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NATSAP

National Association of
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TO:

JTSP

Journal of Therapeutic Schools & Programs

A Publication of the National Association of Therapeutic Schools and Programs

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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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John McKay, J.D., M.S., is Vice-President and General Counsel for Rancho Valmora and The High Frontier residential treatment centers. He is in the process of building and opening Cramer Creek, an 81-bed residential treatment center located outside of Missoula, Montana and is nearing completion of his Ed.S. in Counselor Education from the University of Montana. He is the previous Executive Director of Rancho Valmora and has a Juris Doctor from Vermont Law School and a Master of Science in Environmental Science from the University of Massachusetts Boston. His primary research interest is determining appropriate measures of outcome in adolescent residential treatment centers utilizing the Positive Peer Culture treatment philosophy.

John A. McKinnon, MD is a co-founder and co-CEO of Montana Academy, a therapeutic boarding school located on a ranch in NW Montana. He was educated at Harvard College (BA, English Lit), Cambridge University (MA, Economics) Case Western Reserve School of Medicine (MD), Yale University (Resident Training in Psychiatry) and Vermont College (MFA in Fiction). For eight years he was an Assistant Professor of Psychiatry at University of California (San Francisco), where he was Associate Director of Resident Training and Director of Outpatient Psychiatry Services at the San Francisco VA Medical Center. For twelve years he practiced adolescent and adult psychiatry in Texas and Montana, where he also directed adolescent and adult psychiatric and CD hospital programs. He has written two relevant books (Lantern Press) to be published in 2008: *An Unchanged Mind: The Problem of Immaturity in Adolescence*; and *Why Don't You Just Grow Up?* which is a book for parents and programs attempting to prod teenagers toward maturity. He has been married for 37 years and likes to think he helped his wife bring up three splendid daughters, all now safely beyond adolescence.

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

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Michael Young, M.Ed., has been an experiential facilitator since before he graduated high school. Earlier this year he left his job as the Program Director for North Star Adventure, a community-based therapeutic adventure program, to pursue his PhD in Education at the University of New Hampshire, where he also serves as a NATSAP Research Coordinator.

Dealing With Issues of Program Effectiveness, Cost Benefit Analysis, and Treatment Fidelity: The Development of the NATSAP Research and Evaluation Network

Michael Gass, Ph. D., LMFT & Michael Young, M.Ed.

Say you walked into the office of your trusted medical professional with your sick child. After going through a proper assessment, your doctor advised you of several drug treatment programs that would help your child recover. You were provided three options on the series of drugs your child could take to become well again. Here are choices you were given to consider to select the treatment program for your child:

1. You could choose to select from a group of drugs (Group "A") that had been repeatedly tested against other drugs (Group "B") several times in "blind trials" (i.e., experiments where other children like yours with the same illness were randomly given either Group A and B). Three drugs in Group A repeatedly demonstrated a significant level of beneficial effects in addressing the issues facing you child far beyond what Group B drugs ever did.

2. The costs of the drugs that worked in Group A varied. While both achieved similar results, two drugs (Drugs A1 & A2) cost an amount that you could financially cover. The other drug (Drug A3) was 20 times more expensive than the first two, meaning that if you wanted to have your child become healthy with Drug A3, you needed to take out a second mortgage on your home to have your child become healthy again.

3. With Drugs A1 and A2 that were available to you, one drug (A2) only worked when administered by your specific doctor in a particular manner when conditions were appropriate (e.g., it only worked if your child was not under any other medication, worked much better with girls than boys). And when administered by another physician who was covering for your physician when she was on vacation, it only worked half as well. Contrary to these "interactive" effects, Drug A1 worked to the same level of effectiveness no matter what other medications your child was taking, their personal characteristics, or who administered the treatment.

Which drug treatment program would you choose for your child? Most of us would be hard pressed not to select Drug A1 given the factors of demonstrated effectiveness, cost, and treatment utility. Whether we like it or not, the selection, funding, and values surrounding educational and mental health programs are falling into such a "selection paradigm" in our Society.

While the analogies contained in this story may not be a perfect "fit," there certainly are strong parallels to some of the critical questions facing NATSAP programs regarding the evidence/credibility, costs, and consistency/reliability of programs. As seen with Question #1, clients are often faced with choosing between treatment methods on some basis of comparable and valid effectiveness (for a very personal vignette into such a choice for one family, see the article in this issue by Julianna Bissette and Anna Bissette). As indicated in the articles by Ellen Behrens and John McKay, while there are numerous studies that "demonstrate" the benefits of NATSAP programs, almost all of these studies suffer from threatening weaknesses that not only limit their validity, but also their ability to be generalized outside of the study's single occurrence. The concepts behind what is "demonstrated effectiveness" are appropriately raised through the insightful questions and thoughts by John McKinnon and John Santa in articles relating to their keynote addresses from our 2007 NATSAP Conference in San Diego.

Also portrayed in our story are further questions regarding the costs and benefits of various treatment models (Question #2). As seen with the Bissettes in their story and common to NATSAP clients, treatment options are based on what their family could afford. As seen in many settings (e.g., Aus, 2006, Gass, 2006), some effective treatments options simply aren't "effective" due to their associated costs. As pointed out by John McKay in his article, this is becoming an increasingly pressing issue not only for NATSAP programs, but also for all education and mental health programs.

Finally, the third question in our story mirrors the ability of NATSAP programs to deliver treatment programs as planned with their greatest positive influence in a consistent manner. This is particularly true for NATSAP programs trying to generalize the fidelity of their treatment beyond one specific site. Greater consistency in the delivery of program elements linked to treatment effectiveness is a growing expectation of education and mental health programs.

Given the pressing issues raised by these factors, it is easy to see how one NATSAP professional or program could feel overwhelmed when trying to develop a system to address these issues. In a true collective effort to address these issues, the NATSAP Board of Directors has proposed the development of the NATSAP Research and Evaluation Network.

The NATSAP Research and Evaluation Network

The NATSAP Research and Evaluation Network is being designed to address the pressure to collect outcome and evaluation data on educational and therapeutic programming. Utilizing an inexpensive web-based e-record and outcomes management application, the project includes the development of a data collection network designed to allow for maximum participation by NATSAP member programs. The hope is to create a system that is flexible enough to accommodate individual program evaluation needs, while creating a de-identified aggregate database that will help NATSAP communicate to stake holders the nature and quality of member programs' work. Ultimately, the database will also be available as an archival resource for other researchers in the field. In this way, the project hopes to help tackle the challenges of individual program internal evaluation and quality improvement, organization wide benchmarking and advocacy, as well as on-going research in the field as a whole.

There are, of course, many ways to respond to the need for outcome and evaluation data on NATSAP's educational and therapeutic programming. These approaches include: individual program efforts, multi-site collaborative efforts, and organization/industry-wide efforts. To date, NATSAP member programs have addressed this need through the first two approaches, , but not the third. However other professional affiliations in the fields of education, mental healthcare, and medicine have addressed the need through organization level research initiatives. These efforts by other professional organizations include both the development of multi-site practice resource networks

(PRNs) and electronic data management. Within this context, the NATSAP Research and Evaluation Network is a project that hopes to work in concert with existing efforts within NATSAP while allowing for the collection and analysis of data at the industry-wide level through the use of a web based PRN.

Existing NATSAP Program Research and Evaluation Efforts

Many of NATSAP's programs have already developed their own individual strategies to address the need for program evaluation and outcomes monitoring. Individual program efforts have ranged from in-house protocols using both customized and standardized measures (Lemieux, 2007; Santa, 2007) to integrated efforts with foundations, universities and/or government agencies ("Professor awarded grant to study at-risk youth", 2006, "Utah youth village: Research and evaluation", 2005). There are also examples of larger multi-site initiatives for both residential (Freeman & Moss, 2006) and wilderness based NATSAP programming (Russell, 2006; Sarah Lewis *et al.*, 2007). The efforts cited here are just a couple examples of program, agency, and collaborative initiatives. Other programs have also taken steps to answer the call to evaluate their work.

Organization/Industry-wide Research and Evaluation Efforts

While these research and evaluation efforts have produced significant and valuable work, there are reasons to augment such efforts with an additional organization-wide effort. These reasons include: the need to obtain larger scale aggregate data for advocacy and lobbying needs; the need to increase the numbers of subjects involved in the study in order to ensure more powerful research results; the need to provide access to evaluation tools to smaller less established programs; and the need to create an archive of data for future research and benchmarking efforts.

Examples of such approaches to aggregate research and evaluation can be found within therapeutic and educational fields. Figure 1 summarizes the web addresses and unique aspects of the organizationally based research institutes of the American Association of Residential Centers, Alliance for Children and Families, the American Camping Association, The Girl Scouts of America, and YMCA of the USA. Often with the help of substantial grant funding, these initiatives work to help their member programs by disseminating pertinent research, providing access to evaluation tools, and coordinating organizational research projects (e.g., Abundant Assets Alliance, 2002; Alliance for Children and Families Research, 2007; American Association of Residential Centers, 2007; American Camping Association Research, 2007; Girl Scouts of America Research Institute, 2007). Some of the tools organizations have utilized in their attempts to accomplish their research and evaluation goals include both practice research networks and electronic data management applications.

Practice Research Networks

Similarly to the organizations listed above, both the American Psychiatric Association and the National Association for Social Workers have also undertaken organizationally coordinated research efforts. In their attempts to conduct in-house research projects with their members, these two organizations have attempted to collect data through what they have chosen to call practice research networks or PRNs (American Psychiatric Association PRN, 2006; "National Association of Social Workers PRN", 2007).

PRNs have been used within the medical field as an attempt to coordinate the research and evaluation efforts of a broad collection of clinical sites (Alberta Family Practice PRN, 2002; American Academy of Family Physicians Federation of Practice Research Networks, 2007; American College of Clinical Pharmacy PRNs, 2007; Oregon Rural Practice Research Network, 2007). Through this type of effort, data from a large group of practices can be collected and analyzed providing access not only to real-life contextual information (as opposed to laboratory based experimental data), but also to a potentially larger number of subjects.

Within NATSAP, although it does not explicitly call itself a practice research network, the Outdoor Behavioral Health Research Cooperative is an example of a PRN formed by a number of Outdoor Behavioral Healthcare programs, the majority of which are NATSAP members (Outdoor Behavioral Healthcare Cooperative, 2006).

Electronic Data Management

To effectively collect and manage the wide ranging nature of the data produced by a PRN requires significant effort and organization. The distribution and data entry of traditional paper and pencil assessments and surveys can prove to be a prohibitively time consuming, and thus expensive, endeavor. To address this need some researchers and organizations are turning to electronic data management systems for help. One example of this trend is the University of South Carolina's Department of Family Medicine's Practice Partner Research Network and their use of the "Practice Partner's Electronic Medical Record (EMR) system" (Department of Family Medicine's Practice Partner Research Network, 2007). An example in the mental healthcare industry is the collaboration between the Alliance for Children and Families and the American Association of Residential Centers and their use of the electronic Behavioral Pathways System (Lefkovitz, 2007).

Electronic data management can take on many forms. A simple spreadsheet is, of course, a form of electronic data management. However, data management software can now provide a computer (or palm) based interface for the actual entering of data, such as electronic medical records, demographic information or standardized assessments, while also providing the statistical and clinical reporting necessary to understand the raw figures. Through a variety of licensing options (and pricing), this software can either sit on the hardware of a purchasing program or agency, or it can be accessible to a broad network as a web-based application ("Outcome measurement data management systems for agencies", 2004). Figure 2 lists a number of data management providers that can offer their services through a web-based application. The table also estimates the costs of utilizing each system for a NATSAP-size PRN (i.e., 150-200 sites continuously collecting standardized demographic and outcome data).

The costs are estimates based on brief conversations with the providers themselves, the information provided on their web-sites, or http://national.unitedway.org/files/pdf/outcomes/dataMgt_01052.pdf. It is presented here only to illustrate the variability of the services offered. Actual pricing would ultimately vary with the specifics of a project and the ensuing negotiation.

Proposed NATSAP Research and Evaluation Network

The Board of Directors of the National Association of Therapeutic Schools and Programs (NATSAP) has appointed a Standing Research Committee[1] and hired the authors as part-time research coordinators with the goal of facilitating research within the NATSAP organization. A major aspect of this initiative is the development of a NATSAP Research and Evaluation Network. This project aims to develop a web-based NATSAP PRN. The hope is to create a system and a protocol that can encourage maximum program participation through an affordable and semi-automated protocol, while still collecting useful outcome data.

The system, as currently designed, will include the collection of program demographic information (e.g., type of program, location, types of clients) on-line through www.surveymonkey.com, followed by an extensive client data collection procedure utilizing a web-based outcomes management application. The hope is to give programs access to their own custom research and evaluation tools that can provide confidential outcomes data for internal quality improvement initiatives, while also populating a NATSAP-wide de-identified aggregate database.

This larger de-identified aggregate database will be housed on a secure server at the University of New Hampshire where NATSAP research coordinators will be able to synthesize and analyze the data for dissemination to NATSAP members. In addition to being immediately useful to the organization's efforts to communicate the nature of private residential work to stakeholders, this data collected and stored in this way will create a useful and accessible archival

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[1] At the time of writing, the NATSAP Research Committee was being chaired by John Santa, Ph.D., of Montana Academy, and consisted of the following members: Ellen Behrens, Ph.D., Canyon Research and Consulting; Rob Cooley, Ph.D., Catherine Freer Wilderness Therapy Expeditions; Michael Gass, Ph.D., University of New Hampshire; Kyle Gillette, Ph.D., Telos Residential Treatment; Matt Hoag, Ph.D., Second Nature Entrada; Pam McCollam, Ph.D., New Haven RTC; Michael Merchant, ANASAZI Foundation; Beverly Richard, MSW, Three Springs; Amy Simpson, Ph.D., Montana Academy

database. This database can be combined with the data from other existing similar outcomes studies and be available for approved utilization by future researchers.

Assessment Instruments

The NATSAP Research and Evaluation Network will collect programmatic and client background and demographic information as well as standardized psycho-social assessment. In addition to the program information surveys posted at SurveyMonkey.com, the NATSAP Research and Evaluation Network will collect individual client and client-family demographic data through the use of NASTAP-specific questionnaires accessed on-line through the contracted web-based provider. In addition to age and gender, these forms will ask clients and their parents and/or guardians to address additional issues such as substance abuse, school performance, and investment in their work with the program. In addition to these customized measures, the project will also utilize both the Auchenbach System of Empirically Based Assessments (ASEBA) as well as the Outcome Questionnaire Family of Instruments (OQ).

Specifically, the network will seek to collect psycho-social client information from multiple sources through the use of Y-OQ-SR and ASEBA YSR self-report instruments with youth ages 11 to 19 and the Y-OQ and ASEBA Child Behavior Checklist (CBCL) instruments with all parents and collateral professionals (Achenbach, 1991; Burlingame *et al.*, 1996; M. G. Wells *et al.*, 1999). These instruments assess a variety of behavioral and emotional problems and have considerable overlap between them. Figure 3 compares the subscales measured by both the Y-OQ and the CBCL.

Both the ASEBA and OQ assessments are well known normed tools that have documented validity and reliability. The ASEBA instruments have been in use since the 1980s and since then have been used in thousands of studies all over the world (Bérubé & Auchenbach, 2007). The OQ instruments have been developed more recently. They have published validity and reliability, correlate with the CBCL, and may potentially be more sensitive to client therapeutic change (Lambert et al., 1996; Mosier, 1998; Mueller et al., 1998; Umphress et al., 1997; G. Wells et al., 1996). Programs participating in the network will have the option to use forms from one or both of these groups of instruments. Both options provide the opportunity to produce data that can be widely accepted and understood.

Proposed Study Protocol

The NATSAP Research and Evaluation network is being designed to collect background and assessment information from participants at three different times: admission, discharge, and 12 months post-discharge. This design, arguably, has the potential to detect client change during their stay at the program and to what degree the change is maintained over time. Although causal conclusions about the effects of programs will be limited by the quasi-experimental design (i.e., there is no control group or comparison group built into the design) and lack of specificity of program processes, the study protocol has the potential to provide base-line organizational level outcome information. Information that is potentially valuable for both advocacy and quality improvement purposes. Figure 4 depicts the data collection scheduled for each assessment time.

Data Analysis and Dissemination

The analysis and dissemination of the data collected through the network is currently being conceived at four levels: individual client reports for program staff involved in treatment and treatment planning; program specific reports for internal program quality management and improvement; organization-wide aggregate summaries; and future additional research projects utilizing the data de-identified archive.

The ASEBA and OQ instruments provide valuable and potentially critical assessment information. The consenting process and the web-based data management application in use for the project have been designed to allow for access to this information about clients by their clinical staff at participating programs. The hope is to utilize the data for both treatment as well as outcome monitoring.

In order to participate in the network, a program will sign an agreement that specifies that the data collected through the project cannot be used publicly for competitive marketing purposes. Any violation of this agreement, as determined by the NATSAP Research Committee, will result in the offending program's expulsion from the network (“NATSAP Research and Evaluation Application, 2007). The data collected, however, ultimately belongs to the programs and their clients and should prove to be valuable for the internal monitoring of treatment outcomes for program development purposes.

After this data from the participating programs has been stripped of any identifying information and aggregated, it will be stored on a secure server at the University of New Hampshire. This data will then be analyzed and summarized by the NATSAP research coordinators. The results of this work will be posted on the NATSAP website and presented at annual NASTAP conferences. The information will be available for use by the programs to communicate with stakeholders.

Finally, it is also planned that this larger data set will be available to other researchers as an archival resource. The research committee is already in contact with the authors of other NATSAP oriented studies that have utilized similar instrumentation in an effort to ultimately include that data within the same archival database. Access to the data will be IRB contingent and will likely follow similar protocol as that found at the National Data Archive on Child Abuse and Neglect out of Cornell University (National Data Archive on Child Abuse and Neglect, 2007).

Conclusion

Whether or not this Network will produce a “happy ending” to the story presented at the beginning of this article remains to be seen. Certainly the end goal of an accessible and useful data archive will depend upon the hard work and follow-through by the NASTAP research committee, its UNH-based research coordinators, the web-based data management service provider, and the programs that choose to join the network. The committee, coordinators, and provider are all currently working to ready the network for the enrollment of interested programs. When the testing is complete, an effort will be made to recruit NATSAP programs interested in joining the NATSAP Research and Evaluation Network initative.

Until then, please direct inquiries to michael.young@unh.edu, (603) 862-2007.

Tables and Figures

Figure 1. Organization-level Research Efforts in the Therapeutic and Educational Fields

Organization name and URL	Unique aspects of research initiatives
American Association for Residential treatment Centers http://www.aacrc-dc.org/ (Research efforts found on "Publications" page) Alliance for Children and Families http://www.alliance1.org/	While both organizations have existing independent research efforts, the AACRC and Alliance for Children and Families are working together to conduct a nationwide benchmarking initiative for residential treatment centers serving publicly funded clients.
Girl Scouts of America http://www.girlscouts.org/research/	The Girl Scout Research Institute has as one of its goals getting relevant developmental research to girls themselves, not just to their member programs.
YMCA of the USA http://www.abundantassets.org/index.cfm	The Abundant Asset Alliance is a collaboration between the YMCA of the USA and the YMCA of Canada with the Search Institute that aims to help YMCAs orient their programming and evaluation around the Search Institute's well researched developmental assets.
American Camping Association http://www.acacamps.org/research	While other organizationally driven research tends to be limited to general surveys, the ACA has also conducted broad level pre/post outcome-based research.

Figure 2. Web-based Data management Systems and the Estimated Cost to utilize them for a NATSAP-size PRN

Service	Estimated Cost
Carepaths www.carepaths.com	$200 per site per year
Science Trax www.sciencetrax.com	~$2,000 per site per year
Athena Case Management Software www.athenasoftware.net	Athena can host a solution starting at $60 per month per user. Server software and licenses start at $2,500 for the server and $600 USD for each active concurrent user. Initial training included ($75/hr after that).
CitySpan Provider www.cityspan.com	"CitySpan Provider is very affordable. Please contact us for information about cost."
cmTools, Web Edition cm.cmatechnologies.com	Base monthly single-user subscription is $198. Additional users can be added for an average of $29 per month (~$240/yr). The subscription provides unlimited use and includes all support and software upgrades, plus $1,400 for training.
Efforts-to-Outcomes Software www.socialsolutionsonline.com	$50,000 license, $1,000 per user account per year
Outcome Tracker www.VistaShare.com	Most organizations are between $2,800 - $5,400 for setup and $120 - $225 per month for unlimited user accounts.

Figure 3. Subscales Measured by the ASEBA CBCL and the Y-OQ

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

From: www.aseba.org; www.oqmeasures.com

Figure 4. Data Collection Schedule for NATSAP Research and Evaluation Network Standard Outcomes Study 2

	Time 1 ***Admission***	**Time 2** ***Discharge***	**Time 3** ***1 Year post-discharge***
Youth	1. Assent Form 2. Youth Admission Background Questionnaire 3. ASEBA YSR and/or Y-OQ-SR	1. Youth Discharge Background Questionnaire 2. ASEBA YSR and/or Y-OQ-SR	1. Youth Post-Discharge Background Questionnaire 2. ASEBA YSR and/or Y-OQ-SR
Parent(s)/ Guardian(s)	1. Consent Form 2. Parent/Guardian Admission Background Questionnaire 3. ASEBA CBCL and/or Y-OQ	1. Parent/Guardian Discharge Background Questionnaire 2. ASEBA YSR and/or Y-OQ-SR	1. Parent/ Guardian Post-Discharge Background Questionnaire 2. ASEBA YSR and/or Y-OQ-SR
Participating Professional Collaterals (Including program staff)	ASEBA CBCL and/or Y-OQ	ASEBA CBCL and/or Y-OQ	ASEBA CBCL and/or Y-OQ

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[2] Although this represents the IRB approved NATSAP Research and Evaluation Network Outcomes Study protocol, the hope is to design the network to allow programs to add additional measures and/or assessment times as they see fit

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A Lost Ring: Keynote Address at the 2007 NATSAP Conference

John A. McKinnon, MD

I am glad to speak to you again. By “you” I mean my colleagues and friends who do what I do—take care of troubled teenagers.

Today I want to suggest that we consider: *”What is it that we do?”* When speaking with parents about their children, I regularly ask them: “What sort of problem do they think we are trying to solve together?” I am always interested in their answers—and their difficulty with answering at all. This is question I want to raise with you today: *What kind of problem do you suppose we are trying to solve?* In the process, I want to share with you my answer.

In the past decade we have become colleagues. Many of you are now my friends. I feel at home with you.

This was not always the case. A decade ago when we helped start NATSAP, I was in the midst of an identity crisis. It seemed like I was leaving my medical colleagues and friends behind. This was a wrenching step in a number of ways. For a start, it seemed like a tremendous waste after all the nights I had spent at patients’ bedsides and in seclusion rooms, after all the hours it took to memorize the Krebs Cycle, and after all that practice of doing rectal exams. I had learned to wear a white coat without self-consciousness. I could listen to someone’s grandma talk about her pain without flinching.

Yet I had to walk away.

Actually, it was less dignified than that. For a time I tried to straddle two worlds as these worlds moved further apart. We could not afford to pay salaries either for me or for my partner, John Santa, so we had to keep our day jobs. I had to stop taking new patients into my practice, but every fourth night I saw emergency patients in the ER. At the ranch my pager did not work. It became impossible for me to take hospital call.

So with sadness and anxiety, I quit as medical director of my psychiatric service. I resigned from our regional hospital's staff. Inasmuch as it is an ordeal to secure hospital privileges, I knew I was crossing the Rubicon. This also was an emotional hurdle. Leaving conventional medical practice to join you was the hardest professional decision I ever made.

That was ten years ago. I never went back.

I mention this departure because it illustrates a gulf that many of you may have experienced between conventional professional venues and the leafy alternative (non-medical) world where NATSAP programs have long encountered American teenagers. To gauge how those two models differ, consider that 20 years ago when a friend's son attended Rocky Mountain Academy, there was not a single psychologist or psychiatrist on the staff there. No group or individual counselor on that staff had ever been formally trained to do psychotherapy, although there were lots of ingenious groups and theme workshops. No one on staff there could technically describe, let alone prescribe, a pill. I realize how things have changed since then. For example, currently at Montana Academy there are two board-certified MD-psychiatrists, eight PhD-level psychologists, three MSWs, and two MA-level therapists caring for 85 resident students. Many other schools and wilderness programs also have highly trained professional staffs.

Yet the intensive work we do, relative to psychiatric hospital units and outpatient offices where conventional psychiatrists and psychologists practice, is still what Monty Python used to call "something a little different." Although our staffing patterns now may resemble one another—Montana Academy has more psychologists and psychiatrists and social workers per square inch than most academic departments—we still speak disparate clinical languages. We approach adolescent problems in different ways. I know this, because all the teenagers at Montana Academy already have been evaluated and treated (without success) in outpatient offices and hospitals across the nation before they arrived in Lost Prairie. They already have undergone psychological testing. They already have been through formal physical examinations and physiological laboratory studies. And already they usually have been prescribed multiple psychotropic medications. Moreover, we hear from parents and students many of the same clinical histories our more conventional colleagues hear—the same symptoms, signs, academic and inter-personal failures, the same lists of misbehaviors. So you might think we are talking about the same problems. You might reasonably assume that we are all trying to remedy the same ailments—even if we use a different diction.

But are we?

