JTSP

Journal of Therapeutic Schools & Programs

NATSAP

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.

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JTSP
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Particpating NATSAP Programs Produce Results for Youth

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Note: Consumers and other individuals examining this report are advised to limit their interpretation and generalization of these results only to the NATSAP programs participating in this study.

In its fourth year of active data collection, the NATSAP Practice Research Network (PRN) is showing promising outcomes for participating NATSAP programs. In the current issue of the *Journal of Therapeutic Schools and Programs*, researchers from the University of New Hampshire specifically looked at the positive changes reported by youth as well as their parents from admission to the treatment program to discharge from NATSAP programs. These changes not only occurred following treatment, but also maintained their levels of positive change six months following their discharge from treatment. Participating NATSAP programs not only produced positive statistically significant differences in treatment, but also clinically significant ones. These changes can been seen in Figure 1:

Y-OQ Scores Over Time
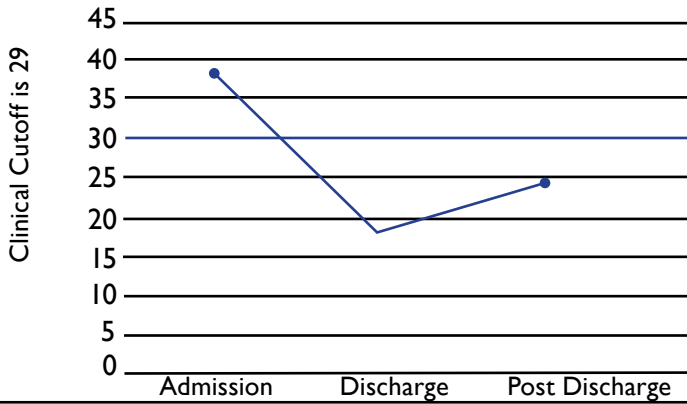
Figure 1 - Clinically and statistically postive changes in the mental health for clients in participateing NATSAP programs in the research study.

When adolescent clients were further separated into clinical presenting issues such as substance abuse, depression or mood disorders, or attention deficit issues, positive client change was seen for these presenting problems as illustrated in Figure 2.

Y-OQ Scores Over Time
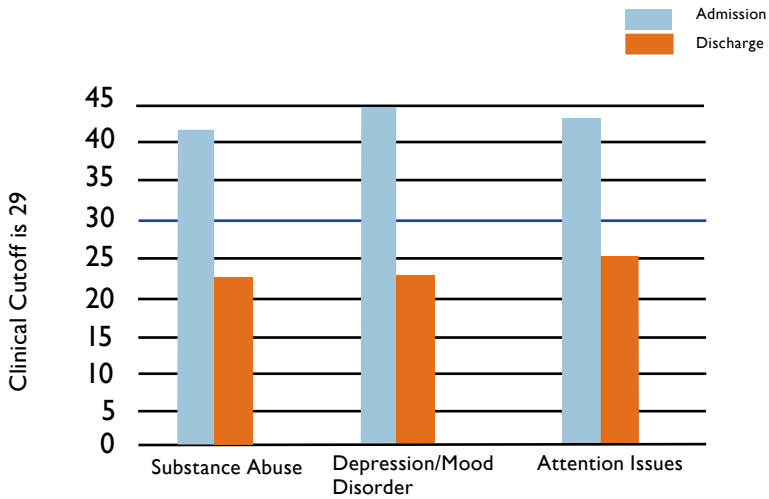
Figure 2 - Clinically and statistically positive changes in the areas of substance abuse, depression/ mood disorders, and attention issues for clients in participating NATSAP programs in the research study.

As seen in Figure 3, note that these positive changes were reported in critical areas of mental health, which included positive changes in the areas of:

- Intrapersonal distress issues such as anxiety, depression, fearfulness, hopelessness, and thoughts of self harm

- Somatic/physical issues such as headaches, dizziness, stomachaches, nausea, and pain or weakness in joints

- Interpersonal relations issues such as attitude toward others, communication, interaction with family and friends, cooperativeness, aggressiveness, arguing, and defiance

- Critical items such as paranoia, obsessive/compulsive behaviors, hallucinations, delusions, suicide, mania, and eating disorders

- Social problems issues such as truancy, sexual problems, running away, vandalism, and substance use/abuse

- Behavioral dysfunction such as ADHD

Y-OQ Scores Over Time

Legend: Admission, Discharge
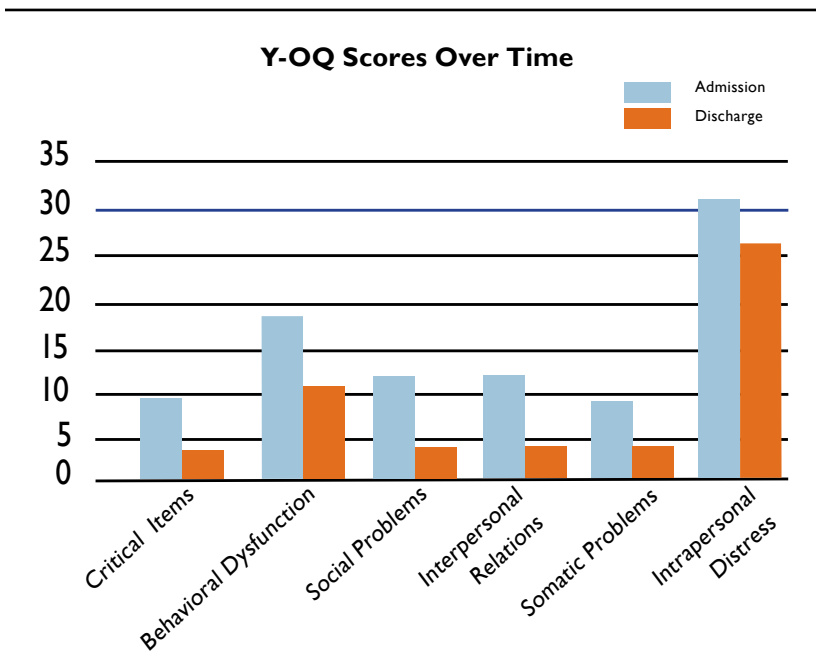
Figure 3 - Clinically and statistically positive changes in the areas of interpersonal distress, somatic issues, interpersonal relationships, critical items, social problems, and behavioral dysfunction for clients in participating NATSAP programs in the research study.

All of these trends were observed in both participating outdoor behavioral healthcare programs and residential treatment centers. Both the adolescents in treatment as well as their parents reported these significant changes.

The majority of the study's participants were male (68%) with 32% being female. The average age of the participants was 16 years old with 94% of the clients between the ages of 13 and 18 years of age. Problematic issues facing the youth in the study included alcohol and substance issues (57.4%), depression (32.7%), Oppositional Defiant Disorder/Conduct Disorder (24.7%), and attention issues including Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder (17.3%). Note that an overwhelming majority of clients in the study were facing interacting and complex problems, with almost 90% of the participants possessing two or more of these difficult issues.

The uses of PRNs like the NATSAP PRN are critical for examining medical, clinical, mental health, and educational issues. PRNs have been established in different fields, but especially in areas of mental health as a response to the call by consumers, government agencies, and insurance companies to increase cost efficiency and the quality of care for clients. Increased support of the research initiative supported by NATSAP promises to deliver even greater and more informative findings in the future.

For the complete findings of this study, see Tucker, Zelov, & Young. (2011). Four years along: Emerging traits of programs in the NATSAP Practice Research Network (PRN). *Journal of Therapeutic Schools and Programs, 5*(1), 10-28.

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Four Years Along: Emerging Traits of Programs in the **NATSAP Practice Research Network (PRN)**

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Abstract

In its fourth year of active data collection, the NATSAP Practice Research Network (PRN) is showing promising outcomes for the NATSAP programs actively participating; however the overall implications of this PRN are still emerging. This study specifically looked at the changes reported by youth and their parents from admission to discharge using the Y-OQ scales. Overall, significant mean differences with large effects sizes were found at discharge, with many changes large enough to show significant clinical change according to the Y-OQ benchmarks. Additional analyses suggested that gender and depression were related to rates of change in both residential and outdoor behavioral healthcare programs. Despite these findings and similar to PRNs overall, there are several limitations to these findings including large variations in the data, limited generalizability, attrition and missing data. Only with increased support both on the research and program side can the potential of this PRN be realized.

Keywords: *NATSAP, Practice Research Network, Outdoor Behavioral Healthcare (OBH), residential treatment centers (RTCs), Y-OQ*

Four Years Along:
Emerging Traits of Programs in the NATSAP Practice Research Network (PRN)

Established in 2007, the NATSAP Practice Research Network (PRN), also known as the NATSAP Research and Evaluation Network, was developed to respond to the call for research demonstrating the program effectiveness of NATSAP programs by clients, allied professional organizations, and federal agencies, such as those sponsoring the *Stop Child Abuse in Residential Programs for Teens Act of 2009* (Gass, 2006; Gass & Young, 2007; H.R. 911, 2009). The NATSAP PRN was seen as a cost effective tool to provide evidence-based outcomes for programs. These outcomes were available as aggregated organizational outcomes indicating what is (and is not) being accomplished by NATSAP programs as an industry group. The outcomes were also accessible by individual programs as credible and confidential feedback on the effectiveness of their particular programs compared to other programs. Four years later, the NATSAP PRN has established emerging support of the effectiveness of NATSAP programs, however many questions still remain about the "true" outcomes achieved by these programs. Despite these limitations, there are a variety of strengths such an approach has over other research efforts.

The use of PRNs (or sometimes called PBRNs for Practice Based Research Networks) to examine medical, clinical, mental health and educational issues is a well-established research methodology (McMillen, Lenze, Hawley, & Osborne, 2009). PRNs have been established in different fields, but especially in areas of health and mental health, in response to a call by consumers, government agencies and insurance companies to increase cost efficiency and the quality of care for clients (Luijsterburg, van den Bogaard, & de Vries Robbé, 2007). Some of the first important examples of PRN research were studies conducted by the RAND organization in the late 1980s. The outcomes of RAND's Medical Outcomes Study (MOS) determined US healthcare policies on the role of financing and reimbursement strategies for public and private care that are still used today (Gilbody, House, & Sheldon, 2002). In fact, "the enduring legacy of the MOS is the fact that patient centered measures of health status developed for the study eventually evolved into the short form 36 (SF 36) - now the most commonly used generic measure of health related quality of life" (Gilbody et al., 2002, p. 1).

While sharing many of the same research and statistical methods, there are several important differences between PRN research and more limited standard experimental and quasi-experimental research design practices. One of the main differences, and the major strength of the PRN approach, is the use of a network of collaborative providers (Gilbody et al., 2002; McMillan et al., 2009). By banding together, these providers create a more compelling research designs by offering a broader understanding

of client treatment than could be typically achieved by analyzing the work of a single organization. Another major difference is when data are interpreted and when these interpretations are used to inform practice. As seen in Figure 1, traditional experimental designs typically wait to implement conclusions drawn from their findings in just the final stages of the research process. PRN research looks to collect data and implement findings throughout all stages of the research process. This has been evident with the NATSAP PRN as several studies have collected and interpreted data early in the "life" of the NATSAP PRN (e.g., Young & Gass, 2008, 2010).

Figure 1: *The Practice Based Research Process*

The Practice-Based Research Process
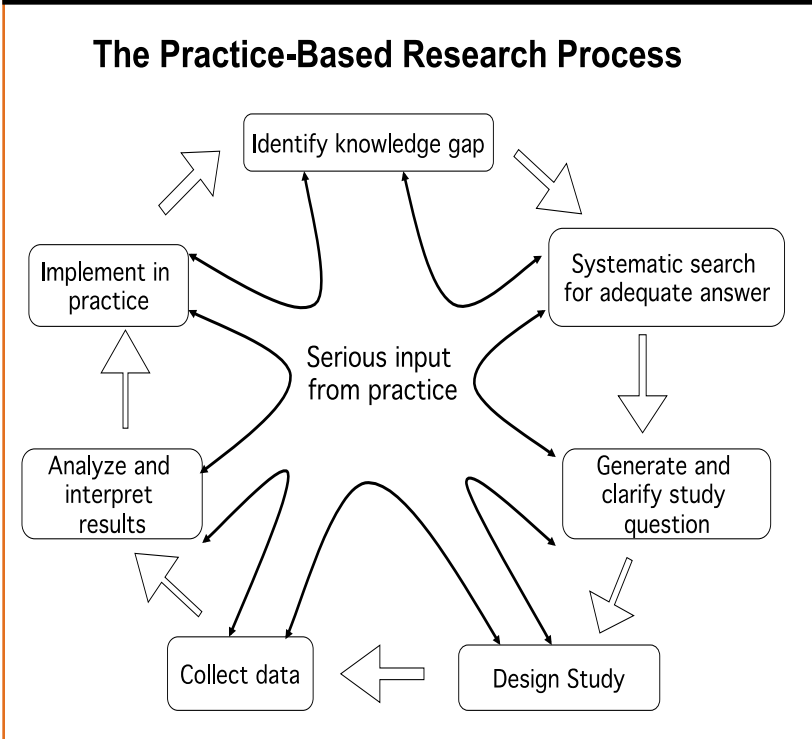
Gilbody et al. (2002) highlight other critical differences that exist between outcome-based research with PRN databases and other traditional research outcome designs (e.g., quasi-experimental designs). PRN research evaluates interventions that are already in place in mental health care settings; collects data that are already in place, part of the treatment process and easily collected; uses clinical staff to collect data; and often collects data even before a specific research question is known. On the other hand, traditional experimental design research collects data only after the research question is known, implements new procedures

for clients as part of the research process and data are generally collected by specified researchers with their only responsibility being to research client outcomes. PRN research also can collect data in multiple settings of providers comparing different and sometimes competing interventions (rather than denying any intervention for some clients); analyzes existing interventions and normative data or established criteria for comparison; and can utilize research methods that are relatively inexpensive and conducted with real-life clients experiencing real-life issues. In contrast, more traditional experimental research conducts studies in one particular setting with one particular research question, involves a research process that is obtrusive and new to the clients, implements more controlled experimental designs with comparison or control groups who receive no treatment or a placebo, and the cost is relatively expensive (Gilbody et al., 2002). While in mental health settings they are often under used (McMillan et al., 2009), it is clear that PRNs may be very valuable to any research on the impact of mental health practices due to their pragmatic flexibility and their efficient practice informed agenda.

When using a practice research network database, several recommendations suggested by Rosenhack, Fontana and Stolar (1999) have been adapted for use with the NATSAP PRN database. These are to use: (1) large numbers of clients, (2) standardized instruments that are appropriate for the clinical condition being treated, (3) outcome measures that are valued by clients and funding agencies, (4) outcome measurements in multiple relevant domains, (5) extensive data in addition to outcome measures in order to support comparison procedures (e.g., large amounts of demographic data), (6) the collection of data in standardized intervals right after important events such as immediately after discharge, and highly valued standard collection periods (e.g., one year post discharge), and (7) aggressive steps to achieve the highest possible follow-up rates.

The purpose of this study was to present the current status of the outcome data of the NATSAP PRN four years along. This article will present the trends in the data, limitations of the database at this stage of its development, and potential directions for the future.

Methods

Measures

The NATSAP programs participating in this study collected psychosocial client information from multiple sources. The NATSAP PRN currently utilizes the Outcome Questionnaire Family of Instruments (OQ) (Burlingame et al., 2005; OQ Measures, 2011; Wells, Burlingame, & Rose, 2003). The Y-OQ-SR 2.0 and the Y-OQ 30 SR are self-report instruments completed by youth ages 11 to 19. The Y-OQ 2.0 and Y-OQ 30 instruments were also completed by parents and guardians at admission and discharge (Burlingame et al., 2005; Wells et al., 2003). The Y-OQ 2.0 assesses a variety of behavioral and emotional problems and possesses a variety of subscales outlined in Table 1. Unlike the Y-OQ

2.0, the Y-OQ 30 does not have a differentiation of subscales but is a shorter version that provides a global index score of youth's behavioral and emotional distress (Burlingame et al., 2005; Wells et al., 2003). The OQ assessments possess established normative scores with documented validity and reliability (Holloway, 2004; Jones, 2004; Lambert et al., 1996; Mueller, Lambert, & Burlingame, 1998; Wells et al., 2003). Programs participating in the NATSAP PRN had the option to use the Y-OQ 2.0 or the shorter Y-OQ 30 version.

Table 1
Y-OQ 2.0 Measure and Subscales

Youth Outcome Questionnaire   64 items

(1) **Interpersonal Distress:** Assesses change in emotional distress including anxiety, depression, fearfulness, hopelessness, and self harm.

(2) **Somatic:** Assesses change in somatic distress typical in psychiatric presentation, including headaches, dizziness, stomachaches, nausea, and pain or weakness in joints.

(3) **Interpersonal Relations:** Assesses change in the child's relationship with parents, other adults, and peers as well as the attitude towards others, interaction with friends, aggressiveness, arguing, and defiance.

(4) **Critical Items:** Assesses inpatient services where short term stabilization is the primary change sought: changes in paranoia, obsessive-compulsive behavior, hallucinations, delusions, suicide, mania, and eating disorder issues.

(5) **Social Problems:** Assesses changes in problematic behaviors that are socially related, including truancy, sexual problems, running away from home, destruction of property and substance abuse.

(6) **Behavioral Dysfunction:** Assesses change in a child's ability to organize tasks, complete assignments, concentrate, handle frustration, including items on inattention, hyperactivity, and impulsivity.

In addition to the standardized instruments, additional data were collected through customized questionnaires used with program staff (e.g., reasons for referral, referral source, admission date, gender, date of birth., 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 (http://natsap. org/research/natsap-research-and-evaluation-network/).

The Sample

Data were collected on 3,041 clients admitted to 23 residential programs between December 2007 and December 2010. All 23 of the programs were predominantly private-pay facilities and were all NATSAP

members. The current study, however only reported on those clients who have left treatment and for whom discharge data were collected via Y-OQ measures. This smaller study sample consists of 983 youth, or 32.3% of the total sample currently in the dataset. The clients in this study came predominantly from OBH programs (89.5%) and the remainder from RTCs (10.5%)[1] . A complete breakdown of the number of clients represented by the 11 programs from which the data were collected can be seen in Table 2. This table clearly shows how varying the degree of participation was for the different programs in the NATSAP PRN. In the RTC group, some programs only had one participant, and in the OBH group, one program provided 640 out of the total sample of 879 OBH clients.

Table 2
Data Collection from Participating Programs (N = 983)

	Program #	*n*	%
Residential Treatment Centers	Program 2	32	31.2
	Program 7	16	15.5
	Program 8	7	6.8
	Program 10	20	19.3
	Program 12	28	27.2
	Program 23	1	1.0
	Total	104	100.0
Outdoor Behavioral Health	Program 3	107	12.2
	Program 17	19	2.2
	Program 19	52	5.9
	Program 22	640	72.8
	Program 24	61	6.9
	Total	879	100.0

The majority of the study sample was male (67.4%) with 32.6% of the clients being female. The average age of the clients in this study sample was 15.8 years (*SD* = 1.7), with 93.7% of the clients between the ages of 13 and 18 years of age. For the clients for whom presenting issues were reported (*N* = 312), the most common presenting issues were alcohol and substance issues (57.4%), followed by depression (32.7%), Oppositional Defiant Disorder/Conduct Disorder (24.7%), and attention issues including Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder (17.3%) (see Table 3). In most cases (89.1%), participants had two or more presenting issues. To see if there were statistical differences between the sample for which we have discharge data (*N* = 983) and the group for which we only have admission data (*N* = 972), independent

1) There were only data from 25 clients discharged from therapeutic boarding schools. The small sample from therapeutic boarding schools was expected given the lengths of stay are traditionally longer in these settings than the other two placement sites, so this sample was not included in this current study, but will be part of follow up studies once the dataset grows.

samples t-tests were completed comparing the admission means scores between these two groups on the youth self report forms and parent forms. At admission, there were no statistical differences between the means levels of functioning of the two groups on any of these measures. These findings support the notion that these groups were comparable and this study sample was typical of the overall NATSAP population.

Table 3
Presenting Issues of Residential Participants (N = 312)*

Issue	n	%
Alcohol and Substance Abuse	179	57.4
Depression	102	32.7
Oppositional Defiant Disorder/ Conduct Disorder (ODD/CD)	77	24.7
Attention Issues (ADHD/ADD)	54	17.3
Anxiety	39	12.5
Trauma	31	9.9
Learning Disabilities	21	6.7
Autism	4	1.3

* NOTE: 89.1% of participants had 2 or more presenting issues

Findings

Youth Self Reports - Y-OQ

The only measure used to collect assessment and discharge data from youth in OBH programs was the Y-OQ 30-SR, with 879 youth completing this measure at admission and discharge. Unlike OBH programs, RTCs used the Y-OQ 2.0 SR with 104 youth completing the Y-OQ 2.O SR at discharge. Discharge data were collected from all students at the end of their programs. As noted, the Y-OQ 2.0 was only used at RTCs, hence there was a smaller amount of subscale data from the youth ($N = 104$) overall. Table 4 provides a complete description of the mean scores at admission and discharge on both Y-OQ measures. Paired samples t-tests were completed as well as effect sizes (*d*) and their confidence intervals for each analysis. Effect sizes measure the strength of a relationship across groups and are used to make numeric comparisons between different findings and their overall treatment effects. Effects sizes are considered to be small when .20 or less, medium at .50 and large when greater than .80 (Cohen, as cited by Gillis & Speelman, 2008). When looking at youth self report, statistically significant differences as well as large effect sizes were found on all measures (see Table 4). Higher scores correlate with higher levels of dysfunction in the lives of the youth. These findings were consistent with the changes reported for the residential youth who completed the Y-OQ 2.0 and reported statistically significant decreases in total scores (signifying increases in functioning) and all six

subscales from admission to discharge, as well as large effect sizes (see Table 4).

