NATSAP Guiding the way
JTSP
Journal of Therapeutic Schools & Programs

NATSAP
Guiding the way

The National Association of Therapeutic Schools and Programs
Board of Directors as of 01/29/2019

NATSAP Staff

NATSAP Guiding the way JTSP
Journal of Therapeutic Schools & Programs

The **JOURNAL OF THERAPEUTIC SCHOOLS AND PROGRAMS (JTSP)** is published by the National Association of Therapeutic Schools and Programs and publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from residential and wilderness/outdoor behavioral healthcare treatment programs. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment outcomes and processes.

PERMISSION TO QUOTE, REPRINT, PHOTOCOPY Inquiries about policy and procedures relating to permission to reproduce material published in the journal should be directed to: Ellen Behrens, Ph.D., Chief Editor, JTSP, Foster Hall, 1840 South 1300 East, Westminster College, Salt Lake City, UT 84015, 801-832-2427, ebehrens@westminstercollege.edu

MANUSCRIPTS The editors welcome manuscripts that are the original work of the author(s) and follow the style of APA as presented in the sixth edition of Publication Manual of the American Psychological Association. Empirical studies (qualitative and quantitative) must have been conducted under the oversight of an Institutional Review Board (IRB).

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

MEMBERSHIP Schools and Programs interested in membership the National Association of Therapeutic Schools and Programs are referred to their website, www.natsap.org.

TABLE OF CONTENTS

TABLE OF CONTENTS

Authors - JTSP Volume XI, Issue I

Kayla Argo
Kayla Argo graduated from Georgia College & State University in August of 2018 with a Bachelor of Science in Outdoor Education and a Bachelor of Science in Psychology. Kayla is currently working in the field at a wilderness therapy program to complete her last course requirement. She worked on this manuscript as a senior at Georgia College. Her intentions are to continue working while starting her application process to begin her master's degree in social work in the fall of 2019.

Matthew (Cole) Brogden
Matthew (Cole) Brogden is a Junior Environmental Science major at Georgia College & State University planning to graduate May of 2020.

Garrett Cook
Garrett Cook is a Junior at Georgia College & State University, majoring in Psychology and minoring in Business Administration. With a strong interest in the field of I/O Psychology, Garrett plans to begin searching for internships with local firms with the hope to begin establishing hands-on experience in the field. He plans to attend graduate school the year following his graduation in 2020 with a focus in either research or consulting I/O Psychology.

Victoria Creighton, Ph.D.
Dr. Victoria Creighton is the Clinical Director at Pine River Institute. She completed her master's degree in 1996 and her doctorate in Clinical Psychology in 2000. Before coming to Pine River, Victoria worked as clinical supervisor at Montana Academy and Hope Ranch, both residential treatment facilities for adolescents. Her mentor is Dr. John McKinnon, and she brought to Pine River his maturity model for working with adolescents who struggle with addictive behaviors.

Harold L. (Lee) Gillis, Ph.D.
Harold L. (Lee) Gillis, Ph.D., Professor and Chair, Psychological Sciences, Georgia College and State University. Dr. Gillis earned his doctorate in counseling psychology from The University of Georgia in Athens. He is a co-author of the text titled Adventure Therapy: Theory, Research and Practice (Routledge Mental Health) with Michael Gass and Keith C. Russell. He has been conducting research on adventure therapy practice and outcomes with organizations all over the world since 1978. The article to which Dr. Gillis contributed was co-authored by the following undergraduate students in the Department of Psychological Science at Georgia College & State University: Paige Mandas, Kayla Argo, Hannah Rose, Taylor Zelenik, Ansley Wetherington, Matthew (Cole) Brogden, and Garrett Cook.

John Hall, LMFT
John Hall, LMFT is the Director of Research and Chief Quality Officer for Telos. He is also a partner at Telos U and Telos Anthem House. He has degrees in Psychology from Brigham Young University and Marriage and Family Therapy from Abilene Christian University and a certificate from the Mental Research Institute. He has published in multiple journals including the Journal of Therapeutic Schools and Programs and is now a member of the editorial board of JTSP having served previously as guest editor for that journal. He has published a chapter in a recent textbook for marriage and family therapy graduate coursework. He is the chair of the research committee for the National Association of Therapeutic Schools and Programs (NATSAP) and has given many presentations at NATSAP, YATA, and other conferences.

Paige Mandas
Paige Mandas graduated with her Bachelor of Science in Psychology from Georgia College & State University in May 2018. She is a first-year student at the University of Georgia in the Master of Education Clinical Mental Health Counseling program. Paige looks forward to becoming a trained mental health professional that will address a wide variety of diagnoses among young adults and others. Her contributions to this article were completed during her senior year at Georgia College & State University.

Jasmine Knight, Ph.D.
Jasmine L. Knight is an Assistant Professor in the counseling program at Regent University in Virginia. She received her Ph.D. in Counselor Education and Supervision from Old Dominion University. Dr. Knight has had the opportunity to speak and publish on numerous topics such as adolescent dating violence, relational aggression, career development, multicultural competence, and working with African-American families. Her research focuses on school counselor preparation, specifically college/career readiness, relational aggression, and multicultural competence.

John A. McKinnon, M.D.
ohn A. McKinnon is a Founder/CEO and Medical Director of Montana Academy. Dr. McKinnon received his BA in English from Harvard College, followed by a master's degree in Economics from Cambridge University, an MD from Case Western Reserve University, and a Psychiatric Residency at Yale University. In addition, he has an MFA in Fiction from Norwich University. He has been an Assistant Professor of Psychiatry and Associate Director of Resident Training at the University of California San Francisco, the Chief of Outpatient Services at the VA in San Francisco, and the Clinical and Medical Director of Inpatient Psychiatric Hospitals in Texas and Montana before founding Montana Academy. Dr. McKinnon has published two books on understanding adolescents along with numerous papers and talks on these subjects.

Jan Moss Courtney
Jan Moss Courtney spent 25 years in the semiconductor industry in the Information Technology field. She held the Chief Information Officer position for SEMATECH prior to joining Spring Ridge Academy as Executive Director. Jan also served as a founding board member, secretary and treasurer of NATSAP. Following several terms on the board of directors Jan became the Executive Director of NATSAP and served in this capacity for five years before retiring.

Debra J. Pepler, Ph.D.
Dr. Debra Pepler is a Distinguished Research Professor at York University. She received her PhD in 1979 from the University of Waterloo and is a Registered Psychologist in the Province of Ontario. Professor Pepler is a scientific advisor for a number of clinical programs, including Pine River Institute (a residential

treatment program for youth) and Breaking the Cycle (a program for substance-using mothers and their children). She also does work in partnership with Indigenous communities.

Mike Petree, MCP
Mike Petree is the founder of Petree Consulting Inc. (PCI), a consulting agency and software company working with treatment providers to measure outcomes and monitor client progress. PCI developed the Remote Research Director Dashboard, a tool that organizes data collection systems and saves providers from the need to dedicate full-time staff to research. PCI plays an integral part in the National Association of Therapeutic Schools and Programs (NATSAP) national outcomes research study.

Jennifer E. Randall Reyes, Ph.D.
Jennifer E. Randall Reyes is an associate professor in the MS Clinical Mental Health Counseling program at Prescott College. She also adjuncts at her alma mater, West Virginia University in their MA Counseling programs. Jen maintains an active private practice specializing in trauma counseling. Her qualitative dissertation has been condensed for this special edition, and she hopes to continue researching and publishing on integrative, holistic, and experiential therapies for years to come.

Julia Riddell, Ph.D. Candidate
Julia Riddell is a Ph.D. Candidate in Clinical-Developmental Psychology at York University. She is completing her residency at the University of Manitoba doing clinical work across the lifespan in urban and rural areas. Most of her research is done in collaboration with Indigenous communities and youth struggling with mental health challenges. Julia's dissertation explores the role of environmental toxins in children's neurobehavioral development. Julia is passionate about using research to advance social and environmental justice.

Hannah Rose
Hannah Rose is from Senoia, Georgia and graduated from Georgia College & State University in 2018 with a Bachelor of Science in Psychology and a minor in Ceramics. Currently, she is pursuing a career in Human Resources. Her contributions to this article were completed during her senior year at Georgia College.

Keith C. Russell, Ph.D.
Keith C. Russell, Ph.D., Professor and Chair, Department of Health and Human Development, Western Washington University. Dr. Russell's research emphases include program evaluation, the study of human-nature relationships, the therapeutic value of natural environments, and international protected area management. He teaches courses in statistics, research methods, and adventure education and therapy. He is a co-author of the recent text titled Adventure Therapy: Theory, Research and Practice (Routledge Mental Health) with Michael Gass and Harold L. (Lee) Gillis, Ph.D. and contributed to the article co-authored with Dr. Gillis' undergraduate students.

John L. Santa, Ph.D.
John L. Santa is a Founder/CEO and Clinical Director of Montana Academy, a therapeutic school that has operated in Montana for more than 20 years. He is the past president of the National Association of Therapeutic Schools and Programs and served as a founding member of their Board of Directors. Dr. Santa received a BA in psychology from Whitman College, followed by a master's and Ph.D. 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 the areas of psychology and education. He is also a licensed clinical psychologist and has served on the Montana licensing board for private residential programs as a member and chair.

David Savinsky, Ph.D.
David M. Savinsky is an associate professor of Counseling and Clinical Training Coordinator of the MA and Ph.D. counseling programs in the School of Psychology & Counseling at Regent University. He also is co-owner of Beach Therapy & Consulting in Virginia Beach, Virginia and is intensively trained in Dialectical Behavior Therapy. Research interests include evidenced-based treatment for adolescent psychopathology, family therapy, qualitative research methodology, and mindfulness in teaching/supervision.

Jared Schultz, Ph.D.
Dr. Schultz is an Associate Professor in the Department of Special Education and Rehabilitation at Utah State University. He is Program Director for the Rehabilitation Counseling Education program and coordinates the Rehabilitation Counseling Specialization in the Disability Disciplines doctoral program. He is Associate Dean of Clinical Education and Community Outreach for the College of Education and Human Services. His research interests include clinical supervision, counselor education, counselor professional identity development, and transition services for youth with disabilities.

Linda Solomon
Linda Solomon is the Research and Administrative Assistant at Montana Academy since 2012. She has a bachelor's degree in engineering and computer science from Colorado State University. She has worked for many years in the Semi-Conductor industry as an engineer and computer scientist. She has also taught courses in computer science at the college level.

Liz van Ryn, MSc, RMFT, RP
Elizabeth (Liz) van Ryn is the Director of Family Programs at the Pine River Institute. She earned her master's degree in Couple and Family Therapy at the University of Guelph and has spent the last 25 years working in the mental health field as a therapist, behavior consultant, supervisor, and manager of outpatient resources in the field of developmental services and mental health. Liz is a Registered Psychotherapist and Registered Marriage and Family Therapist. Her areas of expertise include parenting education and support; mental health and crisis services for children and youth; pre-school behavior issues; infant, child, and adolescent development; and individual, couple, and family therapy.

Lee Underwood, Ph.D.
Lee Underwood is a licensed Clinical Psychologist and Certified Sex Offender Treatment Provider (CSOTP). Dr. Underwood is a tenured Professor at Regent University, School of Psychology & Counseling. Dr. Underwood is also affiliated with Sequel Youth and Family Services and serves as the Director of Clinical and Research Studies. He has authored over 70 refereed journal articles, two textbooks, 17 treatment manuals and technical reports on mental health, substance use, trauma needs of females, sex offending and forensic needs of adolescents. His

most recent books include *Counseling Adolescents Competently* (under review by Sage Publishers) and *Adolescents in Conflic*t (Taylor Made Publishing).

Maria Watters, Ph.D.
Maria completed her masters in Rehabilitation Counseling at Utah State University in 2011 and is currently pursuing her Ph.D. in Disability Disciplines-Rehabilitation Counseling. She is a Certified Rehabilitation Counselor and also is a Licensed Clinical Mental Health Counselor. She is currently the Central Access Administrator at Central Washington University. Her research interests include exploring the role and contributions of experiential therapies as well as understanding sexuality and disability including sexual education and treatment needs.

Ansley Wetherington
Ansley Wetherington graduated in May of 2018 with a Bachelor of Science in Psychology and Minor in Spanish. She is currently interning at Atlanta Ronald McDonald House Charities in their Family Services department. Ansley would like to eventually obtain her MSW and plans to continue gaining work experience in the field of social work over the course of the next year before applying to graduate school. Her contributions to this article were completed during her senior year at Georgia College & State University.

Taylor Zelenik
Taylor Zelenik graduated in 2018 from Georgia College & State University with a Bachelor of Science in Psychology. Contributions to the article were completed while she was a senior at Georgia College. She is currently employed with Children's Healthcare of Atlanta as a Behavior Data Analyst at the Marcus Autism Center. She intends to pursue her master’s degree in psychology or a related field.

Preface

John L. Santa
Montana Academy

It was with great pleasure that I accepted Ellen Behrens' request to be the guest editor of the 11th issue of the Journal of Therapeutic Schools and Programs (JTSP). As a founding member of NATSAP, I clearly remember the struggle and discussions to define the goals and purpose of our organization. The goals that emerged within the first year can best be described as encompassing two broad components:

1. Creation of a Trade Organization capable of providing public awareness, advocacy and representation of our services.
2. Developing a Professional Organization that would focus on improving collegiality and sharing information to provide improved ethical and practice standards as well as providing a conference structure and support for research to improve the understanding and implementation of our programs.

NATSAP is now twenty years old and has accomplished a great deal in terms of achieving the goals that were established in the first few years. I am particularly proud of what NATSAP has accomplished as a professional organization that has created a rich database with more than 45 programs contributing data. The database and research effort were established with the help and guidance of Dr. Michael Gass at the University of New Hampshire. Dr. Gass has managed our database and research efforts, leading to publishing numerous excellent articles that have deepened our knowledge of what works in residential treatment. He was also the editor of the JTSP for 10 years followed by Dr. Ellen Behrens for these past four years. The journal has provided a space to encourage thinking about, writing, sharing, and developing our profession.

The current issue is simply one more example of the variety of exploration we have created in our profession. At the request of the NATSAP board, the first article is a slightly updated reprint of an article written by myself and Jan Moss that appeared in the first issue of the JTSP journal. This article has been updated with information supplied by our current Executive Director, Megan Stokes, to include a brief summary of further progress NATSAP has made in the past decade.

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.10

The next two articles follow the theme of this issue that focusing on the impact of family therapy in our programs. Liz van Ryan and Victoria Creighton's paper, "The Call for an Integrated Family Systems Model," provides a detailed description of how one program developed a coherent and system wide approach to family therapy, and how this approach impacted staff, participants, and families. John Hall's article continues to support the importance of family therapy in our programs and provides empirical support for the change in family function that takes place over the course of treatment and continuing for a post-treatment follow up of 6-12 months. Two articles then follow that provide new methods for assessing adolescents and the impact of residential treatment. Both articles describe measurements of adolescents that are less based on symptomatic diagnosis of mental illness.

McKinnon, Santa, and Solomon have developed an instrument (MAMA-t) designed to measure changes in adolescent maturity and character development. In a series of experiments with both a treatment population and a normative high school population, they demonstrated that MAMA-t scores are related to performance in a therapeutic program, and are related to, and predictive of, grade point average and behavior in a public high school over several years.

Watters and Schultz have developed a short questionnaire that described the current state of an adolescent along the dimensions of emotional, social, and behavioral functioning. Their goal is to have an instrument that provides a useful overall sense of a participant that can be tracked on a regular basis over the course of treatment. The measure stands in contrast to longer assessments that are more focused on specific symptoms of dysfunction.

Next, we have an article by Mike Petree that describes the "Golden Thread Software project" that is a collaborative effort between NATSAP and several related organizations designed to improve the ability of doing outcome research by allowing a single participant to be tracked from when they begin to consider residential treatment all the way through the many potential placements that follow. This approach will provide a much cleaner data set and allow the possibility of various types of control groups and comparisons that were previously not possible.

Lee Gillis and his colleagues then provide a timely article about whether opioid users have different outcomes from outdoor behavioral health treatment programs than other participants who used drugs, but not opioids. They found no statistically significant differences between these populations on measures at intake, during treatment, discharge, and follow-up. However, opioid use served as a stronger predictor for severity of relapse.

Finally, the issue concludes with two articles that employ interviews and qualitative research to capture some of the elements of residential treatment that affect both therapists and participants. Jennifer Randall Reyes interviewed wilderness therapists and used a conceptual mapping approach to summarize the impact of wilderness treatment on therapists themselves. She found themes emphasizing the importance and impact on therapists of the wilderness setting itself, as well as the work-life balance of wilderness therapy, and the experienced differences between therapy in the wilderness as opposed to traditional settings.

Riddell, Pepler, and Creighton again used interview techniques in an attempt to uncover the aspects of residential treatment impacting participant's relational identity development. Among the relational changes they noted were an increase in authenticity, vulnerability, acceptance, empathy, and honesty. They also described a number of program elements contributing to this increased identity development.

So, in conclusion we have a wide varieties and types of research presented in the 11th issue of JTSP that reflect an increasing curiosity in our work and a willingness to capture and share our information. This indeed feels like the development of a true professional organization that is striving to deepen our understanding, improve, and grow.

Finally, great thanks and appreciation are owed to Dr. Ellen Behrens and this edition's manager Caroline Graham for all of their work keeping us on track and making this journal a first-rate professional project.

A Brief History of the National Association of Therapeutic Schools and Programs, Reprinted and Updated

John L. Santa
Montana Academy

Jan Moss Courtney
NATSAP

The current NATSAP board asked if we could re-publish this article that summarizes some of the origins of NATSAP in recognition of our 20th anniversary. I have included the original article followed by a post-script with the help of Megan Stokes who outlined some of the growth that has taken place in the 12 years since the original article. In the original article, Jan Moss Courtney and I attempted to provide a personal account of the development of the National Association of Therapeutic Schools and Programs. Both of us were involved from the beginning, and we have chosen to write this article from the perspective of a personal reflection giving credit to some of the important individuals who have contributed to creating the current organization. This is a selective history rather than authoritative and exhaustive.

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.01

HISTORY OF NATSAP

In the fall of 1998, Montana Academy was in its infancy. My (John Santa's) office was in a temporary trailer when my secretary introduced me to an energetic young man named John Reddan. He described his background working in admissions for a private school in Hawaii and for the National Association of Independent Schools. He also described passionately the need for a professional association that could advocate for this rapidly growing industry of therapeutic schools and programs. He explained how he was visiting programs to determine the level of interest, purpose, and needs of such a national association. He described his personal commitment for creating an association and his need for sponsors to help with the start-up costs. He had already talked with Len Buccellato of Hidden Lake Academy who shared his enthusiasm, and who had generously provided several thousand dollars in seed money to help him launch the association.

Frankly, I was at first a bit skeptical. We were a new school with no money for extras. In fact, we had barely begun to pay ourselves salaries. The idea of contributing seed money to an unestablished national organization sounded somewhat risky. While John seemed a bit like a polished salesman, I saw his focus and honesty. He had vision, and like most of us who have started our own programs, John was an entrepreneur with a dream.

I liked his vision and felt that a national organization would serve many purposes. I also wanted a professional organization that would allow colleagues to exchange information and ideas. The earlier history of therapeutic programs seemed more competitive and isolated. A professional organization could become an opportunity to develop colleagues and share information in a more professional manner.

As a psychologist, I was already participating in several professional organizations and found them immensely helpful, but none of these organizations was directly relevant to my current professional needs. Many of us possessed years of experience and training as psychologists, psychiatrists, social workers, teachers, or experiential educators, but what we were currently doing in therapeutic communities was different. In many ways, we were forging a new and more effective continuum of care for troubled adolescents that extended far beyond the scope and vision of more traditional health care models. We needed our own forum, our own association.

John invited me to attend an organizational meeting hosted by himself and Len Buccellato at an Independent Educational Consultants Association (IECA) conference in Atlanta. I felt honored to be invited, and when I attended the

meeting, I came away impressed and even more enthusiastic about the idea of a national association. Our school and five other organizations put up seed money that added to the donation of Len Buccellato to launch the organization. The founding programs included Hidden Lake, Cascade School, Spring Ridge Academy, Montana Academy, Aspen Youth Services, Three Springs, and Crater Lake. These six founding programs contained a mixture of both new and established programs. Most of us in the new group liked the idea of being included and the opportunity to develop our profession, share information, and learn from others. Those from more established programs joined because it was time for a solid professional and trade association. We all shared John Reddan's well-articulated dream.

The next chapter in the evolution of NATSAP occurred when John Reddan announced an organizational meeting in true "field of dreams fashion." The meeting occurred in January of 1999 in Albuquerque, New Mexico. I was quite skeptical that anyone would come, but 66 individuals from forty-four different programs attended. John Reddan facilitated our discussions, and the group concluded by forming an association, electing the first Board of Directors, and establishing consensus on priorities for the organization.

Jan remembers her early contacts with John Reddan as follows: "In December of 1998, John Reddan contacted me at Spring Ridge Academy. Our Admission Director had attended the Atlanta organizational meeting, and Jeannie Courtney, the founder and CEO of Spring Ridge Academy, had expressed interest in supporting John's vision. Jeannie felt that she could not spare the time from our relatively new program but asked me as Executive Director to represent Spring Ridge at the New Mexico meeting.

"The night before the big meeting, the six sponsors sat around a large dinner table. John assigned us our tasks as facilitators of small group sessions to formulate the wants and needs the various schools and programs would expect from a professional organization. As I look back, I am amazed at John's vision and certainty that the organization already existed, and this meeting was simply a formality in establishing the direction. I found myself caught up with his enthusiasm and commitment and thus began my journey into the foundation and growth of NATSAP."

The first Board of Directors included: Michael Allgood (Cascade School), Tim Brace (Aspen Education Group), Len Buccellato (Hidden Lake Academy), Bobbi Christensen (Crater Lake School), Kimball DeLaMare (Island Lake RTC), John Mercer (Mission Mountain School), Jan Moss (Spring Ridge Academy),

John Santa (Montana Academy), Rosemary Tippett (Three Springs), and Diane Albrecht was asked to join our board as an ex-officio representative from IECA.

At the first board meeting, we elected a slate of officers – Kimball DeLaMare as president, Tim Brace – vice-president, John Mercer –Treasurer, and Jan Moss – Secretary. Kimball was the perfect first president. He had tremendous credibility with vast experience as co-owner of a highly respected program. Even more important, he is a public relations genius. Kimball knew everyone in the therapeutic community – all of the consultants, and probably the names of everyone's children. He has a terrific sense of humor, does standup imitations (particularly of his business partner Jared), and has a deep passion for helping adolescents and their families.

Under Kimball's capable charismatic leadership, our board began meeting regularly to flesh out the organizational structure and to envision how we might carry out the tasks of our new national association. We all paid our own travel expenses to meetings, met in a condominium generously donated by Jared Balmer and Kimball, and began talking. As with any group, the first few meetings were about establishing trust and a sense that we could work together.

As you might imagine, the idea of imposing order and structure on a group of individuals who were mostly therapists, as well as owners or leaders of their own programs, was a challenge. In a remarkably short time, however, we came to respect each other, enjoy one another's company, and saw how each of us could contribute to the group. Michael Allgood and Tim Brace brought a wealth of knowledge about the evolution of therapeutic schools, both tracing their roots in the field directly to Mel Wasserman who was the founder of the original CEDU schools. Both Rosemary Tippet and Tim Brace worked for large therapeutic program corporations but made a point of being supportive and not insisting that the power flow only to the larger corporations. One had a sense that they would help marshal their company's resources to help all of us. Rosemary was particularly impressive in her ability to listen carefully and then share all that both she and her company had to offer in order to make the association more successful. John Mercer quickly emerged as an articulate and thoughtful professional with a background that was more experiential and educational in nature. He had served for many years on the Pacific Northwest Association of Accredited Schools (PNAIS) Board of Directors and readily shared his knowledge of effective non-profit boards. He helped establish a responsible financial structure. Jan Moss's strong background in business and organization helped keep us focused, organized, and on task. She made an extraordinary effort to produce

coherent minutes from our early meetings (when it was rare that fewer than three people were talking at any one time!). As a psychologist and ex-university professor, John Santa added a strong sense of what a professional organization could do to help improve our service to children and families. Diane Albrecht was remarkably warm, encouraging, and supportive. She listened carefully, and if we strayed or were about to make a hasty decision, she would interject with her Maine accent a gentle bit of corrective advice. I am certain that John Reddan had no idea what he was getting into when he proposed an organization with such a strong willed and opinionated board.

We struggled to create order and process out of passion, enthusiasm, and good intention, and it quickly began to happen because everyone so willingly committed time and energy into the project. Special commendation must go to Kimball, who spent endless hours outside of our board meetings promoting the association and providing leadership to establish NATSAP as a credible undertaking that deserved the support of all responsible programs.

The initial organizational meeting also established a set of priority projects including: standards for ethical practice, an annual conference, employee referral service, public relations support, outcome studies, a directory, training workshops, statistics, lobbying support, and a purchasing consortium. These priorities reflected a mixture of goals to create more professionalism and collegiality coupled with the need for political voice, general marketing, resource pooling, and public relations support.

Over the last six years, members of NATSAP have made considerable progress on most of these goals. Within a year, we published a directory listing 66 programs and held our first national conference in Tampa, Florida with 230 individuals attending even though an impending hurricane forced a change in date and venue.

Work on ethics and standards became the top priority and provided a model for engaging broad member input and consensus. The Ethics and Standards Committee conducted a series of retreats or “summits” to forge consensus on basic ethical and practice issues describing ethical, well-run programs. These meetings generated enthusiasm, commitment, and cohesion for the organization. John Reddan wisely chose wonderful sites for the retreats that led people to relax, become colleagues, walk on the beach, and at the same time work hard to develop and achieve consensus on ethical principles and practice standards. The first meeting was in a beautiful home overlooking the Pacific Ocean in Santa Barbara.

We came away from this "West Coast meeting" committed, sun tanned, and engaged in the process of establishing ethical principles.

A year later we had an "East Coast" ethics summit on Tybee Island, Georgia, with more walks on the beach coupled with serious discussion of ethics and standards and sprinkled with my first encounter with Krispy Kreme's, enthusiastically pushed by Carol Thorne and John Reddan. That year we also had a Standards Committee meeting in Bigfork, Montana overlooking Flathead Lake, resulting in a draft of practice standards for NATSAP member programs. We tediously developed consensus around practice standards endorsed by small programs, independent schools, and residential treatment centers. Obtaining a reasonable balance among the influence of wilderness programs, medical models of RTC's, schools, and experiential programs was no simple task.

However, we emerged with a set of general guidelines that would tolerate diversity of approach while still insisting that all programs address basic safety, structural, and process issues necessary for any responsible program. This committee represented a depth of experience and perspective. Sharon Laney from Three Springs and Donna Brundage from CEDU waded through the intimidating language of human resource, OSHA, and risk management issues, translating these concepts for those of us who have resisted bureaucracy. They cut through to the core concepts and made them accessible for all of us. Paul Smith and Penny James grasped the intent of the policies, generalizing them so that they applied to rural and wilderness settings while still allowing these very different approaches to contribute their own flavor. The process was stimulating and effective. While Jared Balmer could not attend the meeting, it is important to note he provided a working draft of standards as a framework to guide our discussion. With his work in hand, we discussed each proposed standard and achieved a workable consensus for all levels of our members. From the beginning, Jared provided tremendous support and "behind the scenes" guidance.

The work on ethics and practice standards was seen by most of us as our first priority for several reasons. First, establishing standards and creating opportunities to discuss ethical issues would raise the level of practice for all programs who participated. Second, having clear standards allowed members to set themselves apart from the many other programs who were not operating according to these basic standards of quality. Finally, the adoption of standards allowed us to advocate our unified positions to the public, legislative bodies, and regulatory agencies.

HISTORY OF NATSAP

Parallel to this work on standards, John Reddan quickly produced the first NATSAP Directory in 2000, containing 66-member programs. This annual directory grew to include over 100 in 2001 and was approaching 150-member programs in 2005. The Directory has become widely circulated and used by all referring professionals. It continues to provide a major piece of public relations, awareness, and marketing for the entire industry with more than 10,000 copies distributed in 2005.

Another early goal was to establish a tradition of first-rate professional conferences. The first NATSAP Conference was scheduled in September 1999 in Tampa, Florida. However, a hurricane threatened to ruin the conference, and John Reddan and Conference Chair Rosemary Tippett (Three Springs) made the difficult and frightening decision to cancel and reschedule our first conference in January 2000. Thus, began the tradition of scheduling our annual conferences in the winter and in warmer climates.

The first conference was intimate with 230 attendees and set a tone of collegiality and professionalism. Most of the presentations were by our own members and were very well received. Talks by John McKinnon, M.D., Jared Balmer, Ph.D., and many others established the precedent of sharing information among professionals rather than pretending to have a special arcane knowledge known and closely guarded by the charismatic owner of a particular program. The openness of these presentations and the atmosphere of talking with each other as colleagues rather than competitors created new relationships, fostered the development of our profession, and promoted a high standard for all future conferences.

In 2001, we found ourselves in San Diego where we shared information on topics ranging from "How Horses Teach Non-Verbal Crisis Intervention" complete with horses on the Mission Bay beach, adoption, and dealing with the impact of suicide on a program in an informative presentation by Andy Anderson. The conference, under the leadership of John Reddan and Conference Chair, Bobbi Christensen (Crater Lake School), proved to be a huge success.

In 2002, Andy Anderson, the new Executive Director, and Conference Chair Jan Moss (Spring Ridge Academy) led us to Hutchinson Island near Stuart, Florida where the focus was "Facing the Future." David Brodzinsky, Ph.D. provided a stimulating address on adoption, and Gary Ferguson, author of *Shouting at the Sky*, gave us glimpses into the power of the human spirit and the healing that is possible when linked with the beauty and challenges of the wilderness.

We continued with our themed conferences in 2003 with "Focusing on Families" in beautiful Santa Barbara, California and chaired by Penny James (Explorations). NATSAP members and colleagues conducted breakout sessions, continuing in the standards of excellence for learning and collegiality. Michael Jenike, expert on Obsessive Compulsive Disorder, and Claudia Black, Ph.D., author of *It's Never Too Late to Have a Happy Childhood*, gave our keynote addresses. By this time, our conference had grown from 230 attendees at our 2000 Conference to 363 attendees at this conference.

In 2004 we found ourselves in Clearwater Beach, Florida as Conference Chair Will White (Summit Achievement) focused the conference on "Best Practices" where he provided 28 excellent breakout sessions and keynote addresses by Dr. Edward Hallowell, M.D., Michael Gass, Ph.D., and Carol Santa, Ph.D. A tradition was born when Kimball DeLaMare, the first President of the NATSAP Board of Directors, was presented the first NATSAP Leadership Award.

At the 2005 "Working Together" Conference held in Tucson, our attendance reached a new record of 636 attendees. Conference Chair James Meyer (Oakley School) began another tradition with "Community Gatherings," with topics ranging from lowering costs to working toward ethical relationships between programs and consultants.

Throughout the planning and organization of all conferences, Rosemary Tippett, Jan Moss, Penny James, and Sarah Moir (Catherine Freer Wilderness) were invaluable resources to their success.

Finally, it is important to credit the direct leadership of NATSAP. Since its inception, NATSAP has benefited from having a succession of three full time executive directors, each of whom brought energy and talent to the position. As mentioned earlier, our first Executive Director, John Reddan, was a major visionary and founding influence. The next Executive Director, Andy Anderson, helped to build membership and offer support to the many smaller and beginning programs. Jan Moss, another past Executive Director, had the benefit of years of history with the board and tremendous organizational skill. She helped to make NATSAP a strong, well-run organization that could support a much broader range of activities. Jan concentrated on expanding regional chapters and conferences to reach deeper into the membership base. She also created a central structure that could support all of the committees and help them to achieve their goals.

NATSAP has also benefited from the committed leadership of three presidents. Kimball DeLaMare, Paul Smith, and John Santa have all provided

support for the executive directors, leadership for the board of directors, and served as effective representatives and spokesmen for the entire industry. All three are dedicated not only to NATSAP but to helping adolescents and their families. All three are clinicians, program owners and developers, and strong advocates of responsible, ethical, residential treatment.