This is an important question. For if we are also treating what psychiatrists and psychologists call *disorders*—then there is nothing to debate about what the problem is. If so, then we only differ in the way we go about treating those same disorders. It won't much matter if we merely have different words for the same problems. If psychiatrists medicate X, and we also treat X (even if we call it Y, and employ alternative means), then it is merely diction that divides our treatment goals. We need only put it to the test whether treating X with Prozac is better than treating X with a raft experience in Oregon. Why not just see which treatment produces better results?

When we started Montana Academy, we used to think it was that simple—that we had merely chosen a less restrictive venue, that we had only banished managed care and reduced the costs of residential care. Some of you may also think it is just that simple—that between ourselves and conventional psychiatry there is only a difference of opinion as to which treatment is better.

Perhaps you think we are just granolas who prefer the outdoors, that we are merely more athletic and better looking, and that as a matter of aesthetics and moral purity we simply prefer to push kids to climb mountains, to endure the cold, and to look up into a vast night sky. Perhaps you think the difference is merely that my medical colleagues are older and less robust than our young wilderness field staffs. Perhaps you think they are just pallid indoor types with prescription pads and a penchant for Prozac. Some of you would say this—that we treat the same problems, and that we merely differ over method and style.

But if that were so, why not just do the outcome-based research study? Why not just park a triage person in the offices of Molly

Barron, Phyllis Kozakoff, Christy Woodfin, and Anita Targan—and then prescribe every first floundering teen-ager Ritalin and Prozac, and treat every second troubled adolescent to a wilderness trek and a stay at Island View? After a year or two we would know, wouldn't we? Then we could all agree—either to close down NATSAP or shut down American psychiatry.

That would be "evidence-based"—would it not?

We actually have done that experiment. But my partners tell me it is not a fair trial. At the ranch our kids get conventional psychiatry first. Then after contemporary psychiatric or psychological outpatient and inpatient therapies fail, those kids go on to wilderness and finally come to our residential therapeutic schools. I am told this is not a fair trial. For we only see psychiatry's treatment failures. The selection of subjects is not random, the experiment improperly controlled, not a true, double-blind research study. So this trial does not produce a clear and valid verdict.

It does not matter. I no longer accept the premise. I no longer believe that we are treating the same thing—or that we even think we are. Contemporary psychologists and psychiatrists think they are treating mental "disorders." In our NATSAP programs we have a variety of peculiar ideas about what we are doing. But as I will explain, I think we are treating incipient character pathology. They treat symptoms; we treat developmental delay. This is to say that when I left Kalispell Regional Hospital to practice on a ranch in Lost Prairie, I left behind one understanding of troubled teen-agers and embraced another. My choice to move into the bucolic world of NATSAP was not merely a transfer of the same diagnosis and treatment to an alternative venue.

It turned out that we left conventional practice to search for a lost ring—a golden idea that psychiatry and psychology lost track of—years ago.

In the 60's and 70's, longer ago than you younger Hobbits can be expected to recall—about the time my partners, John & Carol Santa trained in psychology at Purdue and Stanford, and about the time Rosemary and I trained in psychiatry and child psychiatry at Yale—our professors and our professions had not yet repudiated psychoanalysis. However, the modernists already had revised the Diagnostic & Statistical Manual (*DSM-III*). They were busily renaming all "officially treatable" problems and redefining the criteria for their diagnoses, scrubbing out all traces of psychoanalytic theory. In place of "neurosis," in place of a developmental theory of "arrest" or "delay," they clustered behaviors, symptoms, and signs into descriptive syndromes they dubbed "disorders." You might be startled at how casual and ad hoc this attic-sweeping and syndrome invention process turned out to be.[1] But be as it may be, a more recent revision (*DSM-IV*, 1992) simply extended this rout of psychoanalytic theory.

Tossing out psychoanalytic constructs, the modernists insisted we concentrate upon observable or reportable phenomena (e.g., misbehaviors, symptoms), and discard inferences about internal constructs such as "ego" or "neurosis." This left us in a flux of symptoms. Here is a cumulative listing of symptoms, signs and misbehaviors that parents reported in their teenagers as they applied for places at Montana Academy:

> *Deflated mood; self-loathing; anxiety; insomnia; nightmares; mood swings; tantrums (with or without property destruction); threats; fights; brandished weapons; assaults; vandalism; theft; shoplifting; self-injury (covert or overt) including scratched, cut, abraded or burned skin on wrists, thighs, ankles or breasts; pulled hair; suicide gestures, threats, hints or serious attempts; school anomie; collapsed academic effort; poor concentration; classroom squirminess; disruptive talking in class; failure to do or turn in assignments; falling or failing grades; suspension or expulsion; rudeness with adults and peers; oppositionality or defiance with teachers or parents; eating disturbances—binging, purging, self-starvation, compulsive use of laxatives; drug or alcohol intoxications; arrests for intoxication or possession; drunk or intoxicated use of motor vehicles; dealing; sexual harassment; "addiction" to*

> *pornography; sexual promiscuity; rape (perpetrator or victim); family discord, including alienation from parents; mistreatment of siblings; family squabbles and fights; destruction of belongings or property; failure to keep curfews; "addiction" to computer games; compulsive IM; hacking; chore refusal; running away; pilfering, lying, sneakiness.*

Now if you cluster symptoms and signs together that often occur in the same persons at the same time, you create a syndrome. For this descriptive syndrome the modernists coined a new term: disorder. And so formal diagnosis in psychiatry and psychology took its enduring form as a cookbook filled with Chinese menus—each comprised of an assortment of signs and symptoms from which a clinician could select—"at least 2 from group A," and "at least 3 from group B." There was no new causal theory to replace Freud's "neurosis," which purported to explain resulting symptoms and signs. The authors of the *DSM-III* and *IV* merely substituted clusters of symptoms that often seemed to occur together—and called these a *disorder*.

You also might be shocked at how casual this assembly of clustered symptoms was (see *New Yorker* piece, 2006). The point is that the proper targets for treatment no longer purported to be an underlying *cause* of symptoms, but rather symptoms themselves—clustered into syndromes, gussied up as *disorders*—and never mind that no one had or has any idea what a disorder *is*.

Given how many symptoms, signs, and misbehaviors turn up among parents' complaints about their children, it is not surprising that competent contemporary professionals assigned a large a variety of different *DSM-IV* disorders to those same teen-agers. Here are some of the formal diagnoses that have arrived in Lost Prairie in the past few years—and no doubt these also have arrived in Utah, South Carolina, Oregon, Massachusetts—wherever teenagers are cared for:

> *Cyclothymic Disorder (301.13); Panic Disorder (300.01); Post-traumatic Stress Disorder (309.81); Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (309.4); Generalized*

> *Anxiety Disorder (300.02); Social Phobia (300.23); Obsessive-Compulsive Disorder (300.3); Factitious Disorder (300.19); Anorexia Nervosa (307.1); Sleepwalking Disorder (307.46); Hypochondriasis (300.7); Dissociative Disorder NOS (300.15); Somatization Disorder (300.81); Conversion Disorder (300.11); Body Dysmorphic Disorder (300.7); Gender Identity Disorder in Children (302.6); Frotteurism (302.89); Bulimia Nervosa (307.1); Sleep Disorder (307.42); Narcolepsy (347); Pathological Gambling (312.31); Intermittent Explosive Disorder (312.4); Trichotillomania (312.30); Identity Problem (313.82); Adverse Effects of Medication NOS (995.2); Parent-Child Relational Problem (V61.20); Neglect of Child (V61.21); Sexual Abuse of a Child (995.53); Physical Abuse of a Child (995.54); Bereavement (V62.82). Reading Disorder (315.00); Mathematics Disorder (315.1); Disorder of Written Expression (315.2); Asberger's Disorder (299.80); Attention-Deficit/Hyperactivity Disorder (314.xx); Conduct Disorder (312.8); Oppositional Defiant Disorder (313.81); Enuresis (307.6); Encopresis (307.7); Separation Anxiety Disorder (309.21); Reactive Attachment Disorder (313.89); Alcohol Abuse (305.00); Sedative, Hypnotic or Anxiolytic Dependence (304.1); Amphetamine Abuse (305.70); Cannabis Abuse (305.20); Cocaine-Related Disorder (292.9); Hallucinogen Abuse (305.30); Inhalant Abuse (305.90); Polysubstance Dependence (304.80); Hallucinogen Persisting Perception Disorder (292.89); Dementia due to Head Trauma (294.1); Schizoaffective Disorder (295.7); Schizophrenia (295.9); Brief Psychotic Disorder (298.8); Major Depressive Disorder (296.xx); Bipolar Disorder (296.xx).*

Don't get me wrong. The modernists had a point. The *DSM* revisions had their virtues. Descriptive diagnoses simplified drug trials. The new nomenclature helped to reliably sort subjects into categories based upon symptoms. This made possible the double-blind, placebo-controlled, multi-center pharmacological trials, which some purists consider to be the only reliable "evidence" on which to base "treatment." And so by a somewhat circular logic, they insisted that pharmacology is (nearly) the only legitimate, "evidence-based" form of treatment. Surely in its single most productive use, the DSM diagnostic schema fostered scientifically-respectable trials to determine which drugs best relieved symptoms. It is important to notice, however, that these trials skipped over the question of cause.

This being so, it remains the heavy burden for smug purists to explain to the benighted rest of us—"evidence-based treatment" for *what*? This "Emperor's-New-Clothes" question remains an embarrassment, even after decades of novel scanning techniques, neuro-anatomical correlates, innovative radio-isotope assays, and all the other impressive "razzamatazz" of neuro-psychiatry. For we still have no idea what a "disorder" <u>is</u>. And while it surely has been admirable for psychiatry to struggle to deserve a comparable scientific dignity by borrowing research techniques from molecular biology, genetics, and neuro-physiology, these new branches of psychiatry have yet to produce a "fig leaf" large enough to cover the profession's ignorance of the causes of the most commonplace of adolescent difficulties.

Let me emphasize this. Many therapeutic "purists" have become insistent that we discard all other attempted remedies in favor of "evidence-based" therapies. With rare exceptions and surely not by coincidence, this puritan contempt for "unproved therapies" serves the economic purposes of "Big Pharma." Virtually all double-blind, placebo-controlled, multi-center trials that produce what purists consider adequate "evidence" are drug trials. Admittedly these have proved useful (e.g., that Elavil often somewhat elevates "depressed mood"—a symptom dressed up as Major Depressive *disorder*). These trials have also shown that Lithium stabilizes "mood swings" when repetitive oscillations are extreme. They have convincingly showed that Risperidal suppresses angry irritability and volatile moodiness, even when these symptoms are dubiously dressed up in teen-agers as "Bipolar Disorder."[2] Among many similar successes they have demonstrated that, when symptomatic subjects take Prozac, they often pull out less of their own hair than if they had not taken Prozac—an improvement in a peculiar symptom which has been transformed into a *disorder* called "Trichotillomania." Yet none of us has any idea what causes any of these "disorders." If we get right down to it, what the purists offer as evidence-based "treatment" is really evidence-based "symptom relief."

As you can tell by my comments, this is not a lot to become "arrogant" about. And not all consequences of this vigorous marketing of "evidence" have been salutary. One not so impressive result in adolescent psychiatry has been what looks to me—and to others[3]—like a radical over-reliance on pills. These days when parents bring a troubled teen-ager to a psychiatrist, she is likely to be quizzed about symptoms, given one or more *DSM-IV* syndrome diagnoses (which re-package those symptoms as one or more disorders), and prescribed one or more medications to address those disorders (symptoms). As I say, symptom-relief may be useful, but it is only symptom relief. It does not come without cost or risk. For side-effects and other risks (known and un-known), are associated with psycho-active medications currently prescribed for children and teen-agers.[4]

Moreover, there is a another risk: self-delusion. If contemporary psychiatrists are not scrupulous in their logic, they may imagine themselves "treating" what in medicine and surgery can legitimately be called *diseases*; when in fact they are merely palliating what in medicine and surgery more properly we call a symptom or a sign. Surely treating symptoms is not a bad thing. I have spent many years of my life trying to do this well. But a certain level of humility is warranted, if this is all you have to offer. Symptom relief is not the same as a precisely-targeted attack on the cause of a disease. Those who delude themselves into thinking they are "treating" diseases and who get overly-impressed with "evidence-based" relief of symptoms risk prancing pompously down Main Street without any clothes on. This pharmacological mono-mania, which has been shamelessly promoted by managed-care companies, is why I moved to the ranch in Lost Prairie, and joined you, to escape.

So…what about <u>us</u>? If psychiatrists and psychologists in urban and suburban practice think they are treating *disorders* with pills, what is our theory? What about those of us who administer:

- therapeutic activities and hikes;
- Outward Bound challenges or NOLS-type courses;
- "experiential" education;
- behavioral and "emotional growth" programs;
- rural residential treatment (lasting months, even years);
- confrontational groups and theme conferences;
- the lessons of "natural consequences;"
- 12-step "work";
- individual, group and family therapies;
- milieu therapies?

What is all this for? What kind of problem do we think we are trying to resolve? In particular, are we addressing symptoms? Or is there some more fundamental _cause_ of adolescent problems that we are trying to influence or to eradicate?

Let me ask these questions in another way. Do we have the same treatment targets as my psychiatric colleagues? Are "emotional growth curricula" aimed merely at symptom relief—as Prozac is aimed at a deflated mood? Do "natural consequences" just teach "coping skills" that brief cognitive-behavioral therapy could address in an out-patient office, or slap down the "oppositionality" that appears on a laundry-list of criteria for a *DSM-IV* disorder? Or again, over all these early years in the wilderness or at CEDU Schools, did young pilgrims spend months exiled from their families while engaged in staged progress through tasks, ordeals and "profites"—only to accomplish "anger-management" or reduce post-traumatic shame, or to curtail the frequency of tantrums?

Well, I would have to say yes and no, but the yes is trivial. Surely one goal among NATSAP programs has always been to eliminate unwanted symptoms. This goes without saying. But if a boy at Island View ten years ago had calmed down a bit and ceased for a day to put his fist through the sheetrock, or a girl at Provo Canyon admitted that this afternoon she maybe felt a little better, and maybe her mood was a little better, now that you ask—and so, yeah, maybe she would not kill herself *today*—would our NATSAP therapists have helped that boy or girl to pack up and go home? And if not, if the goal was not symptom relief, what was the goal or end-point of these NATSAP programs?

I ask, because this is EXACTLY what managed care reviewers expect contemporary hospital psychiatrists to do. Once the key symptoms leading to admission abates, they bully the attending physician to discharge the patient. Moreover, if symptom relief is the goal, then managed care reviewers might be right. For surely Prozac *is* cheaper than our programs—if the only goal is symptom relief.

On the other hand, if you agree with me that most NATSAP programs would not have sent these teen-agers home as soon as acute symptoms abated, let us ask: "Why not?" If not symptom relief, what would we be waiting for?

I submit that we would all wait for that boy to change his *approach*. We would wait for that girl to face the challenges of her adolescence in a new way. We would not be satisfied with a little less of this or that acute symptom. Instead, we would want to see that the boy thought differently, felt differently, and behaved differently, because he framed his problems and options in a new way. We would want to see that girl cease to contemplate suicide not because she was a little less blue this afternoon, but rather because her life and her relationships began to look very different to her. I submit what we seek, as an end to our treatment efforts, goes beyond symptoms—to what Robert Kegan called: a "changed mind."[5]

This suggestion brings us to consider the general problem of a troubled teen-ager whose approach to adolescent challenges is flawed and so his parents bring him to one of our programs. Let's consider what kind of problem this approach turns out to be.

We learned about this when we started Montana Academy. For soon it became apparent that parents of troubled teen-agers were not satisfied with psychiatrists' prior explanations, which relied upon symptoms or *DSM-IV* disorders. I became interested in this dissatisfaction. I began to ask them: "What do you think is the problem we are trying to solve together?" They stumbled with their responses. They could not say what problem it was—and I also became interested in that! For after all, they had already consulted the best and brightest of my medical and psychology colleagues. What they had to show for all this hard work was psychological reports, educational testing, diagnostic codes, and multiple prescriptions for pills. Yet they still were not able to answer my critical question. One parent might mutter that her son had “attention” issues. Another wondered about her daughter’s “self-esteem” issues. But I was already unsure what a disorder might be; now we had to contend with what was their *issue*?

Yet most parents knew what needed to change. Parents all seemed to know this. They hoped their sons and daughters would leave the ranch with a more successful approach to their lives.

But what did that mean?

Well, they did not say they hoped to change a boy’s mind about a particular “bad decision,” but rather they hoped he might himself become capable of “making good decisions.” They worried about “attitude,” and “social coping.” They used a language of “learning” as if the desired result were a pedagogical problem, but clearly it was not a “lesson” or a “skill” they hoped he might learn. What they wanted for him was a “new steering system.” They wanted their daughters to “straighten out and fly right.” They wanted a new kind of problem-solving that could be applied successfully to all future problems.

I made a list of the elements of a flawed approach, which they hoped their children could be persuaded to discard. After parents told me again and again, I could tick off these undesireable elements on my fingers:

1. florid narcissism;
2. lack of empathy;
3. magical perspective on time;
4. puppet relationships; and
5. selfish, concrete ethics.

That was the list. That was always the list. If we could only change these aspects of a son’s or daughter’s unsound approach to life, these parents would regard that outcome as a miracle.

Over and over, it was the same. In time, when I told visiting parents that the students at Montana Academy shared these elements of a flawed approach to teenage challenges, parent after parent exclaimed: “You know my son, and you haven’t even met him yet!” They said, “You know my daughter better than any doctor, and you never laid eyes on her!” Of course all I had done was repeat what other parents had told me. Then they wanted to know:

> What is this flawed approach?
> Where does it come from?
> How can it be repaired, or replaced?

These were the $64 questions.

At first we did not know. Certainly this flawed approach was not merely a matter of *learning*. If it were, all those eloquent parental lectures would obviated by an 18-month sojourn at Montana Academy.

From another point of view, these elements summed to a description of gross *narcissism*.

Many adults think troubled teen-agers are simply *bad*. Certainly this flawed approach is close to what Samenow (1984) described as the “criminal mind.”[6]

Another popular adult theory is kid *stupidity*.

But none of these explanations sounded exactly right. We knew that an approach was not a symptom; nor a cluster of symptoms. This problem did not reduce to oppositional defiant disorder, bipolar disorder, attention deficit disorder—or any other symptom cluster. This was *not* what my professional colleagues were diagnosing—and so we were not talking about the same problem, or trying to remedy a problem we conceptualized in the same way. Pouring Prozac, Abilify, or Ritalin on this flawed approach had not produced the changed mind parents longed for. If helpful at all, medications merely produced a troubled teen-ager who was a little less deflated, a bit less anxious or more attentive, but no less troubled. It left a teen-ager who still approached life’s challenges in the same unsound, self-defeating ways.

Our first clue was that this approach was shared in common by almost every student who came to Montana Academy. Its source had to be something shared by most teenagers. The second clue came one day when we were discussing an exasperating student, and my wife, Rosemary, pointed out that the elements of his flawed approach all were perfectly normal in a three-year-old.

Once you have this thought, the answer seems obvious.

For every element of the flawed approach we were talking about was perfectly normal in early childhood. Most problems of the troubled adolescents sent to Montana Academy (and to other NATSAP programs, no doubt) resulted from childishness. What you and I do for a living, then, is to try to inculcate a more successful approach in teenagers who routinely come at all the problems in their lives with the approach of a three-year-old.

When we view teenager's problems in developmental terms, their solutions appear more obvious. The remedy is to transform gross egotism into an awareness that there are others in the picture; to promote empathy where there was only selfishness; to promote consideration where there was only churlishness. The remedy is to transform magical thinking into fully imagined goals, and to invent and follow plausible plans to get from "here to there." The remedy is to promote separate relationships; to get teenagers to acknowledge that other people have a right to a different point of view and to their own decisions. It is to promote a social ethic, which takes into account the larger group, to push a troubled boy to take seriously such abstruse ideas as honesty, honor, kindness, responsibility, chastity, charity, fidelity, loyalty, and the good of the family. It is to prod a lonely troubled girl to value relationships, to risk intimacy, to see relationships as reciprocal, and to do unto others as she would have others do unto her.

It is, in short, to *grow up*.

Presenting these issues this way is to offer an explanation for the cause of the troubles of these adolescents. This is the hypothesis I came to propose: that most struggling teenagers who bring their problems to your wilderness treks, emotional growth programs, therapeutic schools and programs—struggle with the consequence of a developmental delay or arrest.

The problem is: *immaturity*.

Most are not otherwise very pathological. They are often promising young people. But they have been propelled up the on-ramp onto the Santa Monica freeway with only first and second gears in their transmissions. On their suburban back streets this limited repertoire was not obvious, but as soon as they had to negotiate the interstate, their peers begin to pass them as if they were standing still. Wobbling along in second gear, they begin to take hits. Their parents saw that they were at great risk to crash and burn. And that is why these parents brought their sons and daughters first to psychiatrists and psychologists, and, if they still failed to fly right, brought them to you and to me.

Let's unpack this transmission metaphor. I suggest to you that human development in the first two decades is a step-wise addition of new gears—one at a time, one at each stage (for any particular developmental line). These additions come in predictable sequences that have been carefully described in the last century by Sigmund Freud, Anna Freud, Erik Erikson, Margaret Mahler, Jean Piaget, Robert Kohlberg, Robert Kegan—and others.[7] Therefore, normal development is the stepwise, timely metaphoric acquisition of a fully functional, mature transmission.

Note this is a linear model for development, not a linear model of behavior. Teenagers may achieve new milestones at each stage—in cognition, time sense, in relationships and in ethical development—but their behavior does not simply ratchet from Stage A to Stage B to Stage C, so that at each Stage they only behave at the highest level of maturity available to them. This is not correct. I used to think it was, but it is not.

Instead, the gear-boxes of normal teen-agers and young adults, who have all the gears appropriate to their ages and stages, come equipped with a gear shift. An American adolescent may have four on the floor, but he does not drive around all the time in high gear. He can shift up, but also down, through all four gears. He can even put it in reverse. We all know this—that a college freshman can move up and down this normal range of gears in a single day. He may wake-up to calculus, sticking to the plan that got him to college and may lead to a Rhodes Scholarship. He may spend the afternoon going with his girlfriend to visit her mother in the hospital, thoughtfully bringing roses. But at the frat he also may stay up singing half-witted songs and drinking like there were no tomorrow, and end the night by swallowing a goldfish. I need not explain to this audience that a smart college student can look like Senator at one moment, a damned fool the next. And so can a Senator.

In neither case, however, is the problem immaturity.

For immaturity in adolescence is a *lack* of the higher gears. If we go back where I began this discussion, parents of troubled teen-agers complained that their sons and daughters had no consideration for others, no true empathy for those not like themselves, no goals or plans, no knack for separate relationships, and no abstract, social moral reasoning. All these virtues were missing. It is the *lack* of these higher gears that leaves a childish teen-ager with only a flawed approach to the challenges of adolescence and young adult life.

The *lack* is: immaturity.

Why should there be a delay or arrest in development?

The answer is not complex, if we consider the two necessary conditions for developmental progress. To achieve the next milestone in maturation, a child or teenager needs:

1. Neuro-psychological readiness and
2. Suitable experience.

Taking reading as an example, a child cannot be taught to read until she is ready—and that neuro-psychological readiness to read arrives at around age 5. Once this readiness arrives, apt experience will produce the new milestone—a child who can read. If a parent reads *Winnie the Pooh* aloud to a child every night at this critical moment, then without much more ado she will begin to point at the words and then begin read.

Both are necessary, neither sufficient. To develop promptly, children need both readiness—the neurological *sine qua non*; and also apt experience. Without readiness a child cannot read no matter how hard her parents try. Without a literate person to read to a child a child will remain illiterate all her life.

This being so, an **obstacle** to development is anything that prevents readiness or disrupts parenting. In our business it is not difficult to make a list of these obstacles—*intrinsic* hindrances, which interfere with neuro-readiness (e.g., ADHD, chronic intoxication, profound psychological trauma, depression); and *extrinsic* obstacles, which disrupt parenting (e.g., divorce, parental illness or death).

Knowing this, our **diagnosis** must be twofold. Once we notice a flawed approach and global breakdown, we suspect we are looking at the immaturity syndrome. Then we look for the inevitable obstacle(s).

Treatment also must be twofold: first, to remove obstacle(s) or to mitigate their effects; and then to jump-start a stalled development, pushing a childish teenager to catch up with age-peers and to return to a normal trajectory of growing up.

Conventional psychiatry and psychology tend to focus on only half of this dual treatment. Psychiatry and psychology aim to remove or to mitigate obstacles. When a child cannot concentrate because of an intrinsic neuropsychological defect, Ritalin may help him to concentrate. When a child is depressed, an anti-depressant may reduce this "drag" upon effort and pleasure in mastery. When a child is hallucinating and delusional, a neuroleptic may clear his mind for the tasks of development. If marijuana or cocaine cloud a teen-ager's mind, sobriety may free up a readiness to grow up.

However, conventional treatment leaves untouched the second problem—of *immaturity*. Neither Ritalin, Prozac, neuroleptics, or sobriety can remedy this failure to grow up. It is all very well to help children deal with post-traumatic angst or deflated self-esteem. And it is all very well to help them with concentration or dyslexia. But merely mitigating an obstacle leaves an immature character structure untouched, and leaves the fundamental problem of immaturity only half-treated. This half-treatment of developmental arrest explains many treatment failures.