Table 4
Y-OQ YSR Mean Scores at Admission and Discharge

	$M_{Admission}$ (SD)	$M_{Discharge}$ (SD)	t	d	95% CI (lower – upper)
Y-OQ 2.0 Scores from Youth in RTCs (N = 104)					
Total Score	89.38 (34.0)**	**40.00 (37.2)**	10.74*	2.55	-3.87 – 9.08
Critical Items	8.98 (5.5)**	4.2 (3.8)	7.96*	1.99	.73 – 2.98
Behavioral Dysfunction	19.6 (8.2)	10.5 (8.6)	9.63*	1.86	-.64 – 4.06
Social Problems	10.2 (6.7)**	**2.1 (5.2)**	10.06*	1.42	.29 – 2.33
Interpersonal Relations	11.3 (8.3)**	**2.4 (7.9)**	9.74*	2.34	.94 – 3.65
Somatic	7.9 (5.2)**	4.6 (4.4)	6.15*	1.49	.38 – 2.14
Intrapersonal Distress	31.3 (12.9)**	**16.3 (12.5)**	9.27*	2.12	-.19 – 3.80
Y-OQ 30-SR from Youth in OBH (N = 879)	41.05 (17.1)**	**22.61 (15.1)**	27.84*	1.33	.20 – 2.33

* $p < .001$
** Scores above the clinical cut-off which reflects dysfunction.
Bold scores represent changes considered to be clinically significant.

To help track client outcomes as well as client progress, clinical cut-off scores were calculated by the instrument developers who compared scores from a normative sample to two clinical samples of inpatient and outpatient populations (Burlingame et al., 2005; Wells et al., 2003). Based on these cut-offs, all of the mean admission scores for the Y-OQ 2.0 SR and Y-OQ 30 SR were within the clinical range of dysfunction for the participants; however, after participating in their residential programs, all of the discharge means were considered to be within the non-clinical range of functioning. In addition to cut-off scores, a reliable change index (RCI) (Jacobsen & Truax, 1991) was derived for all Y-OQ measures to determine if clients had made significant changes in their symptoms, because statistical significance does not always equate with clinical significance. For an individual's total score to be considered clinically significant according to the Y-OQ 2.0 SR the change must be 18 points or greater (with varying levels for the subscales) and 10 points or greater for the Y-OQ 30 SR in additional to post treatment scores falling below the clinical cut-offs (Burlingame et al., 2003; OQ Measures, 2011). As shown in bold on Table 4, both total scores were considered to reflect scores of significant clinical improvement, as well as three subscales for the Y-OQ 2.0 SR (Social Problems, Interpersonal Relations, Intrapersonal Distress).

Parental Reports – Y-OQ

Similar to the youth self report data, OBH programs used the Y-OQ 30 with parents, while RTCs used the Y-OQ 2.0 with its subsequent sub-scales. Overall, admission and discharge data were available from 87 parents of youth in RTCs and 171 parents of youth in OBH programs for a total of 258 parents reporting (representing 26.2 % of the youth from whom there was self-report discharge data as well). Table 5 provides a complete description of the mean scores at admission and discharge on both Y-OQ measures. Paired samples t-tests were completed and statistically significant differences were found on all measures, as well as high effects sizes (see Table 5).

Table 5
Parent Y-OQ Means at Admission and Discharge

	M$_{Admission}$(sd)	M$_{Discharge}$(sd)	t	d	95% CI (lower – upper)
Y-OQ 2.0 Parent Scores from RTC Youth (N = 87)					
Total Score	98.8 (30.5)**	**30.5 (31.1)**	17.23*	1.48*	-5.06 – 8.63
Critical Items	11.9 (6.0)**	**2.3 (4.7)**	13.31*	1.12	.06 – 1.85
Behavioral Dysfunction	28.0 (11.9)**	**11.4 (10.5)**	12.57*	1.32	-.26 – 2.97
Social Problems	9.0 (5.4)**	**2.6 (4.3)**	9.45*	1.39	.11 – 2.39
Interpersonal Relations	14.0 (6.7)**	**1.5 (6.2)**	15.86*	1.34	-.25 – 2.86
Somatic	8.4 (5.3)**	3.3 (3.1)	9.61*	.83	-.17 – 1.68
Intrapersonal Distress	27.5 (11.0)**	**9.5 (8.0)**	14.12*	1.27	-1.21 – 3.67
Y-OQ 30 Parent Scores for OBH Youth (N = 171)	51.76 (19.6)**	**28.12 (17.0)**	13.278	1.81	-1.13 – 4.36

* *p* < .001
** Scores above the clinical cut-off which reflects dysfunction.
Bold scores represent changes considered to be clinically significant.

Based on the clinical cut off scores for the parent forms, at admission parents reported their children to be functioning at a level of clinical concern or deviant from a non-clinical population of peers on all of the measures. After participating in their residential programs, however, all of the discharge means were considered to be within the non-clinical range of functioning. Unlike what youth reported, parents reported not only statistically significant changes, but changes that were large enough to be considered clinically significant according to the measure's reliable change index (RCI) on almost all measures (Wells et al., 2005; OQ Measures). As shown in bold on Table 5, the means of all of the scores except Somatic were considered to reflect areas of functioning as reported by the parent in which the youth had shown clinically significant changes.

Comparisons by Gender, and Presenting Issues

This study was not only interested in the overall impact of the residential programs on youth functioning, it was also interested in exploring which factors may influence a change in functioning in residential clients. In order to do this and include all youth and parent report data in the analyses, a Y-OQ 30 equivalent score was computed for the 104 students who completed the Y-OQ 2.0 SR version and the 87 parents who completed the Y-OQ 2.0. This equivalent score was created by combining those questions from the larger 2.0 version which were similar to the questions on the short form Y-OQ 30. These scores were included with the 879 students and 171 parents who completed the Y-OQ 30 for a combined total score from 983 youth participants and 258 parents at assessment and discharge. Change scores were then computed for each youth and analyses were made to see if gender and presenting issues were related to the level of change seen in participants both from self and parent reports.

Although this research was also interested in differences due to program types, due to the lack of breadth of data coming from a variety of programs it would have been inappropriate to make these comparisons. This is especially true since a large majority of the OBH data came from one OBH program and most of the RTC data came similarly from one program As the data grows from more programs, such comparisons may be important to make in future analyses.

Gender

Before discussing differences by gender and presenting issues, it must be noted that on average according to the Y-OQ equivalent total scores, youth and parents in the study reported clinically significant improvements overall ($M_{change} > 10$) regardless of gender or presenting issues. In general, the youth in the NATSAP programs made significant gains from admission to discharge. In addition to this, some groups had significantly larger improvements compared to others; but the effect these differences had on rates of change varied as highlighted by varying effect sizes.

According to youth participants, it seemed that on average females ($n = 301$) improved more ($M_{change} = 23.13$, $sd = 21.8$) than the 623 males ($M_{change} = 17.36$, $sd = 19.6$) ($t = 4.03$, $df = 92$, $p < .001$), yet this difference was small to medium in terms of effect size ($d = .28$, $CI = .14 - .42$). According to parents, however, although females ($M_{change} = 30.4$, $sd = 22.7$, $n = 116$) did better than males ($M_{change} = 26.10$, $sd = 23.2$, $n = 126$), these changes were not statistically significant. One factor that is important to discuss when looking at gender influences is that according to Y-OQ self report admission scores, females on average were more acute ($M_{admission} = 45.5$, $sd = 18.7$) than males who reported lower levels of dysfunction ($M_{admission} = 40.7$, $sd = 17.2$) at admission. At discharge, however, males reported similar levels of psychological functioning ($M_{discharge} = 23.3$, sd

= 15.7) as females ($M_{discharge}$ = 22.2, sd = 15.6)(t = .99, df = 928, p = .32). Hense while females had higher levels of improvement, on average males and females were no different in terms of functioning at discharge.

Presenting Issues

A variety of independent samples t-tests were completed with both youth and parent data to see if youth who presented with depression, alcohol/substance abuse, ODD/CD or attention issues had significantly larger changes than those without these issues. Only one significant difference was found. According to youth self reports as shown in Table 6, youth who were referred for depression reported to improve significantly more than youth without depression issues at intake (t = 2.13, df = 310, p = .034), yet the effect of being depressed on change was small (d = .25, CI = .01 - .49)

Table 6
Comparison of Mean Changes in Y-OQ Equivalent Scores by Program Type and Gender.

	Youth Self Report		Parent Report	
Depression and Gender	M_{change} **(sd)**	**n**	M_{change} **(sd)**	**n**
Depression	**23.86 (21.3)**[a]	102	35.29 (17.7)	45
Males	**20.10 (21.3)**[b]	63	**38.93 (19.5)**[d]	14
Females	**30.11 (20.4)**[b]	38	33.65 (16.8)	31
No Depression	**18.02 (20.5)**[a]	210	30.64 (20.8)	85
Males	**14.57 (19.7)**[c]	136	**24.69 (23.1)**[d,e]	39
Females	**24.74 (20.6)**[c]	70	**36.81 (16.3)**[e]	44

[a-e] $p < .05$

Additional analyses were conducted to see if presenting issues combined with gender were related to change. Gender and depression did appear to have an impact of rates of change, at least according to parent reports. As shown on Table 6, for males who presented with depression, their parents reported significantly higher rates of change than parents of males who did not present with depression (t = 2.05, df = 51, p = .045) with a medium effect size found (d = .64, CI = .02 − 1.26). However, male self reports did not support this finding and no significant differences were found between females with or without depression as reported by youth or parents. To further investigate the role of depression and gender, analyses were conducted to see if there were differences in rates of change as reported by youth and parents between males and females with depression, and males and females without depression. Female youth who presented with depression reported significantly higher levels of change than male youth with depression (t = 2.33, df = 99, p = .02, d = .48, CI = .07 - .89), and female youth without depression also reported significantly higher levels of change than males

without depression ($t = 3.459$, $df = 204$, $p = .001$, $d = .51$, $CI = .22 - .80$). Hence according to self report data, gender appeared to have had more of a role on change than depression.

Discussion

Based on these preliminary findings, the programs in the NATSAP PRN appear to be significantly impacting change in their clients, most of whom were adolescents. This was based not only on youth self report, but also on the reports provided by the parents of the youth. Based on the Y-OQ and Y-OQ SR measures, not only did the youth improve significantly from admission to discharge, all but one of their assessment scores were considered above the cut off for clinical dysfunction at assessment, and all below this cut off at discharge. In most instances youth scores also improved enough to be considered clinically significant. For youth self report Y-OQ 2.0, levels of social problems, interpersonal problems and intrapersonal distress all decreased to a level that reflected healthy, non-deviant behavior. Both the Y-OQ 2.0 total scores, as well as Y-OQ 30 SR total score similarly showed improvements considered clinically significant. Youth regardless of setting (RTC or OBH) reported on average to be significantly and clinically improved at discharge. These clinically significant changes as determined according to Y-OQ benchmarks, were also supported statistically by large effect sizes, all but one were above 1.0.

Parent and Youth Differences

Overall, Total Scores for the Y-OQ 2.0 as reported by parents of youth in RTCs and scores for the Y-OQ 30 as reported by parents of youth in OBH programs improved enough to be considered clinically significant similar to youth reports (Jacobson & Truax, 1991). Comparable to the youth subscale scores, the Y-OQ 2.0 parent subscale improvements were strong enough to be considered clinically significant for Social Problems, Interpersonal Relations and Intrapersonal Distress, reflective of the youth reports; however, parents also reported improvements in Critical Items and Behavioral Dysfunction, which were not reflected by youth self reports. Hence, the parents of youth in RTCs reported overall changes in more areas of functioning than their children.

In exploring this difference in perspectives between parents and youth, parents at admission reported higher average levels of dysfunction than their children. For example, the mean Total Scores reflected were 89.38 (Y-OQ 2.0) for RTC youth and 41.05 (Y-OQ 30) for OBH youth while parents' mean total scores at admission were 98.8 (Y-OQ 2.0) for RTC youth and 51.76 (Y-OQ 30) for OBH youth. This pattern was similar for all of the Y-OQ 2.0 subscales as well for RTC youth (see Tables 2 and 3). This variance between parental and youth self report scores was consistent with similar outcomes studies of residential programs (Behrens & Satterfield, 2006) and OBH programs (Russell,

2003; 2005) as well as earlier iterations of this dataset (Young & Gass, 2010). In addition, the admission score variances were similar to patterns that have been observed in other assessment instruments such as the ASEBA (Achenbach & Edelbrock, 1991) and the Social Skills Checklist (Gass, 2005). Based on this, it appears common for parents to see youth as more acute than they view themselves. This was not surprising considering in many instances parents played a key role in youth attending these programs, due to their concern for their child and their behaviors and monetary investments in their child's treatment.

Although admissions score variances between youth and parent reports were similar to previous research, unlike Russell (2003) who observed that parent and self-report scores were similar at discharge, the sample studied in this study showed that for OBH participants, parents reported youth to be functioning worse than youth reported at discharge, as reflected by higher mean Y-OQ 30 discharge scores (28.12) reported by parents than youth (22.61). This pattern, however, was not consistent for RTC participants. Youth in RTCs reported to be functioning worse at discharge than parents of RTC youth report, as reflected by mean Total Y-OQ 2.0 scores and subscales (see Tables 3 & 4). The reasons for this difference were unclear, since there is little information regarding youth and parent report variance in the literature as most studies using the Y-OQ have focused on parent reports and not included self-reports in their analysis (Russell, 2003).

One possible reason for these inconsistencies may be due to differences in the number of males and females in each program and how problems were manifested according to gender. For example, females are more likely to internalize their issues, which are not always visibly noticeably to parents, while males tend to externalize and engage in behaviors that parents can observe (Eschenbeck, Kohlman, & Lohaus, 2007; Maschi, Morgan, Bradley & Hatcher, 2010). Hence because females account for the majority of the findings for RTCs and males for OBH programs, parent perceptions of problems may differ from children between programs based more on the gender of their children than on specific program type. This analysis should be considered tentative until the data on males in RTCs and females in OBH programs grow.

Gender Differences

The results of this study also showed that mean changes reported by all female participants from admission to discharge were significantly larger than those reported by males. These findings are congruent with those found by Russell (2003), where females reported higher levels of improvement than males. It is interesting to note that based on self reports females on average entered the programs with higher levels of dysfunction than males, but were functioning at the same level at discharge. It is unclear why this difference at admission exists, perhaps females have a more realistic sense of their functioning at admission, and males are more likely

to minimize their issues. This perspective is actually supported by the fact that parents of males did not report significantly higher changes than the parents of females and that parents in some cases reported their children to be more acute than their children. Parents may in fact have a more accurate perception of their child's functioning. In addition, small sample sizes for males in RTCs, females in OBH programs, and parent data as well as large variances for all groups may have impacted the power of the study and sensitivity of the analyses to detect change, making the role of gender unclear. Only as the sample sizes grow within the NATSAP PRN will the exact nature of gender and program influences on change become clearer.

Presenting Issues

When the four most common presenting issues were examined (alcohol/substance abuse, attention issues, ODD/CD and depression), youth with attention issues, alcohol/substance abuse and ODD/CD on average significantly and clinically improved in functioning as reported by parents and youth at discharge, but their improvements were not any larger than other youth without these presenting issues. These findings were consistent when factors of program type and gender were controlled for; hence it appears that treatment was equally impactful regardless of these issues of attention, substance abuse or ODD/CD. The data showed that only youth with depression issues at intake improved significantly more than participants who did not have this as a presenting issue according to youth self reports. These findings were consistent with previous research on OBH programs (Russell, 2003), yet inconsistent with previous research that found that the absence of mood disorders was a stronger predictor of positive outcomes for residential youth (Behrens & Satterfield, 2006).

When controlling for gender, the findings were inconsistent between youth and parent reports. According to youth, females with or without depression reported higher levels of change with medium effect sizes than males, but depressed females and males did not report significantly higher levels of change than their non-depressed counterparts (see Table 6). This suggests that gender, not depression was related to mean levels of change at discharge according to youth reports. On the contrary, according to parent reports, only females without depression were shown to improve more than males without depression. In addition, males with depression were found to improve significantly more than males without depression with a medium effect size suggesting that both gender and the presence of depression played a role in overall mean changes in functioning. One of the challenges in understanding these findings on presenting issues was that they were based on data from only a smaller subset of youth from whom there was matched data from admission to discharge [$n = 312$ (youth); $n = 130$ (parent)]. Hence due to missing data, it was difficult to say with certainty the role that depression and gender have on outcomes.

Limitations and Future Directions

As has been shown through the findings of this study, it appears that NATSAP programs that have reported data have shown on average consistent and clinical improvements in clients according to both youth and parents. Despite the positive nature of these findings, it is important to note the large variances among these outcomes. Although the mean differences from admission to discharge were consistently large and significant, the standard deviations of these means were also large. For example, youth in RTCs reported on average a mean change of 28.68 with a standard deviation of 26.0. Based on this, approximately 68% of the RTC youth reported changes between 2.68 points and 54.68. Hence, when looked at individually, there were youth that did not have clinically significant improvements.

These variances also impacted effect sizes. Although large effect sizes were reported for pre post changes as shown in Tables 4 and 5, the confidence intervals were also large. Using the previous example of self reports from youth in RTCs, although the effect size comparing admission and discharge means was large at 2.55, the 95% confidence interval ranged from as low as -3.87 to as high as 9.08. Hence, the effect size could easily have been small to inconsequential or much larger than reported. So while the data in this study showed a trend towards improvement, youth experienced a large range of changes and in some instances a lack of improvement and/or worsening of symptoms. In fact, around 34% of the youth reported changes less than the 10 points considered necessary for clinically significant improvements, while the other 66% reported clinically significant positive changes in functioning. Clearly, success was not global for all of the participants and these findings should not be applied universally to all youth in these programs.

These findings were also limited by some of the challenges that many PRNs face including recruitment and generalizability, measurement validity, managing relationships with members and ongoing program support (McMillan et al., 2009). In terms of recruitment and generalizability, it is important to point out that the data included in this study came from only 11 of the 23 programs (47.8%) actively participating in the NATSAP PRN. In fact, 640 of the total sample of 983 were from one single OBH program. Not all programs in NATSAP are fully engaged in the NATSAP PRN and those which are engaged are at different levels of data entry. Hence, these findings should not be considered representative of all NATSAP programs, or even the 23 NATSAP programs that are part of the PRN. In fact, the OBH outcomes may be more due to one or two programs than OBH as a model overall. Though promising, these findings are only a glimpse of the future.

Another limitation of these findings has to do with the validity and reliability of data. While the OQ measures have shown to have consistently strong reliability and validity, a lack of consistent data entry in

terms of demographics and presenting issues at intake by programs, limited the ability to truly understand how these independent variables impacted changes in youth functioning. In addition, attrition at discharge limited the size of the matched data and the confidence in the findings. Since it was unclear why discharge assessments were not completed, it cannot be ruled out that those participants were more acute or did worse than others for whom discharge data were collected.

If the future potential of the NATSAP PRN is to be maximized, these challenges need to be addressed. As with many PRNs, a lack of data entry is more likely due to the demands of the task rather than belief in the importance of the project (McMillan et al., 2009). In order to minimize the time required by busy practitioners, McMillan et al. (2009) stress the importance of managing relationships with PRN members and the need for ongoing support on both the research and program sides. First of all regular communication and exchanges between members are key. This can require:

> *"a well designed and implemented infrastructure. Needed resources might include ample budgeted time from a project manager, website with interactive features, automated email notification systems, annual open meetings and newsletters detailing findings from previous PBRN studies and describing upcoming and underway studies" (McMillan et al., 2009, p. 313).*

While many of these key features already exist as part of the NATSAP PRN system, like conference calls and progress reports, improvements are underway. In order to deal with past challenges of the complicated nature of data input noted by member programs, a new system of data entry was implemented and put into effect in June 2011, allowing for a more streamlined data entry system with less redundancy. This new system in many cases will provide identical record keeping systems from which to draw demographic and client history data more easily, which will augment the strength of the fact that programs in the NATSAP PRN already use similar standardized outcome measures.

In addition to support from the research side, support from the program side is equally important. If the NATSAP PRN is to endure over time, as is the aim of the database, minimal institutional commitment is needed (Clotier, 2005). Ongoing program and database management are crucial, which could include practitioner incentives, the use of research assistants and possibly reimbursing clinicians for lost time, or budgeting in time to complete assessments (McMillan et al., 2009).

Clearly the NATSAP PRN has shown the potential to produce significant network-wide program outcomes. While the PRN has plenty of room for growth, the positive nature of the outcomes reported here were significant. Future areas of growth should focus on improving consistency of data entry especially around demographic and client history information as well as discharge data, and increasing the rate of participation of

pograms. The growth of the NATSAP PRN requires a high level of care and nurturing and without proper support and commitment, the full potential of this endeavor will not be reached.

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A Multi-Center Study of Private Residential Treatment Outcomes

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Abstract

This paper presents the results from a multi-center study on outcomes for youth treated in private residential treatment programs. The sample of 1,027 adolescents and their parents was drawn from nine private residential programs. Hierarchical linear modeling indicated that both adolescents and parents reported a significant reduction in problems on each global measure of psycho-social functioning from the time of admission up until a year after leaving the program (e.g., Total Problems Scores, Internalizing Scales, and Externalizing Scales of the Child Behavior CheckList, CBCL, and Youth Self-Report, YSR). Furthermore, youth and parents reported that the youth improved on all syndromes between the point of admission and discharge (YSR and CBCL syndrome scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Thought Problems, Attention Problems, Aggressive Behavior, Rule-Breaking) and that most of the syndromes remained stable and within the normal range for up to one year after discharge from treatment.

