at a desk doing homework, although considered a punishment, benefited them by allowing them to focus and accomplish the task. According to Participant 4:

> We got to write in our journals if we needed to, and finish homework, and really focus on ourselves….I feel like that was still a very positive structured environment to where you were still getting things done that you needed to get done, [even though] you lost out on more fun activities because you weren't doing

whatever you were told to. I felt like that was a better, more advanced way to be

punished, versus facing a chair in a wall...or standing in front of a wall.

Subjects gave several rationales for their negative perceptions of the punishments.

Eight participants (80%) agreed that punishments were unhelpful. For example, one

subject considered the denial of food as counterproductive as a punishment because some

youth entered the RTC with food disorders, e.g., anorexia and bulimia, and being denied

food would reinforce such dangerous behaviors. Five participants (50%) stated that some

punishments were degrading, and Participant 4 also characterized it as developmentally

inappropriate for adolescents:

> I still to this day feel like sitting on a chair facing the wall is demeaning.…That's
>
> what I do to my 5 year old. That's not what I do to a teenager. I just don't feel like
>
> it's a necessary punishment for someone older than 8 years old.

Seven participants (70%) described some punishments as unwarranted, excessive,

and emotionally abusive (see "Abuse" section below for discussions of punishments that

were physically abusive), and thus contributed to their negative attitude. For example,

Participant 8 stated:

> Strappin' kids down on boards and putting them in Boxes for days on end,
>
> shooting them up with Thorazine 'til they're…drooling on themselves.…If you
>
> went to the Box, you're there for 24 hours at the very least.…At least in jail you
>
> can get a book to read or something.…It's more in the line of getting
>
> tortured.…It's no worse than waterboarding, you know. They get these kids and
>
> make them stand and stare at walls in absolute silence.…It would dehumanize
>
> them, make them fearless. You know it's stilling their emotions....Do not blame
>
> any kid [who] goes through that [if the kid] coming out is…damaged.

Participant 3 found watching others being punished by staff as difficult as being punished herself:

> You would see them drugging people in Observation, and you'd want to get up and help them, but then [staff] would call Dial 9 on you, and then have like thirty staff go there, and they'd throw you in Obs. I've been thrown in Obs. I've had bruises on me. I heard other people say they [had] staff put their hands on them, and they had bruises on them too....I don't like seeing stuff like that....Or they'd…kick people out of their chairs, and they'd have people sit in the hallway and stuff…and they'd tell people, "You are going to take this shot," and some people were like, "No, I don't want to take the shot,"…but they gave them the shot anyway….Then they'd just be really out of it and stuff. That was kind of traumatizing for me to see that.

Abuse. Seven participants (70%) reported being exposed to overt child abuse, including physical, sexual and verbal abuse, perpetrated by one or more employee(s) at the RTC. "Being exposed" encompasses three situations: (a) experiencing the abuse themselves, (b) observing it perpetrated on others, and (c) being told about it. This section will discuss sexual and physical abuse. (See "Staff relationships" below for a discussion of verbal abuse by staff.)

Sexual abuse. Four participants (40%) reported that one or more employees had made sexual advances and/or had perpetrated ongoing sexual abuse against the youth at the RTC. Two participants (20%) reported knowing about the sexual abuse of others. According to Participant 3:

> There were some male staff in there [who] had relationships with some of the clients in [the RTC]. I knew two of the girls [who] were having sexual

> relationships with these two guy staff [members]....They had to be…secretive
>
> about it, and [one staff member] made sure that the girl made Hotel Status so that
>
> they could [have sex]. He would work [an] overnight [shift] so he could do stuff
>
> with her [during his shift] at the Hotel.

Two participants (20%) reported to have been victimized personally. Participant 6 related

being abused by a female staff member:

> [She] kissed me, and got in my bed with me, and she told me not to scream or else
>
> she would tell everyone that I was lying. I told my therapist, and she had her
>
> fired….But [the abuser] didn't [face] any charges, or anything, because they
>
> wanted to keep good rep on [RTC]….She just got escorted out [and] never came
>
> back.

The other victimized participant, Participant 5, reported that her male therapist attempted

a quid pro quo: he would allow her to go outside of the facility in exchange for sexual

favors:

> My counselor said, "If I told you that if you would just suck my d--- right now, I
>
> would unlock that gate, would you do it?"…I had no reaction….I hate to say this
>
> but…nothing could really shock me….I had experienced a lot by then.

> ***Physical abuse.*** Five participants (50%) reported witnessing and/or experiencing

physical abuse they perceived as cruel and excessive (e.g., slamming, tackling, throwing,

smacking, hitting, beating, jumping on, kneeing, and kicking youth) perpetrated by staff

members that resulted in bodily injury and/or physical pain to the youth. All of these five

participants (50%) described that the acts of physical abuse were in response to what staff

viewed as unacceptable behavior, and used as a means of restraint and/or implementing

corporal punishment. Participant 7 recalled that the use of physical force was somewhat

common among staff, but one staff member in particular seemed to approach students as if they were objects on whom he could hone his fighting prowess:

> Some counselors…were known to beat on some of the students. There was one guy there that thought he was Chuck Norris, he was some kind of black belt or something….He would use his moves on you, and usually you'd get beat if that guy showed up….I've seen him kick a few people because, I don't know what martial arts he took but he used it…when he would show up for Dial 9's….But he never did that on me, because he never showed up when I was doing stuff….I remember seeing him…hit this kid right in the back of his head, right in the face, and his nose and everything just opened up….He would run in there and use his offensive moves…and not restraint, or defensive moves like the other counselors would. Anyway, we knew that if he showed up and you have been fighting, you were going to get beat, smacked up or something, kicked, hit….It was coming.

Participant 5 witnessed a staff member getting "unnecessarily violent" with a female adolescent in the RTC:

> I felt so bad for this one girl….She wasn't even a violent sort of girl, but [a staff member with a massive physique] jumped on her and he bursts all the blood vessels in her upper torso…her eyes, her skin. And I've never seen anything like her skin, like do the blood vessel thing all the way up.

Participant 9 reported that a youth was beaten up so severely by staff, he had to be hospitalized:

> One of the kids ended up getting put in the hospital from a staff beating him up in [the RTC. The perpetrator] actually didn't get fired, he got suspended, and a staff who [witnessed the incident] got fired….But if you cause problems for the

staff, your time there is not going to be fun. They don't have much tolerance for

acting out.

Reasons for abuse. Eight participants (80%) suggested reasons why the abuse of

the youth in the RTC was so flagrant and ongoing. Five participants (50%) agreed that

many staff members do not perpetrate the abuse themselves, but have knowledge of the

abuse and either were present and did nothing to stop the abuse from occurring or just

walked away. The participant directly above indicated that a culture of silence and cover-

up permeated the RTC. It could not go unnoticed that it was the staff member who

witnessed the beating of the youth, and not the staff member who perpetrated the beating,

who got fired. Participant 7 related an incident that illustrated the RTC's culture of using

violence as a method of controlling youth:

> They took [the youth] right to Development, so the next time you see him, he's
>
> healed up because he's been down there standing hours, and they don't let him
>
> talk to anyone else, so there is no evidence that it even happened other
>
> than…what the other students had [seen]….We just all knew it was wrong, but
>
> you also knew that [the staff member] did it because he wanted other people to
>
> see [the beatings] so that you would get fear in you, so you don't misbehave.
>
> Usually when you saw that kind of [escalation of violence], it was because the
>
> other people were silent [when lesser acts occurred].

Similarly, Participant 3 noted the lack of interest the RTC management took in

staff abuse: "They weren't investigating anything. [They] knew about those people

having sex, and they didn't do anything about it." Participant 5 attributed staff

unwillingness to speak up about the ongoing abuse within the RTC to the fact that they

all shared the same religious affiliation and attended the same church. She attributed their

reluctance to take a stand against one another, even if they knew it was the right thing to

do, to their strong bond:

> [Staff] were very [religious as was] the whole town....That's why things were
>
> really hard because…they were all friends, they all go to the same church, and
>
> everything. But I think [that was] used that against them when bad things
>
> happened, and maybe no one wants to speak out….Going along with stuff when it
>
> is wrong, and if they feel it is wrong and they know it is wrong, they need to learn
>
> how to speak up and not be afraid of…the religion and hierarchies in the church,
>
> or anything like that.

> Three participants (30%) reported another reason for the continued abuse was that

abusers were confident in some level of impunity because even when the abuse was

known, there were often minimal, if any, consequences to the abuser. The most severe

consequence was a staff member losing a job. Three participants (30%) cited their fear

that their parents and others would not believe them if they reported the abuse.

Participant 7 stated:

> Whether you told somebody about it or not…didn't even matter because...they
>
> don't believe a word you say most of the time….If you said something about a
>
> staff member or teacher and they denied it, [you wouldn't be believed] because
>
> you're there already because you are a troubled no-good kid.

Other reasons cited by participants included: (a) fear of retaliation for speaking up about

abuse (20%), (b) abuse is "inevitable" in these types of settings (10%), and (c) youth feel

"powerless" in treatment decisions (10%). For example, Participant 10 reported his

experience of telling his parents about the abuse in hopes of improving conditions at the

RTC, only to find out it made his situation worse:

One time when I was at home I talked to my parents about what was going on at

[the RTC]…about how the counselors treated the kids, dosed them with

Thorazine, the sexual harassment and sexual abuse....I told them that in

confidence, but they actually told my therapist….There was something weird

there. [My therapist] was a bit angry with me about the whole thing….That might

have been one of the things that set me back to Investment. I felt totally betrayed

by my parents, they did not believe what I'd told them. The therapist told my

parents it wasn't true. He knew it was true.

Adjustment. Seven participants (70%) described various strategies they pursued

to adjust to living in the RTC and to advance levels in order to facilitate discharge. Two

participants (20%) reported their strategy to suppress all negative instincts, or "fake it

until you make it." Participant 6 described how this strategy was modeled for her by

peers:

The way that the girls when I was there would level up is…if you're having a bad

day, just fake that you're having a good day, so you get through the day and don't

have any problems. So you don't scream, and lash out, and do something bad.

Participant 3 described that the "fake it until you make it" strategy "wasn't really hard to

do": "You could just keep moving up the levels," as she did. "I moved up all the way to

Achievement Status."

A strategy adopted by five participants (50%) was to follow the rules and stay out

of trouble. Three of those participants (30%) analogized this strategy to a "game" or

"system" to be "played." For example, Participant 1 stated: "It really felt like a chess

game….You have to play by these rules....That's what I did and it got me through."

Participant 9 credited a similar strategy for avoiding adversity at the RTC:

> I knew how to play the system pretty much….As long as you don't do anything to
> get yourself into trouble, you don't break any of the rules, you do the minimum of
> what you're supposed to do there, they really can't do much.

Participant 10 stressed that his strategy of playing the game required flexibility regarding staff and other youth as he neared the time of discharge:

> I was just very focused and determined to get out of there. I knew I had to adjust
> [the] kind of a game I had to play among staff and therapists and people who
> make the decisions of letting you go. You had to play the game with staff, and
> you had to play the game with other kids that were there too.

> Another strategy reported by three participants (30%) stressed the benefit of

conforming. For example, Participant 7 reported: "You…learn to conform. If you don't conform, you basically get mistreated in a sense that you don't get to do anything or go anywhere….It was just conform or get in trouble for not conforming." Participant 10 reported the need to suppress any instincts that involved opposition to the system, despite knowing how unnatural and abusive the environment was for adolescents:

> Some kids…fight it, but…I knew fighting it would just ensure that you wouldn't
> see the light of day that much longer. For me, I knew it was bad, I knew I was in a
> place where I went too far, but here I am. There's nothing I can do about that,
> except [to] go through that process. You had to adjust to [a] lifestyle [that] was so
> abnormal for any person, any teenager, to ever have to go through….You…don't
> think beyond…what you have to do [that day] to survive that place.

Participant 8, while stressing the importance of conformity, added that success in school would be another strategy to pursue toward the goal of discharge:

Make good grades at school and keep your ass out of trouble. As long as you're

there and getting in trouble, they can do whatever they want to you. There were

people that were there for two and three years.

Two participants (20%) described disassociating as a strategy to adjust to the

RTC. Participant 1 stated: "I learned to disassociate a lot…,just…like [a] zombie, [I]

walked through all of it. I think was my way of getting through."Another participant

chose to be prescribed psychiatric medication as a means of aiding dissociation.

Although many participants elected conformity as a strategy, every participant

(100%) indicated that adjusting to the strict system of rules and codes of conduct of the

RTC was, to some degree, difficult for them. Eight participants (80%) stated that their

ability to advance levels and the relatively minimal time they spent receiving

punishments demonstrated that their adjustment had been easier than it had been for

others. Three of those eight participants (30%) attributed a relatively easier adjustment to

their perception that an ultimatum had been communicated by the RTC culture: conform

or harm will come to you. As one participant put it, "It's conform or...it's terrible."

Participant 8's witnessing another youth's suicide attempt was the precipitating event that

got him to adopt a strategy of conformity:

I remember a guy trying to gouge his wrist out with a pencil…that he had gnawed

the eraser out of, and tried to gouge his nose. It was pretty traumatizing….He

tried to kill himself. That was probably what broke me and made me decide to

stop being an a------ and getting in trouble and try to get out [of] there.

Another three of the eight participants who had admitted to a relatively easier adjustment

(30%) found that the strict and strictly enforced rules of the RTC gave them a roadmap of

how to proceed, rather than their having to guess what would keep them out of trouble.
As Participant 4 stated:

> I felt it more comforting that I knew what needed to be done versus an
>
> unknown....I knew what was expected of me and I have always been fine with
>
> that. So that was pretty easy for me….It was very stable. You knew…what was
>
> coming next.

