JTSP 2010 Volume IV Number I

JTSP

Journal of Therapeutic Schools & Programs

2010 VOLUME IV NUMBER I

AUTHORS......4-6

ARTICLES

Impact of a Culturally Relevant Residential Treatment Program on Post-discharge Outcomes for Hawai`i Youth, *Jamie N. Burke, Dane Z. Ganes, David T. Mayeda, Michael A. Gass*......7-23

Exploring the Process of a Therapeutic Wilderness Experience: Key Components in the Treatment of Adolescent Depression and Psychosocial Development *Christine Lynn Norton, PhD, LCSW*......24-46

Experiential Therapy in the Mental Health Treatment of Adolescents *Keith C. Russell, Ph.D., H. L. Gillis, Ph.D.*......47-79

Preliminary Data from the NATSAP Research and Evaluation Network: Client Characteristics at Admission, *Michael C. Young, M. Ed., Michael Gass, Ph.D*......80-105

The Evidence Base for Private Therapeutic Schools, Residential Programs, and Wilderness Therapy Program, *Ellen Behrens, Ph. D., John Santa, Ph. D., Michael Gass, Ph. D.*......106-117

Positive Youth Development: What It Is and How It Fits in Therapeutic Settings *Mat D. Duerden, Mark A. Widmer, Peter A.Witt*......118-133

Developing a Therapeutic Community for Students with Emotional Disturbance: Guidelines for Practice *Kevin A. Curtin, PhD, LCPC*...... 134-146

JTSP Order Form......147

NATSAP Directory Order Form......148

Permissions and Copyright Information for Potential Authors......149

Instructions for Authors......150

NATSAP Ethical Principles......151

JTSP
Journal of Therapeutic Schools & Programs

A Publication of the National Association of Therapeutic Schools and Programs

EDITOR
Dr. Michael Gass, Ph.D., LMFT
Professor
School of Health & Human Services
University of New Hampshire
Durham, NH

ASSOCIATE EDITOR
Dr. Keith Russell, Ph.D.
Associate Professor
Western Washington University
Bellingham, Washington

EDITORIAL ASSISTANTS
Jamie Burke, University of New Hampshire, Durham, NH
Ryan Zelov, University of New Hampshire, Durham, NH

EDITORIAL ADVISORY BOARD

Dr. Jared Balmer, Ph.D
Executive Director
Island View Center for Adolescents
Syracuse, Utah

Dr. Michael Berrett, Ph. D.
Executive Director
Center for Change
Orem, Utah

Dr. Michael Berrett, Ph.D.
Executive Director
Center for Change
Orem, Utah

Dr. Robert Cooley, Ph. D.
Executive Director
Catherine Freer Wilderness Therapy
Expeditions Salem, Oregon

Dr. Lee. Gillis, Ph.D.
Chair & Professor
Department of Psychology
Georgia College & State University
Milledgeville, Georgia

Dr. John McKinnon, M. D.
Clinical Director
Montana Academy
Marion, Montana

Dr. John Santa, Ph. D.
Clinical Director
Montana Academy
Marion, Montana

Michael Young
Extension Educator
4-H Youth Development
Brentwood, NH

JTSP PRODUCTION STAFF

Director of Publications
Clifford M. Brownstein
Executive Director, NATSAP
Bethesda, Maryland

Senior Editorial Specialist
Maria Maslennikov
Administrative Assistant, NATSAP
Bethesda, Maryland

JOURNAL OF THERAPEUTIC SCHOOLS AND PROGRAMS (JTSP) is published two times a year by the National Association of Therapeutic Schools and Programs to provide a forum for the exchange of information and opinion on theory, research, and practice in providing comprehensive care for adolescents, young adults, and for families receiving services from member programs. All rights reserved.

PERMISSION TO QUOTE, REPRINT, PHOTOCOPY It is the policy of NATSAP and the Editorial Board of JTSP that abstracts published with journal articles are indicative of, and not a substitute for, the work as a whole; therefore, access services are allowed free use of these abstracts without securing the permission of the JTSP. Enquiries about policy and procedures relating to permission to reproduce material published in the journal should be directed to: Dr. Michael Gass, Editor, JTSP, NH Hall, 124 Main Street, University of New Hampshire, Durham, NH 03824, (603) 862-2024, mgass@unh.edu

MANUSCRIPTS The Journal of Therapeutic Schools and Programs (JTSP) publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from member programs. The editors welcome manuscripts that are the original work of the author(s) and follow the style of APA as presented in the fifth edition of Publication Manual of the American Psychological Association. Manuscripts and related correspondence should be sent to Dr. Michael Gass, Editor, JTSP, NH Hall, 124 Main Street, University of New Hampshire, Durham, NH 03824, mgass@unh.edu. Send six copies of the submission.

ABOUT THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS The National Association of Therapeutic Schools and Programs is a non-profit member organization of schools and programs from around the country and was formed to serve as a national resource for its members. Through a dynamic process, the National Association of Therapeutic Schools and Programs develops and advocates ethical and practice standards designed to protect consumers while improving the effectiveness of programming within member programs.

MEMBERSHIP Schools and Programs interested in membership the National Association of Therapeutic Schools and Programs are referred to their website, www.natsap.org or the Executive Director at (301) 986-8770.

National Association of Therapeutic Schools and Programs
Headquarters Office: 5272 River Road, Ste 600
Bethesda, MD 20816
Telephone: (301) 986-8770 • Fax: (301) 986-8772
info@natsap.org • www.natsap.org

NATSAP
BOARD OF DIRECTORS 2010

Craig LaMont
President
Telos Residential Treatment

James Meyer
Treasurer
Oakley School

Glen Zaugg
Heritage Schools

Mike Merchant
ANASAZI Foundation

Sami Butler
Intermountain

Dane Kane
RedCliff Ascent

Rick Johnson
Summit Preparatory School

Gil Hallows
Aspen Achievement Academy

Sid Parham
Family Foundation School

Brad Reedy
Second Nature

Craig Rodabough
CERTS

Angie Senic
Eckerd Division of Private Academies

John Stewart
New Haven

Sharon Laney
Ex-Officio
Three Springs, Inc.

Anne Thompson
Ex-Officio
Educational Consultant

JTSP
Journal of Therapeutic Schools & Programs

A Publication of the National Association of Therapeutic Schools and Programs

TABLE OF CONTENTS

AUTHORS...4-6

ARTICLES

Impact of a Culturally Relevant Residential Treatment Program on Post-Discharge Outcomes for Hawai`i Youth
Jamie N. Burke, Dane Z. Ganes, David T. Mayeda, Michael A. Gass...................7-23

Exploring the Process of a Therapeutic Wilderness Experience: Key Components in the Treatment of Adolescent Depression and Psychosocial Development
Christine Lynn Norton, PhD, LCSW...24-46

Experiential Therapy in the Mental Health Treatment of Adolescents
Keith C. Russell, Ph.D., H. L. Gillis, Ph.D...47-79

Preliminary Data from the NATSAP Research and Evaluation Network: Client Characteristics at Admission
Michael C. Young, M. Ed., Michael Gass, Ph. D....80-105

The Evidence Base for Private Therapeutic Schools, Residential Programs, and Wilderness Therapy Programs
Ellen Behrens, Ph. D., John Santa, Ph. D., Michael Gass, Ph. D...................106-117

Positive Youth Development: What It Is and How It Fits in Therapeutic Settings
Mat D. Duerden, Mark A. Widmer, Peter A. Witt...118-133

Developing a Therapeutic Community for Students with Emotional Disturbance: Guidelines for Practice
Kevin A. Curtin, PhD, LCPC....134-146

Subscribe to JTSP..147

NATSAP Directory Order Form...148

Permissions and Copyright Information for Potential Authors........................149

Instructions for Authors...150

NATSAP Ethical Principles...151

AUTHORS - JTSP Volume IV, Issue I

Ellen Behrens, Ph.D., a principal investigator for the study presented in Longitudinal Family And Academic Outcomes in Residential Programs, a Utah licensed psychologist. She received her Ph.D. from Michigan State University in 1998, with a major in psychology and a minor in statistics and research design. She has worked with teenagers and families as a therapist, psychologist, clinical director and consultant in residential programs. She is the owner of Canyon Research and Consulting, a company that provides program development, outcome research, and clinical training for mental health programs and providers.

Jamie Burke, M.Ed., ATC, CSCS is a doctoral student in Outdoor Education at the University of New Hampshire. She has extensive experience working with outdoor programming, program evaluation, and statistical analysis.

Kevin A. Curtin is an Assistant Professor of Counseling at Alfred University and the former Clinical Director of The Frost School, a non-public, special education day school in Rockville, MD that serves students with emotional disturbance.

Mat D. Duerden is the Project Coordinator of the Youth Development Initiative (www.ydi.tamu.edu) at Texas A&M University. He received a Ph.D. in Recreation, Park, and Tourism Sciences from Texas A&M University and a MS in Youth and Family Recreation from Brigham Young University. His research focuses on youth development with specific interests in program evaluations, outdoor recreation, and youth/adult relationships.

Dane Ganes, M.A., is the Quality Assurances Director for the Marimed Foundation, whose responsibilities include maintaining the follow-up system used to track youth progress once they leave Kailana. He is a sociologist with a focus on social statistics.

Michael A. Gass, PhD, is a Professor of Outdoor Education at the University of New Hampshire. He is one of the co-founders of the Browne Center for Innovative Learning and is the Editor of the Journal of Therapeutic Schools and Programs.

H. L. Gillis, Ph.D, is chair of the Department of Psychological Science at Georgia College & State University in Milledgeville Georgia. He is also a Licensed Psychologist (#1335 GA) and has researched, evaluated, and practiced in the field of adventure therapy within residential treatment settings since the late 1970s. He can be reached at lee.gillis@gcsu.edu and at leegillis.com/AT.

David Mayeda, PhD, is the Juvenile Justice Research Analyst for the State of Hawai`i's, Department of the Attorney General, Crime Prevention & Justice Assistance Division.

Christine Lynn Norton, PhD, LCSW, Assistant Professor of Social Work at Texas State University-San Marcos, received her PhD in Social Work from Loyola University Chicago. She has a Master of Arts in Social Service Administration from the University of Chicago and a Master of Science in Experiential Education from Minnesota State University-Mankato. Dr. Norton has over 15 years experience working with adolescents in a variety of practice settings including therapeutic wilderness programs, juvenile justice, youth and family counseling, schools, and youth mentoring and educational empowerment programs.

Keith C. Russell, Ph.D., is an Associate Professor in Recreation at Western Washington University, Bellingham, WA, USA. He is also the Director of the Outdoor Behavioral Healthcare Research Cooperative (OBHRC). His research emphasis includes program evaluation, the study of human-nature relationships, the therapeutic benefits of natural environments, and international protected area management. He teaches courses in statistics, research methods, adventure education and therapy, and human relations. He has been a wilderness educator for more than twenty years in the US, Mexico, Costa Rica, and New Zealand.

John Santa, Ph.D., is a co-owner/CEO of Montana Academy. He is the Past President of the National Association of Therapeutic Schools and Programs (NATSAP) and served as a Founding member of their Board of Directors. Dr. Santa received a B.A. in psychology from Whitman College, followed by a masters and PhD in psychology from Purdue University. He has undertaken postdoctoral studies at Stanford University, the University of Montana, and the University of California San Diego Medical Center. Dr. Santa was a tenured faculty member in the department of psychology at Rutgers University and has published numerous articles in areas of psychology and education. He is also a licensed clinical psychologist.

Michael C. Young, M.Ed., has worked in the field of experiential education and counseling for over 15 years. Currently he works as an Extension Educator in youth Development for UNH Cooperative Extension. As a researcher and PhD candidate at UNH, Mike has focused on educational program evaluation and improvement by helping to develop the web-based NATSAP practice research network; facilitating and analyzing the use of Appreciative Inquiry; and convening the international 2007 Adventure Therapy Best Practices Conference.

Mark A. Widmer is a Professor of Therapeutic Recreation at Brigham Young University. He teaches assessment and theory based programming, research and evaluation, and mountain biking. His research focuses on examining the effectiveness of using theory based challenge and adventure programs to promote specific therapeutic outcomes.

Peter A. Witt is Professor and holder of the Bradberry Recreation and Youth Development Chair at Texas A&M University. His academic interests include evaluation of after-school programs, youth development, and impact of camp experiences. He has been at A&M since 1993. He is a former department head at Texas A&M and Graduate Dean and Associate Vice President for Research at the University of North Texas. Dr. Witt received his PhD from the University of Illinois.

Impact of a Culturally Relevant Residential Treatment Program on Post-Discharge Outcomes for Hawai`i Youth

Jamie N. Burke
University of New Hampshire

Dane Z. Ganes
Marimed Foundation

David T. Mayeda
State of Hawai`i, Juvenile Justice Information System

Michael A. Gass
University of New Hampshire

This research was funded by grant number 20081302 from the Hawai`i Community Foundation. We would like to acknowledge the State of Hawai`i Attorney General's Office and the Juvenile Justice Information Committee for their support and collaboration on this project.

Abstract

Drug abuse among adolescents, particularly among Native Hawaiian youth, is a serious concern on the Hawaiian Islands. Native Hawaiians possess the highest incidence of drug abuse and lowest success rates with traditional treatment programs. Some evidence suggests that culturally relevant treatment programs can be more effective for this population, but such evidence is limited. This study looked at the behavioral impact of a drug treatment program in Hawai`i using a culturally relevant model. Youth who were clinically discharged from the Marimed Foundation's Kailana Model for Residential Treatment were compared to those youth who were non-clinically discharged. With no significant pre-treatment differences between the two groups, results of a follow-up 12-months post-discharge found significant improvement in arrest rates, number of days until re-arrest, and number of total arrests. While these are only the results for one specific culturally relevant treatment program, it does offer the foundation for further investigation into this type of treatment model.

Impact of a Culturally Relevant Treatment Program

Long-term, untreated drug abuse for adolescents has been associated with a host of adverse physical, mental, and social consequences including greater involvement with the juvenile justice system, increased mental health problems, lower educational achievement, and increased risk of adult substance abuse patterns (Chatterji, 1998; D'Amico, Edelen, Miles, & Morral, 2008). According to the Substance Abuse and Mental Health Services Administration (2009), the average percentage of adolescents ages 12 to 17 who regularly use illicit drugs is 9.3%. This percentage is slightly misleading when one considers the rate steadily increases from 3.3% in youth ages 12 to 13 up to 21.5% at age 18. In addition, the earlier the age of onset of drug abuse and the longer history of this use are highly correlated to adult substance abuse and mental health concerns (SAMHSA, 2009).

Recent studies have shown Native Hawaiian youth make up the majority of adolescents requiring substance abuse treatment in the State of Hawai`i, possess the highest substance abuse rates in the state, and record the least effective results of treatment outcomes with traditional treatment approaches (Nishimura, Goebert, Ramisetty-Mikler, & Caetano, 2005; Nishimura, Hishinuma, Else, Goebert, & Andrade, 2005). From 2000 to 2006, the number of juveniles entering substance abuse treatment facilities in the State of Hawai`i increased by 41.1%. Of those juveniles entering treatment, the majority (52%) were Native Hawaiian and Pacific Islander (Nahar, et al., 2008).

The most frequently abused illicit drug by juveniles in Hawai`i is marijuana, with methamphetamines being the most abused substance by adults age 18 to 49 (Nahar et al., 2008). This trend toward increasing drug severity with age is particularly disturbing because treatment programs for methamphetamine users tend to possess much less favorable treatment outcomes than other substances (Rawson, Gonzales, Obert, McCann, & Brethen, 2005). Instances such as this illustrate why it is critical to address substance abuse issues as early as possible.

These research findings, combined with both state and national trends in drug abuse as well as the overwhelming health consequences of untreated substance abuse, underscore the critical need for increased knowledge about the types of substance abuse treatment that work best

for Native Hawai`i youth. While many studies have been done on both adult and adolescent residential treatment programs (Godley, Godley, Dennis, Funk, & Passetti, 2002; Morral, McCaffrey, & Ridgeway, 2004; Williams, 2000), very few have focused on programs targeting this specific population.

Several researchers have emphasized the need for culturally sensitive and culturally relevant treatment when working with at-risk, minority populations, particularly youth (Carter, Straits, & Hall, 2007; Paz, 2002; Perez-Arce, Carr, & Sorensen, 1993; Tharp, 1991). Although the term “culturally relevant” has frequently appeared in the literature, particularly in regards to substance abuse treatment programs, the term has not been adequately defined or operationalized. For the purpose of this article, “culturally relevant treatment” refers to a treatment approach utilizing activities, experiences, ways of viewing the world and interacting with others, and norms that are infused with the unique values (e.g. historical, social) of the local community (Dumas, Rollock, Prinz, Hops, & Blechman, 1999). The few studies focusing on drug abuse treatment for Native Hawaiians and Pacific Islanders have found cultural sensitivity to be a critical piece in program effectiveness (Kim & Jackson, 2009; Morelli, Fong, & Oliveira, 2001).

Morelli et al (2001) explored the impact of a culturally relevant treatment milieu when working with pregnant and post-partum women. Women involved in the program were interviewed about their treatment. A consistent theme regarding to their continued participation was the importance of cultural competent practitioners and cultural healing practices. Since this study only looked at an adult female population, there are limitations to the generalizability of the study to youth. In addition, it did not provide information about long-term outcomes for the women.

One evaluation study looking at outcomes specifically for Hawai`i youth in a culturally relevant treatment program was conducted by Kim and Jackson (2009) using the Global Appraisal of Individual Needs (G.A.I.N) instrument. Testing with the G.A.I.N., which is a nationally normed survey validated through use with over 12,000 individuals (LighthouseInstitute, 2002), was done at in-take and then at 3-, 6-, and 12-months post-intake for youth involved in the Marimed Foundation’s Kailana Model of Community Based Residential Treatment. The researchers found statistically significant

differences from intake to 3-, 6-, and 12- months for a number of constructs, including self-reported legal involvement, drug abuse, and mental health problems. This study showed the promise of this culturally relevant model for working with Hawai`i youth, but the lack of a control group limited the degree to which the positive changes could be attributed to the treatment. Similarly, the self-report G.A.I.N. did not provide information about concrete behavioral changes for youth completing the program.

Based on these limitations, the present study was designed to evaluate the impact of the Marimed Foundation's Kailana Model on concrete behavioral outcomes for youth who successfully complete the program as compared to those that did not. It is often difficult to measure concrete behavioral change in terms of drug use and abuse without physically testing for substance use. A recent report by the Substance Abuse and Mental Health Services Administration (2005) found that criminal activity and substance abuse are associated with each other and tend to have co-occurring patterns making it possible to use changes in criminal involvement as a surrogate marker to measure changes in substance abuse patterns. Therefore, through the use of a comparison group and by accounting for several covariates, the present study showed the direct link between successful completion of a culturally relevant treatment and positive post-treatment behavioral outcomes, including re-arrest status and time to re-arrest.

Methods

Program

The Kailana (English translation: "calm seas") Community Based Residential Treatment Program is a highly-structured, staff-secure, residential program for high risk Hawai`i adolescents needing comprehensive treatment and education, including mental health services. Kailana, combines individual, group, and family therapy with educational and vocational services, as well as ocean and land-based therapeutic and recreational activities including sailing and ocean voyaging on Makani Olu (Marimed's sail training vessel), canoe paddling, agriculture, and aquaculture. Kailana is unique in its ocean-based, experiential approach to serve youth with moderate to severe emotional and behavioral problems. In particular, the program serves males ages 14 through 18 requiring an experience more

structured and restrictive than school or home-based services, but not needing hospitalization or incarceration. The program specializes in adolescent males with conduct disorders and dual diagnosis with chemical dependency.

The program incorporates the core values of CHART (Community, Honesty, Aloha, Respect and Teamwork) and is designed to value the historical and cultural aspects of the Hawai`i and Pacific Island people. With this value in mind, the model integrates traditional and modern uses and stewardship of natural resources (ocean and land) as key elements in the healing process. The significant impact of the program is the relationship between what is done in treatment, where it is done, and how it is done. For example, when service learning projects are done in a culturally relevant way and experientially loaded with metaphor and meaning making – they are more profound and therefore therapeutic to the youth.

Subjects

Subjects included in this study were all the youth treated through the use of the Marimed Foundation's Kailana Model of Community Based Residential Treatment during the period from March 2003 through August 2007. Of the 198 youth receiving treatment during that timeframe, only those under the age of 18 at the end of one year of follow-up were included in this study (n=139). This decision was made to insure the records being used to assess behavioral outcomes were complete and could be accessed through the State's juvenile record system without any of the youth being lost to the adult system. The State of Hawai`i maintains a database of information on all juveniles involved in the justice system that is updated every 30 minutes and includes information from the police departments, courts, and parole and probation officers across the state. It was through a data-sharing agreement with this Juvenile Justice Information Committee that data on all youth were compiled.

The youth in the study were classified as either "Clinically Discharged" (n=47) or "Non-clinically Discharged" (n=92). When youth first enter the program, they meet with their new Clinical Treatment Team and a Treatment Plan is designed for the course of their time at Kailana. A youth is classified as 'Clinically Discharged' when he meets 85% of his treatment plan goals. Because the program is not conducted at a locked facility, there are instances when the youth

leave for a variety of reasons. While in many cases the youth return after a few days and complete their treatment, there are other cases where they never meet their treatment plan goals. When this occurs, these youth are then classified as “non-clinically discharged.”

Measures

A list of all Marimed youth involved in treatment for the specified timeframe was generated. This dataset included discharge status, the number of days spent in treatment, age at intake, and age at discharge. This list was then presented to the Juvenile Justice Information Committee to use for data extraction. This Committee collected information on: (a) ethnicity, (b) age of first arrest, (c) total number of arrests prior to treatment, (d) most serious offense prior to treatment, (e) whether the youth was re-arrested in the 12 months following discharge, (f) the total number of arrests following discharge where applicable, and (g) the most serious offense committed following discharge where applicable. The most serious offense for each youth was then classified as a violent crime, a sex crime, a property crime, a minor offense, or a status offense.

Analysis

Many of the variables collected were used to insure the groups were adequately matched prior to examining the 12-month follow-up data. An independent samples t-test was used to compare clinically and non-clinically discharged youth to determine if there were pre-existing differences between the groups for age at first contact with the law, age at intake, age at discharge, number of days spent in treatment, and number of arrests prior to treatment. In addition, Chi-square analyses were conducted to determine if there were differences in ethnicity between the two groups and if there were differences in the types of offenses being committed by the two groups.

A Chi-square analysis was conducted on re-arrest data at 12-months following discharge for both sets of youth. An ANCOVA was then used to compare if there were differences in the number of days between discharge and re-arrest, with number of days spent in treatment serving as the covariate. A Kaplan-Meier survival function curve was also used to estimate and graph true differences in the probability of re-arrest based on discharge status. The outcome of the survival function was considered to be the time spent in the community

until either re-arrest or end of the 12-month follow-up period.

Results

Pre-Treatment Demographics

Table 1. Comparison of Baseline characteristics: Clinically (n=47) and Non-Clinically (n=92) Discharged youth

	Clinical	Non-Clinical	Statistic
Age			
Intake	15.60	15.62	t=-.201
Discharge	16.24	15.88	t=2.886**
Day in Program	231.1	90.6	t=9.268***
Ethnicity			χ2=5.120
Hawaiian/Pac Islander	63.0%	71.7%	
Caucasian	17.4%	12.0%	
Black	6.5%	1.1%	
Asian	4.3%	8.7%	
Other	8.7%	6.5%	
Arrest Information			
Age First Contact	12.49	12.52	t=-.092
# Pre-Treatment Arrests	11.0	11.65	t=-.410

*p<.05
**p<.01
*** p<.001

Table 1 presents the baseline characteristics for clinically and non-clinically discharged youth for age at intake, age at discharge, days spent in treatment, ethnicity, number of arrests before treatment, and age at first contact with the law. There were no significant differences between youth who were clinically discharged and youth who were non-clinically discharged in terms of age at intake, age of first contact with the law, and total number of arrests prior to intake. In addition, there were no significant differences in the ethnic breakdown of the two groups.

Table 2 highlights information about the most serious offenses for the clinically and non-clinically discharged youth. The overall Chi-square was not significant, χ^2 (5, N=129) =3.031, p=.695, indicating there were no significant differences in the types of offenses.

Table 2. Most serious offense prior to treatment for Clinically versus Non-Clinically discharged youth

	Clinical	Non-Clinical	Total
Violent Crime	41.5%	31.8%	34.9%
Sex Crime	2.4%	9.1%	7.0%
Property Crime	41.5%	39.8%	40.3%
Drug/Alcohol Crime	7.3%	11.4%	10.1%
Minor Offense	2.4%	2.3%	2.3%
Status Offense	4.9%	5.7%	5.4%

$\chi 2=3.031$
p=.695

Note there were significant differences in the average number of days spent in treatment when the clinically discharged group was compared to the non-clinically discharged group (t=9.268, p<.001). These differences in the days spent in treatment accounts for the significant differences noted in age at discharge for the two groups (t=2.886, p=.005).

12-Month Follow-Up Outcomes

Youth who were clinically discharged from the Marimed Foundation's Kailana Model for Community Based Residential Treatment experienced significantly lower rates of re-arrest than those youth who were non-clinically discharged. There also were significant differences in the number of days until re-arrest for the clinically discharged youth compared to the non-clinically discharged youth. This difference was maintained even when the amount of time spent in treatment was included as a covariate.

There were significant differences in the total number of juvenile arrests following discharge for those youth who were clinically discharged (4.2 arrests) compared to non-clinically discharged (6.8) (t=-2.630, p=.01). Given there were significant differences in the age at discharge for these two groups (see Table 1) one could argue this difference could potentially be accounted for by the fact that youth who were clinically discharged had less time at-risk of re-arrest out in the community and therefore would have fewer arrests. Thus, it was important to compare these two groups across a consistent time-frame. Therefore, all subsequent results were based on a 12-month follow-up for each youth.

Statistically significant differences in re-arrest were found between the clinically discharged and non-clinically discharged youth

at 12-months ($\chi 2$ (1, N=139) =16.46, p<.001) (See Table 3). Using standardized residuals as a method of post hoc analysis for Chi-square tests revealed positive differences for not being re-arrested for clinically discharged youth (Standardized Residual = 2.9) and negative differences for non-clinically discharged youth (Standardized Residual = -2.1). All of the residuals greater than 1.96 or less than -1.96 were considered statistically significant at the alpha level of .05 or less. This indicated clinically discharged youth were re-arrested less than would be expected, and non-clinically discharged youth were re-arrested more than would be expected. A Cohen's d effect size of d=.733 was calculated using the Effect Size Determination Program (Wilson, 2001). This is a medium to large effect size (McMillan, Lawson, Lewis, & Snyder, 2002).

Table 3. Behavioral outcomes for youth who were clinically discharged as compared to non-clinically discharged following 1-year follow-up

		Clinical	Non-Clinical	Statistic
Within 12-months				$\chi 2$=16.46***
Rearrested	n	28	82	
	%	59%	89%	
Not Rearrested	n	19	10	
	%	41%	11%	
Days to Re-arrest		234	81	t=4.042***
Days to Re-arrest -adjusted for days in program		258	70	
Number of Total Arrests		4.1	6.7	t=-2.63*

*p<.05
** p<.010
***p<.001

In addition to significant differences in re-arrest rates between clinically and non-clinically discharged groups, there were significant differences in the amount of time between discharge until re-arrest (t=4.042, p<.001). Table 3 shows those youth who were clinically discharged were re-arrested almost four times later than those youth who were non-clinically discharged (234 days compared to 81 days). That represents a mean difference of 153 days with a 95% Confidence Interval [76.8, 230.0]. Effect sizes was computed using the Effect Size Determination Program (Wilson, 2001). Cohen's d calculated for the number of days to re-arrest based on discharge status was d=.81, which is considered a large effect (McMillan, et al., 2002).

As seen in Table 1, there were significant differences in the number of days spent in treatment for the clinically discharged youth compared to non-clinically discharged youth. Given earlier research has shown that the number of days spent in treatment can impact outcomes regardless of discharge status (De Leon, 1973), it was necessary to assess the number of days after discharge before re-arrest controlling for this covariate. The resulting ANCOVA showed when the number of days spent in treatment were controlled for, there was still a significant impact of the youth's discharge status on the number of days spent without re-arrest ($F(1,116)=24.324$, $p<.001$, partial $\eta^2=.173$). This means the youths' discharge status accounted for 17.3% of the difference in the number of days between discharge and re-arrest. The adjusted means for number of days elapsed without re-arrest when controlling for days spent in treatment, was 258 days for clinically discharged youth and 70 days for non-clinically discharged youth. Calculations of effect size using the Effect Size Determination Program (Wilson, 2001) produced Cohen's d=.984, which is associated with a large effect size (McMillan, et al., 2002).

Table 4 displays the case summary, means, and standard error for the Kaplan-Meier survival function curve used to estimate the differences in the probability of re-arrest based on discharge status. Risk of re-arrest as determined by the survival function is significantly different based on discharge status (log rank $\chi^2=2.06$, df=1, $p<.001$). The graph of the survival function is shown in Figure 1.

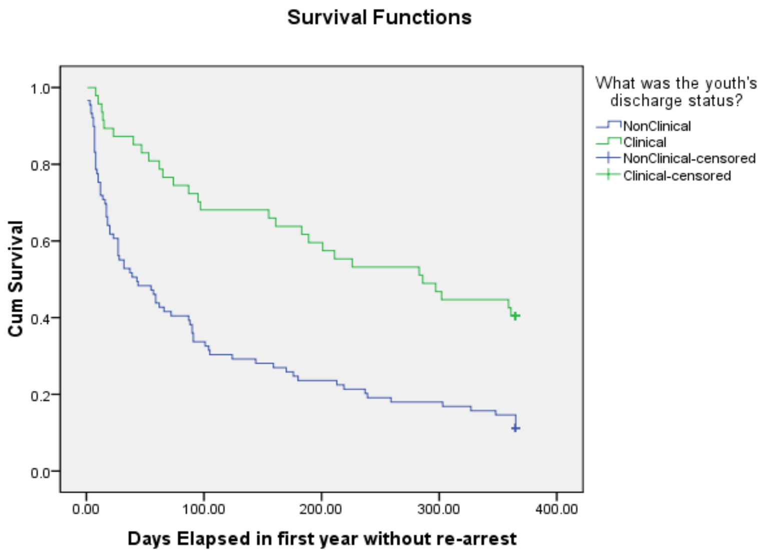
Table 4. Means and Standard Error for Survival Time

Discharge Status	Total N	n of events	Censored	
			N	Percent
Clinical	47	28	19	40.4%
Non-Clinical	89	79	10	11.2%
Overall	136	107	29	21.3%

Discharge Status	Estimate	Std. Error	95%Confidence Interval	
			Lower Bound	Upper Bound
Mean*				
Clinical	230.9	20.5	190.7	271.1
Non-Clinical	110.5	13.9	83.2	137.8
Overall	152.1	12.6	127.5	176.7

*Estimation is limited to the largest survival time if it is censored

Figure 1. Survival curves for Clinical versus NonClinical Discharges for re-arrest within the first year following discharge.