As we entered 2006, we saw that NATSAP had fulfilled the initial vision of creating a strong professional and trade association. Both NATSAP and the entire industry had grown rapidly in the past seven years. NATSAP has helped raise awareness of best practice standards and encouraged a lively professional exchange of ideas and information. By establishing a sense of professional collegiality, NATSAP has contributed to safer, more responsible programs available to serve troubled youth and their families.

In the next ten years, we expect NATSAP to continue to grow in membership, visibility, and stature. NATSAP membership already establishes a standard of practice, quality, and professionalism that sets member programs apart from others who take a less professional and more market-oriented approach. Our programs must continue to offer high quality ethical practice and a willingness to constantly examine our profession to seek improvement.

We must be mindful and careful of competition and marketing as forces that can erode the development of our profession. We must guard the collegial professionalism and sharing that has developed at NATSAP, and in the next decade we must expand our professionalism to offer genuine research and exploration of what we do, of what is effective, and what are the limits of our work. NATSAP members must go beyond customer satisfaction surveys and simple outcome measures to explore across programs what we are doing and determine the basis of effective intervention. Such exploration requires openness, collaboration, and sharing of information. It will require developing data banks that will make possible long-term study of our work.

As a trade association, we envision NATSAP developing more clout and presence as the advocate and spokesperson for our industry. We are already contacted on a regular basis for commentary and information releases, but we need a larger national presence to represent our industry proactively as opposed to in defense from attacks aimed largely at programs who fail to meet NATSAP standards. All of us as members must work to establish NATSAP as our public advocate and representative in order to protect us from potentially harmful legislation and spurious attacks that damage all programs. In summary, we expect

NATSAP to grow markedly in importance as both a professional and trade association in the next decade.

POST SCRIPT—2018

Much has changed as NATSAP begins its 20th year. NATSAP has grown from the initial 66 programs to the current 181 programs, together with 131 individual members, and 11 affiliates. It is also true that many programs have come and gone with only two of the founding programs (Montana Academy and Spring Ridge Academy) still in operation.

Following Jan Moss's Term as Executive Director, Cliff Brownstein served as Executive Director for 8 years followed by our current Executive Director Megan Stokes who has been at the helm of the organization since 2017.

NATSAP has also grown to sponsor much more than an annual conference and a directory. In 2018 we hosted a national conference with 836 attendees as well as seven regional conferences including:

Southwest: 180

Utah: 424

Rocky Mountain: 100

Northwest: 65

Midwest: 106

Northeast: 285

Southeast: 183

In addition, we now have an annual Leadership Summit that allows program executives to gather in a collegial manner to discuss operational issues within a safe environment to discuss important and sensitive issues relating to program leadership, development, and safety devoid of the competitive forces of marketing to referral sources.

NATSAP has continued to financially support a large research effort begun more than 10 years ago when we created in an arrangement with Michael Gass, Ph.D. at the University of New Hampshire. He, in collaboration with the

NATSAP research committee, created a NATSAP database coupled with a basic outcome research protocol that allowed all programs to begin collecting outcome data to help us better understand the impact of our programming. The NATSAP effort combined with the Outdoor Behavioral Health Research Cooperative created thousands of data points across more than 40 programs. These data have led to dozens of articles that better support and define the impact of NATSAP programs and consequently have deepened our understanding of our collective work.

We also launched the *Journal of Therapeutic Schools and Programs* (JTSP) in 2006 that has created a specialized forum to publish both empirical and qualitative research, as well as case studies and reflective articles on the state of our profession. Michael Gass, Ph.D. was the editor for the first decade of the journal succeeded by Ellen Behrens, Ph.D. in the past four years. They have made the journal into an increasingly high-quality vehicle to further investigation, deepen understanding, and create the body of relevant evidence to support the effectiveness and need for NATSAP programs.

In the past two years the support for research has continued as the research committee initiated and the board approved the Research Designated Program (RDP) designation that has encouraged more than 47 programs to engage in systematic outcome research and join in the NATSAP research initiative. In order to achieve the RDP designation, a program must demonstrate that they have established a systematic program for collecting outcome data and examining the impact of their program. A continuation of research initiative is the "Golden Thread" project that has just been launched this year in collaboration with Michael Petree, M.S. This project attempts to provide a sophisticated database analysis that will allow us to track an individual client before the beginning of treatment across multiple NATSAP program placements allowing us to link together relevant data, creating the possibility of a "wait list" control. In addition to all of our research efforts, NATSAP has produced a variety of other publications to keep our members connected and aware of changes in the profession. Publications include the NATSAP Directory, We Are NATSAP and NATSAP Press, Education News, and Best Practices, all in the form of newsletters to provide programs a way to stay connected and discuss the latest activities and changes in their programs. Similarly, the NATSAP website has evolved to provide a rich resource of information about all that NATSAP offers to members, referral sources, parents, and the general public.

HISTORY OF NATSAP

At our national and some regional conferences, we have established Link n' Learn relationship workshops in order to facilitate consultant-program relationships, allowing our programs to introduce themselves to referral sources in an effective and efficient manner.

NATSAP has brought its government relations and lobbying activities in house (at a greatly reduced cost) and is now active on both the state and federal level. Our annual Hill Day has established NATSAP as a presence on Capitol Hill. In 2019, NATSAP will conduct their first state advocacy day in Salt Lake City. Our lobbying efforts are aimed at creating a single recognized voice for our programs that can inform legislators of the value and effectiveness of our programs and guard against uninformed and reactive legislative efforts to control our profession in ways that will reduce our ability to provide quality care for our clients and families.

NATSAP continues to retain 92-94% of its members each year. The average association experiences a less than 85% renewal rate. In short, at twenty years our organization has developed into a helpful, mature professional organization, and we look forward to continued growth and service to our programs, as well as to their clients and families.

The Call for an Integrated Family Systems Model

Liz van Ryn and Victoria Creighton
Pine River Institute

Providing transformative family therapy within a therapeutic treatment program is difficult to do. Pine River Institute attempted to meet this challenge by integrating a family systems model throughout their treatment program. The family systems model is largely informed by Satir Family Therapy, given the focus on strengths, personal responsibility, and experiential nature. Three significant programs changes were needed in order to ensure the success of the integration of the family system model: shifting treatment philosophy and culture within the organization, adopting a family therapy model, and training and self-development work for all staff. Program objectives and descriptions were offered, as well as preliminary findings (from both parent narratives and from the research and program evaluation department) on program efficacy.

Keywords: therapeutic treatment programs, Satir family therapy, family systems

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.02

INTREGRATED FAMILY SYSTEMS MODEL

Providing transformative family therapy within the confines of a therapeutic treatment program presented a challenge on a number of fronts; from the geographical, when parents are far away from where their son or daughter is receiving treatment, to the cultural, when myths about treatment include the concept of sending your child off to "get fixed." Larger still, however, was the challenge of pinning down what family engagement and participation was supposed to accomplish. Even more daunting was the implementation of a family therapy model that achieved sustained change within the family system, which, in turn, sustained positive change for the adolescent. In this article, some of the journey taken at Pine River Institute will be shared to establish efficacy in the family program using a fully integrated family systems model that leans heavily on Satir Family Therapy.

Parent engagement is a key to success in a therapeutic treatment program. The argument is well-established by Krissy Pozatek (2010; 2014) in her books *The Parallel Process* and *Brave Parenting*. What do we really mean, however, when we say that we engage parents and work with the families of the youth that we treat? Levels of engagement can vary tremendously across programs. In some cases, the parents serve solely as administrative support, providing financial resources and ensuring that the child makes it to therapy. In other programs, parents may be included in the therapeutic process to the extent that they are kept apprised of their child's progress and processes, participating through phone calls, letters, and visits. They may be given books to read, podcasts to listen to, educational workshops to attend, and the opportunity to do a personal therapy retreat. Brad Reedy (2015) took it to a level deeper and advocated for deep personal change in the "self" of the parent in his book *The Journey of the Heroic Parent.* But how do we support parents to achieve these crucial changes? As we developed our family program at Pine River Institute, we read these books, we believed in them, and we tried to sell our parents on the idea that their parallel process is essential to the sustained growth and health of their child. We also continued to ask ourselves, what does the parallel process mean for a parent, and how do we help them actually grow alongside their child? How do we build full engagement in the therapeutic process with clear goals towards family system change? How do we ensure that our very differently trained therapists are grounded in an approach that moves families closer to these goals? What are the most effective therapeutic techniques that we can use to deliver therapeutic care to parents? And how do we dispel the myth that youth are dropped off to be "fixed," without indirectly blaming the parent?

In looking for the answers to these questions, we realized what a tall order we had set up for ourselves. First, we discovered that we spoke the words "family

systems approach," but we did not really build a culture within the staff and within the families that could support the kind of deep work that parents needed to do in order to really change the family dynamics. We discovered some hard truths. No matter which way you come at it, parents feel blamed; in truth, we often blame parents when things are not going well. We also discovered that we mostly focused on the child maturing and mostly hoped that the family would shift enough to sustain the emotional growth of the child. In short, we found ourselves wanting.

Subsequently, the process to fully develop from the state of realization that we lacked a true and effective family therapy program into an integrated family systems model that actually transforms parents and families has been a gradual and fairly natural one. There was no single "aha" moment where we felt we "got it." However, by recognizing the importance of parent engagement right from the beginning, we organically evolved our "scatter gun" approach, offering a plethora of options for therapy, learning, and growth, and we developed a comprehensive, unified approach to family work. As our program philosophy grew and matured, we slowly refined and streamlined our approach, adopting a coherent family systems model for therapy and skills development for parents, training all of our staff in the model, and "peppering" our program with the components of the model. Now, with a trained and dedicated staff, we offer a fully integrated and goal-driven family systems model for transformative and sustained change in our families. Before we embark on a description of the mechanics of the program, however, we need to focus on the paradigm shift that has allowed these mechanics to work.

Crucial Components for Program Change

There are three inter-connected crucial components to the paradigm shift that we have achieved in our program. The first is a genuine shift in our treatment philosophy to focus on the health of the family system in which the youth is embedded. We embed this language of system change early on in our program, in our literature, on our website, and in our first meetings with families to mitigate any surprises for parents after the youth is in therapy. The families quickly learn that they are "too important not to be a part of the problem," just as they are the key to the solution. Jokingly, we deliver the good news: "you did not cause this problem with your child," and we deliver the bad news: "but it's not likely to change unless you change." We worked hard to create a culture amongst the parent community that values and is engaged in self-growth and the development of a deeper maturity within themselves with the main message being that if a parent is going to "help develop the self of a child," they need to have a "mature

and separate sense of self" themselves. Parents are daunted by this, as well as curious, often recognizing early in the process the particular steps in the dance they did with their child. Our approach capitalizes on that curiosity, and parents soak in the attention we pay to them and their development, often with a ready willingness to explore themselves and their impact, for better and for worse.

The second crucial component is the adoption of a family therapy model that is strengths-based and focused on self-growth, self-responsibility, and communication. Our culture at Pine River has always been one of appreciation of strengths, so when we stumbled upon Satir family therapy, it was a natural fit. The universality of the model, the firm adherence to the belief that we are all inextricably connected, the focus on congruent communication, and the emphasis on growing the self of the therapist helped instill a genuine belief that we can support anyone to grow their self-esteem (Satir, 1991). Satir family therapy offers parents a chance to honor the coping strategies they learned as a child and to set them aside in order to develop a new relationship with their son or daughter. It has been a winning combination that has offered parents an opportunity to accurately recognize and accept themselves, to dissolve their guilt, own their emotions, and to open up to developing a deeper maturity within themselves. In short, it helps to develop a separate and strong sense of self so that they can be better connected in the relationship with their child.

The third crucial component is a comprehensive training of our clinical staff in Satir family therapy through experiential learning and engaging in our own self-growth. Family work is hard work. It's well worth it, but there is no denying how difficult it is. Many therapists are not adequately trained in family therapy and/or lack confidence in their ability to influence families. Younger therapists who have not been parents themselves can struggle to relate to the issues that parents face. We are all, to some extent, vulnerable to having an imperfect awareness of our own coping stances and unresolved family issues, and therapists are particularly vulnerable as they wade through the deep emotional muck with their clients. An easy trap for any therapist to fall into is the tendency to blame parents and to subsequently dismiss them from the change process. This countertransference can make therapeutic progression difficult, as boundaries between the self of the therapist and that of the client can get blurry. However, by training in experiential learning using the Satir methodology, we mitigate this risk. Our clinical meetings have become a safe space in which we talk about countertransference dynamics, along with other family issues that surface, so that we can move forward in our work with more appropriate boundaries and a healthier therapeutic perspective. This fosters the competency and confidence of therapists and makes for a coherent and highly supportive team.

INTREGRATED FAMILY SYSTEMS MODEL

We have also trained our front-line residential youth workers in components of the Satir model, including coping stances, temperature checks, the iceberg, and family sculpting. We have provided opportunities for everyone to explore their own family of origin dynamics, and we provided safe learning space to reflect on how this impacts their relationships with other staff, the youth, and the parents. With a well-defined Satir family systems approach that includes relevant professional development, therapists and staff on the floor have a framework in which to conceptualize the family dynamics, as well as a clear idea of what needs to change in order for the family system to experience greater health. A sweet example of how this manifested itself is occurred when our somewhat gruff chef shared with staff that he believed a student who was working in the kitchen was "placating" the kitchen staff as opposed to being "congruent."

Each of these crucial components leans heavily on the others and on a belief in the importance of creating an emotional growth program for the family that is focused on the parents growing as much as their child. This model permeates our student, parent, and staff culture with a common language, shared understanding of family dynamics, and collaborative approaches to fostering the necessary growth and healing in our families. This allows us to help families dispel existing myths about blame, engage families in systems change, develop professional competency, and ultimately foster better health among our youths.

How Does the Integrated Family Systems Model Work?

The most important factor in developing a fully integrated family systems model is the director of family programs position, which is dedicated to developing and leading the family program, writing curriculum, supporting therapists who have challenging families, and making sure all that we do is true to our model and philosophy of how to help heal families. While the primary therapist takes responsibility for their specific team of adolescents and their parents, the director of family programs is available as a resource for consultation and support across the entire program for all of the therapists and all of the parents. The training for this position is grounded in specific training in family therapy, supervision, and leadership, which allows this staff member to play an important role in facilitating change within the organization.

Our integrated family systems model seeks to promote and sustain change within the family system by integrating three main strategies:

- Utilizing the theoretical principles of Satir family therapy as our primary methodology for opening up the family's awareness of their strengths, as

well as those aspects of family functioning that perpetuate the adolescent's behavioral issues

- Providing a therapeutic and educational process that supports our parents in developing a separate sense of self from their children so that they can truly recognize and be in connection to their child

- Offering psycho-educational resources to support the mechanics of family health, including healthy boundaries, communication skills, emotional regulation, etc.

All of this is delivered through a comprehensive family program that supplies formal and informal opportunities for growth throughout the length of stay of the adolescent. Contrary to the previous "scatter gun" approach, we have now more carefully shaped our content and mechanisms for growth and learning. We provide formal learning opportunities, biannual two-day parent workshops, an intensive three-day therapy process for parents, family phone calls, therapy sessions, support groups, and multi-family sessions.

The overall goal of the program is to support family members to heal and grow so that they can engage in a healthy and loving relationship with each other. The objectives are:

- To provide programming opportunities that invite family members to reconnect, enjoy each other's company, and build relationship through games, sports, shared meals, low-key visits, and group therapeutic programming

- To build engagement and invite family members to be open to grow

- To increase parents' ability to be attuned to their children and to set limits

- To help parents understand their part in the unhealthy family dynamics and give them the tools to change that

- To support parents to take ownership of the health of their family and assist their child's movement towards independence.

(See Appendix A for a synopsis of how the various components combine to support the objectives and a detailed description of these components.)

INTREGRATED FAMILY SYSTEMS MODEL

Sunday Family Visits

Sunday family visits are the main vehicle for achieving the first objective, and they include Sunday brunch, followed by a multi-family psychoeducational group in which all family members participate, including little ones and grand-parents, followed by an unstructured visit or off-campus outing with the adolescent. The multi-family group provides a venue where we can focus on connection and relationship as families learn the mechanics of healthy family functioning. Themes that would typically be covered include communication skills, how to do a Satir temperature reading, healthy boundaries, Satir coping mechanisms, and the Johari window. The activities are fun and engaging and promote conversations amongst family members that may not occur otherwise.

Tuesday Support Groups

These weekly groups alternate between phone-in support for families who are geographically dispersed, and in-person groups for local Toronto families. They provide a combination of content and process. Phone-in groups center around a topic that aligns with whatever themes are being covered in the Sunday multi-family groups. A provocative article or video is sent out a few days prior to the call, and parents are invited to reflect on themselves in relationship to the material. It is a challenge to make this into a "process group" experience. However, parents seem to share openly about themselves in this format, and emotional expression is not uncommon. As our program develops, we are achieving more refinement in the content for these sessions so that each month covers a particular "unit" or theme that supports our objectives in a more targeted manner. In-person groups are run as process groups where parents bring forward their current concerns. The emphasis is on peer-to-peer learning and support as the therapist promotes sharing of ideas and experiences and punctuates these liberally with Pine River Institute (PRI) philosophy.

Parent Workshop

The second and third objectives are achieved primarily through our formalized parent workshop, a two-day event that takes place at the campus twice a year. This is considered a mandatory part of the program for parents (we usually have 99-100 percent attendance). The content of the workshop is tailored to the stage that the parent/child is at in the program and is comprised of lecture series, self-development groups, and process groups.

The lecture series provides education to ensure that every PRI parent is aware of the maturity model and philosophical stance that our program is built on,

as well as attunement and limit-setting, which are the mechanics of our parenting philosophy. Both are based on the work of John McKinnon (2008) and John Santa. The lectures for first-time attendees also focus on our family systems-based philosophy of parent involvement, and every parent is made aware of our invitation to grow as a person. These lectures are built on the work of Krissy Pozatek and Brad Reedy.

For the self-development groups, we divide up parents according to what we hypothesize to be their area of "stuckness" in their personal growth as evidenced by their style of connection with their adolescent. For example, parents who are enmeshed with the child are grouped together and may discuss how enmeshment is actually a form of abandonment for the child. Parents who have high expectations and a more authoritarian, overtly controlling style would be grouped together to explore what it might be like to let go of control or perfectionism. Parents who have an attachment style that has been shaped by inter-generational trauma are grouped together to learn about the impact of trauma on the brain.

The process group component of the parent workshop includes a parent process group with other parents, as well as a parent/child process group, which is a very powerful experience for most families. Both groups are organized around the child's particular team, and, in both groups, therapists raise a question to the participants to guide and focus the conversation. Parent process groups generally focus on parents sharing what they are working on in their own self-development. This presents yet another opportunity in an iterative process in which, throughout the program, parents are asked repeatedly to try to articulate their understanding of what they need to change in themselves. Depending on the stage of growth of the parent/child, questions posed in the parent/child process group can range from an opportunity to express appreciation for each other, to more challenging questions. For example, we might ask, "What is your biggest worry about your family's functioning? Reflect on what you need to change in order to make things go better in the family." These are generally highly emotional groups, and they lean heavily on the power of having all of the parents and kids witness, honour, and support each other's revelations.

Parents who have attended more than two parent workshops are offered a customized workshop with our after-care coordinator. The after-care coordinator takes over from the primary therapist once the adolescent has transitioned from the residential program. Their role is to help the parent develop and refine the contract between parent and child, set realistic expectations for what might happen in after-care, emphasize the importance of continuing to develop connection with

their adolescent, and continuing to set boundaries. Their focus during the parent workshops is on assisting parents to prepare their child to launch. This captures our fifth objective.

Parent Intensive

The three-day parent intensive is another mandatory activity for parents and is the main venue for achieving the fourth objective, which we believe is crucial to the overall outcomes for the adolescent. The intensive is a residential retreat for up to 10 parents that takes place over two evenings and three days. Participants stay at a small retreat center, sharing in the preparation and cleanup of meals, basically living together during this time. The intensive is rooted in Satir family therapy principles and practices. On the first evening, parents have a chance to share their story with everyone and express their vulnerabilities and their strengths; trust and safety are established within the group. In the morning, we review the Satir coping stances, and each person draws a complete family of origin map. Over the next thirty hours, we work our way creatively through "sculpting" some aspect of each person's family. This is a powerful and moving process as parents participate in each other's sculpt. The magical universality of human experience is what grounds Satir family therapy, and it manifests itself in innumerable ways during this process. Parents then have the opportunity to come back down to earth and sort through what they have learned, its practical applications in their lives, and how it can re-shape their role as a parent. Their adolescents are then invited in for the final process group to share with their parents what they need from them and to hear about what their parents have learned. The degree of alignment at this stage is often astonishing to the parents and extremely validating for the adolescents. For example, a parent who has discovered through her sculpt that what she really needs is to look after her own needs rather than focusing so much on her child is astounded when at the end of the intensive her child says, "Mom, I think you need to look after yourself better." A statement like this from the child or from the therapist would have been empty without the powerful experience of the sculpt to ground it into the parent's conscious awareness.

Parents self-select for the intensive based on their availability. We have tried to group parents from one team together, and although this is great for building support, it has proven to be logistically infeasible due to the staggered entry of our students. We continue to learn about this process. For example, in a recent parent intensive, we had inadvertently grouped together some "reluctant participants." These were parents whose personal experiences made them guarded and reluctant to engage. The justification for their reticence became apparent

when the family sculpting started. Each person had a very difficult and disturbing childhood that they had survived via coping and defense mechanisms that needed to be in place. This shared history of coping helped develop connection and validation for the participants, but it also detracted from the learning, as there was less modelling of health within the group. Some less healthy coping mechanisms were reinforced during the informal discussions that took place in the evening. Families start the program at different times throughout the year, so it is difficult to offer the family program in a specific order. For example, one family might have the intensive workshop in their second month, whereas another might not get this portion until later in the program. Another family might not have accomplished all of the reading assignments before attending a parent workshop. We have found that the order of obtaining information and experiences is not particularly crucial, and that we can only do so much to control a person's change process.

Our multi-pronged approach plants seeds along the way that germinate for different people at different moments in the process. Some families may do all of the required work but not get their "aha" moment until late in the program during a family session that takes place after the child has started the return home. Repetition of the message in different formats, including experiential (e.g., sculpting) and didactic, combined with lots of connecting time with their son or daughter, adds up in its own unique way for all of the families who are truly engaged.

Family Therapy and Weekly Phone Calls

Ongoing family therapy and weekly phone calls with parents build on the self-awareness that grows throughout all of these events. Our weekly phone calls are more than just an update about the child. The primary therapist for the child takes the lead with this work and consults regularly with the director of family programs to provide continuity in the process and to ensure that phone calls and sessions are targeted on the therapeutically salient matters at hand. Consultation and communication between these two roles are critical, and we take advantage of weekly formal opportunities as well as "lunch-line" conversations. In addition, we encourage parents to engage in their own personal therapy outside of PRI. As we succeed in helping parents understand the family system influences, there is more and more involvement of our parents in their own personal therapy.

INTREGRATED FAMILY SYSTEMS MODEL

Has Having an Integrated Family Systems Model Made an Impact on our Families?

PRI is dedicated to understanding and holding ourselves accountable to improving our youth's health and behavior. We demonstrate those improvements by way of ongoing evaluation that measures youth mental, behavioral, physical, and relationship health. Naturally, as our family systems therapy approach evolved, we knew that we would want to show that it optimized our youth and family outcomes. This too was a journey in which we were learning, testing, and improving.

We have seen first hand that an integrated family systems approach can create positive change. Parents express a profound appreciation for the changes that they make in their relationship with their teenagers. In particular, it helps them open up to their own self-awareness and growth, increase their attunement and ability to set limits with their child, and understand their part in the family dynamics (Creighton & Mills, 2016).

The research team at PRI worked with the clinicians to understand the process and outcomes expected from family engagement. Together, we then conducted a cross-sectional study – one that takes a one-time "snapshot'" – using clinician observation and existing client and family data. We were excited to share three important outcomes. First, family engagement with youth therapy was associated with reduced youth length of stay. At PRI, our length of stay is not based on a finite duration; it is a function of therapeutic progression. As such, youths who consistently demonstrate mature functioning in all ways will move more quickly through the program. Youths whose parents were rated by therapists as having higher attunement had shorter length of stay than those whose parents scored lower on attunement. In fact, on a scale of one to ten, for every one unit increase in attunement, we estimated 13 fewer days needed in program. The second finding related to mental health, and particularly to internalizing (i.e. mood) disorders. Youths whose parents scored higher on attunement had lower internalizing scores three to six months after Pine River Institute (PRI). In terms of externalizing (e.g., rule-breaking) disorders, youths who finished the program had the most improvements. In sum, youths who finish the program are more likely to reduce their problematic behavior, and when parents engage and learn skills of attunement, their youth are more likely to progress faster through treatment and sustain improved mental health.

More recent and very preliminary qualitative data suggests that for parents who buy into the process and engage in the integrated family systems approach,

positive change within the family occurs. Parents express a profound appreciation for the changes that they make in their relationship with their adolescents that link directly to our objectives as a program. In particular, we note that they comment on opening up to their own self-awareness and growth, increasing their attunement and ability to set limits with their child, and understanding their part in the unhealthy family dynamics. The Satir family therapy model seems to be an effective tool in setting the stage for change, particularly the family sculpting exercise that takes place at the parent intensive.

Opening Up to Self-Awareness and Growth

Unsettling, exciting, and terrifying are adjectives parents have used to describe the impact of the realization that upon admitting their child to the Pine River program, they too had become part of a learning and growing process:

> When my son entered the Outdoor Leadership Experience, I believed that PRI, with its intensive residential therapy programming, would be life-changing for him. It didn't occur to me that I too would be forever changed as a person and as a parent. The parallel process, the PRI model of family therapy, has taken me from being an enmeshed, anxious person and parent to a more self-aware and confident individual. I did not anticipate that my core beliefs about parenting, personal and family relationships, and "self" would be so challenged. Yet, 14 months later, I would, as a result of this intensive work within the PRI community. I have a new perspective about my role in my son's life.

And from another parent:

> One of the biggest things that was unsettling was the understanding and acceptance that our son needed to change, but so did we. Without blame or guilt, which is next to impossible, we needed to come to the realization and acknowledgement that our son got to where he was through a combination of who he was and what he did, but also who we were and what we did. Through many discussions with many people, therapists, friends, and other parents in the program, I am comfortable that I was not a "bad parent," but I am equally comfortable saying that I was not the parent that my son needed.

Increasing Attunement and Limit-Setting

Increased attunement and more effective limit-setting seem to come with self-awareness and growth as parents use the program to develop a sense of self that was separate from their son or daughter. The ability to be in a real connection with the child increased as parents engaged in this important work:

> …our son's therapist challenged us and set limits that initially were very off-putting but definitely necessary for me to recognize my need to separate from my son.

For this parent, the change seems to be carried forward into other areas of life:

> I make a conscious effort to use this model with my own mother. Putting my perceptions, interpretations, feelings, intentions, and reactions in context has helped me to express myself with clarity, and it eliminates judgements. It also has a sometimes less than desirable effect of setting firm boundaries where none existed before. It can get messy, but it is necessary for separation and setting limits.

For this parent, the awareness that he was separate from his son led to his ability to understand and better hold a boundary:

> I came to a real understanding that my son is different and distinct from me and doesn't and shouldn't think all the same things that I think. My boundaries should be about what I'm prepared to do and accept and not about what he's "supposed" to do. The other highly effective change is that I needed to start to really listen to him and to accept different opinions and accept him for who he was and not focus on the ways that he wasn't the person that I thought he "should" be.

Understanding Their Part in the Unhealthy Family Dynamics

Within an integrated family systems model, this is the crown jewel of the entire process. It seems to be the key that unlocks the door to understanding, acceptance, and moving forward in a positive way. The use of Satir family therapy is critical to this process for this parent as they "sculpt" their own family of origin and relate it to how they behave as a parent in relationship to their own child.

> Learning about the Satir family model of family therapy was perhaps the most challenging part of my experience at Pine River. The parent intensive or retreat, was nothing more than life changing for me. Participating in a family sculpting exercise…helped define why I have always tried to rescue my son and how my parents' parenting has affected how I too parent, or at least used to parent...It was an "aha" moment, unlike any I have experienced. I never understood much about boundaries because my family had so few. It was a painful and powerful experience.

This parent highlights the impact of their own family of origin work on their ability to be in relationships and to parent effectively:

> Prior to PRI, I hadn't given much thought as to how my upbringing affected my parenting. I had been aware of how it may have affected my personality and some of my adult relationships, but even with respect to those, I don't believe that I understood how significant those impacts had been. I would say that the parent intensive and particularly the sculpting that was done, was so jarring that I was forced to look inward and see how all of those things were still driving my behavior all these years later.

Parents who have these types of experiences in the intensive usually see the merit in continuing on with therapy of their own outside of the program. The PRI process just kick-starts things by putting the whole picture into sharper focus for parents.

These preliminary findings were so exciting. They validated what we experienced and led to a deeper dialogue about how and what to measure to capture the benefits of family therapy. We have now added parent practices, parental maturity and attachment, and clinical observations of parent engagement and growth. We will soon be able to quantify parent changes and explore whether these changes foster more profound youth outcomes.

What's Next for Pine River's Integrated Family Systems Model?

As we forge ahead, we are continually seeking better ways to move from instructional skills-based programming to providing more experiential learning opportunities for our families. These provide profound and moving therapeutic experiences that truly speak to the issues of the development of a separate sense of self for the parent so that they can better connect with the separate self of their adolescent. Efficiency in delivering such a program remains a continual challenge. In addition, we know that we have to focus on parent engagement with

parents who are difficult to reach. We operate on the assumptions that every parent wants desperately to be the best that they can be, however, some of our parents remain disengaged and, we believe, fearful of the process of self-growth. Finally, we will continue to collect outcome data to ensure that our efforts are effective. We are confident, however, that an integrated family systems model will continue to be a path on which we can build and grow effective service for adolescents and their families.

References

Creighton, V., & Mills, L. (2016). Family matters: Engaging parents in youth treatment. *Journal of Therapeutic Schools & Programs, 8*, 58-64.

McKinnon, J. A. (2008). *An unchanged mind: The problem of immaturity in adolescence*. New York, NY: Lantern Books.

Pozatek, K. (2010). *The parallel process: Growing alongside your adolescent or young adult.* New York, NY: Lantern Books.

Pozatek, K. (2014). *Brave parenting: A Buddhist-inspired guide to raising emotionally resilient children.* Somerville, MA: Wisdom Publications.

Reedy, B. M. (2015). *The journey of the heroic parent: Your child's struggle and the road home.* Regan Arts.

Satir, V., Banmen, J., Gerber, J., & Gomori, M. (1991). *The Satir model: Family therapy and beyond.* Palo Alto, CA: Science and Behavior Books.