Participant 9 liked how much less of an effort it was to function at the RTC when you
simply followed the rules: "It was easy to be honest. I'd done it before….It's so much
easier to just know you're going to [conform] this time. There's no decision making in
that." Participant 5 stated that she liked the "regimented structure."

Conversely, two participants who considered that they had a relatively easier time
adjusting still found the strict structure objectionable. One referred to the structure as
"restricting," while the other, Participant 3, termed the structure "stressful" and
expressed: "I didn't like the whole trying to conform us stuff, because I don't like
conforming. I like to be my own person."

Two participants (20%) experienced a relatively challenging and poor adjustment,
as evidenced by the frequency and duration of punishments. Participant 6 reported, "I
was just in trouble all the time." The "fake it until you make it" strategy, as discussed
above, that had been adopted successfully by other participants, was not in her nature: "I
can't be a fake person. that is just not me….I'm genuine, and sometimes I'm genuine in a
bad way." The other participant, Participant 2, also attributed her problem adjusting to
her nature. She had a "strong will," and was unable to "deal with their total control and
their craziness."

Treatment decisions. When asked to describe their experience with making treatment decisions while at the RTC, five participants (50%) recalled having a treatment plan and/or goals, while the other five participants (50%) denied having, or did not recall having, any input or involvement with a treatment plan or goals. As Participant 5 firmly stated: "I didn't get to. No. The whole time I was there I don't remember having choices like that." Four participants (40%) had negative attitudes about treatment decisions either due to their disagreement with their treatment plan or their lack of involvement. Participant 3 stated her frustration with a process that left her without a voice in her own life: "We didn't really get to make decisions. It was our parents that made the decisions, or our therapists, or the staff. So not really having control over things was scary for me because I like to be in control."

Participant 1 expressed a lot of dissatisfaction with the facility treatment plan to address her eating disorder as it ignored the reasons why she engaged in the behaviors, focused on the wrong things, imposed sanctions needlessly and, like the participant discussed above, left her without a voice in her own life:

My treatment for the eating disorder…wasn't one I had a part in….It mostly involved eating and food….With eating disorders, you don't necessarily want to focus on the food, and forcing a person to consume more than they are comfortable with…and keep[ing] them away from the toilet….I think you need to deal with what's more underneath, because people with eating disorders have a lot of suppressed emotions. They manifest them physically, dramatically, through food manipulation. [It's] very poor treatment…to just have a person not listen to what their body is saying and force-feed them. [To give] infractions and

consequences…is maybe one of the worst things you could do, or least

compassionate things you can do, when treating someone with an eating disorder.

Two participants (20%), however, reported being somewhat involved with setting

treatment goals. For example, the participant who had attended the RTC previously and

had elected to return to the RTC rather than to her family's home, Participant 4,

explained the contrast between her first and second experiences. During her first stay,

staff proposed actions, goals, and methods and, as an afterthought, suggested she offer

her views. They communicated what they wanted, and tried to get her to accept it as her

own idea:

> [They said] "This is what I want to do, this is what I want to have accomplished
>
> and this is how I think I can do it the best way. What are your thoughts?" [The
>
> second time it was] the other way around. "Well, you don't really need to be here,
>
> so what do you want to do?' I'm like, "I want to graduate and emancipate,"…and
>
> from the get-go that had been the goal.

Participant 10 objected to the premise of the question, stating that he couldn't "imagine

that anybody had any kind of sense of control over their treatment there." He was,

however, determined to have an impact on his treatment, albeit indirect, through

projecting an attitude and conducting himself in ways he intuited would appeal to those

treating him:

> I don't think you had any say whatsoever in your treatment. What you could do,
>
> and what I did for the first while, was to kind of manage the management. You
>
> kind of manage your therapist and manage the counselors without them knowing,
>
> just by playing little games, things like that. I didn't have any direct say in when I
>
> could get out, but I had indirect influence of when I could get out by behaving and

playing the part and doing what I needed to do, and convincing them that I'm

okay, it was kind of a mistake [that I was placed here].

Individual therapy. When participants were asked to describe their experience

with individual therapy while at the RTC, six participants (60%) reported experiences

with their individual therapist(s) that were exclusively negative. Three participants (30%)

reported mixed experiences due to changes in therapists—one experience was positive,

and the other negative. Only one participant (10%) described an overall positive

experience.

When asked to distinguish between individual therapy as a positive experience

and negative one, three participants (30%) who had positive therapy experiences noted

that their therapists were respectful (30%), caring (20%), nice (20%), gave "chances"

(10%), treated youth "like an individual" (10%), advocated on their behalf (10%), and did

not treat youth like a "problem" (10%). The nine participants (90%) whose therapy

experience was negative, in whole or in part, ascribed it to their therapists treating them

as a problem (30%), invalidating (30%), unsupportive (30%), uncaring (20%), not

offering advice (10%), fake (10%), demeaning (10%), and not respectful (10%).

Participant 10, whose experience with a therapist denying abuse despite knowing of its

existence was discussed above, expressed his view that his therapist's conduct violated

the standards of the profession: "He was not on my side, he was not there to protect me."

Four participants (40%) with a negative experience reported that their therapist's focus

was too superficial—concerned with outward manifestations instead of the internal

factors causing the issues. For example, Participant 7 recalled:

It was more of a behavioral conditioning and teaching to conform in a structured

environment, [rather than] in-depth therapeutic, digging in, and trying to find out

why you do the things you do, or why things are happening or what you know.

Four participants (40%) indicated that their lack of trust in the relationship contributed to

a negative therapy experience. One participant reported that she would tell her therapist

"bits of fake information," and that her distrust strengthened when her therapist made

sexual advances. Five participants (50%) expressed the view that their individual therapy

was ineffective.

Family therapy. Six participants (60%) reported that in addition to their

individual sessions, their therapist also provided family therapy. For four of those

participants (40%), family sessions occurred via phone calls; for two participants (20%),

family therapy took place when their parents visited them in the RTC. The regularity of

family sessions varied from every week to only once. Four participants (40%) reported

negative experiences with family therapy, agreeing that sessions focused only on the

youth's behavior and thus were not helpful. As Participant 7 summarized:

I wouldn't call that therapy, it was kind of like a family talk and asking, why are

you doing this? Or, what are you doing? Or, maybe…an update of my progress.

Where I was at, I moved up in this level, my grades are…this….Stuff like that.

That was the extent of the family therapy sessions.

One participant (10%) recalled a mildly positive experience. Participant 3 simply stated,

"it was okay," without elaborating. Participant 9, the only participant who did not identify

family sessions as either a positive or negative experience (10%), found that they

facilitated communication that had otherwise not been possible: "[Family sessions] were

the only times really that I could talk to [my parents]."

Group therapy. Seven participants (70%) recalled having one or more group therapy sessions while at the RTC while one (10%) made no mention of group therapy. One of the two participants (20%) who did not recall having group therapy, Participant 8, found the idea preposterous: "The only therapy we got was to go serve some IPs….Go stare at a wall and figure it out. There wasn't any kind of group therapy or anything like that." In contrast, two participants (20%) stated that group attendance was mandatory.

The participants who recalled having group therapy sessions described the groups as geared to specific presenting issues. For example, three participants (30%) attended a chemical dependency group, two participants (20%) attended an anger management group, and one participant (10%) each attended the following groups: adoptions, relationships, family, self-esteem, body image, and military. Three participants (30%) reported that their individual therapist led a group consisting of other youth in the therapist's caseload.

Participants had different attitudes towards group therapy. Two participants (20%) had positive feelings towards group therapy and found it helpful. One of these, Participant 4, whose individual therapist led a caseload group, found the group cohesive, and praised the therapist's ingenuity in keeping the youth engaged:

> I really liked our group therapy….We did it as a team….We were so close knit as a group. We were all friends. We all got along. We had a lot of common interests. And [the therapist] would bring…crocheting stuff, or knitting things, so our hands were constantly busy during therapy. We didn't sit idle…or feel uncomfortable. We all were doing something while we were talking. And I felt like it really helped calm everybody down....It helped me a lot.

One participant (10%), Participant 2, expressed mixed feelings towards group therapy. Her negative feelings resulted from the group's repetitive format interspersed with having to watch objectionable visual content; however, as it offered a break from other disliked activities at the RTC, it warranted a neutral rating. She stated:

> Every group was exactly the same. You just sat in circles, and one person was chosen to speak. Then you just sat there and in the last 15 minutes of the group, everyone else sat there and said, "I can relate to you," or "I can't relate to you".…I would just sit there and be like, Oh f---, this is a good two hour break….They just started showing us in Relationship Group…movie clips of kids committing suicide. And it was so horrifying.

The most common attitude, described by seven participants (70%), was that group therapy was neither impactful nor helpful. For example, one Participant 10 shared, "Those group sessions, I didn't necessarily find that they helped. I don't think they were geared towards me. I didn't find any usefulness really."

Medical treatment. Eight participants (80%) discussed their experience with the medical treatment while at the RTC, while two participants (20%) made no mention of any medical treatment. Two participants (20%) discussed being regularly prescribed psychotropic medication, and three participants (30%) stated that they were not regularly prescribed psychotropic medications. Seven participants (70%) expressed negative attitudes about the medical treatment they received, although the reasons varied. Two participants (20%) had negative attitudes as a result of being mandated to take psychotropic medication which they didn't believe they needed. Participant 9 described: "I've never really liked medication.…While you're there, you have to take the medication. If you don't, you get put on lock down. So I took it there."

Three participants (30%) had negative attitudes about the psychotropic medications deriving from their usage by the RTC as a means of chemical restraint and thus depriving youth of the option to withhold consent. Five participants (50%) had negative attitudes due to the RTC intentionally over-medicating youth. Participant 2 recounted her experience:

They wanted to give me a Haldol shot, and then they…just kept giving me Haldol shots….They don't give a f---. They shoot you [full of] drugs that [make] you so…sick, and then they just expect you to fully function the next day.

Participant 3, who was not prescribed or administered psychotropic medication herself, found the over-medication of peers appalling and an indication that drugs were not given to help, but to compel passivity:

A lot of people were like zombies….They can control them that way….Some people were just sky-high off of those drugs they gave them….Kids just looked like their brains were fried or something….I didn't take meds….I was a big deal because most of the kids took them. All my friends did, and I felt disappointed because I felt like I had nobody left…because they're all…zoned out, and I was…the only one lucid….I didn't like that at all. It just makes you think about those twilight zones….They had people hearing music where there isn't music, and seeing things, and having seizures. That affected me, that…changed the way that I look at things.

Two participants (20%) indicated that a reason for their negative attitude towards the medical treatment was due to its failure to meet their medical needs. For example, Participant 2's recollection illustrated the lack of care exercised to prescribe proper

dosages, a blatant disregard for patient suffering, and an unwillingness to accept

responsibility and correct mistakes:

> I was always getting bronchitis….They gave me [an] inhaler….I started shaking
>
> and having tremors uncontrollably. I couldn't stop….The next day I got worse,
>
> and then the next day [after that] I couldn't walk….Basically they overdosed me
>
> on steroids through the inhaler…but [what made it worse was] walking to the
>
> unit…I was about to pass out…,and I do pass out. I come back and…[staff]
>
> comes up, and she knees me in the stomach. She is like, "Get in line what are
>
> you doing!?" And I was like, "I can't see anything, can I please go see the
>
> nurse?"…I'm on the ground…and [staff response is], "No, you can't".…The one
>
> who kneed me in the stomach looks at the staff at the front of the line, "Well
>
> she's not an AWOL risk"….And they left me in the hallway sitting there.

This same participant angrily recounted another negative attitude of feeling "sexually

abused" when staff members could produce no rationale for continually removing her

clothes and administering psychotropic medicine rectally that could have been, and had at

other times been, administered orally:

> They said it was for nausea….They're like, "Oh, we need to shove something up
>
> your ass because that's how sick you are." I'm sorry, [but] no one is going to
>
> convince me that was a medical procedure….What kind of medication do you
>
> need to give a 16-year-old kid rectally that you can't give them orally? If I'm so f-
>
> -ing sick that I need stuff f---ing s--t shoved inside me rectally…then why was I
>
> given another f---king pill orally? Why are you going straight to shoving
>
> something up a kid's a--?

Family relationships. When asked to describe their experience with their family while at the RTC, all participants (100%) reported having some form of communication with their family, including phone calls (six participants, 60%); letters (four participants, 40%); one or more visits home (four participants, 40%); and family visits to the RTC (two participants, 20%). When asked about their feelings toward their parents during their stay at the RTC, a significant majority (eight participants, or 80%) reported strong negative feelings towards their parents, one participant (10%) reported having mixed feelings, and one participant (10%), Participant 6, reported having strong positive feelings because her "family was very supportive," and "they never gave up on me…whether I was doing good or bad."

The participant with mixed feelings, Participant 3, expressed "conflicting thoughts" over her parents' decision to send her to the RTC:

> I hated them, I loved them. "How could you send me here? I hate you, but I love you and miss you a lot. You can take me out of here whenever you want to. I love you unconditionally, but I just hate you now because you sent me."

In fact, the most common negative feelings expressed by participants (seven, 70%)—resentment and a sense of betrayal—emerged from parents' decisions to send the participants to the RTC. Participant 8 stated: "I was feeling resentment for them keeping me there….I hated my mom for a long time for setting me up there." Participant 1 shared similar feelings:

> I was really angry with them, and I felt really hurt, and I think…over the course of the…eight months [I was at the RTC] we came to a point of talking like things were okay, but I detached emotionally. I was just like you guys are dead to me.