Discussion

Given the ineffectual outcomes experienced by Native Hawaiian youth in traditional treatment programs, it is important to identify other possible options for effective treatment for this population. Due to the limited number of adolescent drug treatment programs in Hawai`i, let alone culturally relevant drug treatment, few prior studies have examined the impact and effectiveness of culturally relevant treatment programs for working with Native Hawaiian youth. Native Hawaiian or Pacific Islanders represent 65% of the treatment population at the Marimed Foundation. Because of this, Marimed utilizes a culturally relevant treatment model. The results of this study suggest youth who are clinically discharged from the Marimed Foundation's Kailana Model have better outcomes than those youth who are not clinically discharged. As one of the first evaluation studies to look at youth outcomes in a culturally relevant program that includes a matched comparison group, it provides some evidence to the effectiveness of such programs designed specifically for working with Native Hawaiians and Pacific Islanders.

One year follow-up outcomes were compared for youth who

were clinically discharged from the Marimed Foundation's Kailana Model of Community Based Residential Treatment versus youth who were not clinically discharged. Fewer of the clinically discharged youth (59%) were rearrested in the first year following discharge than the non-clinically discharged youth (89%). This means four times as many clinically discharged youth were not rearrested after discharge as compared to non-clinically discharged. While 59% may still seem like a high re-arrest rate, the clinical and practical significance of having 30% fewer youth re-arrested in a year can not be emphasized enough.

In addition, for those youth who were re-arrested, the average number of days elapsing prior to their post-discharge arrest was significantly greater for the clinically discharged youth when compared to the non-clinically discharged youth (i.e., 234 days versus 81 days). In fact, when controlling for the number of days spent in treatment, this difference became even greater at 258 days compared to 70 days. This mean difference of 188 days translates into over six months longer without being involved in the legal system for the clinically discharged youth.

The clinically discharged and non-clinically discharged youth were well matched in this study. There were not significant differences on most pre-treatment demographics, including age at intake, age at first contact with the law, types of crimes committed, and ethnic background. This matching is an important component of the study design because many of these factors have been linked with differential outcomes. For example, age at which youth are first involved with the legal system has been associated with greater subsequent involvement in the legal system (Huizinga & Henry, 2008). Similarly, age at which treatment begins and more violent arrests have also been associated with greater risk (Barrett, Katsiyannis, & Zhang, 2006). Without this type of matching, there would be a great deal of uncertainty about whether any of the observed differences in outcomes were attributable to the treatment rather than to systematic differences between the youth.

There were two differences between the two groups as a result of treatment that should be addressed – the number of days spent in treatment and the age at discharge. The number of days spent in treatment was different for those youth who were clinically discharged. Given that earlier research has suggested a potential

dosage response to treatment (De Leon, 1973) it was possible the differences in treatment outcomes were a function of the number of days spent in treatment as opposed to the clinical discharge diagnosis. To address this, the analysis controlled for the number of days which were spent in treatment and found that there was still a significant impact of the youth's discharge status on the number of days to re-arrest. Thus, even if a youth was in treatment for shorter period of time, if he was clinically discharged, he would, on average, have better outcomes than someone who received more treatment time but was not clinically discharged.

Another difference between the groups was the age at discharge. This is a direct function of the fact that the two groups were the same age at intake but had different lengths of time in treatment. While there is some chance that the differences in outcomes between the two groups could be attributed to the four months difference in age between the two groups, this is unlikely given that the number of days in treatment, which is the cause of the age difference, did not have a significant impact on the outcomes.

There were several limitations to this study that should be noted. Even with the level of matching achieved, there is the possibility that the non-clinically discharged youth differed from the clinically discharged youth in some important and unobserved ways. One potential difference could be the drug of choice for the youth. Some early work has shown that individuals who are addicted to methamphetamines typically have poorer treatment outcomes than those who are addicted to marijuana or alcohol (Rawson, et al., 2005). Therefore, it is possible that those youth that were clinically discharged were all those youth who did not use methamphetamines while those that were non-clinically discharged did. A 2006 study found that less than 5% of the admissions for drug treatment in the State of Hawai`i for youth under 17 years of age were for methamphetamine use (Nahar, et al., 2008). Thus, the likelihood that all 92 non-clinically discharged youth, or 66%, were primarily methamphetamine users is not very likely, but it is possible. Therefore, it is important for further exploration into whether there are differential outcomes for youth who abuse methamphetamines as compared to other illicit drugs when assessing culturally relevant treatment programs.

Another limitation of this study is the comparison group for this study did not consist of untreated youth, but instead were youth who

received varying amounts of Marimed treatment. Therefore, it is not possible to comment on the absolute treatment effect of the Marimed Kailana model, but only on the apparent effect relative to that of the non-clinically discharged group. In order to determine the absolute treatment effect, it would be necessary to compare the clinically discharged youth to a similarly matched group who were placed by the juvenile justice system into the Hawai`i Youth Correctional Facility, which is generally not considered a treatment facility.

Future investigators that are trying to determine the impact of culturally relevant treatment should explore many of the issues that were previously articulated. Is there a differential impact on outcomes based on the type of drug abused? How do youth who do not receive any treatment fare compared to those that receive culturally relevant treatment? In addition, future research should strive to identify the components of the Marimed model, and culturally relevant models in general, that are critical to treatment. Follow-up studies with both the Marimed program and other treatment programs, both those that are culturally relevant and those that are not, should be undertaken in order to further understand the impact of programs on youth in the Hawaiian Islands.

While these results are promising with regard to establishing the positive impacts of culturally relevant drug treatment programs, it is critical to remember these are results for only one program and cannot be generalized to all culturally relevant treatment programs in Hawai`i. Marimed is only one program in a state with limited drug treatment options for youth, particularly Native Hawaiian youth, therefore, it is important to continue to work to identify, develop, and refine effective treatment models for this population.

References

Barrett, D. E., Katsiyannis, A., & Zhang, D. (2006). Predictors of offense severity, prosecution, incarceration and repeat violations for adolescent male and female offenders. *Journal of Child and Family Studies*, 15(6), 709-719.

Carter, S., Straits, K. J. E., & Hall, M. (2007). Project Venture: Evaluation of an experiential, culturally based approach to substance abuse prevention with American Indian youth. *Journal of Experiential Education*, 29(3), 397-400.

Chatterji, P. (1998). The effects of adolescent substance use on educational attainment, adult substance use, and the adult wage rate. Dissertation, The Johns Hopkins University, Baltimore, MD. Retrieved from http://proquest.umi.com/pqdweb?did=738027491&Fmt=7&clientId=22941&RQT=309&VName=PQD

D'Amico, E. J., Edelen, M. O., Miles, J. N. V., & Morral, A. R. (2008). The longitudinal association between substance use and delinquency among high-risk youth. *Drug And Alcohol Dependence*, 93(1-2), 85-92.

De Leon, G. (1973). Phoenix House Therapeutic Community: The influence of time in program on change in resident drug addicts. Proceedings of the Annual Convention of the American Psychological Association, 399-400.

Dumas, J. E., Rollock, D., Prinz, R. J., Hops, H., & Blechman, E. A. (1999). Cultural sensitivity: Problems and solutions in applied and preventive intervention. *Applied & Preventive Psychology*, 8(3), 175-196.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23(1), 21-32.

Huizinga, D., & Henry, K. L. (2008). The effect of arrest and justice system sanctions on subsequent behavior: Findings from longitudinal and other studies In A. M. Liberman (Ed.), The long view of crime: A synthesis of longitudinal research. New York: Springer.

Kim, R. J., & Jackson, D. S. (2009). Outcome evaluation findings of a Hawaiian culture-based adolescent substance abuse treatment program. *Psychological Services*, 6(1), 43-55.

LighthouseInstitute. (2002). *Global Appraisal of Individual Needs. Services: Research and Training Retrieved* September 27, 2008

McMillan, J. H., Lawson, S., Lewis, K., & Snyder, A. (2002, April 1-5). Reporting Effect Size: The Road Less Traveled. Paper presented at the Annual Meeting of the American Educational Research Association, New Orleans, LA.

Morelli, P. T., Fong, R., & Oliveira, J. (2001). Culturally competent substance abuse treatment for Asian/Pacific Islander women. *Journal of Human Behavior in the Social Environment*, 3(3/4), 263-280.

Morral, A. R., McCaffrey, D. F., & Ridgeway, G. (2004). Effectiveness of community-based treatment for substance-abusing adolescents: 12-month outcomes of youths entering Phoenix Academy or alternative probation dispositions. *Psychology of Addictive Behaviors*, 18(3), 257-268. doi: 10.1037/0893-164X.18.3.257

Nahar, Q., Tom, M. F., Yuen, S., Yuan, S., Zhang, J., & Okano, S. Y. (2008). Alcohol and drug treatment services, 2000, 2003, and 2006 (Alcohol and Drug Abuse Division (ADAD) of the Hawai`i Department of Health, Trans.). Honolulu: University of Hawai`i, Center on the Family,.

Nishimura, S. T., Goebert, D. A., Ramisetty-Mikler, S., & Caetano, R. (2005). Adolescent alcohol use and suicide indicators among adolescents in Hawaii. *Cultural Diversity and Ethnic Minority Psychology*, 11(4), 309-320.

Nishimura, S. T., Hishinuma, E. S., Else, I. R. N., Goebert, D. A., & Andrade, N. N. (2005). Ethnicity and adolescent substance use. *Cultural Diversity and Ethnic Minority Psychology*, 11(3), 239-258.

Paz, J. (2002). Culturally Competent Substance Abuse Treatment with Latinos. *Journal of Human Behavior in the Social Environment*, 5(3/4), 123.

Perez-Arce, P., Carr, K. D., & Sorensen, J. L. (1993). Cultural issues in an outpatient program for stimulant abusers. *Journal of Psychoactive Drugs*, 25(1), 35-44.

Rawson, R. A., Gonzales, R., Obert, J. L., McCann, M. J., & Brethen, P. (2005). Methamphetamine use among treatment-seeking adolescents in Southern California: Participant characteristics and treatment response. *Journal of Substance Abuse Treatment*, 29(2), 67-74.

Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health: National findings Rockville, MD: Office of Applied Studies.

Substance Abuse and Mental Health Services Administration. (December 16, 2005). NSDUH Report: Illicit drug use among persons arrested for serious crimes The National Survey on Drug Use and Health Report: Office of Applied Studies.

Tharp, R. G. (1991). Cultural diversity and treatment of children. *Journal of Consulting and Clinical Psychology*, 59(6), 799-812.

Williams, B. (2000). The treatment of adolescent populations: an institutional vs. a wilderness setting. *Journal of Child and Adolescent Group Therapy*, 10(1), 47-56.

Wilson, D. B. (2001). Effect size determination program. College Park, MD: University of Maryland.

Exploring the Process of a Therapeutic Wilderness Experience: Key Components in the Treatment of Adolescent Depression and Psychosocial Development

Christine Lynn Norton, PhD, LCSW
Assistant Professor
School of Social Work
Texas State University-San Marcos
cn19@txstate.edu
(512) 245-4562 office

Abstract

Adolescent depression is a serious mental health crisis, often occurring in the context of negative psychosocial development. This study explored the efficacy of a therapeutic wilderness experience on adolescent depression and psychosocial development by measuring pre-to-post changes on the Reynolds' Adolescent Depression Scale-2 (RADS-2) and the Measures of Psychosocial Development (MPD). Participants in this study were selected from the Intercept program at Outward Bound Wilderness, a therapeutic wilderness program for youth-at-risk. This mixed methods study found clinically and statistically significant pre- to-post decreases in levels and prevalence of adolescent depression and increases in psychosocial health after a therapeutic wilderness intervention. This study also showed qualitative indicators of change in these areas. This study further demonstrated a clinically and statistically significant relationship between adolescent depression and psychosocial development, and showed statistically significant improvements in the areas of school problems, substance abuse, and family conflict. In addition, this study analyzed what process variables were related to the adolescent depression and pro-social outcomes. These findings are highlighted in this article and are presented as key components of the therapeutic wilderness experience.

*This research was presented at the National Symposium on Doctoral Research in Social Work at Ohio State University on April 18, 2009.

Adolescent Depression and Psychosocial Development: The Need for a Holistic Intervention

Adolescent depression has become epidemic in the United States, with statistics showing that one in five individuals may suffer from depression (Brent & Birmaher, 2002). According to the World Health Organization, depression is the second leading cause of disability for people ages 15-44 (World Health Organization, 2009). And despite the prevalence of adolescent depression alone, there is an acknowledged shortage of treatment options and providers in the field of child and adolescent mental health (Koplewicz, 2002).

The reality of this treatment gap for adolescents can be devastating. The consequences of untreated depression can lead to serious problems later in life, including suicide. Recent statistics revealed that approximately three million youth, age 12 to 17, either thought seriously about suicide or attempted suicide in 2000, and the actual suicide rate for all adolescents has increased more than 200% over the last decade (Borowsky, Ireland, & Resnick, 2001). Many teens who commit suicide suffer from undiagnosed or untreated clinical depression, and have experienced serious difficulties in school, work, and personal relationships (Weersing, Rozenman, & Gonzalez, 2008). Because of these alarming statistics, adolescent depression has been recognized as a legitimate mood disorder that affects the functioning of millions of adolescents (Koplewicz, 2002).

Most mental health practitioners agree, however, that the majority of adolescent depression can be treated; yet there is debate about the type of therapeutic intervention that best targets adolescent depression. Researchers and practitioners agree that integration of theory is needed in contemporary treatment of adolescent depression. Allen-Meares (1987) said treatment providers "need to expand their knowledge about risk factors and unique characteristics associated with depression in this population to refine the different schools of thought and to design prevention and treatment interventions" (p. 515). While the majority of research on adolescent depression has focused on the cognitive-behavioral aspects of the problem, current relational theory reinforces that "we are much more than (cognitive) representations of self; rather, they are each versions, complete functional units with a belief system, affective organization, agentic intentionality, and developmental history" (Mitchell, 2000, p. 63).

Adolescence, in particular, is an important time in one's developmental history, where the formation of one's identity takes center stage (Erikson, 1968). For this reason, this study sought to understand adolescent depression by grounding it in the context of psychosocial development. This psychosocial approach takes into consideration multiple systems and domains of development. By viewing adolescent depression in the context of psychosocial development, one may arrive at a theory base and treatment modality that addresses the developmental, neurobiological, cognitive and relational factors that give rise to adolescent depression.

Amesberger (1998) referred to wilderness therapy as a structured holistic model of treatment that addresses these multiple factors of human development and pathology. While people have speculated on the increase in general well-being associated with being outdoors (Miles, 1987), the field of wilderness therapy seeks to augment the power of the outdoors in combination with structured clinical interventions in a way that promotes psychological healing and personal growth. Although wilderness therapy is believed to serve as a powerful intervention that promotes cognitive, affective, and behavioral change (Gillis 1992), leaders in the field of wilderness therapy admit that more research is needed to understand the impact of wilderness therapy on specific emotional and psychological issues (Berman & Davis-Berman, 1994; Russell, 1999). Though the wilderness program in this study does not meet the exact criteria of wilderness therapy, it is considered a therapeutic wilderness program. According to Cason & Gillis's (1994) meta-analysis of outdoor adventure programming with adolescents, both wilderness and adventure therapy programs and basic outdoor adventure programs yielded significant effect sizes. As such, some of the research on the efficacy of wilderness therapy on adolescent depression has been referenced as a basis for understanding the impact of a therapeutic wilderness experience with this population.

Prior Research on Adolescent Depression and Wilderness Therapy

Adolescent depression is a common mental health issue seen in wilderness therapy participants. Russell's (2002) longitudinal study found that 22.4% of adolescents participating in wilderness

therapy programs were diagnosed with mood disorders. While very few studies have examined the effectiveness of wilderness therapy in dealing with adolescent depression, several outcome studies have been done on the efficacy of wilderness therapy and mood disorders.

Wall (1992) was one of the first to examine the efficacy of wilderness therapy in this area. In his study, he compared the intervention of psychopharmacology with wilderness therapy and found that wilderness therapy was as effective as the use of pharmaceutical anti-depressant medication. Wall used the Beck Depression Inventory to measure change before and after participating in a wilderness therapy program and reported that meaningful gains were made in the area of decreasing depression. Limitations of Wall's study, however, include a lack of accountability for moderating variables on participants' moods at the beginning and end of the course. Also, follow-up research was not conducted, so the long-term effects on participants' moods were not measured. However, another wilderness therapy study using the Millon Adolescent Clinical Inventory also noted pre- to post-intervention decreases in the area of depressive feelings and symptoms (Clark, Marmol, Cooley, & Gathercoal, 2004). Russell (2003) examined the pre- to post-test outcomes of wilderness therapy participants' scores on the Youth Outcome Questionnaire (Y-OQ). In this study, participants with mood disorders showed the greatest decrease in their pre- to post-test Y-OQ scores. Yet conclusive findings cannot be derived from this study alone due to the lack of a comparison group.

Nortrom's (2004) study on the efficacy of wilderness therapy on adolescent depression found 70% of adolescent clients reporting decreased depressive symptomology after treatment. Using the Reynolds' Adolescent Depression Scale-2, Nortrom found the combined data from her total sample did not show statistically significant results in the use of wilderness therapy to help lower depressive symptoms. However, when the scores for participants that had moderate to severe depression were analyzed separately, their scores dropped significantly ($p < .02$ level). Through case study narrative data, Nortrom (2004) also found that time spent alone in the wilderness was one of the components of the wilderness therapy program that made the largest impact on depressed adolescents.

The purpose of this study was to explore the efficacy of a therapeutic wilderness program on adolescent depression and

psychosocial development. The study further sought to analyze the process variables related to the adolescent depression treatment to present them as key components of the therapeutic wilderness process.

Method

Participants

Participants in this study consisted of adolescents in Outward Bound's youth-at-risk program, a 28-day wilderness canoeing and camping program called Intercept (N=21). This group consisted of males and females ages 13-17. In this study, 81% of participants were Caucasian, 14% were Hispanic, and only 5% were African American. In addition, 62% of participants in this study were boys and 38% were girls. Not surprisingly, almost 62% of participants in this study came with some kind of unipolar depressive diagnosis, and 76% of participants had previous counseling. Participants in this study matched the overall demographics of the participants in other wilderness therapy programs, as reported by Russell and Hendee (2000). Participants also possessed varying levels of substance abuse, school problems, and family conflict. The main confounding variables of age, race, gender, preexisting diagnosis of depression, and prior participation in counseling were selected as important variables for which to control. It should be noted that, socioeconomic status (SES) and previous involvement in the juvenile justice system may have also been important variables to consider however, that type of demographic information was not available. Youth with prior involvement in the juvenile justice system were excluded from this study due to ethical and logistical constraints.

Overview of Program

The Intercept program consisted of a 21-day wilderness expedition, canoeing, and rock climbing program in Northern Minnesota and South Carolina. This expedition was broken into four stages: training, main, solo, and final. Through these stages, responsibility was gradually transferred over to the participants. During training, instructors provided participants with the wilderness skills they needed to be competent in a new, unfamiliar environment. During main expedition, the group practiced these skills, while still having access to guidance from the instructors. During this phase, the

group also learned communication and problem-solving skills.

During solo, each individual spent three days and two nights at a private wilderness site apart from other participants. Instructors checked in with students several times a day, doing one-on-one interviews, and providing them with journaling exercises and other reflective assignments to foster self-awareness. After solo, the group participated in a final expedition where they were responsible for all aspects of their experience (i.e. cooking their own food, navigating, setting up camp, etc.). The role of the wilderness instructor at this point was to help the group maintain physical and emotional safety, while still letting the group work toward solving their own problems. Throughout the entire expedition, instructors met with students one-on-one to work on personal goals, to help them take responsibility for why they were in the program, and to help them think about what positive changes they could make upon returning home.

This expedition was followed by a gradual transition back into society. This transition included a visit to base camp, where participants challenged themselves through adventure activities such as white water kayaking and a high ropes course. Participants also celebrated the accomplishments of their wilderness phase with a banquet and then traveled to a nearby city for their Urban Expedition. During the Urban Expedition, participants worked in various community settings, performing community service projects. The Urban Expedition culminated with a parent/guardian seminar, where goals for home were articulated through a therapeutic conversation between the adolescents and their parents, facilitated by the instructor. Experienced wilderness instructors, who were well trained in group facilitation and basic counseling skills, led these trips. Many possessed prior experience with at-risk youth, and some held advanced mental health degrees. These trip leaders also facilitated the transitional phases of the course, both at base camp and in the urban setting. They worked with parents/guardians and their children to articulate the learning that occurred during the program, and assisted in setting goals for when the adolescent returned home. A Course Director, who also possessed extensive experience working with youth in the field, supervised them.

After the course, the field instructors provided follow-up for the students, their families, and any third parties involved in the referral process by creating a written narrative about each participant's

progress during the program. By passing on this information, it was hoped that positive changes on the course could serve as an anchor and catalyst for future change.

Design and Measures

This study explored the impact of a therapeutic wilderness experience on adolescent depression and psychosocial development. It also examined the relationship between depression and psychosocial development, as well as the influence of family conflict, substance abuse, and school problems on these constructs.

The RADS-2 was chosen to measure depression because it is developmentally appropriate and has documented reliability and validity in measuring depressive symptomology in adolescent clients (Reynolds, 2002). The RADS-2 is a 30-item, self-report questionnaire that has subscales highlighting various depressive symptoms: dysphoric mood, anhedonia/negative affect, negative self-evaluation, and somatic complaints. The RADS has become "one of the most commonly used self-report measures of depression in adolescents" (Reynolds, 2002, p. 4), and has also been used to examine the efficacy of wilderness therapy and adolescent depression (Nortrom, 2004).

The MPD was selected to measure psychosocial development because it focuses on healthy personality development rather than pathology. Its wide range of applicability and its strong theoretical foundation, made it ideal for this study. To date, the MPD has only been used in two other studies related to depression (Benson, 1992; Kruger, 1993). The MPD consists of 27 scales. Attitudes that describe the basic dimensions of personality are measured by eight Positive and eight Negative scales. The direction and degree of resolution between the Positive and Negative scales is reflected in the eight Resolution scales. Three Total scales provide measures of overall psychosocial health. Users respond to the 112 items on a separate Answer Sheet using a 5-point scale ranging from Very Much Like Me to Not At All Like Me. As Hawley (2005) stated, normal and high scores "indicate an overall positive level of conflict resolution across stages," while low scores suggest "psychosocial stress resulting from an overall low level of resolution of stage conflicts" (p. 11).

These measurements were administered one week prior to the wilderness program and one week after it. A follow-up was also administered three months following the program. Qualitative data

were also collected via pre-course paperwork and three month, post-course phone interviews. The pre-course paperwork included parent/guardian questionnaires and student questionnaires assessing reasons for referral, level of motivation, and the family and student's goals. The post-course follow up phone interview questionnaire included open-ended questions to elicit narrative data about students' subjective experience on course, as well any attitudinal or behavioral changes students made based on their therapeutic wilderness experience. Qualitative data were subjected to multiple levels of thematic coding and narrative analysis. Additionally, this study included survey research to assess the importance of various components of the intervention. The results of this survey were correlated with the outcomes on the pre- and post-tests to understand which components were related to the biggest gains in terms of adolescent depression and psychosocial development.

Results

Changes in Depression and Psychosocial Development

Through an analysis of pre- and post-test scores on the RADS-2 and the MPD, this study found decreases in rates of depression and increases in rates of psychosocial development. This study showed an average decrease in depression of 4.3 points on the RADS-2, which, based on other RADS-2 pre-to-post studies, was seen as a clinically meaningful level of change (Reynolds, 2002). T-tests revealed statistically significant decrease in depression scores pre/post intervention ($p<.001$) with a medium effect size of .394 (Cohen, 1988).

There was also was an increase of 6.1 points on the MPD, reflecting a large shift from low levels of psychosocial development to normal levels (Hawley, 2005). T-tests revealed statistically significant increases in psychosocial health via MPD scores pre/post intervention ($p<.001$) with a large effect size of .848 (Cohen, 1988). Table 1 shows the standardized mean differences used to calculated pre/post intervention effect sizes in this study.

Table 1. Standardized Mean Difference Effect Sizes for Decreases in Depression and Increases in Psychosocial Health

RADS Pre-Test	RADS Post-Test	Cohen's d	Effect-size
Mean=54.38 SD=12.06	Mean=50.04 SD=9.84	.394	Medium
MPD Pre-Test	**MPD Post-Test**	**Cohen's d**	**Effect-size**
Mean=41.29 SD=8.06	Mean=47.33 SD=6.04	.848	Large

Utilizing a Repeated Measures ANOVA, further statistical analyses revealed improvements in the rates of depression and psychosocial health ($p<.001$). Utilizing a Categorical Repeated Measures ANOVA, this study showed a 33.5% decrease in the prevalence of depression ($p<.001$ level) and a 52% increase in the prevalence of positive psychosocial development ($p<.001$).

This study also demonstrated a negative correlation between adolescent depression and psychosocial development ($p<.01$). This finding reaffirmed Highland's (1979) study demonstrating a psychosocial connection to depression in adolescence, paving the way to consider psychosocial interventions, such as wilderness therapy and therapeutic wilderness programs, in the treatment of adolescent depression.

Analysis of qualitative data revealed that related to depression, participants experienced a decrease in learned helplessness, an increase in self-worth, and an increased sense of future. While on course, youth reported no symptoms of depression. Upon completing the course, participants reported an actual elevation in mood, and three months post-course, 76% of youth still reported experiencing more stability in their moods. Further thematic coding of the qualitative data revealed increases in the areas of coping skills, confidence, competence, connection, and caring--all of which are important developmental assets identified in the positive youth development model (Lerner, Lerner, Almerigi, Theokas, Phelps, Gestsdottir, Naudeau, Jelicic, Alberts, Ma, Smith, Bobek, Richman-Raphael, Simpson, DiDenti Christiansen, & von Eye, 2005).

Likewise, based on data gathered from qualitative sources before and after the intervention, the study showed a 47.5% decrease in family conflict ($p<.001$); a 28.6% decrease in substance abuse

(p<.001); and a 61.9% decrease in school problems (p<.001). These emergent dependent variables are important to consider because they reflect concrete behavioral change.

Exploring the Process of Wilderness Therapy

Key Therapeutic Components

Little research has been done to understand the key components of the therapeutic wilderness experience. Russell's (2000) work stands out as a seminal study highlighting several factors important to the change process. While this study showed strong outcomes related to the impact of wilderness therapy on adolescent depression and psychosocial development, there was also a need to consider which components played an integral role in the therapeutic process.

This study hypothesized and collected data on the following components as potentially explanatory variables of any observed change:

- Sex
- Age of participants
- Race (Caucasian, African American, Hispanic)
- Was the relationship with the Trip Leader Strong? (Y/N)
- Did they have a positive Solo experience? (Y/N)
- Did they have a high level of participation in challenge and adventure activities? (Y/N)
- Did they have a Positive Group experience? (Y/N)
- Did they have a high level of participation in Community Service? (Y/N)
- Did they have positive communication with their families? (Y/N)

On the last day of the program, participants were given a Survey of Course Components and asked to rate their experiences in six different areas: relationship with the trip leader, interaction with the group, level of participation in wilderness/adventure activities, solo, level of participation in community service, and communication with parents/guardians during the final seminar. As mentioned previously, some of these course components were identified in the literature as significant aspects of the change process (Russell, 2000).

For the purpose of this study, participants' responses were compared with their levels of change from pre- to post- in the areas of

adolescent depression and psychosocial development. In this way, the author could gauge what components of the intervention may have had the greatest impact in these areas. Table 2 shows the frequency of the participants' responses on this survey. No low or negative responses were reported. While this seems like a positive sign, it is important to note the halo effect that is sometimes seen in wilderness and adventure therapy research in which respondents provide higher scores if given the survey on the same day or immediately following the program (Graham & Robinson, 2007).

Table 2. Survey of Course Components

Course Component	High/Positive	Medium/Fair	Low/Negative
Relationship with trip leader	90%	10%	0%
Relationship with group	67%	33%	0%
Level of participation in wilderness and challenge activities	86%	14%	0%
Solo	76%	24%	0%
Level of participation in community service	76%	24%	0%
Communication with parents/guardians	71%	29%	0%

Table 3 shows the correlations between course components and pre-to-post test differences on the RADS-2 and the MPD. These correlations were all weak to moderate (i.e., between -0.5 and +0.5), which is not surprising given the relatively small sample size (N=21); however, there were some statistically significant correlations between explanatory variables. This, along with medium to large effect sizes, provided a rationale to perform a regression analysis in order to partition out the unique contributions of each variable.

Table 3. Correlations between Course Components and Therapeutic Outcomes as Measured by Difference in T-scores on RADS-2 and MPD pre/post

Pearson Correlation Coefficients, N = 21
Prob > |r| under H0: Rho=0

	Wilderness_N	Solo_N	CS_N	PGS_N	RADS_Tdiff	SHealth_Tdiff
Age	0.51	-0.09	-0.28	-0.10	-0.33	0.24
Male	-0.04	0.48	-0.21	0.16	0.38	-0.31
African_Am	0.09	0.13	0.13	0.14	-0.31	0.64
Relationship_N Was there a strong relationship with the group leader?	-0.13	0.19	-0.18	0.15	0.08	0.13
Positive Group Experience	0.29	0.08	-0.16	0.22	-0.16	0.41
Wilderness_N (wilderness and challenge activities)	1.00	0.09	-0.23	0.04	0.19	0.13
Solo_N	0.09	1.00	-0.31	0.14	0.10	-0.23
CS_N (Community Service)	-0.23	-0.31	1.00	0.14	0.08	0.05
PGS_N (Positive communication during parent/ guardian seminar)	0.04	0.14	0.14	1.00	-0.31	0.31

To limit the effects of the interrelated nature of the course components, further statistical analysis was conducted via a stepwise regression. This was helpful in analyzing which various course components likely predict or explain the observed changes in depression and psychosocial development. Table 4 shows these results and also highlights the negative impact that being male had on pre-to-post changes on the RADS-2 and MPD. This is not to say that males did not make positive changes, but rather that the magnitude of the change was not as great as that that of the females in the study. This finding was beyond the scope of this study; however, it is an important aspect for future research given the number of boys that are referred to wilderness therapy programs.