This brings us back to parenting, which can provide the developmental push. By parenting I mean two essential developmental experiences parents traditionally provide: recognition and limit-setting.

Recognition is the experience of being understood within a close warm relationship. Recognition is what happens in good psychotherapy. It is what happens in relationships with good teachers. It is the salutary experience of being understood in a deep, friendly way. Recognition is the essential core of the parent-child relationship. Recognition may include unconditional love, but surely it has a core of respect and love. And it has its own developmental line. The recognition we provide children must change in form, medium, and message at each stage as a child grows up to become an adult.

Limits are equally necessary. They provide the impetus to maturation, particularly after young people fall behind. The essence of a limit is frustration. Accurately chosen, deftly-applied constraints constitute the "NO" that challenges infantile narcissism. The squirming it provokes makes a teenager wonder whether there might not be some other way. Limits compel a young person to realize she is not the only one on the planet. Limits force teenagers to consider that someone else has feelings, someone else has rights, someone else has a choice, and that they must share. Limits say NO! because it is not your turn, NO, because I don't want to, NO, not yet, and NO, not until your sister and brother have a turn. Limits say NO: because it is unkind, NO, because it is not right, and NO because the family, the group, or the nation has a right to come first.

In short, limit-setting challenges all the elements of immaturity's "flawed approach." It is the push that immature teenagers need.

I have come to believe that this— surrogate parenting—is what most of us do.

Some of you would put it another way. But it seems to me that the general essence of what we do in NATSAP programs is first to form close relationships where we accurately recognize teenagers with affection and hope. Second, and just as important, we set limits within the context of this recognition. In short, we do what parents do—recognize and set limits.

Some of us preside over weather or terrain, distance or discomfort, over hunger or cold. These constraints make children squirm about their narcissism, their grandiosity, their magical thinking, their failure to set goals or to develop and follow a plan. Others among us confront kids with structure and rules that frustrate. We confront their narcissism within relationships—"in the transference" as we used to say—and push them to stop their childish attitudes.

What we hope to accomplish is NOT merely symptom relief. We work at a more fundamental problem: the evolution of character structure. To say so is to emphasize the importance of what we do—to acknowledge its serious ambition. Symptoms come and go. They clear up in the first week of a well-chaperoned wilderness experience, but come back during critical periods in a longer therapeutic school experience when hot issues re-surface.

We, however, aspire to a change that goes beyond symptoms. Our ambitious goal is to forever alter a flawed, childish approach to life. We aim to change the emerging shape of character—and so make a lifetime's difference. In your leafy Hobbit programs during a critical juncture in a young person's development, you and I hope to shift for good the tectonic plates of personality.

This developmental perspective and maturational aspiration is the "Gold Ring." It is a potent idea that psychiatry dropped and mostly lost track of half a century ago. This developmental way of thinking was the baby tossed out with the psychoanalytic bath-water. I submit that when conventional psychiatry reduced its purview to symptoms, however clustered, it marooned itself on Axis I of the diagnostic profile. Your alternative programs, which became NATSAP, continued to aspire to change a young person's developmental course—on Axis II. When psychiatry gave up on (and certainly had a hard time getting paid for) the adult treatment of Borderline or Narcissistic Character Disorders, you continued to quietly endure in trying to prevent a childish narcissism from persisting, and becoming permanently embedded in adult personalities.

I urge you to hang on to this ambition. I hope you will hold on to this long-term perspective with the lives of the nation's young people. I hope you will continue in this noble calling. I encourage you to continue to try to figure out how to better transform troubled young people into civilized adults. You will do so by continuing to push them to grow up. In your leafy kingdoms you preserved this lost Gold Ring, which contemporary psychiatry, psychology, and American culture, badly need to find again.

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Residential Treatment and the Missing Axis

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Abstract

This article is based on a keynote address at the NATSAP Annual Conference in February of 2007. It describes the evolution of modern private residential programs, beginning with early alternative programs of the 60's and 70's that eschewed mainstream medicine and psychiatry and focused on character development. These programs were enriched in the 1980s by the positive influence of wilderness programs and propelled to develop further by changes in mainstream psychiatry brought about by managed care and pharmaceutical companies that limited length of care and created a focus on symptom diagnosis and treatment. These factors combined to create an exponential growth of private residential programs in the last decade. This growth has also resulted in an interesting merger of professionalism with the ideas and environments of the earlier alternative programs. Finally, I suggest that adolescent problems are best understood at a deeper level than offered by the symptom clusters of the DSM. We need an Axis that captures the tasks and delays of personality development to understand properly the struggles of adolescence.

Introduction

Being asked to give a keynote address at the 2007 Annual Conference of the National Association of Therapeutic Schools and Programs (NATSAP) has provided me with an opportunity to reflect on our profession, leading me to ask "Who are we?" and "What are we trying to accomplish in private residential treatment programs?" As a profession we have matured enough to step back and reflect on the forces that have influenced our evolution, as well as consider what we offer in contrast to mainstream outpatient and community based models of treatment. Many professionals in conventional mental health are ignorant, and sometimes distrustful, of us. And as a profession we have not made the necessary effort to clearly define who we are and how our treatment methods are important. Hopefully this article will help address these important issues of ignorance, distrust, and lack of clarity.

In beginning such a process, it is important to provide a brief review of the lines of influence that have led to the current profession of adolescent residential care. Comparing approaches commonly found in NATSAP programs to approaches found in more conventional fields of mental health illuminates the influences that changes in mainstream professions have had on both our growth and evolution.

Key to this analysis is an argument articulated by Dr. John McKinnon (2007) that NATSAP programs do not address the same problems as mainstream psychiatry. Mainstream models of psychiatric care for adolescents typically focus on only one level of explanation, creating an emphasis on short term symptom abatement, skill training, and management with medication. Moreover, the present era of psychiatry is dominated by a biological reductionism expressed in the effort to understand and address emotional problems at the level of the synapse.

An alternative model for understanding troubled adolescents is in terms of immaturity or a delay in personality development. The idea that longer term residential work involves character development is imbedded in the origins of alternative residential programs, but has not been fully articulated. Issues of personality development have been largely ingnored by mainstream psychiatry in part because the diagnostic system guiding psychiatry, the DSM-IVR, lacks an Axis to define the dimensions and causes of an immature personality structure.

Finally, I draw from a variety of personality development theories to describe a taxonomy or classification of adolescent problems based on core issues. Many adolescent struggles are best understood in terms of a personal history and early experiences within the context of the family that form the basis for a child's making sense of the world. These childhood patterns of relating to the world are often reflected in the symptoms and syndromes that appear in adolescence--the period in which children must test and adjust their concept of themselves in a larger less contained world as they become ready to enter adulthood.

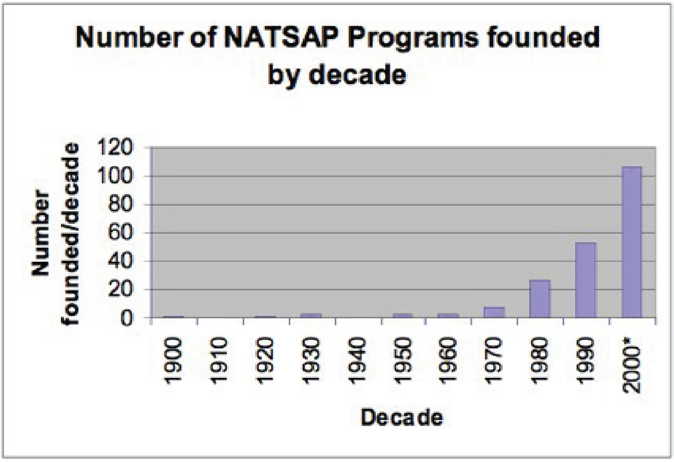
Historical Overview

Let me begin with a question. How has our society approached the treatment of troubled adolescents in the first half of the 20th century? Without claiming to provide an exhaustive or authoritative answer to the question one could summarize approaches to troubled adolescents as follows: reformatories (prisons), military academies, the military, boarding schools, the unskilled labor market in factories, mines, and farms, or for the most seriously disturbed and wealthiest families--long term, psychoanalytically inspired, psychiatric facilities.

Rapid Growth

Since the 1970's, we have seen an explosive growth in a new approach in the form of private alternative programs for troubled adolescents. Figure 1 demonstrates the explosive and exponential growth of private programs by plotting the number of NATSAP programs founded in each decade for the past 100 years.

Figure 1



* 2000-2010 is estimated based on the number of programs founded from 2000-2005.

Several questions emerge as we examine the trend of accelerating growth. What were the characteristics of the early programs and have those characteristics remained or changed as the growth accelerated since the 1980s? What factors led to the recent explosive growth of programs and how have these factors influenced programs?

Early Alternatives

Having interviewed several of the employees and founders of early alternative programs, it seems that most began as different approaches to troubled adolescents. They stood in stark contrast to treatments offered by the penal system or by mainstream medicine and psychiatry. Many of the early programs opposed the "medical model" by explicitly rejecting the use of professional therapists and psychotropic medication. These early programs are perhaps best exemplified by the CEDU schools, the original Provo Canyon Residential Treatment Center, and perhaps Hyde school.

What principles guided these programs? I recall Mel Wasserman, the Founder of the CEDU programs, stating that the path of a troubled adolescent is built on a foundation that is not "plumb and square." To correct this problem, children needed the elements of strong parenting such as clear structure, containment, accountability, and behavioral control. CEDU programs also attempted to promote "emotional growth" by confronting and breaking down defenses to create a cathartic expression of emotions. This confrontational method was derived from approaches commonly found in substance abuse work and in Synanon--a 1960's alternative community approach that was highly confrontational and ultimately cultish. In brief, the early models suggested that adolescents should not be pathologized or diagnosed; they didn't need therapy. Instead they needed a chance to grow up and develop character in a new environment, free from the obstacles that interfered with normal emotional development.

In the 1980's, programs began to accelerate and led to spin-offs, especially from the original CEDU program. Wilderness programs also began to emerge, including the development of SUWS, Wilderness Treatment Center, Catherine Freer, Anasazi, and Aspen Achievement. Wilderness models provided a natural way to attack defenses and to provide meaningful accountability. In addition, they added a spiritual element by forcing self-centered adolescents to confront and be inspired by natural forces much larger than themselves. Wilderness programs also provided the format for a rite of passage and a chance for adolescents to see themselves in a new perspective.

Rise and Fall of Inpatient Psychiatry

At the same time, mainstream psychiatry underwent many changes that coincided with the rise in alternative programs. In the late 1970s and into the mid 1980s, psychiatry underwent a rapid growth in residential programming and in the development of corporate organizations. Numerous psychiatric hospitals opened throughout the country. These facilities offered treatment with medium length of stays up to a month or more, and served thousands of troubled adolescents. These hospitals provided a bio-psychosocial form of treatment, but the environment and management style was heavily influenced by the general medical-hospital model. Psychiatric hospitals were staffed with attending psychiatrists and skilled nursing staff. Treatment included medication management, individual and family therapy, as well as milieu management generally provided in locked and secure facilities with the ability to physically restrain patients when necessary.

In the last 30 years psychiatry also turned from a rich psychoanalytic tradition that had dominated the field for more than 50 years. As with most medical specialties, psychiatry began to stress the biological bases of behavior. The emphasis of treatment increasingly focused on the brain rather than the mind. As early as the mid-50s, psychiatry began to impose order on the diagnostic system by creating a checklist of observable symptoms in the Diagnostic Statistical Manual (DSM) of mental disorders. Professionals attempted to relate these observable symptoms and test results to underlying mental disorders. With each subsequent revision of the DSM, the list of symptoms became increasingly behavioral and gave less attention to personal history and internal struggle. The set of symptoms came to define a “syndrome” or name for the symptoms, but did not in fact identify an underlying disorder or cause. Most of psychiatry moved to a dual emphasis on observable symptoms, and attempts to treat these symptoms by altering the underlying biological mechanisms that presumably led to the symptom clusters. The psychoanalytic tradition persisted, but became more esoteric, arcane, and complex in concepts. It has come largely to be ignored by both medicine and academia.

The rapid expansion of conventional residential psychiatric facilities, however, ground to a halt in the latter half of the 1980s, due in large part to managed care and Prozac (or more accurately stated, to the powerful organizations behind these concepts: insurance and pharmaceutical companies). Insurance and pharmaceutical companies were the agents that dramatically changed the direction of mainstream psychiatry, and in doing so created both the need and opportunity for the rapid growth in private residential treatment of adolescents. Reacting to rising costs, marketing corruption, and greed, insurance companies began to manage and restrict length of stay to the point that psychiatric hospitals became strictly emergent, short-term, palliative treatments for the acutely suicidal. At the same time, psychiatry became enamored with the power of neurotransmitters and in 1985 we entered the age of Prozac, a new antidepressant with fewer side effects that could change an individual's mood quickly by altering the level of serotonin available at the synapse.

The "Love Affair" with Axis I Diagnosis

As psychiatry moved to biological and reductionistic treatments, so did the approach to outpatient treatment and therapy. Professionals sought simple and standardized treatments aimed at reducing symptoms as described in the DSM-III and IV. The focus moved to treating diagnoses on Axis I or mental illness syndromes such as depression, anxiety, bipolarity, ADHD, and oppositional defiance. Behaviorism of the 50's and 60's led psychologists to seek simpler, symptom-focused treatments whose effect could be more easily verified. In the last three decades cognitive psychology has emerged with an emphasis on a more conscious mind. The incorporation of cognitive psychology led to treatments that examined and attempted to alter the relationship of conscious thoughts to both emotional and behavioral problematic symptoms.

Increasingly, psychiatry and psychology sought short-term, focused, cost-effective, evidence based treatments for these disorders. Of course, the emphasis on efficient treatments for Axis I syndromes has led to the development of some effective biological, behavioral, and cognitive-behavioral treatments that have helped reduce symptoms for many patients, although a substantial number of other patients, particularly adolescents, have not been so responsive to either medications or straightforward outpatient treatments.

In the past two decades the emphasis on syndrome diagnosis has expanded, and in order for the Axis I diagnostic system to account for more problems, the criteria began to blur (especially with children and adolescents). Thirty years ago the criteria for diagnosis was more stringent. To be diagnosed with a bipolar disorder, an individual needed to possess a documented manic episode involving a serious disturbance of reality assessment. Currently there is no requirement of needing a manic episode - one only needs to exhibit symptoms that tend toward mania. In general, psychiatry has moved to the more informal concepts of "spectrum disorders" to explain many symptoms appearing in children and adolescents. These spectrum concepts are used to identify autism, Aspergers, bipolar, depression, anxiety, and attention deficit disorders. Loosening the diagnostic criteria with the spectrum concept allows professionals to prescribe for adolescents with the same medications and symptom abatement treatments found effective in adult populations with more defined mental disorder syndromes. In many cases, the diagnostic criteria has blurred to the point that it is relatively easy to place any struggling adolescent onto the "bipolar spectrum" if they are moody, irritable, distractible, have grandiose ideas, doubt their self worth, or have trouble sleeping. What troubled adolescent fails to have at least a handful of these symptoms?

During this same period, managed care and insurance companies forced patients to spend less time in residential treatment, which led to the development of community based, wrap around models requiring a reduction in the level of care as quickly as symptoms are relieved. But many adolescents with diverse symptom clusters do not respond well to the instability of rapid shifts in level of care, or to ample supplies of medication and straightforward skills training.

A simple examination of the number of adolescents currently in NATSAP programs attests to the failure of the standard model of community based treatment. Most children end up in residential treatment only after they have failed in numerous attempts in outpatient and community based settings. The majority of NATSAP participants come from private paying families who have tried numerous interventions with various types of therapy and medication. Private residential placement is attempted only after all else has failed. And yet, there were more than 18,000 young people enrolled in NATSAP programs during 2005. If we add to this the number of adolescents in public sector residential programs, the correctional system, and those wandering the streets, the number grows into the hundreds of thousands if not millions. It seems to me that these large numbers demonstrate the broad failure of the currently preferred model of community based wrap around care, suggesting there is something important missing from the mainstream psychiatric conceptualization of adolescent struggles.

A New Paradigm Emerges

The failure of managed care and Axis I treatments has spurred the growth of private therapeutic programs designed for families who have exhausted all conventional medical and outpatient treatments. These are families who need an alternative approach that addresses the problems of their children. Families who seek private alternatives do not do so lightly or capriciously, but generally out of desperation. They look for alternatives because they see their children failing and unable to get back on a trajectory that will make it possible to become independent, productive young adults.

Private enterprise moved to fill a new market created by the failure of conventional approaches to diagnosis and treatment of adolescent problems. The alternative school and program models developed in the 1970s and 1980s had new appeal, urgency, and demand. However, by the mid-1990s an interesting shift occurred as the alternative approaches to struggling adolescents began to integrate with the many professionals (e.g., psychologists, psychiatrists, social workers) who were also disillusioned with the conventional medical and managed care approaches.

The decade from 1995 to the present can be seen as an era of integration between sophisticated professionals and the earlier alternative approaches and settings. Thirty years ago who would have imagined WISCs in the woods, or that virtually all “alternative programs” would allow the use of medication and have the involvement of trained and licensed therapists. This integration of psychiatry and psychology with alternative programs has enriched both disciplines, and the synthesis of these complementary ideas has led to a deeper understanding and treatment approach for children and adolescents.

As we look at the integration of professionalism with alternative programs, it is tempting to emphasize the improvements made by the contributions of medication, therapy, and specific skills training to help adolescents deal with their emotional disorders. However, I suggest the most important concepts the professional community brings to the alternative approaches is our knowledge of family systems, developmental psychology, and personality development.

I do not mean to discount the value of medication or specific training in the skills of emotional expression and regulation offered by cognitive behavioral and dialectical behavioral techniques. Families also need to make use of systemic principles However, none of these contributions go to heart of what we can offer. A true integration of psychology and psychiatry with alternative programs offers a respectful recognition that the original alternative programs were aimed at something other than treating Axis I diagnoses. Rather, they were aimed at character development achieved through containment, structure, accurate recognition, and re-parenting adolescents.

Adolescence is a time for identity development and consolidation of a young adult personality structure. Adolescents who present with many and diverse symptoms are better understood as youngsters who are immature and struggling to develop a more effective young adult identity and personality structure (see the article by McKinnon, 2007 in this Journal for an expanded presentation of these ideas). These adolescents are attempting to negotiate the challenges of being a teenager with the approach of a much younger child. They tend to be self centered, lack judgment, and fail to control their impulses. Such adolescents have little empathy, no realistic sense of the future as related to the present, and have an undeveloped sense of morality (e.g., “it is only wrong if I am caught”). This approach to life would be perfectly normal for a two or three year old child, but it is not “normal” or even adequate for a 15 year old to manage in school or society. Moreover, teenagers are currently being asked to handle the responsibility and freedoms of adolescence in a society that lacks structure, containment, and moral clarity. In short, they have little support for this transition from child to adult.

The Missing Axis

The DSM system of classification seems to be missing a crucial Axis that would be helpful in describing and understanding the problems of adolescence. We are missing an Axis to describe the dimensions of maturation and failures that occur in the process of developing an adaptive adult personality structure. Although there is no such developmental Axis, a large body of knowledge provides a framework to understand the core patterns that contribute to the structure of an adolescent personality.

It is beyond the scope of this article to provide an adequate review of the literature exploring personality development. Interested readers might review some of the seminal ideas of Sigmund Freud whose work informed and inspired theorists and researchers to document stages and tasks children must master to establish their identity, their sense of self in the world, and their basic personality structure. In particular, Anna Freud (1936), Donald Winnocot (1965), John Bowlby (1973, 1980, 1982), and Erik Erickson (1950) helped lay the foundations for thinking of personality development as a process influenced by the early interpersonal interactions experienced within the context of a child's primary attachments. Several decades of important observations of children revealed stages of maturity in the growth of cognitive capacities Piaget (1966), and moral development (Kohlberg, 1984). Similarly, observations of children's early maternal attachment by Mary Ainsworth and Margaret Mahler (Ainsworth, 1969; Mahler, Pine, & Bergman, 1975) revealed a similar series of stages in the evolution of an independent personality structure. An excellent summary of the work surrounding attachment theory is provided Karen (1998) and Keegan (1982, 1994).

The Relationship of Early Development to Adolescence

In our work with adolescents at Montana Academy, we are struck by how our students' struggles can be traced back to deep patterns relating directly to how they resolved (or failed to resolve) the basic tasks of personality development that these various theorists have outlined.

Because of this, we have found it useful to categorize problems in terms of core issues of personality development. These strategies that once served to protect children from being overwhelmed are no longer beneficial for an adolescent. Moreover, we have found that it is more helpful for both adolescents and their families to understand their struggles in terms of basic patterns of relating to the world, than it is to label their difficulties with the symptom clusters described on Axis I of the DSM.

Responding effectively to an adolescent is easier if we understand the core development issues that tend to be endlessly repeated. The core patterns we see as recurrent themes for our adolescents have roots in the following stages of personality development:

- Attachment
- Separation-individuation
- Autonomy
- Triangular relationships

These tasks must all be negotiated during the first five years of life, and to a large degree define an individual's sense of self in relationship to others and the world. Obviously all adolescents negotiate each of these tasks in some manner as they attempt to create a sense of self that is capable of managing the stressors of the world. The struggle of human development is to become appropriately secure, differentiated, and independent, yet capable of going along with the rules of society and forming intimate relationships. Most adolescents resolve these tasks of personality development in a way that is good enough to continue the path of growing up. Slight hints and shadows of the early struggles are present in most of us (and are revealed to some extent in our most intimate relationships), but are sufficiently resolved for us to function effectively as adolescents and then adults. When the resolution of these tasks is inadequate or too immature to sustain the demands of adolescence, we not only see a multitude of symptoms but also the following hallmark themes or patterns that reveal the core themes of personality struggle.

Attachment. In the first year of life, children emotionally attach to a primary caretaker and develop a basic trust in the world (Erikson, 1950 Mahler et al, 1975). Successful attachment requires emotional attunement and a safe, nurturing environment. A child who feels attached in the first year becomes secure and feels safe in his or her world.

Early attachment failure can lead to emotional and even physical withdrawal and failure. Early motion pictures by Spitz (1947) and Robertson (1953) documented the painful and devastating effects of parental separation on very young children. Our programs are filled with students whose adolescent symptoms relate to core attachment disturbances (e.g., many adopted children in our programs). Public sector programs also serve children with attachment disturbance related to adoption, but they also have many children whose early attachment experience and security has been harmed by chaos, abuse, or lack of basic competence in parenting. Attachment disturbance often leads to a primitive anxiety of being overwhelmed or dissolving, of being uncertain of the reality of one's existence. This anxiety is so primitive that most of us have little or no experience or even understanding of how threatening it can be.

The signs of attachment disturbance in younger children can be easily mistaken for colic or symptoms of a temperamental or willful child. The child's reaction to anxiety frequently involves shutting down or attempting to hide and withdraw. In other situations, they appear stubborn or defiant when really they are simply trying to avoid being completely overwhelmed. Well-intentioned parents can easily misinterpret behavior as oppositional or defiant and respond inappropriately, thereby reinforcing the child's basic sense of not belonging and being misunderstood. Such feelings then lead to negative attributions toward themselves. They do not fit in because they come to see themselves as fundamentally flawed

As adolescents, attachment disturbed children are extremely distrustful and guarded. They continually feel like they are putting on an act, and that no one understands or relates to them. They feel alienated and unable to fit in. They are often overwhelmed by the stresses of adolescence and they want to disappear, withdraw, become emotionally numb or simply "blend in" without any real connection or emotion. These adolescents often long for and seek out a single person to “attach to” in a dependent relationship, and often the individuals who choose each other for such “clingy” relationships are themselves unstable and have poor boundaries. This relationship pattern explains in part why so many young adopted women become pregnant themselves and face the trauma of an abortion or of repeating the cycle of giving their own child up for adoption.

Separation. The next hurdle for a young child is to begin the process of differentiating one’s self from their primary attachment figures in order to begin the process of becoming a separate young person. This process roughly begins in the second year as children start to explore the world around them and begin to tolerate brief periods of separation from their primary attachment figure. Successful resolution of this developmental hurdle leads to the beginnings of a self-confident child. Such children can sooth themselves and begin to enjoy engagement with the world and play without being so dependent on their primary attachment figure.

Struggles with separation are often marked by a lack of early confidence and fears of being separated from the familiar. As children they often have difficulty going to pre-school. They display clinginess when being left off at school and feel exhausted about having to remain in such an uncomfortable and frightening world. Such children usually continue to have difficulty separating later in grade school years where they often have somatic complaints such as stomachaches, headaches, and vague sicknesses used as reasons not to attend school.

Adolescents who have not resolved early separation issues tend to have sensitive mothers who themselves have difficulty differentiating their own fears and feelings from those of their children, and these children subsequently fail to differentiate from their parents. When these issues persist, we see anxious and uptight adolescents who endlessly worry about fitting in. Early separation problems continue into adolescence with symptoms of withdrawal, collapse, sleep difficulties, as well as symptoms of anxiety and depression. These adolescents feel inadequate and incapable. Their anxiety differs from an attachment-disturbed child in that they have a basic self-structure and do not doubt or fear existence itself, but rather fear being alone and incompetent. There is a self, but an anxious, uncomfortable one.

When asked about their fears as children they will often admit to being terrified that a parent would die.