A Multi-Center Study of Private Residential Treatment Outcomes

Since the early 1990's hundreds of private residential programs have been established in the United States. Outcomes of youth treated in these programs are largely unknown (Friedman, Pinto, Behar, Bush, Chirolla, Epstein … & Young, 2006). Previous research has focused almost entirely on public residential treatment programs (RTPs) (Curry, 2004; Curtis, Alexander, & Longhofer, 2001; Hair, 2005; Leichtman, Leichtman, Barbet, & Nese, 2001; Lieberman, 2004; Whittaker, 2004). In fact, there is virtually no published outcome research on private RTPs. This paper attempts to build a research corpus expressly for private RTPs using a large-scale, systematic exploration of treatment outcomes.

It can be argued that private RTPs and public RTPs are fundamentally different. They developed independently and therefore have different histories, professional associations, client services, and client populations. Public RTPs originated in the 1940s, with the work of Bruno Bettleheim, Fritz Redl, and David Wineman (Cohler & Friedman, 2004). The primary professional association representing public RTPs is the American Association of Children's Residential Centers (www.aacrc-dc.org), which was founded in the 1950's. Clients in public RTPs are typically referred through public avenues (i.e., juvenile justice system, child protection agencies, or public mental health systems) (Curtis, et. al., 2001; Epstein, 2004; Hair, 2005) and funded with public money. Public RTP clients are predominantly males and disproportionately selected from ethic minority backgrounds (Asarnow, Aoki, & Elson, 1996). A literature search of the PsycInfo database produced dozens of research studies conducted at public RTPs, enough to warrant a few literature reviews published in referee journals (e.g., Curry, 1991, Epstein, 2004; Hair, 2005, Little, Kohm, & Thompson, 2005).

In contrast, private RTPs were established in the late 1980's and early 1990's (Young & Gass, 2007) with the most rapid growth occurring after 2000 (Santa & Moss, 2006). Private RTPs were founded by a different and loosely organized network of individuals including John Santa, John Reddman, Kimball Delamare, and John Mercer (Santa & Moss, 2006). The National Association of Therapeutic Schools and Programs (NATSAP), founded in 1999, is the major association representing professionals in private RTPs. Private RTPs are typically for-profit entities. Private RTP services typically feature adventure activities, challenge courses, art therapy, and equine programs (Young & Gass, 2007). Services are most often funded by parents or, in some cases, by insurance companies (Friedman et al., 2006; Young & Gass, 2007). The large number of co-educational and female-only programs suggests that female youth are well represented within private RTPs. Unlike public RTPS, private RTPS are costly for families, ranging from $5,000 to $12,000 a month (Young & Gass, 2007), which largely circumscribes the client base to families of a high socio-economic status. In contrast to the large body of research

on public RTPs, only one published outcome study has been conducted at a private RTP , specifically at The Menninger Residential Treatment Program, an intensive, short-term program. The primary measures for the study of 123 youth were the Child Behavior Checklist (CBCL) (Achenbach, 2001) and the Youth Self-Report (YSR) (Achenbach, 2001). The study found that parents and youth reported a significant decline in problems from admission to 3 months post-discharge with maintenance of gains up to 12 months post-discharge (Leichtman et al., 2001).

The findings of Leichtman and colleagues stand in contrast to the large body of literature on public residential treatment. Though a critical mass of studies have found that 60%-80% of adolescents improve during stays in public RTPs (Curry, 1991; Curtis et al., 2001; Epstein, 2004; Hair, 2005; Wells, 1991), many others have found that treatment gains come slowly, are spotty, and leave quickly. For instance, The National Adolescent and Child Treatment Study found that youth treated for "serious emotional disturbance" in public RTPs took three years to move from clinical to normal range of functioning (Greenbaum, Dedrick, Friedman, Kutash, Brown, Lardieri, & Pugh, 1996). In addition, based on published outcomes, reviewers have concluded that residential treatment is most appropriate for higher functioning, less vulnerable youth (Connor, Miller, Cunningham, & Melloni, 2002; Epstein, 2004; Gorske, Srebalus, Walls, 2003; Wells, 1991). Numerous other reviews of public RTPs conclude there is "no evidence" of lasting benefits for youth who received treatment: a significant portion of adolescents who function well at discharge subsequently experience a decline when transferred to a lower level-of-care (Curry, 1991; Epstein, 2004; Hair, 2005; Little, Kohm, & Thompson, 2005). The U.S. Department of Health and Human Services (1999) concluded after a review of the research conducted in public RTPs, "Given the limitations of current research, it is premature to endorse the effectiveness of residential treatment for adolescents." In part because of this pronouncement, public policy shifted from RTP placements to community-based services. Bennett Leventhal and D. Patrick Zimmerman (2004), guest editors for a special issue of the *Child and Adolescent Psychiatric Clinics of North America on* (public) residential treatment, open the issue by stating,

> …*the role of residential treatment seems to have little or no place in the continuum of care for children with mental disorders. Facilities for the intensive, long-term treatment of children and adolescents with serious and persistent psychiatric illness seem to have disappeared or quietly slipped in the shadows of available services. The public sector has seen dramatic downsizing or closures of most long- and short-term inpatient psychiatric treatment centers for children and adolescents. (p.7)*

The poor outcomes reported for public RTPs are based on a research corpus that has been sharply criticized for methodological

flaws. Reviewers have criticized this body of work for its poor samples, retrospective designs, unstandardized measures, and unsophisticated statistical analyses (Curry, 1991; Curtis et al., 2001; Epstein, 2004, Hair, 2005). The majority of studies used only one informant, even though multiple informants have been shown to be necessary (Rend, 2005), and many studies use self-styled measures that lacked normative data and psychometric rigor (Hair, 2005). Sample sizes for studies of public RTPs also tend to be very small. Additionally, relatively few studies used advanced statistics to control for error or explore the impact of moderator and predictor variables.

Method

The present study was designed to systematically explore youth outcomes in private RTPs and to simultaneously address some of the flaws noted in the public RTP research corpus. The study used a multi-center design, with repeated standardized measures, prospective data, a large sample, and two informant groups. The Western Institutional Review Board (www.wirb.org) approved consent/assent forms and issued Certificates of Approval for the study. The research questions were:

1) What are the characteristics of adolescents treated in the private RTPs?

2) How do adolescents function during and after treatment in private RTPs?

   2a) How does adolescent functioning vary across the selected treatment outcomes (e.g., total problems, internalizing problems, externalizing problems, aggressive behavior, anxious/depressed symptoms, withdrawn/depressed symptoms, somatic complaints, social problems, thought problems, attention problems, aggressive behavior, and rule-breaking behavior)?

   2b) Do youth outcomes vary according to age, gender, or number of presenting problems?

Participants

The sample consisted of 1,027 adolescents who, along with their parents or guardians (hereafter referred to as "parents"), agreed to participate in the study and who completed measures at admission, discharge, and 6- and 12-months after discharge from the program (regardless of discharge status). Students were admitted to one of nine programs located in the Eastern and Western United States, between August 2003 and August 2005. Demographic information (i.e., ethnicity, parental income, gender, age) provided by the residential programs indicated the sample was representative of students enrolled in the programs during the same time period.

Description of the residential programs

The nine participating programs were private, out-of-home, licensed (when applicable), therapeutic placements for adolescents and were

member programs of the National Association of Therapeutic Schools and Programs (NATSAP). The RTPs were Academy at Swift River, Aspen Ranch, Copper Canyon Academy, Mount Bachelor Academy, Stone Mountain School, Pine Ridge Academy, SunHawk Academy, Turnabout Ranch, and Youth Care (www.aspeneducation.com). The contribution of each of the residential programs to the sample was relatively equal, ranging from 9% to 16%. This sample consisted of a mean of 55% of adolescents admitted to the residential programs during the identified time period. Though the participating programs were owned by one parent company, Aspen Education Group, curriculum and programming were developed "on-site." This individual development resulted in significant diversity of curriculum and programming. The participating programs varied in terms of size (ranging from 15-bed programs to 120-bed programs), location (Massachusetts, Utah, Arizona, Oregon, North Carolina), treatment philosophy (therapeutic boarding school or residential treatment, the latter of which is more clinically focused and designed for more severely impaired adolescents), and services (e.g., equine assisted therapy, neurofeedback, adventure therapy, partial community placements). The diversity of the participating programs is reflective of the broader private residential treatment industry.

Design and measures

Since no control or comparison group was available, a single-group, pretest-posttest design was used. The primary measures were the Child Behavior Check List (CBCL) and the Youth Self Report (YSR) (Achenbach, 2001). The CBCL and YSR are two related and widely used measures of adaptive and maladaptive psychological and social functioning. The CBCL and YSR syndrome scores, Internalizing and Externalizing Scores, and Total Problem Score have excellent reliability (alpha values range from .78 to .97 for the CBCL scales and from .71 to .95 for the YSR scales) and validity (e.g., Achenbach, 2001; Bérubé & Achenbach, 2006). The CBCL is a parent-report measure of adolescent functioning that consists of 113 items. The YSR is a youth self-report measure that consists of 112 items. The measures have the same item format and scales, which makes them highly compatible. Items are rated on a three-point scale and are primarily objective or behaviorally anchored (e.g., "cries a lot", "gets teased", "fidgets", "truant"). The CBCL and YSR yield 11 scales:

Eight (8) Syndrome scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Thought Problems, Attention Problems, Rule-Breaking Behavior, Aggressive Behavior,

Three (3) Aggregate or broad-band, scales: Internalizing (problems that are mainly within the self), Externalizing (problems that mainly involve conflict with other people and their expectations for the child), and Total Problems (the sum and severity of all the problems reported on the measure).

High scores on a scale indicate clinical deviations from the norm and the presence of numerous and severe problems. Each raw-scale score can be converted into a T-score, percentile rank, and range (Normal, Borderline Clinical, and Clinical). This study used raw scores for statistical analysis, as recommended in the CBCL and YSR manual, because T scores are truncated (Achenbach, 2001). The corresponding range for each syndrome's mean raw score was reported for informational purposes, to provide a benchmark relative to the normative data.

Background questionnaires were completed by both parents and adolescents at admission and discharge, and then again at the six and 12 month marks after discharge. The questionnaires evaluated psycho-social history (e.g., psychotropic medication use, legal problems, grade point average, matriculation in school, presenting problems and program evaluation) and satisfaction with the RTP. Residential program staff completed a brief form for each participating adolescent that indicated discharge status and problems that had been the focus of treatment.

Results

Characteristics of the sample

The mean age for all participants was 16 (SD = 1.2) with 55% being male. Most participants were Caucasian (87%), with small percentages of other ethnic groups. The median annual family income was >$100,000. Almost all (97%) of the adolescents were placed in treatment by their parents. The overwhelming majority of youth had previous treatment at other levels of care (94%). Specifically, 80% had received outpatient treatment in the prior year, 70% had recently been prescribed psychotropic medications, and 31% had at least one psychiatric hospitalization. Only 22% of the youth had a legal record. The mean grade point average for participants was 2.0 on a 4.0 scale (D).

At the admission mark, "Total Problems" raw scores were 74 on the CBCL and 63 on the YSR, placing youth problems at the 97th percentile according to parents and the 91st percentile according to youth. This finding is salient: when treatment began, the adults and adolescents indicated that the adolescents were functioning worse than more than 90% of the adolescent population.

While in the residential program, the majority of adolescents were treated for multiple problems (82%). The most common treatment foci within the sample were disruptive behavior disorders (50%), substance use disorders (40%), and mood disorders (34%). The average length of stay was 10.5 months for those discharged with maximum benefit and seven months for those who were discharged with partial benefit or against program advice. The majority of the sample discharged with staff approval: 54% of students were discharged with maximum benefit,

19.8% discharged early but with approval, 17.3% discharged against program advice, and 8.2% were transferred to a different program. At the discharge mark, mean parental and youth satisfaction with treatment was 4.4 and 4.3, respectively, on a scale ranging from one (poor) to five (excellent).

Change in functioning during and after treatment

Table 1 contains the mean raw scores and ranges of functioning on the CBCL and YSR scales. Both adolescents and parents reported a dramatic decline in youth problems from admission to discharge, on all scales of the YSR and CBCL. Furthermore, scores changed from either the clinical or borderline clinical range at the admission mark to the normal range at the discharge mark and for up to one year after that, on all of the aggregate scales of the CBCL and YSR. For example, as shown in Figure 1, parent report of total problems decreased from the 97th percentile (Raw Score 73.82, Clinical Range) at admission to the 72nd percentile (Raw Score 31.14, Normal Range) one year after treatment. The complementary data from adolescents was similar: youth-reported total problems decreased from the 91st percentile (Raw Score 63.5, Clinical Range) at admission to the 60th percentile (Raw Score 38.5, Normal Range) one year after treatment.

Table 1
Raw Score Scale Means and Range of Functioning

		Admission	Discharge	6-Months Post	12-Months Post
Aggregate Scales					
Internalizing	CBCL	19.09, CL	7.96, N	7.88, N	7.99, N
	YSR	18.15, B	10.41, N	10.37, N	10.49, N
Externalizing	CBCL	28.19, CL	8.34, N	11.13, N	11.12, N
	YSR	24.52, CL	12.52, N	14.23, N	15.06, N
Total Problems	CBCL	73.82, CL	27.81, N	30.94, N	31.14, N
	YSR	63.50, CL	36.37, N	38.49, N	38.35, N
Syndrome Scales					
Anxious/Depressed	CBCL	8.49, N	4.00, N	3.52, N	3.42, N
	YSR	7.97, N	4.84, N	4.61, N	4.87, N
Withdrawn/Depressed	CBCL	6.95, N	2.63, N	2.91, N	2.91, N
	YSR	5.36, N	2.87, N	3.15, N	2.87, N
Somatic Complaints	CBCL	3.64, N	1.34, N	1.45, N	1.66, N
	YSR	4.81, N	2.70, N	2.62, N	2.75, N

Notes. CL = Clinical Range of Functioning, spans the 98th to 100th percentile, B = Borderline Clinical Range of Functioning, spans the 95th to 97th percentile, N = Normal Range of Functioning, below the 95th percentile. CBCL ns = 252-650, YSR ns = 139-773.

Table 1

Raw Score Scale Means and Range of Functioning

		Admission	Discharge	6-Months Post	12-Months Post
Syndrome Scales					
Social Problems					
	CBCL	5.25, B	2.14, N	2.00, N	2.06, N
	YSR	5.30, N	3.43, N	3.39, N	3.31, N
Thought Problems					
	CBCL	5.53, B	2.21, N	2.05, N	2.10, N
	YSR	6.81, N	4.25, N	4.37, N	4.41, N
Attention Problems					
	CBCL	10.10, B	4.73, N	5.24, N	5.27, N
	YSR	8.72, N	5.76, N	6.12, N	5.09, N
Rule Breaking Behavior					
	CBCL	13.80, CL	3.93, N	5.24, N	5.27, N
	YSR	13.07, CL	5.77, N	7.26, N	7.63, N
Aggressive Behaviors					
	CBCL	14.39, B	4.41, N	5.33, N	5.31, N
	YSR	11.45, N	6.75, N	6.98, N	7.43, N

Notes. CL = Clinical Range of Functioning, spans the 98th to 100th percentile, B = Borderline Clinical Range of Functioning, spans the 95th to 97th percentile, N = Normal Range of Functioning, below the 95th percentile. CBCL ns = 252-650, YSR ns = 139-773.

Figure 1.
CBCL and YSR Mean Raw Total Scores Over Time
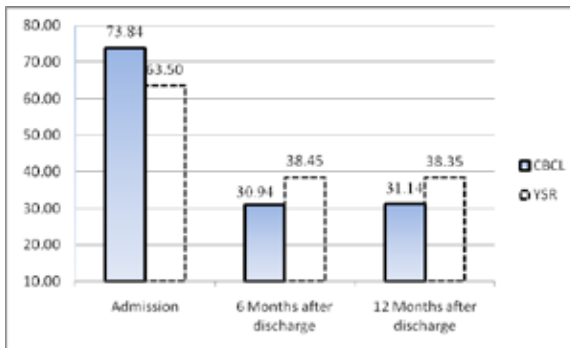
Paired samples t-tests were used to examine change in YSR and CBCL aggregate and syndrome scale scores from the admission mark to the discharge mark.. All scales of the YSR and CBCL showed significant in-treatment changes (Table 2). As shown in Table 1, all syndrome raw score scales reduced to the normal range by discharge or, in the case of those scales that were already in the normal range at admission, reduced to levels further within the normal range at discharge.

One year after the discharge mark parents reported on some other important indicators of outcomes. Eighty-nine (89%) percent of the youth remained at home and had not been placed in any type of out-of-home care (i.e., residential treatment, boarding school, short-term psychiatric hospitalization). Eighty-six percent of parents reported their child was "somewhat better" or "much better" in response to the question, "Currently, how would you describe your child's problems in comparison to when s/he entered the program?"

Table 2
T-tests for Syndrome Scale Scores at Admission and Discharge

	Measure	t test value
Aggregate Scales		
Internalizing	CBCL	21.19**
	YSR	12.75**
Externalizing	CBCL	17.65**
	YSR	13.12**
Total Problems	CBCL	25.22**
	YSR	17.98**
Syndrome Scales		
Anxious/Depressed	CBCL	14.37**
	YSR	11.15**
Withdrawn/Depressed	CBCL	11.47**
	YSR	14.71**
Somatic Complaints	CBCL	9.60 **
	YSR	11.39**
Social Problems	CBCL	13.94**
	SR	10.41**
Thought Problems	CBCL	11.81**
	YSR	10.45**
Attention Problems	CBCL	18.09**
	YSR	14.31**
Rule Breaking Behavior	CBCL	22.82**
	YSR	12.17**
Aggressive Behaviors	CBCL	21.10**
	YSR	13.56**

*Note. ** = p<.001.* CBCL ns = 215, YSR ns = 420

Hierarchical linear modeling was used to evaluate changes in global functioning over time (admission through 12 months after discharge) and to explore if functioning was related to gender, age, or number of presenting problems. Hierarchical linear modeling is ideal when, as with this study, the goal is to model change over time but there are unequal time intervals and missing data (Hedeker & Gibbons, 1997), and when the goal is to determine if outcomes vary for different groups within the sample. Two-level, growth curve models were conducted using HLM6 (Raudenbush, Bryk, & Cheong, & Congdon, 2004) (Table 3). Growth models were estimated separately for Internalizing, Externalizing, and Total Problems scales using raw scores for the CBCL and YSR. Predictor variables were age, gender and number of presenting problems. Models were run separately for each predictor to maximize the available data. Because the major focus for the study was the trajectory of outcomes over time, attention was primarily on the linear and quadratic trend components rather than the intercepts. The linear trend isolated outcomes at admission and discharge. The quadratic trends isolated outcomes during the year after discharge. Table 3 displays chi-square tests that showed significant variability among subjects in their intercepts, linear slopes, and quadratic trends, ($p < .05$). Attempts to account for the reliable variance in linear and quadratic components with the youths' age, gender, or number of presenting problems were unsuccessful. Taken together, the HLM models indicated that youths' problems improved significantly from admission to 12 months after discharge and that these trends did not differ based on gender, age, or number of problems.

Table 3
Growth Model Mean Scores for Internalizing, Externalizing, and Total Problems of the CBCL and YSR

		Intercept	Linear Slope	Quadratic Component	
Internalizing	CBCL	7.21*	-1.96*	1.66*	
	YSR	8.29*	-1.55*	1.51*	
Externalizing	CBCL	7.74*	-2.87*	3.23*	
	YSR	10.44*	-1.51*	2.52*	
Total Problems	CBCL	25.29*	-7.45*	7.30*	
	YSR	30.46*	-4.72*	5.33*	

Note. * = p<.05

Repeated-Measures ANOVAs were computed for all syndrome scales of the YSR and CBCL, using Greenhouse-Geisser corrections, to test whether changes made during treatment were maintained after leaving the program, on each syndrome (Table 4).   The within-subjects variable was time, which was measured by comparing scale scores obtained at the discharge mark to those obtained at six months and 12 months after discharge from the program. The hypothesis was that there would not be significant change over time, rather that gains made during treatment would be maintained. As seen in Table 4, time was not significant for most of the syndrome scales.