Distrust was another negative feeling toward parents, described by three participants (30%). Participant 5 lost trust with her parents after they revealed to her therapist something she'd told them in confidence: "They told my therapist…that I thought about leaving, and so I just felt that I couldn't trust…them, and I just [tuned] them out." Other negative feelings included feelings of abandonment (20%) and pain (20%). Four participants (40%) experienced ongoing negative feelings towards their parents for an inability to look at their own behavior but, rather, scapegoating the child. As Participant 10 expressed:

> There was definitely a sense that my parents had kind of sent away their problems, or…a message saying, "We don't know how to handle you, we don't know how to address this, we don't know how to…figure this thing out [together]." They weren't willing to come together as a family. "This is your fault….You're the problem. You need to go get fixed."…They weren't accepting of their role in anything that was going on in the dysfunction of our family.

Participant 5's negative feelings towards her mother resulted from her mother's refusal to believe that the participant had been sexually abused as a child prior to coming to the RTC. As the subject expressed: "I was able to have good therapy with [my therapist], but it was one issue in particular that we really couldn't touch on [in family therapy], because [my mother] didn't believe it happened. It was really hurtful and tough.

Staff relationships. When asked to describe their experience with staff, all participants (100%) reported having some form of relationship with them. Nine participants (90%) recalled both negative and positive relationships, while one participant (10%) recalled only negative relationships. Participants offered the following qualities that characterized positive relationships: staff treated them well; there was a good bond

between participant and staff; and staff were caring, nice, genuine, empathetic, supportive, helpful, respectful, trusting, showed leniency, and fun to be with. Participant 8 described two staff members with whom he felt he had a very positive relationship: "You could talk to them. They weren't power hungry. They weren't abusive with their positions. They were more like people than anything….They helped you out if you had a genuine problem."

When the relationships were not good, participants characterized staff as hostile, distrustful, rude, racist, uncaring, unsupportive, retaliatory, unhelpful, callous, abusive, invasive of privacy, bullying, and only there for the paycheck. Three participants (30%) expressed the view that some staff abused their authority over youth. Participant 8 described his negative perspective of staff because of their indifference to individual youth and abuse of their authority:

> I mean they are all pretty callous.…Their jobs [are] to keep you herded in like cattle, and if you act up, [they] slam you to the ground, call for back up, and then take you to the Box, and then let you figure it [out].

Participant 4 recalled that an already negative relationship with staff escalated to the degree that she sought legal counsel: "Stuff got bad between me and the staff members…to the point where... I retained a lawyer while I was in [RTC. Then] they backed off."

Four participants (40%) reflected that staffs' pressure on them to conform caused anguish. Two participants (20%) analogized this to brainwashing. Participant 3 described this "stressful" situation:

> They want to brainwash people out there, and they wanted everything to be their way…If you say something they are always correcting you, and I didn't really

like that. I [felt] you are not really leaving room for people to be who they really

are, you are just…putting pressure on people.

Feelings of disempowerment and helplessness were expressed by six participants

(60%), and five participants (50%) reflected feeling silenced. The combination of those

feelings are crystallized in a statement by one Participant 1: "For so long, [I've had the]

experience of us not having a voice in our own treatment…,and that leads to…extended

feelings of…powerlessness, or like my voice doesn't matter. I don't have the right to

share it."

Three of the five participants (30%) felt silenced for fear of consequences.

Participant 2 also felt pressured to mislead others out of that fear:

They were giving parents a tour, and then they picked me and…these other…high

status girls….They made us talk to the parents, and…I had to say to the parents,

"Oh, yeah, this is a good place, blah, blah, blah," because if I didn't all the weird

high status b-----s that I was with would be like, "Oh! She said that it was a bad

place!" and then [I] would get punished.

Six participants (60%) reflected that they felt staff dismissed their humanity. As

Participant 1 noted, "I don't feel like I was treated like an individual." Two participants

(20%) felt that staff looked at them as a "problem" that needed to be corrected rather than

as individuals who needed help. Participant 1 elaborated:

I internalized [the] message that was probably implicitly given but not

explicitly…that was…"You need to be fixed," which is different [from], "You

need help figuring out how to cope with your life, your emotions, your

relationships." Just the framing of things felt...like we were all these problems,

problem people, problem teens, problem kids....Like we needed to be rewired, reworked or something.

Another common negative experience, being ridiculed and mocked by staff, was described by six participants (60%). Participant 3 reported how damaging this was to her:

Staff would purposely pick on you and stuff, and laugh about it. That doesn't really do too much for your self-esteem, and my self-esteem has never been so great….They're not trying to empower you or [be] supportive. They could really hurt you in there.

Participant 1 recalled how an experience with a staff member ridiculing her about the issue that brought her into treatment, an eating disorder, made her feel "unsupported" at the very least:

There were these long cafeteria lines of food….I had this treatment goal or plan that included [having to] take one of everything, and two-thirds of…each thing. Which is…a lot of food, and I had to show a staff…my tray before I sat down to eat.…I remember one time with [a staff member], who…was…very young and not my favorite person, walking over to show her the tray. She was sitting at a table with a couple of other staffers. She…laughs…,and made some comment about how hilarious that was….It was funny to her that, I, a person with an eating disorder, have to eat all of this. Especially being in a situation where I had so little control already.

Participant 4 recalled that staff ridiculed her regularly for conforming to the rules of the RTC, disparaging her efforts as insincere:

I never got in trouble there. I did what was expected of me, that was never my problem. I was just more ridiculed by the staff because I didn't get in trouble. A

few of the staff would make fun of me. They would call me…a liar. They would

say I was a suck-up. I was only trying to play the system. That they knew better.

That I was dumb and they were smarter than I was.

Another common opinion expressed by seven participants (70%) was that staff

members lacked the requisite qualifications and training necessary to work with youth.

As Participant 1 stated, "I don't think they have any sort of background in mental health

care or counseling of any sort." Participant 8 stated that some staff "had no business

being in a position of authority over anybody, much less kids." Participant 2, who

suffered from overwhelming depression, found that staff was totally unprepared to help

her with a serious issue:

> They didn't have any [mental health] education….They are used to dealing with
>
> kids…coming off drugs, or dealing with stupid shit…,like what everyone would
>
> call out-of-control teens. Where I feel like me, and some of the other girls that
>
> didn't really do as well there…,were more…mentally ill….That was the problem
>
> with [RTC], they just didn't understand me, so it was just a nightmare. Because I
>
> wanted to die all the time and they just didn't know what to do.

Four participants (40%) remarked that the young age of many of the staff

members had a negative impact on their interactions with the youth in treatment.

Participant 4 characterized some staff members as "childlike," and Participant 1 found

that often staff members weren't that much older than she was:

> There were a lot of teenagers, basically interns in this position of power….Some
>
> of them were older…,but a lot…were…between 17 and mid- to maybe late
>
> 20s....I was 17 at the time….[They would have been my] peers…had our paths
>
> crossed in a different way.

Four participants (40%) ascribed negative relationships to staffs' personal lives conflicting with the interests of caring for the youth, particularly in the area of substance abuse (cited by two participants, 20%). For example, Participant 6, who identified as a "recovering alcoholic and drug addict," observed a staff member coming into work intoxicated, which she found "just very discouraging." In addition, Participant 4 thought that some staff had "more issues than half the girls that were there" because they "would talk so much about them going out and drinking and trying drugs and stuff," and concluded that such staff members "are not positive people to be here around kids that have problems."

Witnessing or experiencing prejudice and discrimination perpetrated by staff on the basis of a youth's sexual orientation, religion, religious heritage, and/or cultural background, cited by four participants (40%), was another factor that contributed to negative relationships. Participant 3 reported the example of a peer being treated unfairly by staff who displayed remarkable insensitivity to the adolescent's presenting issue and her religious background:

> Because she was really skinny and she was Jewish, they nicknamed her Auschwitz. And we all had numbers…there…, and she's like, "I already feel like I'm in a concentration camp [without them referring to me as] Auschwitz over the intercom, or on their walkie-talkies."…They were like "Auschwitz is coming upstairs."

Two participants (20%) attributed the way some staff members treated youth to their religious affiliation, stating that strict adherence to the tenets of their religion could impede treating a diverse population of youth. Two participants (20%) indicated staff treated youth having same-sex sexual orientations with prejudice, which Participant 3

directly associated with staffs' religion: "What really I never liked out there was they don't like gay people [and] they would force their religion down our throat....And they will…tell us that being gay is bad, and…lots of my friends…there were gay….I didn't like that." Participant 2 described an incident designed to humiliate youth where girls that were known to have an attraction to her were gathered together by the staff and she was asked to choose the one she preferred: "There were all these girls that had a crush on me….So [staff] lined up all these random girls that apparently liked me and [asked me], 'So which one do you like best?'…I'm like, 'I don't know.'"

Two participants indicated prejudice and discriminatory behavior against African Americans. For example, Participant 3 was told to stop "talking Black and ghetto." Another participant, Participant 5, found the staffs' discriminatory attitudes about, and treatment of, African Americans to be "disturbing":

Being Black was an unapproved behavior….There [were] two, maybe three…Black kids there, and I felt really bad for them because the staff didn't…hide the fact that they were…racist….They weren't like belligerent about it, but…maybe it's something that they…couldn't wrap their brains around or weren't used to….The general mentality is…being an ignorant racist and…being in a position of authority over children.

Peer relationships. When asked about their relationships with their peers at the RTC, nine participants (90%) expressed overall strong positive attitudes, and only one participant (10%) expressed an overall negative attitude. Seven participants (70%) stated that their peer relationships had a positive impact on their experience, with some participants identifying these relationships as the only positive factor in their stay. Yet even within the population that found peer relationships positive, participants offered

multiple examples of peers engaging in negative behaviors toward one another. Two

subjects (20%) stated that a social hierarchy existed among their peers. Seven subjects

(70%) recounted incidents of peers' mistreatment of each other, with one participant

(10%) identifying the mistreatment as prejudice, and another (10%) identifying the

mistreatment as homophobia.

Six participants (60%) stated that they witnessed and/or were involved in physical

violence between youth. Two participants reported stabbing incidents with Participant 7

reporting that he saw stab wounds on "kids who were beaten up," and Participant 2 who

"saw a girl get stabbed," and heard her scream, "Oh my God! Oh my God! There's a

pencil in my back!" Two participants (20%) reported that they were aware of rape and/or

sexual exploitation that occurred between youth. One participant indicated that some

adolescents would sexually exploit youth who were younger, developmentally

vulnerable, or smaller in stature.

School and teacher relationships. When participants were asked about their

experiences with attending school within the RTC, eight participants (80%) indicated that

the school differed from traditional schools. Some reasons they gave related to the nature

of RTC-based schools, such as spending longer hours in school without holiday or

vacation breaks (10%), class sizes were smaller (10%), the school year was organized

into trimesters (10%), and school was held year-round (10%). Other contrasts were that

in the RTC-based school attendance was mandatory and youth were required to get "good

grades" (20%). The structure of the RTC-based school, i.e., long hours, no vacations,

mandatory attendance, etc., allowed four participants (40%) to graduate high school

earlier than they would have had they attended a mainstream school, one of whom,

Participant 4, completed "four years of high school [in] 15 months." A total of six

participants (60%) graduated from high school and received diplomas prior to their discharge from the RTC.

Despite the youths' achievement in the RTC-based school, and given the seriousness of their emotional and/or behavioral issues, and understanding that they might not have been similarly successful in a traditional school, there were areas participants identified as drawbacks to their RTC-based school. These included: (a) educational decisions were made without youth consent (10%), (b) the school did not group students as to ability so two participants found classes insufficiently challenging for their intellect (20%), (c) there were no provisions for college-bound youth to take the SATs (10%), and (d) no foreign language courses were offered (10%). Nonetheless, almost all participants—nine out of ten (90%)—identified their experience at school as having had an overall positive impact on their experience, and one participant, Participant 5, identified the school as "the one good thing about that place."

Nine participants (90%) reported having positive relationships with one or more teachers, and offered many qualities of the teachers that merited praise, e.g., they were helpful, supportive, motivational, compassionate, cool, fun, calm, understanding, and took their time to help the youth. Three participants (30%) contrasted their experience with teachers with that of staff. As Participant 1 stated: "The teachers definitely did not have the same attitude as the staff.…I had a good experience with them, and they took an interest in me as…a person…, as a person with a mind." Participant 8 expressed a similar view: "[Teachers] acted like school teachers, and not guards or counselors," and Participant 10 implied that youth were not in danger of teachers abusing their authority, thus "[you] could kind of lower that guard a bit when you went into class."

Five participants (50%) expressed gratitude for the quality of the teachers and gave them the credit for participants' progressing in education more successfully than they would have, or did, in their prior public school. According to Participant 3:

I…graduated two months ahead of time…because we were in a year-round school….Had it not been for the academic part of [the RTC], I probably would have never graduated, and been able to have been accepted in…a good amount of colleges…had I stayed at my regular high school. So I do thank the teachers there for making it possible to teach me in the right way, because the ones at my regular high school, they didn't know how to teach me.

Participant 5 also noted that the teachers at the RTC school were patient and conscientious:

The teachers were very, very good and I learned a lot….They took a lot of time to make sure the kids got it, and that was excellent….I am grateful for the school aspect….I learned more than any kid in the public school.

Despite participants' overall satisfaction with the school experience, two participants (20%) named specific teacher(s) with whom they had negative relationships. Participant 7 recalled being "verbally abused" by one teacher who would penalize him by unfair evaluations, giving him grades based on his behavior rather than his academic performance.

Recreational activities. Eight participants (80%) discussed the recreational activities offered at the RTC, while two participants (20%) made no mention of them.