Table 4. Final Model of Parameters for the RADS-2 and MPD Regression Analysis of Course Components

Model & Variables	Estimate	Error	Type II SS	F	Sig
RADS-2 Intercept	-4.13	2.05	78.402	4.07*	0.05
Male	4.26	1.99	88.368	4.59*	0.05
Positive Communication with Parents/ Guardians-	-3.98	2.15	66.232	3.44	0.08
MPD Intercept	5.13	1.92	143.750	7.18**	0.01
Male	-4.97	2.09	112.861	5.63*	0.03
Positive Group Experience	5.99	2.16	154.616	7.72**	0.01

Analysis of course components revealed that positive levels of communication during the Parent/Guardian seminar were associated with an average change in the RADS-2 scores of -3.98. While this only approached statistical significance at the 0.08 level, the small sample size, as well as the lack of current knowledge about the impact of specific therapeutic wilderness components may justify using a relaxed p-value. In this case, it is more important to begin to understand what components may be related to positive change, and to acknowledge the potential lack of statistical power due to a small sample.

Analysis also showed that a positive group experience was associated with an increase of MPD scores by 5.99, and was statistically significant at the $p<0.01$ level. This is not surprising because the peer group is often one of the most powerful contexts in adolescence for identity development and intimacy. In wilderness therapy, the group may provide relational experiences that can help rework or resolve developmental crises and dysfunctional patterns that were not dealt with earlier (Miles & Priest, 1999).

However, because the therapeutic components of having a positive group experience and positive communication with family members occur in other intervention settings and may not be related specifically to the wilderness realm, it was important to triangulate these results with the findings from the analysis of qualitative data.
Qualitative data, including the pre-course paperwork and transcripts of the follow-up phone interviews, was analyzed using narrative analysis and thematic coding (Strauss and Corbin, 1998). Coding of the qualitative data triangulated the quantitative findings of the Survey of Course Components and provided a more longitudinal perspective. While the statistical analysis of the survey of course components

measured the immediate benefits of positive communication between family members, the qualitative data gained during the follow-up phone interviews assessed the impact of the positive family communication and support 3 months post-intervention. 76% of participants reported mood stabilization, positive family relationships, and maintenance of positive gains three months out.

Certainly, there are many variables that may explain these lasting results, but these findings do reflect what has previously been cited from the literature about the role of family support in preventing relapse (Sanford, 1996) as well as the lasting impact this type of wilderness programming can have on adolescent depression (Russell, 2002). For this reason, therapeutic wilderness programs that work with depressed youth need to include a strong parent component and give families tools to improve communication and ultimately prevent relapse.

Significant Program Components Reported by Participants

While positive peer group interaction and positive family communication were the most statistically significant course components related to positive outcomes on adolescent depression and psychosocial development, the narrative data provided by participants in the qualitative section of this study highlighted several other course components that were significant. From participants' responses, three main subcategories were generated as being the most significant aspects of the therapeutic wilderness program: being in nature, challenge and adventure, and contemplation. These seem to be the main areas that left a lasting impression on participants even three months after the course. While these experiences were of great importance to the participants, one cannot definitively state that they are related to treatment outcomes; however, there seems to be theoretical linkages between the quantitative and qualitative findings of this study.

Being in nature

Interestingly, "being in nature" or "connection with nature" was not even listed on the survey of course components. Fortunately, one of the strengths of a mixed methods study is that the voices of the participants can overcome the bias or oversight of the researcher. The narrative data gathered from participants highlighted that being "out in

the wild," "watching a sunset," "listening to a pack of wolves howl," "seeing the sunlight on the water"—were important components of the therapeutic wilderness experience that were related to positive affective and behavioral change. Traditional wilderness therapy literature focuses more on challenge and adventure; however, the ecopsychology movement contends that simply being in nature is the most important part of the healing process (Roszak, Gomes & Kanner, 1995). Perhaps an ecopsychology approach could shed important light on traditional wilderness programming for youth which has focused more on the role of challenge and adventure than on a connection with nature.

Challenge and adventure

Although being in nature may have had a strong impact on the overall results in this study, it is important not to devalue the traditional perspective of wilderness programming in which great importance is given to challenge and adventure. It should also be noted that the impact of physical activity on adolescent depression has been well-documented previously (Dunn & Weintraub, 2008); however, the unique wilderness context and the nature of adventure-based activities seemed to have a deeper level of intensity for participants than regular physical exercise. Participants reported that the physical challenge and adventure experiences had a powerful impact on them, and referenced a sense of personal amazement at what they accomplished in the context of the wilderness expedition. Students reported that "completing a two mile portage," "paddling into a headwind on big water," "paddling 180 miles" and "climbing to the top of a rock face or rappelling from a cliff," helped them feel more confident in their ability to handle difficulties in their lives.

Contemplation

Lastly, participants used words and phrases like "reflection," "thinking about my life," or even "huge epiphanies." For some students, a great deal of reflection occurred during their solo time, but others talked about time for reflection in general, whether "paddling down a river," "during evening group meeting," "journaling," or in "one-on-one meetings with instructors." Many of the youth expressed having more time to think about their lives than ever before, and reported being "away from a lot of distractions at home." The importance of

reflection has already been highlighted by Kimball and Bacon (1993) who referred to it as contemplation and saw it as a huge benefit of being in nature because they believed it allows participants the potential to access a more spiritual dimension of the human experience. This is important for other therapeutic wilderness programs to consider, as it seems to be a necessary time for shifting one's perspective from the past to the future. Perhaps, in these times of contemplation, a youth is beginning to imagine him or herself in another place, one better than where they have been. Youth seem naturally capable of doing this, and may simply need an environment conducive for doing so.

Discussion

Limitations

There are several important limitations to consider in this study. Much of the study was based on self-report and self-administered tools which can be inaccurate and unreliable. This study also left out youth who did not have the cognitive ability to complete these tests, let alone complete a therapeutic wilderness program. Likewise, youth may not have been entirely truthful and may have underreported high risk behaviors during the follow up phone interview.

By using pre-tests and post-tests, testing threats to internal validity may have occurred. Because this study did not have a control group, there were high single-group threats to internal validity which limits this study to being exploratory in nature, design, and findings. Finally, threats to external validity in regard to the entire study were possible because of the small, non-random sample. While statistical tests were utilized, the generalizability of the results may be suspect due to the small sample size. However, if a degree of proximal similarity among various contexts is found in regards to the population, for example in other similar programs, then perhaps there may be a higher level of ecological transferability to participants in these other programs (Tashakkori & Teddlie, 2003).

One of the limitations of the qualitative data analysis in this study was the potential influence for the researcher's theoretical bias to impact the interpretation of findings and the selection of categories and themes. This was especially true in identifying the emergent dependent variable categories of school problems, substance abuse, and family conflict, which was based largely on participant self-reporting.

Collecting and analyzing self-report data in these areas could have allowed for a lot of subjective interpretation. For this reason, member checking was utilized to assess the themes generated by analysis of the qualitative data. The agreement arrived at via member checking, as well as triangulation of the data, helped validate the findings.

Important Considerations

Despite these limitations, this mixed methods study yielded promising insights into the therapeutic process of wilderness programming, especially in relationship to adolescent depression and psychosocial development. The Survey of Course Components found that positive communication with parents/guardians and a positive group experience were the two most important aspects of the program related to decreasing adolescent depression and improving psychosocial health. These therapeutic components are not unique to the wilderness setting and are often used in other treatment settings with adolescents; however, the unique therapeutic environment of the wilderness and the physical separation between youth and parents that occurs during therapeutic wilderness programs gives these treatment components more depth.

Participants' experiences in the group were influenced by being in nature, particularly being in a challenging, wilderness environment. Travelling in a wilderness environment in a group provided a level of intensity and engagement that began to break down clients' defenses and make them aware of negative patterns they may not have consciously grasped (Miles & Priest, 1999). Russell's (2003) research affirms these findings, and he believes that these opportunities for group cohesion occur in the context of peer feedback, which can help facilitate the change process even more.

Positive family communication has also been identified as a necessary therapeutic component in the treatment of adolescent issues (Robinson, Kruzich, Friesen, Jivanjee, & Pullman, 2005); however, positive communication with parents/guardians occurred only after time spent away from the family system. Harper and Russell (2008) referred to this as "meaningful separation" and saw it as an important aspect of family involvement in wilderness therapy (p. 26). This time away became meaningful as the participants reflected on how their negative behaviors affected their families.

The qualitative interviews with the participants reaffirmed this. For example, upon reflecting upon her rock climbing day as the most significant moment on her course, a female participant began crying as she talked about the strain she felt while belaying. The climber she was belaying kept falling, and it was making her nervous and hurting her arms and shoulders. After processing the experience with her instructors and her group at the end of the day, this participant had an “aha” moment. She realized that her mom must have felt exactly the way she had while belaying. She understood on a deeper level that her mom was constantly trying to support her, but had to watch her continue to fall. This newfound awareness may have helped to promote a more positive, empathically attuned conversation with her parents at the end of this girl’s course.

Conclusion

Along with providing an effective modality of therapeutic intervention for youth with depression and low levels of psychosocial health, this study reaffirmed the importance of applying systems theory to the treatment of adolescent depression and psychosocial development. Evidence of the importance of a systemic intervention was clear in this study. The role of the group experience in furthering psychosocial development was a strong indicator of the need for adolescent treatment to be partially embedded in a positive peer group in order to practice new ways of relating that promote both connection and self-definition. Kimball and Bacon (1993) once stated, “there is no such thing as individual wilderness therapy” (p. 14). While there are wilderness therapy programs that work individually with clients, it does seem that the group process is an essential component for furthering psychosocial development, which is the norm in most therapeutic wilderness and wilderness therapy programs. The development of a cooperative interpersonal framework as a part of group dynamics is a critical piece of the healing process, thus reflecting accepted ideas about group work being an important therapeutic medium (Corey, 2008).

Likewise, Kiewa (1994) speaks to the importance of the group being a safe, relational base, especially for young women, which may be able to partially explain why girls in this study made greater gains than boys in the wilderness therapy intervention. She referenced

Knapp's (1988) ideas on the need for a humane environment, which includes "factors such as respect, trust, high morale, opportunities for input, growth and renewal, cohesiveness and caring" (p. 17).

This study also showed that an effective intervention for youth with depression must include an intervention with the family. This reaffirms Sanford's (1996) earlier study in which positive relationships with parents were a key factor for youth who had been treated for depression to remain in remission. While this idea is certainly catching on in therapeutic wilderness programs, often the problem is still seen as internal to the youth. This study showed that creating opportunities for positive communication and cohesion in the family system are essential as well.

While these assertions may cause controversy for those who conduct therapeutic wilderness programs outside of a group setting or for those whose programs work solely with youth and not with families, the results of this study seem to indicate the need to treat the youth as a part of a larger system, both during the wilderness program and afterwards. This idea mirrors the relational stance that Kimball and Bacon (1993) have regarding the healing process of wilderness therapy. Just as the problems the youth in this study had were embedded in a variety of relationships—family, peers, school—their healing took place in relational contexts as well.

References

Allen-Meares, P. (1987). Depression in childhood and adolescence. *Social Work*, 32(6): 512-517.

Amesberger, G. (1998). Theoretical considerations of therapeutic concepts in adventure therapy. In C. Itin (Ed). (1998). Exploring the boundaries of adventure therapy: International perspectives. Boulder CO: Association for Experiential Education.

Benson, J. L. (1992). The measures of psychosocial development as predictors of depression among Greek Orthodox Christians in Oregon (Doctoral dissertation, George Fox College, 1992). Dissertation Abstracts International, 53, 4931.

Berman, D. S. and Davis-Berman, J. (1994). *Wilderness therapy: Foundations, theory, and research*. Dubuque, IA: Kendall/Hunt Publishing.

Brent, D. A., & Birmaher, B. (2002). Adolescent depression: Clinical practice. *New England Journal of Medicine*, 347(9).

Borowsky, I. W., Ireland, M. & Resnick, M. (2001). Adolescent suicide attempts: Risks and protectors. Pediatrics, 107(3), 485-493.

Clark, J.R., Marmol, L.M., Cooley, R., &Gathercoal, K. (2004). The effects of wilderness therapy on the clinical concerns (on Axes I, II, and IV) of troubled adolescents. *Journal of Experiential Education*, 27(2), 213-232.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). New York: Academic Press.

Corey, G. (2008). *Theory & practice of group counseling, 7th Ed*. USA: Thomson Brooks/Cole Publishing.

Dunn, A.L., & Weintraub, P. (2008). Exercise in the prevention and treatment of adolescent depression: A promising but little researched intervention. *American Journal of Lifestyle Medicine*, X(x), 507-518. Retrieved on 5/28/09 from: http://ajl.sagepub.com/cgi/rapidpdf/1559827608323225v1.pdf

Erikson, E.H. (1968). *Identity: Youth and crisis*. New York: Norton.

Gass, M. A. (1993). *Adventure therapy: Therapeutic applications of adventure programming.* Dubuque, IA: Kendall/Hunt Publishing.

Gillis, H.L. (1992) Therapeutic uses of adventure-challenge-outdoor-

wilderness: Theory and research. Paper presented at the Coalition of Reeducation in the Outdoors Symposium Bradford Woods Indiana University, Martinsville, IN [on line]. Available: http://fdsa.gcsu.edu:6060/lgillis/AT.

Graham, L.B. & Robinson, E.M. (2007). Project Adventure and self concept of academically talented adolescent boys. *Physical Educator*, 9/22/2007.

Harper, N.J., & Russell, K.C. (2008). Family involvement and outcome in adolescent wilderness treatment: A mixed-methods evaluation. *International Journal of Child & Family Welfare*, 2008/1, p. 19-36.

Hawley, G. A. (2005). Measures of psychosocial development. Lutz, FL: Psychological Assessment Resources.

Kiewa, J. (1994). Self-control: The key to adventure? Towards a model of the adventure experience. In Cole, Erdman and Rothblum (Eds.), *Wilderness Therapy for Women: The Power of Adventure*. New York: Haworth Press.

Kimball, R.O. and Bacon, S.B. (1993). The wilderness challenge model. In M. Gass (Ed.), *Adventure therapy: Therapeutic applications of adventure programming*. Dubuque, IA: Kendall/Hunt Publishing.

Knapp, C. (1988). Creating humane climates outdoors: A people skills primer. Washington: Office of Educational Research and Improvement. (ERIC Document Reproduction Service No. 294706).

Koplewicz, H. (2002). *More than moody*. New York: G.P. Putnam's Sons.

Kruger, E. (1993). The relationship of Erikson's early developmental stages with anaclitic and introjective depression. Unpublished dissertation: University of New Mexico: Albuquerque.

Lerner, R.M. & Lerner, J. V., Almerigi, J.B., Theokas, C., Phelps, E., Gestsdottir, S., Naudeau, S., Jelicic, H., Alberts, A., Ma, L., Smith, L.M., Bobek, D.L., Richman-Raphael, D., Simpson, I., DiDenti Christiansen, E. , von Eye, A. (2005). Positive youth development, participation in community youth development programs, and community contributions of fifth-grade adolescents: Findings from the first wave of the 4-H study of positive youth development. *The Journal of Early Adolescence*, Vol. 25, No. 1, 17-71.

Miles, J. (1987). Wilderness as a healing place. *Journal of Experiential Education,* 10 (3), 4-10.

Miles, J.C. & Priest, S. (1999). Adventure programming. State College, PA: Venture Publishing, Inc.

Mitchell, S. (2000). Relationality: From attachment to intersubjectivity. Hillsdale, NJ: The Analytic Press.

Nortrom, A. (2004). The efficacy of wilderness therapy in the treatment of adolescent depression. Prescott College Master's Thesis: Prescott, AZ.

Reynolds, W. M. (2002). Reynolds adolescent depression scale-professional manual. FL: Psychological Assessment Resources, Inc.

Robinson, A. D., Kruzich, J. M., Friesen, B. J., Jivanjee, P., & Pullmann, M. D. (2005). Preserving family bonds: Examining parent perspectives in light of practice standards for out-of-home treatment. *American Journal of Orthopsychiatry*, 75(4), 632-643.

Roszak, T, Gomes, M.E., Kanner, A.D. (1995). *Ecopsychology*. SF: Sierra Club Books.

Russell, K.C. (1999). The theoretical basis, process, and reported outcomes of wilderness therapy as an intervention and treatment for problem behavior in adolescents. Unpublished doctoral dissertation. College of Natural Resources: Moscow, ID 83844-1144.

Russell, K.C. & Hendee, J. (2000). Outdoor behavioral healthcare: Definitions, common practice, expected outcomes and a nationwide survey of programs. Technical Report 26. Idaho Forest, Wildlife and Range Experiment Station. Moscow, ID.

Russell, K. C. (2002). A longitudinal assessment of treatment outcomes in outdoor behavioral healthcare. Technical Report 28, Idaho Forest, Wildlife, and Range Experiment Station, Moscow, ID. 35 pp. Available from the University of Idaho-Wilderness Research Center.

Russell, K.C. (2003). Assessing treatment outcomes in outdoor behavioral healthcare using the Youth Outcome Questionnaire. Child and Youth Care Forum, 32(6), 355-381.

Sanford, M. (1996). Which teens will still be depressed a year later? *The Brown University Child and Adolescent Behavior Letter*, 12, 5.

Wall, S. 1993. The effects of a wilderness survival school on adolescent depression scores. Unpublished Doctoral Dissertation.

Weersing, V. R., Rozenman, M., & Gonzalez, A. (2008). Core components of therapy in youth: Do we know what to disseminate? Behavior Modification, 33, 24-47.

World Health Organization. (2009). Depression. Retrieved on February 19, 2009, from http://www.who.int/mental_health/management/depression/definition/en/

Experiential Therapy in the Mental Health Treatment of Adolescents

Keith C. Russell, Ph.D.
Western Washington University

H. L. Gillis, Ph.D.
Georgia College and State University

Abstract

This paper identifies non-profit and for-profit adolescent residential treatment programs in the United States and hypothesizes the number of adolescents who will enter residential treatment in a typical year. We then explore through a survey of open ended responses how programs or clinical directors define and apply "experiential therapy," including what theoretical basis and practical methods may guide their therapeutic approach in residential treatment. The results indicate that the majority of residential treatment programs believe they are practicing what is defined in this paper as experiential therapy, and that a model of the therapeutic process may be warranted. Central to the model is the use of intentional experiential activities to achieve a variety of therapeutic goals. The proposed model of the theoretical basis, process and reported outcomes provides a framework for practitioners, researchers, and other mental health professionals to continue discussion on the use of experience as a therapeutic tool. The model begins to shed light on the discussion of why experiential methods may be more approachable for adolescents and parents who are turned off by the stigma and barriers presented by traditional residential treatment models.

Experiential Therapy in the Mental Health Treatment of Adolescents

Introduction

According to the U.S. Department of Health and Human Services (2008), approximately 2.9 million youth received treatment for emotional or behavioral difficulties. Of these youth, approximately 40% received treatment in their respective schools, 25% were treated by a pediatrician or general medical practitioner, and 9% were treated by a practitioner offering complimentary or alternative medicine. This leaves approximately 700,000 youth who received treatment from either an outpatient or a residential treatment model in a typical year. Though outpatient psychotherapy is the most common and likely form of treatment for these youth and is the most extensively studied intervention (Weisz, Huey, & Weersing., 1998), in many cases, this intervention fails to result for many youth, including a reduction in the psychological or emotional issues which may have led them to seek treatment and improved family functioning (Burns, Hoagswood, and Maltsby, 1998).

Instead, many of these youth continue to move through the continuum of care after the above types of interventions fail, with the end result being the need for more restrictive settings like residential treatment. Most youth considering residential treatment have tried other forms of treatment and clearly constitute a difficult population to treat effectively (Russell, 2007). Many youth and families are turning more and more to 'experiential therapy programs' that utilize alternative approaches that are largely misunderstood in terms of their therapy, process, and practice. In a recent paper, Russell, Gillis, and Lewis (2008) offered several conclusions regarding the emerging residential group-based treatment alternatives for youth who practice what some researchers are calling 'experiential therapy.' Key among these were their appeal to families, social service agencies, corrections, and other professionals looking for less stigmatized residential treatment options and the increasing need for evaluation and research to determine the scope and relative effectiveness of these types of services.

To better understand this emerging treatment approach in adolescent mental health, this study proposes: 1) to conduct a review of the relevant literature on the adolescent behavioral healthcare service industry operating in the United States and Canada and the well documented historical demand for youth services, 2) to

estimate the number of adolescent residential treatment programs and subsequent student numbers based on data to be acquired from national accreditation agencies, and 3) to conduct a preliminary survey of clinical directors belonging to a national association of residential treatment programs to explore how experiential therapy is practiced in their programs. The survey will be guided by the question: What is experiential therapy and what does it look like when practiced with adolescents in your program? Stemming from previous work by Russell (2008), it is hoped that the results of this study will shed new light on the following issues associated with adolescent mental healthcare in the United States: 1) the persistent and growing problem of a lack of healthcare services for adolescents, 2) the growing movement and subsequent discussion on the role that residential treatment plays on the continuum of available healthcare services for adolescents, 3) the role that direct and intentional experience play in the treatment of adolescents in residential settings, 4) the need to better understand how experience and activity are integrated within existing evidence based practices in residential settings.

Adolescent Residential Treatment Programs in the United States

Currently, demand outweighs the supply of appropriate and effective behavioral healthcare services for adolescents and their families. McManus (2003) examined healthcare services in four major U.S. cities, and found two significant barriers to behavioral healthcare services were provider shortages and inadequate reimbursement rates. The author states: "severe shortages of mental health and substance abuse providers trained to care for adolescents were reported in all four cities" (p. 16). In addition, few inpatient mental health beds are available for adolescents and families in need. Because of this, teens with mental health crises are often hospitalized for extended periods of time awaiting services.

The "continuum of care" talked about by behavioral healthcare experts consists of services in schools, outpatient, inpatient, day treatment, and accessible residential facilities. Such a "continuum" appears to be a myth for most adolescents and their families seeking treatment. The demonstrated historical demand and current lack of services make it highly likely that innovative programs, and more importantly, families in search of help, will utilize effective innovative programs for their children. This increased demand creates the

potential for programs without licensing, or programs that market to desperate parents and their children seeking treatment, could operate unethically without protective oversight. The potential for unethical marketing and dangerous practices (as evidenced by the GAO report (Kutz & O'Connell, 2007) highlights the importance of the need for licensing, standards of best practice, and evaluation and research on program effectiveness for these interventions.

Best Practice in Adolescent Residential Mental Health Treatment

Most research conducted on adolescent treatment services has assessed and evaluated interventions that have been described by Weisz, Weiss, and Donenburg (1992) as research therapies. These therapies are reasoned to be theorized, manual driven, resource intensive, and implemented in research settings that offer intense training, supervision, and monitoring. Many of these treatments have been shown to be efficacious, yet few of these "evidence based practices" are implemented across the country by treatment centers and other service delivery providers because of diverse client needs, staff background and experience, and because most programs subscribe to a "multimodal model" of delivery, drawing on various treatment approaches and behavioral strategies to effectuate change (Lamb, Greenlick & McCarty. 1998).

Most youth considering private residential treatment have tried other forms of treatment and clearly constitute a difficult population to treat effectively (Russell, 2007). Given the difficulty of the presenting population, and some well documented incidents of neglect and abuse, there has been increased scrutiny on residential treatment programs and subsequent therapeutic approaches used to treat adolescents. The Government Accounting Office (GAO) produced a report (GAO-08-146T) entitled Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth (2007) to "(1) verify whether allegations of abuse and death at residential treatment programs are widespread and (2) examine the facts and circumstances surrounding selected closed cases where a teenager died while enrolled in a private program" (p. 1). The GAO report led to House Bill (H.R. 911) Stop Child Abuse in Residential Programs for Teens Act of 2009, currently (February 24, 2009) referred to the US Senate Committee on Health, Education, Labor, and Pensions. This bill, not yet law, seeks to address key program characteristics

of the residential treatment industry. Some of these issues have also been detailed in several articles by a group of researchers called ASTART (Alliance for the Safe, Therapeutic, and Appropriate Use of Residential Treatment), with a particular focus on mistreatment and abuse of youth in residential care. Examples of these articles include Behar, Friedman, Pinto, Katz-Leavy, & Jones, (2007); Friedman, Pinto, Behar, Bush, Chirolla, & Epstein, et al. (2006); and Pinto, Friedman, & Epstein (2005) and make a strong case for regulations to stop abuses occurring primarily at unlicensed and unregulated facilities. They advocate adoption of policies recommended by the American Bar Association (2007) that included closing facilities who cannot provide evidence of their efficacy.

How Many Programs and How Many Served?

The number of youth in private residential treatment remains an elusive number. Cited as fact in several places (Behar, Friedman, Pinto, Katz-Leavy, & Jones, 2007; Pinto, Friedman, & Epstein, 2005) are figures from a newspaper article that estimates (without citing any evidence) 10,000 to 14,000 school age children in private residential treatment (Rubin, 2004). Friedman (2009), coordinator of A START said in a presentation during "Abuse of Youth in Residential Treatment: A Call to Action," "We were dismayed when they (GAO) were no more successful than others in coming up with estimates of the number of youth in private residential placements" (p. 3).

To estimate the number of residential treatment programs for adolescents, leading national associations and accrediting agencies were first identified and contacted. These included the National Association of Therapeutic Schools and Programs (NATSAP), the National Association the Therapeutic Wilderness Camping (NATWC), and accreditation agencies like the Joint Commission, the Council on Accreditation (COA), and the Commission on the Accreditation of Rehabilitation Facilities (CARF). From personal contacts with these bodies, a total number of non-profit and for-profit programs serving adolescents in a residential manner was solicited and identified. The programs were cross-checked across associations to the best of our abilities given the information collected. Table 1 reports the approximately 1,500 known residential treatment programs for adolescents currently operating in the United States and Canada. If each program annually served 250 students a year

(based on estimates reported by Russell, Gillis and Lewis, 2008) then approximately 375,000 adolescents a year would be treated by these programs. This means as many as 375,000 adolescents per year could be in "experiential treatment" in these types of residential programs, yet little if anything has been written on what is meant by experiential therapy.

Table 1. Related associations and accrediting agencies and corresponding total number of programs.

Associations	Number of Programs
American Marine Institute Kids	55
Eckerd Youth Alternatives	12
National Association of Therapeutic Schools and Programs	181
National Association of Therapeutic Wilderness Camps	50
Three Springs	16
Total	**314**
Accrediting Agencies	
Commission on the Accreditation of Rehabilitation Facilities	117
The Council on Accreditation	635
The Joint Commission	729
Total	**1481**

To help address the original question asked in this paper, How many adolescents in residential mental health treatment are treated using experiential methods?, we utilized a sample of programs that are theorized to represent the range of residential treatment approaches in the United States and Canada. Data from a recent survey, and contact information for programs in the National Association of Therapeutic Schools and Programs (NATSAP) were made available to help us begin to answer the question of what is meant by experiential therapy.

Experiential Therapy Defined

To help frame our discussion of experiential therapy, a review of literature was conducted. A PsycNET and Google search elicited multiple definitions when using the key word search "experiential therapy." Within the field of psychotherapy, Pos, Greenberg, and Elliott (2008) speak of experiential therapy as "knowing by experience" in the promotion of change in the client. They couch their approach within the

emotion-focused (verbal) approach to psychotherapy. The Association of Experiential Therapies (n.d) describes experiential therapy, as "a role play method through which past, present and future issues can be resolved when combined with more traditional modalities". C.M. Itin (2002) attempts to collect links to various expressions of "experiential therapy". He notes that experiential therapy is "a general expression of therapy that involves action on the part of the therapist and the client" (p. 1). He includes art, music, dance/movement, psychodrama/drama, narrative, writing, biblio, poetry, and photography as part of expressive therapies. He highlights mind/body therapies as a category of experiences used alone or as an adjunct to traditional therapy. Included among the mind/body therapies are meditation, massage, and various forms of martial arts. Under "activity therapy" he cites adjectives like recreational, play, horticultural, occupational, animal assisted (including equine), and adventure that modify and define subfields of therapy that is experiential. Itin's exhaustive description of the many fields or subfields of "experiential therapy" highlight the confusion one might encounter when using these terms without further clarification of exactly what "experience" is taking place that is called therapy.

Young & Gass (2007) reported that many (87%) of the programs in their survey described their programs as using "experiential" methods in their treatment process. Based on these findings, we seek to identify the types and relative use of "experiential therapies" for youth, families, social service and other agencies seeking treatment in private residential facilities. As researchers, we wondered what level of agreement could be found among clinicians in residential treatment programs regarding the term "experiential therapy." The goal was to move beyond terminology like adventure and wilderness therapy, which past research has shown to be too restrictive because of different misperceptions as to what each may represent in a treatment context (Gillis, 1992). It is reasoned that the use of experiential therapy may be less limiting, carry less stigma, and more accurately capture how physical activity, art, the therapeutic use of caring for animals, adventure activities, drama, and other forms of experience are used in clinical settings to help youth better understand the psychological and emotional issues underlying their need for treatment. Therefore, the purpose of this study was to explore the justification and potential for a clearer and more accurate understanding of what experiential therapy

is and how it is employed in residential programs. The study also sought to evaluate the premise that a significant number of youth may be receiving treatment best characterized as experiential therapy. The problem lies in the fact that few studies have empirically examined what the intervention is and how it may actually work. If that is the case, a better understanding of the key tenets of experiential therapy may be warranted.

Method

Subjects

In this pilot study, a primary association of residential programs for youth provided its mailing list (N=165) for an on-line survey using surveymonkey.com. Of the 165 emails, 11 emails were returned as either incomplete or out of date. Responses were received from 51 programs (33.1% of the 154 remaining programs). Table 2 displays program type. Comparisons with Young and Gass (2007) and NATSAP membership from 2007 indicate that the responses received in this pilot study are closely aligned with membership and provide an adequate sample.

Table 2. NATSAP member programs presented by program types.

Program Type	N	%	Young & Gass (2007)	NATSAP
Residential Treatment Center	21	41.2	33.3%	37%
Therapeutic Boarding School	13	25.5	23%	21.0%
Outdoor Behavioral Health/ Wilderness	11	21.6	20.7%	22.0%
Home-Based Residential	2	3.9	2.3%	2.8%
Young Adult	2	3.9	5.7%	5.0%
Transitional Independent Living	1	2.0	5.7%	2.2%
Other	1	2.0	0%	0.6%
Total	51	100.0	100%	100%

Instrument

The survey was designed to elicit responses that addressed the nature and degree to which each program utilized experiential therapy. Initial items asked brief demographic questions to be used to compare the sample developed in the study to Young and Gass' (2007) sample. Because the study was exploratory in nature, a series of open ended questions then asked respondents to describe: a) the

theoretical approach which guides the program's therapeutic process, b) a yes/no question that straightforwardly asked if they believed their approach was "experiential," (if stated no, the respondent was then directed to not complete the rest of the questionnaire) 3) an open-ended question about how their program was experiential, 4) whether the respondent believed that experiential therapy was tangential, adjunctive, or primary in its use in treating client issues, and 5) a series of questions that asked them to explore how experiential therapy was put into practice in their program. A copy of the survey is included in the Appendix.

Procedure

The on-line survey was distributed from Survey Monkey (www.surveymonkey.com) via email to a program list provided by the National Association of Therapeutic Schools and Programs (N=165). The survey was emailed to each contact person for the organization with instructions to have the clinical or program director fill out the survey. A reminder was sent two weeks after the original email and a final reminder sent one week later.