Table 4

Repeated Measures Analysis of Variance with Time as a Within Subject Variable

Syndrome Scales	MS	df	F	p	Partial eta sq
Anxious/Depressed					
CBCL	3.50	1.94, 317.30	.69	.50	.004
YSR	4.70	1.85, 168.52	.50	.59	.005
Withdrawn/Depressed					
CBCL	9.13	1.93, 314.75	2.58	.08	.016
YSR	6.58	1.88, 173.33	1.79	.17	.019
Somatic Complaints					
CBCL	1.30	1.97, 321.76	.75	.47	.005
YSR	.78	1.95, 179.19	.23	.79	.002
Social Problems					
CBCL	3.43	1.87, 305.12	1.22	.29	.007
YSR	2.72	1.77, 163.03	.57	.55	.006
Thought Problems					
CBCL	1.59	1.93, 315.36	.60	.54	.004
YSR	.78	1.82, 170.36	.08	.91	.001
Attention Problems					
CBCL	55.23	1.92, 313.61	7.76	.001	.045
YSR	29.79	1.88, 72.92	5.19	.008	.053
Rule Breaking Behavior					
CBCL	349.04	1.96, 319. 41	27.02	.000	.140
YSR	184.10	1.79, 164.88	15.42	.000	.144
Aggressive Behaviors					
CBCL	135.24	1.90, 309.73	10.58	.00	.060
YSR	60.17	1.94, 178.41	4.49	.01	.046

These findings indicate that neither the youth nor their parents thought that the youth had changed significantly during the year after discharge from the treatment program in terms of anxiety, withdrawal, somatic complaints, social problems, and thought problems. However, both parents and youth reported that the youth had changed (worsened) significantly in the year after discharge in terms of rule breaking, aggression, and attention. Note that the effect sizes, measured with partial eta square values, were very small for each of these scales, which indicates that there was only a small proportion of total variability. Thus, though statistically significant, the

increase in rule-breaking, aggressive behaviors, and attention problems during the year after discharge was very small. Raw mean scores (Table 1) for the syndrome scales indicate that after discharge, parents and youth reported only a one-to-two point increase in those problems (on scales that have a ceiling of 30-34 points) and that the scores remained well within the normal range.

Discussion

This study represents the first large-scale attempt at a systematic exploration of long-term treatment outcomes in private residential treatment. The 1,027 adolescents who participated in the study were sampled from nine private RTPs that varied widely in their approach and services. The variety among these private RTPs was intended to reflect private residential treatment in general. The typical client in these private RTPs was a white, upper middle- to upper class, 16-year-old male or female with prior treatment failures who was functioning below average academically and had multiple psycho-social problems. The most common youth problems were disruptive behavior, substance use, and mood disorders.

This present sample was fundamentally different from the samples reported in public residential treatment studies (Curtis et al., 2001; Epstein, 2004; Hair, 2005). Public residential treatment clients are primarily males, disproportionately selected from ethic minority backgrounds, and referred by public authorities. In this private RTP sample clients were equally likely to be male or female, unlikely to be from ethnic minority backgrounds, and were placed in treatment by their parents. These demographic data lend credence to the claim that private and public residential treatment programs have distinct services and populations.

Adolescents in this study had serious psychological and social problems. At admission, both adolescents and parents reported that the adolescents' problems were worse than adolescents in the normal population (97.5% and 91%, respectively). Additional study variables point to high levels of distress among the adolescents in the sample such as an extensive treatment history (94% had prior treatment at least one level-of-care), a high rate of multiple problems (82%), and a 10.5 month average length-of-stay for those discharged with maximum benefit.

Both adolescents and parents reported a significant decline in problems during treatment, on every measured outcome of global psycho-social functioning (CBCL and YSR Total Problems, Internalizing, and Externalizing Scales), as well as at the syndrome level (YSR and CBCL syndrome scales). Perhaps the most meaningful finding was that functioning changed from the clinical or borderline clinical range at the admission mark to the normal range at the discharge mark and remained in the normal range during the year after discharge, on all of the aggregate scales of the CBCL and YSR (Internalizing, Externalizing,

and Total Problems Score). In the year after discharge, adolescents also maintained gains on syndrome scales, with relatively minor recurrence of problems with rule breaking, aggression, and attention. These long-term positive outcomes stand in contrast to the outcomes reported for public residential treatment program about which numerous reviewers have concluded that there is no evidence of lasting benefit (Curry, 1991; Epstein, 2004; Hair, 2005).

This study's data suggest that treatment outcomes generally do not vary according age, gender, or number of problems. These null findings stand in contrast to the findings in the public RTP research corpus. A critical mass of research suggests that youth with relatively numerous and severe problems are less likely to benefit from treatment in public RTPs (Connor et al., 2002; Curry, 1991; Epstein, 2004; Gorske et al., 2003; Hussey & Guo, 2002). This finding, however, did not bear out in the present study. In the present study, favorable outcomes were obtained for youth even though co-morbidity rates and problem severity were very high. Furthermore, the public RTP research corpus suggests that outcomes vary by gender and age of the youth (Connor et al., 2002; Epstein, 2004; Lyons & McCulloch 2006). In the present study, males and females as well as younger and older adolescents had comparable outcomes. Perhaps one explanation for these null findings in the present study lies within the differences between private and public residential treatment clientele and services. This is a hypothesis that warrants further empirical study.

Given that this sample had co-morbid conditions, had failed at prior levels of care, and was largely in the severe range at admission, the shift in scores toward the normal range during and after treatment is noteworthy and speaks to the clinical significance of the change. Perhaps a point of comparison will help to interpret these data. Two of the most acclaimed evidenced-based treatments for youth with behavioral and substance abuse problems, Multi-systemic Therapy (MST) and Functional Family Therapy (FFT), show high rates of problematic functioning after treatment. The primary outcome indicator used to establish the effectiveness of MST and FFT was recidivism. Research suggests that recidivism rates were reduced with MST by 25% - 70% and FFT by 25-80% (Fonagy, Target, Cottrell, Phillips & Kurtz, 2002; NREPP). Though primary outcome indicators were different for those studies than the present study, a lesson can be derived. Even treatments already deemed as "evidence-based" do not "cure" all youth. In fact, a significant portion of youth who complete the "best of the best" evidence-based programs, have serious problems that persist. In this context, the clinical significance of the present study's findings is remarkable: youth who came to private residential treatment had the most severe of problems, but a year after discharge function within the normal range.

A number of issues warrant further research attention. First, this study did not use a control group. The lack of experimental designs (i.e.,

control groups, random assignment to different conditions) in residential treatment outcome research is a common occurrence due to the practical and ethical constraints involved in leaving seriously disturbed adolescents untreated or treated at a lower level-of-care. In this age of outcome-based contracting and evidence-based practice standards, it is clearly desirable to use more robust, experimental designs when possible. Curry (1991) has suggested some creative and practical alternatives to classic experimental design that use within-program and across program comparison groups. Private residential treatment research would also benefit from process-focused studies that attempt to attribute change to specific components of treatment. Private residential care is so multi-facetted and complex that it is less an intervention and more a tapestry of interventions (Fahlberg, 1990). As such, attempts to tie program components to outcomes would have profound clinical implications.

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Positive Youth Development: Bridging Theory into Practice at Therapeutic Schools and Programs

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Abstract

Positive Youth Development (PYD) offers a dynamic framework for guiding work with adolescents (Commission on Positive Youth Development, 2005; Lerner, 2009). This article explores the opportunities for and challenges of implementing PYD in therapeutic schools and programs. Using the case example of a therapeutic school, the authors demonstrate how PYD can be put into practice. Positive Development Plans, youth-adult partnerships, and a more positive approach to behavioral consequences provide specific examples of ways that a PYD lens can transform traditional methods of interacting with youth in this setting. The article includes a discussion of design and instrumentation issues in implementing a PYD program evaluation and concludes with a call for collaboration among therapeutic programs and schools employing PYD as their theoretical perspective.

Positive Youth Development: Bridging Theory into Practice at Therapeutic Schools and Programs

Introduction

Positive Youth Development (PYD) is a perspective on working with adolescents that views all young people as having strengths that can be supported and developed to better prepare them for adulthood (Lerner, 2009). PYD focuses on enhancing positive characteristics to promote the full potential of all adolescents, including those who have experienced psychological problems (Commission on Positive Youth Development, 2005). In a recent article, Duerden, Widmer, and Witt (2010) described the potential benefits of PYD concepts in optimizing the development of youth in inpatient settings and urged its integration into therapeutic programs and schools. The authors argue that "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 (Duerden, Widmer, & Witt, 2010, p.122)." In this article, we provide an overview of a comprehensive implementation of a PYD perspective using Shortridge Academy (Shortridge) as an example.

Positive Youth Development

Positive Youth Development is a strengths-based approach to working with young people that draws on positive psychology, developmental psychology, developmental epidemiology, and prevention sciences (Roth & Brooks-Gunn, 2003; Silbereisen & Lerner, 2007; Lerner, 2009). In contrast to more traditional approaches to working with adolescents, PYD focuses on understanding, educating, supporting, and engaging youth rather than targeting problems and trying to correct or treat them (Commission on Positive Youth Development, 2005). Among the key concepts of PYD are the five "Cs" *(Competence, Confidence, Caring, Connection*, and *Character)* that capture many of the most positive characteristics of thriving young people (Gavin, Catalan, & Markham, 2010; Hamilton, Hamilton, & Pittman, 2004; Lerner, 2007; Pittman, Irby, Tolman, Yohalem, & Ferber, 2003; Roth & Brooks-Gunn, 2003). Lerner and colleagues (Lerner et al., 2005) in their 4-H study provided the initial evidence for the five "Cs" as well as a sixth, *Contribution*, which draws upon the other "Cs" and encourages the young person to give to others including family, school, community, and society. Although Lerner (2009) hypothesized that contributing to self, family, community, and institutions becomes possible after the development of other strengths, some authors conceptualize *Contribution* as one of the "Five Cs" (Hamilton et al., 2004) and subsume *Caring* under *Connection*.

PYD is a philosophy for interacting with youth, a developmental

perspective, and a framework that advocates for supports and opportunities (Duerden et al., 2010). The principles underlying PYD include an emphasis on taking a positive approach to building strengths; a belief in universality, the idea that all youth need support in their development, even though needs may differ; a commitment to provide services and supports for youth; and the value of making available a range of challenging activities and supportive relationships from which youth may choose (Hamilton et al., 2004). Inherent in these principles is the understanding that development is a process and that adolescents should not only be allowed, but should be encouraged to participate in making decisions, selecting their experiences, and engaging as active agents in their own development.

Shortridge

Shortridge is an accredited, coeducational, therapeutic boarding school located in rural New England that serves approximately 60 students in Grades 9 through 12 and their families. Founded in 2002, Shortridge blends academic, therapeutic, and residential experiential activities to achieve its mission. A thoughtful and professional team of faculty and staff work in collaboration to offer college preparatory academics, therapeutic services, medical services, and extra-curricular activities. The primary direct care departments at Shortridge consist of Academic, Counseling, Health/Medical, and Residential professionals with departmental staff and faculty members holding degrees ranging from bachelors to PhD's. With an average length of stay between 14-18 months, students typically are able to earn 1.5 to 2 years of academic credit. Families are encouraged to visit regularly and are engaged frequently in the Shortridge community.

This article echoes Duerden, Widmer, & Witt's (2010) enthusiasm about PYD's potential to inform successful therapeutic interventions and provides information about one school's experiences in making an explicit paradigm shift from an emotional growth approach to one comprehensively guided by PYD. At Shortridge, PYD principles and concepts were integrated into all aspects of the school including admissions, academics, clinical work, residential life, and family inclusion. Deliberately incorporating elements of PYD into the therapeutic context provided opportunities for increasing clarity and consistency with respect to program mission, vision, and philosophy. It also presented organizational challenges such as community acceptance by staff, students, and families; philosophical challenges such as authentically including youth in meaningful ways; and methodological challenges such as developing strength-focused instrumentation to facilitate program evaluation.

Building the Foundation

PYD is not an elaborate theoretical framework (Catalano et al., 2010) and therapeutic schools and programs are likely to develop their

own method of "doing" positive development. The approach used at Shortridge draws upon conceptual and empirical information on the benefits of youth involvement (Huber, Frommeyer, Wisenbach, & Sazama, 2003, Mitra, 2006, Zeldin & Petrokubi, 2006), adolescent brain development (Casey, Getz, & Galvin, 2008; Steinberg, 2008a; Steinberg, 2010a; Steinberg, 2010b; Steinberg, et al. 2008; Weinberger, Elvevag, & Giedd, 2005), and authoritative parenting (Baumrind, 1978; Maccoby & Martin, 1983) to complement PYD to guide planning and decisions. These bodies of knowledge help explain how to put PYD into practice as well as why we might expect this to be an effective way to promote development.

Including and Engaging Youth

Pittman and colleagues argued that development is triggered by engagement and provided the PYD mantra that "problem free is not fully prepared and that fully prepared is not fully engaged" (Pittman et al., 2003, p. 9). These authors stressed the importance of "choice and voice" (Pittman, et al., p. 6) for youth and urged organizations to engage youth in all aspects of decision-making. "Bringing youth to the table" (Huber et al., 2003, p.297) offers them opportunities to build supportive relationships, receive mentoring, develop leadership skills, and enhance competence and confidence. It is important to listen to young people, but in order to encourage positive development, we need to really collaborate with youth allowing them to influence the issues that matter to them and giving them opportunities to prepare for and assume leadership (Mitra, 2006). Student ideas and perspectives are validated as they contribute to making meaningful decisions about topics that are important to them.

Including youth and working with them as partners involves sharing power with adolescents, something that most professionals are not trained to do, particularly if the youth have been identified as having problems (Zeldin & Petrokubi, 2006). It appears that the greatest developmental benefit occurs when adults find the optimal balance between supporting agency and autonomy and providing the necessary structure and support for youth to be successful (Larson, 2007). To strike this balance, adults must respect adolescents' potential, be attuned to their strengths and abilities, and have an understanding of normative adolescent development, particularly adolescent brain development.

Adolescent Brain Development

Shortridge's approach to implementing PYD draws on the burgeoning research on adolescent brain development, neurocircuitry, and changes in the dopaminergic system (Casey et al., 2008; Steinberg, 2008a; Steinberg, 2010a; Steinberg, 2010b; Steinberg, et al. 2008; Weinberger, Elvevag, & Giedd, 2005). Through this lens, it becomes clear that adolescent risk taking appears normative and experiences, peer influence, and hormones all have effects on structural and functional aspects of teen brains (Casey et al., 2008; Steinberg, 2008a). Furthermore, research that

identifies adolescent neurodevelopment as a critical period for addiction vulnerability is informative for both adults working with youth and the young people themselves (Commission on Addiction and Substance Abuse, 2011).

The research on adolescent brain development is relatively recent and there is not yet direct evidence that we can influence adolescent brain development through particular experiences or activities (Steinberg, 2008a). However, there is reason to believe that structuring the environment of youth to include challenging opportunities, safe risks, positive relationships, and stimulating activities and education may enhance the development of self-regulation and the neural structures that facilitate more mature functioning (Steinberg, 2008a). Steinberg (2008a) also suggests that there is ample evidence that authoritative parenting results in youth who are more mature and are less likely to participate in risky behaviors. This type of care takes into consideration the developing abilities of the adolescent, provides age-appropriate parental monitoring, and encourages the development of internal controls.

An Authoritative Community as a Context for PYD

Environments that link multiple contexts and cross discipline collaboration are important in supporting well-being in youth (Kirschman, Johnson, Bender, & Roberts, 2009). Therefore, therapeutic schools and other residential programs provide a unique opportunity to create an environment within which youth can be expected to thrive. Decades of research on parenting indicate that authoritative care is much more effective than authoritarian, indulgent, or permissive approaches (Baumrind, 1978; Maccoby & Martin, 1983). Authoritative parenting is warm, but firm and involves dealing with teens in a rational, inclusive manner. Authoritative parents have realistic expectations about the abilities of their adolescents and provide flexible guidance with verbal give-and-take. By providing a balance between restrictiveness and autonomy, authoritative parents monitor, rather than control, their teens and include them in making decisions about rules and consequences for infractions. In addition to educating parents about the advantages of authoritative parenting, program staff can take an authoritative stance with students in treatment. They can offer warmth, but enforce clear boundaries; hold high, but realistic, expectations; and employ discipline techniques that rely primarily on rational discussion and explanation. Just as authoritative parents interact with their children in an inclusive manner and provide flexible guidance with verbal give-and-take, staff in therapeutic programs can support and monitor, rather than try to control students. By providing a balance between restrictiveness and autonomy, and including students in making decisions about rules and the consequences for infractions, staff can nurture an authoritative community.

Authoritative parenting is correlated with a wide range of benefits

for adolescents including strong attachment to parents, increased competence and self-reliance, greater behavioral and emotional autonomy, increased curiosity and creativity, higher social skills, and greater success in school (Steinberg, 2001; Steinberg, 2008b). There is also evidence that authoritative approaches increase reasoning skills, role taking, empathy, and moral judgment (Steinberg, 2008b). Shortridge's implementation of PYD seeks to use the basic methods of authoritative parenting program wide to achieve these benefits for students thereby providing an authoritative community.

Putting Theory into Practice

Switching paradigms to put PYD into comprehensive practice in a therapeutic program or boarding school is both exciting and challenging. This section summarizes information about important steps in the shift that took place at Shortridge. The use of a logic model to guide the entire process is discussed and key aspects of PYD implementation at the school are highlighted. A fuller discussion of some of these topics is available in Baber & Rainer (2011).

Use of a Logic Model

The development of a logic model can be a critical first step in the development of a new program or the revision of an existing one. A logic model provides a graphic depiction of how and why an intervention is expected to function and can serve as a stimulus for discussion about a program's theory of change, as a communication vehicle, and as a blueprint for constructing a formal program evaluation (Izzo, Connell, Gambone, & Bradshaw, 2004; Connell & Clem, 2000). Once developed, the logic model serves as a framework to guide practices and decision-making, a touchstone to remind everyone about the school's philosophy and methodology for working with youth, and a foundation for documenting the program effectiveness.

Shortridge developed a hybrid logic model that includes mission statement, theory of change, goals, and expected outcomes, as well as strategies and activities to achieve these outcomes. Figure 1 provides a summary of the logic model. Seven overarching positive development goals are the backbone of the logic model. These include:

1. *Build positive decision-making skills.*

2. *Establish and maintain trusting relationships.*

3. *Embrace and implement healthy lifestyle changes.*

4. *Recognize and develop individual leadership potential.*

5. *Create personal goals and identify the resources and strategies to attain them.*

6. *Develop resilience and self-efficacy.*

7. *Understand, navigate, and enhance family relations.*

Each goal has a number of specific, measurable, desired outcomes. For example, there are seven outcomes associated with Goal #2 including:

1. *Students will be able to identify the qualities of a healthy relationship.*

2. *Students will understand and be able to articulate how their actions affect others*

3. *Students will be able to understand, communicate, and maintain appropriate boundaries.*

4. *Students will develop lasting friendships at Shortridge.*

5. *Students will be open and honest in relationships with others.*

6. *Students will develop a network of supportive peers and adults.*

7. *Students will demonstrate increased respect for themselves and others.*

Specific strategies and activities were mapped to each goal to ensure that students would have experiences that would maximize the likelihood the outcomes would be achieved. For example, strategies for achieving Goal #2 include strategies such as providing opportunities for students to support one another, teaching students how to give compassionate feedback, and teaching communication skills including active listening and direct communication. Specific activities designed to help students develop the skills they need to maintain healthy relationships include actions such as interviewing staff on boundaries, identifying peer relationships that are positive and supportive, and developing a "get in touch with friends from home" plan.

Positive Development Plans

Both the principles of PYD and traditional clinical services call for individualized plans for supporting the development and care of young people. To better reflect a PYD approach, the term "Positive Development Plan (PDP)" is used as an alternative to "treatment plan," at Shortridge. The PDP, which includes traditional clinical information such as DSM IV-R diagnostic material, as well as clinical and academic assessments, is created collaboratively by the student, the counselor, the parents, and key members of the clinical and academic departments. These personalized plans identify how the student will work towards achieving the seven goals and thereby develop the "Cs" of PYD. Shortridge includes *Competence, Confidence, Caring, Connection, Character, and Contribution* as desired strengths with the expectation that contributing to others will not only derive from other strengths, but also support their development. Integrated into the PDP are the most relevant outcomes on which the student will focus for a particular period of time and the related therapeutic, programmatic, and academic strategies and activities linked to achieving those outcomes.

The Clinical Director supervises the PDPs which are reviewed and revised regularly by staff, parents, and students as progress is made

through the program. PDPs are electronically available to guide the work of counselors, teachers, and therapists. A reporting form based on the plan is used to secure staff, parent, and student perceptions of progress and to communicate this information to parents, students, and other professionals such as educational consultants.

Strategies and Activities

If a program is to be effective, interventions should be structured in a way that there is a logical expectation that strategies and activities will lead to the desired outcomes (Perkins & Borden (2003). At Shortridge, all strategies and activities at the school were reviewed to ensure that they were linked to specific objectives, reflected a PYD perspective, and were evidence supported whenever possible. For example, to address the goal *Embrace and implement healthy lifestyle changes* and the specific objective *Students will better understand the consequences of risky behaviors such as substance use*, all students participate in PRIME for Life (Daugherty & O'Bryan, 2004). This alcohol and drug risk reduction and prevention program is included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (SAMHSA, 2010).

The process of linking activities and strategies to objectives may uncover topics that need to be addressed or addressed more fully. For example, although a stated objective under the healthy lifestyle goal is that *Students will demonstrate healthy attitudes toward sex and sexuality*, staff members are currently reflecting on how best to work toward this positive outcome. Unfortunately, there is little guidance for doing so in the literature on PYD. Taking a positive approach to adolescent sexuality is particularly challenging because of cultural discomfort with the concept, resistance from groups based on religious beliefs, concerns about appropriateness, and fear that open discussion and education will result in youth acting on sexual feelings (Russell & Andrews, 2003). Russell and Andrews (2003) note that including discussion of healthy sexuality as part of youth development efforts has been seen as irrelevant, inappropriate, or has been problem focused. They argue that healthy sexual development should be a central component of PYD programs because it is a fundamental dimension of adolescents' lives for which adult guidance is often absent or seriously lacking (Russell & Andrews, 2003). The authors, unfortunately, stop short of offering practical strategies for addressing sexuality in PYD programs.