In the later stages of separation Mahler and her colleagues noted that young children begin to express ambivalent and conflicting feelings toward their parents. They are often almost simultaneously clingy and rejecting (Mahler, Pine, Bergman, 1975). Parenting of children in these later stages of separation is particularly difficult because they give such mixed messages. They want to be completely attached and dependent, but simultaneously want to be independent and reject adult control or efforts to sooth them.

As adolescents such children are confusing, since at home they often appear simply angry and defiant. Parents frequently describe these children as defiant monsters who have no control of their anger, particularly toward them. Parents have difficulty remembering how emotionally close and entangled they once were with their child. Such adolescents are also unaware of being so emotionally entangled with their parent. They tend to suppress their feelings and anxiety in school and in public, but then dump feelings onto their parents as if the parent should in some magical way take care of all of the adolescent's internal feelings.

As a high school student, one such client presented himself as shy, polite, and withdrawn in school, but at home threw a chair into a wall and threatened his mother with a butcher knife. One could easily diagnose such an adolescent as anxious, depressed, or bipolar, but the underlying issue stemmed from a long-standing separation anxiety often accompanied by self-doubt and loathing about his inability to feel confident and competent in the world outside his family. He resented this dependence and lack of differentiation, and felt trapped by this ineffective strategy of handling his feelings through his parents.

Adolescents, whose core issues resolve around failures to separate and individuate, derive great benefit from residential settings because they must recognize and deal with their feelings in the absence of the parental figure with whom they are so dependent and emotionally entangled. Being removed from home takes away the basis of the maladaptive strategy to which they cling.

Autonomy. The next core issue we see reflected in our adolescent populations are struggles for autonomy. Autonomy issues typically appear as a child develops language and mobility. When children are sufficiently secure to have a sense of self as separate from their parents, they then have to struggle with the fact that the world is not entirely as they want it. They achieve a certain level of legitimate independence, but inevitably they must come to grips with restrictions and limits on their freedom. Healthy resolution of the early struggles for autonomy (roughly between the ages of 2 and 4) leads to an acceptance of authority and an ability to maintain interest and energy within bounds established by parents and child care facilities. It helps if parents can provide clear structure and consistency, while avoiding power struggles that result in the child either winning or losing. Obviously parents walk a “narrow tight rope” in this process. The idea is for the adult to retain authority and structure without defeating or shutting down the child.

Early struggles around autonomy are poorly resolved if the child learns to defeat adult authority. We see such adolescents as self-centered, entitled and lacking in empathy. They often act as if they are adults, but “pseudo adults” in that they have done none of the work or accomplishment to be legitimate adults. Such adolescents are drawn to the drug world where they can gain status and power in an artificial world requiring little or no training, discipline, or effort. These “early winners” of autonomy struggles are markedly less available emotionally and tend to have a false self that is not easily punctured. When this façade is breached, there is an underlying sense of emptiness and loneliness that lurks behind their superficial competence and pseudo adult status.

The other negative outcome of early struggles for autonomy takes place when the parent’s anger, strength, or need to control manages to defeat the child’s early struggles for autonomy. When this happens, the child tends to become passive and withdrawn. As an adolescent such children can be remarkably angry and aggressive. They also indirectly “leak” anger in the form of passive aggressive attacks and behavior. These “shut down children” tend more to depression and withdrawal, and they know exactly how to neutralize a controlling parent. For example, if the parent is invested in the child’s school performance, the child learns quickly how to defeat his parent simply by not trying.

Triangular Relationships. Finally, we occasionally see adolescents who have negotiated all of the preceding tasks of developing a personality structure, but fail in "developing the capacity to handle triangular relationships."[1] The problem of triangular relationships involves learning to live in a more complex family situation with emotional demands from not simply a mother, but from both parents and often step-parents and siblings. The issue is "How does one learn to negotiate the complex mine field that is a modern family?" Virtually all of our students have some difficulties with this stage of development, but only a few are actually defined by the struggle to master complex relationships. As adolescents, children with core issues of triangular relationships are often not in residential placements because they are more solid in their personality structures and can avoid the level of collapse that necessitates residential placement. When we do get such adolescents, they tend to be apathetic and somewhat shut down. They lack initiative, passion, and ambition and seem paralyzed by the difficulty of satisfying the complex needs and expectations of both parents and the family. A major cause of triangular relationship issues is unresolved difficulties in marriages or divorces. Such problems tend to enlist children and place them in the middle of emotional issues too confusing and complex for a child to handle. Or at times we see adolescents with triangular relationship level problems brought on by trauma or loss in childhood or early adolescence.

We have found it useful to design treatments based on the core developmental problems of our students. Such approaches deepen understanding and allow students to discard childlike defenses and strategies in favor of more mature approaches to life.

[1] Triangular relationship issues were the heart of classical psychoanalysis and are much more common in restrictive and repressive cultures such as that found in Vienna at the turn of the previous century. In 21st Century America with a much looser culture and morality problems of personality development tend to occur at earlier stages.

Conclusion

The rapid growth of private residential programs may best be understood by examining the changes and failures that have taken place in the standard community based approaches to psychiatry and psychology. The failures of symptom based diagnoses and medication management in adolescents has led the treatment field to integrate professionalism with earlier alternative residential approaches to troubled adolescents. The integration of these approaches has evolved into a sophisticated blend of treatments aimed at more than symptom reduction. Our approaches to residential treatment programming help children mature and develop effective personality structures. As we reaffirm our task as helping children successfully negotiate their way to adulthood, it is important to make use of the rich literature and data that has accumulated over the past 50 years describing the process of personality development.

We have found it much easier to understand and help adolescents by focusing on core issues of personality development rather than focusing on Axis I symptom clusters. To the extent that residential placements promote maturation and personality development as opposed to symptom control, we must develop and test a theory of our work that relates directly to personality development. In this article I have proposed the outline of a developmentally based theory of adolescent struggles that needs to be tested and filled in with research relating early development to adolescent struggles. Finally, it is crucial in this age of "evidence based" practice that we strive to create both a theory and measurement of what is truly important in our work, or we will run the risk of being measured and discarded by the wrong metric and held accountable to standards that are all but irrelevant to what we truly accomplish.

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So You Want To Run An Outcome Study? The Challenges To Measuring Adolescent Residential Treatment Outcomes

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Abstract

The purpose of this literature review was to identify the considerations that should be addressed in the design of adolescent residential treatment center outcome studies. Specific key word searches were used with four on-line databases to identify adolescent residential treatment outcome studies from 1986 to 2005. While adolescent residential treatment outcome studies have generally indicated positive outcomes for this form of treatment, the literature also acknowledges design limitations in almost all studies. At a minimum, future outcome studies should use appropriate methods and analyses to: (a) define the population served, (b) define the treatment model used and establish treatment fidelity, and (c) define outcome to include treatment and post-discharge measures that are positive and multi-dimensional.

Introduction

Outcome studies of residential treatment of children and adolescents with emotional and behavioral disorders have generally found favorable outcomes for this form of treatment (Curry, 1991; Curtis et al., 2001; Gilliland-Mallo & Judd, 1986; Gorske et al., 2003; Jainchill et al., 2000; Larzele et al., 2001; Lyons et al., 2001; Pfeiffer, 1989; Swales & Kiehn, 1995). The literature widely acknowledges, however, that this form of treatment has been insufficiently studied and problems in the design of many existing studies limit the broad applicability of conclusions from specific studies to this form of treatment (Larzele et al., 2001; Pfeiffer, 1989; Swales & Kiehn, 1995). Problems in study designs include the following: (a) use of weaker (i.e., less valid) forms of quasi-experimental study designs, (b) a lack of clarity around the definition of what constitutes "residential treatment," (c) inadequate definitions regarding the treatment model used and how treatment fidelity is established, (d) inadequate definitions regarding the population served, (e) failure to establish a proper baseline prior to treatment, (f) problems with defining specific outcomes to include positive and multi-dimensional measures of change, and (g) inherent weaknesses when measuring and analyzing outcome data (e.g., sufficient sample sizes, use of reliable and valid instruments, sufficient follow-up data, use of appropriate statistical methods).

And, despite the majority of studies demonstrating positive outcomes for this form of treatment, residential treatment has come under increased scrutiny due to several factors. First, managed care has attempted to shift the emphasis of residential treatment from treatment to stabilization of behaviors, shortening the length of stay in residential treatment and replacing residential treatment with less expensive outpatient services. Second, some studies have found negative outcomes or iatrogenic effects associated with residential treatment (e.g., Hoagwood & Cunningham, 1992, Lyons et al., 2001). Third, some have advocated for the decreasing use of residential treatment because of its perceived inconsistency with the "least restrictive environment" concept. Fourth, instances of abuse have occurred in a few residential treatment facilities, leaving the public with questions concerning the validity and safety of this form of intervention.

Questions concerning efficacy and safety are further heightened by the fact that residential treatment is one of the most expensive forms of mental health services (Lyons et al., 2001). Hoagwood and Cunningham (1992) found an average cost of $6,316 per month (i.e., $210.43 per day), ranging from $763 to $15,893 per month. Bates et al. (1997) suggested the annual cost of residential group care to be $1.05 billion, which was approximately one-third of the total $3.5 billion spent annually on adolescent mental health services in the U.S. The Odyssey Project (Drais-Parillo, 2005) surveyed of 12 residential group care facilities involving 2,487 participants, finding an average cost per day of $226 (SD = $68, r = $158 to $294).

Scrutiny of these monetary figures has led to questions of whether the benefits provided by residential treatment are commensurate with its costs, and whether these benefits could be provided more efficiently (i.e., at lower cost) utilizing different forms of outpatient therapy

(Lyons et al., 2001). Many authors acknowledge that this consideration provides an additional rationale for implementing outcome studies that also look at benefit-cost analyses (Goocher, 1997; Lyons et al., 2001; Pfeiffer, 1996; Pfeiffer & Strzelecki, 1990; Swales & Kiehn, 1995; Wilson et al., 1983). Competition for behavioral health service funding is also increasing and some residential treatment facilities are under increasing pressure to justify the high cost of their interventions if funded by these sources.

The involvement of managed care in residential treatment has also significantly impacted the length of client stay (Chang et al., 1996), altering the purpose of residential treatment to emphasize short-term acute-care and behavior stabilization. One reason for this shift in the purpose of residential treatment is that once behavior is stabilized by a short-term stay in residential treatment, less expensive forms of treatment are typically implemented on an outpatient basis at the community level (Curtis et al., 2001; Lyons et al., 2001). Additionally, community-based outpatient services are perceived to be more congruent with "least restrictive environment" policies.

As managed care organizations have attempted to implement policies decreasing the length of stay at all levels of residential treatment (e.g., psychiatric hospitals, residential treatment centers, group homes), one possible question is how clients requiring more acute levels of care have their needs addressed (Bates et al., 1997; Chang et al., 1996; Pfeiffer, 1989). For example, Chang et al. (1997) noted the length of stay in psychiatric units decreased from an average of four months to 3 weeks over a two year period. No rigorous research exists that clearly demonstrates populations served in residential treatment benefit from the combination of the new structures of managed care treatment and shortened lengths of stay in treatment centers.

Despite some doubts concerning the efficacy of residential treatment, the use of residential treatment for adolescents has undergone significant growth in the past 30 years. Gilliland-Mallo & Judd (1986) reported the number of adolescents in residential treatment to be greater than 29,000, with the number of clients in out-of-home placements to be over 500,000. Pfeiffer and Strzelecki (1990) suggested that approximately 20,000 children and adolescents were provided with services in residential treatment facilities; and that this number is more than twice the rate of 20 years ago. Hoagwood & Cunningham (1992) found the number of youth with serious emotional disturbances to be increasing dramatically and the number of residential treatment facilities has continued to increase. Bates et al. (1997) reported there has been a two-fold increase in the number of children in residential treatment in the previous two decades. A study by the Child Welfare League of America (1999) found almost one quarter million children and adolescents were served in group residential care facilities. Curtis et al. (2001) stated approximately 530,000 children were living in out-of-home care at the end of 1996, with 41,000 in residential group care, 27,000 in community-based group homes, and 23,000 in treatment foster-care. Connor et al. (2002) found the demand for adolescent residential treatment services had grown from 29,000 in 1982, to 65,000 in 1990, to 117,720 in 1997 (including day and residential treatment). The U.S. Department of Justice (2002) found the number of adjudicated cases resulting in out-of-home placement rose from 119,700 in 1989 to 163,800 in 1998, a 37% increase.

These data are somewhat problematic due to the inconsistent use of terms and a lack of clarity in the definition of treatment services. However, residential treatment for children and adolescents clearly is an extremely important form of intervention both in terms of its economic impact and the number of clients served. These studies may also grossly underestimate the number of children and adolescents served in residential treatment because these studies typically focus only on publicly funded facilities. There is very little research on whether the number of children and adolescents in residential treatment has changed over the last 10-15 years with the advent of managed care's involvement in behavioral health services. No studies exist that show a decrease in the number of children and adolescents served by residential treatment facilities.

Problems in Study Design

The importance of residential treatment in the continuum of care of mental health services, combined with the significant cost of this form of treatment, underscore the importance of performing methodologically sound outcome studies to demonstrate the effectiveness of this service. Yet the literature on the assessment of outcomes in adolescent residential treatment widely acknowledges the significant study design problems inherent in residential treatment outcome studies and the paucity of adequately designed studies (Chang et al., 1996; Curry, 1991; Curtis et al., 2001; Gilliland-Mallo & Judd, 1986; Goocher, 1997; Gorske et al., 2003; Hooper et al, 2000; Larzelere et al., 2001; Mann-Feder, 1996; Pfeiffer, 1989; Pfeiffer & Strzelecki, 1990; Swales & Kiehn, 1995; Wilson et al., 1983). These problems begin with a lack of consensus on what constitutes residential treatment (Bates et al., 1997; Curtis et al., 2001) and acknowledge that residential treatment outcome studies are inherently limited by the lack of appropriate comparison groups in the use of quasi-experimental designs (Curry, 1991).

Very few studies, if any, have ever used a true experimental design in measuring residential treatment outcomes. Most studies use weaker forms of quasi-experimental designs, either a one-group posttest only or one group pretest-posttest design (Curry, 1991). Because of the inherent risks, as well as immediate needs of the population served at this level of care, it continues to be extremely difficult (if not unethical) to implement more stringent experimental study designs. Therefore researchers are left with using more complex experimental research designs or implementing quasi-experimental study designs. This limitation does not only mean that the validity of outcome is limited by internal threats of the study, but also that the conclusions from such a study may be limited in the applicability to other facilities or to this general level of care.

Further design problems and limitations include the differences in the treatment models and philosophies utilized, failure to establish treatment fidelity, inadequate definition or establishment of the baseline measures of the population served, inconsistent or inadequate definition of outcome, non-standardized approach to data collection/ sampling problems, insufficient sample size, failure to use validated and reliable instruments, non-specification or lack of data after discharge, inadequate response rates, inconsistent consideration of the post-discharge environment, and a failure to use appropriate statistical analysis (Pfeiffer, 1989; Swales & Kiehn, 1995; Wilson et al., 1983).

Several authors have provided detailed recommendations concerning outcome study methodology. Wilson et al. (1983)

identified the following outcome study components that require sound methodology and design: (a) defining and measuring the client, (b) defining and measuring treatment, and (c) defining and measuring outcome variables. In his review of 32 child and adolescent residential treatment outcome studies, Pfeiffer (1989) identified three basic factors that should be addressed in experimental design: (a) describing the patient population, (b) describing the treatment program, and (c) design, instrumentation, and methodological considerations. These study design limitations can greatly affect the applicability of conclusions made regarding residential treatment efficacy and the identification of reliable factors that may predict outcome. While these articles were printed 24 and 18 years ago, respectively, it is noteworthy how many subsequent studies have failed to follow these straightforward recommendations. For example, Hair (2005) notes that outcome studies are still limited by the lack of comparable data regarding the variability of clients served.

Defining residential treatment

With respect to the definition of what constitutes residential treatment, the literature does not contain one standard or universally accepted definition (Bates et al., 1997; Curtis et al., 2001). This review found that the definition of what constitutes residential treatment varies widely between studies, and may include services ranging from acute psychiatric to group home stays (Bates et al., 1997; Connor et al., 2002; Curry, 1991). Studies referring to their services may use the term "out of home," and may also include services such as treatment foster care. Several outcome studies on residential treatment facilities did not provide a definition of the services provided (e.g., Gorske et al., 2003; Hoagwood & Cunningham, 1992; Lyons et al., 2001; Lyons & Schaefer, 2000; Wilson et al., 1983). In contrast, Bates et al. (1997) provide a list of common characteristics of residential treatment facilities that includes a de-emphasis of the medical model, moderate length of stay, therapeutic use of the daily living milieu, relatively fewer medical staff, a multi-disciplinary team-based treatment approach, exclusion of highly acute patients, and a degree of restrictiveness between acute psychiatric and day treatment.

Some studies define residential treatment relative to the type of clients served or the intensity of services provided within the mental health care continuum. For example, Larzelere et al. (2001) discussed residential treatment as an out-of-home facility more treatment-oriented than a group home, but less restrictive than an inpatient psychiatric unit. Curry (1991) provided a definition of residential treatment relative to more and less restrictive levels of care. On the treatment continuum, residential treatment services are often conceptualized as one step down from acute inpatient psychiatric services and one step up from group home services.

Variations in treatment models

The definition of what constitutes residential treatment is further complicated by the range and variety of treatment models and philosophies currently in operation (Hooper et al., 2000). Bates et al. (1997) noted that the efficacy of residential treatment is difficult to assess because of the utilization of different treatment modalities, making it difficult to compare different programs. A further complication is that many facilities use eclectic philosophies or blend approaches and methods. In addition to considerations of treatment models and philosophies, residential treatment facilities may be highly variable in other components of their programs. These variations include types and range of educational services offered and quality of life issues such, as food services and recreational opportunities.

As well, many studies offer either no description (or only a cursory description) of the treatment program involved in the research (e.g., Gorske et al., 2003, Hoagwood & Cunningham, 1992; Lyons et al., 2001). Hooper et al. (2000) noted the existence of a variety of residential treatment models currently in operation and stated that traditional research paradigms may not be suitable for evaluating the complexity of residential treatment environments. The complexity of potential therapeutic factors occurring within the milieu of a residential setting was the rationale for Swales & Kiehn's (1995) proposal regarding theoretically motivated designs for outcome studies.

Pfeiffer (1989) acknowledged the importance of describing the treatment provided both in terms of the frequency and type of intervention and describing the residential treatment setting from a social-developmental context. To this end, Pfeiffer (1989) stated there have been few attempts to examine the interactions among patients and the treatment environment. Interaction such as unit atmosphere, staff attitudes, treatment philosophy, organizational structure, parent-staff relationships, and the integration of education, treatment, and recreation have rarely been addressed and measured in outcome studies.

Treatment fidelity

Even assuming that the complexity of a residential treatment environment can be adequately defined and measured, Gorske et al. (2003) noted a potential problem in treatment fidelity between treatment described in research and what is actually implemented in programs that utilize the same (or other) models. Treatment provided in a highly structured and controlled research setting may not be easily duplicated in practice, even when the same treatment model or philosophy is being implemented. In other words, the process of designing and implementing an outcome study may influence treatment fidelity for several reasons including: (a) adherence to a formal treatment protocol, (b) intensity and duration of treatment, and (c) identification and treatment of experimental and control factors. Very few studies even address the issue of treatment fidelity, much less identify a process of defining and measuring it. These definitional problems are a preliminary issue; yet they also highlight and provide insight into the difficulty of determining the appropriate study design for assessing adolescent residential treatment.

Defining the population served

Another important problem acknowledged in the literature on adolescent residential treatment outcomes is defining the client population. The literature sometimes conceptualizes the population relative to primary areas of research: juvenile justice, substance abuse, and emotionally/behaviorally disturbed populations. These categories, however, may be more reflective of the research interests of the author or sources of funding, rather than actual differences in the population served. For example, a study by Jainchill et al. (2000) focused on the use of residential treatment for adolescents with substance abuse problems. This study described its population by the characteristics associated with substance abuse (e.g., types of substances, frequency of use). In a separate study, Grietens & Hellinckx (2003) narrowed the parameter of their study to the efficacy of residential treatment for juvenile offenders and defined their population according to criminal behavior and recidivism. Many other studies (e.g., Connor et al., 2002; Lyons et al., 2001; Pfeiffer, 1989; Pfeiffer & Strzelecki, 1990) defined the population primarily in terms of emotionally/behaviorally disturbed (EBD) or seriously emotionally disturbed (SED).

These populations, however, often have overlapping (if not the same) characteristics. This complexity is often not reflected or acknowledged in the literature. Comorbidity, or dual diagnosis of substance abuse and EBD, may exist in a population characterized as EBD or as substance abuse-oriented. In addition, EBD and/or substance abuse problems may exist in a population characterized as juvenile justice-oriented. Therefore, one may question whether the distinction between these populations is merited and, if so, why? Additionally, how the population is initially conceptualized may, in turn, affect how the outcome study is designed, including how treatment and outcome are defined and measured.

Studies are often highly variable in the quantity and quality of data collected to describe the population served in residential treatment including descriptive statistics, demographic data, and psychosocial history. For example, studies vary greatly in the extent of descriptions on important variables such as of gender, age, race or ethnicity, and socio-economic status (SES) of the sample. Additional information concerning referral reason, intelligence, medical issues (including the use of psychotropic medications), diagnoses and acuity (and how these are measured), history of previous treatment, juvenile delinquency problems, family history, physical or sexual abuse history, education history and problems, substance abuse problems, SES, and other protective and risk factors are variably identified and measured. Studies may vary from describing basic demographic data and limited information on educational history (Hoagwood & Cunningham, 1992) to detailed demographic data and psychosocial histories, including age, gender, race/ethnicity, IQ, diagnoses, family history, sexual/physical abuse history, previous treatment history, school problems, and medical history (Hooper et al., 2000).

Wilson et al. (1983) listed four essential components that should be used to define a population in residential treatment: (a) presenting problems, (b) strengths and weaknesses, (c) family structure, and (d) demographic data. Wilson et al. (1983) further reasoned this information is also necessary to meet the client's needs in treatment in order to provide adequate treatment planning. Pfeiffer (1989) also recognized the importance of defining the population served as a pre-requisite to adequate study design. Yet only 4 of the 32 studies reviewed in this study included a breakdown of the population according to diagnoses. In his review of studies on adolescent residential treatment, Pfeiffer (1989) found 75% of the studies offered no pre-admission information on the client and no baseline for the sample population. Pfeiffer (1989) also found 28 out of 32 studies provided no information concerning the client's history of treatment prior to admission.

Another problem is that few studies contain a rationale of how parameters for describing the population were chosen. For example, very few studies describe why specific population characteristics were chosen for measurement and why other characteristics were not considered or measured. Bates et al. (1997) further conceptualized this problem in terms of a lack of standardized placement criteria for the population being served. In other words, there is a great deal of inconsistency outlining how clinicians assess and make placement decisions regarding the use of residential treatment with respect to the populations' characteristics.

Defining outcome

With respect to defining and measuring outcomes, reviews of published studies have acknowledged a lack of definition, inconsistency between studies, and the failure to use valid and reliable instruments (Jainchill et al., 2000; Pfeiffer, 1989; Pfeiffer & Strzelecki, 1990; Swales & Kiehn, 1995). For example, many studies have measured outcomes in terms of a reduction or absence of a negative indicator, rather than an increase in a positive indicator (Jainchill et al., 2000). The reduction or absence of negative indicators is then typically used to infer a positive outcome. Under this definition of outcome, EBD-focused studies typically assess outcome by measuring the reduction in acuity of diagnoses and/or reduction in negative behaviors (Lyons et al., 2001). Substance abuse-focused studies have typically measured a reduction in drug use or relapse rate (Jainchill et al, 2000), and juvenile justice-focused studies have typically measured recidivism rates or reductions in criminal behavior (Grietens & Hellinckx, 2003).

A major flaw in previous outcome studies such as these has been the inference of a positive outcome due to a reduction in negative symptoms or behaviors.

Other studies assess outcome through ecological indicators. These ecological indicators may vary highly from study to study. In addition, some studies do not provide a rationale for why specific ecological indicators were used. For example, one study defined outcome as successful if discharge occurred to home, a significant other, foster care, or group home and defined unsuccessful outcome as either placement in detention or as a runaway (Gilliland-Mallo & Judd, 1986). Another study retrospectively defined outcome based upon a review of the client's chart to determine if treatment objectives were completed (Gorske et al., 2003). A further study measured outcome in terms of the client's functioning in their home school district after discharge from residential treatment (Hoagwood & Cunningham, 1992). These studies illustrate that outcomes have not consistently been defined. Additionally, common measures of outcome only inform the reader what is not happening to the client.

In a review of 32 outcome studies in adolescent residential treatment, Pfeiffer (1989) stated that previous studies have been too restrictive by defining "outcome" as a reduction in negative symptoms. Pfeiffer (1989) concluded that outcomes should be defined in terms of adaptation and coping and should be multi-dimensional and multi-directional. In a study of adolescents in therapeutic communities, Mann-Feder (1996) stated that multiple environmental measures should be used to determine outcomes. Jainchill et al. (2000) stated a multidimensional approach should be used that measures a broad range of outcome variables, and that the measure of change should include changes in positive behaviors. Curry (1991) stated research should be designed to measure multiple levels of outcome including symptom reduction, psychological change, relationship change, and academic or vocational functioning. Hooper et al. (2000) stated that outcomes should be defined multi-dimensionally, including school status, legal status, and level of care.