When asked if they were experiential, a significant majority stated that yes, they did consider their approach to be experiential therapy (88%, n = 46). We then included in the dataset only those that responded yes. We also asked them whether experiential therapy was 1) primary-first in importance and direct and immediate in its utilization (33.3%), 2) adjunctive--an additional component of treatment used in conjunction with more traditional models (64.4%, or 3) tangential--indirectly related to treatment and used more as a recreational outlet for students (2.2%)

To explore the meaning of the term "experiential therapy," we asked each respondent a series of four questions that provided structure and enough latitude to elaborate on specific aspects of how experiential therapy is integrated into their therapeutic approaches. The four questions were: 1) What psychotherapeutic approaches are utilized by your program? 2) Please describe how your therapeutic approach described above is experiential; 3) Briefly describe how experiential therapy might be used in the beginning phase of your program to work with a student in your program; and 4) What are the tangible benefits from experiential therapy that would not otherwise be achieved through more traditional modes of therapy?

Due to the exploratory nature of the study, responses to these questions were analyzed using qualitative analysis techniques. Each question was initially coded using open and pattern coding techniques using guidelines proposed by Miles and Huberman (1994). Consistent coding procedures were used throughout the analysis phase to maintain reliability. After an initial pass through the data, a series of open or descriptive codes were developed that were then pattern coded into different illustrations designed to capture the meaning inherent in the data. Reviews of coded responses by qualified academicians and practitioners were used to establish credibility in the data (Erlandson, Harris, Skipper, & Allen, 1993).

Results

A total of 46 programs who defined themselves as experiential responded to the question asking them to describe their therapeutic approach. Table 4 reports pattern coded responses to the question with associated descriptive codes and an example response. Each of the pattern codes were entered into the SPSS database as a descriptor to conduct frequencies on the number of programs that referenced that specific code. For example, the majority (85%) of the program respondents described their therapeutic approach as eclectic and referenced several different psychotherapeutic models as influencing their approach to working with their students (See Table 3 for list of psychotherapeutic models and theories referenced). It is clear that the programs therapeutic approaches are informed by a wide variety of theories and reflect an integration of these theories to best meet the needs of their students. Three programs cited a specific model that framed their approach [for example, Positive Peer Culture developed by Vorrath & Brendtro (1985)]. Only one program referenced a specific model that was not based in the traditional psychotherapeutic literature or domain. It is important to note that this was an open-ended question asking respondents to describe their approach. The coded responses reflected how respondents answered the question using terminology and meaning inherent in their answers. Fewer programs referenced addictions or recovery theory guiding their primary therapeutic approach (17%), and slightly more than 20% referenced skill development.

Table 3. Pattern and descriptive codes referencing question asking respondents to describe their psychotherapeutic approaches.

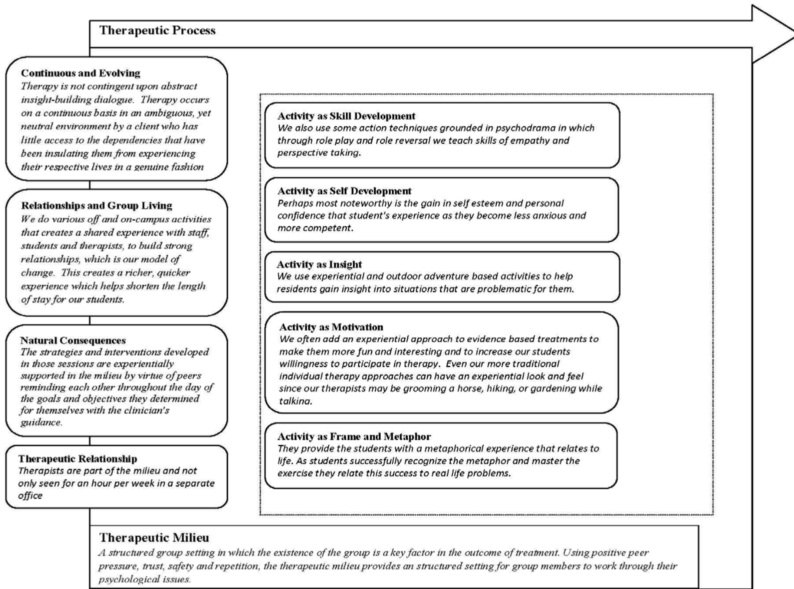
Theme	Descriptive Codes	Examples
Eclectic *Psychotherapeutic approach is referred to as eclectic or is described as eclectic in a milieu oriented system*	-Dialectical -Existential -Family systems -Cognitive behavioral -Gestalt -Behaviorism -Rational emotive -Adlerian -Motivational interviewing -Narrative -Reality Choice theory -12-step -Object relations-Transactional analysis -Solution focused -Positive psychology -Ordeal -Nutritional -Insight oriented -Social constructivist	*Therapeutic milieu, cognitive behavioral treatment, dialectical behavioral therapy, group therapy, brief therapy, adventure / wilderness therapy, and family systems approach.*
Specific Models *Reference is made to a particular and specific model that guides the approach*	-Relational attachment model -Positive peer culture -Token system and levels -Non-punitive -Good lives model	*Our over-arching treatment modality is the Positive Peer Culture developed by Vorrath & Brendtro. Students participate in Group, Individual and Family therapy*
Alternative Model *A reference is made to an alternative psychotherapeutic approach best defined as alternative, or not based in mainstream psychotherapy*	-Outdoor Adventure Therapeutic Model -Emotional growth -Equine -Canine -Creative arts -Service learning -Adventure -Wilderness -Drama	*Canine program teaching students about boundaries, discipline, communication, caring, and empathy. Students have the opportunity to bond and attach with a canine and even adopt it and take it home with them. creative arts--art, dance, poetry, etc.*
Skills Based *References an approach that develops psycho-educational skills* *Specialty Groups* *A reference is made to the creation of specialty groups based on student issues*	-Social skills -Emotional growth -Family education -Leadership -Parent instruction	*Cognitive therapy, drama therapy, equine therapy, behavioral therapy, rational emotive therapy, choice theory, attachment theory, and social skills training*
Specialty Group *A reference is made to the creation of specialty groups based on student issues*	-Adoption -Trauma recovery -DBT -CD or substance	*We provide group therapy 3x/ week, including traditional group process, and some specialty groups (i.e. DBT, adoption, trauma recovery, CD recovery, etc.)*

Defining Experiential Therapy in Practice

When asked to describe how their approach was therapeutic, respondents drew from a variety of theory and provided examples in practice that illustrated how experience and activity comprise the key pillars of what is meant by experiential therapy. Figure two presents pattern codes illustrating how respondents spoke of experiential therapy. Two key themes emerged from their responses: 1) that experiential therapy is utilized to developa certain treatment milieu that facilitates therapeutic factors reasoned to effectuate change, and 2) that experiential therapy was described as activity implemented throughout the therapeutic process to elicit responses learned by the student that can be used in individual, group or family-based therapeutic discussion.

The therapeutic milieu, defined by respondents as comprising the day to day cultural therapeutic environment of each residential facility including staff, therapist, and student interaction, is facilitated by four factors reasoned to help develop this milieu through the intentional practice of experiential therapy. For example, one of the factors titled "Continuous and Evolving" references the idea that group living and shared direct experience allow, in the words of the respondent "Therapy (to) occur on a continuous basis in an ambiguous, yet neutral environment by a student who has little access to the dependencies that have been insulating them from experiencing their respective lives in a genuine fashion."

Figure 1. Illustration of coded responses to responses describing how experiential therapy is practiced in respective programs.



Relationships and Group Living, Natural Consequences, and Therapeutic Relationship were themes that captured how clinicians viewed experiential methods as a way to help adolescents develop relationships in an unstructured way. These three factors capture the essence of how experiential activities are used to develop the therapeutic social environment critical to social and emotional learning and skill development. For example, in reflecting on the "Relationships and Group Living" factor, one respondent stated, "the strategies and interventions developed in those sessions are experientially supported in the milieu by virtue of peers reminding each other throughout the day of the goals and objectives they determined for themselves with the clinician's guidance. Therapy does not solely take place in the clinician's office. Through peer support, therapy is taking place in Algebra class, or on a walk." This comment captures the essence of the unstructured nature of the milieu, the focused intent of experiential interventions, the peer support that accompanies the activities, and the therapeutic guidance provided by licensed (or licensed eligible) clinicians.

As Figure 1 illustrates, as the activities and processes unfold in the milieu, respondents clarified a variety of objectives underlying the use of activity and experience. These include activity for self development, to enhance motivation, to reflect on and use as metaphor in more directed individual and group sessions, and as specific tools for insight into an issue with which a student may be confronted. For example, one respondent stated "the emphasis of our experiential approach is to help residents make effective and appropriate choices, as we relate and re-create the experiences in a variety of experiential settings in order to help them gain experience, insight and understanding." In this way, activity, experience, and the subsequent personal and interpersonal learning that occurs are re-visited and utilized to help make more abstract and tangential concepts, ideas, and understandings, which are often difficult for adolescents to relate to, more real. One respondent described the value of re-visiting the experience. "In order to get the most out of this program, we use (discuss) these experiences in group process after the fact, of course, and have found the "experience" to be invaluable to our students progress through the years."

Benefits of Experiential Therapy

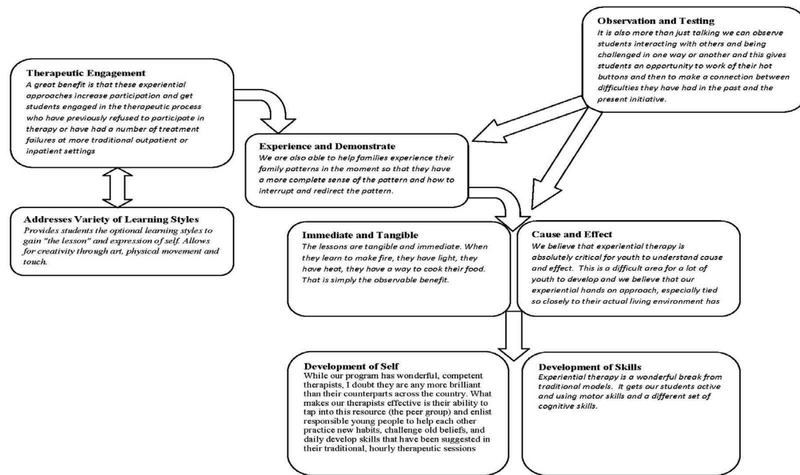
Figure 2 illustrates a conceptual model of the benefits of experiential therapy from the perspective of the respondents. Interestingly, the coded responses did not evoke discussions of skills and therapeutic learning in a more direct sense, though these types of outcomes were mentioned. The meaning captured in their explanations of the benefits was more focused on the benefits of the therapeutic process, rather than just describing a variety of therapeutic outcomes, which in the development of the survey was the intent of the question. The model begins with the idea that a student's willingness to engage in therapy is enhanced through the use of activity and experience. Coupled with this idea is that the approach addresses multiple learning styles, including visual, audio, kinesthetic, and spatial learners. Referenced several times was the way that kinesthetic learners are served through this medium and thrive in the environment. One respondent stated, "in addition some of our students are kinesthetic learners thus therapy becomes more than just an intellectual exercise, it becomes physical and emotional exercise."

experiential activities produced "Immediate and Tangible" learning opportunities and feedback and allowed them to utilize this feedback in a direct way. Linked to this idea, the process also developed a clear understanding for students the "Cause and Effect" of their actions and emotional energy on people and place. As one respondent stated "The student is able to learn how to take immediate accountability and ownership for his emotions and choices after a stress response elicited by an experience which has occurred within the culture of support provided by the peers and staff." During this process, staff and therapists from the programs are able to observe and work with students in real time and witness directly the process and outcome from student interaction. As Figure 2 illustrates, this can include the development of an intentional activity for a student, and the observation of the process and outcome of that process. This was seen as very beneficial and not as easily facilitated in more traditional settings. As one respondent states:

> "*We have students in our program from most of the major metropolitan areas of the United States. I am quite certain each of these cities have an adequate number of competent clinicians. Yet, time and again we receive students whose parents indicate they have been in traditional individual therapy to no avail. While our program has wonderful, competent therapists, I doubt they are any more brilliant than their counterparts across the country. What makes our therapists effective is their ability to tap into this resource (the peer group) and enlist responsible young people to help each other practice new habits, challenge old beliefs, and daily develop skills that have been suggested in their traditional, hourly therapeutic sessions."*

Finally, therapeutic outcomes emerge from this process in the form of intra- and inter-personal skills and improved physical well-being, broadly defined in Figure 2 as the "Development of Self" and the "Development of Motor Skills". The latter code was referenced by several respondents and was viewed as a unique and critical aspect of the process. These types of benefits were seen as integral to the full development of the student, especially given the adolescent stage of their lives.

Figure 2. A conceptual model depicting the benefits of experiential therapy to students in residential settings.



Case Study Vignettes from Respondent Perspectives

What follows are four case studies representing each of the program types based on responses from the question asking respondents to describe how experiential therapy would be used in the initial stages of a program working with a typical student. Of note is that many respondents stated that there is no such thing as a typical 15-year old in our program. Despite these limitations, most respondents provided an example of how the therapeutic process would be initiated at their respective programs using experiential therapy. In this way, a richer discussion of the previous discussion is presented and illustrated with fictitious youth in hypothetical situations, using very real interventions.

The four program types are: 1) residential treatment centers; 2) therapeutic boarding schools; 3) outdoor behavioral health; and 4) other, which comprises a variety of program types not easily categorized.

Residential Treatment Center. Bill, a 15 year old student at a residential treatment center is struggling with mood regulation related to attachment and trauma issues. He is adopted and struggling with questions about why he was adopted and having self-worth and identity issues. As a result, one program found that Bill was acting out sexually and defiantly, as well as having a past dominated by

substance abuse.

In the first phase of the program, Bill would work on disclosures and breaking down resistance to being placed in residential treatment. Early treatment (the first 60-90 days) would revolve around what Bill is learning from his peer group about autonomy and personal responsibility. One survey respondent gave the following description of the process within a residential treatment center.

Most teens (like Bill) have tried to gain autonomy by virtue of irresponsible behavior driven by irrational beliefs about themselves or the world. Students may have been involved in traditional therapeutic approaches that they rejected, or those traditional hourly sessions were insufficient to influence students from the negative peer associations they were seeking. Many of them sought those negative associations due to our human nature's compelling force to belong to something, and for most those negative peer associations negated the effects of the best clinicians. In our Positive Peer Culture model, we first begin developing a positive peer association that challenges them to help each other resolve their problems under the guidance and direction of responsible, care-giving adults. A group of nine teens in a cottage will not evolve into a Positive Peer Culture merely on it's own. Students are led to uncover their own intrinsic value for helping others... not by virtue of punishment or external reward, but because they discover they feel better about themselves when making an altruistic contribution into the lives of other students. As they begin to develop that value to help others, then individual therapy begins to take place and that therapy focuses on the resolution of personal problems by assignments to help others within the peer group.

Therapeutic Boarding School. Therapeutic-based boarding schools often cater to students transitioning from other interventions. One program said, "the beginning phase of our program is essentially geared to help students transfer the skills and insights acquired through a wilderness intervention to a new, larger, more psychologically complex environment. Part of the way experiential therapy is used is to acclimate students to the program and peer group.

Rachel, a 15 year old student diagnosed with bipolar disorder would complete a confidence ropes course with her peer group on a two day outing. In the beginning of treatment, activities would be sequenced to start small and grow increasingly complex requiring

greater levels of teamwork and peer interaction to complete.

Rachel would also engage with her team by participating in chores and team activities on and off campus. A team mentor would be assigned on the first day to help orient her during the coming days and weeks of the program. The concept of "team" is described as being the on-campus "family" and relevant "parental" staff who engage students in all aspects of daily life: chores, classes, sports, group therapy and community living experiences and wilderness challenges. One respondent noted, "every activity that we do has a specific therapeutic purpose and objective, and we work very hard to ensure that we integrate personal growth goals, academic skill development, and recreational / healthy risk-taking into each activity or part of the program." This approach avoids behavioral techniques and instead focuses on building strong relationships and processing experiences so students learn to process "experientially" what they are going through instead of learning to expect a reward or punishment for their choices. This highlights how students like Rachel are receiving therapeutic interventions through daily experiences, whether in the classroom, outdoor adventures, or having dinner with peers or the therapist. Students like Rachel appear to respond very well to the active, real-life situations that can be processed and integrated into her mental models.

Outdoor Behavioral Healthcare. Outdoor behavioral healthcare programs involve wilderness expeditions, requiring the initial phases of the treatment process to be focused on orientation to the group and program and the learning of a variety of skills to become more proficient with backcountry travel. As one respondent stated, "a typical 15 year-old student would come to our program reluctantly but willingly." A significant factor in the early phases would be acceptance of the student by the group and the use of peer support to help ease the student into their experience. Staff typically steps back and lets more experienced students work to orient the student.

Johnny has a history of violent outbursts with his parents, substance use issues, failure in several schools, and a lack of progress in working with his most recent counselor in an outpatient setting. He would spend his first few days learning about how the expeditions work within the program and the roles that each student has in the success of the team on expedition. He would be encouraged to see

he is needed in the program to help the team and himself grow. Task specific skills he would be working on would include understanding the nuances of navigating, backcountry cooking, and playing the role as a leader of the day. Common topics in group discussions around meals and therapy sessions would focus on the therapeutic role of the group as a family system.

In their first therapy session, Johnny would be given letters from his parents that highlight his strengths and specifically do not focus on his weakenesses nor reasons why he may be in treatment. This strengths-based approach provides an opportunity to build on the good inside Johnny and re-think the fractured relationship he may have with his parents. In this way, treatment is not seen as a punishment, but for a chance to rebuild their relationships. Johnny would also be given the chance to explore how making fire or having a "new beginning" applies to not only life in treatment, but more importantly at home with his family and friends. The next steps would be for Johnny to come to an understanding of why he is treatment, write this in a letter to his parents, and ask them for their perspective on why he needed treatment. This discourse is the beginning of the healing process for families and sets the foundation for reconciliation.

Other Types of Settings. The other type of setting chosen to illustrate a vignette would be a ranch that utilizes equine therapy in helping students address their issues. Sarah, a 15 year old, is having personal identity and self worth issues. Consequently, she has been acting out sexually, has been increasingly violent with her recently divorced mother, and has issues with substance abuse. Sarah has seen a social worker through local community services for years, but has not been making any progress. Her mother has become increasingly worried about her personal safety. Because the program utilizes a family systems approach, Sarah would attend a multi-family group with her parents and other families and participate in initiative activities that focus on family reconnection. Sarah and her mother (her father is completely out of the picture and refuses to participate) would process the meaning of the experiences with therapists and discuss their feelings about the activities with their peers their parents. An equine-based activity utilized by the program in the first week would be to use the horses to help Sarah gain insight into her current situation. Sarah has revealed in her family meeting that she is still

very resistant to therapy and change and feels she has been placed in the program as punishment for her previous behaviors. The staff at the program has Sarah go into an arena with 4 to 6 horses and challenges her to “catch” a horse with who she feels she has the potential to form a lasting bond. The horses are resistant to being caught, and are very elusive. The experience is exhilarating, frightening, and challenging all at once. Sarah eventually corners a horse using soothing language and slow and steady patience. From that experience, Sarah, in working with her therapist at the program, begins to gain insight on their own resistance to the first and most difficult phase of treatment, and begins to slowly open up about her adoption issues and her relationship with her mother and previous relationship with her father.

Discussion

This paper reviewed the relevant literature on the adolescent behavioral healthcare service industry operating in the United States and Canada and discussed the well-documented historical demand for services. A discussion of best practices in residential treatment and movements to advocate for best practices and ethical treatment for adolescents and their families was presented. An estimation of the number of adolescent residential treatment programs and subsequent number of students in residence based on data acquired from national accreditation agencies was given. Finally, a presentation of preliminary results from a member survey of a national association was presented. The survey was guided by the question: What is experiential therapy and what does it look like when practiced with adolescents in your program. The following issues emerged from this study which guide this discussion: 1) the persistent and growing problem of a lack of healthcare services for adolescents, 2) the growing movement and subsequent discussion on the role that residential treatment plays on the continuum of available healthcare services for adolescents, 3) the role that direct and intentional experience play in the treatment of adolescents in residential settings, and 4) the need to better understand how experience and activity are integrated within existing evidence based practice in residential settings.

Access to community-based behavioral healthcare services for adolescents has been a persistent and growing concern. The “continuum of care” talked about by behavioral healthcare experts

that consists of services in schools, outpatient, inpatient, day treatment, and accessible residential facilities appears to be out of reach for families seeking treatment alternatives. The demonstrated historical demand and current lack of services make it highly likely that innovative programs, and more importantly, effective innovative programs, will be increasingly utilized by families in search of help for their children. As programs continue to evolve and adapt to meet this growing demand, an increased understanding of the therapeutic approaches being employed by such programs will (a) help researchers in their attempts to evaluate programs that utilize experiential methods in treatment, (b) aid families who are faced with a dizzying array of barriers and challenges in finding the right program for their child, and (c) educate referring mental health professionals in helping them find and place adolescents in appropriate programs.

We estimate approximately 1,500 known residential treatment programs for adolescents currently operating in the United States and Canada. These programs seem to fill an important need in the lexicon of mental health services. An interesting finding in this research project has uncovered what appears to be a growing movement, pushed by organizations like ASTART, that question the value and role of residential treatment services for adolescents and their families. This is surprising given the lack of services available in general, and the fact that many of these programs are private pay, and are driven by market conditions and demonstrated need by consumers. The rhetoric accompanying this movement is predicated on the idea that youth should never be taken out of their homes, and that treatment should be focused on working with families and youth in their homes and neighborhoods. As one author stated, “Instead of removing teens from their environments, therapeutic approaches like Multi-Systemic Therapy (MST) are out in the trenches with teens and families in their own environments, a strategy that works and saves the lives of teens” (Van Orden, 2009, p. 3). Though treatment approaches like MST are appropriate for certain types of youth, MST is an extremely rigid program that requires absolute adherence to the model. In most cases, only families that qualify for government support have access to this intervention, which leaves most middle and upper socio-economic status families with few options other than outpatient treatment (which most have tried prior to turning to residential treatment). Moreover, most research shows that interventions, like MST, are no more effective

than residential treatment models when directly compared in research studies (Littell, Campbell, Green & Toews 2005). An improved understanding of what types of treatment approaches are utilized in residential programs, and the degree to which they help address well documented barriers and stigma associated with traditional treatment approaches, and meet the demand for adolescent healthcare services, is needed so a more informed and less reactive discussion can take place.

We hypothesize that if each program annually served 250 students a year, then approximately 500,000 adolescents a year may be treated by in residential settings. It is difficult to compare these figures to the literature, because as Freidman (2009) states, "We were dismayed when they (GAO) were no more successful than others in coming up with estimates of the number of youth in private residential placements" (p. 3). Despite these difficulties in estimating the utilization of these services, it is clear that our study shows a significant number of programs do indeed utilize direct experience to enhance their therapeutic approach. Continuing to discuss how practitioners utilize experience and integrate it into existing therapeutic modalities appears to be an area that could shed light on what may or may not be more effective. If 'research therapies' that are tested and disseminated through strict adherence to manuals and protocol are not what is being practiced on the ground by creative and well intended therapists, then research and evaluation should focus on what actually is being implemented in these environments. This inquiry would strengthen our understanding of how to work with youth, and what might really constitute best practices.

Our survey focused on the following four questions:
1) What psychotherapeutic approaches are utilized by your program? 2) Please describe how your therapeutic approach described above is experiential, 3) Briefly describe how experiential therapy might be used in the beginning phase of your program to work with a student in your program, and 4) What are the tangible benefits from experiential therapy that would not otherwise be achieved through more traditional modes of therapy. The sample of 51 respondents, though small (33%) appears to match the percentages of program types and geographic locations of a previous survey and of figures of the national association. We consider the sample valid. There were 46 programs that responded to the question of whether their therapeutic approach was experiential.

From the responses of the 46 we hypothesized the following agents of change in this model of activity-based experiential treatment.

The therapeutic *milieu* is continuous and evolving. It involves relationships among and between members of a group. This milieu often involves natural consequences and therapeutic relationships that are on-going and integrated into treatment more than in traditional approaches. While the milieu describes several similarities with group therapy, the continuously evolving, naturally consequencing environment of experiential therapy described here appears to be unique to approaches that make use of challenge courses, wilderness, or animals.

The *process* of this form of experiential treatment centers on activity. Activity provides skill development, self development, insight, and motivation. Activity can provide a frame to experience and serve as a kinesthetic metaphor for life. The centrality of activity within respondents' answers set this form of experiential therapy apart from others in its ability to access clients with various learning styles and its de-emphasis on verbal aspects paramount in traditional approaches.

The interaction of the milieu and the process provide a dynamic, active, often kinesthetic, model of experiential treatment that needs evidence to support or disprove it. Key questions that future research could address include: Are all elements of the milieu necessary? If a student or client is impacted by activity in only one of the ways mentioned, is this sufficient for activity-based experiential therapy to be successful? How might this approach be researched? What if students who had previously been involved in residential treatment where experiential methods took place were asked to identify which elements of their experience provided "triggers" for change in their behavior? What if these responses began to cluster among the same (or different) aspects of this model that has been proposed? This pilot study sheds some light on how experiential methods are being used in residential treatment. It also raises the question of how a larger number of residential programs may or may not also be utilizing experiential approaches. Further study of a larger sample can potentially lead to a more informed discussion of how practitioners are working with adolescents and their families in residential settings to create therapeutic change through experiential methods.

References

American Bar Association (2007). Policy requiring licensure, regulation, and monitoring of privately operated residential treatment facilities for at-risk children and youth. *Family Court Review*, 45(3), 414-420.

Association of Experiential Therapies. (n.d.). Retrieved from http://www.asetonline.com.

Behar, L., Friedman, R., Pinto, A., Katz-Leavy, J., & Jones, W.G. (2007). Protecting youth placed in unlicensed, unregulated residential "treatment" facilities. *Family Court Review*, 45(3), 399-413.

Berman, D. & Davis-Berman, J. (2007). The promise of wilderness therapy: Reflecting on the past, projecting into the future. *New Zealand Journal of Outdoor Education*, 2(2), 24-42

Brown, E. (2002, October 14). When rich kids go bad. Forbes, 170(8), 140-148.

Burns, B. J., Hoagwood, K. & Maultsby, L. T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In M. H. Epstein, K. Kutash, & A. J. Duchnowski (Eds.), Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices (pp. 686–707). Austin, TX: Pro-Ed.

Federal Trade Commission (2008). Considering a private residential treatment program for a troubled teen? Questions for parents and guardians to ask. (July 2008). FTC Facts for Consumers. Retrieved from www.ftc.gov/bcp/edu/pubs/consumer/products/pro27.pdf.

Davis-Berman, J., & Berman, D.S. (2008). The promise of wilderness therapy. Boulder, CO: Association for Experiential Education.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). Doing naturalistic inquiry: A guide to methods. Thousand Oaks, CA, US, Sage Publications, Inc.

Friedman, R. M., (February 19, 2009) Abuse of youth in residential placements: An overview of the problem presentation to "Abuse of Youth in Residential Treatment: A Call to Action," Washington, DC, February 19, 2009. Retrieved from http://astart.fmhi.usf.edu/AStartDocs/overview-abuse-

presentation-021909.pdf.
Friedman, R. M., Pinto, A., Behar, L., Bush, N., Chirolla, A., Epstein, M., et al. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry*, 76, 295–303.
Gass, M. A. (Ed.). (1993). Adventure therapy: Therapeutic applications of adventure programming. Dubuque, IA: Kendall Hunt Publishing Company.
Gillis, H. L. (1992). Therapeutic uses of adventure-challenge-outdoor-wilderness: theory and research. In K. Henderson (Ed.). Proceedings of Coalition for Education in the Outdoors Symposium. [ERIC Document Reproduction Service No. ED35222.
Gillis, H. L., Gass, M.A., & Russell, K.C. (2008). The effectiveness of project adventure's behavior management programs for male offenders in residential treatment. *Residential Treatment of Children & Youth*, 25(3), 227-247.
Gillis, H.L. & Russell, K. C. (2008). Group-based adolescent treatment: Service delivery and effectiveness, and emerging treatment alternatives. Poster presented at the Annual Convention of the American Psychological Association, Boston, MA.
Itin, C. (n.d.). (http://www.geocities.com/experiential_social_work/ Johnson, L. D., O'Malley, P. M., Bachman, J. G., & Schulenburg, J. E. (2006). Monitoring the future national results on adolescent drug use: Overview of key findings 2005. NIH Publication No. 06-5882): Bethesda, MD: National Institute on Drug Abuse.
Kutz, J. D. & O'Connell, A. (2007). Concerns regarding abuse and death in certain programs for troubled youth. U.S. Government Accounting Office, # GAO-08-146T. Report and Testimony to the Committee on Education and Labor, House of Representatives, October 10, 2007.
Lamb, S. (Ed), Greenlick, M. R. (Ed), & McCarty, D. (Ed); National Academy of Sciences, Inst of Medicine, Div of Neuroscience & Behavioral Health, Committee on Community-Based Drug Treatment, Washington, DC, US (1998). Lamb, Sara; Greenlick, Merwyn R.; McCarty, Dennis Bridging the gap between practice and research: Forging partnerships with

community-based drug and alcohol treatment. Washington, DC, US, National Academy Press.
Latessa, E. (2004). The challenge of change: Correctional programs and evidence-based practices. Criminology and Public Policy, 3(4): 547-560.
Littell J.H, Campbell M, Green S, & Toews B. (2005). Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17. *Cochrane Database of Systematic Reviews* 2005, Issue 3, Art. No.: CD004797.
McManus, M. A. (2003). Is the health care system working for adolescents? Washington, DC, Maternal and Child Health Policy research Center: 23.
Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook (2nd ed.)*. Thousand Oaks, CA, US, Sage Publications, Inc.
National Alliance on Mental Illness (2008). A Resource for families considering residential treatment programs for their children. Retrieved from http://www.nami.org/Content/ContentGroups/CAAC/.
Pinto, A., Friedman, R. M., & Epstein, M. (2005). Exploitation in the name of “specialty schooling”: What counts as sufficient data? What are psychologists to do? American Psychological Association: Public Interest Directorate, Children, Youth and Families Division News. Retrieved from http://www.apa.org/pi/cyf/specialty_schooling.pdf
Pos, A. E., Greenberg, L. S., & Elliott, R. (2008). Experiential therapy. In Lebow, Jay L. (Ed), *Twenty-first century psychotherapies: Contemporary approaches to theory and practice.* (pp. 80-122). Hoboken, NJ, US: John Wiley & Sons Inc.
Rubin, B. M. (2004, January 14). The last resort; Therapeutic education industry booms as parents seek programs for their troubled children. *Chicago Tribune*. Retrieved from http://www.chicagotribune.com
Russell, K. C., Gillis, H. L., & Lewis, T. G. (2008). A five-year follow-up of a nationwide survey of outdoor behavioral healthcare programs. *Journal of Experiential Education*, 31,1, 55-77.
Russell, K.C. (2007). Adolescence substance use treatment: Service delivery, research on effectiveness, and emerging

treatment alternatives. Journal of Groups in Addiction and Recovery, 2(2-4), 68-96.
Russell, K.C. (2008). Adolescence substance use treatment: Service delivery, research on effectiveness, and emerging treatment alternatives. In Roth, J. & Finch, A. (Eds.), Approaches to substance abuse and addiction in educational communities. New York: Haworth Press
Russell, K.C. (2006a). Depressive symptom and substance use frequency outcome in outdoor behavioral healthcare. Technical Report 1, December 2006, Outdoor Behavioral Healthcare Research Cooperative, College of Education and Human Development, University of Minnesota, Minneapolis, MN. 62 pp.
Russell, K. C. (2006b). Brat camps, boot camps, or….? Exploring wilderness therapy program theory. *Journal of Adventure Education and Outdoor Learning*, 6 (1), 51-67.
Russell, K.C. (2005). Two years later: A qualitative assessment of youth-well-being and the role of aftercare in outdoor behavioral healthcare treatment. *Child and Youth Care Forum*, 34 (3), 209-239.
Russell, K.C. (2003a). A nation-wide survey of outdoor behavioral healthcare programs for adolescents with problem behaviors. *Journal of Experiential Education*, 25(3), 322-331.
Russell, K.C. (2003b). Assessing treatment outcomes in outdoor behavioral healthcare using the Youth Outcome Questionnaire. *Child and Youth Care Forum*. 32 (6), 355-381.
van Orden, M., Hoffman, T., Haffmans, J., Spinhoven, P., & Hoencamp, E. (2009). Collaborative mental health care versus care as usual in a primary care setting: A randomized controlled trial. *Psychiatric Services*, 60, 74-79.
Vorrath, H., & Brendtro, L. (1985). Positive peer culture. New York: Aldine Publishing
Weisz, J. R., & Gray, J. S. (2008). Evidence-based psychotherapy for children and adolescents: Data from the present and a model for the future. *Child and Adolescent Mental Health*, 13, 54-65.
Weisz, J. R., Huey, S. J., & Weersing, V. R. (1998). Psychotherapy outcome research with children and adolescents. *Advances in Clinical Child Psychology*, 20, 49–91.

Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist*, 47, 1578-1585.

Wells, L. (2006) Prescription medication and street drug considerations in Outdoor Behavioral Healthcare Programs. *Journal of Therapeutic Schools and Programs*, 1(2), 61-74.

Young, M. C. & Gass, M. A. (2007). Member program characteristics of the National Association of Therapeutic Schools and Programs: A technical report from the NATSAP Board of Directors and the NATSAP Research Committee.

Appendix A. Survey

1. CONSENT: I agree to be a participant in the research titled "Amer.Psyc.Assoc/ NATSAP research study", which is being conducted by Keith C. Russell and Lee Gillis, who can be reached at 360.XXX.XXXX or 478.XXX.XXXX. I understand this participation is entirely voluntary; I can withdraw my consent at any time and have the results of the participation returned to me, removed from the experimental records, or destroyed.

- ○ Yes
- ○ No

2. What is your primary program type?

- ☐ Residential Treatment Center
- ☐ Home-Based Residential
- ☐ Emotional Growth Boarding School
- ☐ Young Adult
- ☐ Boarding School
- ☐ Transitional Independent Living
- ☐ Therapeutic Boarding School
- ☐ Outdoor Behavioral Health/Wilderness

Other (please specify) ________

3. In what year did your program begin operation?

____

4. In what state or province are you located (2 letter abbreviation)?

____

5. Is your program accredited?

- ☐ Yes
- ☐ No

6. Are you licensed in your state?

- [ ] Yes
- [ ] No

7. What is the approximate percentage of each gender served: (add to 100%)

Females [ ]

Males [ ]

8. What is the average number of clients/students served annually (over the past three years)?

[ ]

9. What is the maximum enrollment (capacity) for your program?

[ ]

10. What is the average length of stay for a client/student?

[ ]

11. Do you serve clients over 18 years of age?

- [ ] Yes
- [ ] No

12. Do you serve clients between 13 and 18 years of age?

- [ ] Yes
- [ ] No

13. Do you serve clients 12 years old or less?

- Yes
- No

14. What psychotherapeutic approaches are utilized by your program?

15. Do you consider the psychotherapeutic approach described above "experiential"?

- Yes - please proceed
- No - please skip to the bottom of the page and click submit

16. Please write 1-3 sentences to describe how your psychotherapeutic approach is "experiential."

17. In your program, is experiential therapy..

- Tangiential - Only indirectly related
- Adjunctive - Additional, add-on; an approach used at the same time as other treatments
- Primary - First in importance; direct and immediate

18. In the beginning phase of your therapeutic program, how would experiential therapy be used to treat a typical 15 year old student. Briefly describe the client and provide an example of 1-2 sessions or activities.

19. What tangible, observable benefits (if any) do you see from the use of experiential therapy that would not otherwise be achieved through traditional modes of therapy?

20. How important do you think experiential therapy is to your students/client realizing their therapeutic goals?

- [ ] Not important
- [x] Somewhat important
- [ ] Important
- [ ] Extremely important

Preliminary Data from the NATSAP Research and Evaluation Network: Client Characteristics at Admission

Michael C. Young, M. Ed.
Michael Gass, Ph. D.

University of New Hampshire
michael.young@unh.edu
mgass@unh.edu

Abstract

This study presents data collected through the National Association of Therapeutic Schools and Programs' (NATSAP) Research Network. The aim of this study is to further define the subset of residential treatment represented by the NATSAP membership by describing the characteristics of clients upon admission. Ten private-pay residential treatment programs representing the range of programs commonly found in the NATSAP membership (e.g., therapeutic boarding schools, residential treatment centers, and outdoor/wilderness programs) contributed data collected at admission from staff, clients, and client parent/guardians. Demographic and standardized assessment data suggested that on average, these clients are referred by educational consultants; are white adolescents from families with the financial means to pay for services; possess at least average school achievement; and tend to have no major legal issues. They are struggling with elevated substance and alcohol use along with a complex array of clinically significant mental health issues. These youth also tend to be increasingly diagnosed with depression or mood disorders and typically begin their journey into residential treatment at a wilderness/outdoor program.

Introduction

While it is possible to introduce "residential treatment for youth" as a single cohesive concept, in reality there is no clear definition of what services are represented in such treatment or what specific types of clients are involved. Scholars and evaluators have argued that such ill-defined and overlapping categories of services and clients have severely blurred the understanding of residential treatment for youth in the U.S. (Frensch & Cameron, 2002; Kutz & O'Connell, 2007). Because of this confusion, many claim further work in the field should include the careful measurement of both program characteristics and client outcomes (McNeal et al., 2006; Zimmerman, 1998). This clarity is particularly important in light of the fact that residential treatment is currently practiced within a difficult political and ethical context: often serving some of the most challenging cases within a public policy culture emphasizing least-restrictive settings and shorter lengths of stay in treatment. Such dynamics have fostered intense criticism and scrutiny of residential programming (Frensch & Cameron, 2002; Leichtman, 2006; Pumariega, 2006; Whitehead, Keshet, Lombrowski, Domenico, & Green, 2007; Zimmerman, 1998). For example, public concern for ethical treatment of youth in residential treatment has led to recent publications and policy initiatives calling for increased accountability and oversight for residential programming (Friedman et al., 2006; HR 911: Stop Child Abuse in Residential Programs for Teens Act, 2009; Lieberman & Bellonci, 2007)

One specific subset of residential treatment for youth in the North America consists of privately owned programs where the majority of the cost of treatment is paid for by families without the reimbursement or support of third-party payers. These "private-pay" programs fill the needs of families who are not part of publicly funded social, mental health, or juvenile justice services (and may not want to be); whose insurance plans do not cover residential treatment; and who are not succeeding in treatment with either hospitalizations or out-patient clinical services (Friedman et al., 2006; Leichtman, 2006). The majority of programs that are members of the National

Association of Therapeutic Schools and Programs (NATSAP)[1] fall into this category (Friedman et al., 2006; Young & Gass, 2008).

The aim of this study is to further define this subset of residential treatment by describing the characteristics of clients upon admission. The data analyzed in this study came from 10 different NATSAP member programs who were participants in the NATSAP Research and Evaluation Network. This network serves as a multi-site data collection and analysis project sponsored by NATSAP, developed in collaboration with researchers from the University of New Hampshire to answer the call for more descriptive and outcomes data and to "begin to develop the evidence base for our work that is increasingly important and expected in all educational and behavioral health environments" ("NATSAP Research and Evaluation Network," 2009, p. 1).[2]

A need for clarity in uncertain times

Multiple surveys, dating back at least to 1969, have been conducted to gauge the numbers of children in residential treatment in the U.S. (Edwards, 1991; NIMH, 1983; Pappenfort & Kirkpatrick, 1969). Comparing one survey to another can be problematic when examining the scope and history of the industry. Much of this difficulty is due to the various approaches used to define both the types of programming, as well as the differing characteristics existing within the client population (Edwards, 1994).

Two recent attempts to survey the industry utilized the Directory for Exceptional Children. Zimmerman (1998) found 447 program listings when surveying the 12th edition (1990) for programs with residential components serving youth with behavioral disabilities. When using similar criteria to examine the 2000 programs listed in the more recent 15th edition (2004), 298 programs were

---

1 The National Association of Therapeutic Schools and Programs (NATSAP) was created in January 1999 "to serve as a national resource for programs and professionals assisting young people beleaguered by emotional and behavioral difficulties…members include therapeutic schools, residential treatment programs, wilderness programs, outdoor therapeutic programs, young adult programs and home-based residential programs" ("NATSAP Overview," 2008) In spring of 2007, NATSAP consisted of 181 member programs.

2 It should be noted that the data base being developed by the NATSAP Research and Evaluation Network is available to any interested researcher pending approval by the NATSAP Research Committee. Interested parties should contact NATSAP.

identified (Young & Gass, 2008). Although the Directory may offer one of the more complete listings of residential treatment options for emotionally and behaviorally challenged youth in the U.S., it by no means lists all the programs in current operation, and likely lists a number that are no longer in business. And while these surveys are helpful for obtaining a broad view of the field of residential programming for youth, they do not address the issue of blurred definitions of programming and clientele that plague both the academic literature and public perception.

The organizations receiving the label of "residential treatment" are typically "highly structured institutions closely resembling psychiatric hospitals to those that are indistinguishable from group homes, half-way houses, or fostercare" (Tuma, 1989, p. 193, as cited in Leichtman, 2006, p. 286). The tendency for a broad range of programming to be grouped together under the title of "residential treatment" was identified by a 2006 report by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), which according to Kutz & O'Connell (2007) identified 71 different types of residential treatment programs for youth with emotional and behavioral issues (Ireys, Achman, & Takyi, 2006). While a diversity of programming is not necessarily a problem in itself (and in fact may be an asset), when generalizations about treatment modalities based on widely divergent program models are made by researchers, practitioners, or stakeholders, inaccurate assumptions can occur. So even though there have been multiple surveys and studies done in the field, this lack of clarity has led critics and scholars of residential treatment of youth to complain that there is in fact a "dearth of accurate information" (Friedman et al., 2006, p. 295, emphasis added).

For example, any broad assumptions made about the effectiveness of residential treatment for youth are certainly suspect when they emerge from the "lumping" together of "theoretically and programmatically diverse residential care programs" (Handwerk, 2002, as cited in McNeal et al., 2006, p. 304). Consequently, within a concerned social and political context where residential treatment programs and associations try to justify their services and answer calls for accountability, it is important that reports of outcomes be based on sound methodologies and clear definitions. Otherwise, "research in this area will continue to struggle with poor credibility and limited application (Frensch & Cameron, 2002, p. 337).

The Difficult Paradox of Residential Programming for Youth

Clarity around the residential treatment for youth is particularly important considering the often tense social and political environment surrounding these types of services. Reflecting on the past 50 years, Pumarreiga (2006) described the paradoxical trends influencing the field: "One was toward a clinically sound and more humane approach to the residential treatment of youth who were previously thought to be untreatable and hopeless. The other, paradoxically, was a trend toward the large-scale warehousing of youth in the name of therapeutic intervention" (p. 281).

Pumarreiga further identified the tension arising in our society between the stated need for intensive treatments for certain youth and our mistrust of restrictive residential care. Frensch and Cameron (2002) described this as the "double message" facing residential care providers (p. 308). According to Leichtman (2006). the consequence of this double message along with recent trends toward shorter brief therapies and managed care is that: "Over the last decade and a half, these critiques and concerns about the funding of extended inpatient programs have led many in the mental health community to view residential treatment as overused and, at best, as an unfortunate necessity rather than a valuable treatment tool" (p. 286). The paradox of residential treatment is that the conclusion that it is a harsh option of absolute last resort is coupled with the realization that there is a growing need to serve more severe and complicated cases. As Zimmereman (1998) put it, "Thus RTCs [residential treatment centers] are faced with the formidable task of increasing treatment effectiveness and demonstrating this impact with more difficult clients, less money, and shorter treatment stays" (p. 47).

While it is important to understand this paradox as the context where residential treatment programs operate, it would be narrow minded to label residential care providers simply as victims of divergent societal pressures. Of course there is a need for oversight and accountability. As Whitehead, Keshet, Lombrowski, Domenico, and Green (2007) wrote:

> The very youth, who are in most dire need of empathy, care, and holistic treatments, are being bombarded by trauma-inducing interventions within the walls of facilities, masquerading as optimal models of healing and hope. Within these falsified institutions of rehabilitation, human rights are being

> violated through the implementation of inappropriate care or mistreatment. (p. 348)

While these authors may be a bit overdramatic, they accurately depict the fact that the very nature of residential treatment has the potential to be very harmful. There are certainly times and situations where many programs fall short of the intense demands of the work.

In their assessment of the overall failings of many residential care facilities, Whitehead et al, went on to " attribute the lack of clear definition of appropriate residential treatment by mental health professionals as a main contributing factor to a systemic problem" (p. 348). Thus, within this environment of intense scrutiny and ethical obligation, it becomes essential for stakeholders, including researchers, care providers, referral sources, and regulators, to be clear when they discuss, analyze, and ultimately evaluate residential treatments for youth.

Private-Pay Residential Programming in the cross-hairs

Within residential treatment programs, the lives of children and families lie in the balance and the stakes are immeasurably high. It is no wonder that reports of neglect or abuse inspire the desire to literally descend from the sky and rescue the alleged victims (see Pumariega, 2006). These noble concerns have led to the recent formation of the The Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment (A START) (Friedman et al., 2006) to government studies (Kutz & O'Connell, 2007), and to proposed regulatory legislation (*HR 911: Stop Child Abuse in Residential Programs for Teens Act, 2009*). Much of this recent activity has focused on the potential harm of "unregulated" programs and has involved a push for the licensure, accreditation, and government oversight of programs (Friedman et al., 2006; *HR 911: Stop Child Abuse in Residential Programs for Teens Act, 2009*; Lieberman & Bellonci, 2007).

Private-pay residential treatment centers, such as those found within the NATSAP membership, are on average more recently established and less apt to be accredited or licensed than some of their publically funded counterparts (Young, 2008). Consequently, as a somewhat recent and "unregulated" additions to the industry this sector of services has sometimes attracted intense scrutiny (Friedman et al., 2006; Whitehead et al., 2007). While close scrutiny of the care given to children and their families is warranted and necessary, in or-

der for this scrutiny to serve its intended purpose, accurate and clear information describing programs and their clients is necessary. An example of how one subset of the private-pay residential treatment programs, outdoor/wilderness therapy, has been significantly effected by blurred definitions is described in Figure 1.

Figure 1. *Wilderness Therapy, Residential Camping, Boot Camps and Outdoor Behavioral Healthcare*

Wilderness Therapy programming includes a wide range of programs. Only some of these program types fall within the Outdoor Behavioral Healthcare (OBH) model. This model has been developed within the membership of the Outdoor Behavioral Healthcare Council (OBHIC), founded in 1996 (Hendee, 1999, as cited in Russell, 2003). OBHIC, and its affiliated research cooperative, the Outdoor Behavioral Healthcare Research Cooperative (OBHRC), have worked to create clear standards of care within the wilderness therapy industry. As Russell (2007) wrote in regard to OBHRC's latest survey of the industry:

> A further refinement of the definition of OBH was developed, with the goal being a more detailed illustration of two key factors that are reasoned to distinctly define OBH theory and practice: 1) the *clinical* treatment model, supervised and facilitated by licensed professionals, that underlies the approach, and 2) the *primary* use of wilderness expeditions as a therapeutic tool. The reason behind this was not for isolationist purposes by OBHIC programs that developed the definition, but rather to more accurately illustrate to parents, mental health practitioners, and respective agencies what OBH is and how it works. (p. 33)

It is clear from Russell's quote that defining OBH is an on-going, important and sensitive endeavor. There are, for example, overlapping conceptions of wilderness therapy, therapeutic camping, and "boot camps." While the published academic literature often tries to draw distinctions between these programming types, it also suggests that they may often be perceived by consumers or other members of the public as one in the same (Brown, Steele, & Roberts, 2005; Russell 2006). Although the outcomes for all three types of programming are arguably varied (Byers, 1979; Russell 2003; Tyler, Darville & Stalnaker 2001), advocates of both therapeutic camping as well as wilderness therapy stress the difference between these program types' potentially more empathetic practices with the more "militaristic" approaches presumed of boot camps (Brown et al., 2005; Russell 2006). While it is likely that a fairly wide and overlapping range of approaches exist within the three models, it would seem that these concerns over identity confusion are warranted: a recent by the Government Accountability Office (GAO), alleged widespread abuse and mistreatment of youth but arguably blurred some of these definitions (Kutz & O'Connell, 2007).

Advocacy for ethically run and appropriately regulated residential treatment programming is both essential and inevitable. If such advocacy is to work effectively, it must be supported by accurate and useful information. The recent emergence of private-pay "specialty" residential treatment programming indicates that they may be finding new alternative ways to meet some of the many needs exhibited by adolescents and their families (Friedman et al., 2006; Leichtman, 2006),. If, however, this sector of residential treatment is to be a part of the regulatory conversa¬tion, and not just an object within it, then clear definitions of private pay programs and their clients becomes necessary. The objective of this study is to provide clarity around the type of clients using private-pay residential treatment programming.

Sample

The participants for this study were 275 clients admitted to 10 residential programs between December 2007 and December 2008. All 10 of the programs were predominantly private-pay facilities and were all members of NATSAP. While the study used a convenience sampling as a technique for data collection, there is reason to believe the sample is somewhat representative of the total NATSAP client population.

Five of the 10 programs sampled were self identified as "Therapeutic Boarding Schools/Boarding Schools," five as "Residential Treatment Programs," and two as "Wilderness/outdoor" programs. Though not specifically representative, these program types represent about 84% of all NATSAP programs, which in 2007 were distributed in the following manner: Therapeutic Boarding School/Boarding Schools (25%), Residential Treatment Centers (37%), and Wilderness/Outdoor Programs (22%) (Young & Gass, 2008).

The sample was 68% male and 32% female with an average age of 16 (93% of the sample were between the ages 14 and 18). When compared to other studies conducted in the private-pay residential arena, these numbers suggested the sample was a fairly representative one with respect to client gender and age. For example, Russell (2006) found a predominantly male Outdoor Behavioral Healthcare (OBH) client population (68%) (which was argued to be similar to previous assessments of OBH), and Behrens & Satterfield (2007) found their sample of 1027 predominantly

private-pay residential treatment clients were also majority male (55%).[3] Like the current sample, Behrens & Satterfield (2007) and Russell (2006) also identified the average age of their samples as 16 years old. These findings further echo the heavy emphasis on services for high school-age adolescents found within the overall NATSAP membership (Young & Gass, 2008).

Similar to Behrens & Satterfield (2007), who found a mean annual income in their sample of greater than $100K, the sample for the present study included 7% who reported an annual household income of less than $50K, 22% reported an income between $50K and $100K, and 71% reported one over $100K. With respect to ethnicity, the current sample was self identified by parents or guardians as: 84% White, 7% Hispanic, 1% African American, 1% Asian, and 7% Other. This was very similar to Behrens & Satterfield's (2007) sample which was 87% Caucasian and to Russell's (2006) sample which was 81% Caucasian.

The sample also reflects the private-pay residential industry's reliance on the internet and educational consultants for a large amount of its referrals (Friedman et al., 2006; Whitehead et al., 2007; Young & Gass, 2008). Table 1 lists the percentages by referral source for the study sample.

Table 1. Sources of Referral for Study Sample

Source of Referral	Percentage of Sample Referred by Source
Educational Consultant	44.10%
Internet	17.10%
Private Clinical Professional	11.80%
Reference from Previous Client	6.50%
Program of Previous Placement	5.70%
Other	12.50%
School District	2.30%

3 Comparatively, it has been estimated that nationally 69% of youth receiving mental health services are male (SAMSHA, 2007).

In summary, while the sample was one of convenience, there is evidence to support that with respect to the broad categories of program type, age, gender, socio-economic status, ethnicity, and referral source, the study's sample is somewhat representative of the broader NATSAP private-pay client population.

Instruments

The NATSAP Research and Evaluation network, including the 10 programs contributing data to the present study, currently utilizes both the Auchenbach System of Empirically Based Assessments (ASEBA) as well as the Outcome Questionnaire Family of Instruments (OQ). The programs sampled in this study collected psychosocial client information from multiple sources. The Y-OQ-SR 2.0 and ASEBA YSR self-report instruments are used with youth ages 11 to 19. The Y-OQ 2.0 and ASEBA Child Behavior Checklist (CBCL) instruments are used with parents or guardians (Achenbach, 1991; Burlingame et al., 1996; M. G. Wells, Burlingame, & Rose, 1999). These instruments assess a variety of behavioral and emotional problems and arguably have considerable overlap between them. Table 2 compares the subscales measured by both the Y-OQ 2.0 and the CBCL.

Table 2. Subscales Measured by the ASEBA CBCL and the Y-OQ

ASEBA Child Behavior Checklist 118 items	**Youth Outcome Questionnaire 64 items**
Competence scales: Activities, Social, and School	*Interpersonal Distress (ID)* *Somatic (S)*
Problem Subscales: Aggressive Behavior; Anxious/Depressed; Attention Problems; Complaints; Thought Problems; Rule-Breaking Behavior; Social Problems; Somatic	*Interpersonal Relations (IR)* *Critical Items (CI)*
Also Grouped as six DSM-oriented scales: Affective Problems; Anxiety Problems; Somatic Problems; Attention Deficit/Hyperactivity Problems; Oppositional Defiant Problems; and Conduct Problems	*Social Problems (SP)* *Behavioral Dysfunction (BD)*

Both the ASEBA and OQ assessments are well known and have established normative scores with documented validity and reliability. The ASEBA instruments have been in use since the 1980s and since then have been used in thousands of studies all over the world (Bérubé & Auchenbach, 2007). The OQ instruments have been developed more recently but have published validity and reliability, have established correlations with the CBCL, and may potentially be more sensitive to client therapeutic change (Lambert et al., 1996; Mosier, 1998; Mueller, Lambert, & Burlingame, 1998; Umphress et al., 1997; G. Wells, Burlingame, Lambert, Hoag, & Hope, 1996). Programs participating in the NATSAP Research Network have the option to use forms from one or both of these groups of instruments.

In addition to the standardized instruments, additional data was collected through customized questionnaires used with program staff (e.g., reasons for referral, referral source, admission date, gender, D.O.B., and record of abuse), clients (e.g., attitude toward program and drug/alcohol use), and parent/guardians (e.g., previous treatment history, recent school performance, client drug/alcohol use). Copies of all questionnaires used can be viewed at the NATSAP website .

Findings

History of Previous Treatment

Based on data reported by 122 parent/guardians within the sample, a large majority of the clients had experienced some sort of mental health treatment prior to admission: 90 percent had participated in some sort outpatient counseling, 45% had spent some amount of time in a psychiatric hospital setting, and 79% had been recently prescribed medication "for psychological or emotional problems." Within the sample, no clients who were being admitted to a Wilderness/Outdoor program were reported to have a previous placement history in a residential treatment center (RTC), therapeutic boarding school or another Wilderness/Outdoor program. However, among the clients being admitted to RTCs or Therapeutic Boarding Schools, 51% had previously been to a Wilderness/Outdoor program and 34% had previously been to another RTC or Therapeutic Boarding School.

These rates of previous treatment, similar to those found in the private pay residential population by both Russell (2006) and

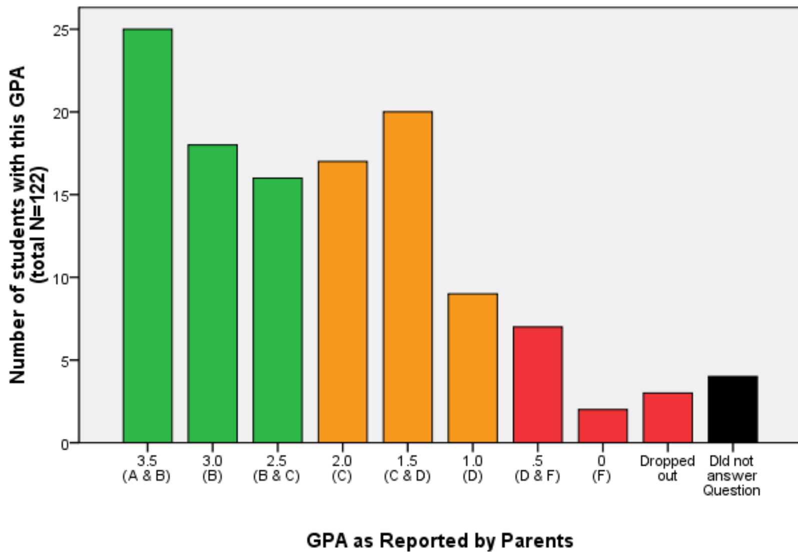
Behrens & Satterfield (2007), indicated that clients entering all of these programs were likely to have been involved in some sort of previous mental health services and that the wilderness outdoor programs are often the first step in a family's involvement with longer term residential care.

School performance and legal issues

With respect to academic achievement and involvement in the juvenile justice system, the sample for the present study was also similar to the larger sample studied by Behrens & Satterfield (2007). On average, a majority of all clients were performing adequately in school and a minority were dealing with legal issues.

As indicated in Figure 2, over half of the sample for the current study with academic data were performing at a "C" level or better. Similarly, Behrens & Satterfield (2007) reported a mean grade point average of 2.0 for their sample.

Figure 2. Previous School Performance upon Admission as reported by Parent/Guardian



According to the reports of parents or guardians respond-

ing to questions about legal issues (N=122), 36% of youth had some sort of previous involvement with the legal system. Seventy one percent (71%) of this involvement (or 13% of the total sample) were involved with either minor charges or no court charges at all. Eleven percent (11%) of those with legal issues (or 4% of the total sample) were on probation when they were admitted to the program. These findings are similar to those of Behren & Satterfield (2007) who found that about 22% of their private-pay residential treatment sample possessed some sort of legal record.

Drug and Alcohol Use

While the majority of the current sample were performing adequately at school and steering clear of legal issues, the majority were using alcohol and drugs. Table 3 represents the frequency of use of alcohol, marijuana, and other drugs for the three months prior to admission as reported by both clients and their parents/guardians.

Table 3. Self Report (N=151) and Parent/Guardian Report (N=122) of Client Alcohol and Drug use

	Alcohol		Marijuana		Other Drugs (including inhalants, or abuse of prescription drugs)	
Frequency of use	Youth Self-report	Parent Report	Youth Self-report	Parent Report	Youth Self-report	Parent Report
None	44%	41%	42%	48%	63%	70%
1-5 times a month	30%	38%	19%	21%	17%	17%
6-20 times a month	20%	14%	13%	14%	11%	10%
21-30 times a month	5%	3%	26%	16%	9%	3%

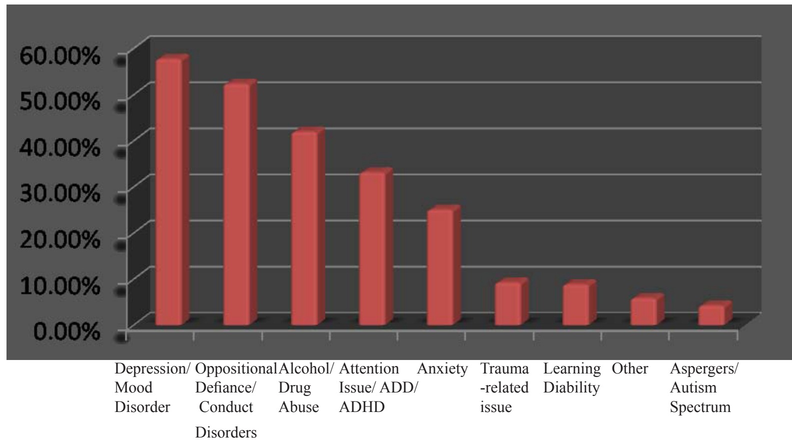
The rates of drug use listed in Table 3 are well above the national average estimated in 2008 by a study conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA). For example: 55% of the current sample self-reported use of alcohol during the last month compared to national average in adolescents of 16%; 58% of the current sample reported use of Mari-

juana compared to 7% nationally; and 37% of the current sample reported use of other drugs as compared to only about 5% nationally (SAMSHA, 2008). These differences seem even more pronounced when one considers the SAMSHA study's percentages of use were based on a question asking whether or not the adolescent had tried the substance once in the last month, whereas the current sample's rates of drug use were based on an assessment over the last three months. Subsequently, while the national rate of "heavy use" for alcohol was only 2.3%, about 25% of the current sample was likely using alcohol between six and 30 times a month. As indicated in Table 3, parent reports of client drug and alcohol use were fairly consistent with their child. However, when it came to the most frequent users parents seemed potentially less aware of this degree of abuse. It should be noted, however, that these differences of reporting were drawn from averages across the entire sample and not through a paired sampling.

Reasons for referral, abuse history, & attitude upon arrival

Substance abuse was a factor in many of the sampled clients' referral to the residential program. It was not, however, the only reason. Among the clients who had reasons for referral reported by program staff (N=265), 77% had three or more reasons for referral. The most common primary reason for referral was reported as Mood Disorder/Depression; the most common secondary reason was oppositional defiance/conduct disorders; and the most common tertiary reason was alcohol and/or substance abuse. Overall rates for reasons for referral (either as primary, secondary, or tertiary) are displayed in Figure 3.