Appendix A

Table 1

Objectives of the Family Program	Activity that supports that objective	When your child is in OLE	When your child is in Stage 2	When your child is in Stage 3	When your child is in Stage 4/5	At your 1st Parent Workshop	At your 2nd Parent workshop	At your 3rd Parent Workshop	At the Parent Intensive	Throughout the program
To re-connect, enjoy the company of my son/daughter, and re-build the relationship.	□ Write letters to your child □ Write a Letter of Impact to your child □ Regular Sunday visits	√ √	√							
To learn and apply the Maturity Model.	□ Read *An Unchanged Mind* □ Attend Maturity Model lecture	√				√				
To be open to grow and develop as a separate person from my son/daughter.	□ Attend Tuesday Parent Support Sessions □ Write your life story □ Attend a Parent Intensive □ Read *The Journey of the Heroic Parent* □ Attend Journey of the Heroic Parent	√	√			√				√

INTREGRATED FAMILY SYSTEMS MODEL

Objectives of the Family Program	Activity that supports that objective	When your child is in OLE	When your child is in Stage 2	When your child is in Stage 3	When your child is in Stage 4/5	At your 1st Parent Workshop	At your 2nd Parent workshop	At your 3rd Parent Workshop	At the Parent Intensive	Throughout the program
	☐ Attend Self-Growth sessions					√	√	√		
To increase my ability to be attuned to my child and to set limits appropriately.	☐ Attend Clinical Parenting session ☐ Attend Attunement and Limit-setting ☐ Read *To Change a Mind* ☐ Learn the communication model			√ √		√	√			
To understand my/our part in the unhealthy family dynamics and develop the tools to change that.	☐ Create a Family Map ☐ Do a "sculpt" of your family-of-origin ☐ Family therapy at PRI ☐ Get your own therapist			√					√ √	√
To take ownership of the health of the family and move to independence.	☐ Learn how to do a Temperature Reading ☐ Read *Not by Chance* ☐ Develop home visit contracts ☐ Attend Preparing to Launch			√	√ √			√		

INTREGRATED FAMILY SYSTEMS MODEL

Objectives of the Family Program	Activity that supports that objective	When your child is in OLE	When your child is in Stage 2	When your child is in Stage 3	When your child is in Stage 4/5	At your 1st Parent Workshop	At your 2nd Parent workshop	At your 3rd Parent Workshop	At the Parent Intensive	Throughout the program
To take ownership of the health of the family and move to independence	□ Attend After Care Contracts session □ Develop After-care Contract □ Attend After-care Parent Support Group					√		√		

Clinical Focus on the Family is Critical in Residential Treatment of Adolescents: Data Informed Intervention within the Family System

John Hall
Telos

This paper discusses the importance of working directly with the family system from a theoretically informed position when the adolescent family member is in residential treatment. Treatment of the entire family system is critical not only to family change but also individual change that will be in sync with the system. This paper presents the methodology and results of a multi-year, ongoing study of change in families with an adolescent in residential treatment. Data is gathered from the adolescent in treatment as well as the parents. Aggregate descriptive statistics are reported for scores of family functioning using the Family Assessment Device-General Functioning scores at admit, discharge, and one year post-discharge. Trends are displayed and analyzed. Feedback informed treatment is discussed in terms of the family system. The use of data can be helpful to the treatment team in assessing effectiveness of treatment and making adjustments to interventions. The use of data can be used to help families and individuals recognize progress in family functioning. Recommendations are made to treatment centers to use data to improve systemic intervention effectiveness and treatment outcomes.

Keywords: residential treatment, feedback informed treatment, family systems

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.03

CLINICAL FOCUS ON THE FAMILY

Residential treatment should not only be an exercise in helping the youth who are admitted to the treatment centers; rather, treatment centers should recognize the necessity of treating the entire family when a member of that family is in residential treatment. Family therapy is a key component of lasting change for adolescents in treatment, as will be discussed in this paper.

Family Systems Theory

In 1958 the Mental Research Institute (MRI) in Palo Alto, California began studying the treatment of the family as a system and built on the work of family therapy pioneers such as Virginia Satir, Murray Bowen, Salvador Minuchin, and Don Jackson. This movement caused a shift away from therapy focused only on the individual and led to a key evolution in the therapeutic process, expanding the focus of the mental health field beyond individual psychotherapy (Watzlawick, Weakland, & Fisch, 1974). As families interact with each other they follow a structure or pattern developed over time through communication and feedback, which tends to form a homeostasis of family functioning that can become predictable and defined (Becvar & Becvar, 1999). Change within this system, or first order change, is governed by the rules the family has set up, both implicit and explicit, and is limited by the dynamics of maintaining the homeostatic balance of the family. Because of these factors, it is difficult for one family member to change his or her behavior in a transformative manner without upsetting the balance in the family system (Lyddon, 1990). Therefore, if an individual generating maladaptive behavior is receiving treatment to change these patterns, it becomes critical to treat the entire family system so that the system can change together, achieving morphogenesis, or a meta-level re-alignment of beliefs about family functioning, boundaries, rules, and patterns of interaction. This process facilitates individual change within the system to meet the parameters of a new systemic concept (Kern & Wheeler, 1977). The forces of homeostasis will now act to maintain this new matrix of expectations within the family instead of pushing the family back into the old system. This change process is known as second order change (Watzlawick et al., 1974), and is the "underlying dynamic that activates the change process in psychotherapy" (Fraser & Solovey, 2007, p. 271).

Family Therapy in Residential Treatment

Likely due to the importance of helping the whole system to change, as a student of marriage and family therapy I had been dissuaded by some to work in residential settings because it is assumed that only one member of the system will be available for treatment, thus reducing the likelihood of second order change

due to the inaccessibility of the system as a whole to engage in the therapeutic process. This further leads to the potential that when an individual who makes transformative change in a treatment process re-enters a family system that has not changed, the forces of homeostasis will lead to degeneration of individual changes if they are not in line with the supported patterns of family interaction. Due to these processes, when residential treatment centers do not engage in treatment of the family they may see higher rates of relapse in symptoms post-discharge. Research indicates that participation of the parents and family in the process of residential treatment leads to improved outcomes and improved ability to integrate lasting change after residential treatment has terminated (Merritts, 2016).

Therefore, if a treatment center does engage the family system in the change process, it follows that the limitations on second order systemic change are likely to be diminished. There is also an argument to be made that one of the limiting factors of community-based treatment is that individuals cannot receive adequate treatment unless they are removed from their problematic context and dysfunctional system (Hair, 2005). Out of home placement can provide the space to begin the change process in the absence of constant triggers to re-engage in unhealthy behaviors and dynamics. Removing the identified and symptomatic patient can allow each individual in the family to begin to make changes at a meta level first, then begin to implement these changes during incrementally increased interaction with each other through long distance communication, increasingly longer home visits, and finally the reintegration process which requires ongoing support (Thayne, 2017).

The purpose of this paper is to demonstrate the importance of using data to identify, track, and validate treatment of the family while an adolescent member of the family is in a residential treatment setting. Furthermore, it is critical for the clinical team in a residential setting to make second order change of the entire system a key goal of treatment, and to create programming that fosters this change process during the course of treatment.

Knowing the Map and the Territory

In his work “On Exactitude in Science” Borges (1946) illustrated the difficulty of using an abstraction, such as a map, to accurately represent the territory. He posited that the only way to have a truly accurate map is to have a map that is the same size as the territory it charts. In family therapy, the territory we are mapping is the family system dynamics, the roles of each family member, their own internal psychology, how they impact each other relationally, implicit and explicit rules, family goals, extended family history, family resources and

deficits, etc. Engaging in family therapy requires being able to understand how each aspect of the territory is important and understand how and where to intervene. This requires a map in family therapy, the map is the theory and associated intervention. For instance, taking a Bowenian approach, the therapist is likely to identify the differentiation of the family members and look at the generational transmissions of family patterns and what maintains those transmissions (Larsen, 1998). A solution focused therapist will focus on the family's goals and helping them identify clear solutions to reach those goals, scaling the change process over a brief period of time and working toward establishing these changes in the system post-treatment (Robbins, Bachrach, & Szapocznik, 2002). There are several other organized theoretical approaches in family therapy including structural, strategic, narrative, Milan-systemic, etc. The interventions used to support the family are guided by the theoretical map, or way of viewing the system, as well as the change process and the purpose of family therapy. An effective family therapist must have a clear understanding of both the theoretical map and the territory to which it is applied.

Treatment programs can support the change process through elevating the importance of family therapy and protecting the therapeutic process from becoming simply a report on how the resident is doing, or to rehash events occurring in treatment; instead, this shift can keep the focus on family interaction and identified goals. It is most helpful when a program develops and follows a consistent model that supports treatment of the entire family. Each family therapist will certainly approach therapy with artful differences, but it is key to have a structural guide for important aspects of systemic treatment. This should be given oversight programmatically, as treatment models are developed on a macro level and should also be reviewed for progress in treatment team meetings. The treatment team should give family therapy oversight.

A key programmatic aspect of family treatment is including the treatment of the family in the treatment planning process. Some helpful things to identify when treatment planning with the family in mind are current family dynamics and roles, areas of dysfunction (which can be assessed through standardized measures), and areas of strength. It should include goals for the parents to make changes as well as the resident of the treatment program. These goals can focus on improving specific skill sets such as communication or conflict management; they can also address specific family roles that need to be adjusted, or implicit or explicit family rules that support change or dysfunction. It can also include identification of family resources that can be drawn upon to support change, both for the individual and for the system as a whole. Finally, having regular

opportunities for families to engage in the treatment process through parent seminars, family weekends, recreation therapy, experiential activities, parent support groups, family-based curriculum, webinars, and recommended readings can help involve the family as a whole in the treatment process.

Can You Effectively Treat the System While One Individual is in Residential Treatment?

Individual therapy involves theoretical approaches that focus on helping the client with their individual psychology, behavior, and emotions. Treatment plans often focus on developing personal awareness and skills for managing identified areas of concern. These often include a cognitive behavioral approach, dialectical behavior therapy, mindfulness training, psychodynamic approaches, emotionally focused therapy, trauma interventions, motivation interviewing, etc. While all of these approaches focus on the individual, a good treatment process does not take place in a vacuum.

One fundamental advantage to residential treatment is the ability to take a holistic approach and use the milieu to make changes to body, mind, and spirit. Research has shown that physical health and mental health are closely related (Bremer, Crozier, & Lloyd, 2016). Additionally, family-focused treatment programs recognize that individual mental health is also closely related with the systemic health of the family (Sunseri, 2004). Individual improvements made while in residential treatment can lead to improved family functioning, but, perhaps more importantly, improved family functioning can lead to individual improvements. In order to effectively do this, the residential treatment center must have interaction with the family to understand the territory and apply the map of systemic theories of change.

This includes assessment not only of the individual but of the family dynamic and sometimes in-depth assessment of other members of the family when needed. It includes interaction with the family on a regular basis including in person and for the whole system. Weekly family therapy sessions (via communications technology as proximity demands), regular visits from family inside and outside the treatment milieu, home passes, and clinical support and assessment in the home when treatment has concluded are all opportunities to engage the whole family system in the change process while one individual is in treatment. During these opportunities, intervention should be focused on the functioning of all of the members of the system as a whole rather than merely on the client within the context of the family.

Method

In order to verify that the above assertions are accurate, standardized family assessment can be utilized to track changes in the family system over the course of the residential treatment process. In 2012 the research committee of the National Association of Therapeutic Schools and Programs (NATSAP) added the General Functioning subscale of the McMaster Family Assessment Device (GF-FAD) to the battery of surveys given to clients and their parents as part of a multi-program research initiative to study outcomes in residential treatment. The assessment has twelve questions and is given at admit, discharge, six-months post discharge, and one-year post discharge from wilderness therapy and residential treatment programs participating in the research initiative.

The 12 questions are:

1. Planning family activities is difficult because we misunderstand each other.
2. In times of crisis we can turn to each other for support.
3. We cannot talk to each other about the sadness we feel.
4. Individuals are accepted for what they are.
5. We avoid discussing our fears and concerns.
6. We can express feelings to each other.
7. There are lots of bad feelings in the family.
8. We feel accepted for what we are.
9. Making decisions is a problem for our family.
10. We are able to make decisions about how to solve problems.
11. We don't get along well together.
12. We confide in each other.

These questions are followed by four options: Strongly Agree, Agree, Disagree, or Strongly Disagree. The questions are scored on a 1 to 4 scale with odd numbered questions being reverse scored. By design, scores of 3 and 4 on an item represents a problematic family dynamic or dysfunction. The test is scored with an average of scores from each item. A score of 2 or lower is labeled a healthy response and in the functional range, while a score greater than 2 is labeled an unhealthy response and in the dysfunctional range (Epstein, Baldwin, & Bishop, 1983).

The data in this study were drawn from GF-FAD test records from clients admitted between 2012 and 2016 to Telos, a private residential treatment center for adolescent boys ages 12-18. The total number of data points at this point was 566, including 279 admission scores, 157 of which were students and 122 of

which were parents. Discharge scores were a total of 186 scores, 113 of which were students and 73 of which were parents scores. One-year post-discharge totals were 85, with 34 students reporting and 51 parents reporting. The entire data set was included as aggregate scores and not matched pairs due to the small number of matched pairs at that time. Average scores at admit were compared with average scores at discharge and post-discharge to evaluate whether there had been improvement in the family system for this sample.

Furthermore, average scores at admit, discharge and one-year post-discharge were calculated and analyzed for each of the 12 questions so that it was clear which areas were still being reported as strengths or weaknesses by parents and students regarding each area addressed by each question across points of reporting. Trends were evaluated and analyzed as discussed below.

Results

After three years the data set included not only admit data, but also discharge and post-discharge data. Post-discharge data is more difficult to obtain, and so we combined data that was collected at 180 days post-discharge with data collected at 365 days post-discharge. Table 1 shows the number of parents and clients at Intake, Discharge, 180 days post-discharge, and 365 days post-discharge.

Table 1

Number of Participants at Each Administration

Individual	Admit	Discharge	Post-180	Post-365
Self	42	45	4	11
Parent	94	34	11	17

Note. The mean GF-FAD scores for Admission, Discharge, and Post-Discharge are shown in Table 2 and *Figures 1* and *2* for Parents, and *Figure 2* for Adolescents.

Table 2

Mean FAD Ratings by Parent and Adolescent

Individual	Admit	Discharge	Post-Discharge
Parent	2.36	2	2.06
Adolescent	2.27	1.91	2.03

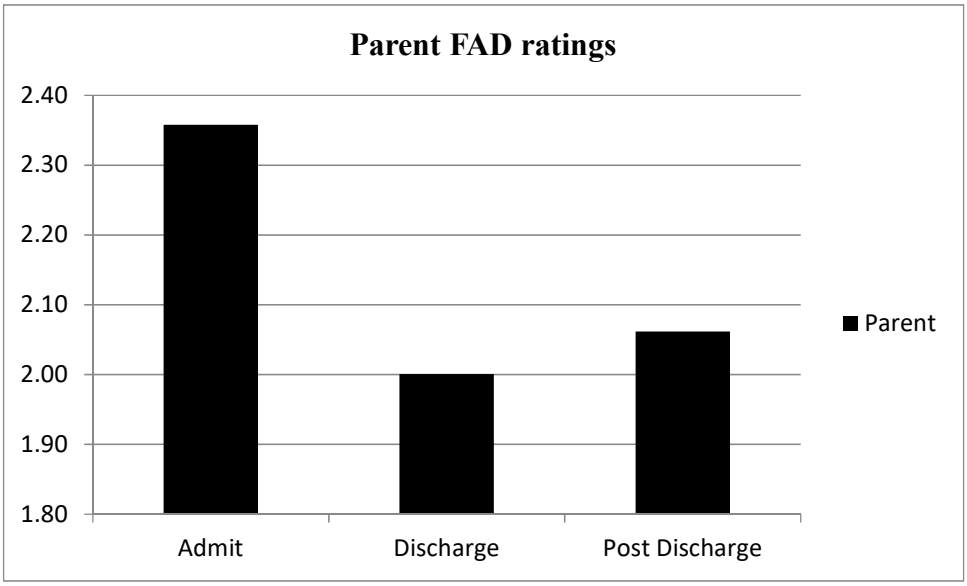

Figure 1. Parent FAD Ratings

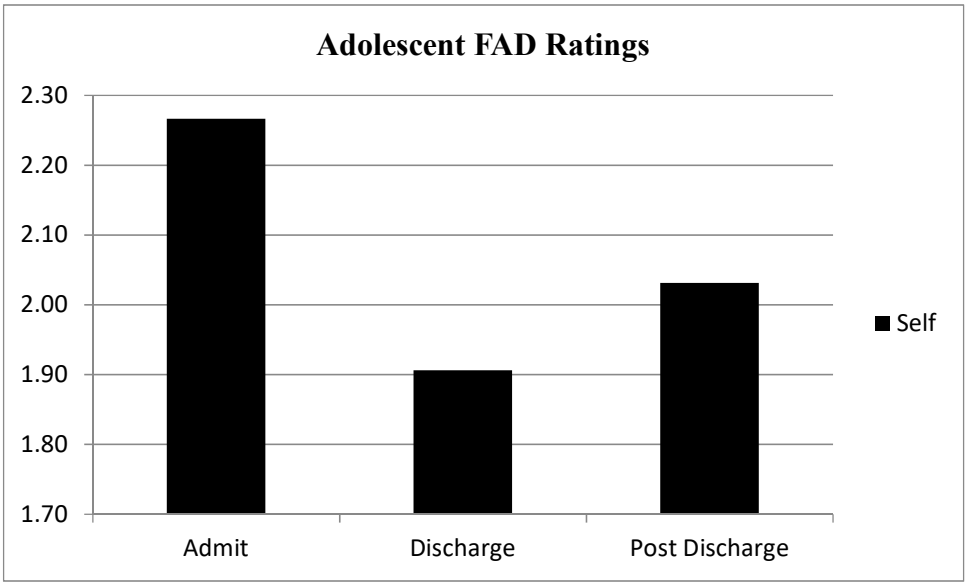

Figure 2. Adolescent FAD Ratings

With a clinical cut off of 2.0 on the GF-FAD (Mansfield, Keitner, & Dealey, 2015), the data indicates that at admit to treatment the average parent and average adolescent client reports the family system is functioning in the dysfunctional range with a mean score of 2.36 for parents and 2.27 for adolescents. At discharge, the average parent reports being just inside the clinical range, but with clear improvement in functioning since admission, with a mean of 2.0. The adolescent client's average was outside of the clinical range at discharge, showing the greatest amount of reported change with a mean of 1.91. At post-discharge, parents report an average of 2.0 and the adolescent clients report an average of 2.06, both maintaining clear improvement from the admission scores.

A two-factor analysis of variance of parent and student data indicates that the differences in GF-FAD scores from admission to discharge and post-discharge are statistically significant ($F(2, 252) = 16.65$, $p < .0001$). There was also a statistically significant difference between overall parent and adolescent ratings ($F(1, 252) = 6.19$, $p<.014$), with parent ratings being generally higher than the adolescents. However, there was no interaction between parent/adolescent ratings and test administration indicating, as the figures illustrate, that in both cases ratings were higher at admissions and decreased at similar rate through discharge and post-discharge ratings. Using Tukey t-tests to examine all pairwise differences indicate that there are significant pairwise differences for both parents and adolescents between admission and discharge and admission and post-discharge. There were no significant differences between discharge and post-discharge scores, indicating that the observed significant improvement in family function remained stable from discharge to post-discharge.

Going a step deeper into the results, three questions remained prominent at discharge as the most problematic family issues, with scores slightly over the clinical cut off of 2. The issue about avoiding discussion of fears and concerns remains as a top concern. It is joined by indications of bad feelings in the family and that planning family activities is difficult because of misunderstandings.

Discussion

While it is clear that for this group of families, family function improved from admission to discharge and the improvement was maintained at post-discharge, it is important to recognize that the data set is relatively small, in a single sex program, and of a diversity that does not match the general population; therefore, the effects might have a limited generalizability. There are also differing levels of acuity in family dysfunction, such that those with higher dysfunction

could have similar rates of improvement but still be in the dysfunctional range after the improvement.

It is clear that improvement in family functioning can happen in different areas at different rates and degrees. For instance, families can get better at sharing feelings and communicating, but might still struggle with problem solving, bringing up concerns, and understanding each other. However, it does appear that growth happens at least somewhat consistently across areas, indicating that family therapy or treatment planning has a net positive effect on multiple areas of family functioning over the course of treatment. Of note is the trend of students reporting less symptoms at all three data points than parents. This is consistent with other data sets such as the Youth Outcome Questionnaire when given at multiple treatment settings (Tucker, Paul, Hobson, Karoff, & Gass, 2016).

Using the Data to Improve Family Therapy Through Clinical Team Strategic Planning

When viewed through a lens of continuous quality improvement and clinical excellence in providing family treatment, there is a clear opportunity to use GF-FAD data to monitor progress of improvement in multiple areas of family functioning. Beyond a passive measurement of progress, the data can be used to provide feedback to the treatment team regarding the effectiveness of interventions being employed by the therapist and programmatically. If a family is not improving their ability to discuss fears and concerns even one year after treatment, it is clear that this is an area that needs to be more effectively addressed in family therapy and programming.

At Telos, the clinical team has used the information gathered for multiple years to inform the annual strategic plan and to increase the focus on conflict management and assertive communication about problems that arise within the family system. Clinical trainings are held to support the therapeutic process, and this goal is frequently reviewed in clinical meetings. Treatment plans are also reviewed in treatment team meetings, where the family system is a mandatory treatment issue to be addressed on each plan.

Additionally, the GF-FAD is now administered monthly to get a more frequent read of trends in family functioning throughout the treatment process. Not only is the treatment team able to see the impact of their interventions, but the data is given to the family directly regarding the progress according to their own report. This can be used in family therapy to discuss not only their progress but also differences in perspective. It can also be used to highlight areas of strength

that can be reinforced and areas of difficulty that can be more intensively addressed. It is hoped that this kind of attention to the family system by using GF-FAD data will ultimately improve a treatment center's ability to effectively treat the family system in the areas that are needed in each individual case. This attention to systemic change, even while one member of the family is in residential treatment, may be the key to maintaining lasting change in both the family and the individual post-treatment.

Concluding Implications

Family therapy and other family interventions are an important part of effectively treating the individual clients that reside in residential treatment centers. It is imperative that all treatment centers understand the impact of the family system on the functioning of individuals in their programs. It is also critical that treatment programs recognize the opportunity and necessity of treating not only the individual residing on location, but also to recognize the family system as the client as well.

Many treatment centers have family programming included in their clinical approach, but it is not always clear how effective these approaches are, especially since the family is not residing in or usually even near the treatment program. Using the GF-FAD, or another normed and standardized assessment, provides the therapist and treatment team with necessary information to effectively treat the whole system and more holistically treat the individuals residing in the programs.

The data can be used to help the families recognize their current level of functioning, and routine progress monitoring can provide the necessary feedback to provide clinically excellent systemic therapy throughout the treatment process. Given the distance of families in most cases with residential treatment, this form of assessment may be one of the only ethical ways to ensure that the family receives effective treatment. Regardless of which systemic approach is used, treatment of the family can be accomplished even when an individual member is in residential treatment. Through assessment and treatment planning, the whole family can track their progress on family treatment goals and work for a happier and healthier family. This will certainly support the long-term progress and changes for the individuals in treatment and is an important component of residential treatment that must not be ignored.

References

Becvar, D. S., & Becvar, R. J. (1999). *Systems theory and family therapy*. Family Therapy (2nd ed.). Lanham, MD: University Press of America, Inc.

Borges, J. L. (1946). *On exactitude in science.* Historia Universal de la Infamia (2nd ed.). Buenos Aires, Argentina: Editorial Tor.

Bremer, E., Crozier, M., & Lloyd, M. (2016). A systematic review of the behavioral outcomes following exercise interventions for children and youth with autism spectrum disorder. *Autism: The International Journal of Research and Practice, 20*(8), 899-915. doi: 10.1177/1362361315616002

Epstein, N.B., Baldwin, L.M., & Bishop, D.S. (1983). The McMaster Family Assessment Device. *Journal of Marital and Family Therapy, 9*(2): 171-180. doi: 10.1111/j.1752-0606.1985.tb00028.x

Fraser, J. S. & Solovey, A. D. (2007). *Second-order change in psychotherapy: The golden thread that unifies effective treatments*. Washington DC: American Psychological Association.

Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993-2003. *Journal of Child and Family Studies, 14*(4), 551-575. doi: 10.1007/s10826-005-7188-9

Kern, R. M., & Wheeler, M. S. (1977). Autocratic vs. democratic childrearing practices & second-order behavior change in parent-child interactions. *Journal of Individual Psychology, 33*(2), 223-232.

Larson, J. H., & Wilson, S. M. (1998). Family of origin influences on young adult career decision problems: A test of Bowenian theory. *American Journal of Family Therapy, 26,* 39-53.

Lyddon, W. J. (1990). First and second-order change: Implications for rationalist and constructivist cognitive therapies. *Journal of Counseling & Development, 69*(2), 122-127. doi: 10.1002/j.1556-6676.1990.tb01472.x

Mansfield, A. K., Keitner, G. I., & Dealey, J. (2015). The family assessment device: An update. *Family Process, 54*(1)*,* 82-93. doi: 10.1111/famp.12080

Merritts, A. (2016). A review of family therapy in residential settings. *Contemporary Family Therapy: An International Journal, 38*(1), 75-85. doi: 10.1007/s10591-016-9378-6

Robbins, M. S., Bachrach, K., & Szapocznik, J. (2002). Bridging the research-practice gap in adolescent substance abuse treatment: The case of brief strategic family therapy. *Journal of Substance Abuse Treatment, 23*(2), 123-132. doi: 10.1016/s0740-5472(02)00265-9

Sunseri, P. A. (2004). Family functioning and residential treatment outcomes. *Residential Treatment for Children and Youth, 22*(1), 33-53. doi: 10.1300/j007v22n01_03

Thayne, T. (2017). Inventing a wheel: Mission driven innovations to boost post residential treatment outcomes. *Journal of Therapeutic Schools & Programs, 9*(1), 29-35.

Tucker, A. R., Paul, M., Hobson J., Karoff, M., & Gass, M. (2016). Outdoor behavioral healthcare: Its impact on family functioning. *Journal of Therapeutic Schools and Programs*, *8,* 21-40. doi: 10.19157/JTSP.issue.08.01.05.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York, NY: Norton.

The MAMA-t: A Measure of Relative Maturity in Adolescence

John A. McKinnon, John L. Santa, & Linda Solomon
Montana Academy

Three studies explore the MAMA-t, as a measurement of maturity, as an assessment of progress and academic achievement in a residential treatment program, and as a predictor of academic achievement, attendance, and discipline referrals in a public high school setting. In the first study, therapists' ratings on the MAMA-t were significantly related to both academic achievement and progress in the treatment program. This study replicated results of a parent form of the MAMA, as did a factor analysis that revealed the presence of three factors most easily named as Planfulness, Empathy/Consideration of Others, and Moral Reasoning. The second study examined the factor structure and predictive usefulness of the MAMA-t in two local public schools with teachers rating students over three years. The study again demonstrated that ratings on the MAMA-t were positively correlated with academic achievement and predicted school performance several years later. Scores were also negatively related to school absence and discipline referrals. Finally, the third study compared the MAMA-t with the GRIT scale and found the MAMA-t was related to the GRIT scale but provided a stronger prediction of school achievement.

Keywords: maturity, residential treatment, assessment, measurement

Note: This paper was edited by Ellen Behrens, Ph.D., Chief Editor.

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.04

McKinnon (2008, 2010) and his colleagues (Hong, McKinnon, Santa, & Napier, 2013; Santa, 2007) have made the argument that changes observed in longer term residential treatment reflect more than reduction in psychiatric and behavioral symptoms. They suggest the changes that take place reflect an underlying shift in personality development towards an increase in maturity. In order to capture this shift in maturity they developed a scale designed to measure maturity in adolescents named the Montana Adolescent Maturity Assessment for use by parents (MAMA-p; Hong et al. 2013). This 35-item scale was designed to operationalize the underlying concept of maturity, or lack thereof, as reflected in listening to years of parental complaints that their son or daughter was extremely self-centered, inconsiderate of others, exhibited little or no empathy, failed to have a realistic plan or view of the future, and lacked age appropriate prosocial morality.

Hong et al. (2013) described a factor analysis of the MAMA-p scale with 550 parent responses that indicated the data was best captured by a three-factor solution which accounted for more than 60% of the variance. The underlying factors were described as: 1) empathy, or consideration of others, 2) planfulness and future orientation, and 3) pro-social moral reasoning. The MAMA-p was also shown to be internally consistent (α = .95), and moreover the MAMA-p was significantly correlated to both progress in the program and to significant decreases in both behavioral and psychiatric symptoms as measured by Achenbach's Child Behavior Check List (Achenbach, 1991).

While the MAMA-p shows considerable promise as a simple instrument designed to measure maturity, it should be generalized beyond a single sample of parents, and it would be desirable if the instrument could be generalized for use by observers other than parents (e.g. therapists and teachers). Therefore, the 35-item MAMA-p was edited and revised to produce an instrument that could be used by therapists, teachers, and parents. The revised MAMA-t was then given to therapists in a therapeutic boarding school to rate their clients, and later to teachers in two public high schools to rate their students.

The goal of these studies was to determine if the MAMA-t, could prove to be a useful instrument for a variety of more normative adolescent populations as well as for raters such as therapists and teachers who are not the adolescent's parents. Moreover, we wanted to see if the MAMA-t would provide a reliable and useful measure of maturity that would be related to actual increases in age/school-grade, and might be a predictor of grades and

behavior in a conventional high school with teachers as raters. Having the cooperation of a public high school system with a diverse, non-clinical population and hundreds of students tested longitudinally over three years also allowed a close examination of the psychometric properties of the revised maturity scale. The high school cohorts also allowed us to examine consistency and change in maturity over time, and the prospective predictability of a maturity measure on subsequent years of performance and behavior.

Study 1

Study 1 tested the MAMA-t in a clinical setting, making use of therapist ratings of all students enrolled at a therapeutic boarding school with these ratings conducted twice, one year apart. Each snapshot of the student body provided basic psychometric statistics; correlations between maturity ratings and program advancement, marked by program level or "Clan" (1-7) status. Clan status in the program is based on the treatment team assessment of academic, clinical, and interpersonal progress. The design also allows us to examine correlations between maturity ratings and academic performance as reflected in grade point average (GPA).

In addition to the between subject comparisons of Maturity by Clan, a sub-set of the sample, comprised of forty (40) students who were rated twice (a year apart), provided a within subject paired comparison of MAMA-t scores that permitted estimates of the magnitude of a 12-month shift in relative maturity that these students managed—in a program whose clinical goal is to encourage immature teenagers to grow up.

Method

The revised, shortened MAMA-t (for teachers and therapists) required a change from a parental diction ("My child") to a generic wording ("This student"); we cut the numbers of items to 32; and, on the basis of our pilot studies, we edited each item to reduce ambiguity; and removed items that cross-loaded unstably in factor analyses. But we preserved four specific parental concerns, which were so often repeated when parents first came to visit that we built the prototype MAMA-p around them. In brief, parents complained, again and again, that a son or daughter was:

a) grossly inconsiderate, oblivious to others' needs, desires, or rights

b) lacking empathy, particularly for others unlike themselves

c) ethically selfish, brazenly breaking rules, sneaky to avoid punishment

d) lacking future-mindedness, oblivious consequences of risky present behavior, and lacking step-wise plans to accomplish fully-imagined goals

These four parental concerns capture the basic aspects of a stunted or immature personality development; if you will, a childlike self-centered obliviousness to others. The normal process of "growing up" involves attaining physical and mental capacities as well as attaining a security of self that allows one to feel comfortable with others, and effectively accomplish the tasks of adolescence and young adulthood. We have found that failure to achieve an age appropriate level of maturity produces a plethora of symptoms in adolescence including anxiety, lack of ability to attend, withdrawal, depression, defiance, and various addictions.

Therefore, we constructed the MAMA-t with 8 items that we felt reflected each of these four concerns resulting in the total list of 32 MAMA-t items. They shape the MAMA-t's underlying conceptual construct, and so implicitly provide our definition of what maturity means. Built into the MAMA-t, then, are potentially four subscales: consideration (cons); empathy (emp), moral reasoning (morR); and planfulness (plan). These are, in theory, sub-constructs which fall under the primary construct of maturity.

We preserved a 5-point Likert-scale used in the MAMA-p, changed the scale anchor descriptors from "Never" to "Almost Never"; and from "Always" to "Almost Always" resulting in the following Likert rating scale: 1 (almost never), 2 (rarely), 3 (sometimes), 4 (often), and 5 (almost always).

Participants

Nine therapists employed by Montana Academy were enlisted to rate each of the client/students on their team (approximately 10) with the MAMA-t. Each therapist rated all of their students who were enrolled in March 2012, and again rated all of their students enrolled in March of 2013. All of the students were enrolled in a therapeutic boarding school for treatment of a variety of behavioral, academic, and emotional issues. The sample in 2012 contained 39.8% females and 60.2% males and in 2013 it was 58% boys and 42% girls. The students were dominantly Caucasian (more than 94%) and almost all from middle and upper middle class families who could afford to pay for private school treatment. The sample in 2012 (n = 83) had an average age of 17.8, and an average Level or "Clan"

status of 3.5 in a program with 7 Levels. In March 2013, the sample (n = 88) had an average age of 17.8 and an average Clan status of 3.6. Students present for both ratings (n = 40) had an average age of 17.3 and average Clan status of 2.1 in 2012 and in 2013 an average of 18.3 and an average Clan status of 5.2

Procedure

Prior to each rating, therapists received a refresher lecture and standard MAMA-t training materials: a one-page "Introduction" to the MAMA-t; a 5-point Likert scale schematic; an "Adolescent Maturity Spectrum," discussed at some length, to provide descriptive anchors for extreme Likert ratings (1 or 5) along the four sub-scale dimensions: (a) consideration (vs inconsiderate selfishness); (b) empathy (vs interpersonal obliviousness); (c) moral reasoning-altruistic-abstract (vs concrete, sneaky and selfish); and (d) planful future-mindedness (vs now-orientation). MAMA-t ratings were recorded on-line by means of SurveyMonkey. Clan status or level in the program (1-7) and GPA were then added to the data set.