Types of recreation. Participants offered examples of different types of indoor and outdoor recreational activities that they could engage in both on and off the RTC campus. Four participants (40%) referenced the RTC's gym where indoor recreational

activities were offered. One participant (10%) recalled playing volleyball and soccer within the gym, one participant (10%) reported that the gym was where youth would "exercise," and two participants (20%) mentioned that running was a mandated exercise. Participant 2 explained: "We'd go do Physical because we all had that after snack, and they'd be like, 'Run!' They always made us run around this big gym." Three participants (30%) mentioned participating in non-athletic on-campus indoor recreational activities that were positive, including playing video games (10%), playing cards (10%), watching movies (10%), crocheting (10%), and knitting (10%).

On-campus outdoor recreational activities, mentioned by seven participants (70%), revolved around playing sports, such as soccer (40%), volleyball (10%), softball (10%), and basketball (10%). Additional on-campus recreational activities participants recalled participating in included swimming in an on-campus pool (20%), and skateboarding (20%). Participant 8 remembered, "Every now and then, they'd take you outside to the driveway. I'd skateboard [on the] little…ramp out there." One participant (10%) mentioned participating in an on-campus recreational activity called "Talk Time" when youth could leave their unit, go outside, and socialize.

Six participants (60%) mentioned attending one or more off-campus outdoor field trips, four of whom (40%) reported going on a nature-related off-campus field trip. Other outdoor off-campus activities participants engaged in included sledding (10%), skiing (10%), snowshoeing (10%), rock-climbing (10%), hiking (10%), rappelling (10%), canoeing (10%), camping (10%), swimming (10%), and taking a trip to a lake (10%). Other off-campus field trips attended by four participants (40%) involved the travel necessary to participate in an indoor activity, e.g., going to the Bill Cosby show (10%), viewing a movie in a movie theater (10%), ice-skating at a rink (10%), eating at a

pizzeria (10%), and spending time in a staff member's home (watching movies, 10%; eating food, 10%). One participant (10%), Participant 8, reported regularly participating in a Boy Scout troop: "Once I got to the Hotel, one of the staff members [led] a little Boy Scout troop…that me and my brother and a couple other kids [attended]. He'd come pick us up…once a week."

   Recreation as a privilege. Five participants (50%) mentioned that participation in recreational activities was a privilege that had to be earned. As Participant 7 put it, "When you first get there you have video games, but [you're not allowed to] play them because you haven't gone to school or started to progress." This participant added that the prospect of participating in the recreational activities operated as a behavior modification technique:

>   For the most part, in the very beginning, I tried to be defiant….But I was real
>   young and learned right away that…I wanted to be able to go to the movies…,the
>   waterpark, and to go out and play softball and soccer and swim,
>   and…skateboarding and all that. I wanted to be able to go down to the gym [and]
>   workout…, so I had to conform….I had to do what it took to be able to do that,
>   which was earn…levels.

   Attitude towards recreation. Five participants (50%) had positive attitudes towards the recreational activities that were offered at the RTC. One participant (10%), Participant 3, expressed a positive attitude resulting from a side effective of exercise: "When I [came to the RTC] I was very heavy, and because we were always working out all the time, and they had us running a mile all the time…,I lost like 75, 80 pounds." Two participants (20%) had a positive attitude towards playing sports. One participant, Participant 3, credited playing a sport with a needed improvement in her mental state:

"Volleyball saved me pretty good....I was able to participate in that. I loved doing that. That saved me because [when] I was depressed [due to] how they made people conform…, at least I had an outlet to go."

Participant 2, who found little to praise about her time at the RTC, one aspect of the facility's recreational activities proved an exception: "The only thing that [RTC] did good for me was…and everyone said it, it improved my soccer skills." Interestingly, another participant, Participant 5, expressed a negative attitude about playing soccer because it provided a smokescreen for youth to act violently toward one another:

They had us play soccer, and we started to get into it…and we kind of used it

to…take…our aggression out on other girls. It was a hierarchy thing, you know.

You always definitely wanted to be on the winning team…because the other side

was getting crushed, literally....One of the girls had her collarbone broken.

Three participants (30%) had positive attitudes towards the outdoor recreational activities because they presented an opportunity to spend time outside of their unit and often provided other benefits as well. Participant 8 described going on fieldtrips "every now and then" as "pretty cool" as it gave him a sense of freedom: He stated: "It was the only time you didn't feel like you were in jail. You're somewhat of a person." Participant 4 found that engaging in outside recreational activities contributed significantly to her emotional wellbeing:

I liked when our units would go outside and…do some kind of…physical

[activity], instead of just being on the unit. I thought that was positive, because it

let out a lot of our energy that's pent up from being inside a building all day long.

I really enjoy that….I think [going out is] what gave me the most self-confidence.

My therapist's team…went rappelling, and we went canoeing one time. We went

up into Sundance another time and did…not a camp-out, because we weren't

gone overnight…,just during the day.

The participant continued, giving details of another field trip of several days'

duration in which therapeutic work was integrated seamlessly into physical activities:

Everything circled around trust or conquering something, and I think that allowed

the most self-confidence. Those are the things that stood out most. And [a

destination in the Mountain West] is…the most beautiful place I've ever been to

in my entire life, still to this day….We were gone for a couple days….We camped

and…were on boats and…swimming and jumping off cliffs. It was just an outing,

and that was definitely not circled around therapy, by any means. It was just fun.

Two participants (20%) experienced the outside activities as positive because they

were "fun," one of whom, Participant 3, expressed the view, as others had, that these

activities represented freedom:

We'd go on trips….That was nice. That helped. They took us to Sundance, they

took us to ski, they took us snowshoeing. They took us to [a nearby city], for…a

five-day hike. We learned how to do stuff in the outdoors, like about powdered

milk and everything. And we made our spoons out of sticks. [Recreational

specialists would] come out and do stuff with us there. Or bring us hiking to [a

waterfall]. It's fun to be out, and not be inside all the time, and looking at the

walls, and having to be keyed in everywhere.

This participant also acknowledged that outside activities that occurred within the

vicinity of her unit, specifically the "Talk Time" activity, could also be fun: "Being able

to go outside [during] Talk Time, and meet other people, that was kind of cool."

One participant (10%), Participant 5, expressed a neutral attitude. While conceding that the few off-campus recreational activities they engaged in were "fun," she found that those diversions had no significant impact on her experience because her sole interest was leaving the RTC permanently:

Yeah, I got to go…see Bill Cosby. Yeah that was fun. That was off of the grounds. They took me to go sledding or something in the snow once and then to somebody's house for a movie. I think those were the three times [I was outside the RTC]. It didn't matter, I just wanted to leave.

Recreational therapy. Of the three participants (30%) who identified some recreational activities they participated in as "recreational therapy," two (20%) expressed a positive attitude towards them and found they had a positive impact on their experience. Participant 6 considered these activities to be fun and helpful in building positive relationships with her peers on her unit:

We got to do something with ourselves, and we got to work as a team, and do all these fun things, and I really liked that you could work on how we're feeling, what is our cottage going through right now, good and bad, and what can you do as a cottage to fix it. We would do activities that would help us be productive and work together….At the end of every rec therapy we would be all talking, all laughing, getting along….Every cottage that I was on we were doing super good, and that would carry on for the week, and maybe towards the end of the week it gets a little negative, but we have rec therapy…week[ly], and we get to retry again. That was really impactful. I really liked that.

The other participant who expressed positivity about recreational therapy, Participant 3, also experienced recreational therapy as "fun" and, in common with the participants who

found outside non-therapeutic recreational activities positive and impactful because of the sense of freedom participation imparted, she "really liked that type of therapy because we got to leave and didn't have to be stuck in here." Participant 2, who engaged in recreational therapy but had a negative attitude towards it, had only one experience that had been characterized as recreational therapy and it had been her only experience of going off-campus. She expressed the view that the activity had nothing to do with therapy: "One day they took us to the skating rink….They just gave us ice skates….The therapist sat there." She further described it as "basically…a fieldtrip for school," and lacking any content: "There was…no therapeutic component….They didn't teach us anything….We never talked about anything, and there was never like a goal, or teamwork, or anything."

Misrepresentation of recreation. Four participants (40%) expressed frustration about the misleading promotional literature they believed the RTC disseminated, portraying residents engaging in recreational activities that were never offered. Participant 5 contrasted her life at the RTC with the one depicted in the brochure:

> The whole place was like smoke and mirrors….They were taking kids, the lucky ones…, to go and get their picture taken and it was like, okay, "sit in this raft," or "sit on this horse" [while they posed for] the catalog….I saw the brochure once, and I didn't get to do any of the things that were on there. They [had] kids just…pretending to be…hiking or river rafting or whatever. And…they were just…making up all the activities that we were supposedly doing. We didn't do any of those things. We had swimming, we had a pool [in the brochure]. There wasn't…anything like that [at the RTC]. There was just either work or school.

Participant 8 also commented on how the brochure misrepresented life at the RTC: "They had some tricolor brochures that showed swimming pools, and horseback riding, and all kinds of stuff…which I guess they had that at some point, but it wasn't…what the school really was."

Participant 6 made similar comments about the RTC website which portrayed a lifestyle at the RTC far different from what she had experienced:

> On the website it looks really nice, and it shows a pool, it shows a basketball court, it shows all the stuff. But that's all on the boys' campus, and the boys don't even use that….We would go outside for 30 minutes a day, and listen to music for maybe half an hour a day….If you were in Tier One…, we'd have outside time for 10 minutes. It was supposed to [be] 20, but they would do it for 10….I remember just being outside and not being able to have freedom. Having those high walls and just that small space. Being able to do nothing, just walk around.

Two participants (20%) described the option to participate in religious activities. One participant (10%), Participant 5, praised the RTC's openness to accommodate a youth's religious faith as "cool" and "a good thing": "Any religion that you wanted, or said that you wanted…, they would help you out with and let you practice." The other participant (10%), Participant 8, attended services, but not out of religious commitment. For him, they allowed him to leave the facility and experience a sense of freedom:

> Back when I was in Hotel [status], I [was invited to attend] church with one of the women that worked there….I hated it. [It] was cool to get out of there for a little while….The only reason I did it [was] to get out for a while. We [also] used to make a pit stop at Mickey D's on the way home.

Experiences Leaving the RTC

  Reasons for leaving. When interviewees were asked to talk about their experiences with being discharged from the RTC, all participants (100%) responded. Six participants (60%) described obtaining a high school diploma as the cause for their discharge. Participant 2 stated: "I basically got discharged because I graduated from high school, so they couldn't keep me any longer." Participant 7 found this accomplishment very gratifying: "Actually the best part of [being discharged] was graduating, having my high school diploma, and at least having the time to finally finish all that."

  Two of those six participants (20%) described postponing their discharge, despite having reached the age at which they could leave voluntarily, until receiving their high school diploma. Participant 1 stated: "The last month…or the last few weeks [at the RTC], I was able to leave. I turned 18, [but] I stayed to get my high school diploma….Graduation was…a couple [of] weeks later." Participant 4 had not reached the age of 18, but had the ability to leave voluntarily as a result of obtaining an emancipation order from her parents. Instead of leaving, she decided to stay at the RTC to complete high school: "I did all 4 years of high school in the 15 months I was there last time. That's why I stayed so long. I…left after I graduated."

  The other four participants (40%) identified factors other than those related to school for their discharge. One participant (10%), Participant 5, had successfully petitioned a caseworker to facilitate her discharge: "I was there for about a year….Then I got my caseworker's name, and I wrote her a letter and I was released within two weeks of her receiving it." Participant 6 recalled that she had been asked to leave the RTC due to continuing sexual misbehavior:

> I got kicked out. I got kicked out of all my [placements] for sexually acting out.
>
> All of them. So, I never changed….It's…literally impossible to get kicked out of
>
> [RTC, but] they told me, "We can't handle you anymore," when I was on the bad
>
> unit.

One participant (10%), Participant 8, reported that the reason for his discharge was that

he had "[run] out of insurance." Another participant (10%), Participant 9, ascribed his

discharge to pursuing a strategy of behavior compliance. "The most effective thing for

me…was where I decided [disobedience is] not worth it. To get out of [the RTC, I

decided that] I just need to do what I need to do to not be here."

Feelings about leaving. Seven participants' (70%) responses revealed how they

felt about their discharge from the RTC. Only one of those seven participants (10%)

indicated solely positive feelings, and one participant (10%) indicated solely negative

feelings, but this was due to a personal situation. He and his brother had attended the

RTC together and both were leaving, but the participant was being discharged and his

brother's departure was temporary:

> Me and my brother were getting on a plane going home together. He was going
>
> for a home visit and I was discharging. I just remember I didn't think it was right
>
> at all that he was going back….I kind of felt guilty.

Another participant (10%), Participant 7, indicated having a "termination attitude" that

jeopardized this high school graduation:

> I ended up, the last three months… with termination attitude, and then I just went
>
> crazy, and did whatever I wanted to do….I had been there three years already, so I
>
> [had] done the nice guy thing the whole time so I decided to be a bad guy for a
>
> little while since [I concluded that] there was nothing they could do to me….I had

gotten so bad that the owner of the school came and had a talk with me and said,

"I'll tell you what I am going to do, if you're good for two weeks, I'll put you

back at Hotel status…, cancel all of the [IPs], and put you back where you were

at before all of this started. But if you continue this way, you won't [attend]

graduation. They will give you your diploma then they will send you away with

your parents."…I knew it would hurt my parents if I did that, so I was good for

the [remaining] two weeks.

The other four participants (40%) had responses that indicated mixed positive and

negative feelings related to leaving. One participant (10%), Participant 3, described her

elation at the prospect of leaving once discharge was imminent, accompanied by a

dismissive and arrogant attitude toward others at the RTC:

I was acting like I was way better than everybody else, and better than the staff,

and didn't care about what they were saying, and I didn't care about how I was

acting because I was leaving anyway. I was like, "Bye! See ya later, thank God." I

was really happy.