A recent supplement to the *Journal of Adolescent Health* (March 2010) reviewed the observational and intervention research related to the effects of PYD on adolescent sexual and reproductive health. Results indicated that programs with PYD characteristics did reduce sexual problems and risk taking (Gavin, Catalano, David-Ferdon, Gloppen, & Markham, 2010). However, the expert panel completing the review noted that most of the outcomes measured were problem focused and that positive sexual and reproductive health measures have received little attention (Catalano, Gavin, & Markham, 2010).

Developing PYD strategies for addressing the topics of sexuality and intimate relationships in coeducational, therapeutic boarding schools are seen by the authors to present important challenges. At Shortridge, for example, staff explore how best to respond to students who are romantically attracted to one another. Sexual relationships of any type are prohibited at the school, but Shortridge would like to support the development of skills students will need to navigate intimate relationships after leaving the school without distracting them from their therapeutic work while in residence. In a demonstration of putting PYD into practice, staff members are drawing upon students as resources by conducting school-wide discussions of peer relationships of all types. They are discussing with students what skills the students need in order to have healthy relationships, how the school might help them develop these skills, and what behavioral guidelines should be enforced by the staff.

Bringing Youth to the Table: PYD in Action

Therapeutic schools and programs promoting PYD should go beyond just including and listening to youth to reach what Mitra (2006) argues are higher levels of engagement—actually collaborating with youth to bring about change and building their capacity for leadership. Although Shortridge had always included students when shaping new features of the school, as PYD gained momentum the breadth and depth of student inclusion increased significantly. Now Shortridge purposefully engages students across almost all areas of daily life from choosing extracurricular activities to designing new policies and protocols. Staff draw upon student interests and strengths to build adult-youth partnerships with the goal of helping to develop competence and confidence while strengthening student-staff relationships. Including students in the process of generating ideas and making decisions has resulted in a broader range of possibilities being considered and more activities, programs, and facilities being influenced by student contributions.

Engaging students in identifying new activities for participation is straightforward. One group of students worked with staff so that interested youth could attend AA and NA meetings in communities near the Shortridge campus. Another activity involved planning for students to attend live music shows. Each activity required different types of adult scaffolding to ensure that the appropriate safety and supervision measures were considered and students' academic and therapeutic responsibilities were met prior to participation.

Capital-intensive student-initiated projects can be more complicated to execute, but often offer great opportunities for development of new skills and abilities. For example, students interested in photography are working with the art teacher to design and build a dark room. This process has engaged students from the point of conceptualization through the tasks of choosing equipment and designing the layout of the room itself. Another group of students created regular opportunities to

participate in golf outings at local golf courses and now is in the process of building a high quality golf putting green at the school. With adults as partners, students designed the plans, identified resources, visited and talked with material suppliers, and created a budget from which to work.

The ever-changing technological landscape offers opportunities for adults and students to engage productively in ways that leverage students' interests to promote positive development. Computers and student access to the Internet are popular and often challenging policy topics at Shortridge. For example, although students receive a laptop intended to enhance academic experiences and prepare them for future academic settings, Internet policies historically focused on reducing opportunities for students to use computers for unintended purposes. After reviewing technology policies using a PYD lens, a decision was made to revise policies to primarily promote digital citizenship rather than to focus on minimizing problematic use. With a goal of providing students opportunities to gain knowledge about creative software, efficient and varied communication methods, and collaborative research tools, Shortridge's technology coordinator and students regularly meet to establish and revise computer policies. During formal and informal meetings, staff and students discuss technology appropriateness, risks, and benefits. This type of youth-adult partnership empowers students to have a voice, to gain important knowledge, and to understand why adults make the decisions they do regarding the rules and limits surrounding technology.

Developing consequences for students' poor decision-making is another important yet challenging area where schools and programs can partner with youth to promote PYD. When the Shortridge consequence system was altered to better promote PYD and to foster an authoritative approach, students were consulted along the way. The consequence system at the school requires anyone violating rules or agreements to reflect on the violation and determine how to positively resolve the consequences of that behavior. The student writes about what happened, why they think it happened, what aspect of their PDP they need to focus on to recover from the violation, and what or who might assist them. The student also is asked to create and make an "action apology" relevant to the infraction and determine what self-imposed restrictions might be appropriate.

During one meeting to process consequences, students recommended that peers who have demonstrated positive progress at the school should be utilized to mentor those students who were currently in the consequence system for poor decision-making. Positive peers could be identified and formally paired with those students in need of support and guidance. This recommendation grew from the belief that positive students are valuable resources to both their peers and staff when making decisions about the community and culture at Shortridge. It also is consistent with research that shows that peers can enhance one

another's development by helping process feedback, encouraging dealing with conflict and problems, and promoting positive qualities and behavior (Karcher, Brown, & Elliott, 2004).

Evaluating Program Effectiveness

There is a growing expectation that interventions of all types be able to demonstrate their effectiveness. This may particularly be true for private pay programs with high fees such as wilderness programs and therapeutic boarding schools. Systematic outcome evaluation of youth development programs of any type is in its infancy. Although therapeutic schools and programs over the past several years have made progress in this area (Behrens, Santa, and Gass, 2010), there still remains a significant opportunity to expand and improve evaluation of outcomes.

In general, even youth development interventions that are evaluated often use approaches that are not theory driven, do not represent sustained programs of research, and tend to rely on measures of deficit reduction (Caldwell & Baldwin, 2003). While reduction of problems and unhealthy risk behavior is desirable, those who advocate for PYD find these outcomes necessary, but not sufficient, and strive for methods of measuring more positive outcomes that "move young people above the zero points of disorders, distress, and dysfunction" (Commission on Positive Youth Development, 2005, p. 511). The Commission (2005) notes that this can be particularly challenging because frequently used measures for tracking youth development in the United States are biased toward negative outcomes and problems, rather than a vision of what might be positive and health promoting. If a number of schools and programs implementing PYD joined together to develop evaluation instruments and methods more consistent with this theoretical approach, there could be important progress made in moving the field forward in this regard. There is a growing inventory of promising instruments such as the Toolkit for Evaluating Positive Youth Development (The Colorado Trust, 2004) and those used by Lerner and colleagues (Lerner et al., 2005) in their work with 4H programs. However, these tend to be generic in nature rather than being designed to capture the outcomes of complex programs, assume that youth are residing with their parents and participating freely in their community, and may not be developmentally appropriate for older adolescents.

A well-designed evaluation component constructed to assess a specific program will not only provide information about success in achieving expected outcomes, but also will help specify which features of the program influenced the observed changes and determine for which youth the program is most successful (Commission on Positive Youth Development, 2005). Such an evaluation requires investments of time, money, and expertise, as well as forward thinking and courage on the part of administrators.

Although the gold standard for evaluation research is experimental design that includes a control sample with which to compare changes observed in the intervention group, even quasi-experimental techniques are unfeasible for most youth programs (Commission on Positive Youth Development, 2005). Using random assignment of participants to different treatment groups or even securing and maintaining a control group for the collection of longitudinal data would make great financial, logistical, and time demands on programs and schools. Therefore, other approaches need to be considered. For example, at Shortridge, we are using a *theory of change approach* (Connell & Klem, 2000; Izzo et al., 2004) which includes identification of a working theory, in this case PYD, by which the program was developed and the evaluation planned. This approach is designed to determine the effectiveness of a program during and after implementation, providing immediate, intermediate, and ultimate outcomes.

At Shortridge, the development of an evaluation component began with the logic model's list of explicit goals and measurable specific objectives. Indicators of key variables were identified and appropriate instruments were selected, or, if necessary, adapted or constructed. Whenever possible, measures with demonstrated reliability and validity were used, but only if the instrument was truly relevant to the actual program at Shortridge and reflected a positive orientation. For example, progress on the goal *Develop resiliency and self-efficacy* was measured in part through the use of Schwarzer & Jerusalem's (1995) Self-Efficacy Scale which includes items such as "I can remain calm when facing difficulties because I can rely on my coping abilities." Several instruments Lerner and colleagues included in their 4-H study (Lerner et al., 2005) were used to measure variables such as connectedness to school, values, and academic engagement. Other instruments such as Sense of Self were adapted from the Colorado Trust Toolkit for Evaluating Positive Youth Development (2004). Examples of constructed instruments include the PDP Progress Form and the Academic Evaluation Form. The PDP Progress Form is completed by parents, students, and staff and used to determine change over time regarding variables such as positive decision-making, establishing and maintaining relationships, healthy life style changes, leadership, goal setting, resiliency and self-efficacy, and improved family relationships. The Academic Evaluation Form is completed by students and teachers to collect data regarding variables such as curiosity and love of learning, communication skills, work ethics, and thinking and learning skills.

This example demonstrates a program evaluation that adheres to recommendations for designs that are guided by explicit theory, are multivariate, longitudinal, and use multiple methods (Commission on Positive Youth Development, 2005). The evaluation also will attempt to provide information about the effectiveness of core components of the program, the effect of timing delivery (both impact on different age youth and length of program), and differential impact based on individual

characteristics such as gender or psychological challenges, areas where current knowledge is lacking (Gavin et al., 2010).

Conclusion

In hindsight, Shortridge's decision to embrace PYD was the easy part; putting "PYD into action" entailed a long, systematic effort that required a paradigm shift on the part of not just staff, but also parents, students, and other professionals such as educational consultants. All adults at Shortridge were required to rethink their own personal beliefs about how best to support students' positive growth. Parents and students had to adjust to an environment that was more authoritative than authoritarian. Everyone associated with the school faced new challenges in gaining a broad understanding of the opportunities of PYD and the work involved in authentically engaging students in meaningful and growth-producing experiences. During this process, the administration and staff revisited the school's mission, theory of change, and program goals through a PYD-based lens to identify strategies and activities for achieving desired outcomes. Results of the comprehensive outcome evaluation just being launched will provide information about how effective the school's efforts might be and which students may be most likely to benefit.

Shortridge Academy provides an example of one school taking the step of shifting guiding philosophies, making implicit goals and beliefs more explicit, and working with students in more inclusive ways. Many therapeutic schools and programs the authors are aware of already possess some of the core attributes identified within a PYD framework. For these programs, an explicit move to PYD would involve an extension or revision of current services. By sharing successes and challenges, therapeutic programs and boarding schools can move the field forward more efficiently to harvest the benefits of PYD. By working together as a therapeutic community that endorses the tenets of PYD, schools and programs that share this vision can better incorporate evidence-based practice, improve services to students and families, and enhance the valid, reliable evaluation of positive youth development programs.

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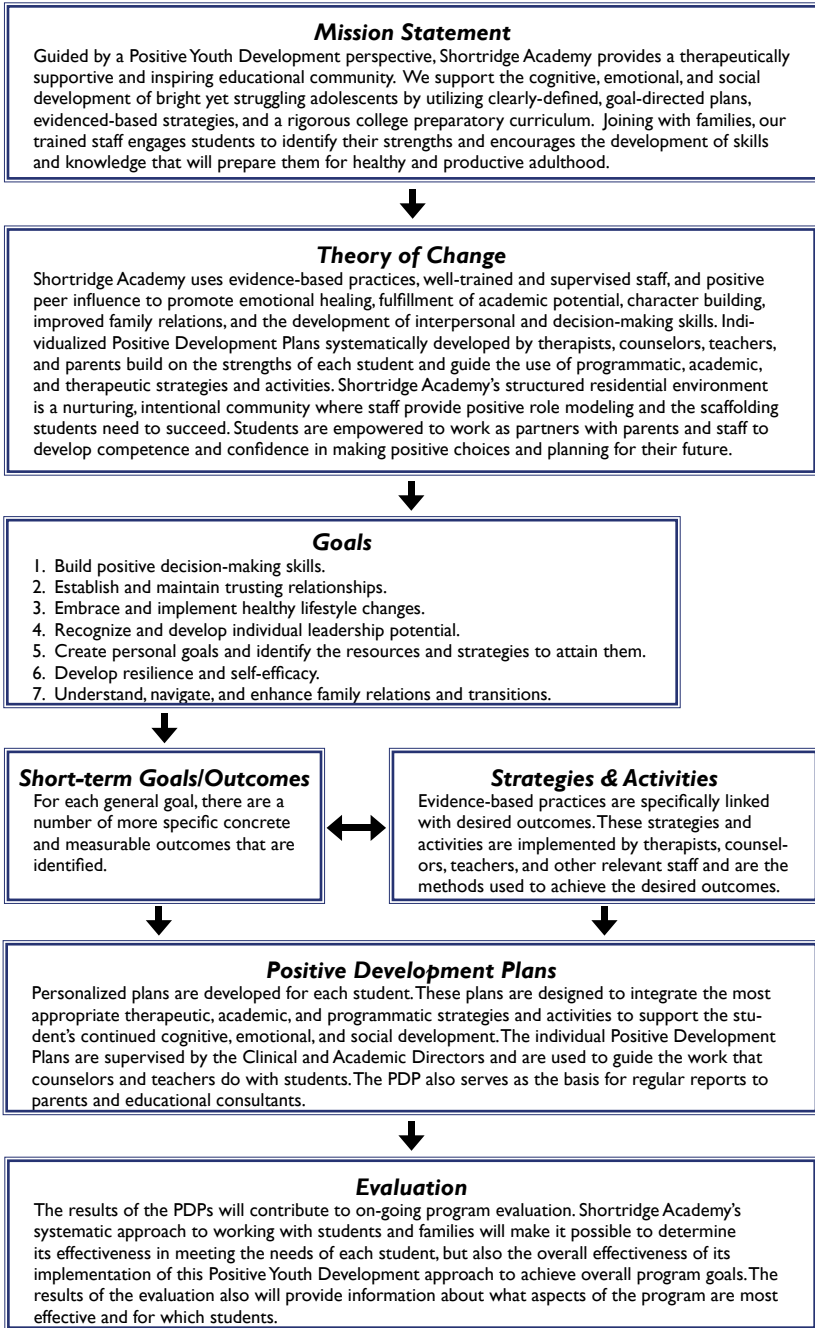
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Figure 1
Shortridge Academy Logic Model.

Mission Statement

Guided by a Positive Youth Development perspective, Shortridge Academy provides a therapeutically supportive and inspiring educational community. We support the cognitive, emotional, and social development of bright yet struggling adolescents by utilizing clearly-defined, goal-directed plans, evidenced-based strategies, and a rigorous college preparatory curriculum. Joining with families, our trained staff engages students to identify their strengths and encourages the development of skills and knowledge that will prepare them for healthy and productive adulthood.

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Theory of Change

Shortridge Academy uses evidence-based practices, well-trained and supervised staff, and positive peer influence to promote emotional healing, fulfillment of academic potential, character building, improved family relations, and the development of interpersonal and decision-making skills. Individualized Positive Development Plans systematically developed by therapists, counselors, teachers, and parents build on the strengths of each student and guide the use of programmatic, academic, and therapeutic strategies and activities. Shortridge Academy's structured residential environment is a nurturing, intentional community where staff provide positive role modeling and the scaffolding students need to succeed. Students are empowered to work as partners with parents and staff to develop competence and confidence in making positive choices and planning for their future.

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Goals

1. Build positive decision-making skills.
2. Establish and maintain trusting relationships.
3. Embrace and implement healthy lifestyle changes.
4. Recognize and develop individual leadership potential.
5. Create personal goals and identify the resources and strategies to attain them.
6. Develop resilience and self-efficacy.
7. Understand, navigate, and enhance family relations and transitions.

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Short-term Goals/Outcomes

For each general goal, there are a number of more specific concrete and measurable outcomes that are identified.

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Strategies & Activities

Evidence-based practices are specifically linked with desired outcomes. These strategies and activities are implemented by therapists, counselors, teachers, and other relevant staff and are the methods used to achieve the desired outcomes.

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Positive Development Plans

Personalized plans are developed for each student. These plans are designed to integrate the most appropriate therapeutic, academic, and programmatic strategies and activities to support the student's continued cognitive, emotional, and social development. The individual Positive Development Plans are supervised by the Clinical and Academic Directors and are used to guide the work that counselors and teachers do with students. The PDP also serves as the basis for regular reports to parents and educational consultants.

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Evaluation

The results of the PDPs will contribute to on-going program evaluation. Shortridge Academy's systematic approach to working with students and families will make it possible to determine its effectiveness in meeting the needs of each student, but also the overall effectiveness of its implementation of this Positive Youth Development approach to achieve overall program goals. The results of the evaluation also will provide information about what aspects of the program are most effective and for which students.

A Mother's Story of Adolescent Substance Abuse

"Elizabeth Douglas"

I am a mother of two children, a daughter who is 17 and a son ("Tom") who is 15. Their father, my first husband, died when they were 8 and 10. I have since remarried and my husband is a captain with the local police department. He is a career officer and has worked in juvenile services for many years, including a decade as the detective sergeant of family services. While we both knew raising teenagers together would be challenging, we had no idea just what "challenging" really meant until my son began to use drugs and alcohol. It has been almost two years since our first incident with Tom and I find myself grateful every day that my son is alive and healthy, my daughter is growing into a lovely young woman, and my husband and I maintain a close and strong relationship. My main purpose in writing this story is that I hope to help other parents who may be experiencing similar problems in their own family, as well as to give a parent's perspective to mental health and dependency treatment professionals.

At the end of 8th grade, Tom was turned in by another student for possessing marijuana on the school bus. I was in a meeting when I saw the school number flash on my cell and stepped out to answer the call. I couldn't really hear very well because of a bad connection but I got the idea. Stunned, I searched for a better cell connection and I will never forget what the principal said: "I have been doing this almost 15 years. I don't believe that Tom is guilty of this, there is no way." I desperately wanted to believe her. But he was guilty, admitted that the pot was his, and subsequently was suspended from school for a week. Our wild ride through the world of drugs, alcohol, and the mental health and juvenile justice systems had just begun.

Reflecting back, I knew something was wrong and I had for months (it's hard to pinpoint when a mother's worrying begins). It was difficult to decipher what was the portion of a typically moody adolescent claiming independence, and what was the part of an early indication of a serious problem. Did he pull away from the other neighborhood children he had played with since he was a toddler because he wanted to form new friendships outside of my close-knit social circle or was it for some other reason? When did he start hating school and all his teachers so much? It seemed as though several days a week I was fielding phone calls and email from the teachers and school administration. Tom was disruptive in class, he didn't do his assignments, and he was too busy being the class clown to get any work done. He routinely lied about assignments (e.g., "No homework again?"). When did my son get so elusive and angry?

At the end of his 8th grade year when he was caught with marijuana, we struggled to do the right thing. I had always maintained a structured home where appropriate rules and consequences were administered. He increasingly chaffed under any authority at all, even arguing when I asked if the home he was visiting was supervised and turned furious when I called the parents to find out myself. There were two school-based consequences to the marijuana incident: community diversion and a LADAC (Licensed Alcohol and Drug Abuse Counselor) evaluation. Tom was required to attend an 8 week community-based drug and alcohol education diversion program. My personal opinion is that this well-intentioned early intervention program was a complete and utter waste of time. Not only did all the kids simply sit in the chairs and restlessly wait for the end of the two hour, $400 class, but I believe it turned into a counterproductive social networking opportunity. Tom graduated knowing more about drugs and alcohol, who used them in his community, and more knowledgeable on how to get them than he did when he started the class. The findings of the required LADAC assessment were equally terrifying: it determined Tom was at high risk for using drugs again because he simply didn't see anything wrong with doing so. This was the core of a battle we would fight over and over. In the months before we pulled him out of public school and placed him in a wilderness program, he just would not stop using and saw no compelling reason to do so. He was unafraid of authority. He was not going to be "scared straight."

Over the summer and ensuing months, Tom grew more and more angry, moody, and seemed to lose interest in almost anything except his friends. He would no longer read books, go anywhere with us, etc. He would not even go into the same room as any other family member or sit at the dinner table without a major battle. He didn't really enjoy sports anymore and demanded to quit the lacrosse team. He begged to be assessed for ADHD, which I resisted. I simply thought he needed to show more discipline in his school work. However, the LADAC professional discussed this with me and encouraged me to have him assessed, as there is a high correlation between early drug use and ADHD. I certainly didn't want to be closed-minded because of my own feelings that ADHD is over-diagnosed—after all, I had been wrong before! I reviewed the research and this correlation seemed valid, so I had him evaluated by the psychiatrist.

This was done through a series of surveys to the child, parents, and teachers. I was called in to review the results, which the psychiatrist said were "compelling." I looked at the "compelling" evidence and I saw what I thought to be marginal results for ADHD behaviors. Not one teacher had ever mentioned ADHD before. Like me, they believed Tom simply preferred not to pay attention and liked joking with his friends more than math class. However, I was pushed by Tom, the psychiatrist, and my own sense of wanting to do something – anything - to make things better. We decided to give a low dose of the medications a try. The drug of treatment choice, Vyvanse, did seem to help with the mood

swings at first, although he later grew more aggressive and I wondered if this behavior was in part due to the side effects of the Vyvanse (i.e., Lisdexamphetamine).

Our lives became worse when high school started in the fall. Beginning in October, Tom's drug use, mood swings and deviant behavior started to escalate. I began to regret agreeing to the ADHD treatment when I learned by reading a text message from one of his friends that he was pocketing the medication and selling it at school. I put an end to that, hiding it in my room and literally placing the medication in his mouth each morning. I kept an inventory of the pills. Having a drug with high street value in our home was one more maddeningly stressful element of our lives. We took away his cell phone permanently. He started football, once his favorite sport, but was routinely seen cutting or going late to practice. He showed up high to the last game of the season and broke his thumb during the last play of the game.