Results and Discussion

Basic Statistics

Cronbach's α for MAMA-t_{total} was 0.96 indicating a high level of internal consistency of the MAMA-t scale; and all four subscales had α >0.86. Table 1 shows the correlations of MAMA-t (total) scores for 2012 and 2013 with both stage of treatment (Levels 1-7) and GPA. Consistent with previous findings on the MAMA-p (Hong et al., 2013), both the overall MAMA-t scores as well as all subscales are significantly correlated with both grade point average and progress in program.

This study provides two estimates of the shifts in relative maturity as a function of treatment, as measured by MAMA-t. The first estimate makes use of the cross-sectional therapist ratings of the entire student body. The average MAMA score combining data from 2012 and 2013 for students in the first Level of Treatment was 2.65 whereas the average MAMA Score for students in the final Level of Treatment was 3.75. This mean difference of nearly two standard deviations was significant ($t(51) = 7.15$, $p < .001$) even though the sample size was quite small (n = 40).

A more powerful test of the hypothesis that MAMA scores and implied maturity increase with progress in the program is provided by the

forty students who were rated twice a full year apart. In 2012 these students were in early stages of the program ($Clan_{avg}$ = 2.1), which explains why they were still in the program a year later, albeit more senior ($Clan_{avg}$ =5.2). A paired (dependent) T-test to compare their MAMA-t_{total} scores a year apart suggested that on average the maturity rating of those 40 students in 2013, as reflected by therapist MAMA-t_{total} ratings (M = 3.56, SE = .08), was substantially greater than in 2012 (M = 3.22, SE = .09, $t(39) = -3.325$, $p < 0.001$). The average stay for the school's students at the time was 18 months. But at a year the change in mean MAMA-t_{total} scores was already significant, the effect size substantial (r = 0.47).[iii]

Table 1

MAMA-t Correlations with Program Progress and Grade Point Average

Therapist Ratings May 2012 – N = 83		
Measure	Program Progress	Grade Point Average
MAMA-t_{total}	0.44	0.52
MAMA-t_{plan}	0.39	0.52
MAMA-t_{cons}	0.34	0.39
MAMA-t_{emp}	0.42	0.36
MAMA-t_{morR}	0.39	0.52
Therapist Ratings May 2013 – N = 88		
Measure	Program Progress	Grade Point Average
MAMA-t_{total}	0.43	0.52
MAMA-t_{plan}	0.27	0.46
MAMA-t_{cons}	0.36	0.38
MAMA-t_{emp}	0.45	0.52
MAMA-t_{morR}	0.42	0.42

Note. $p < .02$

Factor analysis

Factor analysis with a Varimax rotation of the therapist rating data in both years yielded three easily interpretable factors each with Eigenvalues > 1. The strongest factor clustered all 8 Planfulness (plan) items together. As with the MAMA-p these data tended to lump the items from empathy (emp) and consideration (cons)of others into one underlying factor, and the last factor had largely items related to Moral Reasoning (mor). The results produced by analyzing the MAMA-t scores rated by therapists are consistent with previous factor analyses on the MAMA-p (Hong et al., 2013) even though the current data set was much smaller.

Study 2

Study 2 tests the factor structure and usefulness of the MAMA-t in a non-clinical setting—in two local Montana public high schools. By collaborating with a local school district we will be able to determine if the concept of Maturity as measured by the MAMA-t can be reliably used by teachers. Finally if the scale can be reliably used by teachers it might prove useful in detecting students who are immature and likely to struggle and perhaps require a different pedagogical approach than more mature students. In 2012 all Freshmen students in two high schools were rated by teachers with the MAMA-t and the procedure was repeated in 2013 with all Freshman and with all Sophomores. In 2014 all Freshmen, Sophomores, and Junior students were given MAMA ratings by their teachers. In 2014 we also were able to give the GRIT-s (Duckworth & Quinn, 2009) scale to all Freshmen, Sophomore, and Junior students from one of the participating high schools. The GRIT scale has been used in a number of studies (Duckworth & Quinn, 2009; Duckworth, Peterson, Macworth, & Kelly, 2007) and seems to capture some, but certainly not all aspects of maturity that are included in the MAMA-t. Providing a comparison between the GRIT scale and the MAMA-t will also provide a course of construct validity to the extent that the two scales measure similar underlying concepts.

Adding the GRIT scale and being able to compare MAMA scores on the subset of students who are rated as Freshmen, Sophomores, and Juniors will allow further examination of the construct validity of the MAMA-t as an instrument that measures maturation. To the extent the MAMA-t is positively correlated to GPA and negatively related to misbehavior reports it will add further criterion validity. In addition, the data

will allow us to see if MAMA-t scores from one year have predictive ability to performance in subsequent years.

Method

Participants

The MAMA-t data sets included those students enrolled in regular academic classes at two public high schools; and excluded students in special education and alternative programs; students who dropped out or moved away; and those whose data files had missing data. The first data set consisted of a total of 3388 ratings including: all freshmen (n = 495) in May 2012; all freshmen (n = 646) and sophomores (n = 562) in May 2013; and all freshmen (n = 565), sophomores (n = 599) and juniors (n = 521) in May 2014. The second data set, is a subset of the first, which includes the 327 students who were rated as Freshmen, again as Sophomores, and a third time as Juniors.

In May 2012, each of the 495 students belonged to a "Freshman Academy" containing 100-140 students. Each "Freshman Academy" had a set of teachers (Math, Science, English, and Health) who taught the subgroup of freshmen in their "Academy", and each of these teachers rated all students on the MAMA-t in their "Academy" whom they taught. In subsequent years, only English teachers rated freshmen. In 2013 the World History teachers rated the sophomores. In 2014 American History teachers did MAMA-t ratings for juniors. When assembling ratings for the thrice-rated students in the second data set, we had four teacher ratings for each of the 2012 freshman—and arbitrarily chose only the ratings from the English teachers.

Procedure

In order to improve inter-rater reliability participating teachers received a lecture on adolescent development; together with instructions on MAMA-t ratings; a one-page "Introduction" to the study; and a schematic rendering of the 5-point Likert rating scale (which went from 1-almost never to 5- almost always. Each year as a new cohort of teacher raters was added the training became longer and more elaborate. In 2013 a schematic *Adolescent Maturity Spectrum* was added to provide. "anchors" for extreme (1 or 5) ratings along dimensions suggested by MAMA-t subscales: *consideration*; *empathy*; *planfulness*; and *moral reasoning*, e.g. a student who almost always turns in their work on time would be rated a 5, whereas a student who almost never turns in their work on time and frequently asks for

an extension would be a 1. In 2014 the instructor added "sketches" of fictive teenagers for teachers to rate on 3-4 MAMA-t items—and (by raised hands) let them compare their own ratings to the group's consensus.

After this training, each teacher received his or her list of students and research ID codes, a link to an on-line SurveyMonkey version of the MAMA-t, a computer and the remainder of the day (covered by a substitute) to complete all ratings, which were closed to input or change at the end of three days. For attending the training and for each completed rating the teachers received an honorarium. Several weeks later ancillary data were added to the file: cumulative GPAs, attendance (# of missed days), misbehavior (# of disciplinary referrals), DOB and gender.

Results and Discussion

Basic Statistics

In 2012 when four teachers rated each freshman (n = 495), the Internal consistency (ICC) was 0.88 for the MAMA-t_{total}. Inter-rater reliability was nearly as strong for all four subscales, ICC > 0.80. Cronbach's α for the MAMA-t_{total} was > 0.98; for all four subscales α > 0.90.

Table 2 presents basic statistics for the MAMA-t_{total} and its subscales. Its means and standard deviations provide a measure of the distribution of relative maturity within each high school class.

It is worth noting the enormity of the pedagogical challenge to teachers in a public high school since they must deal with a very large range in maturity within each class. For example in the Freshman class of 2012 there were some freshmen who received the lowest possible maturity rating for nearly every one of the 32 MAMA- items; and other students nearly maxed this maturity metric in their first year of high school.

The data also exhibit a predicted trend of MAMA-t scores improving with class such that the mean MAMA-t score for freshmen was 3.41, sophomores 3.81, and juniors 3.98. When looking at the subset of students who were rated both as freshman and as juniors (n = 327) a paired test of the difference in the mean MAMA-t scores is highly significant ($t(326) = 11.7$, $p < .001$). Improvement in maturity scores with high school class is of course what one would predict if the MAMA-t captures the concept of maturity. However, one must look at these data cautiously as the observed differences might be attributable to changes in teacher raters, and

instructions from year to year even though the inter-rater reliability of the MAMA-t is quite high.

Table 2

MAMA-t Correlations With GPA, Missed Days & Disciplinary Referrals

Measure	Mean	*SD*	*r* of MAMA-t with GPA	*r* of MAMA-t with Missed Days	*r* of MAMA-t with Discipline Referrals
Freshman – 2012 – *N* = 493					
MAMA-t_{total}	3.26	0.60	0.68	-0.44	-0.48
MAMA-t_{plan}	3.19	0.74	0.78	-0.47	-0.48
MAMA-t_{cons}	3.34	0.60	0.45	-0.34	-0.39
MAMA-t_{emp}	3.18	0.56	0.55	-0.34	-0.41
MAMA-t_{morR}	3.35	0.71	0.68	-0.46	-0.48
Freshman – 2013 – *N* = 646					
MAMA-t_{total}	3.44	0.85	0.67	-0.42	-0.46
MAMA-t_{plan}	3.38	0.96	0.76	-0.45	-0.41
MAMA-t_{cons}	3.48	0.85	0.51	-0.33	-0.42
MAMA-t_{emp}	3.35	0.83	0.58	-0.36	-0.43
MAMA-t_{morR}	3.55	0.95	0.65	-0.44	-0.47
Sophomore – 2013 – *N* = 562					
MAMA-t_{total}	3.66	0.60	0.57	-0.32	-0.37
MAMA-t_{plan}	3.49	0.95	0.67	-0.34	-0.36
MAMA-t_{cons}	3.79	0.79	0.40	-0.23	-0.31
MAMA-t_{emp}	3.59	0.79	0.47	-0.26	-0.33
MAMA-t_{morR}	3.79	0.89	0.54	-0.34	-0.39
Freshman – 2014 – *N* = 565					
MAMA-t_{total}	3.54	0.88	0.71	-0.36	-0.39
MAMA-t_{plan}	3.45	1.05	0.78	-0.37	-0.32
MAMA-t_{cons}	3.59	0.85	0.55	-0.30	-0.36
MAMA-t_{emp}	3.44	0.89	0.66	-0.33	-0.35
MAMA-t_{morR}	3.71	0.96	0.66	-0.35	-0.42
Sophomore – 2014 – *N* = 599					
MAMA-t_{total}	3.74	0.79	0.41	-0.24	-0.37
MAMA-t_{plan}	3.68	0.95	0.61	-0.32	-0.38

Measure	Mean	*SD*	*r* of MAMA-t with GPA	*r* of MAMA-t with Missed Days	*r* of MAMA-t with Discipline Referrals
MAMA-t_{emp}	3.65	0.81	0.33	-0.16	-0.26
MAMA-t_{morR}	3.86	0.93	0.44	-0.26	-0.40
Junior – 2014 – *N* = 521					
MAMA-t_{total}	4.19	0.93	0.52	-0.31	-0.37
MAMA-t_{plan}	3.75	1.04	0.64	-0.36	-0.36
MAMA-t_{cons}	4.01	0.90	0.38	-0.23	-0.34
MAMA-t_{emp}	3.86	0.99	0.42	-0.23	-0.32
MAMA-t_{morR}	3.91	1.00	0.49	-0.34	-0.39
Note. $p < .001$					

Correlations

The correlations in Table 2 provide strong support for the "immaturity hypothesis." For MAMA-t_{total} ratings correlate solidly (r = 0.41-0.71) with cumulative GPA, suggesting that a competent student is a mature student, and vice versa. Of note, the remarkable correlations with GPA of the MAMA-t_{plan} sub-scale (r = 0.61-0.78) suggests that planful future-mindedness accounts for 40-60% of the academic variance among class-mates. As expected, MAMA-t_{total} also associates negatively (r = -0.30 to -0.48) with Missed Days and Disciplinary Referrals, suggesting that immaturity makes a significant contribution to poor school attendance and disciplinary problems.

Focusing on the 327 students who participated in these studies as freshmen, sophomores, and juniors, one is able to examine the predictive correlations between MAMA-t scores of freshmen and sophomores as they relate to academic performance of the same students when they are juniors. This cohort of thrice-rated students provides a test of the instrument's predictive validity—the capacity of its MAMA-t maturity ratings in one year to anticipate academic performance in the next year. The correlation of total MAMA-t_{total} score of freshman to GPA's of juniors is .42, and the correlation to discipline referrals is -.24 (both $p < .001$). Similarly, sophomore MAMA-t total scores predicts semester GPA as a junior (r = .47, $p < .001$) and as one might expect is also negatively correlated with discipline referrals (r = -.37, $p < .001$). The MAMA-t subscale score for

Planfulness is even more highly predictive of future GPA of the student as a junior ($r = .53$, $p < .001$).

Factor Analysis

The high school study allowed us to perform a factor analysis with a large data set to determine if the same underlying factors emerge when teachers use the MAMA as when it is used by parents or therapists. To this end, we pooled three years of freshman ratings by English teachers (n = 1,685). Again, three clusters of items produced Eigenvalues >1.00, suggesting three factors or fewer (see Appendix A).

A Varimax rotation suggested the data might be best described as having two underlying factors rather than three: Factor 1 loaded decisively nearly all (14 of 16) consideration and empathy items as well as 2 of the Moral Reasoning items. Factor 2 decisively loaded all (8) Planfulness items and 3 of the Moral Reasoning items. In the Varimax solution ten (10) items cross-loaded (i.e., as heavily loaded on Factor 1 as Factor 2) (See Appendix A). Moreover, this cross-loading group contained nearly all (8) Moral Reasoning items, suggesting that teachers cannot reliably make distinctions about their students moral/ethical development, at times basing decisions on their views of the student as planful and responsible, and at times basing decisions concerning a Moral Reasoning question on their view of the students sensitivity or empathic qualities. The difference in the 2 factor solution provided by Teachers as compared with previous 3 factor solutions provided by parents (MAMA-p, Hong, et al., 2013) and therapists in Study 1 (MAMA-t) might result from teachers being able to observe planfulness, empathy, and consideration of others in a classroom setting, whereas parents and therapists would know much more than a teacher about a teenager's ethical thinking and behavior in a broader context than the classroom.

Study 3

As a test of concurrent validity we chose the established "grit" scale, a well-validated measure of "perseverance and passion for long-term goals" (Duckworth, Peterson, Matthews, & Kelly, 2007). Grit predicts several "success outcomes," including cumulative GPA among Ivy League undergraduates. We hypothesized that "grit" was related but not identical to "maturity" as measured by the MAMA-t. We expected the subscale of MAMA-t Planfulness to correlated highly with the GRIT scale, but not

necessarily the other MAMA-t sub-scales, which conceptually have little to do with perseverance or goals.

Method

Participants

In May 2014 we invited regular freshmen, sophomores and juniors in one high school—for whom we had MAMA-t teacher ratings—to complete the 8-item Short Grit (Grit-S) Scale (Duckworth & Quinn, 2009). Both parents and students volunteered to participate in this assessment and were clearly informed that their choice to participate or not would not affect their course grades. A total of 705 participated: 385 girls and 322 boys. Of these, 211 were freshmen; 294 sophomores; and 200 juniors.

Procedure

With Angela Duckworth's permission we transcribed the Grit-S (Children's Version)[iii] onto Survey-Monkey. Participating students, read the on-line standard instructions, entered a research ID, and rated eight brief statements—e.g., "I am a hard worker"—according to a 5-point Likert Scale: 1 = Very much like me; 2 = Mostly like me; 3 = Somewhat like me; 4 = Not much like me; and 5 = Not like me at all (half the items had a reversed polarity). Ratings were later down-loaded, combined with MAMA-t teacher ratings and ancillary data.

Results and Discussion

The Grit-S was internally coherent as indicated by Cronbach's α = 0.69-0.75 for the Freshman, Sophomore and Junior class cohorts.

Correlations

Table 3 shows the correlations of GRIT-s with MAMA-t. In all three class cohorts correlations between grit self-ratings and MAMA-t teacher ratings of maturity were moderate, but significant (e.g., for MAMA-t_{total} r = 0.25-0.37). The subscale demonstrating by far the highest correlation with grit was the MAMA-t_{plan}. (r = .40, $p < .001$)

Table 4 shows correlations of both the MAMA-p and GRIT scores with GPA, missed days, and discipline referrals. The Grit-S self-ratings had modest negative correlations with indices of academic attendance and self-discipline (*r's ranging from* -.12 to -.21) and moderately with semester GPA (r's ranging from 0.33-0.42).

Table 3
Correlations of MAMA-t and GRIT

Year	*N*	MAMA-t_{total}	MAMA-t_{plan}	MAMA-t_{cons}	MAMA-t_{emp}	MAMA-t_{morR}
Freshman	221	0.37***	0.40***	0.33***	0.31***	0.34***
Sophomore	294	0.25***	0.31***	0.16**	0.17**	0.24***
Junior	200	0.29***	0.32***	0.20**	0.29***	0.25***

Note. * $p < .05$, ** $p < .01$, *** $p < .001$

Table 4

MAMA-t and GRIT Correlations With GPA, Missed Days & Disciplinary Referrals

Year	*N*	Missed Days	Disciplinary Referrals	Grade Point Average
MAMA-t				
Freshman	221	-0.26***	-0.31***	0.66***
Sophomore	294	-0.24***	-0.41***	0.42***
Junior	200	-0.29***	-0.36***	0.61***
GRIT-s				
Freshman	221	-0.21**	-0.15*	0.42***
Sophomore	294	-0.12*	-0.177*	0.33***
Junior	200	-0.06	-0.08	0.35***

Note. * $p < .05$, ** $p < .01$, *** $p < .001$

But across all class cohorts in all correlations with all aspects of academic performance, the MAMA-t—in particular, the MAMA-t_{plan} subscale—stood out. The MAMA-t_{total} ratings were solidly correlated with GPA (*r*'s ranging from 0.42-0.66), but the MAMA-t_{plan} demonstrated striking correlations with GPA indices in all three grades ($r > 0.57$). MAMA-t_{plan} accounts for more than half the variance in GPA in all three Freshman classes (*r*'s ranging from 0.76 -0.78).

General Discussion

This series of studies was designed to examine the coherence, reliability and validity of the MAMA-t, a proxy (therapist/ teacher) rating scale designed to gauge relative adolescent maturity (vs immaturity). The MAMA-t was designed as an instrument that could provide a simple measure of adolescent personality maturation and was based on the MAMA-p (Hong et al., 2013) which had previously been developed and substantiated with a set of data based on ratings of parents in a therapeutic boarding school. The MAMA-t was designed as an instrument that might be useful to adult observers other than parents.

When used by therapists factor analysis suggests that the MAMA-t data are best described as having three underlying factors: 1) Planfulness, 2) Empathy/Consideration of others, and 3) Ethical/Moral thinking. This result is consistent with previous research by Hong et al. (2013) on the MAMA-p designed for parents. We originally designed the MAMA to allow for the possibility of four underlying factors that would allow for a separation of Empathy as a separate factor from Consideration of others. However, both the current and past research (Hong et al. 2013) indicate that items designed to relate to empathy and those designed to relate to consideration of others tend to indistinguishably cluster together resulting in a scale that has three rather than four underlying factors.

When the MAMA-t is used by teachers, two underlying factors are preserved: 1) Planfulness and 2) Empathy/Consideration of others. The third presumed factor of items intended to relate to Ethical/Moral thinking drops out. As noted in the earlier discussion, this factor structure makes sense in that parents and therapists are more aware of ethical decisions, and teachers are better able to evaluate dimensions of Planfulness and Consideration of others.

In all three studies, the MAMA-t demonstrated substantial criterion validity by substantiating the relationship of MAMA-t ratings to performance both in a therapeutic program and in a conventional high school in terms of grades and behavior. In the third study when the MAMA-t was compared with the GRIT scale, the two measures both seemed related to maturity. Although, the GRIT scale was designed to measure only a small aspect of personality maturation, which might be called “grit” or determination, whereas the MAMA has been designed to capture broader dimensions of maturity. It turns out that the MAMA-t, and particularly the Planfulness subscale, is actually a better predictor of academic success and

behavior than the GRIT scale. Using the MAMA-p to provide an index of maturity of students as freshman is a powerful predictor of how successful a student will be in future years particularly in terms of academics (as measured by GPA), but also in terms of attendance and disciplinary issues.

The data taken together provide further evidence of the reliability of the MAMA-t as a simple rating scale that can be used by teachers and therapists to gauge the relative maturity of their clients and students. Each of the experiments demonstrate a high level of internal consistency and inter-rater reliability. Moreover, the MAMA-t appears to be applicable and potentially useful for a sample of adolescents who have a mixture of clinical issues as well as a more general population of high school students. Being able to assess maturity might well lead to better designed approaches to pedagogy and clinical intervention that take into consideration the relative maturity of the individual student or client. From a school system point of view, the relationship of MAMA-t scores to future performance might well provide useful information for identifying students who will benefit from more attention, structure, and support to counteract their lack of maturity. It will also provide early indicators of those mature students who can benefit from more independence, enrichment, and challenge.

The set of experiments of course are limited in establishing the measure's general reliability and validity in that the populations and criterion that have been measured are themselves limited. It remains to show that the MAMA-t can be reliably used with more diverse populations and raters. It also remains to demonstrate the relationship of the MAMA-t to other instruments that measure aspects of the underlying concepts of maturity and personality development.

References

Achenbach, T. M. (1991). *Manual for child behavior checklist/ 4-18 and 1991 profile*. Burlington, VT: University of Vermont, Dept. of Psychiatry.

Duckworth, A. L., Peterson, C., Mathews, M. D., & Kelly, D. R. (2007). Grit: Perseverance and passion for long term goals. *Journal of Personality and Social Psychology*, *92*(6), 1087-1101.

Duckworth, A. L., & Quinn, P. D. (2009). Development and validation of the short grit scale (Grit-S). *Journal of Personality Assessment, 91*(2), 166-174.

Hong, N. N., McKinnon, J. A., Santa, J. L., & Napier, M. A. (2013). The Montana adolescent maturity assessment-parent version (MAMA-P): A rating scale for immaturity. *Journal of Therapeutic Schools and Programs, VI*(1), 20-34.

McKinnon, J. A. (2008). *An unchanged mind: the problem of immaturity in adolescence*. New York, NY: Lantern Books.

McKinnon, J. A. (2010). *To change a mind: parenting to promote maturity in teenagers*. New York, NY: Lantern Books.

Santa, J. L. (2007). Residential treatment and the missing axis. *Journal of Therapeutic Schools and Programs, 2*, 45-62.

Appendix A

Factor Analysis – Varimax Rotation

MAMA-t Factor Analysis (Varimax Rotation) with Three Years of Freshman Teacher Ratings (*n* = 1,685)

Item #	Factor 1		Factor 2		Sub-Scale	
M32R	86	*	21		cons	This student has an inflated sense of own importance.
M2R	85	*	17		cons	This student has an entitled attitude.
M7R	82	*	22		cons	This student treats others as servants or puppets.
M24R	76	*	47		cons	This student is willing to inconvenience others.
M11	76	*	39		emp	This student is sensitive to the feelings of others, even those who seem different from self.
M23R	75	*	39		emp	This student is self-preoccupied.
M16	73	*	39		cons	This student is self-effacing, quick to give others credit.
M29R	73	*	52		emp	This student is oblivious to others' needs.
M13	70	*	42		cons	This student is grateful for help and kindness.
M30R	69	*	51		emp	This student does not recognize own social mistakes or see why others take offense.
M15	69	*	46		cons	This student is courteous, considerate and respectful.

Item #	Factor 1		Factor 2		Sub-scale	
M19	64	*	32		emp	This student makes new students feel welcome.
M3R	64	*	56		morR	This student would lie without remorse to parents, if getting caught seemed unlikely.
M22R	64	*	55		morR	This student thinks a rule is less important than what one wants to do.
M8	63	*	57		emp	This student recognizes accurately how own behavior will affect others.
M26R	62	*	61	*	emp	This student cannot imagine how it might look from a teacher's point of view.
M10	61	*	46		emp	This student is tactful.
M14	59		58		morR	This student accepts that all school rules and societal laws apply, even the "silly" or frustrating ones.
M9	57		54		morR	This student would feel ashamed to do or say something dishonest.
M20R	56		56		morR	This student would shoplift if the group thought this was acceptable behavior.
M21	50		32		cons	This student is quick to share.
M1	27		88	*	plan	This student sets priorities to accomplish a goal in a sequence of logical steps.

Item #	Factor 1		Factor 2		Sub-scale	
M25	29		86	*	plan	This student commits to a clear goal with sustained focus, energy and enthusiasm.
M28R	34		85	*	plan	This student gets side-tracked and can't keep to the plan.
M6	34		84	*	plan	This student, when it is time to work, works hard.
M17	29		80	*	plan	This student keeps work spaces and belongings in order.
M31R	32		77	*	plan	This student gets discouraged by setbacks and gives up.
M18R	41		77	*	plan	This student prefers to play now and work later.
M4R	47		71	*	plan	This student fails to anticipate the risks and consequences of present actions.
M5	60	*	66	*	morR	This student identifies with an ideal of integrity and can be trusted.
M27	53		62	*	morR	This student acts on abstract principle, e.g., "honor," even if honor turns out to be inconvenient.
M12R	59		61	*	morR	This student would plagiarize a paper, if getting caught seemed unlikely.

*Note. An * Marks item loadings > = 60.*

Development of an Instrument to Track Changes in Emotional, Social, and Behavioral Experiences of Students in Residential Treatment

Maria Watters
Jared Schultz
Utah State University

Author Note

Maria Watters, Department of Special Education and Rehabilitation, Utah State University.
Dr. Jared Schultz, Department of Special Education and Rehabilitation, Utah State University.

Since submission of this article Dr. Watters changed employment and is currently working in private practice while teaching adjunct courses and Dr. Schultz has accepted a position as faculty and Director of Research in the University of Arizona College of Education. After the completion of all data analyses for this study Maria Watters was hired as an employee of Oxbow Academy, one of the participating programs represented in the focus groups. She has no personal gains, financial or otherwise, associated with the publication of this study. Correspondence concerning this article should be addressed to Maria Watters maria.watters00@gmail.com. Special thanks to the Ascent Companies, namely RedCliff Ascent, Oxbow Academy, Discovery Ranch, and Discovery Academy for their contributions (non-financial) in the development of this assessment tool. For additional training materials, manuals or tools for use of the RESBA please contact the Ascent Company Programs.

This article outlines the development of a tool to measure change in students within a residential treatment center or therapeutic boarding school environment. Specifically, changes are tracked across emotional, social, and behavioral domains using the Residential Emotional, Social, and Behavioral Assessment (RESBA) tool. Currently, there are a limited number of validated instruments available to track and measure change among students in residential treatment settings. The ability of programs to accurately collect and track data increases their ability to track treatment progress and improve overall outcomes (Hall et al., 2014). The RESBA

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.05

is designed to allow for observational data to be reliably recorded across multiple individuals to track and measure change within treatment. Preliminary RESBA results indicate an inter-item reliability (Cronbach's alpha) of $r = .930$. A principle components analysis (PCA) was used to speak to the construct validity of the RESBA with a total combined variance explained being 80.33%. The preliminary steps for establishing validity and reliability of the RESBA tool is provided as well as a discussion of potential applications for research and practice.

Keywords: residential treatment, instrument, track changes, progress reporting, data-informed decision making, adolescents, evidence-based practice

INSTRUMENT TO TRACK CHANGES

In the last decade, there has been increased attention on the need to utilize evidence-based practices across multiple fields (Carlson, Goscha, & Rapp, 2016; Khagram & Thomas, 2010; Spencer, Dietrich, & Slocum, 2012). Professionals in the human sciences have been increasing their efforts to bridge the research-to-practice gap and to integrate evidence-based interventions into clinical work and service provision (Wang & Lam, 2017). The word "service" implies that there is a treatment or intervention that is being provided and assumes that it is beneficial to the recipient. In order to accurately state that a service is beneficial, it is essential that there be an evidence-base substantiating that claim (Spencer et al., 2012). Many professionals have begun to recognize that evidence-based practices can be integrated into the daily practices of practitioners and service providers, improving outcomes for consumers (Spencer et al., 2012).

Closely tied to the evidence-based practice movement is the recognition of the value of data-driven decision making in clinical settings. Engagement in appropriate data collection and analysis is critical for effectively evaluating treatment change and progress. Individuals across many professions use data as a basis for tracking and assessing progress and making decisions regarding the quality of the services being provided (Murray, 2013). The emphasis on the collection of clinical data continues to increase in the human sciences. Data is intended to inform the decision-making process of professions, and multiple sources of data should be utilized for best decision-making (Murray, 2013; Shen & Cooley, 2008; Shen et al., 2012). For example, pre and post tools are helpful in determining overall change throughout treatment, but they do little to indicate how the treatment was effective. These pre and post tools do not provide practitioners with any information regarding the course of improvement, or information regarding the client's experience. In contrast, continuous data collection assists practitioners in identifying fluctuations in the client's progress, intervening when there are significant changes, and recognizing what factors may be playing a positive or negative role in the treatment process.

Residential treatment centers and therapeutic boarding schools are important categories of treatment providers for adolescents to consider. According to a representative from the National Association of Therapeutic Schools and Programs (NATSAP), there were 160 programs that were part of the NATSAP organization, serving over 6000 adolescents in 2015 (M. Stokes, personal communication, Oct. 2016). This is one of multiple organizations that therapeutic schools can join, clearly indicating the number of adolescents and youth served in these environments to be well in the thousands, making it a population warranting consideration in data-tracking and data-informed decision-making processes.

INSTRUMENT TO TRACK CHANGES

Research based on quality data-collection methods and evaluation within residential settings can inform treatment decisions at the individual, program, and state levels. As residential treatment centers seek to adopt evidence-based practices and track outcomes they will be better able to advance the quality of services in the field (Lyons, McCulloch, & Hamilton, 2006). Psychometrically sound measures are critical to be able to demonstrate differences in client outcomes due to specific interventions. The Illinois Department of Children and Family Services completed a project to determine whether a subset of children in residential treatment could be effectively served in therapeutic communities at reduced costs. Their findings indicated that agencies that had a method of tracking changes among students demonstrated an increased ability to meet student needs and inform program and state policy (Lyons et al., 2006). They noted multiple challenges of tracking changes in residential treatment due to the complexity of interventions in that environment. However, they also noted that tracking changes and outcomes are critical for identifying factors that may influence treatment progress (Lyons et al., 2006). Another study conducted in the United Kingdom, evaluating session-by-session outcome measures in mental health services indicated that tracking changes across sessions may improve the completion of follow-up measures, help clinicians detect sudden changes (improvement or decline), and lead to better client outcomes (Hall et al., 2014).

Without psychometrically sound tracking tools, clinicians are limited to pre/post data that leaves gaps regarding what specifically led to changes. Of more concern, they are limited to anecdotal information, which is limited with regards to validity and generalizability. A quality measure for a residential treatment program must include six key features: 1) validity, 2) reliability, 3) related to the services that are being provided (Barkham & Mellor-Clark, 2003), 4) provide clinically-relevant data, 5) be easily understandable and trainable, and 6) parsimonious. The combination of these six elements help to provide continuity, reliability, and accuracy in the instrument's use and application. Additionally, a measurement tool that allows for a shorter interval of measure and specificity in what is being measured may enable users to track more specific changes over time. Currently, there are relatively few psychometrically sound measures available specifically for use in residential treatment that allow for clear and concrete measures to be made to track progress of students, particularly ones based on observable data rather than being reliant on self-report only.