Another participant (10%), Participant 5, was overwhelmed and incredulous at the news

that she would be discharged:

When they told me that I was leaving, I couldn't believe it….My friend…was

there, she was like "You are leaving! You are leaving," and she was shaking me

to help me believe it….I didn't dare to hope. I don't like being let down. I don't

know what happened, but I hit her…in the face. I'd never done that before. It was

a very weird reaction….Like I wouldn't believe it until I was out…away from

there. I was just relieved and on edge until I got far enough away.

The third participant with mixed feelings, Participant 6, was happy to be leaving, but the circumstances—a sense of failure at not having met expectations, and the lack of an opportunity to get closure with peers—were tinged with sadness.

> I was super excited…, but it was really heartbreaking knowing that I still didn't do good, still wasn't good enough….It was really sad…leaving all of those people, and I didn't get to say goodbye….They didn't get to hug me, and say goodbye.

The fourth participant (10%) indicated feelings of excitement about leaving and a determination to make it through the next step: an aftercare placement.

Where they went after. Eight participants (80%) indicated their post-discharge residence. Seven of those participants (70%) went directly home and one participant (10%), Participant 9, was placed in transitional housing because of his age: "I was about 17 when I left, and I ended up living in a step-down home. I turned 18 there….That's where I finished up high school."

Feelings after leaving. When asked how they felt shortly following their discharge from the RTC, seven participants (70%) responded. Only one participant (10%), Participant 3, experienced solely positive feelings: "Once you're out, you're not really thinking about anybody in there. You're just happy to be out." The other six participants experienced negative feelings including shock, panic, worry, fear, and resentment. Several suggested that going from the vigorously structured life at the RTC—which they hated—to one of freedom left them overwhelmed. For example, Participant 2 described going home with confidence in her future only to find that the RTC had, unbeknownst to her, led her parents to believe that she was not capable of following through with those plans:

> [Discharge] was great and stuff, but when I got home, and I [said], "I'm ready to
>
> go to college," [my parents] were like, "No, no, no, we were told you have special
>
> needs, you're not going to college. You wouldn't be able to do it." And so that
>
> was more a big shocker, [making me think] that I wasn't going to be anything,
>
> that I'm…stupid. There was no plan….It was like, "Okay she's just going to
>
> discharge and go home."

Not only were the participant's hopes for college dashed, but her return home held further

disappointments for the participant:

> My parents sold the house where I grew up in and…the apartment they moved
>
> into didn't have a room for me. So it was like, "Welcome home, happy high
>
> school graduation, here is this blow up mattress you can sleep on underneath this
>
> desk."…It was really f---ed up. While I was at [the RTC, the RTC] told them
>
> apparently that they could give away…every single thing, so…I have nothing
>
> from my childhood. Not one f---ing thing.

(It should be noted that the participant later revealed that her parents paid for the RTC out

of pocket and that their lifestyle change was likely motivated by financial strain.)

Participant 1 was unprepared for the transition from a life controlled by rules and

regulations to one where she was free to determine her actions: "Shortly after I got back

[I was] in this moment of…panic, 'Oh, my God, I'm back home. I don't know what to do

now.'" Participant 9, who had left before turning 18, was worried that he would be forced

to return to the RTC. Participant 3, however, had the most negative reaction. She

experienced symptoms resembling post-traumatic shock: "The nightmares started, like

the lockup nightmares at night became really bad, of…being chased." Participant 10

expressed the feeling that his longed-for discharge left him facing the unknown:

It's the hope of getting out at the end, then getting out, that's a whole new

struggle. You expect enjoyment, and it's almost quite the opposite….I

understand…people who have been to prison for a long time and don't want to get

out. Those are two different [situations], but I definitely understand that. Not that

I would want to go back, but it's very confusing when you get out.

Reflections and Recommendations

Shortcomings of the RTC. Eight participants (80%) identified major

shortcomings of the RTC. For example, Participant 10 maintained that despite his being a

"very positive" and "very optimistic" person, he could not find anything praiseworthy

about the RTC, and doubted whether even the staff thought that youth were helped there:

I hate not being able to come up with positive things to say about [RTC], but I

can't come up with positive things….It doesn't do what they think it's supposed

to do….I don't even think people who worked at [RTC] truly think that it actually

helps. They just can't…because what they do is so far from anything that was

helpful.

Similarly, when asked if the RTC helped with any pre-existing problems, Participant 8

firmly declared, "None whatsoever," and added:

I was kind of surprised that they're still operating. I figured they'd be gone a long

time ago by now….I didn't think it was a healthy place. I figured eventually it

would get investigated, and people would realize it was a pretty f---ed up place

that we were sending our kids [to]. But I guess they are turning [a] profit.

These eight participants (80%) referenced the complete absence of quality mental

health treatment. Two participants (20%) denied that any "real treatment" had occurred,

and another two participants (20%) similarly denied that anything "therapeutic" had

occurred. For example, Participant 7 declared: "It wasn't really a treatment program. It was a school. A school that puts you in a severe structured environment....I don't know anybody that will tell you it worked."

Three participants (30%) reported that its failure to prepare youth for the challenges they would face in the future was another major shortcoming of the RTC. For example, Participant 10 stated: "I didn't feel like I gained any positive living skills....You gain a tremendous amount of survival skills, but not living skills." Participant 3 expressed a similar view, but elaborated that the lack of preparation for the future resulted in unfortunate consequences for many youth:

> When I got out I was not really prepared, and made even more mistakes. I'm not blaming it on them. It's just I feel like we could have been a little bit more prepared…had they let us do a little bit more stuff by ourselves and not have everything so restricted or black boxed. Then we would know what we were coming back to….Because [we] were locked up a lot, when [we] got out a lot of us didn't do too well in the real world. [We] weren't really able to do much in there, so we weren't prepared to do anything on the outside world. A lot of people relapsed actually.

One participant, Participant 8, did credit the RTC with teaching him one skill, albeit a rather dubious one: "I just learned how to hate."

Long-term impact. All participants (100%) agreed that their having gone to the RTC as adolescents had a long-term impact on them. Six participants (60%) considered that their placement at the RTC had negative ramifications on their lives Two participants (20%) reported that their experience at the RTC colored their view of mental health treatment. For example, Participant 8 stated: "I'm probably more resistant to therapy

and…things of that nature. I don't know how, it was twenty years ago, or twenty-five

years ago, and it affects me now." His experience at the RTC continued to reverberate for

this participant: "I've always looked back and thought it had a negative impact on my

life."

       Three participants (30%) reported long-term trauma-related symptoms as a result

of their stay at the RTC. (As these participants suffered extensive after-effects from their

experiences at the RTC, their responses to the question regarding trauma symptoms are

more detailed than those to other questions.) One participant, Participant 5, described

multiple trauma symptoms, such as nightmares "of just being chased"; flashbacks:

"When I drink too much I tend to…regress or relive certain things"; and distress upon

trauma-reminders: "I don't like being told what to do. I don't like being controlled." In

addition, this participant doubted whether the list was complete: "I'm sure that there are

other ways that it screwed me up." Despite the many years that have passed since

discharge, Participant 1 continues to experience long-term recurrent and intrusive

memories of her experience at the RTC, including: (a) distress upon reminders of the

RTC; (b) worsened cognition and affect following the RTC; (c) dissociation; and

(d) stunted identity formation that has negatively impacted her interpersonal relationships

and occupational functioning. She describes the long-term impact of her placement:

       I have so much self-doubt and self-criticism, which I think came from [the RTC],

       definitely….If it didn't come from there, it was already in me when I got there,

       and it wasn't addressed. And it's partially because I spent…close to a decade, so

       much time, since I got out just being…in turn…furious, self-pitying, or

       feeling….less than acceptable….There's definitely a point where I was…carrying

       it with me everywhere….If you would ask me to describe myself or introduce

myself, it would be the first thing…that came to mind….I spent so much time living in the past…revisiting this experience…and reevaluating....I was highly disassociated and not at all coping with, or that was me coping, I guess, but not at all handling or engaged in my life….I feel…at this point I'm pretty much living in the present, and if I talk about it, I know I'm talking about something that happened. I know that I'm gonna feel upset afterwards, and I know that I…need a cry…, but I still find really hard to self-motivate and to shake off feelings.

The third participant who experienced trauma-related symptoms, Participant 2, described them as including: (a) hypervigilance, (b) recurrent and involuntary memories of the RTC, particularly of the nurse who forcibly inserted medication rectally, as discussed above; (c) distress upon reminders of the RTC, and (d) avoidance behaviors:

I don't trust anybody that's medical because of what [the nurse] did to me. And…I don't like to do group [therapy] because I think all groups are going to be the same. And walking at night, even though I wasn't kidnapped…like…most kids are, but I was grabbed [because] I tried to run. But…I just always think that people are going to grab me….I have a lot trouble around the holidays…, but [I'm] more…worried about kids that are there now, so it puts a damper on [the holidays]. I'm not able to really get over the thing with the nurse….It isn't going away….For a long time, I didn't shower. I…didn't bathe….I bathed…once a week. Because…showering [was] just so traumatizing for me after they did those shower checks….It's like everywhere I go I see…my [assigned number], and…it always…puts me in…a down position….For a long time, for like eight years, after every time I showered I just remembered what happened to me….It's like my whole life is just revolving around that s--- now. I am still crazy. And angry.

Four participants (40%) expressed long-term resentments towards the RTC. Participant 10 stated: "There's a lot of negative feelings about the place….Thirty years later that place still has an effect on me….The impact that this place has on people [who lived there is] a whole other story." Participant 2's resentment towards the RTC was demonstrated by the action she took after she left: "I sued the school." Two participants (20%) reported that going to the RTC led to long-term negative feelings towards parents. For example, Participant 8 explained: "There was a lot of tension afterward. I hated my mom for a long time for sending me up there. A lot of resentment."

Given the amount of animosity participants have expressed toward the RTC, a significant majority of the sample, seven out of the 10 participants (70%), nonetheless believed that their attendance at the RTC resulted in long-term positive consequences in their lives following discharge. Four participants (40%) reported meeting peers at the RTC with whom they've developed long-term friendships, and three (30%) reported that the RTC prepared them for college. Other positive consequences include: (a) an increased motivation to do well in life (20%), (b) an increased confidence to stick up for what is right (10%), (c) it saved participant's life (10%), (d) it enabled them to engage in more careful consideration of the consequences for actions (10%), (e) they were no longer afraid to be separated from parents (10%), and (f) it resulted in job skills and a long-term interest in construction (10%). Participant 10 credited his RTC experience for halting a descent into self-destruction:

> I was on a path before [RTC] that would have been detrimental to any kind of long-term success. So, what the program did for me was…remove…me from the path I was on, contained me so I couldn't continue down that path. It…put an abrupt stop to the road that I was going.

Recommendations to the RTC. All participants (100%) offered recommendations. There was only one recommendation mentioned by two participants (20%): that the RTC bring their hiring practices in line with their purported goal—to help youth. Thus, Participant 4 recommended that the RTC develop a better "screening process" that would promote a "more professional" and mature staff who would not share their personal issues with the youth. Similarly, Participant 3 recommended that the RTC conduct background checks to help to prevent hiring staff who are likely to "have sexual relationships with the clients." This participant also stressed the need that staff "genuinely care, have a feel [for] what it means to be supportive and…not just come there for a paycheck." Other recommendations suggested by the participants included: (a) a curtailment of the overuse of psychotropic medications on the youth, (b) that the RTC pursue "more focus on treatment," and (c) that the RTC not admit any youth younger than 12-years-old.

Participant 7 recommended that the RTC might make "bond[ing] and work[ing] with the family" more prominent in their treatment approach so that therapists might be able to understand the youth's behavior within the context of the family dynamic and address problems within the family that may be contributing to such behavior. He stressed the importance on working on family issues in light of his own experience: once he returned to his family environment, he reverted to the behavior that brought him to the RTC originally:

> If you don't change what you're coming home to, you're just going to end up with more [problems]. When I came out I severely was gone on drugs and used. I became a very bad person….You would never think that I had gone through a program that changed my life.

Participant 1 offered recommendations that, if adopted by the RTC, would address the

concerns of the other participants, namely: (a) increased regulation, (b) use of best

practices, and (c) patient-informed treatment:

> I feel like there should be some uniform rules or checks that residential treatment
>
> centers should have to abide by….I think [the RTC] was…privately owned and
>
> publicly funded, and I don't think that they're…well-regulated or…in line with
>
> best practices. I think residential treatment centers more than any other places
>
> should have to educate their staff about, and try to observe and prove that they are
>
> observing best practices, because [of their] complete control over [the]
>
> kids….They need to be safe…, emotionally and physically, and I think being
>
> informed by actual patients themselves is what can guide that.

Recommendations to therapists. Seven participants (70%) offered advice to

therapists working in residential treatment centers. Four of those participants (40%)

recommended therapists make efforts to understand the perspective of the youth and, in

the words of one participant, not focus on them "as the core of the problem," but extend

the focus to the rest of the family's "thoughts or feelings and fears." Two participants

(20%) recommended therapists show compassion and make efforts to build trust with the

youth. Participant 8 offered the following recommendations for therapists:

> Really focus on what would be the best thing for [residents] to move
>
> forward…and have…respect for each other and build…trust with each other. You
>
> don't have to love from the bottom of your heart who your patient is, but you
>
> need to have some sort of compassion [for] them….Even if you haven't been
>
> through the stuff that they have been through, you need to understand that it

probably really hurt them….Whether it was good or bad, it had an impact on them….Try to understand them as much as you can.