We began to suspect Tom was using marijuana on a much more frequent basis. Although wildly popular at school, his peer group changed exclusively to kids I knew smoked pot (and more) on a regular basis. One of his friends overdosed on mushrooms and another on ADHD medication. Tom failed a home drug test for marijuana, and was put on restriction until he passed. He asked twice to have another home urinalysis to prove he was clean, and both times I discovered that he faked the results (once with urine that wasn't his and once with warm, dyed yellow water). When I asked him to turn his pockets out before the second home drug test, a $50 bill dropped to the floor. I began to get more and more alarmed and had a terrible sense that I was losing my son and there wasn't one thing I could do to stop it. He just didn't seem to care about doing the right thing, respecting authority, or following the simplest rules. His grades went from bad to worse, and he failed a course because he didn't like the teacher and refused to complete the work.

His teachers began to call and email on a regular basis that he was disruptive, disrespectful, and inappropriately aggressive in class. He was sent to the principal's office on a regular basis, and by the end of the winter he was missing hours of class. I apologized so many times to the school staff they probably stopped reading my emails. I began to notice that petty cash was missing from my wallet and Tom's sister began to report her babysitting money was gone. He took his new (Christmas) iPod to school against my wishes and when pressed on its whereabouts, he told me that it was "stolen" from his locker. I suspect that he traded or sold it.

His behavior began to worsen still. He changed his morning routine, leaving early, skipping breakfast, and rushing out the door to meet friends. I found out he had begun to stop at a friend's house on the way to school to meet a group of boys to smoke pot. His language and behavior became threatening, intimidating, and even menacing. He is a big kid—at 14 he was 5'10" tall and 175 pounds. He used his size to scare us, screaming

and swearing at all of the family. He began to come and go as he wanted, telling me to "fuck off bitch" when I told him "no." He destroyed his bedroom, taking a golf club and smashing holes in the wallboard. He broke two wooden doors, four telephones, and the TV remote.   The police - my husband's employees no less - were regulars at our house. Every time Tom opened the front door to come home, my stomach clenched and I felt myself hold my breath. I was in complete overdrive because of stress, fear, and the unknown. Would he be angry? High? Would he threaten us? Or would he just go to the TV room and refuse to interact with us the rest of the day? School was a nightmare. Once he was caught cutting class to get high. When he was returned to campus, the principal gave him a detention. When he was given Saturday school as a consequence, and he proceeded to shred the write-up and throw it at the principal while screaming and swearing at him. He routinely received detentions, Saturday school sessions, and suspensions. Nothing slowed him down or gave him pause to consider the consequences of his actions. He had no remorse for his behavior.

In November of his freshman year he was arrested for possession of marijuana. The prosecutor filed a juvenile petition for drug possession and a CHINS (Child In Need of Services) petition for his behavior at home and school. We went to court, my first interaction with the juvenile legal system. I am grateful every day that I had my husband to help me navigate the complex and completely foreign world of the juvenile legal system. For example, it never would have occurred to me that we should hire a defense attorney for him until my husband told me it was part of the process. We had to pay legal bills with no information and no input—in fact, by following the mandates of his job the defense attorney often worked against us. As a parent, it was the first time I experienced being a bystander in the outcome of a serious event which would affect the life of my child. During the hearing, I sat quietly in the galley as Tom, his defense attorney, and the prosecutor made their case. No one asked me any questions. He pled "not true" to the juvenile petition and true to the CHINS. We had been prepared that the State would ask for placement, as it was felt by the prosecutor he might benefit from being removed from our home for a period of time. However, the judge met with him for over a half hour in chambers (which was highly unusual), and determined that with support services he could come home. Tom was given probation for a year and his juvenile petition was placed on file. We were assigned a probation officer and home-based family counseling services. We were required to find him an individual counselor (previously he had always refused to go) and the court ordered a new psychiatric evaluation.

All of these things worked for a while. Tom was drug tested and stayed clean. He obeyed curfew, stayed away from the friends from whom he was court ordered from having any contact, and was courteous to his probation officer. While he deeply resented us his aggression lessened somewhat. A new psychiatric evaluation determined that indeed

he did not have ADHD, and the psychiatrist withdrew the Vyvanse and Tom was placed on a low dose anti-anxiety medication that helped with the mood swings. No one was able to answer if the Vyvanse contributed to the anger and aggression and his seeming inability to control it, but these symptoms improved when he was taken off the medication. He participated, albeit reluctantly, in family therapy.

Through all this, what I missed was that Tom was passing the drug tests because he was drinking. I was always looking for signs of marijuana use, but I was wrong. Yet as we moved from winter into early spring, I knew something was wrong and I worked obsessively to figure out what it was. I researched the side effects of mushrooms, which I knew could not be tested for in a urine kit. I even contacted a national expert on psilocybin through my research connections. I described Tom's behavior and he told me in an email, "nope, not mushrooms." Reflecting back, my only hint was that he wore cologne. I took it away, but it kept re-appearing. Then my husband came home early one Saturday afternoon and found Tom and a friend, passed out on his bedroom floor with a bottle of vodka next to them. I had literally been gone for 45 minutes when he came home and found the boys. It was March.

I knew something had to happen or we were going to lose our son. The principal mentioned in passing about having worked at the National Outdoor Leadership School, and that maybe a program like that would help him. This was the first idea that I thought, "Okay, that makes sense." So I did what I do best: I researched, read, emailed, and asked. I finally connected with faculty who evaluated wilderness programs. When I talked to admissions staff and read the websites of some of the highly regarded programs I was stunned: Many of the case studies described my son. I contacted the one most highly recommended program and arranged his intake.

We went to the high school at 9:30 on a Tuesday morning; the probation officer called early that morning to say the judge had signed the order allowing him to be placed in private treatment. I had taken the day off and we had packed his things after he left for school, put them in the back of the van, and drove a surprised, sullen, and angry Tom for 2-1/2 hours to begin his wilderness program. When we pulled out of the driveway of the treatment center I felt an immense sense of relief. For the first time in months I was not going to worry where he was, what he was doing, and who he was with. He would be safe.

Tom confessed later he entered the program intoxicated. I have to admit, we just didn't understand how bad it was and I am not sure we ever will know everything that happened. Over the next weeks in the program, Tom slowly began to improve. He responded well to the structured environment of the program. We had weekly conference calls with the therapist and Tom, who became less angry as the weeks passed. Over time he became an active and engaged participant in the program, and seemed proud of his newly found wilderness skills. The staff truly liked him.

He stopped talking obsessively about drugs and started to think about the future, particularly about wanting to go to college. Surprisingly he began to realize that he could not go back to his high school and his old friends, and he agreed to research boarding schools with the staff and other students. Our conversations were not continuous arguments about privileges he wanted restored when he returned, or obsessions about the friends he left behind. The program moved him from a dedicated drug user to someone who wanted to have a future, and when he made mistakes he contemplated the consequences of his actions. I believe the combination of a high staff ("guide") to participant ratio, the demand for accountability in all aspects of the program (e.g., outlining their own treatment goals, packing their own backpack, doing assigned chores), and the intensive and relentless group and individual therapy were key elements of the program. The staff were excellent and clearly able to connect well to teenagers. As he progressed through the levels of the program, he was able to assume more responsibility, until he told us proudly on his last week that he had planned a "tough expedition" for his team. Tom later told me that he didn't think a "pure wilderness" program would have worked for him. "I would have just been pissed off that I was in the woods all the time. I needed wilderness and the program at the center," Tom later told me.

He graduated from the program in six weeks <u>and</u> transitioned into the program's school and therapy program. Altogether, he was in treatment for three months. There was one interesting occurrence at the end of his stay at the program. He had graduated the program, successfully completed the school year, and was looking forward to coming home. However, his behavior became more and more confrontational, agitated to the point I believed that he was in danger of relapsing at home and losing all of the hard-won progress he made. Reluctantly, I went to pick him up and when I was 15 minutes away, I received a call from the lead clinical therapist—himself quite surprised, indicating Tom wanted to stay another week. It seemed this behavior was attributed in part to his own internal conflicts about being home and using substances. This was a real turning point in Tom's ability to recognize the magnitude of his dependence on drugs and alcohol. He told me he had an "epiphany" and wanted to stay until he felt more ready to transition home.

At his graduation ceremony I could not believe all the wonderful things his guides, therapists, teachers, and peers said about him. They talked about his sharp sense of humor, his intelligence, and how he was a great leader and a peer they could look up to. Tom spoke of his time at the program and how he felt he had changed, and chose a single parting word to describe his time in the program: "brotherhood." He chose this because he felt his team were brothers and were always there for each other. I wept not only because he made such amazing progress, but because for the first time in years I was hearing really nice things about the son I love so much. The day he was discharged he came home, and for the first time in two years we spent the afternoon together. We

talked and laughed, and at one point over dinner he said how very sorry he was. That wasn't why I sent him to treatment, and it wasn't what I needed to hear—it was the fact that he finally had empathy for those around him. And one more thing that I thought was the most dramatic: when he went into his program, he had $20 which was kept until he was discharged. When we were shopping at Walmart, he picked out a pair of clippers for cutting his hair and asked if he could have them. I said, "sure." When we got to the counter he gave me the $20 to put toward the purchase without being asked. That he voluntarily gave me $20 and didn't hide it away to use for drugs was the most small, yet powerful indication that he had started to change.

Learnings to Share with Others

There are several things I learned from our experiences that I would share with other parents. First, if you think something is wrong, there is something wrong and it's probably worse than you think. Follow your instincts and don't listen to people who give you some version of "kids are kids, they outgrow it." That is true, some kids do. But be honest with yourself and about your child's problem. Assess if your child's behavior is a phase or if your child needs help to quit. No matter how much of a problem your child has with addiction or other issues, no expert knows your child better than you do. Don't let things continue because your kid has convinced you that you are "crazy" or "irrational." At the height of his substance abuse, these were Tom's favorite words for me. Address each and every thing when it happens, no matter how exhausted it makes you.

Second is use your connections. Get to know other parents, teachers, and community members and talk to them. Ask people to share any suspicions and be open to hearing negative "rumors" about your child and his or her friends. We caught Tom skipping school to get high one day because a neighbor happened to be home and saw him walking up the street with a friend he knew used drugs. He texted me immediately, and Tom was caught within 25 minutes of leaving school (the school did not yet know he was gone).

Third, if you allow your child to use Facebook, require that you are their "friend." Many children leave their privacy settings on low, and you'll learn a lot about what your child and his or her peers are doing in their spare time. Information is power, even if it is painful.

Fourth, do not wait to act or think it will get better. It won't. One reason I believe that Tom was able to make these changes, or that the treatment "worked," is because he was so young and we caught his problem relatively early. Many parents wait until the child is in their late teens when the family is finally so desperate there is no other conceivable option. That's more years of using, which makes it much harder to quit.

Fifth, think hard about what kind of program might work for your child. Conduct extensive research, get referrals, and ask to talk to

other parents who had a child go through the program. Take this very seriously. These programs are exceedingly expensive, often not covered by insurance. You want it to be the right fit for your child and your family. After careful research, I chose wilderness not because it would be tough or make my child "think twice about the comforts he has," but because my son is a physical, athletic child who I knew could be successful in wilderness. In my opinion, he needed success to start to feel good about himself and begin to work on his addiction issues.

Sixth, and the most difficult thing I would say: *You cannot put your child through treatment and then put them back in the same community or school with the same friends and expect different results.* I do know two other parents who did so, paying for expensive wilderness treatment with dramatic results, only to see the changes erode almost immediately when the child returned to their old crowd. As the secretary of my son's school told me, "He can't come back here, the other kids really just wait for them to get out of treatment." In many ways, having my son attend boarding school is the only option for him—our family can't move to a different community, although it breaks my heart to have him live away from us. But I would rather have him sober and away from home than being at risk of making life-altering choices which threaten his future.

Tom is only 15 and I know we are far from "out of the woods." The parties, the pressure, and the lure of drugs and alcohol will be everywhere around him. But I know we won't ever go where we were before. Under his own initiative, Tom selected and enrolled in a private boarding school this coming fall and wears his new school shirt with pride. We took a family vacation to visit prospective colleges for his sister and it was actually fun! These everyday things, these simple pleasures are hard won and I intend to enjoy each single day with my son and my family.

Self-Injurious Behavior: Who's Doing It, What's Behind it, and How to Treat It*

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Abstract

Over the last few years, increasing media attention has been given to self-injury behaviors among adolescents, which has subsequently led to increased awareness among treatment providers. Self-injury is of particular concern within residential programs, with some estimates showing that 40-80% of adolescents in clinical settings engage in self-injury. Complicating the matter is that assessment and intervention for suicide risks have been applied to dealing with self-injury behaviors, even though there are important differences between the two issues. The purpose of this paper is to provide an overview of current trends in adolescent self-injury and to provide recommendations for the development of policies and procedures.

Self-Injurious Behavior: Who's Doing It, What's Behind it, and How to Treat It*

In recent years, increasing attention has been given to self-injury behaviors among adolescents, which has consequently led to an increase in the examination of the frequency of the behavior, its causes, and effective treatments. Residential programs treating adolescents have struggled in their efforts to develop effective best practices for responding to self-injurious behavior. The purpose of this article is to address some of these common concerns, and outline some considerations that should be taken into account when developing appropriate policies. In this article, we will use the definition of self-injury advocated by Klonsky (2007): "the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned" (p. 1039).

Behaviors that constitute self-injury are cutting, burning, carving (words/symbols), scratching, hair-pulling, preventing wounds from healing, biting (to cause bleeding), hitting (to bruise or otherwise damage tissue), tattooing or piercing (if done to moderate emotion), and embedding objects (in the skin, to moderate emotion). It should be noted that "body modification," such as piercing and tattooing, does not necessarily equate with self-injury. In many cases, body modification does not fit Klonsky's (2007) definition of self-injury since the behavior is largely sanctioned by society. However, it is possible for body modification to cross over into self-injury, especially when the intent of the person engaging in the behavior is to mediate an unpleasant emotion.

Historical Perspectives

Before delving into current trends, it is important to recognize that self-injury is not a new phenomenon. Timofeyev, Sharff, Burns, and Outterson (2002) provide a good overview of some of the major historical examples where self-injurious behavior was reported. Below are some of the examples they described:

- Between 496 and 406 BC, Sophocles wrote the play titled *Oedipus the King* in which Oedipus unknowingly kills his father and marries his mother. Upon discovering what he had done Oedipus blinds himself and declares: "Wicked, wicked eyes! You shall not see me nor my shame - Not see my present crime. Go dark, for all time blind to what you should have never seen" (Sophocles, trans. 1909).

- Between 460 and 370 BC, Hippocrates outlined the precepts of "humor" theory and describes the utility of "…bloodletting, blistering, purging by vomiting or anal purgatives, or other potions that would cleanse the body" (Hippocrates, trans. 1891).

- In the first century BC, the Roman priests participated in the "Day of Blood." On this day, priests openly slashed themselves and sprinkled their blood on the statue of Cybele in celebration.

- During the 11ᵗʰ century AD, some within the Christian faith began to participate in self-injurious behavior. Followers of the faith were known to starve, purge, flagellate, and scar themselves as a demonstration of devotion or penance.

- In 1886 the first case study was written about self-injury. The document describes the case of a widow who enucleated her eyes (i.e., removed them) while grieving for her husband.

- In 1888 Vincent Van Gough famously cut off his own ear and sent it to a prostitute.

- Menninger (1938) provided one of the first modern descriptions of self-injury that distinguishes suicidal intent from self-injury. He wrote that "local self-destruction is a form of partial suicide to avert total suicide" (p.271).

- Pattison and Kahan (1983) wrote the first article in modern psychiatry devoted to self-injury where they described predisposing factors and characteristics of those who engage in deliberate self-harm.

Since Pattison and Kahan (1983) published their findings, a number of important developments have occurred that have affected public awareness of self-injury among adolescents. Probably the most noteworthy of these is the emergence and growing acceptance of "emotional hardcore" or "emo" music, which is characterized by lyrics heavily-laden with distressing emotion. Emo was originally a break-off from the punk bands of the 1980's and steadily gained fans throughout the 1990's. Given the type of music emo bands produce, it is not surprising that those adolescents drawn to their music might be experiencing distressing emotional states, and adolescents who experience high levels of emotional distress are also more likely to participate in self-injury. Over time, emo culture consequently became associated with self-injury in general (though somewhat unfairly).

The public became increasingly aware of emo culture between the years 2000 and 2005, during which time emo bands like "Dashboard Confessional" achieved national recognition and financial success. Despite the commercial success of the music, the general public was distrustful of emo music, but somewhat tolerant. Perceptions changed dramatically in 2008 when a 13 year-old girl named Hannah Bond committed suicide after becoming a fan of the band My Chemical Romance. Shortly before Hannah committed suicide she had shown her father cuts on her wrists and explained that they were part of her "emo initiation" (Levy, 2008). Her father had accepted her explanation and her commitment not to do anything like that again.

Despite the ensuing backlash against emo, the visibility of self-injurious behavior has risen sharply in recent years. Numerous websites devoted to self-injury currently glamorize the behavior. A simple search on a video service like YouTube also reveals over 100 clips devoted to self-injury. Furthermore, several celebrities (e.g., Johnny Depp and Angelina Jolie) have added to the public's awareness by speaking openly about their history of self-injury.

Current Trends

Profile of the Self-Injurer

A common myth concerning self-injury is that this is a new problem, or one that only affects certain groups of people (e.g., emo kids). In reality, self-injury is seen across many different ethnic groups (e.g., Whitlock, Eckenrode, & Silverman, 2006), though some studies have found that Caucasians are more likely to engage in self-injury than non-Caucasians (e.g., Gratz, 2006). Furthermore, self-injury is not limited to adolescents and young adults. In fact, Klonsky and Muehlenkamp (2007) reported that up to 4% of the adults in the general population engage in some form of self-injury, with 1% engaging in severe self-injury.

Even so, Klonsky and Muehlenkamp (2007) argue that the prevalence rate is still much higher among adolescents and young adults (i.e., approximately 15%), and one recent study of 9th and 10th graders found that 46% of those surveyed had engaged in at least one self-injurious behavior within the last year (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Not surprisingly, the prevalence rate among adolescents in a clinical population is even higher, with 40-80% engaging in some form of self-injury (Darche, 1990; DiClemente, Ponton, & Hartley, 1991; Nock & Prinstein, 2004). Finally, although many assume that females engage in self-injury more than males, large sample studies have not found this to be the case (Briere & Gil, 1998).

Among the various types of self-injury, the most common form is cutting, with up to 70% of those who have self-injured engaging in this practice (e.g., Briere & Gil, 1998). When treated for self-injury in the emergency room, 25% of 17 to 24 year olds also reported use of this method (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). Klonsky & Muehlenkamp (2007) pointed out that despite cutting probably being the most frequent method used, the more important thing to understand is that most individuals who self-injure are likely to use more than one method. Finally, self-injury may occur on various parts of the body, with the arms, hands, wrists, thighs, and stomach being the most likely (Whitlock et al., 2006).

Contagion

Perhaps one of the most striking trends in self-injury is that the rate seems to be increasing among adolescents. One possible reason for this observation may be related to the phenomenon of "contagion."

Contagion is derived from social learning theory, which posits that individuals are likely to reproduce the behavior they see in others (Muehlenkamp, Licht, Azure, & Hasenzahl, 2008). Muehlenkamp et al. studied contagion as it relates to self-injury among college students and found that those who were exposed to suicidal or self-injurious behavior were significantly more likely to engage in self-injurious behavior themselves. Given increasing media attention and the increasing frequency of public displays of self-injury (as discussed above), it is not surprising that more adolescents are engaging in this type of behavior.

Contagion within therapeutic programs for adolescents can be problematic for all those involved (e.g., Walsh, 2006; Walsh & Doerfler, 2009). In fact, Walsh (2006) wrote: "treatment programs can be hotbeds of contagion" (p.232). Parents send their children to a program in the hope that the symptoms exhibited by their child will be reduced, not so that they can develop new issues. Therapists and line staff are likely to feel increased burden and even guilt when a student begins to engage in self-injury during his/her stay in the program. Accordingly, it is important to manage contagion effectively. In order to do so, it is essential to be aware of some factors that contribute to contagion in a residential setting. Once other students become aware of self-injury among their peers, there are generally two possible directions for contagion to develop. The first is based on competition, and the second is based on affiliation.

With regard to competition, there may be a desire on the part of another student to "one-up" the adolescent who is participating in self-injury. The message being sent is, "I can hurt myself better (more, worse, longer) than you" (e.g., Walsh, 2006). Students may also see the amount of time staff devote to the self-injurer and engage in self-injury themselves to draw the staff back to them. In addition, they might use self-injury, rather than violence or substances, to express strong emotions while avoiding more aversive program consequences of the latter behaviors (Walsh, 2006). One last form of competition arises when the student engages in self-harm with the implicit (and sometimes explicit) intention to punish parents or program staff for keeping them in the program, or otherwise "hurting" them.

In terms of affiliation, the most common occurrence is for a student to begin engaging in self-injury to develop a relationship with the original self-injurer, in this case based on shared interests. Also, when one student engages in self-injury it may provide an excuse for others to "take the leap" (e.g., Walsh, 2006). In this sense, self-injury may act as a form of peer pressure to conform, especially when the original self-injurer holds a position of power within the group. Finally, when an individual lacks effective communication skills, mimicking behavior provides a way to demonstrate understanding and empathy to a self-injurer.

Motivation

The reasons adolescents engage in self-injury are varied and sometimes contradictory. For example, some adolescents report that they self-injure because they are overwhelmed with emotion and need something to distract themselves. In this sense, self-injury can act as a means to gain control or reduce anxiety. The unbounded distress the adolescent feels becomes manageable and restricted. On the other hand, some adolescents report that they feel emotionally numb, and will self-injure just to be able to feel something. Self-injury may provide an excuse for treating oneself as worthy of care, even if it is limited to treating self-inflicted wounds.