Swales & Kiehn (1995) provided an in-depth discussion of study design alternatives in residential treatment and proposed "theoretically motivated quasi-experimental designs" as an alternative to double-blind controlled trials. For example, the authors proposed that one alternative for a study design would be to outline a specific treatment approach that is then used to make specific predictions about outcome. These predictions would then be tested in a series of single cases. Under this proposal, an outcome study for an adolescent residential treatment facility could focus on measuring changes that are consistent with the philosophical basis of the model.

Another important issue concerning measuring outcomes is when and how the measurements are taken. Reviewers have noted that many studies fail to use validated and reliable instruments to measure outcomes (Bates et al., 1997; Curry, 1991; Pfeiffer, 1989; Swales & Kiehn, 1995). Many studies also fail to measure outcome after discharge (Bates et al., 1997; Pfeiffer, 1989; Swales & Kiehn, 1995). Pfeiffer (1995) recommended that validated and reliable instruments be used, follow-up periods should be specified, and outcomes should be assessed at discharge, no earlier than 90 days, at 6 months and at 12 or 18 months post-discharge. Pfeifer (1989) also found that 63% of the studies reviewed had response rates greater than 75%, while 27% of the studies had a response rate between 50-75%.

Results of Outcome Studies

Bearing in mind the potential problems and limitations of study designs and methodology, another issue concerns the results of outcome studies on adolescent residential treatment. Pfeiffer (1989) stated a majority of studies have found positive outcomes associated with residential treatment, but that firm interpretation and generalization is difficult due to study design flaws. Curry (1991) noted that research on adolescent residential treatment efficacy has lagged behind other areas of research, but that clients generally appear to improve in residential treatment and that the post-discharge environment can be a strong determinant of positive or negative adaptation. Erker et al. (1993) found that the majority of reports indicated that adolescents in residential treatment generally improved at the time of discharge, but residential treatment did not appear to be more effective than day treatment services. Mann-Feder (1996) found significant improvement on a variety of measurements for adolescents in two different residential treatment programs (therapeutic community and token economy). Bates et al. (1997) found that efficacy often depends upon what variables are measured, but that residential treatment was generally effective at discharge. This study also found that treatment effects typically declined with time.

Hooper et al. (2000) noted that outcomes can vary significantly from study to study, but in their study they found that program benefits were maintained for one to three years after discharge. Jainchill et al. (2000) acknowledged that some controversy exists regarding the efficacy of residential treatment, but that residential treatment is more effective than outpatient services. Larzele et al. (2001) found that adolescents in residential treatment showed significant improvement, and that these improvements were generally maintained after discharge. Lyons et al. (2001) reported that adolescents in residential treatment generally improved during their course of stay, but that there was considerable variation in which symptoms improved, as well as significant variations in outcomes between different programs. In their review of the literature, Gorske et al. (2003) and Hoagwood & Cunningham (1992) concluded there is a small amount of evidence regarding the effectiveness of residential treatment for adolescents. In sum, conclusions regarding residential treatment may be characterized as generally positive, but there also are enough limitations and caveats concerning the complexity and range of services offered, the lack of definition concerning the treatment population, some negative outcomes, and inherent limitations and flaws in study designs that present serious questions about the extent to which general conclusions may be made.

Predictive factors

This questioning is further justified by the inconsistency found in attempts to identify factors that can predict outcomes in adolescent residential treatment. Predictive factors, or factors correlating with outcome, are highly variable both in terms of what factors are identified and whether a specific factor is negatively or positively correlated to outcome. Gilliland-Mallo & Judd (1986) reported race, larger programs, longer length of stay, and high pre-commitment offense levels were correlated with high post-commitment levels of offense. Pfeiffer (1989) stated the following predictor variables should be considered in assessing residential treatment outcomes: father's involvement;

academic status; locus of control; need to achieve/affiliate; perceived alienation; attitude toward school, rules, authority and parents; feelings toward treatment; after-care services; internalization of external rules and structure; interpersonal competence. In their review of 32 outcome studies, Pfeiffer & Strzelecki (1990) addressed the following predictors of particular outcomes: IQ (3 of 7 studies found positive relationship); organicity (associated with negative outcome), diagnosis (psychotic and behavioral disorders responded less favorably); symptom pattern; age at admission (not predictive); gender (not predictive); family functioning (generally positive relationship); treatment (not generally investigated); length of stay (positive relationship in 3 of 7 studies, no relationship in 4 of 7 studies); and aftercare (strong positive association).

Curry (1991) found level of functioning post-discharge was related to post-discharge environment. Hoagwood & Cunningham (1992) found positive outcomes were associated with shorter lengths of stay, more severe presenting dysfunctional deficits at intake, and the availability of community-based services after discharge. Whittaker and Pfeiffer (1994) found acuity and treatment models were not associated with post-discharge adjustment; community network and family involvement were correlated with positive outcome; and age, gender, IQ and length of stay are only weakly related to positive outcomes. Bates et al. (1997) and Curtis et al. (2001) found level of functioning in treatment was not predictive of post-discharge functioning. Hooper at al. (2000) found that successful outcomes were associated with gender (female), higher IQ, better reading skills, fewer psychiatric diagnoses, higher ratings of internalizing behaviors, and earlier follow-up. This study also found ecological variables (e.g., history of abuse, living with the family) had lower correlations with outcome. Jainchill et al. (2000) found that the following predicted positive outcome with respect to lower drug use: Hispanic origin, level of pre-treatment drug use, the client’s rating of his or her relationship to the counselor, completion of treatment, and not associating with deviant peer groups after discharge. Jainchill et al. (2000) also found the following variables associated with decreased criminal behavior: gender (female), completing treatment, and not associating with deviant peers. Curtis et al. (2001), however, found that age, gender, intelligence, and length of stay were only weakly related to outcome.

Connor et al. (2002) found that positive outcome was predicted by less severe dysfunction, better personal and social adjustment, acute (vs. chronic) onset, greater academic ability, greater capacity for interpersonal relationship, anxiety or mood-related disorders (rather than behavioral), gender (female), younger age of intervention, and higher verbal IQ. This study also found poor outcome was predicted by comorbid substance abuse, history of sexual or physical abuse, and early onset. Gorske et al. (2003) found that adolescents in residential treatment were less likely to succeed if they lived in a placement other than with their family, had more severe antisocial problems, or did not receive multiple treatment modalities.

Conclusion

The use of residential treatment for children and adolescents is an essential form of treatment for children and adolescents with emotional and behavioral problems, substance abuse, and/or juvenile delinquency problems. Residential treatment for these populations is important both in terms of the number of clients served in treatment and benefits related to treatment costs. The use and cost of residential treatment has been increasingly questioned with the advent of managed care and policies that often prefer community-based services because they are perceived to provide services in a less restrictive environment. Yet few alternatives have been successfully implemented that can safely and effectively serve this acute population in a less restrictive setting.

The research generally concludes that some forms of residential treatment for children and adolescents are effective, but also that such a statement is severely constrained by problems in study design inherently limiting the ability to make broad conclusions between programs and populations served. These inherent limitations and problems in study design have been repeatedly raised and discussed in the literature.

These limitations often begin with a lack of consensus on what constitutes residential treatment. The literature acknowledges that children and adolescent populations in residential treatment have been poorly defined, and that providing such definition is an important component of any outcome study. The literature further acknowledges the failure of many studies to adequately describe the treatment model used, the difficulty in describing and defining other aspects of the treatment milieu, and the failure to adequately assess treatment fidelity.

Other significant problems in study designs and methodologies exist, including the failure of many studies to define outcomes. Previous studies have sometimes been flawed by defining outcomes negatively (as a reduction in symptoms or negative behaviors), and by a failure to provide a multidimensional measure of outcome that includes positive change. The lack of utilizing valid and reliable outcomes measures has also limited many studies' findings.

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Longitudinal Family and Academic Outcomes in Residential Programs:
How Students Function in Two Important Areas of Their Lives

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Abstract

This paper presents academic and family outcomes from a multi-center study of youth enrolled in private residential programs. The sample of 1027 adolescents, and their parents, was drawn from nine Aspen Education Group residential programs. Youth academic functioning and youth functioning within the family improved significantly during treatment and those gains were maintained, relative to admission functioning, one year after discharge. The study results suggest that academic and familial outcomes for youth in private residential treatment can be positive and lasting.

Longitudinal family and academic outcomes in residential programs: How students function in two important areas of their lives

When asked what he thought a normal person should be able to do well, Freud said "Lieben und arbeiten" (to love and to work). He was reported to have added: "It pays to ponder on this simple formula; it gets deeper as you think about it" (Erikson, E., 1950).

Family and school are the foundation of "love" and "work" during the transition that defines adolescence. Unfortunately, youth in residential programs often have serious problems with their family and school systems. The extant research offers little to inform clinical practice on these issues: there is a dearth of research on the academic and family outcomes of youth in private residential care.

The PsycInfo and Education Resources Information Center

(ERIC) databases list only two articles on family outcomes in private residential treatment. At one private residential school, Stage (1999) studied whether any the following were predictors of "successful discharge" (e.g., graduation) to a less restrictive setting: family dysfunction, disruptive behaviors, family therapy, and history of victimization. Surprisingly, family participation in therapy was the only significant predictor of successful discharge. It is important to note that the author did not follow these students after discharge to determine if "successful discharge" was predictive of post-discharge functioning. Springer and Stahmann (1998) studied parent perceptions of the therapeutic benefit of telephone therapy at one private residential program. With a sample of 47 parents, they found that parents believed their family functioning and family communication improved in direct proportion to the amount and quality of telephone family therapy they received. Note the benefit of telephone therapy was only significant when sessions involved all three parties: therapist, parent, and student. Outcomes were not correlated with telephone sessions that involved either a parent and student or a parent and therapist. The study offers valuable insight into parents' views of telephone family therapy. It also suggests that telephone family therapy -- a service that is common in private residential care, but lies outside of the "norm" in mental health care and especially in family therapy -- may be valuable. A limitation of the study was that the authors only gathered data from parents during treatment; there was no data about long-term outcomes. Another limitation was that the study did not examine the change in the students' functioning within the family. It is possible that student behavior did not change and, instead, that changes made by other members within the family accounted for the parents' perceived change in family functioning. Although a family-systems perspective is critical to establishing effectiveness of residential care, it is also critical to study changes made by the youth within the family system.

In recent decades several outcome studies have been published on family outcomes in public residential treatment. Before reviewing that research, it is important to note the differences between public and private residential care. Youth treated in public residential programs are typically referred by the juvenile justice or child welfare systems and are funded with public money (Curtis, Alexander, & Longhofer, 2001; Epstein, 2004; Hair, 2005). Public residential clients are predominantly males, who are disproportionately from ethnic minority backgrounds (Asarnow, Aoki, & Elson, 1996). In private residential treatment, adolescents are generally placed in these settings by their parents who typically pay for their treatment. Though no client demographic and background information are available for private residential treatment programs, informal observation across a variety of programs suggests that clients are equally likely to be male or female, are predominately white, and come from upper middle class or upper class socioeconomic backgrounds.

Despite the likely differences between public and private residential treatment, the public residential treatment body of literature seems more closely related to private residential treatment than any other body of literature (e.g., private outpatient therapy, acute psychiatric hospital care). The literature summarizing public residential and family service practice standards emphasizes the importance of fostering the student's attachment with the family during out-of-home care (Downs, Moore, McFadden, & Costin, 2000). Also within the public residential literature, researchers have demonstrated that family involvement during out-of-home treatment and the stability of the discharge environment are significant predictors of outcomes after discharge (e.g., Connor, Miller, Cunninghan, & Melloni, 2002; Epstein, 2004; Gorske, Srebalus, & Walls, 2003; Wells, 1991). For example, a study by Landsman, Groza, Tyler, & Malone (2001) used two groups of clients at one public residential program: one group was treated with a family-based approach; and the other group was treated with the standard youth-based approach. The family approach provided skill training for families, extended aftercare, and active family participation in therapy and decision-making. The individual approach used "treatment as usual," including individual and group therapy, behavior management, and educational, medical, and recreation services. Results showed youth who received the family-based approach had significantly shorter lengths of stay and were more likely to be discharged to home than to another placement. Along similar lines, therapeutic foster care studies have found that visits with biological parents are correlated with shorter lengths-of-stay (Benedict & White, 1991; White, Alber & Bitonti, 1996) and improved behavioral and emotional functioning (Cantos, Gries, & Slis, 1997). Using varied and rigorous methodologies, studies such as these have led expert reviewers to conclude that family-based interventions in public residential care improve youth outcomes (Hair, 2005; Huang et al., 2005). Based on this literature, there is good reason to hypothesize that a family-based treatment focus could also improve outcomes for youth in private residential treatment. However, this question has not yet been explored in the residential treatment literature. More directly related to the present study is another set of unexplored questions: does youth functioning in the family change during treatment and are those changes maintained after discharge?

A query of the PsycInfo and ERIC databases revealed one article that mentioned academic outcomes for adolescents treated in a private residential treatment program (Bratter, Bratter, Coiner, Kaufman, & Steiner, 2006). The article was primarily devoted to delineating the theoretical model of the John Dewey Academy, a college preparatory therapeutic boarding school. In support of their theoretical model, they reported that all their graduates, over a 20 year period, attended quality colleges and more than 70% attained a college degree. The study used a retrospective design and did not explore changes in academic functioning over time.

A few articles from the public residential treatment literature reported secondary findings on academic outcomes. Weis, Wilson, and Whitemarsh (2005) studied a variety of outcomes for adolescents treated in a public military-style residential program Six months after discharge, those who successfully graduated from the program were far more likely than those who withdrew from the program to graduate high school/earn a GED. Successful graduates were also more likely to be engaged full time in some combination of work and school. In another study, a cross-sectional design using 111 youth from one program found that the majority of youth performed satisfactorily in school after discharge: 94% at 6 months post discharge and 80% at 12 months and 24 months post discharge (Hooper, Murphy, Davaney, & Hultman, 2000).

A couple of limitations are noteworthy in these studies. First, the few studies that exist were conducted primarily within public residential programs. Whether the findings generalize to the private residential population is an empirical question, worthy of attention.

A second limitation pertains to the studies' research focus. The studies were limited to an examination of academic functioning *after* discharge. No study has explored whether academic functioning changes during treatment and if post-discharge academic functioning is significantly different from pre-admission discharge functioning. Whether students' academic performance changes from pre-admission to post-discharge is a question meriting empirical attention and one that has profound practical implications for youth. Clinical observation suggests that many youth admitted to programs are underachieving and performing poorly in school. If youth academic functioning doesn't improve during treatment and/or if those improvements are not typically maintained after they discharge, there would be good reason to question the validity of the current focus on academics in private residential care. On the other hand, if youth academic outcomes are improved and maintained, there is good reason to continue and to promote an academic focus in private residential care.

This study used a multi-center design to explore the following questions:

1. Does youth functioning within the family change during treatment and in the year after treatment?
2. Does youth academic functioning change during treatment and in the year after treatment?

Method

Participants

The Western Institutional Review Board (www.wirb.org) approved consent/assent forms and issued Certificates of Approval for the study. The sample consisted of 1027 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, and/or discharge, three, six, 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. This sample consisted of a mean of 55% (range 37-75%) of the adolescents admitted to the residential programs during the time period. Demographic information (i.e., ethnicity, parental income, gender, age) from admission data provided by the residential programs indicated the sample was representative of students enrolled in the programs during the same time period.

Study participants were 55% male, with a mean age of 16 (SD = 1.2). Most were Caucasian (87%), with small percentages of several other ethnic groups. The median annual family income was >$100,000. Ninety-seven (97%) percent of the adolescents were placed in treatment by their parents. The overwhelming majority of youth had been treated at other levels-of-care (94%). Specifically, 80% had received outpatient treatment in the prior year, 70% had recently been prescribed psychotropic medications, 40% had a history of prior outdoor therapy, and 31% had at least one psychiatric hospitalization. Only 22% of the sample had a legal record. The mean grade point average at admission was 2.0 (D) on a 4.0 scale. While in the residential program, the majority of adolescents were treated for multiple problems (82%). The most frequent treatment foci 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 7 months for who were discharged with partial benefit or against program advice.

Programs

The nine participating programs were private, out-of-home therapeutic placements for adolescents and are member-programs of the National Association of Therapeutic Schools and Programs (NATSAP). All nine were programs within the Aspen Educational Group and were as follows: Academy at Swift River, Aspen Ranch, Copper Canyon Academy, Mount Bachelor Academy, Stone Mountain School, Pine Ridge Academy, Sun Hawk Academy, Turnabout Ranch, and Youth Care (See www.aspeneducation.com). The contribution of each of the nine residential programs to the sample was relatively equal and ranged from 9% to 16%.

Design and Measures

A single-group, pretest - posttest design was used. Questionnaires were completed by both parents and adolescents at admission and/or discharge, and at three, six, and 12 months post discharge. Questionnaire items assessed the student's grade point average, status with high school credits, communication with family members, compliance with family rules, and family relationship quality.

Four items on the questionnaire related to youth functioning within their families. In order to allow for parsimonious data analyses, factor analyses were conducted using the principal component extraction method and varimax rotation on the items. One series of factor analyses was for the parent-reported items, with another series for the youth-reported items. Both the parent and youth series of factor analyses examined the four items at 5 measurement points: admission, discharge, three months, six months, and 12 months-post discharge.

Using the four parent-report items (communication quality, compliance with family rules, and relationship quality with parents, relationship quality with other family), the series of factor analyses for parents clearly loaded onto one factor (N = 295 - 895). Communalities were high for each of the four items, with a range of .61 to .90, and component loadings ranged from .76 to .94. Across the measurement periods, eigenvalues ranged from 3.17 to 3.30 and the factor accounted for 77% to 82% of the variance. Reliabilities across measurement periods were moderate to high (a = .78 - .92). The items were therefore summed into a scale: *Youth Functioning in Family Scale, Parent-Report*. The factor analytically-derived scale has a range of 1-20, with high scores reflecting good functioning.

The second series of factor analyses used the youth-reported items pertaining to youth functioning within the family, at 5 measurement periods (admission, discharge, three months, six months, and 12 months-post discharge) (N = 137 - 973). The four items (communication quality, compliance, and relationship quality with parents, relationship quality with other family) loaded clearly onto one factor. Communalities were high for each of the 4 items, with a range of .44 to .88, and component loadings ranged from .54 to .92. Across the measurement periods, eigenvalues ranged from 2.46 to 3.37 and the factor accounted for 56% to 73% of the variance. Reliabilities across measurement periods were moderate to high (a=77 - .83). The items were therefore summed into a scale: *Youth Functioning in Family Scale, Youth Report*. The factor analytically-derived scale has a range of 1-20, with high scores reflecting good functioning.

Results

Response rates

Survey response rates for the study are noted in Figure 1. Response rates were high for parents and youth at admission and discharge. As is common in longitudinal survey studies, post-discharge response rates were lower. The mean post-discharge return rate for parents was 27% and for youth was 19%. The obtained post-discharge return rates are within the "norm" for survey-based research, as outlined by Sommer & Sommer (1991), who cite typical return rates ranging from 10% to 33%.

Changes in youth functioning in the family

The repeated measures ANOVA statistical test "drops" a participant's responses from the analysis if one or more surveys are missing (e.g., if person A did not submit a 3 month survey, the entire set of data is excluded from the statistic). In order to maximize the available data, the researchers made the decision to use only 3 of the 5 available time periods: admission, discharge, and 12 months post-discharge. Repeated measures ANOVAs were computed using the parent- and youth-reported scores on the *Youth Functioning in Family Scale*. For both analyses, the within-subjects variable, the variable of time was significant indicating a change in youth family functioning scores over time, Parent-report, $F(1, 1.88) = 347.11$, $p < .001$, $n^2 = .65$ and Youth-report $F\ (1, 1.82) = 143.61$, $p<.000$, $n^2=.539$. The linear and quadratic models also were significant, suggesting that the change over time could be described as both linear and curvilinear. The means of the parent-report and youth-report scales are presented in Figure 2. Examination of mean scores shows the curvilinear trend, specifically, family functioning scores were low at admission, improved substantially at discharge, and subsequently decreased slightly by 12 months after discharge. In addition, the linear trend is evident in the mean scores: one year after discharge, students' functioning in the family remains significantly better than it had been at admission.

Changes in youth academic functioning

Parents reported on two aspects of youth academic functioning: grade point average (i.e., 0=F, 1=D, 2=C, 3=B, 4=A) and high school credit status (i.e., 1 = More than 1 year behind, 2 = About one year behind, 3 = About 1 semester behind, 4 = On schedule, 5 = Ahead of schedule). Repeated measures ANOVAs were computed to investigate whether scores changed over time. Again, to maximize the available data only 3 time periods were used: admission, discharge, and 12 months post-discharge. For both analyses, the within-subjects variable, time, was significant, indicating that Credit Status and GPA changed over time, Credit Status, F (1, 1.95) = 21.02, $p<.001$, $n^2 =.137$; Grade Point Average, F (1, 1.9) = 96.15, $p<.001$, $n^2=.397$. Linear and quadratic models were significant for both analyses, suggesting that the change over time in Credit Status and GPA can be explained as both linear and curvilinear . Figure 3 shows mean scores for Credit Status and GPA. Examination of mean Grade Point Average and Credit Status scores at each time period indicates the curvilinear trend: students perform poorly at admission, improve substantially by discharge, then decline somewhat in the 12 months after discharge. The linear trend is evident in the scores at admission and 12 months after discharge: one year after discharge students' academic functioning remains significantly better than it had been at admission.

Conclusions

This was the first large-scale exploration of long-term academic and family outcomes for students in private residential programs. The 1027 adolescents and their parents were sampled from nine private residential programs that varied widely in their approach and services. This variety among participating programs is believed to be a general reflection of the broader industry.

According to both parents and youth, adolescent functioning in the family typically improved during treatment. Although some of the "gain" was lost one year after discharge, youth functioning in the family remained significantly better than it had been at the time of admission. A similar trend was found for academic functioning. Grade Point Average and high school credit status improved significantly during treatment. One year later, academic functioning declined slightly, but remained significantly better than it had been at the time of admission.

A number of issues warrant further research attention. First, like most outcome research in public residential treatment, this study did not use a control group. The lack of stronger and more valid experimental designs (e.g., control groups, random assignment to different conditions) in residential treatment outcome research is a common occurrence because of the practical and ethical constraints involved with 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 desirable to use more robust, experimental designs when possible. Curry (1991) has suggested some creative alternatives to classic experimental design which use within-program and across program comparison groups. His recommendations are practical and may be a reasonable "next step" in research designs. Private residential treatment research would also benefit from process-focused studies that attempt to attribute academic and family changes to specific components of the residential program (e.g., telephone therapy, parent visits, parent support groups, one-to-one instruction, computer-based instruction, tutoring). Attempts to tie academic and family therapy program components to outcomes would have profound implications for program development.

The data indicate that youth academic functioning and youth functioning within the family improve during residential care. Effort spent by care providers to target those areas seem to be fruitful. Positive outcomes, combined with the salience of family and academic functioning to youth overall functioning (recall Freud's "love" and "work") offer a strong rationale for promoting academic and family foci in private residential care.

The trends for academic and family functioning over time have some important implications for clinical care. Care providers, parents, and youth may benefit from knowing that the majority of youth experience a "dip" in their academic and family functioning after they leave the program. Such predictions may be used to guide the discharge decisions and aftercare planning. For example, it may be worth "setting the bar high" for discharge criteria as they pertain to how the youth functions in the family or how well the youth is gaining school credits. After youth discharge they are likely to experience a slight "dip" in those areas, so it seems prudent to schedule discharge after they have exceeded minimum criteria. In addition, it would be prudent for youth to seek academic and family services in the months after discharge to focus on maintaining and transferring gains made in the residential program. All too often youth leave programs believing their work is complete, when it may be more helpful for them to devote themselves to on-going, transition services. These implications have a common goal: to help youth learn better ways to approach family and school—"love" and "work".

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Figure 1. Parent and youth return rates at all measurement periods.

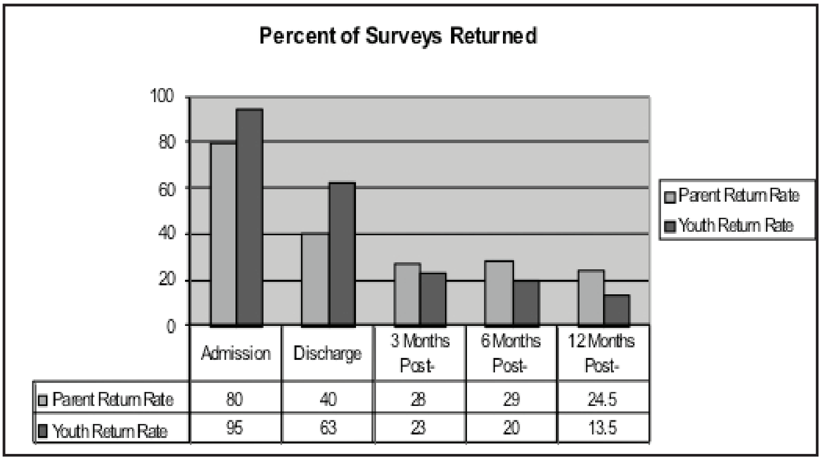


Figure 2. Mean scores for parent- and youth-reported data on the Youth Functioning within Family Scale.