Figure 3. Percentage of Clients with specific Diagnosis or Problem as a Reason for Referral (N=265)



The complexity of client issues found in the current sample was similar to those found by Russell (2006), where half the sample was dual diagnosed with both mental health and substance abuse issues, and by Behrens and Satterfield (2007) where 82% of the sample was referred for multiple reasons. One critical difference between the current sample and these previous studies is the reported incidences of depression/mood disorders as reasons for referral. While in this current study these types of issues were a reason for referral for over 50% of the clients (as well as the most common primary reason for referral), Russell (2006) found about 36.5% of clients to be entering a program at moderate or severe rates of depression and Behrens & Satterfield (2007) found about 34% of their sample to be referred for mood disorders. While this potential contrast seems worth noting and certainly is worth following as more data is collected in the future, it is important to note that the mood disorder/depression categories for these three studies were not identical and were not derived in identical ways (i.e., both the current study and Behrens & Satterfield (2007) used reasons for referral as reported at admission by program staff and Russell (2006) used a standardized depression inventory).

In addition to reviewing intake/admission information in order to determine the reasons for referral, staff members were also asked to review client histories for evidence of abuse. For the clients

with data in this area (N=221), 10% were reported to have either witnessed or experienced physical abuse. Additionally, 28% of girls and 9% of boys were reported to have either witnessed or experienced sexual abuse. It is possible that these percentages could be a bit low considering that for about 10% of the sample in each category (physical and sexual abuse) program staff indicated that they were "not sure" about the client's abuse history.

Nonetheless, these rates are significantly higher than national estimates. For example, recent studies conducted by the US Department of Justice and US Department of Health and Human Services estimated that there are reports of maltreatment for about 1.2% of boys and girls (USHHS, 2008) and there are reports of sexual assault for .4% of girls and .04% of boys (Finkelhor, Hammer, & Sedlak, 2008).

Clients' attitudes toward their program upon admission were assessed by asking them on a questionnaire how they felt "about being at the program." For the 151 clients who responded to this question, 25% reported feeling "Negative" or "Very Negative," 25% reported feeling neutral about it, and 50% reported feeling "Positive" or "Very Positive." Russell (2006) reported that consistent with six years of previous research into OBH, that about 50% of the 2006 study sample and felt ambiguously towards their treatment at admission, about 25% felt negative, and 25% felt positive (p. 20-1). While both findings suggest that the majority of clients entering private pay programs report themselves to be feeling at least neutral about their treatment, the differences in these numbers (i.e., the seemingly more positive outlook presented by the clients in the present study) could be due to selection bias within the current study sample or differences between clients entering outdoor programs versus residential treatment centers or therapeutic boarding schools which are less likely to be the clients' first experience in a program.

Standardized Assessments

The mean scores for the sample on the standardized Youth Outcome Questionnaire (YOQ) and Achenbach System of empirical Assessment (ASEBA) instruments are presented in the following four tables. Tables 4 and 5 include the mean scores as reported by youth and parents on the ASEBA assessments. According to the tests' publishers, higher scores correlate with higher levels of dys-

function or deviance. The scores displayed are T scores allowing for comparisons across scales and instruments. The conversion to T scores slightly truncates extremely high and low "raw" scores, but is reasoned to show sufficient variability for a valid assessment and analysis (Achenbach & Rescorla, 2001). Normative percentiles are also provided as a way to compare the mean T score to the percentage of a non-referred same age population who scored lower. Scores indicated within a "Clinical" range are based on cut-off scores suggested by the assessments' developers to indicate a dichotomous separation between youth who are "deviant" or "warrant concern" versus those who are "in the normal range" or "nondeviant" (Achenbach & Rescorla, 2001, pp. 90, 96).

Table 4, which presents scores from self-reports made by youth, shows that the mean scores on all the subscales except one (social problems) are in the most troubled 20th percentile of the normed population and the mean total score is within the "clinical" range. Table 5, which represents scores from parent-reports, reflects that the mean scores on all the subscales except one (somatic complaints) are in the most troubled 7th percentile of the normed population and the mean total score of eight of 10 subscales (including the cumulative internalizing and externalizing subscales) are within the "clinical" range. It is also clear when one compares table 4 (youth self report) to table 5 (parent report) that parents in this sample on average perceive their children to be more severely troubled than do the youth themselves.

Tables 4. ASEBA Youth Self Report T Scores at Admission†

Subscale	N	Minimum	Maximum	Mean	Std. Deviation	Approximate Normative Percentile
Anxious/ Depressed	64	50	89	60.92	9.940	86%
Withdrawn/ Depressed	64	50	96	60.58	9.698	86%
Somatic Complaints	64	50	83	58.75	8.482	81%
Social Problems	64	50	85	57.89	7.693	78%
Thought Problems	64	50	78	61.34	7.181	86%
Attention Problems	64	50	91	62.27	9.577	88%
Rule Breaking Behavior	64	50	88	69.80*	10.382	98%
Aggressive Behavior	64	50	85	60.67	8.790	86%
Total Internalizing	64	27	81	59.38	11.695	81%
Total Externalizing	64	42	84	65.63*	9.088	94%
Total	64	41	79	62.92*	8.523	90%

† Date of assessment within first 16 days at program

* Score is in "Clinical" range

Table 5. ASEBA Child Behavior Checklist (parent reported) T scores at Admission†

Subscale	N	Minimum	Maximum	Mean	Std. Deviation	Approximate Normative Percentile
Anxious/ Depressed	61	50	88	66.79*	10.702	95%
Withdrawn/ Depressed	61	51	93	67.07*	9.539	95%
Somatic Complaints	61	50	84	60.75	9.574	86%
Social Problems	61	50	84	64.75	7.215	93%
Thought Problems	61	50	84	65.48*	9.321	93%
Attention Problems	61	50	100	70.34*	11.182	98%
Rule Breaking Behavior	61	54	97	74.46*	8.417	>99%
Aggressive Behavior	61	54	95	71.38*	9.869	>98%
Total Internalizing	61	40	81	66.21*	9.320	94%
Total Externalizing	61	59	94	72.95*	7.156	>99%
Total T-Score	60	51	88	71.05*	6.588	>98%

† Date of assessment within the first 17 days at program

* Score is in "Clinical" or range

Tables 6 and 7 include mean scores as reported by youth and parents on the YOQ questionnaires. Higher scores are supposed to correlate with higher levels of dysfunction or deviance. Mean scores obtained by a non referred "community" population by the questionnaires' developers are provided for normative comparison. Scores indicated as within a "Clinical" range are based on cut-off scores that were calculated by the instruments' developers by comparing scores from samples drawn from a normative non-referred "community" population and two "clinical" samples drawn from inpatient and outpatient populations (Burlingame et al., 1996, pp. 10-11; M. G. Wells et al., 1999, p. 6).

Table 6, which presents scores from self-reports made by youth, shows that the mean scores on all the subscales as well as the total score are well above the normative mean and are all within the "clinical" range. Table 7, which represents scores from parent-reports, reflects similarly that the mean scores on all the subscales as well as the total score are well above the normative mean and are all within the "clinical" range. As with the standardized ASEBA scores reported intables 4 and 5, it is also clear when one compares the mean scores in table 6 (YOQ youth self report) to the mean scores in table 7 (YOQ parent report) that parents on average in this sample perceive their children to be more severely troubled than do the youth themselves.

Tables 6. Youth Outcome Questionnaire Self Report Scores at Admission†

Subscale	N	Minimum	Maximum	Mean	Std. Deviation	Approximate Normative Percentile
Critical Items	90	0	28	8.00*	5.675	5.08
Behavioral Dysfunction	90	0	30	14.86*	7.193	8.38
Social Problems	90	-2	29	8.59*	6.584	1.21
Interpersonal Relations	90	-6	23	5.94*	6.664	.100
Somatic	90	0	25	7.28*	5.378	5.49
Intrapersonal Distress	90	-1	57	21.92*	12.773	13.96
Total Score	90	0	166	66.59*	36.481	34.21

† Date of assessment within the first 16 days at program

* Score is in "Clinical" or range

Table 7. Youth Outcome Questionnaire (parent reported) Scores at Admission†

Subscale	N	Minimum	Maximum	Mean	Std. Deviation	Approximate Normative Percentile
Critical Items	83	0	23	9.33*	5.250	2.7
Behavioral Dysfunction	83	3	38	22.35*	8.095	6.5
Social Problems	83	-1	26	12.63*	6.080	.6
Interpersonal Relations	83	0	31	15.19*	6.512	.3
Somatic	83	0	20	7.23*	4.817	3.1
Intrapersonal Distress	83	1	60	31.11*	11.857	8.1
Total Score	83	23	171	97.83*	32.614	21.4

† Date of assessment within the first 16 days at program

* Score is in "Clinical" or range

Conclusion

The preliminary data from the NATSAP Research and Evaluation Network collected and analyzed for this study confirms a number of conclusions already reached by other researchers about the clients entering private-pay residential treatment programs. On average, these clients are referred by educational consultants; are white adolescents from families with the financial means to pay for services; possess at least average school achievement; and tend to have no major legal issues. They are struggling with elevated substance and alcohol use along with a complex array of clinically significant mental health issues. These youth also tend to be increasingly diagnosed with depression or mood disorders and typically begin their journey into residential treatment at a wilderness/outdoor program.

While the assessment and oversight of the industry must certainly honor the values and ethical imperatives of the stakeholders involved, it must also include valid empirical data. Thus, it is important to assess private-pay residential clients at this aggregate level. It is also important, however, not to put them into over-generalized categories. As the participating programs in this study, in the larger NATSAP Research Network, and in the industry as a whole attempt navigate the politically charged and often paradoxical social environ-

ment surrounding residential treatment, it is paramount that aggregated data be carefully used. While necessary to a degree for certain policy-level decisions, over-generalizations can undermine insightful understandings.

Since the collection of the data used in the present study, the NATSAP Research and Evaluation Network has doubled the number of client families with admission level data and has begun to gather data at discharge. Researchers at the University of New Hampshire have continued their work and three additional external research projects have been approved that will utilize some of the data. Hopefully this ongoing data collection process and subsequent database development will not only aid in a better understanding of residential treatment for youth, but will also improve its quality.

References

Achenbach, T. M. (1991). Integrative guide for the 1991 CBCL/4-18, YSR, and TRF Profiles. Burlington,: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Behrens, E., & Satterfield, K. (2007). Longitudinal family and academic outcomes in residential programs: How students function in two important areas of their lives. *Journal of Therapeutic Schools and Programs*, 2(1).

Bérubé, R. L., & Auchenbach, T. M. (2007). Bibliography of Published Studies using the ASEBA. Burlington, VT: University of Vermont, Research Cneter for Childeren, Youth, and Families.

Brown, K. J., Steele, R. G., & Roberts, M. C. (2005). Therapeu tic Camping Programs. In Handbook of mental health services for children, adolescents, and families. (pp. 305). New York, NY, US: Kluwer Academic/Plenum Publishers.

Burlingame, G. M., Wells, M. G., Hoag, M. J., Hope, C. A., Nebeker, R. S., Konkel, K., et al. (1996). Manual for the Youth Outcome Questionnaire. Stevenson, MD: American Professional Credentialing Services.

Byers, E. S. (1979). Wilderness Camping as a Therapy for Emotion ally Disturbed Children: A Critical Review. *Exceptional Children*, 45(8), 628.

Edwards, J. K. (1991). The Use and Administration of Family Therapy in Residential Treatment for Older Adolescents: A National Survey. Residential Treatment for Children & Youth, 9.

Edwards, J. K. (1994). Children in residential treatment: How many, what kind? Do we really know? *Residential Treatment for Children & Youth*, 12(1), 85-99.

Finkelhor, D., Hammer, H., & Sedlak, A. (2008). Sexually Assaulted Children: National Estimates and Characteristics. Washing ton, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Frensch, K. M., & Cameron, G. (2002). Treatment of Choice or a

Last Resort? A Review of Residential Mental Health Place ments for Children and Youth. *Child & Youth Care Forum*, 31(5), 307.

Friedman, R. M., Pinto, A., Behar, L., Bush, N., Chirolla, A., Ep stein, M., et al. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry*, 76(3), 295-303.

Handwerk, M. (2002). Least restrictive alternative: Challenging assumptions and further implications. *Children's Services: Social Policy, Research, & Practice*, 5, 99–103.

Hendee, J. C. (1999). New Outdoor Behavioral Healthcare Research Cooperative Founded at the University of Idaho. *International Journal of Wilderness*, 6(3), 39.

HR 911: Stop Child Abuse in Residential Programs for Teens Act. (2009). Referred to Senate from House, Feb. 2009

Ireys, H., Achman, L., & Takyi, A. (2006). State Regulation of Residential Facilities for Children with Mental Illness. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Kutz, G., & O'Connell, A. (2007). Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth: United States Government Accountability Office.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., et al. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy* (3), 249-258.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present, and future. *American Journal of Orthopsychiatry*, 76(3), 285-294.

Lieberman, R. E., & Bellonci, C. (2007). Ensuring the preconditions for transformation through licensing, regulation, accreditation, and standards. *American Journal of Orthopsychiatry*, 77(3), 346-347.

McNeal, R., Handwerk, M. L., Field, C. E., Roberts, M. C., Soper, S., Huefner, J. C., et al. (2006). Hope as an outcome variable among youths in a residential care setting. *American Journal of Orthopsychiatry*, 76(3), 304-311.

Mosier, J. (1998). The predictive validity of the Youth Outcome

Questionnaire: Prognostic Assessment. Unpublished disser tation, University of Utah, Salt Lake City.

Mueller, R., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the Outcome Questionnaire: A confirmatory factor analysis. *Journal of Personality Assessment* 70, 248-262.

NATSAP Overview. (2008). Retrieved March, 2008, from http://www.natsap.org/overview.asp

NATSAP Research and Evaluation Network. (2009). Retrieved June, 2009, from http://www.natsap.org/research_evaluation.asp

NIMH. (1983). Residential Treatment Centers for Emotionally Disturbed Children 1977-78 and 1979-80. Rockville, MD: National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch.

OBHIC. (2008). Outdoor Behavioral Healthcare Industry Council. Retrieved April, 2008, from http://www.obhic.com/

Pappenfort, D., & Kirkpatrick, D. (1969). Child-caring Institutions, 1966: Selected findings from the first national survey of chil drens' residential institutions. *Social Service Review*, 43, 448-459.

Pumariega, A. J. (2006). Residential treatment for youth: Introduction and a cautionary tale. *American Journal of Orthopsychiatry*, 76(3), 281-284.

Russell, K. (2006). Examining Substance Use Frequency and De pressive Symptom Outcome in a Sample of Outdoor Behavioral Healthcare Participants, Technical Report 1: Outdoor Behavioral Healthcare Research Cooperative, University of Minnesota, Minneapolis, MN.

Russell, K. C. (2003). An assessment of outcomes in outdoor be havioral healthcare treatment. *Child and Youth Care Forum*, 32(6), 355-381.

Russell, K. C. (2006). Brat Camp, Boot Camp, or...? exploring Wilderness Therapy Program Theory. *Journal of Adventure Education and Outdoor Learning*, 6(1), 51-68.

Russell, K. C. (2007). Summary of Research from 1999 - 2006 and Update to 2000 Survey of Outdoor Behavioral Healthcare Programs in North America 1999-2006 Minneapolis: University of Minnestota, Outdoor Behavioral Research Cooperative.

SAMSHA. (2007). The DASIS Report: Adolescent Treatment Admissions by Gender. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

SAMSHA. (2008). Results from the 2007 National Survey on Drug Use and Health: National Findings. Rockville, MD.: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Tuma, J. M. (1989). Mental health services for children: The state of the art. *American Psychologist*, 44, 188-199.

Tyler, J., Darville, R., & Stalnaker, K. (2001). Juvenile boot camps: a descriptive analysis of program diversity and effectiveness. *Social Science Journal*, 38(3), 445.

Umphress, V. J., Lambert, M. J., Smart, D. W., Barlow, S. H., Clouse, G., & Hansen, N. B. (1997). Concurrent and construct validity of the Outcome Questionnaire. *Journal of Psychoeducational Assessment*.

USHHS. (2008). Child Maltreatment 2006 Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (U. S. G. P. Office).

Wells, G., Burlingame, G., Lambert, M., Hoag, M. J., & Hope, C. A. (1996). Conceptualization and Measurement of Patient Change during PSychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire. *Psychotherapy*, 33(Summer), 275-283.

Wells, M. G., Burlingame, G. M., & Rose, P. (1999). Manual for the Youth Outcome Questionnaire Self-Report. Wharton, NJ: American Professional Credentialing Service.

Whitehead, K., Keshet, M., Lombrowski, B., Domenico, A., & Green, D. (2007). Definition and accountability: A youth perspective. *American Journal of Orthopsychiatry*, 77(3), 348-349.

Young, M., & Gass, M. (2008). Current Descriptions of National Association of Therapeutic Schools and Programs (NATSAP) Members Journal of Therapeutic Schools and Programs, 2(2).

Zimmerman, D. (1998). A Survey of Residential Treatment Centers' Outcome Research Practices. Residential Treatment for Children and Youth, 15(4), 45-59.

The Evidence Base for Private Therapeutic Schools, Residential Programs, and Wilderness Therapy Programs

Ellen Behrens, Ph. D.
Canyon Research & Consulting

John Santa, Ph. D.
Montana Academy

Michael Gass, Ph. D.
University of New Hampshire

Members of the Standing Research Committee of
The National Association of Therapeutic Schools and Programs

In the past 25 years adolescent risk factors have dramatically increased. Approximately one-third of public high school students fail to graduate (National Center for Higher Education Management Systems, 2006). Drug use is rampant in middle and high school. More children have been diagnosed with mood, anxiety, attention, substance, and behavior disorders than ever before (Substance Abuse and Mental Health Services Administration, 2006). Alarmingly large percentages of youth participate in high-risk behaviors, such as carrying weapons and attempting suicide (Centers for Disease Control and Prevention, 2007).

Unfortunately during this period of heightened need, mental health systems have experienced an unprecedented decline in intensive services for high-risk youth. This decrease in the availability of adequate mental health services has been driven by a paradigm shift to crisis stabilization and medication management designed to manage care and contain costs for insurance companies. These real and palpable problems have led to a rapid growth of private therapeutic programs.

Private therapeutic schools, residential programs, and wilderness therapy programs are aimed at serving the complex needs of struggling adolescents and their desperate families who have not been helped

by palliative remedies offered by outpatient therapy or short-term psychiatric hospitalization. Enrollment in these programs is typically preceded by complex and intensive academic, legal, substance abuse, behavioral, emotional, and familial problems for which the adolescents' caregivers (e.g., parents, guardians, teachers, therapists) are unable to provide adequate support. In most cases, youth treated in private therapeutic programs return home after receiving individual and family therapy designed to facilitate their return. The National Association of Therapeutic Schools and Programs (NATSAP) (www.natsap.org) is the primary professional association serving private therapeutic schools, residential programs, and wilderness therapy programs. Its member programs typically consist of "brick and mortar" programs (e.g., therapeutic residential programs) and outdoor-based therapeutic programs. Most NATSAP member programs are independently owned and licensed by appropriate state agencies.

The Evidence

In the past 10 years, a growing body of evidence has accumulated documenting the effectiveness of private therapeutic schools, residential programs, and wilderness therapy programs. This body of research is comprised of studies led by university faculty with the oversight of federally recognized institutional review boards. Collaborative studies have been conducted among NATSAP member programs as well as at individual NATSAP programs.

There are five major research initiatives that, combined together, provide a growing base of research support for private therapeutic programs. These research initiatives are particularly ambitious: many use large samples, longitudinal designs, multiple research sites, multiple informants, and "gold standard" outcome measures.

Initiative # 1

The Outdoor Behavior Healthcare Research Cooperative (OBHRC) (www.obhrc.org) is a research collaborative comprised of several wilderness therapy programs that are NATSAP member organizations. It is currently located at the University of New Hampshire and is operated by several research scientists. In the last decade, these researchers have generated over 100 published research

studies based on outdoor programs addressing the needs of youth.

Two foundational studies within this initiative systematically explored youth outcomes in outdoor programs. The first was conducted at seven OBHRC wilderness therapy programs (http://obhrc.org/publications.php). Using the Youth Outcome Questionnaire (YOQ, Burlingame, Wells, & Lambert, 1995), a commonly used measure of outcomes in mental health treatment, Keith Russell, Ph.D. (2002, 2003a) found statistically and clinically significant reductions of behavioral and emotional symptoms of youth immediately following treatment. A one year follow up study with a random sample of these youth found that, on average, the gains made during the program had been maintained.

Mean scores on Y-OQ at Admission, Discharge, and 12 Months After Discharge for Adolescent Self Reports and Parent Assessments (Russell, 2002, p. 29)

Rater	Sample Size	Admission	Discharge	12 Months After Discharge
Adolescent	621	71.80	50.58	37.70
Parent	560	99.04	55.10	42.84

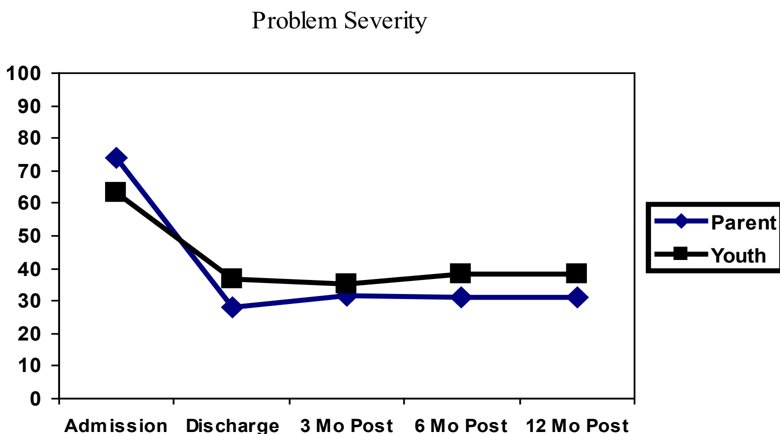
In a second foundational study within this initiative, Russell (2005) followed the same sample of youth two years later and found they had maintained therapeutic progress initiated by treatment. Furthermore, according to youth self-report data, these youth continued to improve after leaving the program. In fact, the majority of parents and youth indicated they were doing well and parents believed that their son or daughter could not have begun their recovery without the initial impact of the wilderness treatment.

As with many initial quantitative studies designed to determine basic effectiveness of programming, Dr. Russell's work did not include various control groups that would help determine more precisely the reasons and generalizability of the strong positive effects obtained with wilderness intervention. Qualitatively, parents obviously did not need control groups to attest to the degree of positive changes produced by several weeks of wilderness intervention. Dr. Russell's work begins to empirically document these positive effects.

Initiative # 2

Ellen Behrens, Ph.D. (2006) conducted another major, IRB-approved research initiative at nine “brick-and-mortar” NATSAP programs owned by Aspen Education Group. Generated by repeated surveys of nearly 1000 youth and their parents, these results were presented at the American Psychological Association Annual Conference in 2006. Employing standardized measures of psychosocial functioning developed by Achenbach (2001), the study found strong positive effects of treatment on internalizing problems (i.e., depression, anxiety, attention), problematic behaviors (i.e., aggression, rule breaking), and overall functioning. In addition, youth academic functioning and youth family relationships improved significantly during treatment. A study that followed the youth for 12 months after treatment found that the positive treatment effects were maintained (Behrens, 2007; Behrens & Satterfield, 2007).

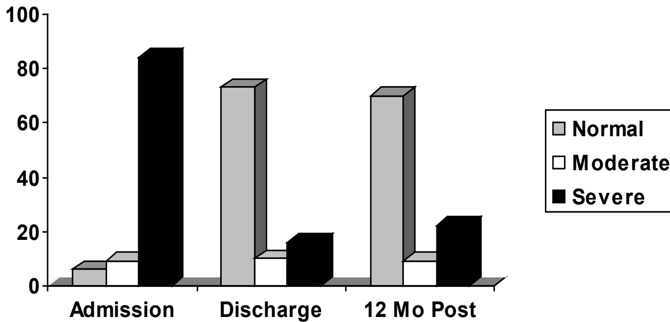
Problem Severity



These data are perhaps most striking when considered in terms of changes in youth level of functioning. By the end of residential treatment and one year after treatment, the majority of the youth demonstrated clinically significant improvement by shifting from the abnormal (or clinical) range to the normal range of behavioral and psychological functioning. These results are especially remarkable when considered in the context of other evidence-based treatments. For example, the maintenance of gains after private residential treatment is more favorable than those reported with two of the most

highly acclaimed evidenced-based treatments for youth (i.e., Multi-systemic Therapy and Functional Family Therapy) (see Fonagy, Target, Cottrell, Phillips & Kurtz, 2002; U.S. Department of Health and Human Services, 2001).

Percentage of Youth in normal, moderate, and severe ranges of functioning at admission, discharge, and one year after discharge



Initiative # 3

In collaboration with the University of Arkansas, Sarah Lewis, Ph.D. coordinated a program evaluation initiative at Aspen Education Group's wilderness therapy programs (Dixon, Leen-Feldner, Ham, Feldner, Lewis, in press; Lewis, Rogers, Dixon, Barreto, Leen-Feldner, & Daniels, 2007; Rogers, Dixon, Barreto, Farrell, Daniels & Lewis, 2007; Rogers, et. al., 2007). This longitudinal outcome study used the Treatment Outcome Package (TOP) questionnaire (Krause, Seligman, & Jordan, 2005) to measure changes in participating youth. The study confirmed the findings generated by the evaluation initiatives of Russell (2003a, 2005): wilderness therapy was associated with statistically significant positive changes in overall functioning. Youth in the study experienced significant decreases in suicidal ideation, anxiety, depression, substance abuse, social conflict, sleep disruption, violence, as well as an overall reduction in externalizing behaviors such as impulsivity, defiance, and hostility. Furthermore, these youth demonstrated improvements in work and academic functioning during the follow-up portion of the study.

Initiative #4

Michael Gass, Ph.D. and colleagues (2009) provided a summary of preliminary analyses of the NATSAP Outcomes Research project. The project involves systematic data collection from more than 33 NATSAP programs examining the status of participants at the beginning of treatment in residential or wilderness settings, at the conclusion of treatment, and one-year post discharge. This large-scale study has currently collected more than 1200 participant surveys using either the Youth Outcome (Burlingame et al., 1995) or Achenbach (Achenbach, 2001) assessments of psychiatric and behavioral symptoms. Preliminary analysis indicates strong positive effects of program intervention with large statistically significant reductions in both psychiatric and behavioral symptoms from admission to discharge. The data collection process is ongoing and later analyses will allow for a more detailed and prescriptive assessment of the effect of different types of program intervention on a range of specific presenting problems. This large-scale database is located at the University of New Hampshire and will be available to investigators who have various research questions.

Initiative #5

A number of other published, well-designed studies have been conducted at single NATSAP member programs. For example, one study conducted at The Menninger Residential Treatment Program with a sample of 123 youth found that parents and youth reported a significant decline in problems from admission to 3 months after completing the program, and these gains from treatment lasted up to 12 months after completing the program (Leichtman, Leichtman, Barber, & Neese, 2001).

Another published study, conducted at Alpine Academy, employed a strong control group design and found families reported significant improvement in child behavior, parental effectiveness, and parent–child relationships when compared with similar difficulties in families who were referred for the service but not served (Lewis, 2005). These changes were maintained on assessments three months after discharge.

Wediko Children's Services, another NATSAP member program, has participated in numerous research projects with Jack

Wright, Ph.D. of Brown University and Audry Zakriski, Ph.D. of Connecticut College. These studies examined adaptive and contextually based behavior for youth in residential treatment (Wright & Zakriski, 2003; Zakriski, Wright, & Parad, 2006; Zakriski, Wright, & Underwood, 2005).

Nick Hong, Ph.D. and his colleagues (Hong & Santa, 2007; Hong & McKinnon, 2009; Hong, 2010) at Montana Academy conducted a series of studies demonstrating marked increases in parent ratings of their child's maturity over the course of treatment, and these gains persisted one year after discharge. They also demonstrated that over the course of treatment school performance improved markedly, psychiatric and behavioral symptoms dissipated, and parents increased positive warmth and decreased negative emotional control of their children.

Joanna Bettmann, Ph.D. has produced a series of valuable studies on the positive influences of wilderness therapy on attachment issues for both adolescents and adults (Bettmann, 2007; Bettmann & Jasperson, 2008; Bettmann, Demong, & Jasperson, 2008). Her work demonstrates how wilderness therapy programs can aid in the treatment of insecure attachment cycles.

Conclusions

Private therapeutic schools, residential programs, and wilderness therapy programs possess a solid and growing research base. This collective body of research demonstrates that participating youth improve significantly during treatment and these improvements continue after youth return home. These findings are based on several different research programs of study: studies that were large scale, multi-center, and longitudinal, conducted by nationally recognized university researchers, and reviewed by federally recognized institutional review boards. Further research of course is needed, and encouraged, that will include a variety of control conditions aimed at refining the explanations of the powerful treatment effects that have been revealed.

References and Recommended Reading

Achenbach, T.M. (2001). Manual for the ASEBA School-Age Forms& Profiles. Burlington: University of Vermont.

Attarian, A., Ewert, A. Hollenhorst, S., Russell, K. & Voigt, A. (2006). Evolving adventure pursuits on public lands: Emerging challenges for management and public policy. J*ournal of Parks Recreation Administration*, 24, 2, 125-140. [authors acknowledge equal contribution].

Behrens, E. (2006, August). Report of findings from a multi-center, longitudinal study of youth outcomes in residential treatment. Paper presented at the American Psychological Association Annual Convention, New Orleans, LA.

Behrens, E. (2007). Longitudinal Outcomes in Private, Regulated Residential Programs: How are the youth one year later? Paper presented at the semi-annual conference of the Independent Educational Consultants Association, Boston, MA.

Behrens, E., & Satterfield, K. (2007). Longitudinal family and academic outcomes in residential schools: How students function in two important areas of their lives. *Journal of Therapeutic Schools & Programs*, 2, 1, 81-94.

Bettmann, J.E. (2007). Changes in adolescent attachment relationships as a response to wilderness treatment. *Journal of the American Psychoanalytic Association*, 55 (1), 259-265.

Bettmann, J., & Jasperson, R. (2008). Adults in wilderness treatment: A unique application of attachment theory and research. *Clinical Social Work Journal,* 36(1), 51-61.

Bettmann, J., Demong, E. & Jasperson, R. (2008). Treating adolescents with adoption and attachment issues in wilderness therapy settings. *Journal of Therapeutic Schools and Programs*, 3(1), 116-137.

Burlingame, G. M., Wells, M. G., & Lambert, M. J. (1995). The Youth Outcome Questionnaire. Stevenson, MD: American Professional Credentialing Services. Centers for Disease Control and Prevention. (2007). Trends in the prevalence of selected risk behaviors for all students, National YRBSS: 1991-2007. Retrieved May 10, 2010 from http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbs07_us_summary_trend_all.pdf.