His further recommendations included that the therapist not "say things that would make the person feel like crap, [as if] they're intentionally doing this," and for therapists to "use a normal tone of voice, normal way of speaking" that is not "demeaning." Participant 3 recommended that therapists "genuinely care" and "listen." She also stressed that therapists not be dismissive when youth confide in them about staff abuses: "If the client was telling you something about what the staff was doing on the unit, investigate it."

Recommendations to parents. Five participants (50%) offered advice to parents considering sending their children to a residential treatment center. Three participants recommended parents carefully explore whether other less restrictive options might be indicated for their children, such as "outpatient" treatment. Once a parent has determined the residential placement is the appropriate intervention given a child's needs, however, parents should thoroughly research the places they are considering. The other two participants were emphatic that parents not send their children to residential treatment centers but instead make greater efforts to keep the child at home. For example, Participant 8 recommended that "parents…be more [responsible] instead of just shipping their kids off to some program to teach them values and virtues, and what they need to learn about life." Furthermore, Participant 10 recommended that parents develop more empathy for their child, not treat the child as "bad" or as the "problem," and to try to understand the underlying issues that are causing the unwanted behaviors.

Recommendations to youth. When asked what advice they would offer youth about to enter a RTC or advice that they would have given to their younger selves at the

RTC, seven participants (70%) responded. Two participants (20%) recommended that youth persevere. Participant 9 stated: "You're going to be here a while, don't give up. Just keep going." He also cautioned them not to get discouraged when it seems as if they will never leave the RTC: "Don't get that attitude of what's the point. Keep moving forward." Two participants (20%) recommended obeying the rules and meeting the expectations of the program. Two participants (20%) recommended taking the time for self-reflection. Participant 1 stated: "Spend time with yourself…don't be afraid to look at what you're feeling." She went on to suggest that youth "be an advocate for yourself, don't be afraid to speak up." One participant (10%) recommended that youth "slow down" and not "rush" into adulthood.

Three participants (30%) recommended that youth identify someone to help them. Participant 6 suggested staff as sources of help and a therapist who's "actually going to help you and you feel comfortable with." Participant 5, whose contacting a caseworker resulted in her being able to leave the facility, as discussed above, suggested that youth to find help from a caseworker: "Get your caseworker's name as soon as possible. Focus on nothing but that. That is all I would do….That could have changed my life [more quickly]."

Chapter VI. Discussion

This chapter will explore the central themes that emerged from interviews with participants of this study as reported in the Results chapters, investigating how former residents in residential treatment centers perceived their experiences. These themes included: (a) from struggling child to scapegoat; (b) treatment versus oppression; (c) experiences of maltreatment, trauma, and the conspiracy of silence; and (d) the ability to find solace, sanctuary, and support. Limitations and implications of the study will also be addressed.

Central Themes

From struggling child to scapegoat. Many participants felt that their family unjustly targeted them, blamed them for being the source of the difficulties in the family, and labeled each individual as a "problem child" who needed to "be fixed." Some participants normalized their negative behaviors as "acting out," i.e., their responses to adverse situations or conditions not in their control. When participants discussed reasons for their placements, most endorsed a history of struggling with emotional, behavioral, academic, substance abuse, and/or psychiatric problems. This is consistent with the research exploring the characteristics of youth entering residential treatment (Connor et al., 2004; Milazzo-Sayre et al., 2000), including: (a) the existence of family dysfunction prior to placement (Connor et al., 2004), and (b) finding that youth in residential treatment programs have high rates of trauma exposure (Briggs et al., 2012; Connor et al., 2004; Jaycox et al., 2004).

While many of the participants acknowledged struggling with behavioral and/or mental health problems, they did not believe that such difficulties merited long-term commitment in an out-of-state private residential treatment center. This is consistent with

a study of needs-based assessments of children and adolescents in residential treatment.

The study found that although their mental health needs were significant, a "substantial

portion of children in residential treatment were not at high levels of risk," suggesting

that lower levels of care were likely to have been adequate for treatment (Lyons et al.,

1998). This is also consistent with the literature: adolescents and parents have divergent

perceptions regarding the degree of adolescent problematic behaviors (Grills &

Ollendick, 2003; Rey, Schrader, & Morris-Yates, 1992), with parents perceiving the

behaviors as more severe than adolescents (Ferdinand, Van der Ende, & Verhulst, 2006).

Beliefs that their parent(s) could have chosen to make reparative actions to serve

the needs of the youth rather than send them to a facility were reflected in participant

responses. Their conviction that parents freed themselves of responsibility and guilt by

the placement decision caused many participants to feel like they served as the family

scapegoat. As defined by Merriam-Webster (n.d.), a "scapegoat" is "a: one that bears the

blame for others; b: one that is the object of irrational hostility." This definition accords

with the experience of many participants who often felt: (a) unjustly blamed for their

parents' problems, (b) that their parents thought they could "send away" their problems

through the placement, (c) burdened by their parents to "repent and atone," and

(d) imprisoned until judged to be obedient enough or "without sin" to rejoin their family

and community.

Family therapy literature has addressed the issue of scapegoating a child (Bowen,

1993; Minuchin, 1974; Vogel & Bell, 1960). According to family systems theorists, the

scapegoat has been characterized by the family as the "problem child," "black sheep,"

and/or "troublemaker," and is one presentation of what Gurman and Kniskern (2014)

refer to as the "identified patient," or "the member expressing a disturbance existing in the entire family" (Gurman & Kniskern, 2014, p. 365).

Research indicates that scapegoating a child functions as a means by which parents can relieve tension and thus have a more harmonious relationship. Unfortunately, this may be at the expense of a child's development (Bell, Bell, & Nakata, 2001; Napier & Whitaker, 2011). Scapegoating has also been related to lower parental support, family conflict, and adolescent adjustment problems (Arnold, 1985). Yahav and Sharlin (2002) found that children aged 10-17 who reported greater subjection to parental blame for family conflict, exhibited more externalizing symptoms than children in comparable family situations who were not scapegoated, whose symptoms were more internalized.

For many of the participants in the study, scapegoating did not only occur at home but at the RTC as well. They felt blame was displaced onto them by staff during the intake and orientation phases and endured for the entirety of their placement stay (an average of 18 months, with a range from 9 to 36 months). Participants often experienced scapegoat treatment as both individuals and as a social group. Scapegoating was reflected in actions from staff, and sometimes therapists, that involved: (a) prejudice and practices of discrimination, (b) blame for minor incidents, (c) being ridiculed or bullied, and/or (d) being a victim of excessive aggression and/or abuse. While most participants were indignant at their treatment and rejected the scapegoat identity, a few recalled an inner acquiescence to the message of being "bad" and absorbing the associated guilt and responsibility. For example, one participant related the genuine efforts she had made to try to "prove" to her therapist and the staff that she was not the "bad" child she had been labeled and subsequently internalized.

The experience of scapegoating may also account for the intensity of resentment that some of the participants felt towards their parent(s) and the RTC, during their stay and long after their discharge. Although the continued resentments that adolescent patients had towards their parents and the residential treatment center are likely to have occurred in other populations of youth that have received this intervention, the impact that these resentments had on parent-child relationships and on the youth's outcome has not been investigated by researchers.

Treatment vs. oppression. The experiences described by many of the participants during their residential treatment, such as a lack of privacy and constant surveillance and scrutiny, are consistent with the process of oppression. Participants also reflected the experiences of oppressed groups, where the negative behavior of one person from a group is unfairly displaced upon the whole group. For example, many perceived themselves as being judged, blamed, stigmatized and then treated unfairly for being "in the group" of troubled youth.

Participants described lacking autonomy, choice and agency, and felt helpless and/or powerless to challenge those in power. Moreover, many participants felt that their placement was a sentence forced upon them, and that their stay was far more comparable to imprisonment than an opportunity to receive "treatment"—a process they associated with therapy, care, collaboration, empowerment, and helpfulness—none of which, alone or in combination, appeared to have been emphasized at the RTC.

To the extent that participants had choices, they were limited. For example, choices in movement, activity, and speech were highly regulated and allowed only if approved by those in power at the RTC. Participants identified that power was centralized in staff, therapists, and teachers. Many participants described staff as the primary

authority figures with the ability to make the youths' lives pleasant or unbearable.

Interestingly, participants' descriptions of the dehumanization, depersonalization and

disempowerment they experienced were also found with studies done on a population of

psychiatric in-patients with intellectual disabilities in hospitals (Chinn, Hall, Ali, Hassell,

& Patkas, 2011).

Conformity and obedience via coercive methods was a theme across interviews.

Many participants felt coerced to change their behaviors and to submit to authority for the

following reasons, including: (a) escape intolerable environments; (b) avoid discomfort;

(c) avoid harm; (d) avoid punishment; (e) avoid being singled out; and (f) gain freedom

of movement, activity, connection, and, however limited, choice. While some

participants' responses indicated intentional efforts of defiance, most found that non-

conformity and non-obedience triggered such degrading and loathsome punishments,

e.g., sitting in a chair or standing facing the wall for extended hours of time, that the cost

far outweighed whatever benefit there was to be derived from oppositional behavior.

Experiences of maltreatment, trauma, and the conspiracy of silence. Reports

from many participants mirror the findings of Polvere (2011) that adolescents in

residential mental health treatment settings experienced fear, frustration and

powerlessness when direct care staff verbally and physically asserted their authority and

power to control them. These behaviors were perceived by youth as threatening, hostile,

unjust, and sometimes abusive. Indeed, maltreatment, including neglect, and abuse—

physical, emotional, sexual, and medical—was another major theme across interviews.

Participants' experiences are consistent with the findings of a congressional investigation

into the child neglect and abuse occurring in private residential treatment facilities (Cases

of Child Neglect and Abuse at Private Residential Treatment Facilities, 2007).

Some participants felt that maltreatment began before their arrival at the RTC—during the transport process—when they had been restrained either physically and/or chemically. During their stay, efforts at restraint were often so disproportionate and excessive as to constitute physical abuse. The environment of abuse at the RTC was pervasive: it was common for youth at the facility to abuse other youth. Given the above, it is not surprising that trauma was another common theme. For some participants, trauma was a consistent presence in their lives: before their placement in the RTC, during their placement, and manifesting as post-traumatic symptoms following their discharge.

Many participants also described experiences within the RTC that suggested a conspiracy of silence concerning the maltreatment of youth. This was true for both youth and employees at the RTC—they received the same message, whether explicitly or implicitly. A research study conducted with boys who had been placed in a residential institution in the U.K. had similar findings. The boys had experienced ongoing sexual abuse and physical abuse from staff, including high-ranking management, as well as from other residents, and a "cult of silence" dominated. All complaints of abuse were dismissed and suppressed (Waterhouse, Clough, & le Flemming, 2000). In Colton's (2002) study, the researcher identified the following factors associated with abuse within residential care institutions:

> failings in relation to staff recruitment, training, and supervision; ineffective
> management and systems of accountability; the development of inappropriate
> institutional cultures; public ambivalence towards children in care; the slow
> footed response to the threat posed to children and young people by dangerous
> men and other youngsters in care. (Colton, 2002, p. 33)

The participants in the present study offered responses to researchers regarding the RTC that were strikingly similar.

The ability to find solace, sanctuary, and support. Despite an environment permeated with abuse, participants identified people, situations, and events which offered them sources of solace, sanctuary, and support. One major source of support for several, although not most, participants was their therapist. Participants described these relationships, when positive, as meaningful and empowering. Other participants reported having positive relationships with one or more staff members. Those participants could have fun with staff in those instances, as well as form an alliance with them that would improve the youth's experience or at the least make it more bearable. An additional source of solace for some occurred when they were given an opportunity to change their routine. For example, recreational activities, especially those that involved going outside, were highly valued sources of relief and enjoyment.

School was the most commonly identified place where participants found solace, sanctuary, and support. Participants described teachers as (a) offering emotional support, (b) providing a safe space for youth to "be themselves," (c) assisting with academic achievement, (d) crucial for their personal growth, and (e) providing joy and positivity, connection, respect, and understanding. The positivity and gratitude for the education and teachers at the RTC, expressed by many participants, not only reflected the important role that teachers had in their lives, but offered a stark contrast to the non-educational aspects of the RTC and its staff, many of whom inspired only negative reflections by the participants.

Another common identifiable source of support came from peers. Friendships with peers within the RTC, many of which lasted long after discharge, were additionally

significant in light of what many felt as a lack of support and understanding from staff.

Some participants expressed the view that their profound bonding with peers was due to

everyone coping with the stress of living in the RTC together.

Limitations of the Current Study

A number of limitations should be considered in interpreting, utilizing, and

applying the results obtained in the present study. Readers are thus cautioned to avoid

generalizing the results of this study to all youth treated at residential treatment centers.

The first limitation of this study was the small sample size. Recruitment for the study was

a difficult process and only 10 individuals completed interviews. This may be due to

three factors:

- Individuals may have been reluctant to participate due to confidentiality

  concerns. Several participants questioned whether this research was connected

  to the RTC and whether their identity would be traced to the RTC.

- The topic of the RTC might have elicited unwanted memories and feelings in

  the individuals. Several participants expressed the view that talking about

  experiences related to the RTC was emotionally difficult; however, they were

  highly motivated to share their stories if it would help other youth.

- Individuals may have been distrustful about the intentions of the research and

  the researcher. Some subjects inquired about the researcher's intentions prior

  to participation. The researcher satisfied their doubts, which resulted in their

  expressing positive feelings towards the research and researcher, trusting the

  researcher, and finding the researcher's intention as noble.