The purpose of this article is to report the creation and initial steps towards validation of an instrument for residential treatment programs. The Residential Emotional, Social and Behavioral Assessment (RESBA) has been

developed to measure student progress across three core domains: behavioral, emotional, and social experiences. The purpose of this instrument is to assist in the effort to engage in data-informed decision making and establish an evidence-based practice within a residential treatment context - consequently increasing the quality and effectiveness of treatment interventions and improving outcomes.

Methods

Instrument Development

Instrument creation began with a focus group, the purpose of which was to develop the items that were to be included. Members of the focus group included eight individuals who were residential, clinical, and academic directors from four residential treatment programs that together have been providing residential treatment services for troubled youth for over 20 years (RedCliff Ascent, n.d.). These programs provide services for a wide scope of issues in varying contexts, including: a wilderness program for troubled youth, treatment for addiction, and treatment for sexually inappropriate behaviors. All programs are located in the state of Utah, with students enrolled from all over the United States as well as some international students. One of the programs was specific to adolescent males while the other three were co-ed with both male and female adolescents at the time of the instrument development.

The focus group met three different times, for four hours each time, to develop potential items for the instrument. The focus group process began with a discussion of the purpose of evaluation, and the identification of the primary constructs that participants would benefit from assessing regularly. Participants identified emotional, social, and behavioral domains as the primary constructs that would be of most benefit to assess. Consensus was then reached regarding the definitions of these terms. Potential items were then developed to measure each construct. Following each focus group, accuracy checks of qualitative analyses were conducted. Using this process of discussion, elimination, and evaluation, the group of potential items was refined to include 23 items to be utilized in the pilot version of the evaluation tool. The potential items were written with a variety of individuals intended to be recording the data, including therapists, academic teachers, and residential support staff.

After development, the 23 items were sent to each program for pilot data collection. Therapists, academic teachers, and residential support staff from each program completed the questions based on observations of students in treatment at that time. It is likely that a therapist, residential staff, and teacher were the ones

completing the RESBA assessment on each student, however, this was not specifically tracked. Student populations across these treatment programs were diverse in age, race, gender, socioeconomic status, and other demographic factors; more detailed demographic information was neither required nor collected. The data as collected was sufficient to accomplish the intended goal of the pilot study, which was to begin determining the construct validity of these measures and if they would discreetly load to the identified factors (emotional, social, and behavioral). This data was evaluated to determine the validity and reliability of the instrument items. All data evaluation and processes were done in accordance with ethical guidelines and principles.

Data Analysis

The data analysis utilized 1,055 client evaluations that were completed by clinical, academic, and residential support staff across four different programs using the pilot instrument (23 items). These clinicians, residential support staff, and therapists were all given basic instructions on how to understand, interpret, and respond to the items. A principle components analysis (PCA) was used to establish the construct validity of the RESBA. The data were factorable as evidenced by the Kaiser-Meyer-Olkin measure of sampling adequacy, which was $r = .910$. Additionally, Bartlett's Test of Sphericity was significant at the $p < .000$ level. The PCA is utilized to statistically group individual items together into constructs, or factors. The RESBA items were developed to measure three distinct areas: Emotional, Social, and Behavioral experiences of the students. Establishing support for the underlying factor structure can be accomplished utilizing a PCA, as that statistical procedure determines the constructs to which individual items are loading. If an item loads to multiple constructs, we can determine that the particular item is not accurate and does not assist us in measuring a mutually exclusive construct, and thus it can be removed from the instrument. An item that fails to adequately load to any factor demonstrates a lack of accuracy in the item and can also be eliminated from the instrument. The strength of a PCA is determined by how much of the variance in the responses are accounted for by the items in the final model. A higher percentage of variance explained by the factor is indicative of a more accurate model. To measure the reliability, a Cronbach's alpha correlation was utilized. An a priori level of .70 was used as our reliability cut off level.

Results

The items of the RESBA, as completed by therapists, teachers, and residential staff, were all combined into one group and resulted in an overall inter-

item reliability (Cronbach's alpha) of $r = .930$. The construct validity of the instrument was addressed using a PCA, using Varimax rotation. The data was determined to be factorable based on the results of the Kaiser-Meyer-Olkin measure of sampling adequacy, which was $r = .910$. Additionally, Bartlett's Test of Sphericity was significant at the $p < .001$ level. The analysis was a forced, three-factor solution and was run several times to determine the most parsimonious model. The final model eliminated 13 of the original test items. Each of these items were dropped due to inadequately loading on any factor or loading to multiple factors. A .400 cutoff was used to determine what factor to which an item loaded. The loading data for each item is provided in Table 1.

Table 1

Individual Item Loading Value Across Each Factor

Item	Factor 1	Factor 2	Factor 3
Student used appropriate coping skills for dealing with emotions.	.834	.262	.335
The student's behavior appropriately matched reported emotional state.	.877	.199	.306
When experiencing emotions, the student recognized and expressed awareness of the emotion.	.854	.261	.299
Student appropriately prompted others.	.225	.859	.258
Student actively worked to build positive relationships.	.335	.728	.338
Student took initiative on assignments and tasks.	.245	.314	.772
Student stayed on task without prompting.	.235	.239	.786
Student responded positively when asked to complete a new/different task.	.310	.166	.796
Student willingly responded when asked to complete a new/different task.	.278	.193	.811
Student completed task to the expectation.	.275	.237	.782

Note. Used .400 cutoff for loading factor.

This left a final instrument with 10 items across three factors. Factor one represented observed emotional reactions (e.g. behaviors appropriately match reported emotional state), and had three items, which accounted for 27.21% of the variance. Factor two represented observed social interactions (e.g. appropriately prompted others.), and had two questions, which accounted for 17.20% of the variance. Factor three represented observed behaviors (e.g. when asked to complete a new/different task student willingly responded.), and had five items, which accounted for 35.92% of the variance. Together these three factors accounted for 80.33% of the variance. A summary of these results is found in Table 2.

Table 2

Total Variance Explained by Each Loading Factor

Factor	Total Value	% Variance	Cumulative Variance
Factor 1	2.721	27.21	27.21
Factor 2	1.72	17.20	44.41
Factor 3	3.592	35.92	80.33

Discussion

The primary goal of this study was to obtain preliminary data to support the initial stages of establishing validity and reliability of the RESBA instrument. A central purpose for developing this instrument was to increase the ability of residential facilities to engage in data-informed decision-making and improve the ability of residential treatment programs to establish and maintain evidence-based practices. The ability of programs to accurately collect and track data increases their ability to monitor the effectiveness of treatment interventions, leading to overall improvement of outcomes (Hall et al., 2014). This instrument was conceived, developed, and implemented by and for residential treatment centers. The items identified within it are intended to specifically speak to the broad range of activities and requirements an individual will face in residential treatment that may not be present in outpatient scenarios. Most residential treatment includes an academic component, residential component, and therapeutic component; the questions were designed to span each of these contexts and still provide meaningful data. For example, in the question “student stayed on task without prompting,” there is a deliberate lack of specification on the nature or type of task so that it could be applicable for an academic, residential, or therapeutic

environment. Additionally, since it is based on observational data, staff from across these areas will be able to identify if there was prompting required and complete accurate documentation. Because this tool is based on observational data and completed by various individuals who have interactions with students in treatment, it potentially allows for a greater range of interpretation and comparison. This enables it to be used as a tracking tool with behavioral data from multiple perspectives and in multiple contexts, which can be viewed in their entirety or individually to compare differences in behaviors across contexts.

In addition, having documented observational data could allow programs to make comparisons to other instruments that may rely on self-report, allowing for tracking of trends for both an individual and their peer group. With enough data being collected, measures could be looked at in terms of predictive value for determining if certain scores are predictive of successful treatment outcomes. For example, an individual's RESBA score trends could be compared to what other students' trends look like during the same time period; or, they can be compared to what other students' trends were when they were in the same phase or time period of treatment. With consistent use over time, programs may have many opportunities for utilizing this tool to determine trends, norms, and establish predictive values within treatment.

Limitations of this Study

There are several considerations regarding the use and implementation of the RESBA. First, while preliminary results are supportive of the instrument demonstrating construct validity and internal reliability, use of this instrument in research without additional psychometric studies should be done with caution. While it has potential for utilization as a tracking tool as well as a dependent variable in research, these findings remain preliminary. In addition, this instrument is not intended to be used as a single administration outcome measure as there are no established norms or cutoffs to indicate clinical significance of behaviors observed. The data from this instrument currently seems to be most meaningful when it is placed within a specific context and tracked over time. Future research may be appropriate for exploring if there are differences between different groups and populations. Second, the sensitivity of this instrument to detect discreet changes across the various domains is currently undetermined. It may not detect small changes that would serve as indicators of progress and instead may be more appropriate for identifying larger change patterns. The level of sensitivity at this time is unclear. Currently, it is best suited to detect trends and patterns across individuals as well as groups. Looking at trends in the RESBA

scores throughout treatment can also be of benefit in determining progress and change of the student, based on their observable data.

A third significant limitation of this instrument is recognition of the role of fidelity in the instrument's reliability. Fidelity of implementation is a concern across measures, treatment settings, and contexts. It is important that those who are scoring the RESBA have instruction regarding the interpretation and responses to each item. The preliminary results of internal reliability show promise that consistency can be obtained across observers and evaluators with appropriate training. Without consistency in the interpretation of the items, the instrument may no longer be measuring what it is intended to measure, compromising the data.

Conclusion

In this pilot study, the RESBA instrument demonstrated promising results for preliminary reliability and validity, suggesting it may be appropriate for use in a residential treatment or therapeutic boarding school environment, alongside other measures. The continued push for operating from an evidence-based practice approach encourages programs to invest in appropriate and sound data collection processes. As programs do so, they will be better able to provide appropriate and effective services to their clients and their families, make data-informed decisions, advance research in residential treatment, monitor overall treatment provisions of the program as a whole, and improve marketability of their program.

Implications for Research

The RESBA has many potential uses in research within a residential environment. Because the RESBA is appropriate across a variety of contexts and populations, it lends itself to utilization for a variety of research goals and objectives. For example, because it is depending only upon observations of a given population and is not used comparatively to other populations, it can be equally useful to a researcher working in a wilderness program to track change as well as in an addiction treatment center, transition programs, or programs working specifically with Autism Spectrum Disorder populations, to name a few. The RESBA has particular merit when looked at as a dependent variable. For instance, if a researcher were interested in knowing the impact of a certain intervention, the RESBA tool scores could be used as a dependent variable to measure change occurring as a result of that intervention. Having a consistent and reliable dependent variable allows for programs to design studies looking at specific aspects of their treatment to determine their overall impact on actual behaviors of

those they work with. This kind of measure provides opportunities for researchers to ask a broad range of research questions and investigate their answers.

The RESBA would benefit from repeated studies examining its psychometric properties. Future research going beyond the item and construct validity and beginning to explore other areas of validity, such as convergent validity with other instruments or test-retest reliability, would be of great value. This would further speak to the accuracy with which this instrument actually measures what it is intended to measure. In addition, further exploration of the trends and range of scores that connect to successful outcomes may aid in being able to use the RESBA as a predictive tool in positive outcomes. Another potential area of exploration includes evaluating the sensitivity to change this instrument allows. By manipulating the number of response items there could be added value; however, this would need to be balanced with consideration to fidelity of implementation. The overall fidelity of implementation, including looking at consistency of rating across various staff, could also add to the understanding of how the fidelity of this instrument impacts its usefulness.

Implications for Practice

In addition to opening up opportunities for research projects within programs, the RESBA may be valuable to provide service providers within treatment as a potential means of making data-informed decisions. By keeping track of how a student changes over time, making informed decisions to assist the student based on observing the data for behavior trends and patterns becomes possible. The RESBA could be used on an individual client level which an individual is compared only to his/herself, but it also has utilization for being able to compare an individual to his/her peer group in order to determine if an individual is functioning in a manner that may be out of the ordinary for the population. This kind of information can assist service providers in making key decisions for advancement within the program's structure, as well as in determining if a client is responsive to specific interventions and feedback. For inter-rater reliability and consistency in question interpretation, a manual has been created to clearly define each question as well as potential formats for responses.

Implications for Program Evaluation

Finally, the RESBA can be useful in looking at overall program evaluation and marketing. By collecting data consistently over time, with an accurate measure, a program is able to look at its overall ability to produce change across a range of individuals and contexts. Once this information is obtained,

strengths of a program may become more apparent as well as areas that can be improved or are in need of adjustment. This kind of feedback on a programmatic level can improve the overall quality of services being provided as well as provide assurance to parents, education consultants, and other key players, that the program is seeking to monitor and improve their overall services in order to be most effective.

In conclusion, a gap in residential treatment may exist where it may be difficult to track progress in a pragmatic and clear manner across various providers. There are limited resources available for tracking change over time that are based on observation rather than self-report. The RESBA appears to have construct validity and preliminary reliability, potentially adding a much-needed instrument to the toolbox of those working in residential treatment. This tool has potential to increase the ability of residential treatment centers to make data-based clinical decisions on an individual and programmatic level. It could also increase the ability of treatment programs to meaningfully engage in the establishment and utilization of evidence-based practices, contributing to the body of literature and moving forward the field of residential treatment.

References

Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy*, *10*(6), 319-327. doi: 10.1002/cpp.379

Carlson, L., Goscha, R., & Rapp, C. (2016). Field mentoring: An important strategy for evidence-based practice implementation. *Best Practice in Mental Health, 12*(2), 2-13.

Hall, C. L., Taylor, J., Moldavsky, M., Marriott, M., Pass, S., Newell, K., ... & Hollis, C. (2014). A qualitative process evaluation of electronic session-by-session outcome measurement in child and adolescent mental health services. *BMC Psychiatry*, *14*(1), 113. doi: 10.1186/1471-244X-14-113

Khagram, S., & Thomas, C. W. (2010). Toward a platinum standard for evidence-based assessment by 2020. *Public Administration Review*, *70*(s1), S100-S106.

Lyons, J. S., McCulloch, J. R., & Hamilton, J. (2006). Monitoring and managing outcomes in residential treatment: Practice-based evidence in search of evidence-based practice. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(2), 247-251. doi: 10.1097/01.chi0000190468.78200.4e

Murray, J. (2013). Critical issues facing school leaders concerning data-informed decision-making. *School Leadership & Management*, *33*(2), 169-177. https://doi.org/10.1080/13632434.2013.773882

Shen, J., & Cooley, V. E. (2008). Critical issues in using data for decision-making. *International Journal of Leadership in Education*, *11*(3), 319-329. doi:10.1080/13603120701721839

Shen, J., Cooley, V. E., Ma, X., Reeves, P. L., Burt, W. L., Rainey, J. M., & Yuan, W. (2012). Data-informed decision making on high-impact strategies: Developing and validating an instrument for principals. *The Journal of Experimental Education*, *80*(1), 1-25. doi: 10.1080/00220973.2010.550338

Spencer, T. D., Detrich, R., & Slocum, T. A. (2012). Evidence-based practice: A framework for making effective decisions. *Education and Treatment of Children*, *35*(2), 127-151.

Wang, M., & Lam, Y. (2017). Evidence-based practice in special education and cultural adaptations. *Research & Practice for Persons with Severe Disabilities, 42*(1), 53-61. doi: 10.1177/1540796916685872

INSTRUMENT TO TRACK CHANGES

Appendix A

The Residential, Emotional, and Behavioral Assessment (RESBA) Tool

Item	Factor	Never	Occasionally	Often	Always	Not Observed
Student used appropriate coping skills for dealing with emotions.	Emotional					
The student's behavior appropriately matched reported emotional state.	Emotional					
When experiencing emotions, the student recognized and expressed awareness of the emotion.	Emotional					
Student appropriately prompted others.	Social					

INSTRUMENT TO TRACK CHANGES

Item	Factor	Never	Occasionally	Often	Always	Not Observed
Student actively worked to build positive relationships.	Social					
Student took initiative on assignments and tasks.	Behavioral					
Student stayed on task without prompting.	Behavioral					
Student responded positively when asked to complete a new/different task.	Behavioral					
Student willingly responded when asked to complete a new/different task.	Behavioral					

INSTRUMENT TO TRACK CHANGES

Item	Factor	Never	Occasionally	Often	Always	Not Observed
Student completed task to the expectation.	Behavioral					

The Golden Thread Software: Improving the Scientific Value of the NATSAP Practice Research Network

Mike Petree
Petree Consulting Inc.

This article describes how the Golden Thread (GT) software solves important problems in the NATSAP Practice Research Network. Prior to the GT, researchers were unable to match clients in the de-identified database. Clients and families were completing surveys redundantly, and treatment providers were unable to conveniently view change data from prior treatment services. The GT addresses each of these concerns through the development of a client matching algorithm, the creation of the GT Portal, and the auto-population of surveys. Additionally, the GT creates systems that support educational consultants and other professional referents to collect and contribute data from those who inquire about receiving treatment services but do not place in a treatment program. These data work as a "quasi-control group," further enhancing the scientific value of the dataset.

Keywords: client progress monitoring, outcome research, continuum of care

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.06

GOLDEN THREAD SOFTWARE

The Golden Thread (GT) is a software solution directed by the University of New Hampshire that is designed to improve the scientific value of the NATSAP Practice Research Network (PRN), the national outcomes study coordinated by NATSAP, and the Outdoor Behavioral Healthcare Council (OBHC). The GT enhances scientific value by matching clients who have attended or are attending multiple programs. Through a portal designed for educational consultants, data can be collected from clients who inquire about treatment services but do not actually participate. These data can be used as a quasi-control group. The software also includes educational consultants and inquiry data that can provide quasi-control groups. Finally, programs can reduce data collection redundancies and provide clinicians with client progress data that informs the overall treatment process.

The NATSAP data collection initiative is structured to collect outcome data by sampling adolescent and adult clients, the parents of adolescent clients, and key staff members four times: at admission, discharge, six months post-discharge, and twelve months after discharge. The resulting NATSAP database is managed by the University of New Hampshire and provides the ability to measure treatment outcomes. It also provides a resource for programs and researchers to explore the impact of treatment for various diagnoses and populations, as well as to answer questions not yet asked. While both the initiative and the data set have proven to be valuable for scientific inquiry and increasing the accessibility of treatment services through insurance reimbursement, they have also exposed areas in need of improvement. To address these needs, NATSAP, OBHC, and two associations of professional referents (The Therapeutic Consultants Association [TCA] and the Independent Educational Consultants Association [IECA]), collectively financed the development of the Golden Thread (GT) software. As the name suggests, the GT will increase the scientific value of the data set by linking together an individual participant's data throughout the treatment process including pre-treatment, various stages of treatment, and post treatment. This data will provide a more accurate examination of the impact of treatment on final outcomes.

The Golden Thread Improves the Database

To understand how the GT will improve the database it is necessary to understand the structure of the study and to consider the logistics involved in data collection. Each participating program subscribes to an online data collection system called OutcomeTools (OT). OT accounts are discrete systems that have no between-account communication. When clients and families consent to participate in the study their data are de-identified and contributed to the national NATSAP

database. The Golden Thread software sits between OT and the database and works with the identified data to match clients before de-identification takes place.

Currently, the NATSAP research initiative collects three types of data: demographic, mental health status such as emotional and behavioral symptom issues, and family functioning. Mental health data are collected using the Youth Outcome Questionnaire 2.0 SR (YOQ 2.0 self-report), Youth Outcome Questionnaire 2.01 (YOQ 2.01 parent report), and the Outcome Questionnaire 45.2 for adult clients. Family functioning data are collected using the McMaster Family Assessment Device (FAD). Demographic data are collected using surveys completed by staff, clients, and parents at admission, discharge, six months post-discharge, and twelve months post-discharge.

OutcomeTools accounts come pre-loaded with the surveys defined above. These surveys can be completed on paper, via email, or on a tablet or computer with Internet access.

It is common for clients to participate in more than one type of programming. Often, clients will transition from "door-to-door," meaning that they may leave one program and begin another within a 24-48-hour window. When both programs are participating in the study, unnecessary redundancies in data collection are placed on the clients and families, as well as on the program staff.

Consider this scenario: on the day of discharge from a wilderness therapy program, a client (Jane) reports a 37-point improvement on the YOQ 2.0 SR from admit. Her changed score indicates that she made "clinically significant" improvements, meaning that someone close to her would recognize positive changes. While she made measured improvements, she wasn't quite in the non-clinical or normal range at the time of discharge.

On the same day Jane transfers to a therapeutic boarding school and is given another YOQ 2.0 SR to document her baseline score for the new program. The baseline score is consistent with the discharge score that she'd completed at the wilderness therapy program. She attends the boarding school for twelve months, and her discharge score indicates that she moved into the non-clinical range with a 22-point improvement.

Jane's data indicate that from the beginning of wilderness to the end of boarding school, she changed a total of 59 points. In the database, however, researchers can only view Jane as two separate people with less robust outcomes.

While clinically significant improvements were made at both locations, the full story of Jane's change is not available to researchers.

To further complicate things, the wilderness program is scheduled to follow up with Jane at six and twelve months after discharge. Jane was at a therapeutic boarding school at both instances. In order to obtain these data, staff at the wilderness therapy program must request that current staff administer surveys on their behalf. The process of making contact and securing data is laborious and time consuming. In cases when these data are collected, it is not entirely clear to researchers where the client was when the post-discharge surveys were completed. The complicated logistics result in significant data loss. The absence of location results in ambiguous information about the reality of post-discharge status.

The Golden Thread Solves Four Primary Problems

In the scenario above, there are four primary issues. The first is that the researchers are hindered in their ability to match de-identified clients in the existing database which precludes examining a single client's change over the course of treatment. The second is that clients, parents, and staff are asked to complete surveys redundantly at multiple times through the full survey cycle for each program, which results in participation attrition. The third is that there is no consistent system for tracking whether or not a client completed post-discharge surveys while in treatment or when they returned to the home or normal living environment. The fourth is that clinicians who might benefit from viewing a client's full outcomes history are only able to view data collected locally.

Addressing the problem of matching clients in the database, the Golden Thread organizes the existing database through two third party entities, OutcomeTools and Petree Consulting Inc. (PCI). PCI created a client-matching algorithm that searches the identified data and compares client information along a number of variables. The client-matching algorithm produces a "match certainty score." Once matches are made, the data are de-identified and clustered to show cases that meet the criterion for a "match." This allows researchers to select the desired threshold based on the "match score" and to track clients with multiple treatment episodes with a high degree of certainty while still protecting confidentiality.

Addressing the second issue the GT will reduce the need for redundant survey completion by tracking clients from one program to another. If post-discharge surveys are due from a previous program while the client is in treatment

elsewhere, the GT will do one of two things:

1. If a needed survey such as the YOQ 2.0 SR was completed by the current program within the on-time window, its score will be included as a post-discharge data point for the prior program.
2. If needed surveys were not completed within the window, they will be auto-populated within the OT account of the current provider thereby eliminating the need for data collection personnel to manually push survey links to current providers.

Addressing the third problem the Golden Thread will employ standardized release of information forms that give clients and families the ability to authorize the sharing of results between programs within the GT portal designed for this purpose. Additionally, all completed surveys are stamped with location, when possible, so that post-discharge results can be binned to either "at home" or "in treatment" categories. In cases where post-discharge data are collected while clients are in programs that do not participate in the study, NATSAP demographic surveys have been adjusted to document location and living circumstances at the time of completion. This allows for more accurate post treatment outcome descriptions, by accounting for differing post-treatment locations.

Finally, clinicians will be able to access the full data history for clients through the Golden Thread portal. These results can be used to augment the clinical process by providing encouragement to clients through documentation of their improvements, helping clients to recognize patterns in their own treatment process, or demonstrating the continuing need for services to families or other stakeholders.

The Golden Thread Tracks Clients Before They Enter the Treatment Process

In the summer of 2018, revised versions of the NATSAP demographic surveys were approved by the University of New Hampshire IRB. Revisions were guided by feedback from users and researchers studying the database.

The IRB also approved the inclusion of weekly client progress data using the YOQ. Client progress monitoring is a method for improving outcomes and is being used by an increasing number of study participants. These data will potentially give researchers greater insight into what happens for clients during the treatment process.

The Golden Thread is designed to include data collected by professional referents so that the clients can be tracked even before they enter the treatment

process. An additional bonus to having educational consultant participation is the collection of data from those who inquire about, but do not ultimately use, treatment services. These data can function as a quasi-control group enabling researchers to study the differences between clients with similar mental health profiles who do and don't participate in treatment programming.

The objectives driving the NATSAP study include improving the quality of services, increasing accessibility of treatment through insurance and other funding sources, protection against legal or governmental aggressors with unfounded claims, and self-promotion through marketing.

Despite the weaknesses that the GT was designed to address, the existing NATSAP dataset has been valuable in establishing the general effectiveness of NATSAP treatment programs. With the improvements made possible by the Golden Thread it is highly likely that the "black box" of treatment will become less opaque. With the ability to match clients and to study change patterns across different types of programs providers will be better equipped to improve the quality of treatment services, demonstrate outcomes, and use research results to expand accessibility to treatment.

Differences between Opioid and Non-Opioid Users During and After Outdoor Behavioral Treatment

Paige Mandas[1], Kayla Argo[1], Hannah Rose[1], Taylor Zelenik[1], Ansley Wetherington[1], Garrett Cook[1], Matthew (Cole) Brogden[1], Harold L. (Lee) Gillis, Jr.[1], & Keith C. Russell[2]
Georgia College & State University[1], Western Washington University[2]

Enviros Shunda Creek is an Outdoor Behavioral Healthcare (OBH) program treating young adult males with substance use disorders. There are no psychosocial treatments for use of specific drugs. Based on this and the ongoing opioid epidemic, the current study investigates whether OBH is equally effective for the treatment of opioid users compared to non-opioid users at Shunda Creek. This study found no statistically significant differences at intake, during treatment, discharge, and follow-up. Opioids served as a stronger predictor for severity of relapse than other drugs of choice, $R^2 = 0.098$, $F(1,73) = 7.930$, $p < .001$, 95% CI [0.118, 0.687].

Keywords: substance use disorders, young adults, opioids, relapse

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.07

OPIOID AND NON-OPIOID USERS

Opioid Use Disorder (OUD) is a current public health crisis in the United States and Canada. The rise of OUDs creates a need for extended research on effective treatment strategies (Liebling et al., 2016; Sokol, LaVertu, Morrill, Albanese, & Schuman-Olivier, 2018). Outdoor Behavioral Healthcare (OBH) is shown in numerous studies to be an effective treatment strategy for youth and adolescents struggling with Substance Use Disorders (SUD; DeMille et al., 2018). This study serves as a follow-up to Chapman et al. (2018), which demonstrated that OBH was equally effective for high and low SUD involved young adult males. Here, we examine treatment trajectories of clients who use opioids and clients whose drugs of choice do not include opioid use.

Despite the watchful eye and diligent work of numerous politicians, clinicians, and researchers in Canada since the early 2000's, nonmedical prescription opioid use (NMPO) has increased at a baffling rate (Liebling et al., 2016). In 2010 alone, the death toll from prescription opioid use exceeded 16,000, and the rate of heroin overdoses increased steadily from 2010 to 2013 (Dart et al., 2015). The Canadian Federal Health Minister officially declared the opioid problem a national public health crisis on August 31, 2017 (Health Canada, 2017). To reduce the stigma associated with drug-related deaths and raise awareness for the various treatment options available, the Prime Minister proclaimed an International Overdose Awareness Day in Canada. The United States has also declared a public health opioid crisis, demonstrating that the substance abuse issue knows no boundaries (Beletsky & Davis, 2017).

Currently, the psychosocial treatment of SUD is similar, if not the same for both opioid and non-opioid users (Mayet, Farrell, Ferri, & Davoli, 2004). Available psychosocial therapies include cognitive-behavioral therapy, 12-step programs, and motivational interventions, among others (Chapman, et al., 2018; Jhanjee, 2014).

The majority of modern medical treatments are centered around replacement therapy, which is the administration of a weaker opioid to addicts in order to avoid withdrawal symptoms and eventually curb cravings (Mattick et al., 2003). According to a double-blind study conducted by Fudala et al. (2003), buprenorphine, a partial opioid agonist, functions as an effective form of treatment both by itself and when combined with naloxone. Methadone, a mild opioid, has also been found to aid in the recovery of opioid abusers; however, a controlled trial in Canada found that injectable diacetylmorphine performed significantly better than methadone in the treatment of opioid dependence (Oviedo-Joekes et al., 2009). In the event of an overdose, an opioid antagonist called naloxone, often referred to as the life-saving drug, can also be safely administered to counteract

the effects of the overdose (Tobin, Sherman, Beilenson, Welsh, & Latkin, 2009). Group Based Opioid Treatment (GBOT; Sokol et al., 2018) is a combination of office-based group counseling with the prescription naloxone. Compared to pharmacological treatment alone, the literature suggests that GBOT has the added benefit of group-based support where clients can feel more accepted. However, the inadequate number of studies cannot judge the overall efficacy of GBOT.

Current research suggests that mindfulness-based approaches to therapy show positive results in terms of reducing harm to clients. Garland, Froeliger, and Howard (2014) found that implementing a Mindfulness-Oriented Recovery Enhancement (MORE) intervention effectively aids in reducing the behaviors and cravings associated with opioid addicts. Additional research by Russell, Gillis, and Heppner (2016) studied the integration of mindfulness-based experiences (MBE) into the treatment process at an outdoor behavioral healthcare program for young adult males with SUD. Statistically significant changes were found in clients' Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) scores from pre- to post-treatment. Moreover, these changes were also significantly correlated with changes in clients' Outcome Questionnaire-45.2 (OQ-45.2; Lambert et al., 1996) scores. Analysis of these results highlight how the development of mindfulness skills helps clients to increase their awareness and cognitive control of unregulated cravings and triggers.

OBH is a treatment option for adolescents and young adults with SUD that are seeking a nontraditional treatment program (Russell, 2003). Russell, Gillis, and Lewis (2008) distinguish OBH from other residential treatment programs by its primary use of wilderness expeditions as a therapeutic milieu with the application of a clinical treatment model by licensed mental health professionals. OBH focuses on treating and strengthening the client’s mental and emotional state, as well as their behavior by using MBE. Clients gain growth as an individual as they develop a better self-concept while also learning to interact with peers in a social setting.

According to Lewis (2018), OBH was an effective treatment alternative for treating SUD in the young adult population compared to traditional treatment settings. Lewis (2013) also identified that these changes were consistent in the adolescent population, with a reduction of symptomology maintaining statistical significance 12 months after discharge. Current literature suggests that OBH can also provide positive treatment outcomes for adolescents in terms of their family dynamic and relationship with both parents (Tucker, Paul, Hobson, Karoff, & Grass, 2017). Bettmann, Russell, and Parry (2013) examined the specific factors that contribute to the treatment progress and outcome in OBH. Their results

(*N*=189) indicated that wilderness therapy (i.e., OBH) programs are effective in reducing mental health symptomatology through the use of abstinence-based coping methods. Additionally, the results suggested that readiness to change is not required for wilderness therapy to be effective. When applied correctly, OBH can create positive long-term effects within young adults throughout the treatment as well as the following months (Roberts, Stroud, Hoag, & Massey, 2017). This body of literature supports the case that OBH is effective in treating SUD in several age groups.

Chapman et. al (2018) studied treatment effectiveness at Enviros Shunda Creek in relation to clients' prior drug use. Clients completed the Personal Involvement with Chemicals Scales (PICS; Winters & Henly, 1989) at intake to measure their drugs of choice and frequency. To measure treatment outcomes, clients completed the Outcome Questionnaire-45.2 (OQ-45.2) (Lambert et al., 1996; Lambert & Finch, 1999) and the Five Facet Mindfulness Questionnaire (FFMQ; Baer, et al., 2006). The OQ-45.2 monitors treatment progress by administration every two weeks. One subscale of OQ-45.2 assesses Symptom Distress and was found to be positively correlated with PICS scores. This finding suggests clients that self-report higher drug use also report higher symptom distress. Results from the FFMQ's Acts with Awareness subscale were negatively correlated with PICS, suggesting that those with higher drug use report lower scores of awareness. The OQ-45.2 change scores (intake-discharge) were found to be significantly correlated with PICS scores at intake. These results suggest treatment is effective regardless of the differences in clients' drug use.