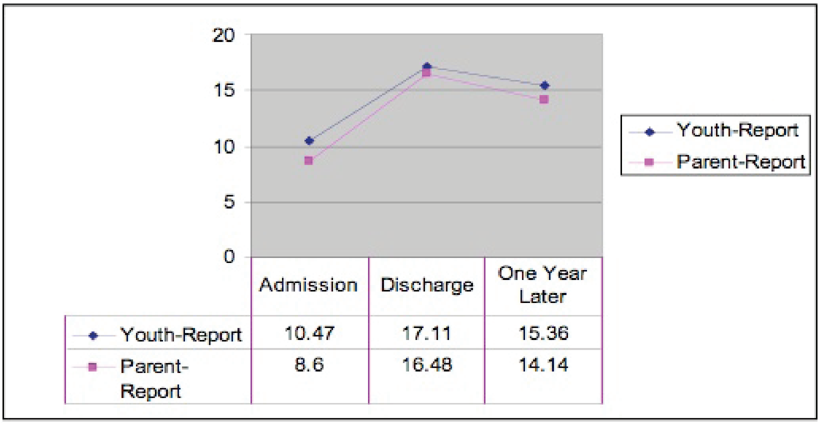
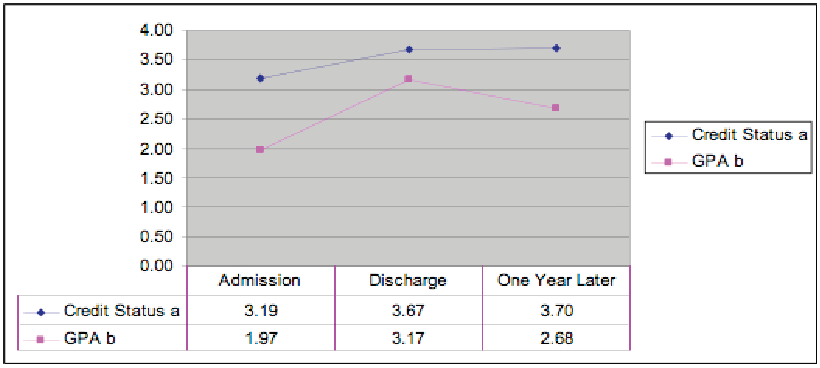


Figure 3. Mean scores for measures of youth academic functioning.



	Admission	Discharge	One Year Later
Credit Status a	3.19	3.67	3.70
GPA b	1.97	3.17	2.68

Note: [a] Scale 1-5, with 1 = More than 1 year behind, 2 = About one year behind, 3 = About 1 semester behind, 4 = On schedule, 5 = Ahead of schedule [b] Scale 0-4, with 0=F, 1=D, 2=C, 3=B, 4=A

Recognizing and Treating Reactive Attachment Disorder

Peter M. Lake, MD

Abstract

Reactive attachment disorder is one of the most complex childhood psychiatric disorders. It develops from disrupted or pathogenic caregiver relationships during birth to three years and can leave a child unable to establish healthy relationships with family, caregivers and peers. Early intervention is essential to prevent lifelong behaviors of developmentally inappropriate social relatedness. This article presents information on why RAD can be difficult to diagnose and provides key behaviors that can distinguish RAD from other childhood psychiatric disorders. The article also includes behavior management techniques for parents or caregivers of children with RAD, an overview of treatment methods, and the importance of having a treatment provider who specializes in childhood psychiatric disorders and is experienced in diagnosing and treating RAD.

Author Biography

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Introduction

Reactive attachment disorder (RAD) is a complex childhood psychiatric illness that begins in infancy or early childhood. While the exact cause is unknown, RAD is thought to stem from a disruption of the exclusive and unique relationship between a child and her/his primary caregiver.

As defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), children with RAD have developmentally inappropriate social relatedness as a result of pathogenic care. This negligent care typically includes at least one of the following: persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child's basic physical needs; or repeated changes of the child's primary caregiver that prevents the child's formation of stable attachments (APA, 1994). The DSM-IV further states that this inappropriate social relatedness is presented in one of two behaviors:

1. Inhibited RAD, where there is persistent failure to initiate and respond to most social interactions in a developmentally appropriate way and shows a pattern of excessively inhibited, hypervigilant, or highly ambivalent responses.
2. Disinhibited RAD, in which there is a pattern of diffuse attachments, indiscriminate sociability or a lack of selectivity in the choice of attachment figures (APA, 1994, p. 250).

RAD does not seem to favor a certain gender, race, nationality, or socioeconomic status. Evidence that children have problems with emotional attachment can surface even before their first birthday. Symptoms may include severe colic and/or feeding difficulties, failure to gain weight, detached or unresponsive behavior, and difficulty being comforted (Maldonado-Duran, Helmig, Lartigue, 2003).

Diagnostic Concerns

Diagnosing RAD is complicated because its behaviors can be similar to those associated with other childhood disorders, such as conduct disorder, oppositional defiant disorder, post-traumatic stress disorder and separation anxiety disorder. What differentiates RAD from these disorders is a history of attachment disruptions and grossly pathological care, as well a positive response to therapeutic intervention (APA, 1994).

No current studies of the frequency or prevalence of attachment disorders in children exist, and the estimated rate of occurrence varies by source. A position statement on RAD by the American Academy of Child & Adolescent Psychiatry (AACAP) states the condition "affect(s) a small number of children" (2002, p. 1). However, a Tulane University study of RAD among maltreated toddlers who had been removed from their parents and placed in foster care showed an occurrence rate of 38-40 percent. This same study also stated "… using categorical and continuous measures, both types of RAD (emotionally withdrawn/inhibited and indiscriminate/disinhibited) can be reliably identified in maltreated toddlers (Zeanah, et. al, 2004, p. 1).

In 2000, an American Academy of Pediatrics (AAP) Committee on Early Childhood and Adoption and Dependent Care stated "Greater numbers of young children with complicated, serious physical health, mental health, or developmental problems are entering foster care during the early years when brain growth is most active." (p. 1145). A report by the U.S. Department of Health & Human Services Administration for Children & Families (2005) showed that of the more than 523,000 children in foster care in 2003, 30 percent were between the ages of birth to five. The average length of stay within the foster system was 18 months, but the number of placements per child during that time was not listed.

The degree to which an interrupted caregiver relationship can affect a child's mental and physical development was demonstrated in a 1993 case study of Shannon, a four-year-old girl placed in temporary foster care by child protective services. Several children had died under mysterious circumstances while in the care of Shannon's mother.

Shannon exhibited mild delays in fine and gross motor skills, but her performance was most delayed in areas of language, self, and social relatedness. Her vocabulary was about 20 recognizable words and she could not follow simple verbal instructions. Shannon was not toilet trained and could not feed herself with a spoon. She was at the 15th percentile for height and the 10th percentile for weight. Affectively, she was anxious, depressed, and apathetic. As stipulated in DSM-IV, a response to therapeutic intervention is considered confirmatory evidence for the diagnosis of RAD. Once in a supportive setting, Shannon demonstrated both marked developmental and physical improvement. This response to treatment approaches like this aids in understanding how RAD differs from other disorders, and should continue to be a marker for the diagnosis (Richters & Volkmar, 1994).

Stages of RAD Development

The first stage of emotional development is *trust of caretaking*. This stage occurs during the first year of life, and during this time a child develops the ability to attach or bond emotionally to a primary caregiver. The infant feels a need (e.g., hunger, comfort) and enters a state of high arousal (e.g., crying). The caregiver meets the infant's needs (e.g., food, cuddling). This gratification relaxes the infant's tension and builds the infant's trust in, and attachment to, the caregiver. The necessary ingredients for development of basic trust and attachment during the first year are eye contact, food, motion, touch, verbal contact, emotional contact, and physical contact. (Erikson, 1985) writes, "The general state of trust … implies not only that one has learned to rely on the sameness and continuity of the outer providers, but also that one may trust oneself … and that one is able to consider oneself trustworthy..." (p. 248).

Around 36 months, a child who has experienced this consistent reassurance and emotional support with a primary caregiver begins to develop what psychologist Margaret Mahler terms *object constancy* (Mahler, Pine, and Bergman, 1975). As the child receives the mother's eye contact, smiling expressions, and mirroring, the child internalizes that the mother is reliable and a source of safety. This confidence that the mother will return increases the child's ability to tolerate separation from her and to interact with others in her absence. The result is that by the age of three or four years, children raised in a consistent, supportive environment are able to regulate their emotions and empathize with others (Mahler, Pine, and Bergman, 1975).

Conversely, children from birth to 24 months who have developed RAD due to abuse and/or neglect often experience unmet developmental needs. These children cannot self-soothe and lack impulse control and empathy for others. From about age five through the teen years, children with RAD may exhibit temper tantrums, mood swings, stealing, and self-injurious behavior, as well as coexisting

ADHD and depression. RAD children may also exhibit peculiar food habits, such as hoarding, sneaking or gorging food.

Early intervention is key to minimizing the long-term and permanent effects of abuse, neglect or multiple caregivers on a child's brain development. After the first several years of life, patterns of interaction with the world are formed, both psychologically and in the brain structure. These patterns become deeply ingrained and make it more difficult, although still possible, to improve a child's cognitive, emotional, and physical abilities.

Part of these difficulties are due to the fact that without consistent, positive nurturing, the limbic and cortex systems do not completely develop. The result is a neurological deficiency where behavior is regulated by survival and biological responses, and the child has little if any ability to regulate emotions, form attachments, and empathize with others. The child is emotionally stunted and, in severe cases, is physically underdeveloped.

A University of Wisconsin-Madison study of children adopted from Eastern European orphanages demonstrated that supportive and stimulating environments for infants and young children can lessen the adverse effects of prior negative environments. According to the study, the longer children lived with their adoptive families, the greater and continual the gains in attention, language skills, reasoning, sensory motor development, and reduction in attachment disorder symptoms (AACAP, 2000).

Supporting Parents of Children with RAD

Therapists should be nonjudgmental and supportive to parents who are lacking parenting skills or using parenting techniques that usually work well with typical children but are not effective when parenting a child dealing with an attachment disorder. The key is for therapists to encourage the parents' willingness to learn ways to be more responsive to and involved with their child.

With these parents, child therapy and relational therapy (parent-child) may be useful. Caregivers may struggle when disciplining a child while trying to foster the child's ability to relate and trust. The therapist needs to provide the parents with a positively oriented and developmentally appropriate behavioral management program, avoiding punishments that are inappropriate or unsuitable for a child with RAD. One example would be for the therapist to explain that prolonged timeouts are not to be used, because to a RAD child timeouts can feel like abandonment.

One example of the effective use of timeouts for children with RAD is to explain to parents that timeouts begin with clearly setting ground rules for them with the child before confrontations occur. Timeouts are to be short, perhaps only two minutes depending on the child's age, and never to exceed 15 minutes. The goal is for every timeout to be structured the same, whether handled by a parent, caregiver, or school staff member (e.g., the same length of time, same location when possible, and same contact with the adult such as seated side by side holding hands or looking at a book during the timeout). The goal is to focus on the behavior, not the child. This is done with concrete language using the word *this* and excludes the word *you*: "This two minute timeout is because yelling is hard to hear." or "This two minute timeout is because hitting hurts."

Children with RAD often possess a skewed sense of the meanings of words such as *trust*, *friendship,* and *responsibility*. It's important for the parent or caregiver to repeatedly define these words in the context of concrete examples, so the child can actually experience the meaning of the word with this new definition. As a result, children can translate the meaning of the word into a skill they can practice with others. For example, the concepts of:

1. Trust can be illustrated through the comparison to the library trusting a child to return books on time and in good condition;
2. Friendship can be demonstrated by making a birthday card for a sibling or classmate;
3. Responsibility can explained as dishes go in the sink when you are through eating.

Note that in the last example, the word *you* is used in a direct connection of the child and the child's behavior. This connection allows the child to begin changing his or her sense of identity and awareness of self-worth.

In parenting support groups, it also can be useful to explain to parents of children with RAD the importance of helping the child build new perceptions of adults as people who can be trusted and dependable. For example, stealing or hoarding food is common among children with RAD. Confronting this behavior can provide the current caregiver an opportunity to ask, "Can you trust me that I will prepare your dinner for you in one hour?" If the child says no, the parent can say, "I can understand how trusting is hard for you because your dad didn't give you dinner every night. You had to find your own meal. Can you sit with me for five minutes and trust me that in five minutes I will prepare you a snack while we wait one hour for dinner?"

Play therapy can also help parents learn how to let the child initiate play activity, select toys, or direct an art project. In working with adolescents, board games such as Life and Clue are useful in helping teens master frustration, tolerance, and self-control while also improving socialization skills. The teen's reaction to winning or losing, and their occasional attempts to change the rules (or even cheat) all are matters for therapeutic discussion (Webb, 1991).

Narrative therapy is useful with older children who are verbal, as the therapist can organize the experience into discussions illustrating cause and effect relationships. This approach helps older children verbalize feelings, distinguish between past and present, and build a sense of distance from the experience. Being able to think, rather than act, strengthens self-control.

Treatment Methods for RAD

Some treatments of RAD have been controversial. One recent method, called *attachment, holding or in-arms therapy*, maintain children suffering from RAD have no moral foundation and no empathy or remorse. They also lack the ability to give and receive love, lack cause and effect thinking, and may lack appropriate levels of self-control (yet are superficially charming and engaging). As such, traditional therapies – talk therapy and behavior modification—are ineffective with these children. Before they can learn to trust and bond with primary caregivers, attachment holding proponents believe children with RAD must be emptied of the rage they feel for caregivers that abandoned or abused them. Holding therapy can range from a mother rocking a child in her arms with forced eye contact to "rebirthing," a forced simulation of the birth process in which the child is wrapped in blankets. A typical holding involves the therapist provoking the child into a rage. Then the therapist holds the child, possibly pinning the child's arms back, to take away control. Advocates believe holding therapy encourages the child to go back in time and experience distress and anger while a loving adult remains in control.

However, the American Academy of Child & Adolescent Psychiatrists (AACAP) (2002) reports in a position statement on RAD that "There is no scientific evidence to support the effectiveness of such interventions" and adds that at least six documented child fatalities have occurred in the use of holding therapy. These deaths created a negative awareness of the therapy, which has since been forbidden in Massachusetts, New York, New Jersey, Pennsylvania, Texas and Utah.

The AACAP statement continues, "Children who exhibit signs of Reactive Attachment Disorder need a comprehensive psychiatric assessment and individualized treatment plan. Treatment of this complex disorder involves both the child and the family. *Without treatment, this condition can permanently affect a child's social and emotional development*" (emphasis added by author) (2002a, p. 1).

Pediatricians, social workers, and day care workers must be alert for evidence of neglectful parenting among infants and preschoolers, as early intervention, close coordination of services, and follow-up care are key to successful treatment outcomes. Once a parent is identified as being at high risk for neglect, parenting classes should be made available. Either a social worker or doctor should monitor and support the parent to insure the child's needs are being met.

As infancy and early ages can be the most fragile stages of child development, every effort should be made to either maintain children in their homes with social services support or to place them in a kinship community setting (as long as the child's safety can be assured). Placement with a relative provides the child the advantage of knowing his or her biologic roots and family identity. Whether the child's placement is in foster or kinship care, the key for a positive placement involving a child with RAD is a consistent, responsive caregiver.

Parents or caregivers of children with RAD must be prepared to spend a large amount of time and energy in learning and practicing supportive, nurturing, consistent, and limit-setting parenting techniques. One of the most complete resources for understanding attachment disorders is Siegel and Hartzell's *Parenting From the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive* (2003). The book explains:

1. How a typical brain develops from birth through adulthood.
2. How a traumatic event affects a child's brain development and the child's ability to form attachments.
3. Examples of positive interventions parents, caregivers and therapists can use to help a child repair current relationships and build positive new ones.
4. How these interventions can help people of any age learn to deal with their attachment issues and connect more effectively with others.

Treating Severe Cases of RAD

As children with RAD can be hyperactive, depressed, and even suicidal, it may be necessary to manage these symptoms with medication but always in combination with therapy. Options may include stimulants, anti-depressants, and mood stabilizers, but there are no medications specifically developed for RAD.

For children experiencing severe RAD, hospitalization may be necessary, especially when medical care is unable to establish clinical stability. If the hospital program is experienced with RAD, this treatment setting can enable the most thorough evaluation of both the child and the home environment. It also can maximize the opportunity for non-medication based interventions, (e.g., supportive limit setting and parent education). Hospital settings may enable coordination of social service support options and special education interventions. Once a child with RAD is stabilized and responding well to treatment, the next treatment step can be partial hospitalization.

Summary

In conclusion, RAD is one of the most complex and most misunderstood childhood psychiatric disorders. Early intervention and in-depth evaluation of both the child and home environment are vital for the best treatment outcomes. Parents and caregivers should be extremely diligent in interviewing potential treatment sources for their child. Treatment providers—whether child and adolescent psychiatrists, psychologists, pediatricians, or therapists—should be forthcoming in detailing their experience with the disorder and facilitate a connection to the most experienced treatment provider available.

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Differentiating Bipolar Disorder and Borderline Personality Disorder: Utilizing Effective Clinical Interviewing and the Treatment Environment to Assist with Diagnosis

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Abstract

Adolescent mood swings can create diagnostic confusion for clinicians. Adolescents presenting with mood fluctuations are often diagnosed with Bipolar Disorder. A closer review of the context for mood fluctuations as well as response to medication trials may suggest that mood fluctuations are consistent with a Borderline Personality Disorder diagnosis rather than a Bipolar diagnosis. This paper reviews criteria for these diagnoses as well as clinical indicators, supported by the work of Gunderson, et al. (2006), which can help clinicians make the proper diagnosis. Effective collaboration of an inpatient or residential interdisciplinary treatment team facilitates accurate diagnosis, as the integration of observational data across multiple settings can provide a more accurate analysis of mood variability.

Affective instability or reactivity is the *sine qua non* of borderline personality disorder (Koenigsberg, Harvey, Mitropoulou, Schmeidler, & Goodman, 2002). As clinicians we all know this. Yet this instability, which most of us would say we recognize, contributes to a great deal of difficulty in differentiating borderline personality disorder (BPD) from bipolar disorder (BD). Reactivity of mood leads to the affective instability, which is often equated to the mood swing of bipolar disorder. Reactivity may imply that the patient is unable to use cognitive skills to control or dampen affective response to a particular situation, hence the patient can present with a confusing picture of wildly fluctuating mood states. If the clinician is not careful, these presenting symptoms can easily lead to a diagnosis of BD.

A significant number of admissions to our adolescent inpatient unit come with a diagnosis of Bipolar II Disorder or Bipolar Disorder

NOS; and many leave, not with a diagnosis of BD but with a diagnosis of BPD. Many of these adolescents (initially mostly female, but now including more males) have held a BD diagnosis for at least a year prior to coming. Typically there has been a history of multiple medication trials, as is appropriate for treating bipolar disorder; and the focus of treatment has been medication, visits monthly or less frequently, with supportive therapy from an individual therapist. Sometimes as many as 20 medications have been tried over a two-year period in various combinations to help mood, depression, sleep and anxiety. Unfortunately, none of these clinical efforts have significantly improved the adolescents' level of functioning or prevented the need for hospitalization.

Bipolar II Disorder

One or more major depressive episodes with hypomanic episodes

- One or more major depressive episodes
- At least one hypomanic episode
- Never manic or mixed
- Not Schizoaffective or Schizophrenic
- Symptoms cause clinically significant distress

A variety of reasons are given for admission such as:

- *"the medications are not working",*
- *"he or she is still cutting on him/herself",*
- *"she can't make decisions",*
- *"she's still not functioning",*
- *"she still tries to kill herself and we never know when it is going to happen",*
- *"his moods are all over the place no matter what medicine he's on",*
- *"she's not improving", and*
- *"we just don't know what else to do".*

The majority of parents want clarity about what is "really" wrong with their youngster, and ask that we "please get the medications right." Getting the medications correct is an appropriate expectation with a diagnosis of any type of BD and, initially we wonder, along with parents, why the medications have not been more effective (or, in psychiatric jargon, why so many adolescents seem to have 'treatment resistant' forms of Bipolar Disorder?).

Most parents give similar versions of the trajectory of their youngster's illness. The following is a summary of a number of common scenarios, but does not cover all possible presentations:

Peter was 15 years old when he was admitted to the hospital. Peter's parents reported that Peter seemed happy enough in kindergarten and through seventh grade. There were periods of separation anxiety early in kindergarten, but with support from his parents he soon adjusted and did well. He had friends, was invited to parties, and seemed happy enough. When he was nine years old, the family moved to another city for mother's job. Peter had a hard time adjusting to his new school. He missed his old friends, and didn't seem to make new friends very easily. He used to play soccer at his old school, but at this school he was convinced the new kids didn't like him. His parents decided to let him quit the soccer team, and things seemed to settle. He had some periods of sadness and isolation, but in general, things went well. In eighth grade, he seemed to stumble badly. His grades fell markedly to the point where he was failing most of his subjects. He became angry and irritable and often argued with his parents about insignificant matters. He became intensely involved with a girlfriend, herself a depressed and unhappy person. All of his other tenuous friendships dropped away as Peter became convinced that most of his classmates hated him anyway. He was convinced they were talking about him all the time, so much so that he hated walking into class when the others were already seated. The girlfriend became the focus of his life. It seemed, as his parents described it, that the girlfriend took over his life. Many of their arguments centered around Peter's wanting to be with her when his parents felt he should be home doing homework. Peter felt better around his girlfriend and said she helped him "calm down"; and that when he was with her he didn't have all the mood "ups and downs" he complained so bitterly about *at home. He felt "lonely and empty" when he was away from her. At first, his parents did everything to keep them together, because at home Peter's irritability and moodiness were becoming harder to live with. If the girlfriend made him happy, they reasoned, why not let him spend time with her. However, this strategy soon backfired as Peter exhibited more and more need to be with his girlfriend. Peter's parents insisted he decrease his contact with her. He began to stay up all night, and his parents could hear him walking through the house. He claimed he couldn't sleep because he "couldn't shut his mind down." In the mornings he was too tired to go to school and slept until mid-afternoon. During a routine pediatrician's visit they discovered he had been cutting on himself quite regularly. His therapy visits began at that time but didn't seem to help. His parents felt less and less able to manage Peter, as "everything we say is the wrong thing" and "we never know what's going to upset him or make him start talking about suicide." Soon Peter, his moods and his irritability began to dominate the house. The arguments at home continued and became so explosive that the police had to be called. During one argument Peter threatened to kill his father and himself and was hospitalized. The medication trials began. He was diagnosed with Bipolar I Disorder, based on his parents' descriptions of his moodiness and explosiveness, and his description of not being able to control his moods. He was initially put on Depakote. Since then there have been three more acute hospitalizations, two for suicide attempts which followed arguments with his girlfriend, and one for severe self-harm. His medications have been changed many times: Lithium, Lamictal, Geodon, Risperdal, Zyprexa, and Effexor have all been tried, but side effect problems or lack of efficacy have plagued his medication management. He was admitted to our extended-stay hospital program directly from his third acute inpatient admission on a combination of Lamictal and Tegretol for mood stability, Paxil and Cymbalta for depression, Adderall to help give him energy in the morning, Abilify for reasons which were not clear at admission, Topamax to help counter weight gain caused by previous medication trials and Ambien CR for sleep. Drug screens done at each acute hospitalization were negative. No drug screens were done in outpatient treatment as Peter insisted he was not using.*

Peter's age might have caused some clinicians diagnostic confusion. The diagnostic criteria for BPD (see Table 1 below) state that symptoms begin in early adulthood, yet that is not the experience of many clinicians who treat adolescents (Bleiberg, 2001). Very often, a 12 or 14-year-old presenting with symptoms of BPD is diagnosed with BD because many clinicians believe BPD cannot be diagnosed under age 18. This unfortunate state of affairs denies adequate treatment for many adolescents. The situation is complicated by the developmental state of the adolescent brain. Recent research (Gogtay, Giedd, & Rappaport, 2002) indicates that the adolescent brain is undergoing intense and important developmental changes. This research further states that during adolescence the brain is developing the connections between the frontal lobes and the limbic system that will eventually enable the adolescent to better use thinking (frontal lobes) to manage emotions (limbic system). This research helps us understand the source of the "normal" irrationality and moodiness of adolescents. In normal development, the ability to manage emotions develops as the brain matures. Some amount of emotional variability is normal in the trajectories of many adolescent lives, but the adolescent's developmental path should not be stopped or stalled by their emotional variability. There may be more arguments at home, but daily fights are not the norm. Frequent recourse to the police to maintain order should give cause for concern, as should threats of suicide, failing grades, or any combination of behaviors which clearly stops the forward movement of development. In Peter's case, his developmental trajectory was clearly impacted by his symptoms.

Peter's story demonstrates some important areas of confusion in distinguishing BPD from BD. This is a youngster with wildly swinging erratic moods, intense irritability, irregular sleep, and problems with obsessive thought ideologies. If one pays attention purely to the mood symptom picture and not to the context where the symptoms are occurring, it is possible to misconstrue Peter's problems as some kind of mood swing disorder such as BD. However, a careful reading of DSM IV criteria will begin to cast doubt on the diagnosis. There is nothing in Peter's story indicating a manic episode or hypomanic episode as described by the DMS IV criteria. Frequent explosive arguments or temper tantrums are not 'equivalent' to manic or hypomanic episodes. The mood swings of mania and hypomania fit a particular descriptive pattern as described in DSM IV.