Dixon, L.J., Leen-Feldner, E.W., Ham, L.S., Feldner, M.T., Lewis, S.F. (in press). Alcohol use motives among traumatic event-exposed, treatment-seeking adolescents: Associations with posttraumatic stress. Addictive Behaviors.

Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2002). What works for whom? A critical review of treatment of children and adolescents. Guilford: New York.

Gass, M.; Zelov, R.; & Young, M. (2009). The 2009 annual report of the NATSAP Research Database. Bethesda, MD: The National Association for Therapeutic Schools and Programs.

Gassner, M., Kahlid, A. & Russell, K.C. (2006). Investigating the long-term impact of adventure education: A retrospective study of Outward Bound Singapore's classic 21-day challenge course. In Paisley, K., Bunting, C.J., & Young, A.B. (Eds.) Research in Outdoor Education, (Vol. 8) (pp. 75-94). Cortland, NY: Coalition for Education in the Outdoors.

Gassner, M. & Russell, K. C. (2008). Relative impact of course components at Outward Bound Singapore: a retrospective study of long-term outcomes. *Journal of Adventure Education and Outdoor Learning*, 8, 2, 133-156.

Gillis, H. L. & Gass, M. A. (2010). Residential treatment of juveniles in a sex offender program using an adventure-based behavior management program: A matched group design. *Journal of Child Sex Abuse*, 19, 20-34.

Gillis, H. L., Gass, M. & Russell, K. C. (2008). The effectiveness of Project Adventure's behavior management program for male offenders in residential treatment. Residential Treatment for Children and Youth, 25, 3, 227-247.

Harper, N. & Russell, K. C. (2008). Family involvement and outcome in adolescent wilderness treatment: A mixed-methods evaluation. *International Journal of Child and Family Welfare*, 1, 19-36.

Harper, N., Russell, K.C., Cooley, R. & Cupples, J. (2007). Catherine Freer Wilderness Therapy Expeditions: An exploratory case study of adolescent wilderness therapy, family functioning, and the maintenance of change. *Child and Youth Care Forum*, 36, 111-129.

Hong, N.N. & Santa, J. (2007). Family functioning in the lives of adolescents in therapeutic boarding schools. Symposium presentation at the Annual Meeting of the National Association of Therapeutic Schools and Programs, La Jolla, California.

Hong, N.N. & McKinnon, J. (2009). Beyond symptomatology: Maturation in adolescents. Symposium presentation at the Annual Meeting of the National Association of Therapeutic Schools and Programs, Austin, Texas.

Hong, N.N. (2010). A Longitudinal Study of Change in the Quality of Adolescent Relationships Symposium presentation at the Annual Meeting of the National Association of Therapeutic Schools and Programs, La Jolla, California.

Kraus, D. R., Seligman, D. A., & Jordan, J. R. (2005). Validation of a behavioral health treatment outcome and assessment tool designed for naturalistic settings: The Treatment Outcome Package. *Journal of Clinical Psychology*, 61, 285 – 314.

Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71, 2, 227-235.

Lewis, R.E. (2005). The effectiveness of Families First services: An experimental study. *Children and Youth Services Review,* 27, 499-509.

Lewis, S. F. (2009, January). Evaluating Treatment Outcomes in a Sample of Adolescents: A Prospective Study. Paper presented at the 2nd annual Aspen Education Group symposium for referring professionals. Atlanta, GA.

Lewis, S. F., Rogers, S. M., Dixon, L. J., Barreto, C. J., Leen-Feldner, E. W., & Daniels, S. G. (2007, October). Treatment-Resistant Adolescents: Outcome Data from a Promising Therapeutic Intervention. Paper presented at the 54th Annual Convention of the Southeastern Psychological Association, Charlotte, NC.

National Center for Higher Education Management Systems. (2006). Public high school graduation rates. Retrieved May 14, 2010 from http://www.higheredinfo.org/dbrowser/index.php?submeasure=36&year=2006&level=nation&mode=data&state=0

Rogers, S. M., Dixon, L. J., Barreto, C. J., Farrell, H. J., Daniels, S. G., & Lewis, S. F. (2007, October). Outdoor Behavioral

Healthcare: A Case Demonstration of Effectiveness. Poster presented at the 54th Annual Convention of the Southeastern Psychological Association, Charlotte, NC.

Rogers, S. M., Dixon, L. J., Barreto, C. J., Farrell, H. J., Lewis, S. F., Leen-Feldner, E. W., & Daniels, S. G. (2007, October). Adolescent Substance Use and Abuse: The Role of Gender and Treatment-Resistance. Poster presented at the 54th Annual Convention of the Southeastern Psychological Association, Charlotte, NC.

Russell, K. C. (2000). Exploring how the wilderness therapy process relates to outcomes. *Journal of Experiential Education*, 23, 3, 170-176.

Russell, K. C. (2001). What is wilderness therapy? Journal of Experiential Education, 24, 2, 70-79.

Russell, K. C. (2002). A longitudinal assessment of treatment outcomes in outdoor behavioral healthcare. Technical Report 28, Idaho Forest Wildlife and Range Experiment Station, Moscow, ID. 35 pp.

Russell, K.C. (2003a). Assessing treatment outcomes in outdoor behavioral healthcare using the Youth Outcome Questionnaire. *Child and Youth Care Forum*. 32, 6, 355-381.

Russell, K.C. (2003b). A nation-wide survey of outdoor behavioral healthcare programs for adolescents with problem behaviors. *Journal of Experiential Education*, 25, 3, 322-331.

Russell, K.C. (2005). Two years later: A qualitative assessment of youth-well-being and the role of aftercare in outdoor behavioral healthcare treatment. Child and Youth Care Forum, 34, 3, 209-239.

Russell, K.C. (2006). Evaluating the effects of the Wendigo Lake Expedition program for young offenders. *Journal of Juvenile Justice and Youth Violence*, 4, 2, 185-203.

Russell, K.C. (2008). Adolescence substance use treatment: Service delivery, research on effectiveness, and emerging treatment alternatives. *Journal of Groups in Addiction and Recovery*, 2, 2-4, 68-96.

Russell, K.C. and Farnum, J. (2004). A concurrent model of the wilderness therapy process. *Journal of Adventure Education and Outdoor Learning*, 4, 1, 39-55.

Russell, K. C., Gillis, H. L., & Lewis, T. G. (2008). A five-year

follow-up of a nationwide survey of outdoor behavioral healthcare programs. *Journal of Experiential Education*, 31, 1, 55-77.

Russell, K. C. & Harper, N. (2006). Incident monitoring in outdoor behavioral healthcare programs: A four-year summary of restraint, runaway, injury, and illness rates. *Journal of Therapeutic Schools and Programs*, 1, 1, 70-90.

Russell, K. C., & Phillips-Miller, D. (2002). Perspectives on the wilderness therapy process and its relation to outcome. *Child and Youth Care Forum*, 31, 6, 415-437.

Russell, K.C. & Sibthorp, J. (2004). Hierarchical linear modeling of treatment outcomes in outdoor behavioral healthcare. *Journal of Experiential Education*, 27, 2, 176-191.

Substance Abuse and Mental Health Services Administration. (2006). Results from the 2005 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

U.S. Department of Health and Human Services. (2001) Youth violence: A report of the Surgeon General. [Full text online] Retrieved may 17, 2010 from http://www.surgeongeneral.gov/library/youthviolence.

White, D.D. , Caulkins, M., & Russell, K.C. (2006). The role of physical exercise in wilderness therapy for troubled adolescent women. *Journal of Experiential Education*, 29,1, 18-37.

Wright, J. C., & Zakriski, A. L. (2003). When syndromal similarity obscures functional dissimilarity: Distinctive evoked environments of externalizing and mixed syndrome boys. *Journal of Consulting and Clinical Psychology*, 71, 3, 516-527.

Zakriski, A. L., Wright, J. C., & Parad, H. W. (2006). Intensive short-term residential treatment: A contextual evaluation of the "stop-gap" model. Brown University Child & Adolescent Behavior Letter, 22, 6.

Zakriski, A. L., Wright, J. C., & Underwood, M. K. (2005). Gender similarities and differences in children's social behavior: Finding personality in contextualized patterns of adaptation *Journal of Personality and Social Psychology*, 88, 5, 844.

Positive Youth Development: What It Is and How It Fits in Therapeutic Settings

Mat D. Duerden
Texas A&M University

Mark A. Widmer
Brigham Young University

Peter A. Witt
Texas A&M University

Lead Author Contact Information: Mat D. Duerden, 2261 TAMU, Texas A&M University, College Station, TX, 77843-2261, fax (979) 845-0446, phone (979) 845-5983, duerden@tamu.edu

Abstract

This article provides an overview of Positive Youth Development (PYD) and suggestions for the application of PYD principles and practices in therapeutic schools and programs. The historical context of this developmental paradigm is provided as well as a comparison with other perspectives of adolescence. Much like positive psychology, PYD focuses on the promotion of positive growth as opposed to solely attempting to prevent and diffuse negative behavior. PYD can be conceptualized as a philosophy, developmental perspective, and a programming framework. Insights are provided within each of these areas regarding the relevance of PYD to therapeutic settings.

Introduction

A shift has taken place over the last 20 years in the way many practitioners and researchers perceive adolescent development. Adolescent programming has historically targeted the alleviation and/or prevention of deviant behaviors. In contrast, positive youth development (PYD) proposes that youth possess an innate ability to thrive and programming should be designed to promote this natural propensity (Lerner, Almerigi, Theokas, & Lerner, 2005; Witt & Caldwell, 2005a). The purpose of this paper is to facilitate the understanding of PYD, and provide a foundation for the application of PYD principles and practices in therapeutic settings for adolescents. The goal of the paper is to promote the integration of PYD principles and practices into therapeutic program and schools as these agencies seek to help youth engage in optimal development and eventually become responsible, productive, fulfilled adults.

Perspectives of Adolescence

Adolescence is a socially constructed developmental period with origins in the transitions of the late nineteenth and early twentieth centuries (Witt, 2005). This stage between childhood and adulthood was cast from its earliest beginnings as a time of storm and stress (Hall, 1904). Over the past 100 years, four distinct perspectives on adolescence have emerged. The earliest approach, and perhaps most influential in terms of public perception (Walker, 2000), focused primarily on adolescent deviance. Much of the research, programming, and funding directed towards adolescents over the last century drew from this perspective (Pittman, Irby, Tolman, Yohalem, & Ferber, 2003). Accordingly, within this framework treatment is only applied after the manifestation of problems. The focus is not on the prevention of behavioral issues or the promotion of positive development. Recent research (e.g., Benson, 2006; Newman, Smith, & Murphy, 2000; Seligman, Steen, Park, & Peterson, 2005) suggests focusing on the promotion of healthy lifestyles and positive development may be more effective and less costly than simply reacting to problems.

Although the traditional treatment approach directly influences research and policy, the one dimensional focus spurred the development of alternative frameworks. During the late 1970s and early 1980s

practitioners and researchers noted the effectiveness of preventing rather than waiting to react to adolescent problems (Small & Memmo, 2004). The field of prevention science grew out of this movement (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002). Research in this area focused on identifying risk factors associated with deviance (e.g., low SES, academic failure, family conflict, etc.) and protective factors (e.g., school involvement, religiosity, family attachment, etc.) that buffer individuals against the impact of risk factors and subsequent negative behavior and outcomes (Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002).

As the prevention approach gained momentum, some researchers also began to examine factors associated with healthy adolescent development in the face of extreme hardships (Benard, 1991). Researchers discovered that many disadvantaged youth succeed even in the face of multiple risk factors. For example, in a landmark longitudinal study of children who experienced multiple risk-factors, researchers found a significant number of these youth developed normally (Werner, 1986). The term "resilient" was attached to this group of "overachieving" kids, and the resiliency framework was born. Resiliency refers to an individual's "ability to bounce back successfully despite exposure to severe risks" (Benard, 1993, p. 44).

Although the prevention and resiliency perspectives present a more proactive approach to working with adolescence, both retain a primary focus on deviance (Small & Memmo, 2004). In contrast, some researchers and practitioners began to seek a greater understanding of the promotion of positive development (Catalano et al., 2002; Pittman et al., 2003). The rallying hallmark for this positive youth development (PYD) movement became "problem free is not fully prepared" or in other words, merely removing deviance and risk factors from youths' lives does not guarantee developmental success (Pittman et al., 2003). Although still a relatively new paradigm, PYD is becoming a powerful influence among academics and policy makers. Textbooks (e.g., Witt & Caldwell, 2005b) and graduate programs focusing on positive youth development are now available in increasing numbers.

PYD is growing concomitantly with similar movements in psychology (Park, 2004) and substance abuse and mental health services (Katzenbach, Burlinggame, & Jensen, 2009; SAMHSA, 2005). Positive psychology, with its focus on the factors and processes associated with happiness and satisfaction, is a growing force in

the diagnosis and treatment of behavioral and emotional problems (Peterson & Seligman, 2004). Characteristics or strengths associated with a high quality of life are used to help people with mental illness. Positive psychology moves beyond traditional approaches of studying and treating the causes of mental illness in the development of treatment strategies. Like PYD, positive psychology is the focus of new graduate programs, textbooks, conferences, and training seminars. It is also becoming the foundation for outcomes required in federally funded programs for people with severe mental illness (SAMHSA).

In the areas of substance abuse and severe mental illness, the "recovery" movement also focuses on wellness rather than pathology (Anthony, 2004). This recent movement focuses on an individual's ability to live a full and meaningful life in spite of the presence of underlying illness (Davidson & Roe, 2007; Jacobsen, 2004). Resnick & Rosenheck (2006), suggest that there are strong similarities between positive psychology and recovery. Although, these two movements have developed independently of each other, as (Katzenbach et al., 2009) point out, the emerging disciplines espouse similar key assumptions (Katzenbach et al., 2009).

A number of similarities exist between positive psychology, recovery, and positive youth development. As previously suggested, each of these approaches moves beyond a deficit focus to a strengths based approach. A summary of the top 10 characteristics of recovery (SAMHSA, 2006) mirrors a similar list of key components of PYD (Witt & Caldwell, 2005a). Key categories within the recovery movement are self-direction/empowerment, holistic, strengths based, and peer support. PYD describes similar constructs of youth-involvement, developing a full range of skills, asset based, and involving supportive adults. Superficial semantic differences do not mask the fact that these two movements share nearly identical approaches to promoting positive development, although they focus on different populations. The fact that research and theory in the positive psychology, recovery, and PYD movements have all come to similar conclusions regarding the importance of promoting positive development, provides strong support for the importance of both facilitating healthy functioning and alleviating problems.

This shift in focus from treatment pathology to promoting positive growth is also reflected in public and private grants specifically for research and programming using PYD, positive psychology, and

recovery modes (e.g., Department of Health and Human Services, 2008). Agencies serving youth with behavioral and emotional problems need to be aware of this interest and support for this new direction in order to remain on the cutting edge of service provision and research regarding best practices. In addition, funding sources associated with PYD may provide therapeutic schools and programs with unique opportunities to collaborate on research and demonstration projects. We suggest that PYD, positive psychology, and recovery, are similar movements occurring simultaneously across scientific fields and service areas. Consequently, it is timely for therapeutic schools and programs to consider PYD as a powerful scientific and programmatic modality to be integrated with, added to, or even replace existing clinical models.

What is Positive Youth Development?

PYD is a movement that encompasses "all of the people, places, supports, opportunities and services that…young people need to be happy, healthy and successful" (Center for Youth Development Policy and Research, 2003, para 4). Successful negotiation of adolescence, from a PYD perspective, is marked not only by the avoidance of problems such as substance abuse, school failure, oppositional behavior, and depression (Pittman, Irby, & Ferber, 2001), but also by the successful transition into adulthood as a healthy, happy, fully functioning member of society (Furstenberg, Elder, Cook, & Eccles, 2000). PYD can be conceptualized as a philosophy, a developmental perspective, and a programming framework (Whitlock & Hamilton, 2001). The following sections address these unique and interrelated components of PYD.

PYD as a Philosophy

PYD is a fundamentally different perspective of dealing with youth issues than intervention and prevention efforts. At the core of this perspective are a number of key assumptions and principles pertaining to adolescents and their development:

1. All youth have the inherent capacity for positive growth and development.
2. A positive developmental trajectory is enabled when youth are embedded in relationships, contexts, and ecologies that

nurture their development (often a characteristic of therapeutic schools and programs).
3. The promotion of positive development is further enabled when youth participate in multiple, nutrient rich relationships, contexts, and ecologies.
4. All youth benefit from these relationships, contexts, and ecologies.
5. Community is a viable and critical "delivery system" for positive youth development.
6. Youth are major actors in their own development. (Benson, Scales, Hamilton, & Sesma, 2006, p. 896)

These principles guide PYD practice and research, and encourage the adoption of a fundamentally different view of adolescents than traditional paradigms. PYD frames youth as integral and contributing components of society and proposes that both the private and public sectors need to be actively engaged in their development (Witt & Caldwell, 2005a).

PYD as a Developmental Perspective

PYD draws upon a variety of theoretical frameworks, but the most fundamental assumptions can be linked to developmental systems theory (DST) and ecological systems theory (EST). DST proposes that development occurs as individuals interact with objects and individuals within their environment and therefore researchers need to focus on these relationships as the key units of analysis as opposed to individual or environmental characteristics (Lerner, 1989; Lerner & Kauffman, 1985). Accordingly, the plasticity of developmental trajectories is greater than previously considered because growth is not predetermined by certain constellations of contextual and intra-individual factors but is constantly in flux as individuals engage with their environment (Griffiths & Gray, 1994; Lerner, 1989). In other words, all youth can experience positive development so long as they are provided with the necessary assets and opportunities.

As noted in Benson et al.'s (2006) assumptions, PYD occurs most effectively in the context of community wide collaborations. This assertion is supported by Bronfenbrenner's (1979) ecological systems theory (EST). In EST, development is a process influenced by interactions both within and across individual contexts. For example, the quality of relationships between teachers and students', and their

students parents impacts academic performance (Hughes & Kwok, 2007). Youth do not exist in a vacuum and the effectiveness of PYD programs is dependent upon the ability to address and impact as many applicable contexts as possible. Consequently, a major effort is underway to promote the efficacy of PYD efforts that span multiple contexts (Benson, 2006; Eccles & Gootman, 2002; Villarruel, Perkins, Borden, & Keith, 2003). For example, when youth are taken from their homes and placed in treatment programs, effective interventions and therapy can target specific areas of concern but youth often struggle to translate positive gains made within the program to other contexts post-participation. To address this problem, therapeutic programs should focus on incorporating the principles of PYD in both onsite offerings and after care plans. Families and communities thereby become active participants in the promotion of their youths' positive development, providing greater opportunity for successful transitions to the community and to adulthood.

PYD is facilitated through the provision of key developmental assets. Much like prevention researchers' focus on risk and protective factors, and positive psychology researchers focus on identifying key character strengths, PYD researchers have attempted to identify the assets most likely to promote positive development. For example, the Search Institute (2006) identified 20 external and 20 internal assets associated with positive development. Although some of these assets may be part of current interventions in treatment programs, understanding and intentionally integrating these assets will strengthen existing programs. Other examples of developmental lists include the 5 C's (i.e., competence, confidence, positive connections, character and compassion; Pittman et al., 2001) and America's 5 Promises (i.e., caring adults, safe places, healthy development, effective education, opportunities to help others; America's Promise Alliance, 2007).

Practitioners should critically review their programs offerings in terms of both the assets they are currently providing and those they could potentially incorporate. Seligman (2002) proposes that practitioners should focus on developing strengths rather than focusing on weaknesses. This same advice can also be applied to therapeutic programs and the provision of developmental assets. No one program should be expected to offer all assets to all individuals; rather each program should determine what asset niche they can most effectively fill. A real strength of the assets approach is that it promotes intentional

programming designed to include targeted deliverables. In addition to increasing program effectiveness, this approach provides an excellent framework for the measurement of program outcomes

PYD as a Programming Framework

Youth are more likely to experience successful development when they have access to important assets and opportunities whether in wilderness or adventure therapy, therapeutic programs or residential schools, or in foster care or at home. One of the major foci of PYD is to design and promote programs that serve as contexts for positive development. The delivery of necessary developmental assets and experiences are organized into a framework of supports, opportunities, programs, and services (Benson & Pittman, 2001; Pittman et al., 2001).

Supports

Supports are "tangible activities that are done with youth to facilitate access to interpersonal relationships and resources" (Whitlock, 2004, p. 2). The resources mentioned are those assets youth need to succeed (e.g., External supports within 40 developmental assets). Adults often play a key a role in the provision of developmental supports to youth (Larson, 2006). This is especially true in therapeutic contexts where adult staff members play a major treatment role. Mentoring research shows that impactful youth/adult relationships form when staff possess high youth worker efficacy which is promoted by regular and ongoing training opportunities (DuBois, Holloway, Valentine, & Cooper, 2002). Wilderness and adventure therapy, and residential schools are among the programs that provide the most intense and potentially impactful youth/adult relationship opportunities. Long term, ongoing exposure allows staff to model appropriate behavior and provides developmental support. A recent study of a wilderness adventure programs found the key themes in youth experiences in the program centered around their relationships with staff, not necessarily on the actual activities provided (Taniguchi, Widmer, Duerden, & Draper, 2009).

The PYD literature provides a number of insights into the effective facilitation of positive youth/adult relationships. For example, research findings indicate that relationships develop when programs intentionally make time and space for unstructured

youth/adult interactions (Grossman & Bulle, 2006). Duerden and Gillard (Winter 2008-2009) make a case for the incorporation of the principles of self-determination theory (i.e., autonomy, relatedness, and competence; Ryan & Deci, 2000) in youth program settings. Regardless of the approach or technique, therapeutic schools and programs need to encourage their staff to intentionally provide youth with developmental assets.

Opportunities

In order for PYD to take place youth must be given the chance to actively engage in their development. Therapeutic schools and programs can be prime contexts for youth to have access to important developmental opportunities such as youth voice, initiative, and identity exploration. Youth voice refers to the "perception that one's opinions are heard and respected by others—particularly adults" (Ellis & Caldwell, 2005, p. 281). To truly promote youth voice, it is not enough to simply allow youth a venue to express what is on their minds; rather, they must also feel their opinions have the power to affect real change (Ellis & Caldwell). The degree to which this process can be achieved varies from program to program, but even small opportunities to experience youth voice can have strong positive effect.

Additionally, youth need opportunities to develop initiative, which Larson defines as "the ability to be motivated from within to direct attention and effort toward a challenging goal (Larson, 2000, p. 107). Larson suggests initiative requires youth to participate in activities that promote intrinsic motivation, concerted engagement require sustained involvement, and that these prerequisites of initiative are outcomes of structured voluntary activities (e.g., recreation, sports, clubs, etc.). Therapeutic school and programs need to evaluate their program offerings with these qualities in mind in order to assess the degree to which the promotion of initiative is actively occurring. These authors have seen outstanding examples in wilderness adventure programs and residential therapy programs that use recreation or equine therapy to challenge participants and engage them over long periods of time. These types of programs are excellent contexts for youth voice, intrinsic motivation, development of long term adult mentoring relationships, and other PYD assets.

Identity development (Erikson, 1959, 1963) should theoretically

occur when youth receive opportunities to experience youth voice and to develop initiative. Since exploration and commitment represent the main processes whereby identity development occurs (Marcia, 1980), it seems plausible to assume that youth who develop initiative and experience youth voice would be more likely to engage in identity exploration. Research findings suggest that youth who engage in voluntary structured activities are more likely to experience identity development than less involved youth (Coatsworth et al., 2005; Schmitt-Rodermund & Vondracek, 1999) appear to support this assertion. Recreational contexts such as sports (Shaw, Kleiber, & Caldwell, 1995) and adventure recreation (Duerden, Widmer, Taniguchi, & McCoy, In Review) have also been shown to promote adolescent identity development.

Programs and services

This category includes all "actions done to or for youth intended to enhance health, safety, performance, and other forms of essential well being and physiological functioning" (Whitlock, 2004, p. 1). Programs serving youth with behavioral and emotional problems are part of a broader tapestry of youth programs and services. While organized programs can be prime context for the promotion of positive youth development, not all youth programs are created equal and only the most effective facilitate PYD. Eccles and Gootman (2003, ch. 4) suggest programs are most likely to promote PYD when they provide participants with the following:

1. Physical and Psychological Safety
2. Appropriate Structure
3. Supportive Relationships
4. Opportunities to Belong
5. Positive Social Norms
6. Support for Efficacy and Mattering
7. Opportunities for Skill Building
8. Integration of Family, School, and Community Efforts

Practitioners should use this list to evaluate the quality of their program contexts.

Conclusion

It is the authors' hope that this article will both provide therapeutic schools and programs with insights into PYD and its potential application in therapeutic programming and increase practitioners' awareness that the integration of PYD is both timely and necessary given the new trends in research and funding in positive psychology and resilience. It is possible that the principles from these new models will be tied to future accreditation standards in health care.

First and foremost, PYD provides practitioners with a paradigm to evaluate their own philosophies and program offerings. For example, practitioners should ask themselves how youth are viewed within their organization. Are youth seen as assets or liabilities? PYD makes a strong case for why youth need to be seen as assets regardless of their current situations or behavior. Second, if youth are to be viewed as assets what efforts are being made to promote their positive development in addition to energy spent towards reversing negative trajectories? The previous sections on supports, opportunities, programs, and services provide insights of specific actions that can be taken within a program setting to promote PYD. For example, staff can be trained and programs adapted to promote specific development assets.

In comparison to more established approaches to adolescent research, PYD is relatively new but its application is already positively impacting the lives of youth. While the claim that that today's youth represent the future is overused, it is true. Adolescence can be a time of struggles and challenges, conditions deserving of attention, but youths' innate potential and ability to succeed also needs intentional promotion. PYD can prove a powerful tool to frame and assist efforts to help kids succeed. PYD promotes an intentional and proactive approach to working with adolescents, one that can be readily implemented with positive effects in a variety of therapeutic settings. Practitioners should refer to this article's reference section and also feel free to contact the authors for additional PYD information and insights.

References

America's Promise Alliance. (2007). Every child every promise: Turning failure into action. Alexandria, VA: America's Promise Alliance.

Anthony, W. (2004). The recovery effect. *Psychiatric Rehabilitation Journal*, 27(4), 303-304.

Arthur, M. W., Hawkins, J. D., Pollard, J. A., Catalano, R. F., & Baglioni, A. J. (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors: The Communities That Care youth survey. Evaluation Review, 26(6), 575-601.

Benard, B. (1991). Fostering resiliency in kids: Protective factors in the family, school, and community. Portland, OR: Western Regional Center for Drug-Free Schools and Communities.

Benard, B. (1993). Fostering resiliency in kids. Education Leadership, 51(3), 44-48.

Benson, P. L. (2006). *All kids are our kids: What communities must do to raise caring and responsible children and adolescents (2nd ed.)*. San Francisco, CA: Jossey-Bass Press.

Benson, P. L., & Pittman, K. (Eds.). (2001). *Trends in youth development: Visions, realities and challenges.* Norwell, MA: Kluwer Academic Publishers.

Benson, P. L., Scales, P. C., Hamilton, S. F., & Sesma, A. (2006). Positive youth development: Theory, research, and applications. In R. M. Lerner (Ed.), Theoretical models of human development (6th ed., Vol. 1 of *Handbook of child psychology*, pp. 894–941). Hoboken, NJ: Wiley.

Brofenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Catalano, R. F., Berglund, M. L., Ryan, J. A. M., Lonczak, H. S., & Hawkins, J. D. (2002). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. Prevention & Treatment, 5(1), 1-117.

Center for Youth Development Policy and Research. (2003). What is youth development? Retrieved July, 31, 2008, from http://cyd.aed.org/whatis.html

Coatsworth, J. D., Sharp, E. H., Palen, L.-A., Darling, N., Cumsille,

P., & Marta, E. (2005). Exploring adolescent self-defining leisure activities and identity experiences across three countries. *International Journal of Behavioral Development*, 29(5), 361-370.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459-470.

Department of Health and Human Services. (2008). Research project grant: Reducing risk behaviors by promoting positive youth development (PA-08-241).

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology*, 30(2), 157-197.

Duerden, M. D., & Gillard, A. (Winter 2008-2009). Promoting supportive relationships in youth programs: A self-determination theory perspective [Electronic Version]. *Journal of Youth Development, 3*, from http://www.nae4ha.org/directory/jyd/jyd_article.aspx?id=e341422c-1fc5-46cf-9da6-603693e6a110

Duerden, M. D., Widmer, M. A., Taniguchi, S., & McCoy, J. K. (In Review). Adventures in identity development: The impact of a two-week adventure program on adolescent identity development. Identity.

Eccles, J. S., & Gootman, J. A. (2003). *Community programs to promote youth development.* Washington, DC: National Academy Press.

Eccles, J. S., & Gootman, J. A. (Eds.). (2002). Community programs to promote youth development. Washington, DC: National Academy Press.

Ellis, J. M., & Caldwell, L. L. (2005). Increasing youth voice. In P. A. Witt & L. L. Caldwell (Eds.), *Recreation and Youth Development* (pp. 281-299). State College, PA: Venture Publishing.

Erikson, E. H. (1959). Identity and the life cycle. In G. S. Klein (Ed.), *Psychological Issues* (pp. 18-171). New York: International Universities Press.

Erikson, E. H. (1963). *Childhood and society*. New York: Wiley.

Furstenberg, F. F., Elder, G. H., Cook, T. D., & Eccles, J. (2000).

Managing to make it: Urban families and adolescent success. Chicago, IL: University of Chicago Press.
Griffiths, P. E., & Gray, R. D. (1994). Developmental systems and evolutionary explanation. *The Journal of Philosophy*, 91(6), 277-304.
Grossman, J. B., & Bulle, M. J. (2006). Review of what youth programs do to increase connectedness of youth with adults. *Journal of Adolescent Health*, 39, 788-799.
Hall, G. S. (1904). *Adolescence: Its psychology and its relation to physiology, anthropology, sociology, sex, crime, religion, and education (Vol. I & II)*. Englewood Cliffs, NJ: Prentice-Hall.
Hughes, J. N., & Kwok, O. M. (2007). Influence of student-teacher and parent-teacher relationships on lower achieving readers' engagement and achievement in the primary grades. *Journal of Educational Psychology*, 99(1), 39-51.
Jacobsen, N. (2004). *In recovery: the making of mental health policy.* Nashville, TN: Vanderbilt University Press.
Katzenbach, J., Burlinggame, G., & Jensen, D. (2009). Well-being in mental health care: Recovery and positive psychology, integrating the models. Unpublished Manuscript.
Larson, R. (2006). Positive youth development, willful adolescents, and mentoring. *Journal of Community Psychology*, 34(6), 677-689.
Larson, R. W. (2000). Toward a psychology of positive youth development. *American Psychologist*, 55(1), 170.
Lerner, R. M. (1989). Developmental contextualism and the life-span view of person-context interaction. In M. H. Bornstein & J. S. Bruner (Eds.), *Interaction in human development* (pp. 217-239). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
Lerner, R. M., Almerigi, J. B., Theokas, C., & Lerner, J. V. (2005). Positive youth development: A view of the issues. *Journal of Early Adolescence*, 25(1), 10-16.
Lerner, R. M., & Kauffman, M. B. (1985). The concept of development in contextualism. *Developmental Review*, 5(4), 309-333.
Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 159-187). New York: Wiley.
Newman, R., Smith, S. M., & Murphy, R. (2000). A matter of money:

The cost of financing youth development. In *Youth Development: Issues, Challenges and Directions* (pp. 82-124). Philadelphia: Public Private Ventures.