Chapman et al. (2018) encouraged progress monitoring of outcomes during treatment as well as recommended further examination of different drugs used prior to treatment. With the current opioid crisis affecting young adults, this study compared client outcomes between self-reported opioid and non-opioid users during and six months after treatment.

Method

Treatment Program

Enviros Shunda Creek is a 10-bed, 90-day OBH program for individuals with SUD. The program is designed to treat adult males, ages 18-24. To increase awareness of substance use patterns, clients participate in MBE (Russell, Gillis, & Heppner, 2016). Through adventure in nature, clients initiate and prepare one to five-day outdoor experiences that are based upon the goals of treatment (e.g., canoe trips, river crossings, rock climbing, backpacking). The intentional

relationships formed between the clients and staff emphasize the connections that are made between the outdoor experience and the treatment process. For example, fears that occur during a canoe trip may coincide with post-treatment social situations that elicit a drug relapse. Within their cohort, clients reflect "in the moment" and after in hopes of solidifying the significance of the experience. On average, clients participate in one trip per week of the 90-day program.

Participants

The average age of clients was 21.7 years (*SD* = 2.15) and the average length of stay in treatment was 87.8 days (*SD* = 17.85). The current database for Shunda Creek includes 190 clients. This study consisted of clients (*n* = 75) who completed the OQ-45.2 at intake, discharge and 6 months after discharge with the alumni survey. The alumni sample consisted of 41.8% who identified as White, 14.3% who identified as First Nation, 12.7% who identified as "Other," and 31.2% whose ethnicity was "Unknown" at intake. Clients had the option to disclose their ethnicity. Those who declined were classified as "Unknown." Participation in treatment was voluntary; therefore, clients could leave at any time. The top four drugs that clients reported prior to treatment were 1) alcohol, 2) marijuana, 3) cocaine, and 4) opiates. Of the participants, 52.1% acknowledge use of opioids and 47.9% did not acknowledge use of opioids.

Measures

Outcome Questionnaire 45.2. The Outcome Questionnaire-45.2 (OQ-45.2; Lambert et al., 1996; Lambert & Finch, 1999) is a psychosocial self-report instrument that contains 45 questions and utilizes a Likert-scale for responses to compute a total score. Scores range from 0 to 180 with higher scores indicating low levels of functioning. The OQ-45.2 has three subscales: Symptom Distress, Interpersonal Relations, and Social Role performance. An example question for Symptom Distress is, "I feel no interest in things."; for Interpersonal Relations, "I get along well with others."; and for Social Roles, "I feel stressed at work/school."

Alumni Survey. The Alumni Survey is a self-report instrument developed by Enviros Shunda Creek staff. It is administered six months after clients' discharge. The survey contains 22 questions scored on a scale of 1-10 with 10 implicating the strongest level of agreement. This instrument assess how alumni are doing in current relationships, quality of life, and information about relapses. An example question asking about relationships is, "How satisfied are you with your relationships with your family of origin?" A question asking about relapse is, "How would you rate the severity of your relapse?"

Personal Experience Inventory (PEI). Winters and Henly (1989) designed the Personal Experience Inventory (PEI) which has multiple scales to explore the frequency, duration, and age of onset for use of 12 categories of drugs. The Personal Involvement with Chemicals Scales (PICS) is one subscale that assesses drug use prior to treatment. The PICS is self-report and contains 29 questions that are answered on a scale of 1 (never), 2 (once or twice), 3 (sometimes), or 4 (often). The subscale asks clients how often they use drugs and/or alcohol for a variety of reasons, such as "to have fun" or "to get your mind off problems." This instrument assesses the frequency, amount, and the reasons behind clients' drug use from the last 90 days before admission into the program.

The Substance Use Frequency Scale (SUFS) is another subscale from the PEI. This instrument is a self-report and used to assess how severe a client's drug use is prior to treatment, specifically within the last 90 days. It follows the PICS with 22 questions. An example question is, "In the past three months: Alcohol (Example: beer, wine, coolers, hard liquor, etc.)" and clients could answer with "Never. 1-2 times, 3-5 times, 6-9 times, 10-19 times, 20-30 times," or "40 or more times."

Procedure

Clients at Enviros Shunda Creek were administered the PICS and SUFS at intake to assess the frequency and severity of clients' drug use during the 90 days prior to treatment. These assessments are both self-report subscales of the PEI. The OQ-45.2 is administered at intake, biweekly during treatment, and at discharge. This instrument monitors clients' treatment progress. The alumni survey was administered 6 months after discharge.

Results

Table 1 shows the OQ-45.2 mean scores and standard deviations for non-opioid users and opioid users at intake, discharge, and follow up. A one-way analysis of variance was conducted to examine the differences in the OQ-45.2 scores of opioid and non-opioid users at Enviros Shunda Creek. The results indicated that there were no statistically significant differences at intake, (F (1,66) = 0.261, p = .611), during treatment, (F (1,62) = 0.585, p = .447), or at discharge (F (1,71) = 0.127, p = .722). Additionally, no statistically significant difference was found between OQ-45.2 total change scores (discharge – intake) (F (1,61) = 0.038, p = .847). When examining the length of treatment between opioid and non-opioid users, results indicated no statistically significant differences F (1,71) = 0.034, p = .854).

Table 1

OQ-45.2 Total Score Means and Standard Deviations for Non-Opioid Users and Opioid Users at Intake, Discharge, and Follow Up

	Non-Opioid User			Opioid User		
OQ-45.2 Scores	*n*	*M(SD)*	95% CI	*n*	*M(SD)*	95% CI
Intake	29	82.41 (24.95)	[72.92, 91.90]	34	85.74 (18.88)	[79.15, 93.32]
Discharge	29	35.52 (21.64)	[27.28, 43.75]	34	41.76 (26.31)	[32.58, 50.94]
Follow Up	29	48.59 (23.40)	[39.69, 57.48]	34	51.65 (21.90)	[44.00, 59.29]

Table 2 shows the bivariate correlations between the top four drugs and severity of relapse. Clients' severity of relapse scores significantly correlated with high self-reported opioid use (r (73) = 0.313, p = .003) and high self-reported cocaine use (r (73) = 0.213, p = .033). However, no statistically significant correlations are found between severity of relapse scores and clients' self-reported use of alcohol or marijuana.

Based on the significance found in the bivariate correlations, a multiple linear regression predicted clients' severity of relapse based on their top four drugs of choice. As seen in Table 3, Model 1 includes opioid users alone and the regression is significant (F, (1,73) = 7.930, p = .006, 95% CI [0.118, 0.687]), with an R^2 of 0.098. When cocaine is added in Model 2, R^2 increases to 0.01 ((F, (2,72) = 4.351, p = .016 95% CI [-0.172, 0.451]) with an R^2 of 0.108. When alcohol and marijuana are added in Model 3, the change in R^2 is only 0.004. There is no statistical significance.

Table 2

Pearson Correlations and Significance Levels for Severity of Relapse, Opiates, Cocaine, Marijuana, and Alcohol

		Severity of Relapse	Opiates	Cocaine	Marijuana
Opiates	*r*	0.313			
	p	0.006			
	n	75			
Cocaine	*r*	0.213	0.343**		
	p	0.066	0.001		
Marijuana	*r*	0.144	0.355**	0.385**	
	p	0.216	0.000	0.000	
Alcohol	*r*	-0.046	0.000	0.269**	0.178
	p	0.698	0.997	0.007	0.078

Note. **< .01

Table 3

Regression Models for Severity of Relapse, Opioids, Cocaine, Alcohol, and Marijuana Use

Severity of Relapse					
	Model 1	Model 2		Model 3	
Variable	*B*	*B*	95% CI	*B*	95% CI
Opioids	0.313	0.271	[0.04,0.67]	0.259	[0.01,0.66]
Cocaine		0.108	[-0.17,0.45]	0.118	[-0.19, 0.49]
Alcohol				-0.066	[-0.64, 0.36]
Marijuana				0.019	[-0.38, 0.44]
R^2	0.098	0.108		0.112	
F	7.93	4.351		2.205	
ΔR^2		0.010		0.004	
ΔF		0.795		0.160	

Discussion

Results demonstrate no statistically significant differences between opioid users and non-opioid users in OQ-45.2 scores at intake, during treatment, at

discharge, or follow-up, indicating that OBH treatment at Shunda Creek is equally effective at treating SUD for both opioid and non-opioid users. Additionally, the results support the idea that clients with high self-reported opioid use predict more severe self-reported relapse.

Clients had the option to complete a question on the survey that asks how they define their relapse on a scale from 1-10 and were also asked to qualitatively define their relapse. For instance, a client commented, "I used but wouldn't consider this a full-blown relapse" and provided a rating of four for his qualitative response. On the other hand, another client reported, "extreme use, happened within a week of leaving, new drugs tried, almost got a criminal record (charges dropped), most relapses were brought on by depression." The relapse descriptions of the high self-reported opioid users support the prediction of severe self-reported relapse. For example, a high self-reported opioid user rated the severity of his relapse as a 10 and defined his relapse as "ignorance" and "didn't want to use tools to deal with stress."

Other questions on the alumni survey relating to friends, significant others, and family of origin also give insight into the potential influences of interpersonal relationships on opioid users. Whereas it may be obvious, this study suggests that the need for a positive community is imperative for less severe relapses. For example, a high self-reported opioid user who also reported high relapse severity commented on his satisfaction with his relationships with friends by reporting, "I don't have any sober friends." When asked how satisfied he was with the relationships with his family of origin, the same client reported, "there needs to be more work on this" and "I feel they don't help out when it comes to addiction stuff." However, another opioid user with low self-reported relapse severity reported his relationship with his friends as a "good care group – call me out when I need it." When asked about his relationship with his family of origin, he indicated that he "became more of a family guy" and that he is "visiting family more." These comments indicate that the quality of clients' relationships with family and friends could also be related to the severity of relapse.

Limitations

Limitations of this study include that all of the instruments are self-report measures, and no objective measures of drug use were utilized (e.g. drug screens). Similarly, severity of relapse was measured subjectively based on clients' own opinions. At intake, clients report their prior drug use based on 12 categories. The various drugs are rated at the same time, on the same scale; therefore, it may be difficult for clients at intake to recall what they have used. Additionally, there is

missing data that results from absence during home visits or lack of follow-up responses after treatment.

This study consists of one sample, so there is also no comparison group. The sample of this study was chosen by complete data sets. Because this sample was less than half of the total data set, there is a chance the results would be different with a more complete data set. Only 40% of clients with data from intake through follow-up were included in the study (n = 75) Because of this, it is possible that results could be different if a higher percentage of the data set could have been used. The alumni survey also did not ask where the clients went after discharge limiting analysis of those who went back to their respective communities or into additional treatment. The probability for Type I error is high due to the large number of questions in the alumni questionnaire, increasing degrees of freedom.

There was also no qualitative analysis of the alumni survey; no mixed methods were used. To better understand a client's rating on the alumni survey scale, the clients' comments were used to provide more context for how they rated and defined their relapse. Descriptions of clients' settings after treatment was not collected to determine how it may have impacted relapses.

Strengths

One strength of this study is its relevance to the public health crisis (Sokol et al., 2018). This study was able to analyze treatment outcomes for opioid users. This study serves as the first examination of the differences in opioid and non-opioid users in OBH treatment. Thus, it is a call to action for other OBH programs to further examine clients' drug histories. These findings provide evidence that OBH is an effective treatment option for those with SUD, regardless of their drug of choice.

Conclusion

Literature suggests that psychosocial treatments are the same for opioid and non-opioid users (Mayet, Farrell, Ferri, & Davoli, 2004). This study supports the notion that OBH treatment programs such as Enviros Shunda Creek are effective in increasing psychosocial outcomes with clients who use a variety of substances. This is supported by the idea that no statistically significant differences were found between opioid and non-opioid users' OQ-45.2 scores at intake, during treatment, at discharge, or follow-up. As mentioned, the purpose of this paper was answering Chapman et al.'s (2018) recommendation to investigate

various drugs of choice and how they relate to treatment effectiveness at Enviros Shunda Creek. By investigating both specific drugs of choice as well as alumni's psychosocial outcomes (OQ-45.2), this study reinforces the effectiveness of OBH in improving psychosocial outcomes regardless of drug choice. Overall effectiveness of SUD treatment is difficult to measure, as relapse is a complicated statistic as "individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers (National Institute on Drug Abuse, 2000, "How effective is drug addiction treatment?" para 2).

References

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*(1), 27-45.

Beletsky, L., & Davis, C. S. (2017). Today's fentanyl crisis: Prohibition's iron law, revisited. *International Journal of Drug Policy*, *46*, 156-159.

Bettmann, J., Russell, K., & Parry, K. (2013). How substance abuse recovery skills, readiness to change and symptom reduction impact change processes in wilderness therapy participants. *Journal of Child & Family Studies*, *22*(8), 1039-1050. doi:10.1007/s10826-012-9665-2

Chapman, J., Groark, S., Beale, M. M., Mandas, P., Argo, K., Gillis, H. L., & Russell, K. (2018). The relationship between self-reported prior drug use and treatment effectiveness in substance use disorder during outdoor behavioral healthcare treatment for young adult males. *Journal of Therapeutic Schools and Programs*, *10*(1), 93-106.

Dart, R. C., Surratt, H. L., Cicero, T. J., Parrino, M. W., Severtson, S. G., Bucher-Bartelson, B., & Green, J. L. (2015). Trends in opioid analgesic abuse and mortality in the United States. *New England Journal of Medicine, 372*(16), 1573-1574.

DeMille, S., Tucker, A. R., Gass, M. A., Javorski, S., VanKanegan, C., Talbot, B., & Karoff, M. (2018). The effectiveness of outdoor behavioral healthcare with struggling adolescents: A comparison group study a contribution for the special issue: Social innovation in child and youth services. *Children and Youth Services Review, 88*, 241-248.

Fudala, P. J., Bridge, T. P., Herbert, S., Williford, W. O., Chiang, C. N., Jones, K., . . . & Ling, W. (2003). Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. *New England Journal of Medicine*, *349*(10), 949-958.

Garland, E. L., Froeliger, B., & Howard, M. O. (2014). Effects of mindfulness-oriented recovery enhancement on reward responsiveness and opioid cue-reactivity. *Psychopharmacology, 231*(16), 3229-3238. http://dx.doi.org/10.1007/s00213-014-3504-7

Health Canada (2017, August 31). *Message from the Minister of Health - international overdose awareness day*. Retrieved from www.canada.ca/en/health-canada/news/2017/08/message_from_theministerofhealth-internationaloverdoseawarenessd0.html.

Jhanjee, S. (2014). Evidence based psychosocial interventions in substance use. *Indian Journal of Psychological Medicine*, *36*(2), 112–118. http://doi.org/10.4103/0253-7176.130960

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical & Psychological Psychotherapy*, *3*(4), 249-258.

Lambert, M. J., & Finch, A. E. (1999). The Outcome Questionnaire. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (pp. 831-869). Mahwah, NJ: Lawrence Erlbaum Associates.

Lewis, S. F. (2013). Examining changes in substance use and conduct problems among treatment-seeking adolescents. *Child and Adolescent Mental Health, 18*(1), 33-38.

Lewis, S. F. (2018). A novel investigation of substance use outcomes in substance-specific outdoor behavioral healthcare programs. *Journal of Therapeutic Schools and Programs*, *10*(1), 106-126.

Liebling, E. J., Yedinak, J. L., Green, T. C., Hadland, S. E., Clark, M. A., & Marshall, B. D. (2016). Access to substance use treatment among young adults who use prescription opioids non-medically. *Substance Abuse Treatment, Prevention, and Policy, 11*(1), 38.

Mattick, R. P., Ali, R., White, J. M., O'brien, S., Wolk, S., & Danz, C. (2003). Buprenorphine versus methadone maintenance therapy: A randomized double-blind trial with 405 opioid-dependent patients. *Addiction, 98*(4), 441-452.

Mayet, S., Farrell, M., Ferri, M., Amato, L., & Davoli, M. (2004). Psychosocial treatment for opiate abuse and dependence. *Cochrane Database of Systematic Reviews, 4*. doi: 10.1002/14651858.CD004330.pub2.

National Institute on Drug Abuse. (2000). Principles of drug addiction treatment: A research-based guide. National Institute on Drug Abuse, National Institutes of Health. Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment.

Oviedo-Joekes, E., Brissette, S., Marsh, D. C., Lauzon, P., Guh, D., Anis, A., & Schechter, M. T. (2009). Diacetylmorphine versus methadone for the treatment of opioid addiction. *New England Journal of Medicine*, *361*(8), 777-786.

Roberts, S. D., Stroud, D., Hoag, M. J., & Massey, K. E. (2017). Outdoor behavioral health care: A longitudinal assessment of young adult outcomes. *Journal of Counseling & Development, 95*(1), 45-55. doi:10.1002/jcad.12116

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

Russell, K. C., Gillis, H. L., & Heppner, W. (2016). An examination of mindfulness-based experiences through adventure in substance use disorder treatment for young adult males: A pilot study. *Mindfulness, 7*(2), 320-328.

Russell, K., Gillis, H. L., & Lewis, T. G. (2008). A five-year follow-up of a survey of North American outdoor behavioral healthcare programs. *Journal of Experiential Education, 31*(1), 55-77.

Sokol, R., LaVertu, A. E., Morrill, D., Albanese, C., & Schuman-Olivier, Z. (2018). Group-based treatment of opioid use disorder with buprenorphine: A systematic review. *Journal of substance abuse treatment, 84*, 78-87.

Tobin, K. E., Sherman, S. G., Beilenson, P., Welsh, C., & Latkin, C. A. (2009). Evaluation of the staying alive programme: Training injection drug users to properly administer naloxone and save lives. *International Journal of Drug Policy, 20*(2), 131-136.

Tucker, A. R., Paul, M., Hobson, J., Karoff, M., & Gass, M. (2017). Outdoor behavioral healthcare: Its impact on family functioning. *Journal of Therapeutic Schools and Programs, 8*(1), 24-45.

Winters, K. C. & Henly, G. A. (1989). Personal Experience Inventory (PEI) test and manual. Los Angeles, CA: Western Psychological Services.

The Lived Experience of Mental Health Providers in Wilderness Programs

Jennifer Randall Reyes[1], David M. Savinsky[2], Lee Underwood[2], & Jasmine L. Knight[2]
Prescott College[1], Regent University[2]

In 2012, over 200,000 adolescents were placed in out-of-home treatment settings in the United States. A subset of those settings is wilderness programs. Relatively little research links the components of wilderness programs to the successful client outcomes reported by wilderness programs. A phenomenological inquiry using the conceptual mapping task (CMT) provided a mechanism for wilderness therapists to define their experience in the treatment process. Results of the study indicated that wilderness therapists delineated four themes: a) positive experiences in the outdoors, b) unexpected changes and life transitions, c) work-life balance, and d) being a wilderness therapist versus a traditional therapist.

Keywords: wilderness therapy, outdoor behavioral healthcare, qualitative methods

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.08

Some adolescent mental health concerns are so severe they necessitate out-of-home placement to adequately address them (Farmer, Mustillo, Burns, & Holden, 2008; The Annie E. Casey Foundation, 2015; Zinn & Havlicek, 2014). A number of investigators have documented the effectiveness of wilderness therapy (WT; Gass, 1993; Gass, Gillis, & Russell, 2012; Greggo, 2008; Itin, 1998; Norton, Carpenter, & Pryor, 2015; White, 2012) to support a distinctive approach to address the mental health concerns of adolescents in need of out-of-home placement.

The current study implemented a phenomenological design using the conceptual mapping task (CMT; Impellizzeri, Savinsky, King, & Leitch-Alford, 2017) to better understand the lived experience of mental health therapists in wilderness programs, as a distinct type of therapy and a subset of adventure therapy. The goal in doing so is to provide a mechanism for wilderness therapists to define what their practice.

Review of Literature

While authors have discussed the need to explore the unique role of mental health providers working in these out-of-home placements (Bunce, 1998; Itin, 1998), research to date has focused on the potential burnout risks and stressors for field staff or instructors, rather than mental health therapists (Arizmendi, 2011; Marchand, 2008; Marchand, Russell, & Cross, 2009; Marchand & Russell, 2013). In their meta-analytic study, Bettman, Gillis, Speelman, Parry, and Case (2016) identified stronger effect sizes amongst clients for locus of control, behavioral observation, and interpersonal measures when a therapist was on staff; additionally, they noted "...our results may also indicate that published WT research may not be explicating clearly the roles and impacts of utilized therapists" (p. 2669).

Over the last two decades, the primary research focus in wilderness therapy has been on self-reported client outcomes based on the Youth Outcome Questionnaire (Y-OQ; Burlingame et al., 2005) given at various times throughout the treatment process (Bettman, Olson-Morrison, & Jasperson, 2011; Gass & Gillis, 2010; Russell, 2006). However, outcomes-based research (Behrens, Santa, & Gass, 2010; Behrens & Satterfield, 2011; Daniels, 2014; Larivière et al., 2012; Neill, 2003; Russell, Gillis, & Lewis, 2008) has not clearly identified what makes wilderness therapy a distinct approach from other therapeutic modalities. Russell and Gillis (2017) deepened understanding of the components that contribute to the effectiveness of wilderness therapy with their Adventure Therapy Experience Scale (ATES). The ATES will allow researchers to look at four primary factors: 1)

group adventure, 2) reflection, 3) nature, and 4) challenge, to more accurately reflect characteristics inherent to the wilderness therapy process and the treatment gains reported. The ATES has since been used in at least one quantitative study using routine outcome monitoring (Russell, Gillis, & Kivlighan, 2017) that found group adventure to be significant to treatment gains both between-client and within-client. It may be helpful for future research to look at the remaining three factors that the ATES assesses to ascertain how their impact on treatment may be more indirect yet still a significant component of the therapeutic process in adventure and wilderness therapy.

Qualitative Wilderness Therapy Research

Several qualitative studies have looked at techniques implemented in wilderness therapy settings. A case study by Caulkins, White, and Russell (2006) examined the impact of physical exercise for adolescent women in wilderness therapy programs, using both adolescent clients and female instructors to conduct semi-structured interviews. A second study (Mossman & Goldthorpe, 2004) employed a mixed-methods approach that focused on the client's perception of their experience, which in part incorporated mental health therapists' input. From the findings, one could ascertain the components that the mental health therapist found useful in wilderness therapy. Russell (2003) used a case study design to interview past clients and their parents/caregivers to understand how the significant reduction in reported symptoms was either maintained or lost after discharge from wilderness treatment.

The challenge remains to conduct qualitative research that explores the experience of wilderness therapists (Berman & Davis-Berman, 2013; McKenzie, 2000). As Tucker and Rheingold (2010) asked, "How can adventure professionals know if they are doing something well if they do not know what it is they are doing" (p. 260)?

Research Questions

Three research questions were selected by the principal investigator (PI), who used these questions to guide the formation of a verbal prompt that was given to each participant during their interview.

Research Questions:

1. What is the lived experience of professional mental health providers in wilderness therapy programs?

2. What characteristics make wilderness therapy distinct from other forms of experiential therapies?
3. How is the therapeutic process, and more specifically the therapeutic relationship, distinct in wilderness therapy programs versus more traditional mental health settings?

Method

Using a phenomenological inquiry approach, this study drew from the lived experience of mental health professionals working in private wilderness settings. The programs from which participants were drawn self-identified as having wilderness therapy as the heart of their program model. Through the interviews, the PI gained insight into what wilderness therapists are doing in therapy sessions with clients as that relates to their program's treatment model.

During the planning stages of this study, the PI presented sessions at the annual NATSAP conference. As an outgrowth of those presentations, five wilderness therapy programs expressed interest in participating in this study. While the PI followed up with all five programs that expressed interest, only two wilderness therapy programs proceeded. Both programs were accredited members of the Outdoor Behavioral Healthcare Council (Pace et al., 2014). The accreditation was independently maintained through an external entity, the Association for Experiential Education (AEE). The study had nine mental health professional participants, drawn from two programs: one situated in the Northeastern United States, the other in the Southwestern United States.

Participant Profiles

Therapists were selected to participate if they met the criteria of employment in a private wilderness therapy program and an active state or provisional license as a counselor, social worker, psychologist, or substance abuse counselor. All nine participants received an informed consent packet and were given a chance to ask clarifying questions prior to audio recording. Four participants were at the Northeastern site, while the remaining five participants were at the Southwestern site. Participants had the CMT prompt below read aloud and received a copy of the prompt for their reference. Each of the nine therapists created a CMT map, which presented the information visually during the interview process. The CMT's below in *Figure 1* and *Figure 2* serve as examples of the finalized product.

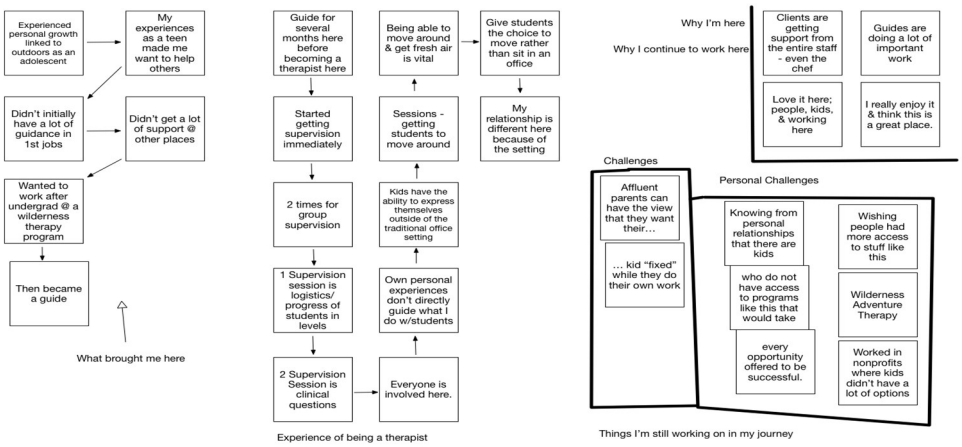

Figure 1. Conceptual map created by northeastern program participant.

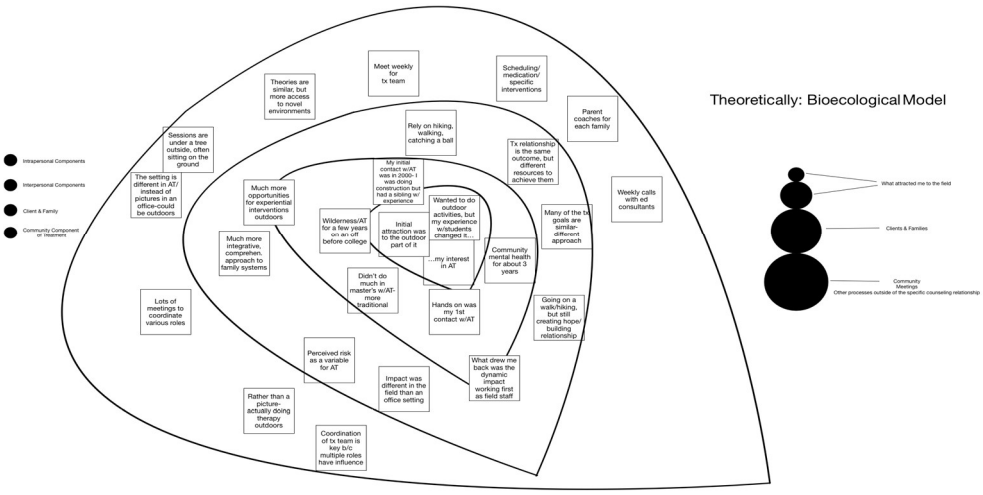

Figure 2. Conceptual Map Created by Southwestern Program Participant

CMT prompt:

> I want you to take about 10-15 minutes to tell me the story of being a wilderness therapist. Please give me some background as to what about wilderness therapy and working in a wilderness therapy program attracted you to this field. Some areas to consider as you are thinking about your answer are how you conduct therapy and if being a wilderness therapist is different from others' experiences you may have had as a mental health provider before. What do your sessions look like? How do you coordinate your therapeutic work with the rest of the treatment team? How is the therapeutic relationship you create with your clients different in this setting than you think it could be elsewhere?

CMT Process

An additional feature of the data collection and data analysis process was the ability of the CMT to provide in-depth member checking (Hays & Singh, 2012) when the PI was limited to being on site only once. Impellizzeri et al. (2017) discussed the efficacy of using the CMT in their seminal article on eliciting four distinct member-checking phases within a single semi-structured interview to both collect data and include participants in the data analysis process: a) gathering information and rapport building, b) participant storying, c) creating the conceptual map, and d) reflecting on the conceptual map. Phase 1 consisted of meeting with participants individually to collect and clarify their demographic forms, as well as reviewing the informed consent process that included a consent for audio recording. This initial phase was also a time to share with each participant that the PI might be asking clarifying questions to ensure the accurate reflection of their story, rather than allowing the PI's narrative to bias their statements. Phase 2 began with reading the CMT prompt aloud for the participant and beginning the audio recording. During the interview, Impellizzeri and colleagues delineate that the "...interviewer records the participant's story on small rectangular Post-it® Notes designating one concept (statement/thought) per note" (2017, p. 3).

After the interview, participants were asked to review their Post-it® Notes that had been placed on a blank, white tri-fold poster board that could easily be moved between the PI and participant. Notes could be changed or added to if they did not accurately reflect what participants ultimately chose to leave on their boards. Phase 3 was a process of the participant creating their own conceptual map. Participants were encouraged to create a physical representation of their ideas as they made sense to them. They were asked to draw connecting lines,

circle themes, and do any type of creative, additive mechanism for their conceptual maps. The only boundary provided by the PI was to request that statements not be removed for any reason, and if they truly fall outside the scope of the map, to be left as part of the project with special separation to distinguish them. Phase 4 provided time for participants to reflect on their CMT with the PI. This final phase included participants describing what themes they saw in their own narrative as demonstrated by their CMT's and reflecting on their experience of the process.

Results and Discussion

Clear themes emerged that answered the research questions. A standard prompt resulted in several participants using the components to shape both their responses and how they grouped concepts in their conceptual maps. There was enough variation in the nine CMT's created to lend credence to the idea that the themes reflected below add an additional layer of depth to the analysis of the interviews, transcripts, and CMT's. The PI used multiple aspects of the nine CMT's to pull four primary themes that encompass the lived experience of mental health providers in wilderness therapy programs; the four themes are listed below in *Figure 3*. Aspects of the CMT's that were used to delineate the themes included visual clues present while observing participants create their CMT's, the participant's reflections on their CMT's after they were created, and repetitive statements and themes across multiple CMT's.

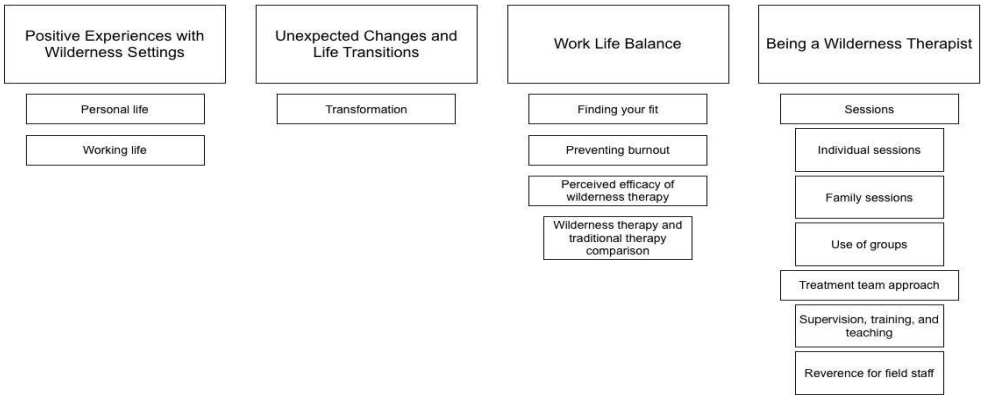

Figure 3. Flowchart of Primary Themes with Secondary and Tertiary Categories

The first theme was related to the positive experiences with outdoor settings in the participant's personal lives, from early childhood to adulthood, prior to becoming wilderness therapists. A second theme emerged that revolved around the unexpected, but meaningful, changes and life transitions that happened to the participants personally as a result of working in wilderness settings. The third theme was related to the desirable work-life balance provided by the wilderness setting. The fourth theme was related to the benefits of a close treatment team approach that applied to individual, family, and group therapy work. These themes and subcategories are addressed in more detail below as they served to answer each of the research questions.