A second limitation is that the current research did not make use of a random

sample or control group, and was restricted to a networked sample of adults reflecting on

their experiences in a single private residential treatment facility. Therefore, these results

may not generalize to youth in other private residential treatment facilities or other

residential treatment programs. Furthermore, all participants had been out-of-state

placements. Therefore, these results may not reflect youth experiences in community-

based residential treatment placements. In addition, since there was a considerable length

of time since discharge for most of the sample, it is possible that this study's findings do

not reflect the current experience of youth in the specific private residential treatment

center. In addition, since this was a retrospective study, the passage of time may have

distorted the perspectives of the participants.

A third limitation is that, given the nature of this sample, selection bias may exert

an impact on the generalizability of the results. Specifically, those subjects who

responded to advertisements for this study, and ultimately became participants, may have

been more likely to: (a) have an interest in improving the quality of residential treatment

for youth, (b) have had significant negative and/or positive experiences that they wanted

others to know about, and/or (c) feel comfortable reflecting on their experience at the

RTC.

A fourth limitation further affecting the generalizability of the results involved the

exploratory nature of this qualitative study. Data analyzed and theories developed were

not necessarily used to support or challenge research conducted by others in this area of

inquiry. Furthermore, in the interest of providing a comprehensive overview of

participants' experiences associated with the RTC and avoiding presumptive questions,

the researcher did not explore in detail some significant aspects of individual participant's

experiences. For instance, participants expressed conflict related to: (a) expressing their

genuine selves at the RTC, (b) their development, and (c) sexual behaviors between

youth. From these themes, the topics of adolescent development, particularly adolescent

identity development and adolescent sexual development, could have been explored.

Also, when the researcher inquired about the "treatment" they received by the RTC, some

expressed confusion, or disagreed entirely with the premise that the RTC provided

"treatment" or was a "treatment facility or center." This topic could have been explored

further to inquire: (a) how all participants defined the RTC, (b) if their expectations of

"treatment" impacted their experience, and (c) how well they believed their parents'

expectations conformed to the reality of what the participants experienced. Another topic

that could have been explored arises from the gender segregation at the RTC. Some

participants described the opposite gender living on a separate "campus," and one

participant noted that recreational activities featured in the RTC's brochure were only

available on the boys' campus. Thus, the existence of gender differences, if any, in the

treatment of youth within the RTC may warrant exploration. These topics and others

would bear further research, and a future study about the experience of youth living in

residential treatment centers could focus more closely on any of the specific categories

identified in the current study.

      Despite issues of generalizability discussed above, this study represents a first

exploratory step in understanding processes upon which themes related to treating

adolescents with serious emotional and behavioral problems in restrictive treatment

facilities can be identified for further qualitative and quantitative research.

Implications

      The current study has several implications for future research, residential

treatment practice, practitioners, legislation and policy, and parents.

Implications for future research. The major implications for future research

suggested by the current study are that more research should be conducted in the area of

residential treatment centers for adolescents, particularly those that are privately run,

have long-term treatment stays, and admit youth from dispersed geographical locations.

The current study sheds light on the conditions that may occur within these centers, and

hopefully encourages future researchers to explore an overlooked treatment setting. The

exploratory nature of this study invited reflections on the broad experiences of youth, and

thus future studies could focus on one or more specific components associated with

private residential treatment centers having a diverse adolescent population. Examples of

topics that may be investigated further in future research include: (a) the use of

transportation escort services; (b) youth consent to treatment, including psychotropic

medication; (c) characteristics of front-line staff; (d) staff attitudes and practices towards

youth; (e) the role of the therapists within residential treatment centers; (f) intrinsic

versus extrinsic motivation for behavior change within residential treatment; (g) reward-

and-punishment systems in residential treatment centers; (h) factors in residential

treatment facilities that may contribute to abuse towards youth; (i) investigation of the

different forms of abuse in these facilities; (j) impact of parental involvement in

residential treatment centers that are not community-based; (k) role of social advocacy

within systems; and (l) youth adjustment following long-term private residential

treatment.

Implications for residential treatment. Participants in the current study noted

the ways in which the practices and approaches to treatment provided by the RTC were

either helpful or unhelpful and/or may have affected their well-being during treatment

and following discharge. Regarding mental health treatment, many participants noted the

lack of staff training in the field, and limited access to therapy. In addition, the therapy modalities, approaches, and interventions that were provided were often described as not helpful. Participants especially found fault with the behavioral and problem-focused approaches. These comments raised doubts as to whether residential treatment programs for youth provide quality mental health treatment. Given that this intervention is for high-need youth who have not been treated successfully with lower levels of care, it is very important that these facilities re-examine and reform their programs in light of the present study's findings.

Access to the outside and/or recreational activities, although limited, were found to be memorable and helped to relieve stress. Peer support was also a formative element of youths' experience, and these relationships were described as vital to coping within the RTC. This suggests that recreational programming and social activities are important parts of residential treatment for adolescents and are areas of treatment worth bolstering in such settings.

Common practices within the RTC, such as the use of punishment, restraint, isolation and overuse of psychotropic medication, were described by participants as coercive and harmful and, for some, traumatic. As such, it is recommended that residential treatment centers should focus behavior modification approaches that: (a) use the least restrictive interventions possible (b) depend less on psychotropic medications; (c) impose punishments more sparingly; and (d) increase the use of therapeutic intervention, discipline as opposed to punishment, and positive reinforcement. For example, a research study conducted with youth with serious behavioral disorders placed in an intensive residential treatment center found that therapeutic interventions, e.g., medically-directed cognitive-behavioral treatment, significantly reduced psychotropic

medication rates, behavioral disturbance, seclusions, and restraints used on youth (Huefner, Griffith, Smith, Vollmer, & Leslie, 2014). Modification of the clinical approach implemented to manage behavioral disorders in the youth may also help to achieve medication reduction, reductions in assaultive incidents, and reductions of restraints (Bellonci, Huefner, Griffith, Vogel-Rosen, Smith, & Preston, 2013). For example, a study evaluating the implementation of a comprehensive aggressive management program in an adolescent forensic unit found that the program researchers developed successfully reduced aggressive behaviors of youth, injuries to staff, and physical intervention time (Kaltiala-Heino, Berg, Selander, Työläjärvi, & Kahila, 2007). Guides for managing aggressive behavior of youth in residential treatment have been developed (dosReis et al., 2003), and these, along with future studies, should provide the structure for more effective treatment and positive outcomes in residential treatment centers for youth.

Family-centered treatment, such as family systems approaches and multidimensional family therapy, have been shown to be helpful in addressing youth problems in outcome research of family-centered practices in residential treatment (Brown et al., 2010; Landsman, Groza, Tyler, & Malone, 2001; Vaughn & Howard, 2004; Walter & Petr, 2008); however, family involvement in youths' treatment received little, if any, attention in the RTC. Increased parental engagement and family-centered approaches are recommended. Family involvement in treatment may also help identify and remediate scapegoating within the family, and alleviate resentments that youth may have towards parents. The present study indicated that the uniformity of treatment—"one size fits all"—was not helpful in addressing participants' individual issues. This is supported by a research review of residential treatment outcome studies from 1993 to

2003 that indicated that "children and adolescents with severe emotional and behavior disorders can benefit and sustain positive outcomes from residential treatment that is multi-modal, holistic, and ecological in its approach" (Hair, 2005).

The duration of the placement for many participants was comparatively long, and little was done to prepare them for discharge, or their return home and to the community. Thus, residential treatment centers should consider the ways in which they can improve home and community reintegration, particularly given the findings of Hoagwood and Cunningham (1992) that demonstrated positive outcomes for youth who have been discharged from residential treatment centers. It should be noted, however, that the sample in Hoagwood and Cunningham's (1992) study differed from the sample in the present study in that youths' stays were shorter and they had community-based post-discharge supports.

McCurdy and McIntyre (2004) recommended that residential treatment centers strongly consider implementing a "stop-gap model" of service delivery to address these concerns, stating:

The stop-gap model of residential treatment emphasizes empirically validated, or evidence-based, practices coordinated to immediately lessen, or decrease, barrier behaviors while simultaneously initiating plans and treatment services intended to help the youth succeed upon return to the community. RTCs intending to implement the stop-gap model should consider an array of services that spans three levels of care: (i) environment-based intervention, including eco-behavioral and skill teaching strategies designed to immediately reduce barrier behaviors and to provide an all inclusive, skill-oriented environment; (ii) intensive intervention, consisting of functionally derived treatment planning for individuals with the

most serious and intractable problem behavior whose needs cannot be

immediately addressed via environment-based intervention; and (iii) discharge-

related intervention, designed to prepare the individual and prospective family

(i.e. biological or foster) for discharge to the home and community. (McCurdy &

McIntyre, 2004, pp.147-148)

Patient engagement, empowerment, and youth-guided practices have been found

to promote positive development and outcomes in community-based mental health

settings. Integrating approaches related to increasing youth involvement in shaping

treatment might prove beneficial in residential treatment settings as well, especially when

participants indicated that their residential treatment intervention—as it was then

implemented—was oppressive and disempowering. Furthermore, in an effort to improve

treatment and prevent maltreatment, including abuse, residential treatment programs need

to take steps that are consistent with their responsibility to help troubled youth, and are in

accordance with legal and ethical requirements, such as: (a) communicating a strong

message to patients and staff that maltreatment will not be tolerated; (b) making the

process of reporting maltreatment simple; (c) changing practices and/or policies in

response to maltreatment that have been demonstrated to decrease these offenses;

(d) reporting the abuse to the state's department of child protective services;

(e) conducting and internal investigation and, if the allegations are substantiated, inform

the caregivers with youth still in the program; and (f) terminate staff who perpetrated the

abuse as well as staff aware of the abuse who failed to report it.

As many participants in the current study perceived that employees were

unqualified to address the needs of the youth, residential treatment centers should

carefully evaluate applicants before hiring them. Participants spoke about the need for

employees to have training that would address the specific mental health needs of youth. This is consistent with Polvere's (2011) research conducted with patients in residential treatment who perceived direct care staff as having deficient training in mental health and trauma.

Reflecting the findings from this study and other studies on staff training in residential treatment, the following trainings are suggested: (a) fundamentals in psychology, child and adolescent development, family relationships, and sociology; (b) social skills; (c) ethical issues and group dynamics; (d) trauma and posttraumatic stress; (e) psychopharmacology; (f) crisis prevention and intervention; (g) discipline as an effective alternative to punishment; (h) cultural competence; (i) professionalism; (j) confidentiality; (k) mandated reporting of abuse; and (l) the exploration of power and privilege in the institution and in their roles of authority. Moreover, given many participants' reported histories of trauma exposure, it is suggested that residential treatment centers draw on the research on effective empirically-supported treatments of traumatized youth to implement an integrated approach to care with this population (Briggs et al., 2012; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013).

Participants stressed the significance of staff providing safety, trust, and compassion in the treatment of youth. This emphasis is consistent with research studies demonstrating that the quality of staff-adolescent interactions, having a substantial impact on the structure and successful operation of group care, is the most crucial component in residential treatment (Pazaratz, 2000). Pazaratz (2000) outlined an integrated approach to training youth workers in residential treatment programs to maximize therapeutic effectiveness. In the present study, the negative attitudes staff displayed toward youth had a detrimental impact on participants' wellbeing. Thus, training staff how to engage

adolescents in treatment may facilitate staff members' ability to convey positive

attributes such as respect, empathy and trust, and thus will help to improve the relations

between staff and youth. Furthermore, many participants raised the issue of the age of

staff as it related to their maturity. It is suggested that residential treatment programs with

adolescent populations should include the level of maturity of the applicant when making

hiring decisions. In conclusion, given the findings in the current study, residential

treatment centers should review their hiring, training and treatment practices, as well as

consider developing a system of self-evaluation and accountability.

Implications for parents. Some participants encouraged parents to seek

alternatives to their placement in residential treatment, and many participants expressed

the view that lower levels of care would have been more appropriate for their mental

health needs. This is consistent with the literature. For example, in a study comparing the

outcomes for behaviorally troubled children receiving intensive in-home therapy (IIHT)

versus those receiving residential care (RC), one year post-discharge those who received

IIHT, "had a greater tendency (.615) toward living with family, making progress in

school, not experiencing trouble with the law, and placement stability compared with RC

youth (.558; p< .10)" (Barth, Greeson, Guo, Green, Hurley, & Sisson, 2007, p. 497). In

addition, many participants also reported that their parents were influenced to send them

to the RTC by the use of deceptive marketing practices. This is consistent with warnings

issued by the Federal Trade Commission to parents (Federal Trade Commission, 2008).

Participants indicated a culture of silence and/or suppression regarding the

pervasive levels of maltreatment within the RTC. As there is no publicly available data

tracking abuse within residential treatment programs, parents should be hypervigilant

when assessing the appropriateness of this placement for their children, and are

encouraged to consult the guidelines outlined by the FTC before making a decision.

Furthermore, parents should look at public reviews of the site and interview prior

patients, if possible, as current patients may be reluctant to be candid for fear of

retaliation, a fear stated by some participants in this study.

Participants expressed the view that their stay at the RTC was unnecessarily

protracted, and motivated by concerns other than the youth's mental health, such as the

lucrative nature a long placement represents to the RTC. Thus, parents are advised to

seek facilities that utilize evidence-based treatments (EBTs) and monitor progress. It is

also suggested that local rather than out-of-state centers be selected, as local placements

will more easily allow parents to evaluate the center at different times of the day and

increase parents' ability to be involved in their children's treatment. Furthermore, if their

youth report maltreatment, parents should be wary of facilities that dismiss these

allegations as "manipulation," and refuse to investigate them.