Others self-injure as a "cry for help," hoping that someone will notice how much distress they are feeling. This particular type of behavior can sometimes be confused with simple manipulation or "attention seeking," instead of the more accurate interpretation of "attention needing" (Sutton, 1999). One client who came through our program proudly showed the approximately 25 cuts on his arms to staff and students alike. When he was asked in private what led up to the behavior, the bravado quickly faded as he described feeling severely depressed and wishing that his parents would have noticed sooner. This student's experience supports the research as well, showing that up to 83% of hospitalized adolescents report the primary reason for engaging in self-injury was to alleviate feelings of depression (Nixon, Cloutier, & Aggarwal, 2002).

Although some adolescents are fairly open about their behaviors, it is important to keep in mind that many adolescents who engage in self-injury experience significant levels of shame and attempt to hide their wounds. In such cases, adolescents are likely to suffer from a distorted sense of self, often to the point of feeling disgusted. When others discover their behavior and react with shock or disgust, it confirms the self-image they have constructed, which only increases feelings of shame and the likelihood that they will self-injure in the future (Levenkron, 1998).

After such an adolescent engages in self-injury, the impetus to continue the behavior can be connected to the relief she/he was seeking. This relief then reinforces the behavior, and the next time the adolescent is feeling distressed or numb, self-injury is again seen as a viable option for dealing with the problem. In this way, self-injury can begin to develop into an addictive behavior. The same pattern as that seen in other addictive behaviors (e.g., gaming, gambling, etc.) is demonstrated in self-injury as well. When an adolescent engages in self-injury the endogenous opiate system in the brain is activated, which over time becomes dependent on the self-injurious behavior to get a "fix" (Sandman, 1990). The addictive nature of self-injury bears out in recent research as well, showing that 97.6% of adolescents who engage in repetitive self-injury endorse at least three addictive symptoms related to their behavior (Nixon, Cloutier, & Aggarwal, 2002).

Assessment

Although self-injury is not synonymous with suicidal ideation, there is a correlation between the two. One study found 70% of adolescents who engaged in self-injury reported having made a suicide attempt as well (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Accordingly, it is important to conduct a thorough assessment whenever self-injury is a concern. Some of the correlates Nock et al. identified for suicide attempts were absence of pain during self-injury, longer history of self-injury, and use of multiple methods to create wounds. Despite this relationship, one of the major problems with the current standard of care is that assessment for suicidal ideation is also often considered sufficient to assess for self-injury. This section will focus on what we have found to be the most important aspects of assessment specific to self-injury.

History of Self-Injury

When it comes to self-injury it is important to ask clear and direct questions early in the admission process. One useful way to increase identification of self-injury is to have multiple opportunities for assessment. Questions about self-injury should be incorporated into the admissions application, initial screening during the intake process, and during the clinical interview at the least. The question we most often use to begin the clinical assessment for self-injury is: "Have you ever cut, burned, carved, or otherwise deliberately hurt yourself?" Asking about self-injury in such a direct manner provides the student with an initial level of confidence that we want to hear the answer, and will be able to handle an affirmative response.

When the student affirmatively answers a question about self-injury, a number of follow-up questions can be asked. These questions are intended to determine the frequency/duration, severity/location, precipitating events, consequences of the behavior, and potential for future self-injury. The interviewer should use sound clinical judgment to select questions that will provide essential information, without over-focusing on self-injury. Below are some questions that can be used to assess each of these dimensions for a student with a history of cutting (and can be tailored to other forms of self-injury):

1. How often have you cut yourself in the past? How old were you the first time you did it? Has there been an extended period of time when you didn't cut?

2. Have you ever had to get stitches, or see a doctor, after you cut yourself? What have you used to cut yourself? Is there anything else that you have used to cut yourself? Where on your body have you cut yourself? Is there more than one place that you have cut yourself?

3. What was going on for you in the moments and hours before you decided to cut? Are there times in your life when you are more likely to be tempted to cut yourself?

4. How did you feel after you cut yourself? Did you feel better or worse? How did other people around you act when they found out? Did you feel pain when you cut yourself?

5. When was the last time you felt like cutting? Are you currently having any thoughts of cutting?

We have found it is also useful to ask students to show us easily accessible marks (e.g., on their forearm) that they have made through self-injury. The primary purpose of doing so is to: 1) demonstrate to the students that we are not disgusted by their behavior; 2) show confidence with clients in the face of self-injury; and 3) be able to gauge the severity of past injury. Students possessing a history of self-injury often feel deep shame about their past and benefit greatly from having someone who can show a neutral reaction to their behavior (Levenkron, 1998). When observing the evidence of self-injury it helps to make factually grounded observations to the student. For example, the interviewer might comment that "the injury looks like it is healing well," or "that looks like it was pretty deep." From the latter comment, the interviewer might ask for further information regarding what led to a particularly deep injury, helping to increase understanding of what function the behavior serves or gathering information about significant emotional events the student experienced. Again, the intent is to send the message to the student that they are not a "freak," and that they can have confidence in us to treat them with dignity and respect. As one may surmise, it is essential for interviewers to manage their personal reactions to the student's self-injurious behavior. Looks of disgust and judgmental statements only serve to confirm the shame felt by the student, which in turn may lead to an increase in self-injurious behavior.

Case Example

What follows is an example of what might occur during a typical initial intake screening when a student first arrives at the program. In order to protect client confidentiality, the following dialogue does not represent any single student, but instead represents the accumulation of commonalities across numerous initial screening interviews.

Therapist: (After building rapport and asking non-pertinent questions.) "Have you ever cut, burned, carved, or otherwise deliberately hurt yourself?"

Student: "Yes, but I haven't done it for a while."

Therapist: "What led you to stop?" (The therapist moves onto discussing consequences of the behavior and likelihood of recurrence, given that the behavior does not appear to be active.)

Student: "I didn't really like how it felt. Basically it hurt! The only reason I tried it was because my friends said it would help." (This statement implies that the behavior was isolated (i.e., frequency), and gives an indication of motivation that can be used in follow-up questions.)

Therapist: "What did you use to hurt yourself, and where did you do it?" (Here the therapist is assessing severity and location.)

Student: "I used a knife and cut myself on the arms." (Student points to each of her arms and shows the therapist the scars.)

Therapist: "That one on your left arm looks like it was deep, but also appears to have healed well. What was going on for you at the time you cut yourself?" (Therapist makes factual comments about the injury, without showing a negative emotional response, and then moves onto assessing motivation.)

Student: "I was just really depressed and my parents were always mad at me. It was just a really bad time." (This statement provides a glimpse into the underlying issues that motivate the behavior.)

Therapist: "Do you currently feel depressed enough that you are thinking about cutting yourself?" (Therapist is again assessing the likelihood of recurrence of the behavior.)

Student: "No, like I said, it was just a really bad time."

Therapist: "That's good news but, I should point out that this program can be stressful, so if you do begin to feel stressed or depressed would you be willing to let your therapist or one of the staff know so that we can help you?" (Here the therapist shifts focus from the outward manifestation of self-injury to addressing the underlying issues driving the behavior.)

Student: "Yes, I'll let someone know."

At this point the therapist moves on to other questions that are part of the initial intake screening. The dialogue that comprises this example only requires a few minutes of time; however, when this short screening in complete the therapist has valuable information that can be passed to the primary therapist and line staff who will be working with the student. When the primary therapist conducts a full initial assessment, the topic would be revisited and additional information gathered.

Active Self-Injury

When a student is suspected of actively engaging in self-injury, or is directly observed performing the behavior, the assessment process needs to be modified. Nevertheless, it is still important to determine the role of past self-injury in the student's life. Accordingly, the staff/therapist should use the above outlined questions to fill in gaps about the student's history. This process can also be particularly helpful in determining whether contagion plays a role in the student's current behavior.

Although the student's history provides relevant information for current problems, when conducting an assessment for active self-injury there is a need to focus on the dynamics of the current situation. This provides important clues on how best to work with the student to overcome or decrease the behavior. The interviewer should ask specific questions focusing on the most recent incident and assess the function it serves. Examples of such questions include: "What feelings led you to consider hurting yourself today?" or "How did hurting yourself today help?" Discovering the antecedents of self-injury can significantly benefit the treatment process by helping the student/therapist identify the underlying issues that motivated the behavior. This also helps to draw attention away from the act of self-injury itself, and instead focuses on the underlying issues.

Another way to use the assessment process to facilitate future treatment is to ask solution-focused questions about coping strategies. For example, the interviewer might ask "Has there been a time when you were able not to hurt yourself when you wanted to?" and "What did you do instead?" Asking these types of questions helps to instill the idea that self-injury is not the only option and provides students with hope that they can deal more effectively with their problems. When assessing active self-injury it is always important to remember that the focus should be identifying factors that will aid in the treatment process.

Treatment

When considering treatment issues, one of the first considerations is whether the student has a desire to stop the behavior. Much like with substance dependence (e.g., Prochaska & DiClemente, 1983), it is not uncommon to encounter a student who feels that the behavior serves a purpose and has little desire to change. In such a case it may be best to begin by highlighting dissonance between the desired and actual outcome for the student (Miller & Rollnick, 2002). Some of the consequences that can be contrasted with the benefits include: 1) the risk of significant injury and/or death; 2) the potential for developing a psychological/physical addiction; 3) the need to increase severity to obtain the same effects over time (i.e., tolerance); 4) how the behavior interferes with daily life (e.g., time spent hiding wounds); 5) a deepening sense of shame and despair; 6) permanent scarring and tissue damage; and 7) that the underlying issues don't get any better.

When the student shows a commitment to recovery, providers (i.e., line staff, therapists, etc.) should work with the student to identify underlying issues that motivate the behavior, and then deliver interventions designed to ameliorate these issues. There are a number of effective interventions and programs that can be used to decrease self-injury. One of the more well know treatment programs is Dialectical Behavior Therapy, which has been effectively applied to adolescents with a high potential for self-harm (e.g., Katz & Cox, 2002; Linehan, 1993).

Another resource for treatment has been developed by the Cornell Research Program on Self-Injurious Behavior (http://www.crpsib.com/). Their website provides a number of documents outlining how providers can effectively work with someone who engages in self-injury. We refer those interested in increasing their knowledge about specific treatments to the above listed resources for further information. Note the general "guidelines" presented in this paper can be applied to all cases of self-injury, regardless of the chosen treatment method.

As was described for the assessment process, one of the major concerns with treatment is that providers consciously need to manage their own reactions to self-injury. Severe reactions to self-injury rarely have a positive effect on prognosis for the student. In the case of a student who self-injures because of shame, a negative reaction confirms the negative view of self. For "attention needing" students, dramatic reactions reinforce that self-injury will get them the attention they are seeking. Although it is easy to understand why this is important, it is not always easy to manage our reactions, especially since it is hardwired into our brain to react negatively to any kind of physical distortion (e.g., Perry, 2009).

When engaging the student directly it is important for the provider to focus on emotions and motivations, not on the behavior itself. This can be accomplished by exploring the underlying needs of students and showing interest in their perspective. When discussing the self-injurious behavior, guide the discussion back to a consideration of how the behavior is ineffective at resolving the real underlying issues. To this end, motivational interviewing techniques are particularly valuable (Miller & Rollnick, 2002). When providers focus extensively on the specifics of the injurious behavior itself, the tendency is to begin making demands (e.g., "You must quit doing this!") or asking judgmental questions (e.g., "Why on earth would you ever want to do that?"), both of which are likely to actually increase the behavior over time.

Providers should also consistently convey to the students they are committed to helping and empathetic. Expressing empathy is very different from expressing sympathy. Telling a student "I can see how much pain you are experiencing" shows empathy, while saying "I feel so sorry for you" is sympathetic. It is important to convey acceptance and understanding while not condoning the behavior. Another helpful recommendation is to make a conscious effort to see self-injury as an attempt to communicate, rather than an attempt to manipulate. When the provider consciously attends to the communicative nature of self-injury, she/he will be much more likely to get to core issues quickly and treatment will be more effective. Sometimes providers are legitimately concerned about the welfare of the student. When expressing concerns it is important to be direct and honest while avoiding value statements. For example, a provider may effectively convey concern to a student by saying "I am concerned for you and I don't like to see you hurt

yourself." On the other hand, including a value statement such as "Your body is a temple and it pains me to see you defile yourself" is clearly inappropriate.

It is also important to remember that self-injury is not something that is likely to immediately dropped by the client. Providers should help the student by encouraging small steps toward recovery. One possible way of accomplishing this is to interrupt the rituals and routines the student has for self-injury. For example, if the staff notices that a female student begins to isolate herself, the student can be encouraged to join a group activity or help the staff with a project. Interrupting the student's rituals and routines also serves the purpose of increasing the amount of time before the student engages in self-injury. The resultant delay is a good opportunity to work with students to increase their use of healthy coping skills to increase their ability to tolerate distress (Linehan, 1993). Providers also exert positive influence when they model healthy coping skills, effective communication, firm boundaries, and awareness of their locus of control.

Should it become necessary to examine the injuries, providers should be conscious of maintaining the student's dignity. If the student reports injuries to private parts of the body, qualified medical personnel should be called in to conduct the examination when necessary. Just because a student has engaged in self-injury does not mean that they have waived their right to privacy. Medical personnel can also be helpful in determining if medication might be a useful additional to the treatment plan. At least one study has shown that interrupting the endogenous opiate system through psychotropic medication significantly reduced rates of self-injury (Sandman, 1990). One final point to consider is that some providers will be tempted to ignore the problem, or hope that "it will just go away." All incidence of self-injury should be taken seriously and appropriately addressed.

Managing Contagion

One of the most difficult aspects of working with self-injuring adolescents, especially in a residential setting, is effectively handling the potential for contagion. Both Walsh (2006) and Walsh and Doerfler (2009) offer good suggestions for addressing this issue. They suggest that providers should avoid triggering language, examples, details, or "war-storying" during group sessions. It can also be useful to have students who self-injure cover their wounds (with clothes or jewelry, not with bandages), and providers can explain to students they may be hurting others by discussing or displaying their own self-injury. As can be surmised from the above information, it is critical that staff be trained in how to recognize self-injurious behavior and how to compassionately insulate other students from the negative behavior of another student.

Policies and Procedures

Within our organization, the original impetus for learning about self-injury was the lack of a formal policy for responding to it. At that time, the standard response was to conduct a suicide evaluation and place the student on a corresponding level of suicide watch. However, this felt incongruous since the student would firmly deny any suicidal ideation. Over the last few years we have developed a number of standards for dealing with self-injury, including: 1) the need for staff training; 2) opportunities for assessment; and 3) responding to active self-injury.

Training

The most pressing need we identified was that line staff were largely unaware of the difference between non-suicidal self-injury and true suicidal ideation. Regular training is needed to disseminate information about self-injury. Because of turnover in staffing, this type of training should be repeated at least bi-annually, and possibly more frequently (i.e., quarterly) depending on the program. Among the topics covered should be: the various types of self-injury, the difference between self-injury and suicidal ideation, the ways to identify and assess the behavior, the person to whom the behavior should be reported, and the best immediate response.

Staff should also be taught to avoid hyperfocus on the injurious behavior, process underlying needs and emotions, and manage their own reactions to the self-injurious behavior. We have found it useful to show pictures of self-injury to staff in order to help them become less sensitive to what they might see from a student. A common question from staff is whether they should use a therapeutic hold to stop the student from self-injuring. In our program avoiding a therapeutic hold is strongly encouraged, except in situation where the staff feel that the student is engaging in behavior that can endanger life, limb, or eyesight. Finally, staff members need to be taught how to properly document the process they followed and decisions made about intervention.

Assessment and Response

It is not uncommon for students to disclose self-injury to someone other than the primary therapist. As mentioned above, multiple opportunities for assessment should be structured into the program's procedures. Again, some possibilities include questions about self-injury on the admissions application, during the medical intake process, and during the initial clinical assessment conducted by the therapist.

When line staff identify active self-injury, they should conduct an on-the-spot assessment, evaluate the risk of suicide versus self-injury, and report the findings of the assessment to the therapist. With this information the therapist will develop a response plan and deliver it to staff, inform parents of the plan, and debrief staff after it has been implemented. The response plan is tailored to the student and addresses

the specific behaviors of the student. Having a "one size fits all" approach is unreasonable given the diverse ways that self-injury presents itself. For example, taking away all sharp implements would have little effect on a student whose primary method of self-injury is burning.

Nevertheless, there are some common topics that should be covered in the response plan. First, actions may need to be taken to separate the student from potential self-injury implements. Providers can explain to students they cannot in good conscience provide them with the means to hurt themselves. Second, the plan should cover how medical care will be delivered. There may be a temptation to provide less adequate care when the injury is self-inflicted (McHale & Felton, 2010). Regardless of the source of the injury, the policy of the program must be to treat all injuries with appropriate medical intervention. Third, the appropriateness of collaboration with the student in plan development should be determined. In some cases the student may be able to accurately identify strategies that will help effectively manage the behavior, and in other cases this would be inappropriate. Finally, various methods for limiting contagion should be discussed and appropriate methods should be selected.

Within these issues there are a couple of unique situations that should be highlighted. The first is the use of "no harm contracts" to solicit student cooperation. We avoid the use of strict no harm contracts because of the potential for relapse with self-injury. When a well-intentioned student signs a no harm contract and then relapses, the result is an increased sense of failure. Conversely, when the student does not have a desire to cease self-injury, this type of document can result in a power struggle between the providers and the student. However, collaboratively developing "agreements," where the student expresses a sincere desire to cease self-injury, can be very helpful.

Another situation that should be considered is the use of a therapeutic hold during "dissociative self-injury." The general policy we advocate is to avoid a therapeutic hold except in the case of threat to life, limb, or eyesight. A possible exception might arise in the case of dissociative self-injury. Dissociation is often associated with a history of severe sexual abuse (Levenkron, 1998) and is characterized by a mental detachment from consciousness. Those who engage in self-injury while in a dissociative state report that they do not have any memories of hurting themselves, and these injuries are often quite severe (Levenkron, 1998). Therefore, when a student engages in dissociative self-injury, it may be appropriate to use a therapeutic hold to reduce the potential for significant injuries. However, this should be handled on a case-by-case basis, and may still fall under the threat to life, limb, or eyesight exception described above.

Conclusion

Self-injury is increasingly a concern for those who provide services within a residential setting. Regardless of whether this is due to more

awareness of the problem or increasing prevalence, there is a significant need to develop industry standards for addressing the issue. Our intention in this article was to discuss issues related to the motivation, assessment, and treatment of self-injury, and begin a discussion of how programs should respond. This discussion should be seen more as a starting point that needs to be continued forward, with the hope of eventually establishing standards that can be adopted industry-wide.

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Adolescent Treatment Coercion

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Abstract

The clinical practice of treatment coercion among adolescent private treatment programs is both controversial and widely debated among industry supporters and critics. Empirical measurements for the current methods of adolescent treatment coercion are essentially nonexistent. This article explores the current practices of adolescent treatment coercion, addressing both the perceived benefits and disadvantages in application to adolescent care. While potential benefits are cited for some adolescent populations, further examination of coercive care methods is essential to sustaining and improving its function.

Adolescent Treatment Coercion

Adolescent private treatment programs (PTP) have recently faced an array of public scrutiny (Cases, 2007; CAFETY, 2011; Committee, 2011). Mental health and government officials (Cases, 2007; Committee, 2011) have argued that the current regulation of adolescent PTPs is inadequate, advocating for increased federal legislation to ensure licit treatment practices for youth populations under the age of 18. Amid the variety of concerns, adolescent PTP critics (Huffine, 2006; CAFETY 2011) have collectively contested the practices of: (1) the coercion used to admit and retain adolescents in treatment and (2) requiring adolescents to be placed outside the home for a portion of treatment.

In general discourse, coercive care encompasses a wide range of debatable classifications (Rosenblatt 1988). For purposes of this article, coercive treatment refers to one or more of Russell's (2006) three definitions: (1) the adolescent is omitted from the reasoning process for entering treatment, (2) the adolescent is compelled by force or therapeutic deceit into treatment, or (3) adolescent PTPs may engage in coercive actions to retain the adolescent in their care. This article examines adolescent treatment coercion (ATC), or the use of coercive treatment tactics with adolescent populations entering PTPs. It is asserted that the clinical technique of ATC can prove beneficial to some adolescent populations, and in certain cases, may be paramount to accessing treatment. This article is intended to incite discussion and acknowledgement for further exploration of ATC among its supporters and critics.

Individual Autonomy and ATC

One criticism of ATC is its potential to violate individual autonomy (Rosenblatt, 1988; Tannsjo, 1999). Levying one person's (parent's) viewpoints over another's (adolescent's) can yield conflict (Rosenblatt, 1988). Tannsjo (1999) notes that coercion can violate autonomy under two conditions: (1) treatment is permitted, predominantly, for the benefit of others, such as family members, and (2) coercion falsely presumes the individual is incapable of making an autonomous decision to enter treatment. Although Tannsjo (1999) is primarily referencing adult populations, critics of ATC parallel these concerns (CAFETY, 2011; Huffine, 2006). Huffine (2006) asserts that adolescents as young as 13 may have the capacity to make competent treatment decisions. Some states (e.g., California and Washington) provide legislation supporting an adolescent's right for autonomous treatment before the age of 18 (Huffine, 2006; New Start Transports, 2011). Washington State requires adolescents from age 13 to 17 to be voluntary participants of inpatient care, with a few exceptions (Huffine, 2006). California law precludes a parent's authority to place a minor in a mental health facility without the child's consent, with limited exceptions (National Center for Youth Law, 2010). Ironically, neither State enforces legislation to

preclude parents from admitting involuntary youth in out-of-state PTPs via ATC.