DSM IV Definition of Manic Episode

1. A distinct period of abnormal and persistently elevated expansive or irritable mood lasting one week (or any duration if inpatient is necessary)
2. During the period of mood disturbance 3 or more of the following symptoms have persisted and have been present to a significant degree
    - Increased self-esteem or grandiosity
    - Decreased need for sleep
    - Talkative or pressure to keep talking
    - Flight of ideas; racing thoughts
    - Distractibility
    - Increased goal directed activity/agitation
    - Excessive involvement in pleasurable activity
3. Symptoms don’t meet criteria for mixed episode
4. Severe enough to cause marked disturbance in occupational functioning/psychotic features/need IP
5. Not due to drug or antidepressants, ECT, light therapy etc

DSM IV Hypomanic Episode

1. Distinct period of persistently elevated expansive or irritable mood for four days
2. During period of mood disturbance, 3 or more of the following are present
    - Increased self esteem or grandiosity
    - Decreased need for sleep
    - Increased talking
    - Flight of ideas/racing thoughts
    - Distractibility
    - Increased goal directed behavior
    - Excessive involvement in pleasurable activity
3. Unequivocal change in functioning
4. Change observable by others
5. Not severe enough to cause marked impairment
6. Not due to medical problems, medications etc.

It does not behoove us as clinicians to label all fluctuations of mood as bipolarity when there is no surrounding history to support this diagnosis. Temper tantrums, rages or arguments are not manic episodes, even if they occur four or five times in a day. Emotional ups and downs related to relationships are not manic episodes or "some kind of bipolar mood swing" as they are sometimes loosely described. Astute clinicians will note that the diagnostic criteria for BPD provide further assistance in distinguishing between the two disorders: recurrent self harm is not a feature of BD, and identity disturbance and chronic feelings of emptiness are not a feature of BD (Gunderson, Weinberg, Daversa, Kueppenbender, & Zanarini, 2006).

While Peter stays awake at night and sleeps during the day, it is not "as if" he has a decreased need for sleep. Sleep shift problems should not be confused with the sleep difficulties of mania or hypomania. The poor sleep of the anxiety-driven patient who has trouble getting to sleep and staying asleep because they "can't stop thinking" should not be confused with the decreased need for sleep of the manic or hypomanic patient. "Worrying a lot" or "thinking too much," both very common in patients with anxiety, is not to be thought of as equivalent to the racing thoughts of mania. Many anxious people don't sleep well because they "can't shut my brain down." Peter's moods shift – but careful questioning of Peter and his parents might elicit the information that his mood shifts seem to be dependent on his environment (i.e., he is intolerable at home; but seems to do better if he is with his girlfriend, as long as that relationship is running smoothly). The intensity of Peter's relationship with his girlfriend bears noting, and the fluctuations of his relationship seem to parallel the fluctuations in Peter's moods. The mood fluctuations and irritability of interpersonal relationships are not to be confused with BD. Many patients with BPD have mood fluctuations that are triggered by interpersonal stressors, whereas the mood problems of BD are far less likely to be linked to environmental issues. BD is not situation dependent; the mood swings of BD occur across all domains, regardless of who is or is not present.

There also is the "interesting role" of paranoia in this case study. Peter's thoughts concerning his peers talking about him are often described as "paranoia," as if it is equivalent to the paranoia of schizophrenics and treated with antipsychotics. Further questioning of Peter's parents indicated that Zyprexa was started to treat just this symptom. But careful conversation with Peter will help the clinician to see that his thinking that others are talking about him is a derivative of his poor self esteem and not psychotic pathology. Because he thinks he is ugly, stupid, and not likeable, he thinks others also believe this and projects his insecurity onto those around him. As well as causing the distortions in thinking often referred to as "paranoia," these self esteem problems often drive the patients' mood swings. BPD patients may have shifts in mood occurring as rapidly as every hour, based on their constant monitoring of the environment, looking for slights which confirm their belief in their essential worthlessness. The perception that someone dislikes the patient can cause a precipitous drop in mood, while the perception 15 minutes later that someone admires the patient can raise them to giddy heights of pleasure. The BPD patient's use of cognitive distortions and other rigid thinking styles makes it difficult to exhibit the necessary flexibility in thinking that healthier people use to negotiate the world. Abandonment fears and self-esteem issues are not typically an integral part of BD. If a BD patient has relationship troubles, it is typically not chronic as with BPD, but is more likely to be related to inappropriate behavior that occurs during a manic episode. A great deal of the "acting out" of BPD can be construed as mania or hypomania. However, clinicians need to remind themselves of manic defenses which the BPD patient uses to ward off unwanted affect. Manic defenses should not be confused with episodes of mania.

Careful questioning of patient and parents can usually elicit information that can help distinguish BPD from BD. In Peter's case well meaning clinicians, with their focus on the symptom picture, did not ask questions about the context of Peter's life.

- *What about his relationships?*
- *How much time exactly did he spend with his girlfriend?*
- *What happened inside him when he was not with her?*
- *What does he think about when he is not with her?*
- *What events preceded each admission to the hospital?*
- *What does the patient think of him/herself?*
- *What does the patient think others think of him/her?*
- *Can he walk into school without worrying about what others are saying or thinking about him?*

DSM IV Borderline Personality Disorder

- Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
    - Frantic efforts to avoid abandonment
    - Pattern of unstable and intense interpersonal relationships
    - Identity disturbance
    - Impulsivity in at least two areas: sex, spending, substance use etc
    - Recurrent suicidal behavior, gestures, threats, self-mutilation
    - Affective instability due to marked reactivity of mood
    - Chronic feelings of emptiness
    - Inappropriate intense anger
    - Transient stress related paranoid ideation or severe dissociative symptoms

These are important questions that can help clarify the diagnosis because they may help treating clinicians begin to see that how the patient sees him/herself in the world may be contributing to his/her emotional difficulties. The questions may not always provide the answers, but they need to be asked in cases that are not responding to adequate treatment as usual for BD. Most adolescents do not think of themselves as responsible for managing either their thinking or their emotions. To the question about what events precede each hospital admission, the answer may well be, “Nothing happened. I just all of a sudden got suicidal.” Yet a careful chronological history of which events happened when will clarify the picture. Today’s adolescents, taught by the culture to focus almost exclusively on their (and others) electronic accoutrements and external appearances, are not at all used to plumbing their inner depths in order to understand themselves. They may genuinely not make a link between an event and their response. More importantly, without careful and thoughtful questions, the therapist or parent may not know that the adolescent is totally different with friends (e.g., happy, laughing, talkative, eating well) as compared to being belligerent and explosive at home. The therapist may not know that the symptoms being treated exist only at home and never show up in a setting where the parents are absent. The therapist may not know that the parents have learned to manage the adolescent by buying or doing whatever the adolescent wants (e.g., that their fear of 'causing' another suicide attempt is so strong they will do anything to avoid it). The therapist may interpret the statement, "I feel better when I'm buying things" as evidence of mania with impulsive shopping, not realizing that the intense activity is simply a method of managing anxiety. Parents having to "walk on eggshells" around the adolescent, not knowing what will "set him/her off"; and if not carefully examined, may be interpreted as signs of the mood instability of bipolar disorder.

In addition to careful questioning of patients and their parents to elicit helpful information in differentiating BPD from BD, observations within the treatment environment are invaluable in making an accurate diagnosis. The treatment environment of an inpatient or residential setting is often referred to as milieu or a therapeutic community. One of the hallmarks of an effective therapeutic community is that it provides life-like situations where difficulties encountered outside the treatment setting are experienced and opportunities present themselves for managing these difficulties in a healthy manner (Kennard, 2004). Therefore, within these settings, clinical symptoms are observed and can be understood within the context of the environment.

Observations within the treatment environment that would support a BD diagnosis include: (a) observable mood shifts unrelated to interpersonal dynamics and (b) random mood shifts and complaints about thinking and cognition. Mood and cognition problems show up in group settings as well as one-on-one interactions; during structured activities as well as during leisure activities. Patients will often report a sense of being out of control or "being changed' inside.

In contrast, observations supporting a BPD diagnosis are significantly related to interpersonal difficulties. These adolescents engage in many more discussions about relationships (e.g., who does or does not like them). Program staff find themselves implementing interventions to manage interpersonal problems for these patients. Mood shifts are apparent, but are presented as clearly linked to interpersonal events or to the patient's interpretation of the event. Incidents of self harm are common as are concerns with body image. Exacerbation of anxiety is typically present and can be understood as related to patients becoming overwhelmed by interpersonal difficulties.

It is therefore critical that the treatment team work collaboratively in gathering observational data and clarifying diagnoses. Using data from effective clinical interviewing and behavioral observation, the team can come to a more accurate understanding of patients' difficulties. Our experience has been that once diagnosis has been clarified and shared with patients and parents (providing examples of observations within the treatment setting which support the diagnosis), they report a sense of relief in finally 'understanding' what really is going on and can engage in an effective treatment course.

The clinician should always consider co-morbid diagnoses. ADHD, anxiety disorders, Major Depressive Disorder (MAD), PTSD and Substance Use Disorder (SUD) all may co-occur with BPD. In Peter's case random urine drug screens would have been helpful. He had been using both marijuana and cocaine with his girlfriend, and even more intensely when he was away from her. He said the drugs helped him feel less lonely and empty. BPD and BD do co-occur, but co-occurrence of BPD with SUD, PTSD, and MAD are much more common. Rapid cycling BD is often a common diagnosis given to BPD patients, and can be seen as an attempt to quantify the rapid shifts in mood of the BPD patient. Rapid cycling BD, ultra rapid cycling BD, and ultra-ultra rapid cycling BD occur, but are not common enough to justify the frequency with which they seem to appear as diagnoses. If BD and BPD co-occur, treating the BD does not alter the course of BPD and does not change the need to use therapy models for treatment of BPD. In other words, while there is significant evidence for the efficacy of mood stabilizers in treating BD, there is much less evidence for the efficacy of mood stabilizers in BPD. One should also remember that in the attempt to use medications for BPD, suicide attempts of BPD patients are most often due to affective instability and not to depressions; hence the failure of antidepressants in preventing the troubling and dangerous swings into suicidal behaviors. A final point about trauma and BPD is that while there is an association between BPD and trauma, clinicians should not assume that there has to be trauma for BPD to be diagnosed. In our setting, a lack of parental fit is often seen as a common precursor. For example, a very emotionally intense, anxious child born to very pragmatic parents may live in what has been referred to as a non-validating environment. Because the child's anxious responses would not make sense to these pragmatic parents, they may unwittingly say or do things that invalidate the child's experience of the world.

There has been a regrettable tendency in the field to broaden and stretch criteria to make them as inclusive as possible. Some of this may be due to insurance pressures. It has been reported that between 1990 and 2000 the proportion of discharges with a principal diagnosis of BD increased from 2.9% to 15.1% (Case & Olfson, 2007). As well as reflecting a greater awareness of BD in the adolescent population, a significant portion of the increase may reflect the greater willingness of third party payers to reimburse for a diagnosis of BD, but not for a diagnosis of BPD (which is not viewed as being a 'biological illness' and not amenable to treatment with medications). Peter's story also exemplified why it is important to distinguish BPD from BD – the treatment modalities are different. BPD treatment relies on DBT, mentalizing therapies, transference-based therapies, and supportive psychotherapy; with medications possibly having a supportive role. The treatment of BD is primarily medication based with psychotherapy having a supportive role.

An accurate diagnosis is crucial to directing appropriate and effective treatment. To prescribe medications when they are not indicated is as troubling as withholding medications when they are indicated. The effective use of psychosocial interventions (such as CBT and DBT) can be invaluable to patients troubled by BPD. The authors hope that the contents of this paper will assist readers in making clinical decisions which truly help patients improve their lives.

Points in Differential Diagnosis	
BPD	**BD**
1. Mood shifts triggered by interpersonal difficulties	1. Mood changes are autonomous
2. Self injuring behavior is common	2. Self injuring behavior is rare
3. Problems with self esteem and identity	3. Consistent sense of self
4. Use of defensive splitting interferes with interpersonal relationships	4. Relationship problems related to inconsistent behavior in the context of mood episodes

Adapted from G Gabbard (personal communication, October 2006)

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Equal Experts: Peer Reflecting Teams In Residential Group Therapy

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Abstract

The postmodern concept of the reflecting team was developed to increase the freedom of the dialogue of change by including many alternative narratives for consideration. The use of reflecting teams can be expanded to a new level in a residential group environment by using the highly valued perspectives of peers in the group therapy environment. Peer reflecting teams generate a unique development in the dialogue of change due to the importance of peer validation and support as well as the value of peer perspective among teenagers. A look at the evolution of reflecting team theory and use is followed with descriptions of a peer reflecting team model used at Telos Residential Treatment. Case examples are also provided. The effects and application of this model is evaluated, including the apparent positive impact on peer change connected with mutual openness and empathy. Current implications are discussed for future research directions.

Equal Experts:
Peer Reflecting Teams In Residential Group Therapy

The implementation of reflecting teams in the therapeutic process was developed for the purpose of enhancing the dialogue of change through the inclusion of additional alternative narratives. By using the highly valued perspectives of peers in group therapy, this team-oriented intervention can provide valuable therapeutic information in a residential environment. Peer reflecting teams can generate unique developments in the dialogue of change based on the importance of peer validation and support, as well as providing the value of peer perspectives among teenagers. By appropriately putting both the individual and the peer group at appropriate levels of expertise, this intervention can build increased diversity in possible narratives as well as provide further credibility to the client's perspective. This mutual level of assigned credibility has the potential to open up possibilities in the dialogue that may not be attainable merely by having the classic panel of professional therapists as the only source from which to draw alternative narratives.

History And Evolution of the Reflecting Team Method

The history of reflecting teams as an intervention can be connected to a theoretical shift in the therapeutic field to a postmodern perspective. In his review of the theoretical underpinnings of postmodern influenced therapy, Sprenkle (1995) summarized the process as a shift from absolute, scientific, or societal truths to a respect for personal perspective and meaning. He further describes the progression of therapy from a hierarchical modality to a collaborative enterprise where the therapist and client offer each of their unique perspectives to the process of defining the new realities where clients can operate. One method used to accomplish this is the reflecting team.

In the reflecting team method, a panel of therapists typically listens to clients working with a primary therapist through a two-way mirror (or an outside circle of chairs). Following an appropriate and often predetermined period of time, the positions are reversed where clients view and consider the discourse generated by the professionals as they reflect on what they observed in the therapy session. This process provides the inclusion and introduction of multiple theories or perspectives of reality, providing the client with latitude to construct a narrative that holds personal meaning (Sprenkle, 1995).

According to Andersen (1991), the primary theorist in the development of the reflecting team method, "reflecting teams evolved from the idea that therapeutic sessions are a process that can become stuck." (p. 9). He goes on to assert that the language used with a client is imperative in the presentation of alternative perspectives since it shapes the meaning of the session and the relationship, including whether or not they are stuck.

The use of reflecting teams to communicate the existence of multiple perspectives is often an effective means of moving the individual or family out of a stuck position (Russell and Arthur, 2000). In order to maintain a productive session, members of the reflecting team are encouraged to focus on constructive statements that add to, and deepen, the multiple perspectives that may exist for the clients' reality. This is often found to be supportive, which often engenders an increased level of collaboration (Russell and Arthur, 2000).

A study of reflecting teams used to help clients coping with parental illness demonstrated that, by interacting with the personal experiences and emotional reactions of other professionals and families, therapists were able to remain more grounded by understanding alternative coping strategies (Altchuler, 1999). In a study of the concurrent use of reflecting teams and narrative therapy techniques, it was further observed that the process of externalization of the problem, central to the reconstruction of the family narrative, is encouraged by the presence of multiple perspectives, suggestions, and alternatives. This is especially true when these perspectives support all of the members of the client system (O'Connor, Davis, Meakes, Pickering, and Schuman, 2004). All of these findings indicate the benefits of using the reflecting team to explore new possibilities with stuck clients.

Incorporating Reflecting Teams Into Other Therapeutic Modalities

The use of reflecting teams has evolved through its application with other modalities. The reflecting team has been applied within a solution-focused modality incorporating a general set of guidelines (Johnson, Waters, Webster, and Goldman, 1997). These guidelines included avoiding negativity, using tentative language, balancing comments equally between team members, encouraging inter-team member interaction, encouraging humor, and developing an atmosphere of inclusiveness. Researchers found that by using these rules they could set up a specific therapeutic environment with a community structure where specific messages were constructed to help families reach a solution focused perspective. In the study, clients reported feeling increasingly validated as other therapists recognized their strengths and resources (Johnson et al, 1997).

Reflecting teams have also been used in multiple contexts. Griffith and Frieden (2000) discussed the benefits of reflective thinking, fostered in the team discussion, in the cultivation and assessment of counselor skills during training seminars. This team approach enabled therapists to evaluate a variety of beliefs or positions that may be contributing to the therapeutic process finding itself in a "stuck" or unproductive state. The model has also been adapted to group therapy through the construction two therapeutic groups, the working group, and the reflecting team. In this structure group members are able to gain access to multiple perspectives and apply those perspectives to the group process (Griffith & Frieden, 2000). In treatment of women with eating disorders, reflecting teams have also been used to facilitate a productive environment for therapy group members (Russell et al., 2000). In this way, group patterns of interaction preventing progress were addressed and further risk taking among group members was encouraged. This culminated in a safe environment that engendered higher levels of connectedness (Russell et al., 2000).

In a recent article, Faddis and Bettmann (2006) demonstrated the use of the reflecting team model in a wilderness based treatment setting that used a family sculpture intervention with a team that incorporated a combination of client families, staff, and peers into the team in combination with a therapist. They noted the risks of using non-professionals in the reflecting team, including a lack of predictability due to emotional reactivity and the intrusion of other team member's personal issues. In order to maintain a coherent therapeutic direction, they further delineated a highly structured progression of topic specific discussions. The researchers indicated anecdotal evidence that this is an effective form of treatment as well as the need to further identify empirical evidence of its success (Faddis et al., 2006). The evolution of the reflecting team concept has reached new and promising directions in the quest to incorporate the perspectives of experts in life's experiences, regardless of their professional status.

The Use of Peer Reflecting Teams: A Case Study at Telos Residential Treatment Center

A reflecting team model has been applied at Telos Residential Treatment, LLC similar to the model used at the wilderness program described by Faddis et al., 2006. This model utilizes non-professional team members differently in a few specific ways. Rather than having a combination with other therapeutic interventions (e.g., the family sculpture), the concept of the reflecting team is applied independent from other modalities. It can be used in several topic specific and open topic group therapy sessions, further demonstrating its versatility. There also is no specific layout or progression of sessions applied for a single therapeutic purpose. Instead, the therapists at Telos use the reflecting team intervention as a means of creating dialogue in any group that becomes stuck and may benefit from tapping the resource of peer perspectives and mutual validation. This model has led to an outpouring of creative and collaborative innovation in the group therapy milieu.

Open Method

The primary application of this reflecting team model in group therapy has an open and fluid structure. A licensed therapist serves as the facilitator of the group. The therapist divides the clients (in this case, boys ages 13-17) into two separate groups. The group members are then given a topic of discussion related to the purpose of the group (e.g., self-esteem, problem solving, addictions, stress management). The therapist then indicates for one group to discuss the topic while the other group silently observes. After a given period of time the therapist calls for a switch to be made in the roles of the two groups, where the previously silent group discusses what they heard and their impressions and thoughts. Over the course of the group, usually lasting 90 minutes, the two groups switch roles several times as the concepts and ideas gradually culminate into a rich dialogue based on collaborative peer feedback and experience.

Rules for the group are monitored by the facilitating therapist include: (1) no cross talk (verbal or non-verbal) between the separate groups, (2) a focus on positive comments and validation, and (3) a focus on the topic of discussion rather than on the individuals in either group. These rules are intended to create an emotionally safe environment where otherwise unexpressed ideas and perspectives can find a voice and evaluation through peer feedback from which all of the group members can benefit.

The following case example of an open group discussing personal motivation illustrates the effects of using a peer reflecting team to generate an expanded dialogue through peer validation and expression.

This group consisted of two teams with three group members each. The therapist facilitated with direct questions for members of both teams to encourage further reflection. The groups switched between roles of active and observing at intervals of approximately ten minutes. Names have been altered in the script to protect client confidentiality.

During the first ten minutes "David" indicated no desire to participate due to his unwillingness in the group that day. While "Ricky" encouraged him, David only provided a superficial response to the topic of motivation, claiming that his only motivation was to get out of treatment. Upon reflection, the second team discussed their thoughts about this dialogue. Two of the team members wondered why "David" did not want to participate. "Jerry" validated "Ricky" regarding his desire to leave treatment (citing personal experience), but then discussed the need for more internalized motivation in order to successfully complete treatment as well as gain meaningful experiences through the process of change. After multiple reflections, "David" had participated in the group in order to explain his feeling of only being in the group to avoid a consequence. "Ricky" was able to expand upon his motivation by first indicating a non-caring attitude about anything except being alive, and then through recognition of peer concern and indirect discussion about his desire to have as much time as possible to live his life, he was able to identify a core fear of non-existence.

Family Groups

During family intensive weekends (held five times a year at Telos), this same method has been applied in groups comprised of several families coping with a similar issue (e.g., adoption). The same format as the open group has been applied in this milieu, however, format varies slightly between therapists. Variations have included an introductory framework designed to help the families hear new ways of thinking about their situation, as well as a 15 minute debriefing at the end of the session used by the group members to reflect on the impact of the session.

An example of a common variation of family reflecting teams can be evaluated from Family Days group that took place in November 2006. Two therapists facilitated this group and divided it into two teams, one comprised of Telos students and one comprised of those student's parents. They were given the topic of parent-child relationships. The following script includes changed names to protect confidentiality.

The students began the discussion and "Jerry" brought up the topic of not feeling acceptable to his parents. Several of the other boys responded and discussed their perspective on why their parents did not accept them because they did not like their behavior. One of them, "Jason," was not speaking with his parents at the time and complained vociferously about their having sent him here only because they have a lot of money which they had apparently hid from him. The parents were able to reflect upon the statements of the boys and offer support and validation to each other as well as comment on the boys' perspectives. "Jerry's" parents were able to recognize that their desire to follow a high set of standards had left him feeling unacceptable. At the same time other parents validated them in their need to have expectations of appropriate behavior and interaction as well as tolerance for individual differences. When the boys had the floor again, "Jerry" was able to recognize his parents' validation and also began moderating some of the other boys' aggressiveness.

"Jason's" parents were able to express surprise about the financial issue and revealed to the other parents that they were receiving state funding and could not afford treatment, but cared so much for their son that they had exhausted every avenue. They received a lot of validation from other parents who were in the same financial situation. As the group switched roles multiple times over a two hour period, "Jason" was able to soften toward his parents and stated that he had gained a lot of empathy for his parents' decision by listening to the parent group discussion.

The results of these groups were surveyed along with other aspects of the Family Days experience in November of 2006. Nineteen percent (19%) of the families attending participated in the group. With all participants responding to the survey, 100% indicated that they "strongly agreed" (the highest marks available) that the group was useful. Comments on the survey included positive responses from families such as feeling more open to share, as well as feeling validated, safe, and supported. Furthermore, it appeared to the facilitating therapist that discussing difficult topics in this manner led some families to indicate an increased ability to verbalize and process their feelings and thoughts. Through this method inter-family empathy seemed to be enhanced by creating a support network throughout the treatment process. Another benefit also observed by facilitating therapists was a release from old patterns of thinking due to the introduction of multiple narratives from other parents, boys, and staff members present.

Role Plays

One final variation of the reflecting team being used is the technique of role play. In this model the therapist facilitates and guides students in specific roles found in a classic reflecting team. One student acts as self or client while another student has a conversation with him about a group-relevant issue (e.g., esteem, stress management). The rest of the peers in the group are assigned the role of the reflecting team and are coached in their effort to change their perspectives to assist the therapeutic process.

In this process, the boys in the group use the open discussion and freedom of perspective gained by the reflecting team model to expand their perspectives. The issue can be seen from another vantage point, (in this case, understanding how therapists might see such an issue and render assistance). This model often entails a struggle for the students to fill the role of the therapist, which presents a slow start to the group process. However, once the students have gained a level of comfort in their assumed roles, they have been able to demonstrate a higher level of processing skills. In turn, this has encouraged a proliferation of questioning by peers who possess unique perspectives on the situation. Through this process, information can be gathered and processed that may have otherwise remained hidden. Furthermore, this variation offers a new perspective that could potentially help the student gain increased collaboration in the therapeutic alliance by seeing the situation from a therapist's point of view

Future Directions

The peer reflecting team appears to create a unique dialogue among peers where new and valuable information can be revealed and processed through appropriate guidance by a therapist. The opportunity for a teenager to be exposed to peer perspectives, which may certainly be of equal, if not more, value than the perspectives of authority figures, appears to be extremely helpful. Furthermore, the freedom of the format and the empowerment of each member of the group seem to encourage mutual openness and empathy. As seen at Telos, there are strong indications that this modality is influential of positive peer driven change.

Further research is needed to determine the empirical reality of these apparent benefits. As innovations in therapeutic approaches continue to be employed in the industry, they need to be further assessed and validated. The clientele served will benefit from the continued application of effective change-promoting interventions. The peer reflecting team model seems to be one such promising intervention.

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Experience, Strength and Hope: One Mother and Daughter's Journey Through Addiction and Recovery

Julianna Bissette and Anna Bissette

Author Biographies: Pseudonyms are used for authors to maintain their anonymity due to the personal nature of the article.