Implications for legislation and policy. Recommendations for policymakers

with regard to private residential treatment centers include: (a) increased regulation,

transparency, and accountability; and (b) devising comprehensive guidelines setting

standards for these facilities. In establishing guidelines for ethical and competent

practice, recognized accrediting behavioral health agencies, such as the Joint Commission

on Accreditation of the Healthcare Organizations (JCAHO), the Council on Accreditation

(COA), or the Commission on Accreditation of Rehabilitation Facilities, may wish to

consider linking accreditation of the residential treatment center to the use of empirically-

proven practices, and requiring ongoing trainings of staff. If obtaining and maintaining a

residential treatment center's license was contingent on establishing training for staff, the

development of a broader, more intensive, and more competent curriculum on helping

youth in need of care would be the likely result, elevating the effectiveness and future

development of residential treatment centers, those pursuing employment in these

establishments, and professionals seeking to further their education and careers in mental

health related fields.

Conclusion

The current study sought to illuminate the unique experiences of high-need youth

experiencing an intensive intervention in a restricted environment, utilizing qualitative

methodology to enhance the richness of the study. The present study remains one of the

few to examine the largely under-regulated and under-researched practices within one

segment of the mental health service sector—out-of-state private residential treatment for

youth and, its facilitator, the youth transportation industry. Furthermore, this study

identified specific characteristics or elements, including structure and services that may

differentiate this particular RTC from other programs, in order to facilitate the

comparison of findings across residential treatment programs. The amount of detail

provided by participants who have undergone this treatment intervention formed the basis

for recommendations and implications for further research, cautions to parents

considering sending their children to these settings, discussions of residential treatment

center practices, and the need for legislation and policy changes so that youth will receive

informed and effective treatment.

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Appendix A: Advertisement

Dear _____,

My name is Christina Ortiz and I am a fourth-year doctoral candidate in the Clinical Psychology program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

I am conducting a study to explore resident experiences of living in a private residential treatment facility for adolescents. Are you an adult who had lived in a private residential treatment center sometime during your adolescence for six-months or longer? If so, please consider participating.

Participants will be interviewed about their experiences living in a private residential treatment facility sometime during their adolescence. Results obtained will be used to increase understanding of the treatment provided to adolescents in private residential treatment facilities and the short-term and long-term impact of those treatments on adolescents in order to help researchers, mental health professionals, and program developers provide a more patient-informed treatment for adolescents in these environments.

If you are interested in participating or learning more about the study, please contact Christina Ortiz by phone at (310) 706-1563, or by e-mail at ctinamarieo@gmail.com for more information. In addition, if you know of any past residents who lived in a private residential treatment facility sometime during their adolescence and might be interested in participating, please consider forwarding this message to them.

Interviews will last approximately 90 minutes and will be conducted in person or via Skype. All interviews will be audiotaped to ensure accuracy in transcription.

Confidentiality of all data obtained is ensured. Participants will not be compensated for this study.

Thank you so much for your time and consideration.

Sincerely,

Christina Ortiz, Psy.M.

Doctoral Student, Clinical Psychology
Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
Piscataway, NJ 08854
(310) 706-1563
ctinamarieo@gmail.com

Appendix B1: Informed Consent Agreement

Study Title: Living in private residential care: Experiences in a private residential

treatment facility for adolescents in the United States.

Invitation to Participate: You are invited to participate in a research study that is

being conducted by Christina Ortiz, B.A., 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 the experiences of adults who

had lived in a private residential treatment facility as an adolescent. In doing so, this will

shed light on the specific needs of adolescents receiving care in these settings in the

hopes of providing a more patient-informed treatment.

Participants: This study will use a network sample of approximately 10-20

adults, aged 18 and older, who had previously lived in a private residential treatment

facility during sometime during their adolescence, between 13 and 17.

Procedure: If you participate in the study, you will be interviewed individually

during a designated time at an agreed upon location. The interview will be audio

recorded. It is expected that the interview will take approximately 90 minutes to

complete. However, the length may vary greatly depending on the depth of the answers

provided. All interviews will take place in-person at a location in New York or New

Jersey or via Skype, mutually agreed upon by you and Christina Ortiz. All in-person

interviews may be conducted in a location that allows for privacy, comfortability, and

convenience for the interviewees. For those interviews taking place via Skype, it is

important to choose a place to talk that is comfortable and private. In the case of

interviews taking place via Skype, the interviewer will be alone, at home or in a secure room in the Psychology Building at Rutgers University.

Risk: The interview focuses on your experiences in a private residential treatment facility and there is a chance that discussing your experience may cause you to get upset. If, in reflecting on your experiences, you experience any discomfort recalling memories or discussing personal matters, it is important that you notify the principle investigator immediately so she may discuss these feelings with you. I will try to prevent this by allowing you to discuss only topics you want to discuss and to take breaks at any time. Furthermore, you will be provided with a list with several referrals to local counseling services in your respective county and state of residence. You may also contact the Psychological Services Clinic at Rutgers University at 1-848-445-6111 to make an appointment or for referrals to further counseling services in your area. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services.

Benefits: Participation in this study may or may not benefit you directly. However, many people find it rewarding to share their stories with a mental health professional who responds with empathy, non-judgment, and compassion. Additionally, when people are given the opportunity to reflect on their past experiences it often leads to better understanding of themselves. Furthermore, the present research will contribute to the literature on youths' experience of living in a residential treatment facility.

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. I will keep your personal information private. I will remove all information that can identify you. I will use a participant code and pseudonym rather than your name on all study records. If you decide you want to be in this study, it means that you agree to let the research team use and share your personal health information for the reasons we have listed in this Consent Form. While I am doing this research I may use only the personal health information that you have given me. Please refrain from providing identifying information. You will not be asked to disclose any confidential information about other residents. Any information that you provide which may be used to identify other residents will be removed from the transcript. Names of people and places will be replaced with pseudonyms.

Data: Hard copies of interview data and audio recordings will be stored in a locked filing cabinet in the principal investigator's home and no one else will have access to the information. However, you may be able to look at or get a copy of the data that you provided at the end of the study. Once the data is transcribed the information will transferred to a password-protected and firewall-protected computer at the principal investigator's home. In addition, you will be given an identification code and a pseudonym and only the researcher will have access to the code key. Information that identifies you will be stored apart from other data to keep your privacy. 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 are presented at a professional conference, your information will be disguised to not have any identifiable information. The findings will be summarized and reported in group form and you will not be identified personally. After the completion of the research, all study documents including

participant identification codes, audio files and other computer files will be kept for three

years, after which time all study data will be destroyed by the researcher.

Voluntary Participation and Withdrawal: Participation in this study is

VOLUNTARY. You may choose not to participate, and YOU MAY WITHDRAW AT

ANY TIME during the study procedures without any penalty to you. You may refuse to

answer any questions with which you are not comfortable.

If you have any questions about the research, you may contact me or my

dissertation faculty chairperson Dr. Nancy Boyd-Franklin at:

Christina Ortiz, B.A.   Nancy Boyd-Franklin, Ph.D.
GSAPP, Rutgers University   Professor, Department of Clinical Psychology
152 Frelinghuysen Road   GSAPP, Rutgers University
Piscataway, NJ, 08854   152 Frelinghuysen Road
Tel: (310) 706-1563   Piscataway, NJ, 08854
Email: ctinamarieo@gmail.com.   Tel: (848) 445-3977
Email: boydfrank@aol.com.

If you have any questions about your rights as a research subject, you may contact

the IRB Administrator at Rutgers University at:

mail to   Institutional Review Board
                                      Rutgers, The State University of New Jersey
                                      Liberty Plaza / Suite 3200
                                      335 George Street, 3rd Floor
                                      New Brunswick, NJ 08901
                                      Email: humansubjects@orsp.rutgers.edu
                                      (732)235-9806

Copy of Consent Form to Subject: I will give you a copy of this consent form to

keep.

I have read and understood the contents 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 B2: Audio Addendum to Consent Form

You have already agreed to participate in a research study entitled: Living in private residential care: Experiences in a private residential treatment facility for adolescents in the United States., conducted by Christina Ortiz, Psy.M. We are asking your permission to allow me to audiotape the interview as part of the research study. This procedure is mandatory; you must agree to be audio recorded in order to participate in the main part of the study.

The recordings will be transcribed to ensure 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 other prior or current residents. Any names of people or places which are disclosed will be replaced with pseudonyms. We will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured 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 audio record you as described above during participation in the above-referenced study.

The investigator will not use the recording(s) for any other reason than that/those stated

in the consent form without your written permission.

Participant (Print) _____

Participant Signature _____   Date _____

Investigator Signature _____   Date _____

Appendix C: Semi-Structured Interview Protocol

<u>**Opening**</u>

Thank you for your time and willingness to talk. This interview is all about your experiences that you had as a teen in a private residential treatment program. The reason I would like to hear about your experience is to try and improve residential treatment programs for future generations of teens and mental health providers. Therefore, the questions I will ask you all deal in some way with your experience at the treatment program. Do you agree to talk about this?

For in-person interviews:

> Please take a look at the consent form I had sent you ahead of time, which I am going to ask you to fill in and sign. It contains details of how the information will be used and who will be able to read it. I will walk you through the form and make sure that you agree with what is on there. If there is anything you do not understand, then please ask me. (Review consent form with participant.) Please take your time to read through the form again and when you're ready, initial each page and sign.

For Skype interviews (research has received signed consent form):

> Thank you again for sending me your signed consent form prior to this interview. Before we get started, do you have any questions regarding how your information will be used and who will be able to read it?

And just to remind you again, you can take a break at any time during the interview, or you can stop the interview at any point without having to explain why, and you can withdraw your information and remarks from the study after the interview if you feel that you'd like to, again without having to explain why. Do you agree with all this?

Do you have any questions before we get started with the interview? Thanks. Well, I wonder if a good place to start would be for you to tell me a little bit of background information about you and your history with residential treatment program(s) as a teen.

Demographics

1. How old are you?

2. What is your gender identity?

3. How do you ethnically and/or racially identity?

Treatment History

1. How old were you when you went into your first residential treatment program?

2. How many residential treatment centers had you lived in prior to (name of treatment program)?

3. How many residential treatment centers have you lived in after (name of treatment program)?

4. How old were you when you were first admitted to (name of treatment program)?

5. What are the approximate dates that you were a resident at (name of treatment program)?

6. How many total months did you stay there?

7. How were you referred to (name of treatment program)?

8. What U.S. state were you living in prior to your admission?

Open-ended "Tell-me-your-story" prompt

"You have had a unique experience to have lived in a private residential treatment program as a teen. *Tell me your story* beginning with how you arrived to (name of treatment program)."

The Treatment Experience

Admission phase

1. What was your experience like arriving to <u>(name of treatment program)?</u>

2. Who brought you?

3. Were you aware that you were going?

4. What was it like when you stepped into the place?

5. How were you first treated by the staff there?

Treatment phase

Milieu

6. What was your experience like living in that type of structured environment?

7. What was your experience of being in a locked facility?

8. Were there any particular experiences that you had at the placement that had a strong impact (negative or positive) on your life during that time? Tell me about what happened.

9. What was your experience like as you moved through the levels/statuses and gained/lost privileges?

10. What was your experience like with the consequences for unapproved behavior? (e.g., infractions, "taking a chair," "dial 9," solitary confinement, enforced silence, restraints, chemical restraint (e.g., Haldol), "investment," "class II/III," etc.)?

11. What treatment practices did you find the most helpful to you?

12. What treatment practices did you find the most harmful to you?

13. What didn't make a difference one way or another?

Involvement in treatment

14. During your time there, what was your experience like with making decisions

regarding your treatment? Including:

- Treatment goals (what to accomplish during your stay)

- Treatment planning (how to achieve those goals)

- Therapy

- Activities

- Education

- Medication

Therapy

15. Tell me about your experience with individual therapy.

a. What was your relationship like with your therapist?

b. Was there anything over the course of therapy that had a strong impact

(positive or negative) on your experience? Tell me about it.

Were there any groups or activities that you participated in that had a strong impact

(positive or negative) on your experience? If yes, what was it about this group or activity

that made it so impactful? For example:

- Group therapy (including specialized groups [e.g. trauma, body image,

self-harm, DBT])

- Family therapy

- Art therapy

- Chemical dependency and substance abuse recovery groups (e.g. AA/NA

groups)

- Skills groups (e.g. anger management)

- Recreational group outings

- Religious affiliated groups

- Recreational or competitive sports

Relationships

16. Tell me about the relationship(s) with the counselors (nonprofessional direct care staff) that had the most impact (positive or negative) on your experience?

17. Any other professional staff that had a strong impact (positive or negative) on your experience? Tell me about that relationship. Consider: psychiatrists, nurses, teachers, case managers, etc.

18. What was your relationship like with the other residents?

19. What was your relationship like with your family/primary caregivers during your stay?

20. What was your relationship like with your home community outside of the facility?

Discharge phase

21. What was your discharge experience like?

Reflections

22. Reflecting back, how do you overall feel about your experience at (name of treatment program)?

23. Did the treatment program help you overcome problems that you had prior to going?

24. If you could, what would you have most liked to change about the treatment program?

25. What aspects of the treatment do you feel may have had the most impact (positive or negative) on your life as an adult?

Advice

26. What would your advice be to a therapist seeing a teen in a residential treatment facility for individual therapy?

27. If you could go back, what advice would you give to your younger self?

Wrap-up Question:

28. Is there anything that we haven't discussed about your experience in the treatment program that you feel is important to talk about?

Summary and closing:

Thank you for sharing your story with me. You shared about your experience arriving to treatment, your most memorable experiences there, the relationships that had the most impact on your stay, your reflections on how your experience may have had an impact on your life as an adult, and your advice for therapists who may become involved in this type of treatment.

How did you find the interview?

Do you agree for your data to be included in my study?