Park, N. (2004). Character strengths and positive youth development. *The ANNALS of the American Academy of Political and Social Science*, 591(1), 40-54.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification.* New York: Oxford University Press.

Pittman, K., Irby, M., & Ferber, T. (2001). Unfinished business: Further reflections on a decade of promoting youth development. In P. L. Benson & K. Pittman (Eds.), *Trends in youth development: Visions, realities and challenges* (pp. 3-50). Boston: Kluwer Academic.

Pittman, K., Irby, M., Tolman, J., Yohalem, N., & Ferber, T. (2003). Preventing problems, promoting development, encouraging engagement: Competing priorities or inseparable goals? Washington, DC: The Forum for Youth Investmento. Document Number)

Resnick, S. G., & Rosenheck, R. A. (2006). Recovery and positive psychology: Parallel themes and potential synergies. Psychiatric Services, 57(1), 120-122.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68.

SAMHSA. (2005). Transforming mental health care in America. [Electronic Version]. Retrieved September 19, 2007, from http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx

SAMHSA. (2006). National consensus statement on mental health recovery. Retrieved June 10th, 2009, from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Schmitt-Rodermund, E., & Vondracek, F. W. (1999). Breadth of interests, exploration, and identity development in adolescence. *Journal of Vocational Behavior*, 55(3), 298-317.

Search Institute. (2006). 40 developmental assets for adolescents. Retrieved October 23, 2006, from http://www.search-institute.org/assets/40AssetsList.pdf

Seligman, M. E. P. (2002). *Authentic happiness*. New York: Free Press.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005).

Positive psychology progress: Empirical validation of interventions. *American Psychologist*, 60(5), 410-421.
Shaw, S. M., Kleiber, D. A., & Caldwell, L. L. (1995). Leisure and identity formation in male and female adolescents: A preliminary examination. *Journal of Leisure Research*, 27(3), 245-263.
Small, S., & Memmo, M. (2004). Contemporary models of youth development and problem prevention: Toward an integration of terms, concepts, and models. *Family Relations*, 53(1), 3-11.
Taniguchi, S. T., Widmer, M., Duerden, M. D., & Draper, C. (2009). The attributes of effective field staff in wilderness programs: Changing youths' perspectives of being "cool". *Therapeutic Recreation Journal*, 43(1), 11-26.
Villarruel, F. A., Perkins, D. F., Borden, L. M., & Keith, J. G. (2003). *Community youth development: Programs, policies, and practices.* Thousand Oaks, CA: Sage Publications.
Walker, G. (2000). The policy climate for early adolescent initiatives. In P. P. Ventures (Ed.), *Youth development: Issue, challenges and directions* (pp. 65-80).
Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol*, 47, 34-30.
Whitlock, J. (2004). Understanding youth development principles and practices, Facts and Findings. Ithaca, NY: Act for Youth.
Whitlock, J., & Hamilton, S. (2001). Youth development principles and practices: Defining what it is and is not. Unpublished Manuscript. Department of Human Development, Cornell University.
Witt, P. A. (2005). Why and how youth services were developed. In P. A. Witt & L. L. Caldwell (Eds.), *Recreation and Youth Development* (pp. 81-96). State College, PA: Venture.
Witt, P. A., & Caldwell, L. L. (2005a). 10 principles of youth development. In P. A. Witt & L. L. Caldwell (Eds.), *Recreation and Youth Development* (pp. 3-23). State College, PA: Venture Publishing.
Witt, P. A., & Caldwell, L. L. (2005b). *Recreation and Youth Development*. State College, PA: Venture Publishing.

Developing a Therapeutic Community for Students with Emotional Disturbance: Guidelines for Practice

Kevin A. Curtin, PhD, LCPC
Alfred University

Abstract

The therapeutic community has been widely studied for its use in psychiatric treatment centers, hospitals, and residential addiction programs. It has received limited attention in the research when it comes to special education day programs for students with emotional disturbance. This article suggests that the therapeutic community is a viable approach to treatment for this population given their interpersonal difficulties in school with both peers and adults. The author discusses the process of developing and implementing a therapeutic community in a special education school, focusing on specific guidelines, concepts, activities, and implications for research and practice.

Developing a Therapeutic Community for Students with Emotional Disturbance

Students with emotional disturbance (ED) exhibit inappropriate behaviors and poor interpersonal relationships with peers and adults across a variety of settings that includes school, home, and their community. ED is a condition that adversely affects educational performance and includes a variety of diagnoses such as schizophrenia, affective disorders, anxiety disorders, or other sustained disorders of conduct or adjustment (U.S. Department of Education, 2004).

What is most relevant for this article is the fact that students with ED have considerable difficulties with interpersonal relationships. Several longitudinal studies have found that this population of students is more likely to display significant social problems in school, including bullying, being bullied, fighting, and being suspended (Armstrong, Dedrick & Greenbaum, 2003; Wagner & Cameto, 2004). In addition, students with ED have the worst secondary school performance of all students with disabilities, including the highest rate of absenteeism, lowest grade point average, highest percentage for course failure, and highest grade retention rate (Marder, 1992).

A critical challenge facing students with ED then is the development of effective interpersonal skills with peers and adults during high school. Students with ED need effective therapeutic interventions that focus on social skill development within an interpersonal therapeutic environment. One such promising intervention is the therapeutic community, a type of group treatment that is based on milieu principles in which members are active participants in their own and each other's mental health treatment and in which they assume responsibility for the progress of the community as a whole (De Leon, 2000).

There are a couple important reasons to utilize therapeutic community as a treatment approach in special education programs. First, there are a number of studies that demonstrate the efficacy of this approach, primarily in residentially-based psychiatric treatment centers and addiction programs (De Leon, 2000; Lees, Manning, & Rawlings, 2003; Perfas, 2003; Ward, Kasinski, Pooley, & Worthington, 2003). Second, therapeutic community is a treatment approach that can provide students with ED opportunities to experience peer support for actual problems as they occur in the here-and-now. It is a viable

alternative to curriculum-based social skill and behavior modification programs that are much more prevalent in special education schools (Folse, 2006).

Theoretical framework

Therapeutic community is derived from several theories, including addiction theory, self-help approach, psychoanalysis, gestalt therapy, behavior modification, and social learning theory (De Leon, 2000). However, with the emphasis on the development of quality interpersonal relationships, the author suggests a theoretical framework to include constructivism and interpersonal learning.

Constructivism

The use of the therapeutic community essentially involves a constructivist method of treatment based on the premise that students actively construct new ways of learning based on reflections of their experiences (Kelly, 1955). Theoretically, constructivists emphasize cognitive concepts of assimilation, accommodation, and action schemas. Constructivists further assert that knowledge is constructed socially through interpersonal processes whereby people observe each other's contributions and seek out ideas from others (Neimeyer & Mahoney, 1995).

Thus, the therapeutic community becomes an experiential way to develop more effective social skills in an interpersonal environment. This is because the therapeutic community is an actual social environment involving genuine social issues and relationships. It is an interactive approach that addresses situational problems as they occur, allowing community members to reflect upon and learn more adaptive ways of interacting appropriately with each other (Perfas, 2003).

Interpersonal learning

The therapeutic community also has its foundation in the interpersonal theory of Irvin Yalom (1995). In a therapeutic community, students with ED are able to develop an understanding about both their healthy, and unhealthy ways of relating to each other, through various curative processes, such as the here-and-now, interpersonal feedback, peer confrontation, and cohesion (Yalom, 1995). The therapeutic community fosters interpersonal learning so

that students with ED can learn to deal with feelings of isolation, establish healthy relationships, make constructive choices in handling conflicts, provide meaningful support and honest feedback about each other's behaviors, and experience successful relationships that will lead to an improved sense of self-confidence (Miller, 1976). Given this theoretical framework, the therapeutic community allows for the generalization of social skills to other settings and relationships.

Guidelines for practice

There are three particular guidelines to keep in mind when developing a therapeutic community for students with ED. It must be hierarchical; it should provide students with a sense of empowerment; and it has to have a climate of positive peer support.

First, the hierarchy is essentially the overall structure contained in the entire school. This includes the daily academic schedule, rules, and the boundaries for both the staff and students. The rules must be clear and specific to ensure the physical and psychological safety for students. They should include no violence of any kind, no drug or alcohol use, and no undermining another member's therapeutic progress. The environment must allow students to feel safe enough to bring up any potentially vulnerable issues without the fear of being verbally attacked, made fun of, or threatened in any way.

The hierarchy must also provide clear boundaries and roles for the staff, which is made up of teachers who teach and ultimately enforce the rules, and therapists who facilitate the treatment (Perfas, 2003). The hierarchy of students involves both veteran and new students. The veteran students are seen as the leaders and/or role models. They have not only come to understand the concept of the therapeutic community, but they also have begun to convey this understanding to others, a passing of the torch so to speak. The newer students are only beginning to learn about how the therapeutic community operates, and they benefit from the support and modeling of the veteran students.

Second, a therapeutic community must provide students with a sense of empowerment. Even though therapists and teachers are an important part of the therapeutic community, the facilitation of peer interaction is essential to both constructivist and interpersonal learning. This can only occur when the students are empowered to work with each other and assume responsibility for their interpersonal

growth and the progress of the community.

If the staff becomes too active or talks too much in a therapeutic community, the students are likely to become less engaged, less empowered, and more resistant. The staff usually makes the mistake of talking too much simply out of good intentions, that is, trying to fix the problem, obtain as much information as possible, or give their wonderful sound advice. Such intentions can unfortunately lead to particular communication traps (e.g. lecturing, persistent questioning) and furthering resistance.

It is therefore imperative that the staff, particularly the therapists, empower the students through intentional facilitation. Facilitating a therapeutic community is much like conducting group therapy, but on a larger scale. The group therapist must be able to draw out the less assertive members, contain the more dominant and verbose ones, foster an interactive climate, and attend to the various group dynamics, presenting issues, and underlying themes. As a community becomes empowered, its members gain collective strength and an improved sense of social responsibility, allowing the therapists to focus on the social interactive processes and the interpersonal strengths and needs among students.

Finally, a therapeutic community is most effective when a climate of positive peer support exists among the students. The therapeutic community strongly discourages the street mentality or code of no snitching by requiring that students not only follow the rules themselves, but they also encourage others to comply with the rules. This entails confronting each other on misbehaviors and poor choices, and warning and even stopping each other from breaking the rules and/or undermining the treatment process.

The therapeutic community then promotes pro-social behaviors, positive peer pressure, and social concern and responsibility. Students are expected to handle rule breakages and misbehaviors directly with each other. This reinforces the therapeutic community as a constructivist and interpersonal learning environment in which community members benefit socially while they are helping others, reducing any sense of dependency on the therapists.

Therapeutic Community Activities

Activities in a therapeutic community refer to the everyday

routines and rituals that are necessary for the interpersonal growth of the students. Activities, routines, and rituals, among the daily schedule of academics, create a sense of purpose that is critical for students with ED who require stability and predictability (Miller, 1976). More importantly, they promote interpersonal skills, such as listening, sharing experiences, providing feedback, confronting behaviors, and expressing feelings.

A summary of therapeutic community activities utilized by one non-public, self-contained special education day school for high school students with ED includes: (a) the morning meeting, (b) community meetings, (c) in-house presentations, (d) peer review, (e) awards, positives, and rituals, and (f) goodbye meetings.

The Morning Meeting

The morning meeting is a brief 15-minute gathering involving the community of students and staff members. This meeting is held at the start of each school day and provides the important element of routine and structure. The morning meeting gives students a chance to check-in with each other, providing opportunities to express concern and offer support to anyone who may be struggling with an issue.

The morning meeting is also a chance for the therapists to gauge the emotional tone of the community and observe which students may need support and which ones may be in a position to help (Perfas, 2003). It can also serve as a heads-up for the teaching staff about what kind of day they can expect from a particular student. With the right facilitation, problems can be anticipated early and often times prevented.

Community Meetings

There are two types of community meetings that can occur in a therapeutic community: End-of-the-day community meetings and the large group, a type of community meeting that is called at any time of day when a staff member feels there are significant problems that need to be addressed.

An end-of-the-day community meeting is held after the last academic period of the day. Like the morning meeting, it provides routine and is an opportunity to add certain rituals and group-work activities that the community comes to look forward to. It is largely focused on how the individual students are doing relative to

the overall functioning of the therapeutic community. There can be several different items on the agenda for any given meeting; however, students are free to raise any issue they wish which can include peer conflicts, misbehaviors in the classroom or general milieu, staff-student discrepancies, and overall community functioning. The therapist focuses on facilitating an interactive process that includes such interventions as peer mediation, conflict resolution, problem solving, and relationship building.

The large group is a community meeting in which a significant problem has occurred during any part of the school day resulting in a need to bring the community together in order to resolve the issue at hand. This could be misbehavior in class with which the teacher needs more help, or simply behaviors that, in the judgment of the teacher, need to be confronted by the student's peer group. Examples include disruptions in class, bullying, disrespect, and oppositional behavior.

While these types of community meetings are generally solution-focused, they may also serve to establish boundaries and limits on certain behaviors. More importantly, the large group is viewed by teachers and therapists as an opportunity to empower students to deal with each other on a more interpersonal level.

The large group is typically called by a teacher, although a student may request one as well, as long as it is approved by the staff. The process begins with the teacher who initiated the meeting describing the behaviors that led up to it. A therapist facilitates the meeting and gathers various perspectives of the problem. While discussing the problem, the therapist empowers community members to both confront and support the student, letting that individual know how his or her behavior is affecting them personally as well as how the behavior is impacting the class or the entire community. The student in question often feels some pressure from the community to take responsibility for their behavior.

Depending on the individual's comfort or the level of community cohesion, the student may accept responsibility, which often becomes a chance to gain support and understanding. The therapist has the additional task of exploring and processing potential underlying themes or issues that may be related to the problem or that may involve the community-as-a-whole. A successful meeting is one in which the student not only takes responsibility for his or her behavior, but with the help of the community is able to gain some insight into

their behavior, recognize how they could have handled the situation differently, learn a few new coping skills, and make a commitment towards change.

In-house presentations

In-house presentations occur after a student has been suspended in-school or out-of school. It is a therapeutic process in which a student must present a re-entry paper to the community. Essentially, it involves taking responsibility for the behavior(s) that resulted in the suspension, describing any feelings, thoughts, or circumstances that may have contributed to these behaviors, discussing any underlying issues or insights, making commitments to change, and developing an appropriate plan for this change. After making the presentation, community members are given an opportunity to offer feedback, comments, and advice. If the student does not take the process seriously, fails to take responsibility for their actions, or lacks any sense of commitment towards learning, the rest of the community can vote to have the student remain on in-house suspension. When this occurs, the student is paired up with a community member who helps the individual make any necessary changes, such as taking more ownership for their behavior, developing new coping skills, or even apologizing. The student can then present again at the next community meeting.

This process portrays a sense of the positive-peer environment that is essential in a therapeutic community. That is, the community expects each student to follow the rules, but when a student does slip up, he or she is expected to take responsibility for their actions, learn from it, make commitments towards positive change, and with the help of the community, brainstorm ways in which to do so.

Peer Review

The peer review is an activity in which a student self-selects particular interpersonal categories and is both ranked and given feedback by the rest of the students. Examples of categories includes relates well to peers, demonstrates self-confidence, or expresses feelings appropriately. Ranking is done on a 4-point likert scale from just a little to very much. The ranking provides a community average so the student has an understanding on how the community as a whole views him or her. This is similar to the Johari Window in which

interpersonal qualities are seen by others but of which the student is not aware (Luft, 1970). To explain further, certain aspects of an ED student's life are open and understood by others, while other areas are hidden and unknown. The Johari Window is a conceptual device used to help individuals become more fully aware of their blind spots and hidden self.

The process allows for students to take turns stating out loud what number or rank he or she gave, and a chance to provide feedback supporting this rank. Students who are the recipients of this interpersonal feedback have a chance to reflect and discuss it so that they can gain insight into their behaviors in order to make the desired changes. Verbal feedback is perhaps the most important aspect of this activity, as students learn to give constructive feedback as well as receive it.

Awards, Positives, and Rituals

The end-of-day community meetings feature opportunities to provide awards and positives for members. Awards can include community member of the week, academic student of the week, and most improved student. For example, in selecting each most outstanding community member for that week, students are asked to give nominations along with specific reasons why, and then a public vote is taken. This award usually reflects a community member who has demonstrated outstanding support and care for others and whose behavior has been without incident.

Rituals that reflect positive behaviors should be included as much as possible. One that is most common is the ritual that each day always ends with positive feedback, compliments, or words of appreciation. An entire meeting can be spent with members taking turns hearing positive feedback from others. Other rituals that can be positive include community-building activities, icebreakers, and introduction exercises.

The Goodbye Meeting

The goodbye meeting is essentially a termination group that takes place whenever a student leaves the school. The community gathers in their usual circle and the therapist conducts a meeting in which the departing student and community members say or express goodbye. The process is reciprocal and includes students sharing with

each other what they will miss, what they have meant to one another, parting words of advice, words of appreciation, constructive feedback, and even humorous stories and memories. This often involves a student who is moving on successfully from the school such as a graduation or mainstreaming to a public school. Even for those moving on less successfully, the goodbye meeting is still a very important process and is most often very emotional.

Goodbye meetings are necessary because there are often underlying issues related to grief and loss. There may also be feelings of sadness and anxiety over leaving and losing the support of the community they have come to appreciate. Goodbye meetings serve to reinforce the progress one has made since their entry into school, noting the need to move beyond this particular program. It is a chance to process any feelings about termination and acknowledging any unfinished business.

Implications for research and practice

Meta-analytic research shows a clear and positive treatment effect for therapeutic communities (Lees, Manning, & Rawlings, 2003). The therapeutic community is an effective method in the treatment of adolescents; however, most studies with this population focus on residential treatment centers (Ward, Kasinski, Pooley, & Worthington, 2003). In addition, there are a number of studies that involve the use of the therapeutic community in drug treatment settings, prisons, halfway houses, residential treatment centers, and inpatient psychiatric hospitals (DeLeon, 2000). So while the evidence clearly shows this to be a valuable approach, the therapeutic community is not a widely practiced method of treatment for students with ED in special education day programs. Given the academic, social, and postsecondary concerns students with ED face, more research into the use of therapeutic community needs to be conducted with this particular population, focusing on particular techniques, processes, and mental health outcomes.

Therapeutic communities are important for the mental health treatment of students with ED because of the continuing need for this population to develop more appropriate behaviors and interpersonal relationships with both peers and adults. In addition, students with ED require this constructivist and interpersonal approach to treatment as

it is easier to generalize outside of the treatment context.

Finally, the implementation of the therapeutic community in special education day schools could greatly reduce the need to place students with ED in residential treatment centers, which are quite costly and questionable in terms of cost-to-benefit ratio (Hoagwood & Cunningham, 1992). This could have a significant impact on the cost and practice of special education services for the most severe students with ED.

References

Armstrong, K. H., Dedrick, R. F., & Greenbaum, P. E. (2003). Factors associated with community adjustment of young adults with serious emotional disturbance: A longitudinal analysis. *Journal of Emotional and Behavioral Disorders*, 11, 66-76.

De Leon, G. (2000). *The therapeutic community: Theory, model, and method.* New York: Springer Publishing.

Folse, R. T. (2006). Emotional disturbance. The Child Psychologist. Retrieved July 18, 2009, from http://www.childpsychologist.com/mod/resource/view.php?id=11

Hoagwood, K., & Cunningham, M. (1992). Outcomes of children with emotional disturbance in residential treatment for educational purposes. *Journal of Child and Family Studies*, 1, 129-140.

Kelly, G. A. (1955). *The psychology of personal constructs (2 vols.)*. New York: Norton.

Lees, J., Manning, N, & Rawlings, B. (2003). Therapeutic community research: An overview and meta-anaylsis. In J. Lees, N. Manning, D. Menzies, and N. Morant (Eds.), *A culture of Inquiry: Research evidence and the therapeutic community.* London: Jessica Kingsley Publishers. Washington, DC: American Psychological Association.

Luft, J. (1969). *Group process: An introduction to group dynamics.* Palo Alto, CA: National Press Books.

Marder, C. (April, 1992). Secondary school students classified as seriously emotionally disturbed: How are they being served? Paper presented at the annual meeting of the American Educational Research Association, San Francisco.

Miller, R. A. (1976). A retrospective study of a day treatment program for disturbed adolescents. Unpublished doctoral dissertation, The Union Graduate School.

Neimeyer, R. A., & Mahoney, M. J. (1995). Constructivism in psychotherapy. Washington, DC: American Psychological Association.

Perfas, F. B. (2003). Therapeutic community: A practice guide. New York: iUniverse.

U. S. Department of Education (2004). IDEA 2004. Retrieved November 27, 2007, from http://www.idea.ed.gov/explore/home.

Wagner, M., & Cameto, R. (2004). The characteristics, experiences, and outcomes of youth with emotional disturbances. A report from the National Longitudinal Transition Study-2 (NLTS2). Menlo Park, CA: SRI International.

Ward, A., Kasinski, K., Pooley, J, Worthington, A. (2003). *Therapeutic communities for children and young people.* London: Jessica Kingsley Publishers.

Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS

JTSP Order Form

The National Association of Therapeutic Schools and Programs offers the following options for publication of the *Journal of Therapeutic Boarding Schools (JTSP)*.

1. **Single Copy** – *Check applicable category*

   Institution ($30)___ Individual ($20)____ Member Program Staff ($15)____

2. **Previous Volumes** – *Check applicable category*

   Institution ($30)___ Individual ($20)____ Member Program Staff ($15)____

   Previous Volume(s) Requested:
   Volume, Number, Date ______________________________

   Volume, Number, Date ______________________________

   Volume, Number, Date ______________________________

Name *(please print clearly)*: _______________________________________

Company/Organization: _______________________________________

Address: ____

City: ______________________ State: _________ Zip: ___________

Telephone Number: ____

Email:____

Payment
(*This form also serves as your invoice and payment is due once you submit your request.*)

☐ Check Enclosed
☐ Credit Card Number ____________________Exp Date: ____________ CVC: _____

Please return completed form and payment to:
- Fax: (301)-986-8772
- email - info@natsap.org
- NATSAP, 5272 River Road, Ste 600, Bethesda, MD 20816

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS

2010 Directory Order Form

To order a copy of the 2010 Directory, please complete the form below and mail, email or FAX your order, with your check or credit card information for shipping and handling, to NATSAP, Inc.

First/Last Name:____

Organization: ____

Mailing Address: ____

City:___________________________ **State:**__________

Zip:_________________________ **Phone:** __________________________

Email:_______________________________________

Please indicate your profession:

- ☐ Educational Consultant
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ NATSAP Member Program Staff Member
- ☐ Parent
- ☐ Licensed Counselor
- ☐ Licensed Therapist
- ☐ College/University Professor
- ☐ Alumnus
- ☐ Student
- ☐ Other _________________________(please specify)

Please select your NATSAP Membership Status:

☐ NATSAP Member (Staff of Member Program or Individual Affiliate) ☐ Non-Member

Shipping and handling charges

(We ship via United States Postal Service.)

Single Copy *(Media Mail)*............................. $-0- (*complimentary)*

2 directories.......................... $5.00

3 to 15 directories................. $10.00

16 to 30 directories................ $20.00

31 or more ....*contact the NATSAP office*

Number of Copies Requested:______ Total Shipping Charges (*see above*):$_______

(Media Mail: Allow 7 to 10 days for delivery, Priority Mail: Allow 3 to 5 days for delivery)

Payment

(*This form also serves as your invoice and payment is due once you FAX your request.*)

☐ Check Enclosed

☐ Credit Card Number ______________________Exp Date: _____________ CVC: ______

Please return completed form and payment to: ● Fax (301) 986-8772

● email - info@natsap.org

● NATSAP, 5272 River Road, Ste 600, Bethesda, MD 20816

JTSP

Journal of Therapeutic Schools & Programs

A Publication of the National Association of Therapeutic Schools and Programs

PERMISSIONS AND COPYRIGHT INFORMATION FOR POTENTIAL AUTHORS

Authors must provide the Journal of Therapeutic Schools and Programs (JTSP) with all necessary permissions to reproduce in print and electronic form any copyrighted work prior to acceptance of publication (e.g., photographs of people, quotations longer than 500 words). JTSP policy prohibits an author from submitting the same manuscript for consideration by two or more publications at the same time. When appropriate, authors must provide journal editors with assurance that subjects rights were respected and research protocol's were ethical prior to the publication of any data.

Authors are required to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test procedure, external funding provided by program) when their manuscript is submitted.

It is the policy of the National Association of Therapeutic Schools and Programs (NATSAP) to retain the copyright of its publications and the contributions contained therein in order to protect the interests of the Journal of Therapeutic Schools and Programs (JTSP) and its authors, and at the same time to facilitate the appropriate reuse of this material by others.

Therefore, upon acceptance of their manuscript for publication by the JTSP, authors will be sent a copyright assignment form to complete and return to the editor. Publication of the manuscript will be contingent upon receipt of the completed copyright transfer form. In the event that the JTSP decides to re-publish an article that has already been published in copyrighted form, the Board will require explicit permission from the copyright holder.

Note: NATSAP and the JTSP reserve the right to publish these materials in both written and electronic form. Authors will be notified of the use of their material.

Questions may be directed to: Dr. Michael Gass, Editor - JTSP
NH Hall, 124 Main Street
University of New Hampshire
Durham, NH 03824
(603) 862-2024 • mgass@unh.edu

INSTRUCTIONS FOR AUTHORS

Journal of Therapeutic Schools and Programs (JTSP)

Manuscript Topics The *Journal of Therapeutic Schools and Programs (JTSP)* publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from member programs. The editors welcome manuscripts that are the original work of the author(s) and follow APA style as presented in the fifth edition of *Publication Manual of the American Psychological Association.* Authors are reminded to keep a current copy of their manuscript to guard against loss. Manuscripts may include, but are not limited to, case studies, topical clinical articles, overview articles, book reviews, and research. Topics of interest may identify and address diverse issues encompassing program enhancement and development, continuum of care, and transition planning. Articles may address specific interventions for special populations or clients with special needs such as substance abuse dual diagnosis, developmental disorders, or adoption issues. Articles are encouraged that address issues of staff training and retention and general personnel management and leadership, as well as articles that address governmental/regulatory topics. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment effectiveness.

Submitting the Manuscript Electronic submission is encouraged. Manuscripts may be sent as email attachments in Word format to Dr. Michael Gass at *mgass@unh.edu* with a copy to the NATSAP Executive Director at *info@natsap.org* Manuscripts will be accepted by mail, whereby the author(s) is asked to send six (6) copies to the editorial office to *Dr. Michael Gass, JTSP, NH Hall, 124 Main Street, Durham, NH 03824.* All manuscripts should be submitted in a form that allows blind refereeing (see APA guidelines – 5th edition). The author's name and any identifying information must be visible ***only*** on a detachable front page. Manuscripts will be retained by the *JTSP* Editorial Board and will not be returned to the author(s).

Manuscript Evaluation Submitted manuscripts will initially be reviewed and evaluated by Dr. Michael Gass and Dr. Keith Russell. After the initial evaluation, manuscripts will be sent to a Review Board who will forward their recommendations to Dr. Gass. The JTSP management team reserves the right to edit or to require editing of content, format or style, or to make other revisions before accepting a manuscript for publication. Dr. Gass will make final decisions regarding publication status.

Manuscript Format Manuscripts should be formatted to 8 1/2" x 11" paper as follows: • *Font to be used is "Times New Roman – Size 12"* • *Italics and Underline are accepted* • *Document must be in black text only* • *1-inch margins are required on all sides* • *Double line spacing is required* • *Pages are to be numbered in the top right hand corner*

Total manuscript length including abstract, tables, and references should ordinarily not exceed 15 pages. The entire manuscript including footnotes, references, and quoted material and figures/illustrations should conform to the style specified in *The Publication Manual of the American Psychological Association – 5th Edition.*

Submit manuscripts in the following order: *1) Title Page; 2) Abstract (no more than 100 words); 3) Text; 4) References; 5) Figures (Tables, Charts, Graphs)*

Images depicting aspects of the contribution are strongly encouraged. Insertion notations for figures, tables, and images should be included in their intended place within the document though the actual figures, tables and images along with appropriate captions should be appended to the end of the submitted manuscript. Please attach original camera-ready art or jpeg/gif files for figures and images.

Author Bios Submit a 50 word or less biography of the author(s) with the manuscript.

Journal Management The National Association of Therapeutic Schools and Programs (NATSAP) Board of Directors has engaged Michael Gass, Ph.D. for the editorial and managerial responsibilities for the *Journal of Therapeutic Schools and Programs (JTSP).*

THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS ETHICAL PRINCIPLES

Members of the National Association of Therapeutic Schools and Programs (NATSAP) provide residential, therapeutic, and/or education services to children, adolescents, and young adults entrusted to them by parents and guardians. The common mission of NATSAP members is to promote the healthy growth, learning, motivation, and personal well-being of program participants. The objective of all member therapeutic and educational programs is to provide excellent treatment for program participants; treatment that is rooted in good-hearted concern for their well-being and growth; respect for them as human beings; and sensitivity to their individual needs and integrity.

The members of The National Association of Therapeutic Schools and Programs strive to:

1. Be conscious of, and responsive to, the dignity, welfare, and worth of our program participants.

2. Honestly and accurately represent ownership, competence, experience, and scope of activities related to our program, and to not exploit potential clients' fears and vulnerabilities.

3. Respect the privacy, confidentiality, and autonomy of program participants within the context of our facilities and programs.

4. Be aware and respectful of cultural, familial, and societal backgrounds of our program participants.

5. Avoid dual or multiple relationships that may impair professional judgment, increase the risk of harm to program participants, or lead to exploitation.

6. Take reasonable steps to ensure a safe environment that addresses the emotional, spiritual, educational, and physical needs of our program participants.

7. Maintain high standards of competence in our areas of expertise and to be mindful of our limitations.

8. Value continuous professional development, research, and scholarship.

9. Place primary emphasis on the welfare of our program participants in the development and implementation of our business practices.

10. Manage our finances to ensure that there are adequate resources to accomplish our mission.

11. Fully disclose to prospective candidates the nature of services, benefits, risks, and costs.

12. Provide informed professional referrals when appropriate or if we are unable to continue service.