Julianna Bissette has two daughters and is a college professor. She worked for many years as leader in outdoor programs. Her former careers include outdoor leadership, human resource development, and recreational therapy. She enjoys kayaking, gardening, movies, hiking, attending twelve step program meetings, and playing with her two dogs.

Anna Bissette is a freshman in college, intending to dual major in Art and English. She works on campus and attends twelve step meetings every day. She enjoys hanging out with friends, movies, running, writing and drawing. She loves all animals, even snakes.

Abstract

This story is an exchange between a mother and a daughter during their three-year experience in the recovery system. The purpose of this article is to help others understand the mindset of one parent and one adolescent at different stages of recovery. The mother's mindset progresses from one of trying to find solutions for her daughter to learning how to take a supporting role. The daughter's mindset changes from one of hopelessness to taking responsibility for her recovery. The authors believe the sharing of their experiences, strength, and hope can benefit parents and treatment professionals by providing insight into feelings and lessons of their experience.

Introduction

Mother: Early in 2004 my daughter made it known that she was depressed and cutting. Three years later she was discharged from a long-term stay at an adolescent residential treatment program. Today she is reasonably happy, employed, in college, and active in the community. In addition to depression, she also now knows that she is an addict. Not every child entering a therapeutic school and program is an addict, but many are. For my daughter, the support of a residential program that included twelve-step work was key to her recovery. The purpose of this paper is to share our experience hoping that it will help others. Rest assured that our experiences are not unique—there are thousands of others living their own versions of this story. Names, faces, and events are different, but key elements are the same. Whether you are a child, parent, or treatment professional, it is our hope that you find some beneficial information and strength in these pages.

As I look back, I realize that if "I knew then what I know now" I might have done things differently. As a parent (and human being) I now know I am not perfect, and I am destined to make mistakes. However, I take comfort in knowing that I did the best I could under the circumstances, even though hindsight indicates different actions would have perhaps been better. When my child was in crisis and courting death, my best didn't seem nearly good enough. I wanted to fix things for my daughter—to find the "magic bullet cure" that would make all her problems go away. I know now that no such thing exists, and when I try to fix things for her I get in the way of her recovery. I also know what makes me a good mother is striving, engaging, making mistakes, learning from them, adjusting, and doing the best I can each day for my children and myself. Words cannot express how grateful and proud I am that my daughter is now living her life on her own terms and wants to share in this dialog.

Daughter: I am co-authoring this article with my mother because I think it will be helpful to treatment professionals and parents of troubled and unmanageable youth to hear my story. The main point I would like people to understand is that I am the one responsible for my recovery, and the most helpful thing my mother has done for me in my recovery was sending me to treatment and providing an environment for me where I could do what I needed to do to recover. Changing my ways was a decision I had to make myself. I often see parents trying to control their children in hopes that they are keeping them safe. In my experience, there has been nothing anyone could do for me to keep me safe no matter how controlled I was, unless *I* was willing to live healthfully. I hope that this article is helpful to those who read it and brings more understanding into the mindset of an addicted teenager.

Where We Started

Mother: This story doesn't really begin at any one point in time because for years there were warning signs that my daughter was deeply unhappy. The starting point for this story is January 2004.

What does a mother say when her daughter tells you she is depressed? This memorable conversation took place while I was driving my daughter to Best Buy to purchase a CD that she "had to have now." I had been out of town on a business trip for about a week so I was trying to make up some lost mother/daughter time. This may be familiar to some parents who tried, like me, to make up for their child's unhappiness by buying them things they wanted.

My daughter told me she was depressed. I tried to make light of the situation by saying something like, "Everyone gets sad sometimes," but then she pulled up the sleeve of her sweatshirt and exposed fresh scars on her arm, stating: "But not everyone does this." This was my point of awakening. A voice in my head said, "Something is seriously wrong." I felt panicked. My child was cutting up her arm and I hadn't known about it. As her mother I felt helpless and responsible.

What was I to do? I felt responsible for finding a solution. I started at the doctor's office, which was the only place I could think of. What she got there was a tetanus shot, a referral to a psychiatrist, and a lecture about how good her life really was.

Daughter: At this point in my life I never considered the way my mother felt. I knew she wouldn't get me into trouble or hold me accountable, so that is why I chose to tell her I was hurting myself and I needed help.

Feelings of alienation, self-hatred, depression, anger, and resentment had brought me to a point where I could not will myself into healthy thinking. I did not want help from anyone—I just wanted to quit feeling pain. I told my mother I was hurting because I felt like I would kill myself if I continued to keep my depression a secret. I am not sure where my downhill path began or where my dark moods came from. No matter how good my environment was, and how many people reached out to me, I chose to isolate myself and dwell in emotional pain. I entered a self-destructive mindset where I idolized addiction and mental illness. All of this happened before I picked up drugs. I was sure I wanted to destroy my life and make the biggest bang possible on my way out. Without regret, I chose the consequences I had coming for my behaviors. I could not find emotional relief because I was unwilling to change.

The Rocky Road

Mother: Our “rocky road” covers over a year and a half of trials and failures in the treatment system before my daughter was admitted to her second residential treatment program. For her, treatment consisted of outpatient treatment from psychiatrists and therapists, five hospitalizations in acute psychiatric units, and a four-month residential treatment stay. I now know that it’s not unusual for families of children with addictions to follow a similarly complex and painful path before finding appropriate treatment.

Outpatient treatment for my daughter started with regular visits to a psychiatrist and therapist specializing in adolescents and children with psychiatric problems. The doctor and therapist were the best in the region, and they used everything in their extensive toolbox to help. My daughter’s diagnosis changed from severe depression to bipolar disorder. I now believe her bipolar disorder diagnosis to be “over-diagnosed.” I have heard of many others who, like her, were diagnosed with bipolar subsequent to depression because of manic reactions to antidepressant medications. During these months it seemed as though everyone was trying to help her, but none of the “helping persons” or I stopped to ask how much she was invested in helping herself. We tried many different combinations of medications and therapeutic support. I felt like we were looking for *the* medication or therapeutic technique that would make her pain go away. Nothing worked, but that didn’t keep me from thinking and hoping that it would. This time of medication trials was very frustrating and emotionally painful. For me, it was a cycle of hope and despair. Hope each time a new medication was prescribed, and despair when it didn’t work. The side effects were debilitating and preceded several hospitalizations. The medication trials didn’t have any guarantees or end point. That’s just how it was. As I understand psychiatric medication today it seems as much of an “art” as it is a “science.” There are no specific answers. Treatment professionals searched for the right combination for what seemed like an eternity. In hindsight, I believe there were some organic bases to my daughter’s difficulties, but nothing medication could have fixed. Meanwhile my daughter started using drugs and she became worse instead of better.

My daughter’s first referral to an acute inpatient psychiatric hospital came as a complete surprise to me. It was a new stage of crisis. It tore at my heart the first time I left her at a psychiatric hospital. Later it became a standard part of her treatment routine. Somewhere during this time she started smoking marijuana, using alcohol, and stealing any narcotics she could get her hands on. I knew some of what was going on, as did her treatment professionals, but she said it made her feel better. I was complicit. All I wanted was for her to feel better. I was manipulated (as were treatment professionals) because we all knew she was using, but we were powerless to stop it. I was in denial about how bad her drug use was, and I hoped she would stop using drugs once she felt better. I now know that this was a false hope. As a parent, I now believe that if you know your child is using some drugs, in reality they are probably using a lot more than you think.

Daughter: When I started receiving treatment. I was too ashamed of myself to be honest about my reasons for being sick. Outpatient therapists and psychiatrists were incapable of holding me accountable and made a very small effort to call me out on all of my deceptions. My mother continued to enable me in all of my unhealthy behaviors. I began to resent her for her constant involvement in my life. I thought I was completely independent and did not need her. The reality was that I was irresponsible, immature, scared, desperate, lonely, and self-pitying (I was the last person who wanted to see *that*). My drug use started when I manipulated my parents into letting me drink. I believed that psychiatric medications would be the ultimate cure for my problems. From prescribed medications I progressed to illegal substances. I thought I had finally found the solution to my unhappiness regardless of the warnings I received from counselors, institutions, friends, and family. Because I was not using “hard drugs,” I didn’t think I was an addict. I was so insecure I thought that the worse my behavior became the more people would think I was cool.

I quickly got to a point where I could not function when I was not high. I manipulated my mother and therapists to let me have drugs. However, there were not enough drugs to fill up the emptiness inside of me. I still believed that I could find a way to successfully get high.

Mother: Around Christmas when my daughter was hospitalized for the fourth time, it became clear that she was too much of a danger to herself to live at home. She needed more support than outpatient treatment could provide. By this time I was incredibly frustrated and felt helpless. With all the resources I had at my disposal (i.e., education, experts, medical insurance), how could I not help my daughter get better? I asked, "Where should I send her for treatment?" No one could give me a specific answer. Her helping professionals had some ideas, but little time to support the process of selecting a facility. It was a difficult position to be in. My daughter was in the hospital and needed to transfer to a residential program, but there was little time. To me, she was in eminent danger and she had to go somewhere NOW. There were so many considerations: proximity, insurance, diagnosis and age, accreditations, and do they have beds and will they admit her? What I didn't know then was that treatment facilities differ considerably, and at the time I didn't know what questions to ask. Some treatment programs are good, and many are not. Some are a good match for adolescents, and others are not. The first question I should have been asking is, "Are they helping adolescents with issues like she has?" Now I would never recommend sending a child anywhere without documentation of treatment plans, family involvement, documentation of outcomes, and references from other parents. At the time, I didn't feel I had enough time or even knew what questions to ask (see the conclusion of this article for more information on questions to ask). The first treatment center she went to did help in some ways. She did not use drugs during that time. She did achieve the minimal level of her treatment goals. Yet I had a nagging feeling during this four-month period that she wasn't really getting better. Our family was only peripherally involved in her first treatment program.

At this point I still didn't realize that my daughter was not trying to help herself. Neither this treatment facility (not a very good one), nor any other, could actually do anything *for* her. All a good treatment program could do was facilitate a process whereby she would eventually want to help herself, and then they could give her the tools she needed. I also now know that substantial family involvement throughout the treatment process is necessary to support a successful recovery.

I signed my daughter out of the first treatment program and brought her home to family chaos. Although she returned to her original high school and continued in outpatient therapy, her drug use escalated. My daughter began skipping school, running away, manipulating, lying, and stealing to get drugs. It became apparent that I couldn't take care of her at home, and my worst fear was that if she continued on her present course she would soon be dead. I started looking for a better treatment option. I sincerely believed she couldn't get better in a clinical environment, and an experiential/outdoor component would be necessary for her to recover. However, my insurance plan required that a program have national accreditation, 24 hour nursing support, and other therapeutic components more common to clinical settings than wilderness programs. However, there are programs that provide both outdoor and clinical components. By now I was prepared to look past glossy advertising for documentation of long-term outcomes. This time, I asked for evidence of program outcomes, and I requested names and numbers of other parents whose children had attended. I decided on Peninsula Village, a residential treatment center in the Smokey Mountains near Knoxville, Tennessee. The third time she ran away, she called me to come get her after being missing for three days, and we left for Peninsula Village that same day. It's difficult to leave your sick child in someone else's care, but I was aided by the knowledge that I couldn't keep her safe at home. I knew I had tried my best, and my best wasn't enough. I also still didn't know she was an addict. This was a decision she would later make for herself during treatment.

Daughter: I started running away, prostituting myself, and stealing money to get high. Every time I ran away, I would come home physically, mentally, spiritually, and emotionally beaten. I would claim I was going to change my ways and sometimes I believed myself;

my desire to use drugs always won out over my commitments to stay clean and safe. I continued to run away. In the end I knew that I was going to be locked up somewhere because my using was taking me to extremes, but I went on drug binges anyway. I thought a one night high was worth months of treatment. When my mother, the police, and my outpatient therapists reached the realization that there was no possible way I was going to recover without being restrained from myself, I ended up going to treatment.

Journey Into Recovery

This section really belongs to my daughter. My role became one of supporting her recovery process. There were three distinct phases at Peninsula Village: Assessment, Outdoor Program, and After-Care. In hindsight, I understand the critical importance of each stage as necessary preparation for the one that followed. And at the start of her treatment I could not have understood what I currently do about the how's and why's of these stages. Fortunately this time I had done my homework; I knew this treatment program had excellent credentials and it was a good fit for her needs. This allowed me to trust the program staff despite periodic misgivings. The lesson I took from this was: Make sure you choose a good program, and then let the program work with your child. Trust the process. I've seen other parents question the treatment program and be manipulated by adolescents who are telling parents they are being abused. I believe any adolescent who needs treatment will try to escape using any means they can, including well-crafted manipulations that target parent's weak spots, and parents need to be prepared to stay the course. If you think your child needs to be in treatment then they probably do. What was going on was far worse than I realized, and I think this is true in many cases. Denial is very powerful, and while it may help parents survive the trauma of having a troubled child, it can be a tremendous obstacle when it obscures the seriousness of the situation.

The Beginning

Mother: It wasn't that hard for me to leave my daughter at Peninsula Village because I was terrified for her safety, and I knew I could no longer keep her safe at home. Her commitment to using drugs combined with her history of outpatient treatment, repeated hospitalizations, a failed residential placement, and more recently, running away, convinced me as nothing else could have. If it had not been for these events, I don't know if I would have had the courage to take her to treatment. The team informed me she would likely have a one to four month stay on the assessment unit. At the time I was convinced she would get through it faster. To me, it seemed like she wasn't doing much except sitting on a bed in a locked unit and participating in groups a couple times a day. I questioned the program and would hint that she needed to move forward. I was concerned that the program was too harsh. They took away things she used for comfort, such as her journal, art, books, and her phone call privileges. I felt sorry for her, but I shouldn't have. It was what she needed. She would make some progress only to break rules and backslide. Every time it looked like she was close to moving to the outdoor program, she'd sabotage herself. At the time, I wanted her to move on to the outdoor program quickly, and I was frustrated with her slow progress. Now I know she was exactly where she needed to be. Everything in the program had a distinct purpose, and even though it didn't always appear therapeutic to me, it was therapeutic and it was working. I now believe that without this time in assessment she would not have been prepared to take responsibility for her own problems.

Daughter: I hated my mother for sending me to treatment. I didn't want to tell the truth about myself so I didn't get any recovery. I spent hours on end daydreaming about getting high and what I should have done differently in order to successfully run away. I wanted to go back in the past or be dead in the present because I had lost all hope for myself. At first, the restrictions of the environment in treatment created an atmosphere where I had to sit with myself. I had been running from my issues for so long I needed the tough love and hours of thinking time the unit had to offer. Over time, I started complying with the rules in the program because I wanted my life there to be as painless as possible. I eventually became complacent in my recovery because the restrictions of the Girls Adolescent Assessment Unit had become too familiar and comfortable for me to change. As a result, on Tuesday, September 13th, I was pushed from (the polite word for "kicked out") the Assessment Unit to the Outdoor Program. To me, the Outdoor Program was an intimidating war zone where everyone had to learn how to get honest and do 1000 push-ups. I was the awkward new peer suddenly thrown out into a group of strong young women, who expected me to be more than a sad little girl pretending she was on a different planet.

The Outdoor Program

Mother: When my daughter started becoming a little too comfortable on the assessment unit they placed her to the outdoor program. I learned there were two ways out of assessment: (1) earn it by complying with program structure, or (2) get pushed out by your treatment team. My daughter went through a difficult transition because she was pushed. Peninsula Village treatment teams design an individual focus for each child and "care methods" (i.e., consequences) for poor behavior and rule breaking. Care methods were contrived, but they served as effective metaphors for consequences that would occur in the outside world. One of my daughter's difficulties was respecting rules and authority figures. For this she was assigned push-ups. Another was carrying a Hula Hoop everywhere because she violated others' boundaries. At first I worried that this was abusive, but after watching and waiting I saw her begin to appreciate the structure and learn important lessons from her care methods. She became proud of her pushups and developed respect for rules and authority. Patients earned privileges by progressing through levels. The level system was very difficult, and she was the one who had to do the work. As such, the levels and privileges that came with them were very meaningful to her. She was the one doing the work, and she had something to be proud of. Throughout her stay we had weekly family therapy sessions. As she progressed, the treatment team scheduled off-campus days and weekends so we could learn to live together again in a healthier way.

Daughter: I hated the outdoor program. I went through a lot of pain there because the environment was harsh for patients who were unwilling to recover. I had consequences for my actions and people quit trying to be nice to me. I was called on all of my crap and I didn't have any friends. I realized acting depressed and self-pitying wasn't getting me anywhere. I decided about six months into treatment that at some point in my life I wanted to leave treatment, and I was the one responsible for how long my stay would be. I started talking to my group about my secrets I had previously decided to take to the grave.

My staff members and peers introduced me to the 12 steps and I began to work them.

Realization that I am an addict was not a sudden epiphany. As I struggled to change my behaviors I learned that I am a really sick person. I became aware that if I wanted to have any part of a satisfactory life I could not use drugs; however I did not fully understand what being an addict means to me. This is something that I am still learning to accept today. Treatment gave me the roots I needed to fully accept my disease.

Change is a long, slow, painful process, yet I discovered rewards for healthy behavior. There isn't space to describe the spiritual change that took place inside of me. To sum it up into one sentence I would say that every month I was amazed by how my thoughts were rearranging themselves as a result of the work we did in treatment. I learned the skills to live in treatment successfully and started progressing through the level system. Occasionally I was happy, which was a strange phenomenon to me after my previous hopelessness.

After-Care Planning

Mother: The last part of treatment was both exciting and frightening. I worked with my daughter to set home rules, and she identified yellow and red flags (i.e. behavioral signs that she was in danger of relapse). While sober and in the therapeutic environment, she determined what course of action she and I would take in case these problems occurred. For example, if she had a desire to use she was supposed to tell someone and call someone in the Twelve-step program for support. We attended a workshop with other parents and patients to work through a family discharge plan. The main thing that stuck with me was the therapist's comment: "You don't have to go back to living the way you were." That's when it dawned on me that my daughter and I now had the tools to support her recovery. If she wasn't working her program, I did not have to go back to care taking, enabling, and so on. A key question I had was "What would I do if she relapsed and didn't take steps to regain recovery?" I got my answer from a local treatment professional: "Put her out, let her go. When she decides to stop using she can go to a halfway house." I shared this with my daughter. I am grateful this has not occurred, but I am prepared to follow through if it does. None of what I tried before had worked. I received support from a Twelve-step program for families and friends of people in recovery, and this group helped me during the discharge transition.

Daughter: By the time I was in treatment for 18 months, they decided that I had a good chance of surviving if I went home. I was scared, but I knew by that time I was willing to do anything to stay clean. Treatment wasn't comfortable, but I learned how important it was to stay away from old people, places, and things while I was in there. I now had to learn how to live in the "real world" and be responsible for myself. I knew that it was going to be a long scary process, but the only way to achieve it was to do it.

Mother: During the treatment program my daughter realized that she was the one ultimately responsible for doing the work in treatment and supporting her recovery when she came home. She makes choices everyday, and experiencing the consequences of those choices (good or bad) is important to staying in recovery. As her mother I had other supporting responsibilities, including: not enabling, not shielding her from consequences, not anticipating what she needed, not helping her unless she asked for assistance, and not doing things for her that she could do for herself.

Where We Are Today

Mother: Today we live pretty average lives of work, school, and play. My daughter lives in the college dormitory, and I live a half hour away and provide support when she asks for it.

When my daughter came home things were a little tense and artificial for a while. However, we have stronger communication skills and have been able to talk through difficulties as they arise. We also have a family therapist to facilitate when needed. My biggest challenge is to not help her unless she asks for help, and I'm getting better at it. Our relationship is much more relaxed now. I'm surprised how similar it is to our relationship before treatment, but now it is healthier because we have better boundaries. I continue to attend a

Twelve-step program for families and friends of people in recovery and have found my work in this program invaluable in terms of peace of mind and guidance for day-to-day healthy living.

My daughter has my financial support as long as she continues to follow a plan we've agreed on. This plan currently includes attending daily meetings, school, working and living in the dorm at college (rather than an apartment). She is free to make different choices, but if I don't support them I don't help pay the bills. Now the problems she deals with are good ones because they are normal teenage problems like time management, getting enough sleep, eating right, and getting her homework finished on time. I am grateful every day for her continued recovery, and we remember to say "I love you" everyday. I make suggestions, but I am much less involved in how she lives.

Daughter: When I came home I was able to stay clean thanks to a Twelve-step program I attend daily, my Higher power, and women I met through that program. I got a sponsor, started working the steps, and am going to school as well as keeping a job. I have become more comfortable at home and have built a recovery network that I can use to stay clean. Many people in my support network are older then me, but I have found the only way to stay in recovery is to look at our similarities instead of our differences. My mother and I have a healthier relationship now that we are taking care of ourselves.

I recognize today that I am responsible for my recovery and that I will never be cured. My mood is significantly better now that I cope with my feelings in a healthy way. I am blessed for the opportunities I have laid in front of me, but most of all for being taught how to recover at such an early age.

Conclusion

Mother: As stated at the beginning, hindsight would indicate that we could have handled things differently. Maybe so; maybe not. I now believe that wherever we are is where we are supposed to be. On one hand, I believe that my daughter's earlier treatment professionals and I could have helped her get the help she needed earlier if we had identified her potential for addiction sooner. On the other hand, hindsight is 20-20. It's possible all our collective experiences were necessary to get us to where we are today.

The following suggestions may be helpful for parents of troubled adolescents. The HBO Addiction Program (www.hbo.com/addiction/) and Drug Strategies (www.drugstrategies.org) provide families with current, unbiased information to find the help they need for troubled adolescents with addictions. There are many programs out there. It's confusing and baffling for a parent trying to choose a good one. Some programs are so bad they are dangerous; and some are mediocre, some are good, and some are great. Match is critical; even the best program may not help if the program is not designed to treat adolescents. I asked my daughter if the treatment program she attended would have helped it if she had only had the depression and cutting issues and was not an addict. Her answer was "yes, a good program will help adolescents with many different issues because the root of their problems is the same and the coping strategies are the same." My daughter recommends that parents visit the program in person and spend as much time as possible on-site observing what it will be like for their son or daughter. She advises, "Don't take the therapist's word for what the program will be like." Parents should also ask for the names and numbers of parents and alumni of the program and call them. HBO Addiction recommends five questions parents should ask a treatment program:

1. Is your treatment program specifically designed for teens? If so, how?
2. What questions do your staff members ask to determine the seriousness of the teen's substance use problem and whether the teen will benefit for this particular program?
3. How does the program involve the family in the teen's treatment?
4. How does the program provide continuing care after treatment is completed?
5. What evidence do you have that your program is effective? (www.hbo.com/addiction)

While it is beyond the scope of this article to provide details about these questions, the resources listed at the end of this article provide additional information. In my experience, all these questions were important, but I want to place special emphasis on Question #5 regarding evidence. In cases where family members don't have the skills to critically scrutinize the evidence a program provides (if any), I suggest seeking an unbiased expert (e.g. therapist, social worker, researcher) to assist you. During my investigation I located one promising program via the Internet. Upon closer scrutiny of this particular program, I discovered the evidence of success they provided actually came from a different program. In short their website looked great, but they lied to me. Please do your research, look for a good match, and make use of the information in the resources below if your family has a loved one facing similar problems.

In closing, I'd like to share my daughter's wise observation that this isn't a story with a happy ending because the story isn't over. Our lives are both immeasurably better now than if this crisis had never happened. We have both grown mentally, spiritually, and emotionally. However, there are no guarantees of what tomorrow will bring. It's best for us to take life one day at a time and be grateful everyday for what we have.

Resources

HBO Addiction can be accessed at http://www.hbo.com/addiction/ This web site contains current information on adolescent addiction and has specific recommendations for treatment of adolescents. The section on "Drug Treatment for Adolescents" contains five key questions parents should ask about a treatment program.

Drug Strategies, a non-profit research institute, developed *Treating Teens: A Guide to Adolescent Drug Programs*. This guide describes nine key elements that are important in successful teen drug treatment and provides reliable information on 144 adolescent drug programs. Go to the Drug Strategies website at www.drugstrategies.org for more information on teen treatment.

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INSTRUCTIONS FOR AUTHORS

Journal of Therapeutic Schools and Programs (JTSP)

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

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

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

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

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

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

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

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

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

THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS ETHICAL PRINCIPLES

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

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

1. Be conscious of, and responsive to, the dignity, welfare, and worth of our program participants.
2. Honestly and accurately represent ownership, competence, experience, and scope of activities, and to not exploit potential clients' fears and vulnerabilities.
3. Respect the privacy, confidentiality, and autonomy of program participants within the context of our facilities and programs.
4. Be aware and respectful of cultural, familial, and societal backgrounds of our program participants.
5. Avoid dual or multiple relationships that may impair professional judgment, increase the risk of harm to program participants, or lead to exploitation.
6. Take reasonable steps to ensure a safe environment that addresses the emotional, spiritual, educational, and physical needs of our program participants.
7. Strive to maintain high standards of competence in our areas of expertise and to be mindful of our limitations.
8. Value continuous professional development, research, and scholarship.
9. Place primary emphasis on the welfare of our program participants in the development and implementation of our business practices.
10. Manage our finances to ensure that there are adequate resources to accomplish our mission.
11. Fully disclose to prospective candidates the nature of services, benefits, risks, and costs.
12. Provide an appropriate professional referral if we are unable to continue service.