In response to these criticisms, Rachlin (Rosenblatt, 1988) asserted that the freedom to be psychotic is not true autonomy, and in some cases represents the most restrictive alternative. Mental health experts (Gaylin & Jennings, 1996) suggested that adolescents reach the point of autonomy when they acquire a deliberate self-consciousness and appreciation concerning obedience to rules and authority. Other experts (Gaylin and Jennings, 1996) stated that autonomy requires an indubitable level of independence or self-reliance, self-mastery, detached rationality, and the ability to pursue life without direct interference from others. In sum, having autonomy requires complete independence and reliance on one's self, while competently coexisting in a society of other individuals with rules (Gaylin and Jennings, 1996). The ability to act autonomously reaches beyond a single decision for treatment. Moreover, Rachlin (Rosenblatt, 1988) argued that rights should be in accordance with an individual's needs to merit value. In reference to adolescents, Tannsjo (1999) stated that although some individuals may intermittently be capable of making autonomous treatment decisions, they lack the overall judiciousness required for such ability to exist. The U.S. Supreme Court established precedence in its 1979 ruling that no judicial process is required for the commitment of minors into treatment (Rosenblatt, 1988). Under the presumption that many adolescents have not yet acquired the intellectual or legal faculty to act autonomously (Rosenblatt, 1988), ATC may not violate autonomy in these cases. Moreover, it can be reasoned that parent guardians retain the right and burden to dictate treatment decisions for children (Gaylin and Jennings, 1996).

Coercion's Influence on Treatment Outcomes

Connected to the argument of autonomy is coercion's influence on treatment outcomes (CAFETY, 2011; Huffine, 2006). Winick (1997) noted that the potential for negative effects on treatment's efficacy and compliance exist when a client is improperly coerced. Furthermore, Winick (1997) pointed out that even if a client participates in treatment, recidivism will likely occur once coercive conditions are removed. Russell (2006) conceded that coercion can create roadblocks to complete recovery, as internal motivation is essential to change. Russell (2006) emphasized that the presence of coercion should be adequately considered in treatment methodology. PTP critics (CAFETY, 2011; Huffine, 2006) use these concerns to uphold claims that coercive care can impede an adolescent's treatment.

The Group for the Advancement of Psychiatry (Mollica & Piwowarczyk, 1994) stated that coercion is not preclusive to successful treatment outcomes, but in certain cases may be essential to it. Moreover, other psychiatrists (Forced, 1994) have asserted that although some adolescents arrive into treatment by force, which may include

physical, financial, or emotional intimidation, blatant coercive treatment approaches can be converted into effective treatment interventions.

Empirical examination into the effects of legal coercion has produced favorable results for the practice of court-initiated coercion (Anglin, Predergast, and Farabee, 2008). Research (Anglin et. al., 2008) of court-coerced substance abusers has indicated that it is ultimately the client that determines treatment outcome, regardless of the coercion used to enter treatment. Though court-initiated coercion is not identical to parent-initiated coercion, it can be analogous in an adolescent's perception (i.e., an authoritative source over the adolescent coerces the youth into treatment). If extrapolated, this data can indicate that parent-initiated coercion could potentially yield positive treatment outcomes, providing a basis for further evaluation.

Adolescent PTP Costs

A third concern noted by ATC critics is the cost of adolescent PTPs (Cases, 2007). With PTPs ranging from $200-$500 per day, and length of stays averaging from one month to two years (Aspen Education Group, 2008; NATSAP, 2011), monetary concerns can arise for those funding treatment. Henggeler et al (1998) debated that more affordable treatment can often be provided when the child participant remains living in the current home environment.

In a quick cost comparison to adolescent treatment provided in several Utah hospitals, PTPs appear to offer competitive rates of care (UNI, 2008; Utah, 2008). The University of Utah's Neuropsychiatric Institute (UNI, 2008) charges exceed $1000.00 per diem. UNI (2008) states that its fees are comparable to other hospitals in Utah such as Utah Valley Hospital and Children's Primary Hospital. Prices for other non-private adolescent treatment services in Utah can range from $460 and more per day (Utah, 2008). Addressing that treatment costs can be less when youth participants reside at home, PTPs can involve more time and work by mental health professionals. If appropriated, this imbalance of professional time and effort can cost less per staff-day. In comparison to community-based treatment (CBT) the fees for PTPs may be greater because more involved services are provided. One distinction existing for many parents is that PTPs are not often subsidized by health insurance companies as is hospital care or some CBTs (Outback, 2011; SUWS, 2011). This may suggest a need for further evaluation by government legislators and insurance companies.

Empirical Support For Coercive Care

Adolescent Treatment Coercion (ATC) is a recent adjunctive treatment technique and its empirical research remains notably deficient (Russell, 2006). Demand for supplemental exploration of the practice of ATC is intensifying (Cases, 2007; Russell, 2006). Acting as its own inhibitor, coercion is a complex construct, exhibiting barriers to gathering

such data (Klag, Creed, and O'Callaghan, 2006; LeBel, 2011). Among these challenges is the development of an effective evaluation system (Klag et al., 2006). Klag et al. (2006) and Winick (1997) divulge that various researchers have omitted its complexity, leading to inconsistent result patterns and several anecdotal conclusions. Moreover, Russell (2006) sustains that no empirical data currently identifies the magnitude and methods of coercion used for admitting youth into treatment. Establishing a universally accepted measuring scale and identifying methods are two critical steps to supporting and refining coercive care.

Henggeler et al (1998) present that CBT has established long-term credibility while only limited scientific research favors the efficacy of out-of-home placements such as PTPs. Research (Henggeler et al, 1998) indicates that non-coercive CBT options may be clinically appropriate and prove efficacious for some adolescents. Therefore, ATC can be considered as a clinical alternative for adolescents that are unresponsive to CBT or to reduce suffering and promote healthy functioning to those that would reject treatment otherwise. For appropriate populations, ATC can facilitate three possible benefits: (1) A safe refuge is offered to an adolescent away from turmoil, drugs, and other hazardous conditions that can eventually preclude access to treatment. This sanctuary can provide time for sober reflection, allowing the adolescent to coherently evaluate and improve his life's direction, perception, and confidence in the future (Freeman, 2007; Russell, 2001). (2) Time for family evaluation and development. An adolescent's delinquency can be connected to the family environment (Perkins-Dock, 2001). As a family recognizes and repairs its weaknesses, an adolescent's potential for a successful treatment outcome can increase; making family participation and development critical components to the recovery process (Perkins-Dock, 2001). (3) ATC may be essential for adolescents before they experience more severe consequences (Mollica and Piwowarczyk, 1994; Russell, 2006). If not coerced into treatment, some adolescents may continue progressing in behavioral delinquency and severity of consequences. This progression can result in additional treatment barriers. Russell's (2006) findings indicate that adolescents are sometimes forced into treatment because they have not experienced severe enough consequences for their destructive behavior at home.

Conclusion

Placement in a PTP through ATC may be appropriate for adolescents who are unable to make healthy autonomous treatment decisions in current living situations. Such adolescents may be unable to receive the opportunity to change without consideration of ATC. The costs of PTPs can be considerable, but are comparable to other costs of mental healthcare, with the exception of insurance reimbursement. Coercive treatment can provide access to a safe treatment environment for reflection and recovery of mental competency, free from negative outside pressure and potential substance abuse. Such opportunity can result

in adolescents increasing susceptibility to treatment, attaining internal desire for change, and developing propensity for healthier decisions. Deliberation of this article provides a basis for additional evaluation of coercive care and its methodology among PTPs, insurance providers, and mental health professionals within the United States.

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Second Order Change Through Principle Based Treatment

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Abstract

Theoretical and practical knowledge is constantly expanding the
conceptual framework of therapeutic intervention that underpins
wilderness and residential treatment models. The implications of these
changes have imperative application in the continual improvement of
treatment models and practices. Second order change (or cybernetics),
as first proposed by the Mental Research Institute (Watzlawick,
Weakland, & Fisch, 1974) continues to gain empirical validation as an
integral aspect of successful and lasting therapeutic change (Fraser &
Solovey, 2007). Several aspects of residential treatment can be improved
through application of the principles of second order change. Use of
second order change through principle-based residential treatment is
viewed in practice at Telos Residential Treatment Center. Considerations
for implementation in all residential treatment settings are suggested.

Second Order Change Through Principle Based Treatment

Second order change as proposed by the Mental Research Institute (Watzlawick et al., 1974) indicates an imperative shift in thinking from changing mere behavior within a problematic system to a meta-change process of shifting the principles that support the structure of the system. The concept of behavioral change being effected by change at systemic level was extrapolated from principles of Mathematical logic. By comparing and contrasting change within elements (individuals) and the whole (family system), the underlying dynamics that drive them are delineated (Lyddon, 1990). By focusing treatment on changing or developing principles upon which behavior is based, behavioral changes will often occur as a product of intrinsic motivation rather than as a response to external environmental conditioning. By effecting change at an internal level, behaviors are more likely to be maintained than those behaviors that have changed merely to adapt to a temporary structure.

Theory of Principles of Change

First and second order change are best characterized as two different stages of the change process. First order changes are those that take place within the current rules and parameters governing the interaction of a family system (Becvar & Becvar, 1982). These changes do not change the structure of system dynamics.   Second order change restructures the system on a fundamental level, altering the rules of interaction and roles that were previously definitive of the system (Lyddon, 1990).

First order change (cybernetics) occurs within the current structural components or family dynamics including boundaries, communication patterns, the context of individual perspectives within the family, principles of homeostasis, level of openness to external influences, feedback loops, recursive cycles, current relationships, etc. (Becvar et al., 1982). Change occurs only in behaviors as relating to and because of the defined structure of the family system (Becvar et al., 1982). First order cybernetics lead to change in individual members for the purpose of maintaining harmony with the current accepted principles of living as defined by past interactions, beliefs, expectations, rules, roles and established patterns of human behavior distinct to and defining of each family as a whole (Lyddon, 1990).

Second order cybernetics changes the family on levels of definition and structure often through self-evaluation. Such change occurs by accessing the multiverse of each individual's perspective, evaluating their consent to participate in patterns of interaction or not, exploring how well the family fits within the larger social context, identifying non-purposeful drift to old family dynamics, and considering feedback through behavior that encourages or discourages change (Becvar et al., 1982). Priest & Gass (1997) provide the following metaphoric example on the difference

between first and second order change that may help illustrate this concept further:

First order change produces change within a structured system using the same set of rules and components. This can be like peddling a bike up a steep hill without shifting gears. As the hill becomes steeper, the bicyclist must work harder within the structure of that gear ratio, using techniques that enable her/him to keep from falling over and reach the top of the hill (e.g., stand up, pull on the handlebars, exert more pressure on the peddles). However, say that as the hill steepens and the gear ratio becomes inappropriate or dysfunctional for this task, the bicyclist shifts gears to a more appropriate ratio. Using the new set of "rules" dictated by the more functional gear ratio, the bicyclist exerts the same amount of effort yet progresses up the hill much more effectively. This "shift" is analogous to second order change, working in a different and new way by changing the structure of the system. First order change uses "more of the same" rules to produce change; second order change creates transformation by changing the way change is achieved (Waltzlawick, Weakland & Fisch, 1974). (Priest & Gass, 1997, p. 37)

Systemic change occurs as the whole family transcends old rules and dynamics and achieves a state of discontinuity until it stabilizes into a new and transformed system of principles and rules (Kern and Wheeler, 1977). The principle of second order change is the "underlying dynamic that activates the change process in psychotherapy" (Fraser et al., 2007, p. 271). This principle can be found in multiple disciplines including concepts of paradigm change, core change, structural transformation, positive feedback, movement through forms (Lyddon, 1990), and even spiritual systems (Bowman & Baylen, 1994). Rather than focusing on changing first order patterns in the family or social system, these principles focus on transcending the problematic context and instead seek an insightfully different state (Bowman et al., 1994). From this enlightened perspective, choices can be made intentionally based on their known value (Bowman et al., 1994). The importance of recognizing and utilizing second order change has generated an appreciation for constructivist concepts of alternative perspectives of reality and the power of changing on a structural level when working with clients cognitively, emotionally, and behaviorally (Ellis, 1992).

Fraser et al (2007), state that, "second-order change is central to treatment methodologies that are gaining notoriety as empirically supported treatments (p. 87)." Traditional interventions, when considered carefully, usually "attempted solutions" address problems within a first order context, or according to the parameters of the existing system, including destructive patterns of interaction (vicious cycles). Treatment models that attempt to address problem behaviors within the existing systemic structure typically exacerbate the problems, rather than effectively changing the process of finding and implementing solutions (Fraser et al., 2007). Employing the principles of

second order change within the treatment model can provide increased opportunity for meaningful growth and positive change within the family system (Fraser et al., 2007).

Application

Watzlawick et al., (1974) stated that second order change occurs "at the end of long, often frustrating mental and emotional labor." Because of this, therapeutic modalities and treatment structures that value or seek second order change must recognize the complexities of the family and work to transfer the existing parameters into a new paradigm.

It is important to begin with a recognition and validation of a client's existing beliefs and principles (Kroeker, 1987) before actively seeking second order change. Once the therapist or treatment team has established this connection, the process can move the family through stages of therapy, including insightfully recognizing multiple perspectives, identifying the problem, engaging the problem, and actively changing according to the new conceptualization of the family (Hanna & Ritchie, 1995). Furthermore, in order for the client to initiate the process, they must be motivated to change. Clients need to recognize the need for change and be willing to endure the obstacles and stress associated with it to be successful (Maier, 1985). As insight occurs through engagement of the problematic system, the function of therapy can shift from first order tasks of psycho-education to second order tasks of reframing the structure of the system (Maier, 1985). Abandoning ineffective dynamics and less effective structure allows the family to engage in new patterns of thinking, rules, roles, and dynamics of interaction rather than trying to change behavior according to the existing paradigm (Maier, 1985).

This second order change in thinking (reframe) can often be sparked through novel experiences that are processed according to a new template of understanding of self and context (Murray, 2002). One method for impressing a new way of thinking about personal experiences is through metaphor. Providing an additional level of abstraction can help clients to access unconscious conceptualizations of new solutions and resources that are not limited by the rigidity of their conscious perspective regarding his or her specific presenting problem (Kersey, 1985). Through careful matching of the client's emotional experience, the leap can be made unconsciously from the abstract analogy to the concrete situation thus enabling direction while avoiding direct resistance (Kersey, 1985).

Employing a milieu approach to therapy that utilizes all of the potential relationships within the treatment program's system can generate novel, powerful experiences for clients. Indeed, it has been suggested that interventions of any kind are relational acts (Fraser et al., 2007). Each time a new relationship is formed between system members (or as a whole family) and an outside party such as a staff member, a therapist, or a treatment milieu as a whole, a powerful link is established in which

mutual influence can occur (Fraser et al., 2007). These relationships can be intentionally and strategically shaped to intervene in the family system. As with all second order change, the system itself will influence the new relationship in a reciprocal process, thus revealing circularity between designed interventions and the family system; interventions vitalize the relationship and the relationship also vitalizes the interventions (Fraser et al., 2007).

Finally, the key to creating permanence in these second order change processes is for the entire system to redefine itself according to the newly defined parameters. In doing so, system maintenance, or first order change processes, can create equilibrium around the new principles instead of the older, dysfunctional ones (Becvar et al., 1982). In application, this illustrates the importance of changing the family's relational dynamics at a core level. Although this can be approached procedurally from a myriad of differing theoretical models, it is clear that each method accomplishes this through shifting the current pattern utilized by the parents to generate behavioral change in their children (Fraser et al., 2007). Strategically speaking, doing the opposite of what is not working can create positive change.

Telos Residential Treatment Center: A Case Study in Principle Based Treatment

Theoretical constructs representing the process of second order change are present in all treatment settings that produce measurably lasting change (Fraser et al., 2007). All programs also include first order change processes designed to elicit change within the existing system. Usually changes in clients are seen to be externally motivated or due to current system boundaries, until they begin internalizing the change process and seeing the world in a new way. In order to foster the internalization process, residential treatment programs employ a therapeutic milieu individual, group, family, and recreational therapies, as well as other experiential techniques including adventure or wilderness therapy. These are all means of trying to access second order or permanent, positive change.

The principle-based protocol employed at Telos Residential Treatment includes an overarching assertion of a *priori* principles of love, family, spirituality, principled living, and insightful choices as central areas of consideration in the treatment process. At the same time, it is important to recognize the client's current world view. Therefore, each family member in the program is required to identify his or her own underlying principles and goals. This forms a solid basis of understanding that can set the stage for insight to occur as the treatment process moves forward. Additionally, inclusion of autobiographies, recognition of underlying thinking errors and defense mechanisms, collaboration with the client on the formation of the master treatment plan, and a review of past and current progress serve to invest the client in the process of insight regarding their need for second order change.

By applying the theoretical constructs of this type of principle-based treatment protocol, programs can engage residential clients in the second order change process. This approach could potentially support lasting or more permanent positive change more than the theoretically limited treatment approaches that focus solely on first order change (Becvar et al., 1982).

During each phase of treatment a client will complete at least three "principle beads." A principle bead is essentially a list of tasks that are related to a given principle and designed to instill the principle within the client. Insight-evoking tasks suggested by specific principle beads help clients reframe their experiences, and therefore their conceptualization of principles, resulting in new patterns of cognition and behavior. Each principle bead includes a list of possible assignments that are chosen or created by the therapist and the client to meet his/her individual needs. Principle beads address many topics including personal identity, esteem, emotional management and maturity, social appropriateness, psycho-educational training on healthy living, eating, balance, anger and stress reduction, and relationship building. These include pushing outside current system parameters through therapeutic discussion and experiential activities, such as recreational therapy and rigorous physical exercise that put a person in a new context, inviting them to consider new possibilities and principles. These powerful experiences create a rich and fertile proving ground for direct intervention, and for challenging the individuals and families to assimilate their experiences into new defining principles, and thus initiate new vectors of growth and understanding.

These changes are further guided by a principles coach who helps coordinate and explore the purpose and application of insights and experiences gained through performing the tasks in the principles beads. In this way the coach can enhance the understanding and internalization of each principle of healthy living. This relationship also provides a model for engaging in appropriate and healthy relationships that can be generalized to family, peers, and other important relational contexts. Therapeutic relationships provide a safe arena to test and practice new principles, systemic parameters, and behaviors developed through interventions before clients return home. Further, these new patterns should be practiced while on home visits to begin integrating these patterns in that environment. Relationships are encouraged on all levels, and many interventions involve connecting with peers, staff, and administrators to support full integration of each individual into a new and healthy system from which principles can be generalized to the family system upon completion of treatment.

It is therefore critical that both the residents and their families become immersed in the treatment milieu as much as possible in order to generate second order change in the entire family to prevent system relapse into previous patterns of unhealthy family interaction. The family is consequently an integral part of the entire treatment

process. In addition to weekly family therapy, the family has specific phase requirements which they must complete in order for their child to advance through the program. These assignments focus on specific experiential tasks and psycho-education in areas such as communication training, formation of principle based rules and consequences, role assessment and restructuring, family processes (i.e. recognizing appropriate expression of love), mutual validation and emotional connection, and specific family principle beads. Each bead addresses therapeutic concepts including forgiveness, trauma, power, family structure, responsibility, validation, communication, emotional safety, negotiation, and family systems relapse prevention. Furthermore, parents are asked to progress through parent-specific phase requirements that include setting and charting progress on personal goals for themselves, completing psycho-educational material on parenting skills, understanding themselves and their children, and relational dynamics culminating in an individually-designed therapeutic objective project assigned by the treatment team. Families are strongly encouraged to engage in the on-site, intensive workshops and therapeutic experiences that are held five times a year. These multi-day workshops provide opportunities to participate in family therapy, family recreational therapy, parent support groups, other therapeutic groups, triathlons, talent shows, and a principles ceremony in which residents and their families are recognized for their achievements. Parents are informed of the expectations for family involvement in these important aspects of treatment and the need for commitment to parental change in the therapeutic process

Finally, it is important to solidify the changes made in the treatment process as well as provide opportunities for clients to advance to leadership roles among peers through recognition at a graduation ceremony. In this ceremony tangible reminders or talismans gained during the treatment process of representing the principles learned and absorbed are presented to the student and family. They are encouraged to continue to evaluate and maintain the changes they have made to their systemic functioning. This can be enhanced through transitional programs and aftercare services that provide continued support to families at a less structured and intense level.

Treatment Considerations

Most programs employ many of the practices suggested above. Any program can apply the principles of second order change thus increasing their capacity to provide lasting systemic change to the clients and families engaged in the treatment process.   In order to better solidify lasting internalized change, it is important for the student to maintain consistency in the application of the newly developed core principles in all contexts over time including in the milieu, on therapeutic passes, and also when in a position of personal responsibility. A treatment regimen can be individually created and applied successfully in creating lasting change. It is essential that every opportunity is taken to connect to the

internal principles that guide behavior and ultimately lifestyle, rather than focusing solely on behavior modification. Recognizing the importance of consistently and intentionally integrating interventions designed to create second order change will help programs demonstrate the use of empirically validated (Fraser et al., 2007) dynamics for creating lasting change. In this way treatment programs can not only help individuals and families manage problems, but continue to help youth and families develop successful, healthy, and long lasting patterns of living.

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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.

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

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