1. What is the lived experience of professional mental health providers in wilderness therapy programs?

As noted above, in the first theme of positive experiences with outdoor settings, participants overwhelmingly spoke of their love for the outdoors and their appreciation of the time they have spent in the outdoors in their personal and working lives. This strong positive regard for the wilderness work place environment offers an additional perspective because the extant literature that has primarily evaluated the stressors and potential burnout risks for wilderness instructors (referred to as guides or field staff).

A second theme that emerged with participants in this study were the unexpected changes and life transitions that accompanied working in the outdoors. This was described as having been personally transformative. Participants used words like powerful, impact, blessing, and healing to describe how their personal experiences with the outdoors was transformative in their lives. One participant said:

> I had my own experiences with wilderness, and sort of the power of it, if you will. That stemmed back to a point in my life where I was really struggling. And I found that, I felt the most me, when I removed everything else in my life. When it really just became about being with myself all day, every day, alone on the trail. And my tasks were quite simplistic. Get up. Eat. Make sure I have enough fuel, literally calories, for myself for the day to take care of myself. Enough hydration. And hike. And be with myself. The metaphor of carrying everything I needed, truly needed not wanted, needed on my back was very powerful. And so, that sort of started my curiosity because it was such a powerful experience.

Quotes such as the one above suggested that the reported transformation was inextricably related to resilience that participants found through their outdoor experiences, fueled by heightened self-sufficiency.

Participants believed that the third theme, related to work-life balance, was aided by the wilderness settings in which they worked. It is worth noting here that this sentiment was salient for every participant interviewed. Therefore, further questions occurred to the PI in the data analysis phase. What if wilderness therapy is not just the clients and families responding to the nontraditional approach, but equally the staff themselves? Is there a resilience factor emerging when therapists have an innate capacity to prevent burnout in their workplace settings because they get to do what they love, where they love to be? As one participant reflected:

> Such a huge part of being a clinician is self-care, right? They talk about that ad nauseam in any program [graduate school] you take, and I think for the right person and certainly for me, this setting is such a huge part of my self-care.

2. What characteristics make wilderness therapy distinct from other forms of experiential therapies?

In six out of nine interviews, participants shared they had been wilderness instructors, guides, or field staff themselves at some point in their career in wilderness therapy programs. Their prior experience in the field meant they were often coming back to wilderness therapy programs to work after an extended time away from the field as they pursued their graduate educations. However, some returned during summer breaks to work as guides or field staff. Wilderness therapists described their roles as ones of leading their treatment teams, yet there was also a sense that this role was done with an increased focus on decreasing power differentials to ensure that everyone contributed to the process for clients and families. There was also a consistent description in their language choices that reflected active, rather than passive participation in their clients' wilderness experiences. For example, all participants spent some amount of time out in the field with their clients and stated that this experience created some of their most effective work. There was an additional sense from participants that they made a career choice to be a wilderness therapist that they recognized was nontraditional where they were often immersed in the treatment team process.

Wilderness therapists are accustomed to living and working in remote locations, where they rely on their peers and staff for support. They also reported engaging in leisure pursuits that were consistent with the outdoor experiential

activities available to them in these more remote locations. However, there was a sense that this work environment could create an insulated approach to therapy. One protective factor, which participants used to address insulation, was the ongoing educational opportunities they took to expand their knowledge base. Engaging in continuing education seemingly mitigated becoming isolated in their therapeutic approach, along with seeking additional credentialing for specific modalities of therapy. For example, one participant discussed being credentialed in a trauma-specific therapy. Another continuing education opportunity seemed to come from attending professional conferences, as many participants stated they had done. Finally, participants guarded against becoming too isolated by seeking leisure activities, such as yoga, that created opportunities for interaction with members of the community beyond their wilderness therapy programs.

Wilderness therapists differentiated their therapeutic work with clients and families from non- wilderness therapy settings in three key ways: a) the positive use of challenging the client, coupled with metaphorical learning via experiential interventions, b) the role of all members of the treatment team as equals, specifically embracing field staff as driving components of the therapeutic process, and c) the explicit use of movement.

In the present study, wilderness therapists did not emphasize the role of the milieu as much as the importance of individual and family therapy sessions. This could have been due to participants focusing on the role of the therapist, assuming, due to the PI's background, that she understood the foundational role that group work and individual therapy plays in most wilderness therapy programs. Perhaps this juxtaposition was best summarized in one participant's initial comments during his interview when he said, "…in a wilderness therapy program it's much more the milieu and the guide staff," to describe how the wilderness therapist is just one component of the treatment team.

The important role of the treatment team was present in all participant interviews and consistently showed that wilderness therapists relied on each other for support with challenging cases. It seemed to be a priority to have case consultations for support in areas which clinicians were working on becoming proficient.

The program model is the heart of each of the wilderness therapy programs included in this study. Building on that model, the wilderness therapists serve as the arms and legs that generate movement, which field staff make possible through their contributions. Field staff add the five sensory components with their observations and reflections of the client's experience, while

simultaneously going through those experiences with clients. Of the six participants who had prior experience as field staff, all discussed how they saw the therapeutic benefit of wilderness therapy through their embedded (field) experiences embedded with clients.

Physical movement was a primary component that was viewed as distinct from other experiential therapeutic approaches. Creative interventions that were similar to other experiential approaches, like art therapy, were discussed; such as, the example of picking an object from the natural world to represent some facet of a client's life, or creating a mandala using only natural objects found in the backcountry. However, the key differentiation, even when more traditional experiential activities were implemented in wilderness settings, was the use of expedition and backcountry skills as an element that participants perceived to be impacting client growth.

Participants shared that having the flexibility to use various experiential interventions with clients was a key factor in their positive experience working in wilderness therapy programs. They suggested that the time they spent outdoors with clients were some of the most powerful moments they remembered when reflecting on a client's journey. In every participant interview there was a priority placed on being outdoors for individual sessions. Wilderness therapists used the physical environment to create a sense of calm and clarity, free from the distractions of modern life. These concepts were consistent with widely-adopted definitions of adventure therapy that included the positive use of challenging experiences that are new to the client, the healing nature of outdoor settings, and clients receiving therapeutic support from trained professionals and licensed staff that is tailored to their specific needs (Gass et al., 2012; Pace et al., 2014). The added components that emerged from this study were the positive effect that the wilderness settings had for members of the treatment team and the strength of having the capacity to use movement in individual sessions to promote an active therapeutic alliance.

3. How is the therapeutic process, and more specifically the therapeutic relationship distinct in wilderness therapy programs versus more traditional mental health settings?

The treatment team and the flexibility to use experiential interventions in outdoor settings were the two primary components that participants consistently discussed as distinctions of their therapeutic relationship with clients in wilderness therapy settings. Regarding the therapeutic relationship between client and wilderness therapist, one participant summarized:

> I know how much they're sleeping, I know if they're taking their meds. I know what they're eating, and I get a written report in my mailbox every Monday morning about everything that happened on their wilderness expedition. If nothing else, the wilderness and expeditions. Yes, they can be transformative for kids, but at the same time probably the best thing they do is in the assessment of the student. Like they can't hide who they really are.

Indeed, participants spoke of a comprehensive perspective on their client's because they were aware of the degree to which clients implemented treatment goals and objectives. This is distinct from traditional mental health settings, where therapists sometimes rely on a client's self-assessment. Individual, family, or group sessions are opportunities for mental health providers in traditional settings to interact with their clients, whereas wilderness therapists have many more possibilities for interacting with their clients. For instance, when a client is struggling with an academic issue, the wilderness therapist can work through the soft skill of communication in the classroom setting. In another example, the wilderness therapist can work alongside a client when they successfully create their first fire and thereby participate in their client's success, rather than just hearing about it later.

Implications of the Study

The present study supports the idea that wilderness therapy is in unique and different from more traditional forms of therapy. It would serve us well to better understand the lived experience of wilderness therapists in order to capture the subtle ways in which wilderness therapy effects change. The present study provides a deepening of our understanding that might inform training in practice of wilderness treatment. Such training could lead to a specialty degree in wilderness therapy much like courses of study offered in art or music therapy. Alternatively, such advance training could lead to a wilderness therapy certification program for mental health professionals, much like existing certification programs such as Dialectical Behavior Therapy (DBT) or Eye Movement Desensitization and Reprocessing (EMDR).

Suggestions for Future Research

Emerging from the data was a sense that wilderness therapists experience resilience when they combine their love of the outdoors and adventure-based activities with their work. Future research could investigate how work-life balance in wilderness therapy might mitigate compassion fatigue and burnout. One of the

most salient themes was that participants use consultation to rely on their peers for input. An assessment such as the Professional Quality of Life scale (ProQOL) could be given to wilderness therapists to better understand how their perception of preventing burnout with their career choice compares to other professionals on the subscales of Compassion, Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm, 2010).

A final consideration is the loyalty that participants expressed for their specific program models. While there is strength in employees being fully committed to specific programming components with clients and families, there is a concern that creating this type of adherence could lead to a blind spot in being able to evaluate program efficacy. The use of impartial, outside research teams to conduct program evaluations, may foster the trend of best practices.

References

Arizmendi, J., Jr. (2011). Wilderness therapy: The impact of the psychosocial work environment on field instructors (Order No. 3481356). Available from ProQuest Dissertations & Theses Global. (906785997). Retrieved from http://0search.proquest.com.library.regent.edu/docview/906785997?accountid=13479

Behrens, E., Santa, J., & Gass, M. (2010). The evidence base for private therapeutic schools, residential programs, and wilderness therapy programs. *Journal of Therapeutic Schools and Programs, 4*(1), 106-117.

Behrens, E., & Satterfield, K. (2011). A multi-center study of private residential treatment outcomes. *Journal of Therapeutic Schools and Programs, 5*(1), 29-45.

Berman, D., & Davis-Berman, J. (2013). The role of therapeutic adventure in meeting the mental health needs of children and adolescents: Finding a niche in the health care systems of the United States and the United Kingdom. *Journal of Experiential Education, 36*(1), 51-64. doi: 10.1177/1053825913481581

Bettman, J. E., Gillis, H. L., Speelman, E. A., Parry, K. J., & Case, J. M. (2016). A meta-analysis of wilderness therapy outcomes for private pay clients. *Journal of Childhood and Family Studies, 25*, 2659-2673. doi: 10.1007/s10826-016-0439-0

Bettman, J. E., Olson-Morrison, D., & Jasperson, R. A. (2011). Adolescent in wilderness therapy: A qualitative study of attachment relationships. *Journal of Experiential Education, 34*(2), 182-200. doi: 10.5193/JEE34.2.182

Bunce, J. (1998). Sustaining the wilderness therapist. In C. M. Itin (Ed.). *Exploring the boundaries of AT: International perspectives.* Proceedings of the 1st International AT Conference. (pp. 189-200). Boulder, CO: Association for Experiential Education.

Burlingame, G., Cox, J., Wells, G., Latkowski, M., Justice, D., Carter, C., & Lambert, M. (2005). The administration and scoring manual of the Youth Outcome Questionnaire. Salt Lake City, Utah: OQ Measures.

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

Daniels, B. S. (2014). Adolescent subjective experience of wilderness therapy: A phenomenological approach (Order No. 3620297). Available from ProQuest Dissertations & Theses Global. (1537040547). Retrieved from http://0-search.proquest.com.library.regent.edu/docview/1537040547?accountid=13479

Farmer, E. M. Z., Mustillo, S., Burns, B. J., & Holden, E. W. (2008). Use and predictors of out-of-home placements within systems of care. *Journal of Emotional and Behavioral Disorders, 16*(1), 5-14. doi: 10.1177/1063426607310845

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

Gass, M. A., & Gillis, H. L. (2010). Clinical supervision in AT: Enhancing the field through an active experiential model. *Journal of Experiential Education, 33*(1), 72-89. doi:10.5193/JEE.33.1.72

Gass, M. A., Gillis, H. L., & Russell, K. C. (2012). *AT: Theory, research, and practice*. New York, NY: Routledge.

Greggo, S. P. (2008). *Trekking toward wholeness: A resource for care group leaders.* Downers Grove, IL: InterVarsity Press.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings.* New York, NY: The Guilford Press.

Impellizzeri, J., Savinsky, D. M., King, J. A., & Leitch-Alford, L. (2017). Conceptual mapping task: An effective verification tool for qualitative counseling research. *Counseling Outcome Research and Evaluation, 8*(1). doi: 10.1177/2150137816684926

Itin, C. M. (1998). Many paths to becoming an adventure therapist. *Insight, 6*(1), 4-5.

Larivière, M., Couture, R., Ritchie, S. D., Côté, D., Oddson, B., & Wright, J. (2012). Behavioral assessment of wilderness therapy participants: Exploring the consistency of observational data. *Journal of Experiential Education, 35*(1), 290-302. doi:10.5193/JEE35.1.290

Marchand, G. (2008). Challenges affecting field instructors in wilderness therapy. *The Journal of Experiential Education, 30*(3), 286-289.

Marchand, G., Russell, K. C., & Cross, R. (2009). An empirical examination of outdoor behavioral healthcare field instructor job-related stress and retention. *Journal of Experiential Education, 31*(3), 359-375.

Marchand, G., & Russell, K. C. (2013). Examining the role of expectations and perceived job demand stressors for field instructors in outdoor behavioral healthcare. *Residential Treatment for Children & Youth, 30*, 55-71. doi: 10.1080/0886571X.2013.751809

McKenzie, M. D. (2000). How are adventure education program outcomes achieved?: A review of the literature. *Australian Journal of Outdoor Education, 5*(1), 19-27.

Mossman, E., & Goldthorpe, C. (2004). Adventure development counselling research study: Some "hows" and "whys" of doing research. In S. Bandoroff & S. Newes (Eds.). *Coming of age: The evolving field of adventure therapy* (pp. 156-171). Boulder, CO: Association for Experiential Education.

Neill, J. T. (2003). Reviewing and benchmarking AT outcomes: Applications of meta-analysis. *The Journal of Experiential Education, 25*(3), 316-321.

Norton, C. L., Carpenter, C. & Pryor, A. (Eds.). (2015). *Adventure therapy around the globe: International perspectives and diverse approaches.* Champaign, IL: Common Ground Publishing.

Pace, S., Bisson, C., Stremba, B., Fouche, T., Hirsch, J., Smith, P., … Tierney, S. (Eds.). (2014). *Manual of accreditation standards for adventure programs* (6th ed.). Boulder, CO: Association for Experiential Education.

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

Russell, K. C., & Gillis, H. L. (2017). The adventure therapy experience scale: The psychometric properties of a scale to measure the unique factors moderating an adventure therapy experience. *Journal of Experiential Education, 40*(2), 135-152. doi: 10.1177/1053825917690541

Russell, K. C., Gillis, H. L., & Kivlighan, D. M. (2017). Process factors explaining the psycho-social outcomes in adventure therapy. *Psychotherapy, 54*(3), 273-280. doi: 10.1037/pst0000131

Russell, K. C., Gillis, H. L., Lewis, T. G. (2008). A five-year follow-up of a survey of North American outdoor behavioral healthcare programs. *Journal of Experiential Education, 31*(1), 55-77.

Stamm, B. H. (2010). The concise ProQOL manual, 2nd Ed. Pocatello, ID: ProQOL.org.

The Annie E. Casey Foundation (2015, February). *Too many teens: Preventing unnecessary out-of-home placements.* Retrieved from http://www.aecf.org/m/resourcedoc/aecf-TooManyTeens-2015.pdf#page=32

Tucker, A. R., & Rheingold, A. (2010). Enhancing fidelity in adventure education and adventure therapy. *Journal of Experiential Education*, *33*(3), 258-273. doi: 10.5193/JEE33.3.258

White, W. (2012). A history of adventure therapy. In M. A. Gass, H. L. Gillis, & K. C. Russell (Eds.)., *Adventure therapy: Theory, research, and practice* (pp.19-46). New York, NY: Routledge.

Zinn, A., & Havlicek, J. (2014). Pathways to residential care: Latent class and confirmatory analyses of adolescents' adverse placement event histories. *Social Service Review, 88*(3), 367-406. doi: 10.1086/677569

Youths' Perspectives on Their Relational Identity Development through Residential Treatment

Julia K. Riddell and Debra J. Pepler
York University

Victoria Creighton
Pine River Institute

Author Note

Julia K. Riddell, M.A. in Clinical Developmental Psychology, Doctoral Candidate, York University; Dr. Debra J. Pepler, Ph.D., C.Psych, York University; Dr. Victoria Creighton, Psy.D., Pine River Institute.

We are deeply grateful to the youth who participated in this study for their willingness to share their journey with us.

Correspondence concerning this article should be addressed to Julia K. Riddell, 4700 Keele Street, Toronto, Ontario, Canada, M3J 1P3. Contact: 647-787-2848; jriddell@yorku.ca

The goal of this study was to examine youths' narratives of their identity development during a residential, wilderness, and family therapy program. A semi-structured interview was conducted, and thematic analysis was used. Youth described their identity in terms of who they learned to be in their relationships, which included being authentic, vulnerable, accepting of themselves and others, empathetic, and honest. They discussed a number of program elements that influenced their identity development, all of which involved relationships with staff, therapists, and other students. Results of this study have implications for staff training, program development, and program evaluation.

Keywords: residential treatment, wilderness therapy, family therapy, adolescent development, identity, relationships

ISSN 2469-3030 online © 2019 Journal of Therapeutic Schools and Programs DOI: 10.19157/JTSP.issue.11.01.09

In the present study, we examined youths' narratives of their identity development during an intensive residential, wilderness, and family therapy program for youth with addiction and mental health challenges. Emerging research has documented a reciprocal relationship between identity issues and mental health problems in adolescence (Wiley & Berman 2013). Specifically, externalizing problem behaviors and lack of a coherent sense of identity may reinforce each other (Crocetti, Klimstra, Hale, Koot, & Meeus, 2013). Although most adolescents move through a process toward identity maturation during adolescence (Becht et al., 2016), about 14% of youth experience significant identity issues (Berman, Weems, & Petkus, 2009). When identity development is not well established by the end of adolescence, youth may struggle in future developmental periods. For example, female college students with clinically significant identity distress showed significantly more externalizing symptoms and antisocial behaviors, and males experienced significantly more internalizing symptoms such as anxiety, depression, peer problems, and social withdrawal (Hernandez, Montgomery, & Kurtines, 2006). Thus, it is essential to understand identity development in youth experiencing mental health problems.

Marcia created the identity status model based on Erik Erikson's work (Erikson, 1959). Marcia (1967) documented four identity statuses, which are defined by where someone falls along the two orthogonal dimensions of exploration and commitment. These four statuses include: achievement (high exploration, followed by commitment), moratorium (high exploration and low commitment), foreclosure (low exploration and high commitment), and diffusion (low commitment and low exploration). Those who have reached achievement status have experienced a period of identity crisis and have been able to resolve this crisis and commit to a stable sense of identity (e.g., cultural, political, religious, occupational, personality, values, life goals, etc.). The moratorium status refers to individuals who are actively exploring their identity, values, and life goals and attempting to settle into a stable sense of identity. Individuals in the foreclosure status have not experienced an identity crisis but instead hold firm and often parentally determined commitments related to their identity. Those in the identity diffusion status have not committed to a stable identity and are not engaging in active exploration of the different identities available to them (Marcia, 1967).

Over the course of adolescence and young adulthood, commitment processes tend to increase in a linear fashion (Luyckx, Klimstra, Duriez, Van Petegem, & Beyers, 2013). Individuals who have made commitments in the

achieved and foreclosed identity groups report higher levels of psychological well-being, adjustment, and emotional stability (Crocetti, Rubini, & Meeus, 2008; Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005; Wiley & Berman, 2013). On the other hand, individuals stuck in the exploration process may experience anxiety, depression, and distress (Luyckx & Robitschek, 2014; Schwartz, Zamboanga, Weisskirch, & Rodriguez, 2009).

Identity Development in a Relational Context

Recent longitudinal studies have revealed how proximal and distal social contexts shape and are shaped by youth identity development (Crocetti, Beyers, & Çok, 2016). A number of studies have demonstrated how identity development is embedded within family and community relationships (Beyers & Goossens, 2008; Crocetti, Garckija, Gabrialaviciute, Vosylis, & Zukauskiene, 2014; Schwartz, Mason, Pantin, & Szapocznik, 2008, 2009). For example, Schwartz and colleagues found that changes in adolescent-reported family functioning significantly relate to changes in identity confusion (Schwartz et al., 2009). Further, Crocetti and colleagues reported that identity is promoted by warm and supportive parent-child relationships (Crocetti et al., 2014). In terms of the community context, adolescents with different identity styles have been shown to differ in terms of their civic engagement (i.e., involvement in volunteering activities and in youth nonpolitical organizations; Crocetti et al., 2014).

An emergent body of literature has identified the essential role of family relationships in facilitating identity formation (Arseth, Kroger, & Martinussen, 2009; Crocetti, Branje, Rubini, Koot, & Meeus, 2017; Meeus, Iedema, Maassen, & Engels, 2005; Meeus, Oosterwegel, & Vollebergh, 2002). In particular, identity development has been found to be positively associated with warm and nurturing parent-child relationships (Arseth et al., 2009; Crocetti et al., 2017). On the other hand, youth who perceive their parents as psychologically controlling tend to explore a breadth of identity alternatives and experience greater difficulty committing to meaningful life domains (Luyckx, Soenens, Vansteenkiste, Goossens, & Berzonsky, 2007). Emerging evidence suggests that there is a reciprocal relationship between difficulties with identity development and adolescent-parent relationships; it may be that family relationships affect identity, and identity has significant effects on family relationships (Crocetti et al., 2017). In this study by Crocetti and colleagues, identity certainty was related to nurturing family relationships, and, in turn, adolescents' identity commitment led to a more supportive relationship with their mothers and a more egalitarian relationship with

their siblings (Crocetti et al., 2017).

Early research on psychosocial maturity in adolescence revealed that mature young women used interpersonal relationships for identity resolution (Josselson, Greenberger, & McConochie, 1977). That is, they used friendships to explore and clarify their identities in relation to others, referred to as self-differentiating experiences (Grotevant, Thorbecke, & Meyer, 1982). Josselson and colleagues concluded that mature individuals are "identity seekers, attempting to discover who they are and who they want to be in relation to the significant others in their lives" (Josselson, Greenberger, & McConochie, 1977). Further, it has been suggested that ego development arises through social interactions that challenge individuals and require them to think deeply about the relation between self and others (Loevinger, 1976; Syed & Seiffge-Krenke, 2013). More research is needed to fully understand how identity develops in the context of relationships.

An Intervention for Youth Who Struggle with Addiction and Mental Health Problems

Pine River Institute (PRI) is a 36-bed residential program for youth struggling with addiction and mental health challenges. Located in Ontario, Canada, PRI combines four services: wilderness therapy, residential treatment, parent intervention, and aftercare. There are five stages of the program: Stage 1 is the wilderness phase, Stages 2 - 4 take place on the residential site, and Stage 5 involves the provision of aftercare services while youth transition back to their homes and communities.

The wilderness therapy component occurs during the first two months of the program, where youth live in a wilderness environment, camp in tents or yurts, and engage in physical activities such as hiking and canoeing. Personal growth is facilitated through group initiatives, individual therapy, journaling, and other therapeutic activities. After youth graduate from the wilderness, they spend the next eight to ten months at the residential campus completing high school credits, living collectively, and participating in individual, group, and family therapy. An important aspect of the program is the requirement of parent involvement. Parents meet individually with staff and in groups to learn how to respond to their adolescents in developmentally appropriate ways. Furthermore, youth and parents engage in family therapy. In the final phase of the program, youth are re-integrated into the community with the support of aftercare services.

PRI's program is partly based on the maturity model, which posits that youth struggle with mental health challenges and addiction due to immaturity (defined as blocked emotional/social development; McKinnon, 2008). A blockage of social-emotional development obviously has the potential to affect the core adolescent task of identity development. Similar to other youth treatment programs, PRI's program is designed to accelerate development through treatment and raise youths' developmental capacities to levels normative for their same-age peers (Pepler, 2016). This makes it an ideal setting to study the impact of treatment on the processes of identity development in adolescence. Numerous types of programs exist to support youth struggling with mental health challenges. There is, however, very little research on how treatment programs support adolescents in the core task of identity development. There are also few studies examining youths' identity development from their own perspectives.

The goal of this study was to understand youths' perspectives on their identity development and how this development was accelerated through treatment. In this qualitative study, we interviewed adolescents struggling with mental health challenges and addiction about their experience in a treatment program. The qualitative approach enabled us to derive an in-depth understanding of youths' process of identity development in their own words and to answer two main research questions: (1) What are youths' perspectives on their identity development? (2) What aspects of the program support this development?

Method

This study was conducted at Pine River Institute (PRI) with ethics approval from the York University Ethics Review Board. Parents were informed about the research project and provided written consent for youth to participate. Parental consent was obtained for 24 youth (71%). Only youth with parental consent participated in this study and the youth themselves assented to participate. Youth were informed that if they declined to participate in the study, it would not jeopardize their relationships with staff nor the services they received at PRI. Conversely, if they chose to participate, every effort would be made to de-identify their responses. They were cautioned that it was possible that individuals who knew them well might recognize quotations as belonging them.

Participants

Youth were informed about the study by the PRI principal and were invited to speak with the first author if they wanted more information about the study and/or were interested in participating. It was decided a priori that the sample would be 10 youth, as this is a manageable sample size when conducting in-depth interviews and doing qualitative analyses. The total sample consisted of seven boys and three girls. Youth were chosen for the interviews to represent the gender ratio at PRI, which ranges from 66% to 85% male (Pine River Institute, 2014). During daily activities, six male youths mentioned that they were interested in being interviewed. All six of these youths were interviewed. For the remaining four participants, four girls were selected from diverse stages in the program. Of the youth invited to participate, one female youth declined, and a male youth who was interested in the study was chosen instead. Youth were also chosen from different stages of the program: two participants were from Stage 2, four from Stage 3 and four from Stage 4. No youth were from Stages 1 or 5 as they were not present in the center. Similar to the population at PRI (Pine River Institute, 2015), all 10 youth who participated in this study were white and their average age was 17.5 years old, with an age range between 14 and 18 years old. Half of the participants were from the Greater Toronto Area and the others were from within the province of Ontario. More than half of youth admitted to PRI have been diagnosed with a significant mental health challenge, the most common being anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder. Similarly, many of the youth in this sample struggled with a range of mental health challenges in addition to addiction, including: self-harm, school refusal, family conflict, and past trauma. Information on socioeconomic status (SES)/income is not formally collected by the program, however, clinicians have reported that most youth tend to be from mid to high SES families. At the time of interview, the youth in this study had been in the program for an average of 8.5 months, whereas youth spend an average of 11 months in the program in total (Pine River Institute, 2015).

Procedure

The first step in developing this study was to meet with the clinical staff to discuss the project and receive feedback on the research goals and procedures. The research questions and methods were mutually decided upon with the clinical staff. The primary researcher spent a few days a week at PRI for about eight months, participating in daily activities with the youth and staff. This extended

time at PRI was essential in developing trusting relationships with the youth and staff, as well as getting a deeper understanding of the program. Since the goal of this study was to capture the perspectives of youth in their own words, open-ended interviews were conducted with the youth.

Analyses

The semi-structured interview guide contained 15 main questions, which are included in Table 1. These questions were intentionally broad to give youth the opportunity to discuss the aspects of themselves and their experiences that they considered most important. Subsequent follow up questions were asked, such as asking youth to provide more information about something they have shared. Interviews lasted between 30 and 90 minutes, with the majority of interviews lasting 60 minutes. Thematic analysis was chosen to analyze the transcripts. Thematic analysis is a flexible and accessible approach for identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006). In short, and like other qualitative methods, thematic analysis is a way of parsing qualitative data into themes that are internally coherent, consistent, and distinctive. The decision to use a descriptive approach as opposed to a more interpretive approach was made before beginning the analysis. In the analysis phase, the primary researcher worked on bracketing assumptions from previous reading, research, and personal experiences to allow the themes to emerge from the data. Care was taken to stick closely to the language of the participants when creating categories and to limit the amount of interpretation.

In the first phase of the analysis, transcripts of the 10 interviews were coded using NVivo software with the initial main categories and subcategories identified. NVivo is a software used to organize data. It allows the researcher to manually highlight sections of text and code it with the name of a theme that the researcher creates. All parts of the text that have been given the same theme name can then be viewed in one section to allow the researcher to then assess the theme for internal consistency.

In the second phase, all 10 interviews were re-coded to identify any additional examples of existing categories, as well as to identify new categories. In the third stage of analysis, each category was examined to ensure it was internally consistent (i.e., the properties within the category were conceptually similar), as well as to ensure the category was conceptually distinct from other categories. All categories that contained properties from only one or two

participants were excluded in the final model. The final step was sorting all categories into domains, and the main categories and subcategories that fall under those domains. A consensus was reached amongst researchers on the structure of domains, categories, and subcategories.

Table 1. *Main Questions from Interview Guide*

1. Think of yourself before you came to Pine River. How would you have described yourself? How would your parents have described you?
2. Now think of who you are at this moment, how would you describe yourself? What has changed?
3. What challenges led you to participate in this program?
4. Since you've been at Pine River, have you noticed any changes? What part(s) of the program was (were) most helpful in making these changes?
5. Think of a time you felt you could be yourself around someone else. Who was this person? Who else do you feel like you can be yourself around?
6. Think back to the circle of trust activity you completed at the beginning of the program. What did your circle of trust look like then? What does your circle of trust look like now?
7. Has your relationship with your parents changed since coming to Pine River? If so, how has it changed? What aspects of the program helped you and your parents make these changes?
8. Think back to when you wrote your letter of accountability to your parents. Describe the experience of writing the letter in as much detail as you can remember. Did this letter impact your relationship with your parents?
9. Describe your relationships with your friends before you came to Pine River. Have these friendships changed at all in the time you've been at Pine River?
10. Describe your romantic relationships before you came to Pine River. Have these relationships changed at all in the time you've been at Pine River?
11. Please describe your relationships with the staff at Pine River.
12. Please describe your relationships with your team members.
13. Please describe what it's like to participate in the weekly process groups.
14. How would you summarize your experience in this program overall?
15. What do you think the future holds for you? What are your plans after you finish at Pine River?

Results

Relational Identity

The first aim of this study was to determine youths' perspectives on their identity development. From the interviews, the domain Relational Identity emerged, which is represented in *Figure 1*. In this domain, youth described the interaction between their identity development and their relationships with staff and other youth at PRI. They explained that who they are becoming (e.g., empathetic, accountable, funny, grateful, etc.) developed in the context of their relationships during treatment. Youth also articulated that to build these close relationships, they needed to show their true selves to others (e.g., being authentic, being vulnerable, accepting themselves, being honest). For example, one youth discussed how their[1] ability to provide support to others (a relational pattern) is a core aspect of their identity:

> I went through patches here where I didn't do too well in process groups[2]… I was dealing with my own stuff and I just shut down, and that's not a good me…when I'm at my best is when I'm offering support to people.

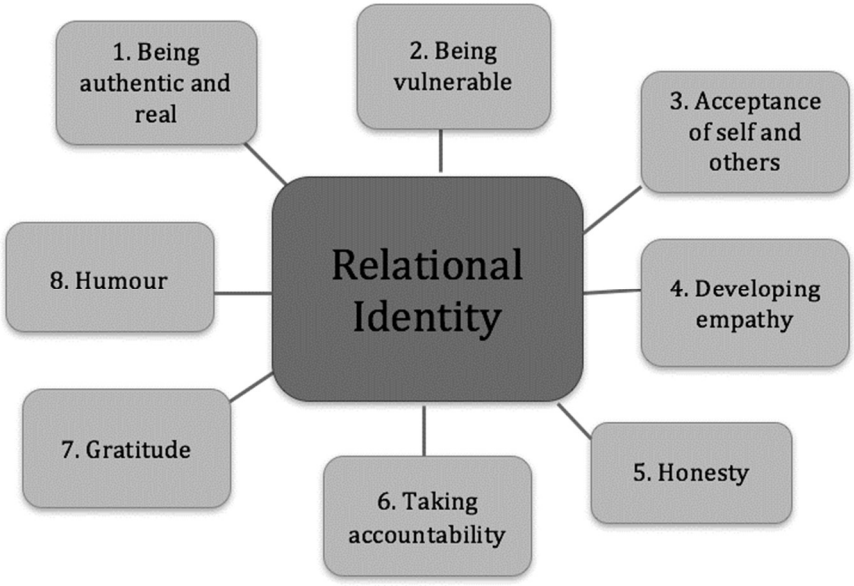

Figure 1. Aspects of youths' identity development.

Another core aspect of their identity development involved positive relationships acting as a mirror through which youth can begin to see and develop positive aspects of themselves. For example, following feedback on a youth's hope and wisdom in the face of adversity, they replied, "People tell me a lot of the time that I'm a wise person and it makes me feel really good because back home, I wasn't seen that way. I was just seen as crazy and angry." In these ways, the process of identity development was represented by youth as occurring within the context of close, healthy relationships with both peers and staff at PRI. Youths' descriptions of "who they are" related to their ways of being in relationships as opposed to static individual characteristics, such as being 'smart.' The eight categories within this domain are described below.

Being authentic and real. The theme of authenticity came up across multiple questions during the interviews. One youth said, "I've worked a bit on identifying who I am… when I came I didn't really know who I was, because I'd been like browsing around, looking for someone's personality to try on. Like a new pair of pants." Another youth explained that through feedback with people at PRI they were able to construct an authentic sense of self. They said, "Especially with your masks and walls you put up. You don't even realize those are walls until someone calls you on it and they're like 'You're putting up a front right now, that doesn't feel authentic.'" The culture of authenticity at PRI allows for healthy experimentation with different ways of being, as youth receive feedback from people they trust about how any their attitudes and behaviors are experienced by others.

Being vulnerable. The second aspect of relational identity development is the importance of being vulnerable in relationships, which involves showing true parts of oneself to others and having others see and validate these parts. One youth explained how some of their behaviors before PRI were the result of being afraid to show their true selves in relationships. They said, "Yeah, so a lot of it came down to vulnerability. Immaturity saved me from having to be vulnerable." Another youth commented, "To be in an empathetic relationship you need to learn how to be vulnerable." Similar to other participants, this youth drew a connection between having the courage to be truly oneself in a relationship (vulnerability) and to be seen and accept attuned care within a healthy (empathetic) relationship.

Acceptance of self and others. Participants mentioned that cultivating acceptance for themselves and other people was important in their developmental process. One youth explained that a large part of their therapeutic work was,

"analyzing my behavior and accepting what I don't really like about myself or my behavior." Accepting themselves allowed youth to be authentic and vulnerable with others, which facilitated building close relationships. Acceptance of self was also related to youth's capacity to be accepting of others, which was another relational pattern that became part of their developing sense of self. Furthermore, feeling accepted by others was a core part of the context at PRI that made identity development possible.

Developing empathy. Many youth mentioned that the capacity to be empathic was a core relational pattern they had developed throughout the program, and this in turn became a way that they self-identified (i.e., as an empathic person), as well as a quality that they would look for in future relationships. One youth said of their peers at PRI, "We all can relate a lot…we learn how to really feel empathy for people and care about people."

Honesty. Another prominent change noted by youth was their ability to be more honest in relationships. While the theme of authenticity captures youth's sense of being able to be themselves in their relationships, the theme of honesty relates to youth's ability to be tell the truth even when it is difficult. One youth explained, "I've become more close and more honest with my dad and my family…It's the feeling that I actually feel that good in our relationship, that it feels authentic and honest. And the ability to be vulnerable with him." Another youth explained how being honest was connected with their sense of self-confidence. This youth gave advice to others to, "Stand up for what you believe in, be respectful, be honest and direct." Similar to the other categories in this domain, being more honest is a way of being in relationships that became part of youths' identity.

Taking accountability. Youth mentioned the importance of taking responsibility for their behavior, which in the PRI program is referred to as "taking accountability." One youth described this as "admitting things you've done, coming to terms with things you did, understanding why you did the things you did, and most importantly wanting to change." The youth discussed this way of relating to people as helping them have mutually satisfying relationships, as well as being an essential aspect of how they viewed themselves.

Gratitude. Participants commented on the importance of being grateful for things in their lives, as well as expressing gratitude towards others. For example, one youth said, "You just gotta appreciate where you're at and what you get here…so you just got to appreciate things." Becoming someone who expresses

gratitude informs youths' developing sense of self and impacts the quality of their relationships.

Humor. Youth described using humor as a way to connect with others and be authentic in relationships. One youth explained, "You gotta laugh… sometimes you even have to laugh at yourself. Saying that was stupid, what I did, but whatever." In this way, participants have identified humor as a way to learn, grow, and make mistakes without harming their self-esteem. They also identified humor as a way to be gentle with themselves and others.

Elements that Facilitate Identity Development

The second aim of this study was to understand what aspects of the program youth view as responsible for their development. These themes are captured in the domain Program Elements Linked to Change, part of which is represented in *Figure 2.* Youth discussed the key aspects of the program that they considered highly influential in their identity development. The seven categories in this domain included: the process group, the opportunity to practice skills, the process of giving and accepting feedback, check-ins, Dialectical Behavior Therapy (DBT; Linehan, 1987), being accepted within a community, as well as opening up to and connecting with others.

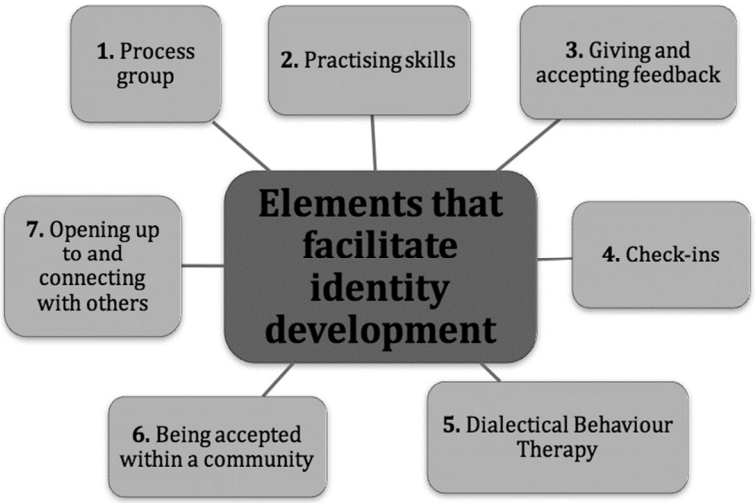

Figure 2. Aspects of the program that youth discussed as responsible for their identity development.

Process group. All youth mentioned process group as being a main space in which they worked on their relationships with other students in the program. Process group involves a team of students (about 10 youth in total) and a staff or therapist meeting three times per week to discuss how things are within the team. This includes: discussing problems, sharing how each member is doing, giving feedback to others about their behavior, asking for support, and offering appreciation to fellow team members. One youth shared their experience in process group by saying:

> I enjoyed process group because people are honest and it's a safe place…they can trust you and you can trust them. It feels good to be in a relationship with that many people …makes everybody feel really open and honest.

Another youth described process group as "a really good place to grow, and to hear support from everyone."

Practising skills. A second influential part of the program involved learning relationship skills in therapy, then applying these skills in relationships with staff and other youth. Youth also discussed learning interpersonal skills at PRI that they could then apply with family, friends, and others outside of PRI. One youth explained, "I also learned how to deal with interpersonal situations. Relationships I developed with team members and staff have been a practice for situations that I may come across later on."

Giving and accepting feedback. Youth discussed the importance of giving and accepting feedback about one's behavior as a mechanism that facilitated their identity development. Often, this process of giving and accepting feedback occurs during process group; it may also occur during therapy sessions, or informal conversations with staff or other students. One student explained giving and receiving feedback in process group, "Everyone has taken at least one or two pieces of feedback and probably given some to other people… and it has been given in such a way so it's productive and it helps people deal with their issues." Many youths described how the process of giving and receiving feedback helps people grow and become more authentic in relationships.

Check-ins. At PRI a check-in refers to an informal conversation between a youth and a staff member or two youth in which the youth opens up about how they are doing. One youth described a check-in as, "just talking about how your day is, or what you're feeling or what you've been doing in therapy, or anything." Participants talked about how important check-ins were in their process of change, as they function to both help the individual youth in their development and facilitate a deeper relationship among the individuals involved in the check-in.

Dialectical Behavior Therapy. Youth discussed Dialectical Behavior Therapy (DBT; Linehan, 1987) as a way to gain skills that helped them be themselves in relationships. One youth stated that "DBT teaches you a lot. It teaches you how to be mindful, and how to be aware of certain issues you have." After learning these skills in DBT, youth were able to practice skills like mindfulness and interpersonal effectiveness in their relationships with the staff and students at PRI, as well as with their families who were also learning new skills in therapy.

Being accepted within a community. Youth mentioned that being part of a whole community of staff and students working to be their true selves in relationships was the reason PRI was so effective at facilitating their identity development. One youth explained, "I think the biggest thing here is because it's a community…it's like a sort of society where you can just learn to be yourself." When asked directly what helped them in their personal growth, one participant responded, "I think the community, like being in a culture that's extremely accepting."

Opening up to and connecting with others. Youth described how the process of opening up to others and having their vulnerability met with care and trust was essential in their developmental process. One youth described their relationships with team members by saying, "I've opened up to so much. And it's really helped and, yeah, I just have the deepest relationships with everybody here." When asked what parts of the program had been most helpful in their journey, one youth answered, "The main thing is making connections with people. Umm, being around people who I can relate with and talk to. I think most of my work has been figuring out how to connect with people, you know?"

Discussion

The goal of this study was to enhance understanding of how a key aspect of adolescent development, identity, is accelerated through a residential program

for adolescents struggling with addiction and mental health challenges. PRI's programming is based on the maturity model, which recognizes that adolescent addiction results in stalled emotional and social development (McKinnon, 2008). In the present study, youth were receiving treatment for their addiction and mental health challenges. Participants described the process of opening up to themselves and others during treatment, which allowed them to take the risks and opportunities necessary to advance their identity development. They noted a number of specific program elements that supported this process, all of which were related to their relationships with staff and other students in the program.

In their interviews, youth highlighted the central role of relationships in promoting their development. They explained how their identity development and their experiences in relationships were interconnected. For example, they shared the importance of being authentic in relationships as a way of both developing a sense of who they are and connecting with others. They mentioned the importance of being able to be vulnerable with others, empathetic, honest, accountable, and grateful, as these were all part of who they wanted to be in the context of their relationships. In this way, their identity development represents the ongoing process of constructing a sense of self through connections with others. This way of understanding identity development, as fundamentally relational, is consistent with ecological perspectives on development, which emphasize the primary role of relationships in adolescent development (Collins & Steinberg, 2006). Relational identity development also relates to Harter's focus on the developmental and sociocultural contexts through which the self is constructed (Harter, 1999, 2006, 2012). In examining the self-worth of adolescents, Harter and colleagues found a four-factor solution with negligible cross-loadings, suggesting different contributions to self-worth stemming from relationships with parents, teachers, male classmates, and female classmates (Harter, Waters, & Whitesell, 1998). They discovered that perceived support or validation for oneself as a person from those in each relational context predicted self-worth in that context. This work, along with the results of the current study, suggest that it may not be adequate to study identity development without considering relational contexts, as was done in early work on identity development (e.g., Marcia, 1967).

Youth in this study mentioned seven program elements that facilitated their identity development: process group, practicing skills, giving and accepting feedback, check-ins, DBT, being accepted within a community, and opening up to and connecting with others. During process group, youth share their emotions with their team, make requests for support, and learn how to handle conflict

constructively by working through problems with staff support. They also learn how to give both positive and negative feedback, such as telling someone how their behavior is affecting them. Youth learn how to respond to such feedback from others and begin to integrate these skills into their relationships outside of process group. Abraham and colleagues examined adolescents' perceptions of both process group and specialty group therapy and discovered that adolescents rated on-going process groups as more helpful for relating to staff and peers, and specialty groups were considered to be more helpful for cognitive, social, and interpersonal skill development (Abraham, Lovegrove-Lepisto, & Schultz, 1995).

All seven of the program elements identified by youth as important in their identity development involve relationships with other students and staff in the program. This finding is consistent with surveys of youth placed in residential care who cite relationships with staff as one of the most helpful and positive aspects of their residential experience (Anglin, 2004; Devine, 2004; Gallagher & Green, 2012; Smith, McKay, & Chakrabarti, 2004; Zimmerman, Abraham, Reddy, & Furr, 2000). The relationship components of residential treatment, whether formalized or informal, have been identified by youth clients and staff as the most helpful dimensions, with planned and/or spontaneous social interactions between staff and clients being perceived as highly valuable and important (Zimmerman et al., 2000).

Limitations

Given the highly personal nature of this research, it was important to allow youth to self-select into this study. This led to a potential sampling bias, as participants may have over-represented youth who had a positive attitude toward and who had benefitted from the program. To get a more complete picture of youths' development of self in relationships, it would be useful to interview parents and others with whom the youth have a close relationship. Given the results of the current study, it is important to explore how youth's sense of self develops in different relational contexts. Moreover, the present study had a small sample size and contained youth from one treatment program. As such, findings from this sample of youth at PRI may not generalize to other programs. It is essential to conduct similar research with other samples in other programs and in other geographic regions. It is also important to follow up on this research with a larger sample size and a mixed-methods approach. Finally, the current study was cross-sectional. Longitudinal research is needed to determine whether these

changes are sustained and to measure the underlying processes in the development of self. These limitations present important avenues for future research.

Implications for Prevention and Intervention

Several implications for prevention and intervention can be drawn from youths' perspectives of their relational identity development. This study highlights the value of using a developmental lens when studying programs to support youth who struggle with mental health challenges and addiction. An important function of interventions for struggling youth is to accelerate development in key areas, such as identity development. It is, therefore, essential to tailor interventions to enable youth to accomplish these tasks and to measure changes in identity development at various stages of the treatment process.

Youth discussed how their sense of self was relationally defined and constructed. These findings highlight the importance of training staff who work with adolescents to be attuned to the nature of youths' developmental tasks and challenges, as well as to the quality of their relationships with youth. To ensure youth are able to develop authentically within their relationships, it is essential for staff to create a positive peer culture and teach youth how to support each other's journey of change. Future research is needed to examine how specific experiences in relationships within different programs relate to the diverse range of outcomes youth achieve during these programs designed to guide them onto healthy pathways.

References

Abraham, P., Lovegrove-Lepisto, B., & Schultz, L. (1995). Adolescents' perceptions of process and specialty group therapy. *Psychotherapy, 32*, 70-76.

Anglin, J. P. (2004). Creating "well-functioning" residential care and defining its place in a system of care. *Child and Youth Care Forum, 33*(3), 175-192.

Arseth, A. K., Kroger, J., & Martinussen, M. (2009). Meta-analytic studies of identity status and the relational issues of attachment and intimacy. *Identity, 9*, 1-32.

Becht, A. I., Nelemans, S. A., Branje, S. J., Vollebergh, W. A., Koot, H. M., Denissen, J. J., & Meeus, W. H. (2016). The quest for identity in adolescence: Heterogeneity in daily identity formation and psychosocial adjustment across 5 years. *Developmental Psychology*, *52*(12), 2010.

Berman, S. L., Weems, C. F., & Petkus, V. (2009). The prevalence and incremental validity of identity problem symptoms in a high school sample. *Child Psychiatry and Human Development, 40*, 183-195. doi:10.1007/s10578-008-0117-6

Beyers, W., & Goossens, L. (2008). Dynamics of perceived parenting and identity formation in late adolescence. *Journal of Adolescence, 31,* 165-184. http://dx.doi.org/10.1016/j.adolescence.2007.04.003.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Collins, W. A., & Steinberg, L. (2006). Adolescent development in interpersonal context: Socioemotional processes. In W. Damon, & N. Eisenberg (Eds.), *Handbook of child psychology: Socioemotional processes* (Vol. 4, pp. 1003-1067). New York, NY: Wiley.

Crocetti, E., Beyers, W., & Çok, F. (2016). Shedding light on the dark side of identity: Introduction to the special issue. *Journal of adolescence*, *47*, 104-108.

Crocetti, E., Branje, S., Rubini, M., Koot, H. M., & Meeus, W. (2017). Identity processes and parent-child and sibling relationships in adolescence: A five-wave multi-informant longitudinal study. *Child development*, *88*(1), 210-228.

Crocetti, E., Garckija, R., Gabrialaviciute, I., Vosylis, R., & Zukauskiene, R. (2014). Reciprocal associations between identity and civic engagement in adolescence: A two-wave longitudinal study. *International Journal of Developmental Sciences, 8,* 115-124. http://dx.doi.org/10.3233/DEV-1400139.

Crocetti, E., Klimstra, T. A., Hale, W. W., Koot, H. M., & Meeus, W. (2013). Impact of early adolescent externalizing problem behaviors on identity development in middle to late adolescence: A prospective 7-year longitudinal study. *Journal of Youth and Adolescence*, *42*(11), 1745-1758.

Crocetti, E., Rubini, M., & Meeus, W. (2008). Capturing the dynamics of identity formation in various ethnic groups: Development and validation of a three-dimensional model. *Journal of Adolescence, 31,* 207-222. doi:10.1016/j.adolescence.2007.09.002

Devine, T. (2004). A study of ways a residential group care facility can foster resilience in adolescents who have experienced cumulative adversities. (Unpublished doctoral dissertation). Fielding Graduate Institute.

Gallagher, B., & Green, A. (2012). In, out and after care: Young adults' views on their lives, as children, in a therapeutic residential establishment. *Children and Youth Services Review, 34*(2), 437-450.

Grotevant, H. D., Thorbecke, W., & Meyer, M. L. (1982). An extension of Marcia's identity status interview into the interpersonal domain. *Journal of Youth and Adolescence*, *11*(1), 33-47.

Harter, S. (1999). *The construction of the self: A developmental perspective*. Guilford Press. Harter, S. (2006). The self. In N. Eisenberg, W. Damon, & R. Lerner's (Eds.) *Handbook of child psychology: Social, Emotional, and Personality Development* (505-570). New Jersey: Wiley.

Harter, S. (2012). *The construction of the self: Developmental and sociocultural foundations*. USA: Guilford Press.

Harter, S., Waters, P., & Whitesell, N. R. (1998). Relational self-worth: Differences in perceived worth as a person across interpersonal contexts among adolescents. *Child development*, *69*(3), 756-766.

Hernandez, L., Montgomery, M. J., & Kurtines, W. M. (2006). Identity distress and adjustment problems in at-risk adolescents. *Identity*, *6*(1), 27-33.

Josselson, R., Greenberger, E., & McConochie, D. (1977). Phenomenological aspects of psychosocial maturity in adolescence. Part II. Girls. *Journal of Youth and Adolescence*, *6*(2), 145-167.

Linehan, M. M. (1987). Dialectical behavior therapy for borderline personality disorder: Theory and method. *Bulletin of the Menninger Clinic, 51*(3), 261-276.

Loevinger, J. (1976). *Ego development: Conceptions and theories.* San Francisco, CA: Jossey-Bass.

Luyckx, K., Goossens, L., Soenens, B., Beyers, W., & Vansteenkiste, M. (2005). Identity statuses based upon four rather than two identity dimensions: Extending and refining Marcia's paradigm. *Journal of Youth and Adolescence, 34,* 605-618.

Luyckx, K., Klimstra, T. A., Duriez, B., Van Petegem, S., & Beyers, W. (2013). Personal identity processes from adolescence through the late 20s: Age trends, functionality, and depressive symptoms. *Social Development*, *22*(4), 701-721.

Luyckx, K., & Robitschek, C. (2014). Personal growth initiative and identity formation in adolescence through young adulthood: Mediating processes on the pathway to well-being. *Journal of adolescence*, *37*(7), 973-981.

Luyckx, K., Soenens, B., Vansteenkiste, M., Goossens, L., & Berzonsky, M. D. (2007). Parental psychological control and dimensions of identity formation in emerging adulthood. *Journal of Family Psychology, 21,* 546-550. doi:10.1037/0893-3200.21.3.546

Marcia, J. E. (1967). Ego identity status: Relationship to change in self-esteem, "general maladjustment," and authoritarianism. *Journal of Personality, 35*, 118-133. doi:10.1111/j.1467-6494.1967.tb01419.x

McKinnon, J. A. (2008). *An unchanged mind: The problem of immaturity in adolescence*. New York, NY: Lantern Books.

Meeus, W., Iedema, J., Maassen, G., & Engels, R. (2005). Separation-individuation revisited: On the interplay of parent-adolescent relations, identity and emotional adjustment in adolescence. *Journal of Adolescence, 28,* 89-106. doi:10.1016/j.adolescence.2004.07.003

Meeus, W., Oosterwegel, A., & Vollebergh, W. (2002). Parental and peer attachment and identity development in adolescence. *Journal of Adolescence, 25,* 93-106. doi:10.1006/jado.2001.0451

Mills, L. (2014). *Pine River Institute Annual Evaluation Summary.* Available upon request from: laura.m@pineriverinstitute.com.

Mills, L., Dubois, M., & Bingley, J. (2015). *Pine River Institute Annual Evaluation Report – January 1, 2015 – December 31, 2015.* Available from: http://pineriverinstitute.com/s/PineRiverAnnualReport-2015-2016-WebEmail-161024

Pepler, D. (2016). Stepping sideways to move forward: Closing the science-practice gap. *Canadian Psychology/Psychologie Canadienne*, *57*(1), 44-50.

Schwartz, S. J., Mason, C. A., Pantin, H., & Szapocznik, J. (2008). Effects of family functioning and identity confusion on substance use and sexual behavior in Hispanic immigrant early adolescents. *Identity: An International Journal of Theory and Research, 8*, 107-124. doi:10.1080/15283480801938440

Schwartz, S. J., Mason, C. A., Pantin, H., & Szapocznik, J. (2009). Longitudinal relationships between family functioning and identity development in Hispanic adolescents: Continuity and change. *Journal of Early Adolescence, 29,* 177-211. http://dx.doi.org/10.1177/0272431608317605

Schwartz, S. J., Zamboanga, B. L., Weisskirch, R. S., & Rodriguez, L. (2009). The relationships of personal and ethnic identity exploration to indices of adaptive and maladaptive psychosocial functioning. *International Journal of Behavioral Development, 33*, 131-144.

Smith, M., McKay, E., & Chakrabarti, M. (2004). What works for us – Boys' views of their experiences in a former list D school. *British Journal of Special Education, 31*(2), 89-94.

Syed, M., & Seiffge-Krenke, I. (2013). Personality development from adolescence to emerging adulthood: Linking trajectories of ego development to the family context and identity formation. *Journal of personality and social psychology*, *104*(2), 371.

Wiley, R. E., & Berman, S. L. (2013). Adolescent identity development and distress in a clinical sample. *Journal of Clinical Psychology, 69*(12), 1299-1304.

Zimmerman, D. P., Abraham, P. P., Reddy, L. A., & Furr, M. (2000). Adolescents' and mental health workers' perceptions of helpfulness in a residential treatment setting. *Residential Treatment for Children & Youth*, *17*(4), 55-66.

Footnotes

[1] In this manuscript, the gender of the speaker is intentionally not included to protect confidentiality at the request of the program, and the terms 'they', 'them' or 'themselves' have been adopted for this reason.

[2] The term "Process Group" is explained in detail in the next section on *Elements that Facilitate Identity Development.*

NATSAP Guiding the way
JTSP
Journal of Therapeutic Schools & Programs

PERMISSIONS AND COPYRIGHT INFORMATION FOR POTENTIAL AUTHORS

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

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

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

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

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

Questions may be directed to:

Dr. Ellen Behrens – JTSP Chief Editor
Westminster College
1840 South 1300 East
Salt Lake City, UT 84105
(801)832-2427 • ebehrens@westminstercollege.edu

Manuscript Topics

The *Journal of Therapeutic Schools and Programs* (JTSP) is published by the National Association of Therapeutic Schools and Programs and publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from residential, wilderness/outdoor behavioral healthcare, and transition treatment programs. The editors welcome manuscripts that are the original work of the author(s), have been approved by an Institutional Review Board when data was collected, and follow APA style as presented in the sixth edition of the *Publication Manual of the American Psychological Association*. Manuscripts may include, but are not limited to, case studies, topical clinical articles, literature reviews, qualitative research and empirical research. 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 required at www.natsap.org. **Author/s must submit an abstract, keywords, and author bio/s along with the manuscript.** Authors are required to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test procedure, funding provided by program) when their manuscript is submitted. Contact Dr. Ellen Behrens at ebehrens@westminstercollege.edu with questions.

Manuscript Evaluation

Submitted manuscripts will initially be reviewed and evaluated by Dr. Ellen Behrens or a Guest Editor. After the initial evaluation, manuscripts will be sent to a Review Board who will forward their recommendations to Dr. Behrens or the Guest Editor. 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. Behrens will make final decisions regarding publication status.

Manuscript Format

All manuscripts should be submitted in a form that allows blind refereeing (see *APA guidelines – 6th 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).

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
- Submit manuscripts in the following order: 1) Title Page (de-identified), 2)

Abstract (no more than 100 words) and keywords, 3) Text, 4) References, 5) Figures (Tables, Charts, Graphs).

Total manuscript length including abstract, tables, and references should ordinarily not exceed 25 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 – 6th Edition*.

Images depicting aspects of the contribution are strongly encouraged. Insertion notations for figures, tables, and images should be included in their extended 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.

Journal Management

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

Publication Ethics and Publication Malpractice Statement

It is necessary to agree upon standards of expected ethical behavior for all parties involved in the act of publishing: the author, the journal editor, the peer reviewer, and the publisher. Our ethic statements are based on COPE's Best Practice Guidelines for Journal Editors.

Publication Decisions
The editor of the journal is responsible for deciding which of the articles submitted to the journal should be published. The editor may be guided by the policies of the journal's editorial board and constrained by such legal requirements as shall then be in force regarding libel, copyright infringement, and plagiarism. The editor may confer with other editors or reviewers in making this decision.

Fair Play
An editor will at any time evaluate manuscripts for their intellectual content without regard to race, gender, sexual orientation, religious belief, ethnic origin, citizenship, or political philosophy of the authors.

Confidentiality
The editor and any editorial staff must not disclose any information about a submitted manuscript to anyone other than the corresponding author, reviewers, potential reviewers, other editorial advisers, and the publisher, as appropriate.

Disclosure and Conflicts of Interest
Unpublished materials disclosed in a submitted manuscript must not be used in an editor's own research without the express written consent of the author.

Duties of Reviewers

Contribution to Editorial Decisions
Peer review assists the editor in making editorial decisions and through the editorial communications with the author may also assist the author in improving the paper.

Promptness
Any selected referee who feels unqualified to review the research reported in a manuscript or knows that its prompt review will be impossible should notify the editor and excuse themselves from the review process.

Confidentiality
Any manuscripts received for review must be treated as confidential documents. They must not be shown to or discussed with others except as authorized by the editor.

Standards of Objectivity
Reviews should be conducted objectively. Personal criticism of the author is inappropriate. Referees should express their views clearly with supporting arguments.

Acknowledgement of Sources
Reviewers should identify relevant published work that has not been cited by the authors. Any statement that an observation, derivation, or argument had been previously reported should be accompanied by the relevant citation. A reviewer should also call to the editor's attention any substantial similarity or overlap between the manuscript under consideration and any other published paper of which they have personal knowledge.

Disclosure and Conflict of Interest

Privileged information or ideas obtained through peer review must be kept confidential and not used for personal advantage. Reviewers should not consider manuscripts in which they have conflicts of interest resulting from competitive, collaborative, or other relationships or connections with any of the authors, companies, or institutions connected to the papers.

Duties of Authors

Ethical Oversight
Authors are required to have full oversight and approval from a recognized Institutional Review Board (IRB) for any human subjects' data collected as part of a research study, whether that study be qualitative or quantitative.

Reporting Standards
Authors of reports of original research should present an accurate account of the work performed as well as an objective discussion of its significance. Underlying data should be represented accurately in the paper. A paper should contain sufficient detail and references to permit others to replicate the work. Fraudulent or knowingly inaccurate statements constitute unethical behavior and are unacceptable.

Data Access and Retention
Authors may be asked to provide the raw data in connection with a paper for editorial review and should be prepared to provide public access to such data (consistent with the ALPSP-STM Statement on Data and Databases), if practicable, and should in any event be prepared to retain such data for a reasonable time after publication.

Originality and Plagiarism
The authors should ensure that they have written entirely original works, and if the authors have used the work and/or words of others that this has been appropriately cited or quoted.

Multiple, Redundant, or Concurrent Publication
An author should not in general publish manuscripts describing essentially the same research in more than one journal or primary publication. Submitting the same manuscript to more than one journal concurrently constitutes unethical publishing behavior and is unacceptable.

Acknowledgement of Sources
Proper acknowledgment of the work of others must always be given. Authors should cite publications that have been influential in determining the nature of the reported work.

Authorship of the Paper
Authorship should be limited to those who have made a significant contribution to the conception, design, execution, or interpretation of the reported study. All those who have made significant contributions should be listed as co-authors. Where there are others who have participated in certain substantive aspects of the research project, they should be acknowledged or listed as contributors. The corresponding author should ensure that all appropriate co-authors and no inappropriate co-authors are included on the paper, and that all co-authors have

seen and approved the final version of the paper and have agreed to its submission for publication.

Disclosure and Conflicts of Interest
All authors should disclose in their manuscript any financial or other substantive conflict of interest that might be construed to influence the results or interpretation of their manuscript. All sources of financial support for the project should be disclosed.

Fundamental Errors in Published Works
When an author discovers a significant error or inaccuracy in their own published work, it is the author's obligation to promptly notify the journal editor or publisher and cooperate with the editor to retract or correct the paper.

NATSAP
Guiding the way

2019 JTSP Order Form

The National Association of Therapeutic Schools and Programs offers the following options for ordering of Volume XI of the *Journal of Therapeutic Schools and Programs (JTSP).*

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

☐Institution ($30) ☐Individual ($20) ☐Member Program Staff ($15)

2. **Multiple Copies** – *List amount desired*

☐Institution ($20) ☐Individual ($10) ☐Member Program Staff ($10)

Name (*please print clearly*): _____
Company/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____
Email: _____

Payment

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

□ Check Enclosed Total Amount:_____

□ Credit Card Number _____

Exp. Date:_____CVC: _____

Please return completed form and payment to:

- Fax (301) 986-8772
- Email - info@natsap.org
- **NATSAP,** 4350 East West Hwy, Ste 925, Bethesda, MD 20814

NATSAP
Guiding the way

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS
Member Directory Order Form

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

First/Last Name:_____
Organization:_____
Mailing Address: _____
City:_____State:_____Zip:_____
Phone:_____Email:_____

Please indicate your profession:

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

Please select your NATSAP Membership Status:

- □ *NATSAP Member (Staff of Member Program or Individual Professional)*
- □ Non-Member

Shipping and handling charges

(We ship via United States Postal Service.)

Single Copy *(Media Mail)* _____$-0- (*complimentary)*
2 directories *(Priority Mail)*_____$5.00
*3 to 15 directories (Priority Mail)*_____$10.00
16 to 30 directories (Priority Mail)_____._____$20.00
31 or more _____contact the NATSAP office

Number of Copies Requested:_____Total Shipping Charges (*see above*): $_____
*(**Media Mail:** Allow 7-10 days for delivery, **Priority Mail:** Allow 3 to 5 days for delivery)*

Payment

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

- □ Check Enclosed
- □ Credit Card Number_____Exp. Date:_____CVC: _____

Please return completed form and payment to:
Fax: (301) 986-8772 • Email: info@natsap.org

NATSAP
Guiding the way

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.

When applying to become or continue as a member of The National Association of Therapeutic Schools and Programs, the program / school Executive signs the Ethical Principles stating that *our organization supports and follows the NATSAP Ethical Principles*.

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

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

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

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

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

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

7. Aspire 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 informed, professional referrals when appropriate or if we are unable to continue service.

13. NATSAP members agree to not facilitate or practice reparative therapy.